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This guide is in three parts:

- Assessing the problem
- Making a diagnosis
- Planning management and matching evidence-based treatments to the diagnosis.

It is designed, in particular, for use by General Practitioners (GPs) and their patients.

The word depression can be used to describe a mood (sometimes normal, sometimes signalling a problem) or an illness (or disorder). It is a word that has meaning in common parlance as well as in the clinical setting. Whether we are talking about the common parlance depression, or a severe clinical depression, each may require help, be it from friends, family or professionals.

General Practitioners often work at the problem level. Disorders are diagnosed when the depression is severe or prolonged, and when there is interference with normal daily functioning. The following taxonomy acknowledges that there is a range of distress for which people come for help. General Practitioners deal with the whole range.

Murtagh’s safe diagnostic strategy can be useful here – whereby the doctor looks for the common probability diagnosis, as well as considers the less common, but serious, not to be missed diagnoses (Murtagh, 2007).

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Professor of Psychological Medicine at Monash University, Clinical Director at Southern Health, former Research Advisor at beyondblue, bbDMHP Advisory Committee
This guide is designed to aid General Practitioners in their enquiry with a patient, moving from the common-sense meaning of depression through to a diagnosis of clinical depression—a disorder. Although the distinction between normal sadness and clinical depression is often a hard one to make, perhaps it does not matter all that much. A person in distress who comes for help needs help. The question is selecting the best and most appropriate form of help.

Questions to be asked are:

1. **Is this person distressed and/or depressed (in the common sense meaning of depressed)?**
   
   A person may spontaneously admit to being depressed. Alternatively, their depression may be recognised by another person, a friend or a doctor. Common indicators are:
   
   - a change from usual mood, behaviour or demeanour
   - a sullen look, loss of sparkle in the eyes, loss of joy
   - apparent loss of interest in things, social withdrawal
   - crying or unusual moods, including irritability.

2. **How severe is this depression? (Should I be concerned?)**

   **Severity** is determined by:
   
   i. presence and severity of symptoms of depression
   ii. level of impairment of daily functioning
   iii. degree of hopelessness or suicidal thought.

Appendix 1 gives a guide to making a judgment of severity of depression. Much of this is done through the elicitation of symptoms. However, a significant contributor is also the empathic understanding of the level of sadness, hopelessness, shame and giving up—things that are often communicated non-verbally.

Enquiry of suicidal thought, and an assessment of risk, needs to be undertaken if:

   - the depression is severe
   - there is expressed feelings of helplessness or hopelessness
   - there is a pervasive [not situational] loss of enjoyment (anhedonia).

Appendix 2 summarises how to assess suicide risk.
3. **How long and how much of the time have these symptoms been present?**

   To make a diagnosis of clinical depression symptoms must be:
   
   - *persistent* – for several weeks; at least two but probably more
   - *pervasive* – present in all situations e.g. not ‘depressed at home, but happy at work’.

4. **What is the context of the depressive symptoms?**

   Ask the patient why they think they might be feeling this way, or “And what else has been going on in your life during this time?”.

   Note: although the context will guide the treatment to some extent, the absence of an identifiable specific situational context or cause does not mean that help or treatment is not available.

   Is there, or has there recently been:

   i. A bereavement
      
      - i.e. the death of someone close.
   ii. Some other acute event or loss
      
      - e.g. diagnosis of a physical illness, loss of job, loss of a relationship, a traumatic event.
   iii. Chronic stress
      
      - e.g. in family, relationship or work.
   iv. No apparent life event or chronic stress
      
      - Could there be a physical cause of the change in mood? e.g. a new medication, menopause or a recent inflammatory illness.

5. **Past history and family history**

   - Has there been any prior episode of depression?
   - Has there been anything like a manic episode in the past? [see Appendix 3 for a description of mania]
   - Is there a family history of depression, mania or non-specific mental breakdown?

6. **Co-morbidity – other accompanying problems**

   Is there a significant other problem complicating the situation that will require attention, such as:

   - an anxiety problem
   - an alcohol or drug problem
   - an active medical condition.
Before planning management or treatment of depression, a multi-level diagnosis needs to be made.

The following table provides a framework for the key elements of this.

<table>
<thead>
<tr>
<th>Multi-level diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>Severity of depression</td>
</tr>
<tr>
<td>Secondary diagnoses</td>
<td>Assessment of risk</td>
</tr>
<tr>
<td>Formulation</td>
<td></td>
</tr>
</tbody>
</table>
1. Is the primary diagnosis depression and what type of depression is it?

The ICD-10 criteria shown in Appendix 3 provide a guide to making a formal diagnosis of depression. However, we also need to consider the full range of depression types. These are illustrated in the tear-out flow chart at the back of this booklet. Consider the probability diagnoses which include stress, grief and hopelessness depression – sometimes called demoralisation – and the not-to-be-missed diagnoses such as melancholic depression and bipolar disorder. The specific characteristics of the melancholic form of depression are listed in Appendix 4. Consider also the possibility of chronic depression.

2. Are there any important secondary (co-morbid) diagnoses?

Consider especially:

- anxiety
- alcohol abuse
- personality contribution (dispositionally anxious, angry, obsessional, depressed, low self esteem, labile moods, sensitive to rejection)
- active medical condition and/or on medications.

3. Write a formulation – a paragraph answering the question “Why is this person ill in this way at this time?”

Note especially:

- nature of stressor: why is this a stressor for this person?
- personal strengths and vulnerabilities
- social networks – supports or vulnerabilities.

4. Quantify severity of depression

- Use Appendix 1 as a guide to determine mild, moderate or severe status.
- In addition, scales such as the PHQ-9, K10, DASS, SPHERE or Demoralisation Scale can be used to give a score of severity that may be compared with later measurements to monitor progress.

5. Note your assessment of risk

- See Appendix 2 for a guide.

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Part 3 | Planning management of depression

The issue of safety and place of care are important questions: Can this person be managed in primary care or do they require urgent mental health assessment or supervision (i.e. assessment by a mental health crisis team) or referral to a psychiatrist?

If able to be managed in primary care

Management will depend on:
- severity
- nature of depression (e.g. grief, stress reaction, hopelessness depression, melancholic depression) (see tear-out flow chart)
- co-morbidity – especially anxiety and alcohol abuse
- expectation – will this depression resolve naturally, albeit with support and counselling?
- patient preferences and availability of treatment options.

Interventions are generally determined not so much by the diagnosis of depression, but by the elements of the depression most strongly present. In this sense, treatment is symptomatic or problem-based. For instance, see Box 1.

Box 1: Principles of matching presentation with an appropriate therapeutic response

<table>
<thead>
<tr>
<th>If the main issue is...</th>
<th>The intervention will be...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief and loss</td>
<td>Comfort, reassurance, counselling, mobilising support</td>
</tr>
<tr>
<td>Realistic assessment of practical problems</td>
<td>Problem solving; and if the problems are insoluble, help with adjustment, re-setting of goals and expectations, strengthening social support and coping</td>
</tr>
<tr>
<td>Unrealistic evaluations (cognitive distortions)</td>
<td>Identifying and challenging dysfunctional thinking</td>
</tr>
</tbody>
</table>
Depression does not come in pure form. Often there is an element of grief (something lost that will not be regained), a problem (that requires problem solving), loss of joy (needing pleasant event scheduling) and/or cognitive distortions (requiring identifying and challenging). All patients require behavioural activation to bolster self-efficacy, reduce feelings of helplessness, increase hope and strengthen their active participation in the recovery process.

Melancholic depression (sometimes called endogenous depression) does represent a clear sub-type of depression – perhaps representing a biogenic depression, requiring medication. It is especially characterised by pervasive anhedonia (loss of pleasure), consequent loss of reactivity of mood, and physical and mental slowing (psychomotor retardation) (See Appendix 4).

Remember also to consider what has helped in the past.

**Box 2** presents a way of putting all this together and matching treatment to the type of depression/distress. Remember, all patients will benefit from (see tear-out flow chart):

- reassurance, information, explanation and problem solving
- the common factors in therapeutic counselling (empathic listening and reflecting back)
- behavioural activation, mobilisation of social support, sleep hygiene, encouragement of healthy lifestyle behaviours.

These help diminish the feelings of anxiety, helplessness and aloneness that are invariably present when people become depressed. Exercise, good sleep and nutrition will increase vigour.

At times, doctors will empathically feel the same helplessness and demoralisation felt by the patient. It is important in these circumstances that the doctor is able, after reflection, to step back and see a positive way forward, providing confidence and hope for the situation.
### Box 2: Matching depressive syndrome with intervention

<table>
<thead>
<tr>
<th>Depressive syndrome type</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grief reaction</strong></td>
<td>• Mild-moderate-severe mood disturbance</td>
</tr>
<tr>
<td></td>
<td>• Understandable as a reaction to the loss</td>
</tr>
<tr>
<td></td>
<td>Comfort, listening, reassurance, counselling, mobilising social support,</td>
</tr>
<tr>
<td></td>
<td>problem solving</td>
</tr>
<tr>
<td><strong>Stress</strong> (adjustment difficulties)</td>
<td>• Mild-moderate distress</td>
</tr>
<tr>
<td></td>
<td>• Understandable in the context of the stress (either specific events</td>
</tr>
<tr>
<td></td>
<td>or chronic stress)</td>
</tr>
<tr>
<td></td>
<td>• Expected to resolve (perhaps with help) when the stressor remits</td>
</tr>
<tr>
<td></td>
<td>Counselling, problem solving, watchful waiting.</td>
</tr>
<tr>
<td></td>
<td>If the depression/distress persists (either beyond the stress or the stress</td>
</tr>
<tr>
<td></td>
<td>persists):</td>
</tr>
<tr>
<td></td>
<td>• consider medication – particularly if melancholic symptoms are present</td>
</tr>
<tr>
<td></td>
<td>• consider cognitive therapy – particularly if cognitive distortions are</td>
</tr>
<tr>
<td></td>
<td>present.</td>
</tr>
<tr>
<td><strong>Hopelessness depression</strong> (severe</td>
<td>Moderate-severe depression marked by Beck’s ‘cognitive triad’ feelings of:</td>
</tr>
<tr>
<td>demoralisation)</td>
<td>• worthlessness (about the self)</td>
</tr>
<tr>
<td></td>
<td>• pessimism (about the world)</td>
</tr>
<tr>
<td></td>
<td>• hopelessness (about the future).</td>
</tr>
<tr>
<td></td>
<td>Cognitive therapy is most appropriate.</td>
</tr>
<tr>
<td></td>
<td>Antidepressant medication could be used either initially, or after</td>
</tr>
<tr>
<td></td>
<td>cognitive therapy is established if symptoms have not resolved fully.</td>
</tr>
<tr>
<td><strong>Melancholic depression</strong></td>
<td>Characterised by symptoms of:</td>
</tr>
<tr>
<td></td>
<td>• anhedonia (loss of joy and pleasure, non-reactive mood)</td>
</tr>
<tr>
<td></td>
<td>• physical slowing, not eating</td>
</tr>
<tr>
<td></td>
<td>• cognitive slowing.</td>
</tr>
<tr>
<td></td>
<td>Antidepressant medication is indicated.</td>
</tr>
<tr>
<td></td>
<td>Some form of psychotherapy (cognitive, interpersonal or brief dynamic</td>
</tr>
<tr>
<td></td>
<td>therapy) is useful once the medication has begun to have an effect.</td>
</tr>
<tr>
<td>If <strong>anxiety</strong> is prominent:</td>
<td>specific treatment for anxiety is required, such as:</td>
</tr>
<tr>
<td></td>
<td>• cognitive therapy</td>
</tr>
<tr>
<td></td>
<td>• relaxation and stress reduction</td>
</tr>
<tr>
<td></td>
<td>• exposure – facing the fears</td>
</tr>
<tr>
<td></td>
<td>• antidepressants may also help reduce anxiety and the frequency of panic</td>
</tr>
<tr>
<td></td>
<td>attacks.</td>
</tr>
<tr>
<td>Depressive syndrome type</td>
<td>Intervention</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
</tbody>
</table>
| If excessive **alcohol use** is present: | • specific attention to alcohol abuse is required  
  (The AUDIT questionnaire may assist evaluating the degree of any alcohol problems)  
  • goals of management depend on level of use:  
    - Hazardous drinker ➤ controlled drinking  
    - Dependent drinker ➤ abstinence  
    - Recalcitrant drinker ➤ harm minimisation  
  • assess motivation for change, reinforce safe drinking behaviour. |
| If active **physical disease, injury or illness** is present: | • maximise control of the physical disease and associated symptoms  
  • use principles of Chronic Disease Self Management to strengthen the patient’s sense of control over their illness and to reduce helplessness  
  • although there are some drug interactions to consider, in general the same pharmacological, behavioural and psychological treatments are effective for depression in the context of physical illness. |
| **Chronic depression**  
Enduring personality traits and poor quality relationships are often important maintaining factors in depression. | A combination of helps and supports are required to minimise disability and distress, such as:  
• supportive counselling – regular appointments plus help when necessary  
• controlling stress, strengthening coping behaviours  
• maintenance on antidepressant medication. |
Now, on the basis of the clinical assessment from pages 8 and 9 and treatment considerations, write a Mental Health Management Plan.

### The Mental Health Management Plan

<table>
<thead>
<tr>
<th></th>
<th>What?</th>
<th>When?</th>
<th>By whom?</th>
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</thead>
<tbody>
<tr>
<td><strong>Further investigation required:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Pathology tests</td>
<td></td>
<td></td>
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<tr>
<td>• Mental Health Assessment</td>
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<tr>
<td><strong>Need for information</strong></td>
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<td></td>
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<tr>
<td><strong>Behavioural advice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific counselling or psychotherapy:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Grief counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Problem solving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cognitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interpersonal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social supports</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Medication</strong></td>
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<tr>
<td><strong>Referral</strong></td>
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<tr>
<td><strong>Clinical review</strong></td>
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</tbody>
</table>

On the basis of this management plan, treatment can be instituted. The notes and resources that follow give more specific evidence-based guidance, on a range of management issues.
Screening
Screening all patients by asking two questions about mood (feeling down, depressed or hopeless) and anhedonia (little interest or pleasure in doing things) is useful as a routine procedure for at-risk patients and, if done, should be followed up by a diagnostic assessment and management as appropriate (ICSI, 2008).

Watchful waiting
Watchful waiting acknowledges that some depressions will get better without specific intervention. In mild depression, a wait and see approach in regard to medication is reasonable – though information and behavioural interventions should be given, and a further assessment arranged within two weeks (NICE, 2004).

Information and guided self-help
Giving information about depression, the particular type of depression, what causes it and what can help, will assist a person gain a sense of coping and competency, and reduce the distress and helplessness. Furthermore, it aids the therapeutic alliance (NICE, 2004; ICSI, 2008; Ellis & Smith, 2002). In addition, resources are available that teach people the principles of CBT, problem solving and writing a journal, which all help (see resource list on page 14).

Relaxation and stress reduction
Relaxation and stress reduction techniques include progressive muscle relaxation, breathing exercises and mental imagery. These are helpful in reducing tension, worry and anxiety (Jorm et al, 2001).

Sleep hygiene
Good sleep habits include the following:
- establish a proper sleep environment
- go to bed only to sleep, not to study or watch television
- take regular physical exercise in the late afternoon or early evening
- allow a wind-down time before bedtime
- avoid alcohol, caffeine or nicotine
- go to bed only when you are sleepy
- have a light snack or warm milk before going to bed
- if you do not fall asleep within 15 minutes get up and go to another room and stay up until you are sleepy
- get up regularly at the same time each morning (Treatment Protocol Project, 1997).

Behavioural activation
Behavioural activation refers to the ‘B’ component of CBT. It includes:
- monitoring of daily activities
• assessment of pleasure and mastery associated with engaging in various activities
• scheduling of activities that engender pleasure and/or a sense of mastery
• cognitive rehearsal of scheduled activities to identify obstacles
• interventions to ameliorate deficits in social skills (e.g. communication skills, assertiveness).

Behavioural activation is effective in the treatment of depression [Jacobsen et al, 1996].

**Exercise and lifestyle**
Physical exercise, three times per week of at least 45 minutes, is helpful in promoting wellbeing and lifting mood. As in any behaviour (see behavioural activation) anticipating barriers and introducing a feasible plan is important [NICE, 2004; ICSI, 2008].

**Exposure therapy**
Exposure is part of behavioural activation. It is important that people face their fears to reverse the avoidance and withdrawal behaviour that is common in depression and anxiety. Exposure can be accompanied by relaxation to reduce anxiety and arousal, and cognitive rehearsal to identify possible barriers or difficulties. Exposure should be done determinedly, but with preparation [Andrews et al, 1994].

**Therapeutic counselling**
Problem-solving counselling is a useful intervention for many depressions presenting in primary care. It helps the patient resolve the problem, but also strengthens their sense of competency and self-efficacy [NICE, 2004; ICSI, 2008].

Grief counselling is used when there is an acute loss (e.g. of relationship or job). It involves talking over the situation to try and make sense of it, showing empathic support and allowing emotional expression [Worden, 2001].

**Psychotherapy**
Psychotherapy can be used alone (without medication) for mild or moderate depression, depending on patient preference. Treatment should be given for 12 weeks in the first instance. Partial response should be expected within four to six weeks and full remission within 10 to 12 weeks [AHCPR, 1993]. Antidepressant medication is required for severe depression or when recovery with psychotherapy is incomplete (i.e. when depressive symptoms persist).

Cognitive therapy focuses particularly on the cognitions that lie behind the emotional state and is particularly appropriate for people expressing depressed cognitions – pointlessness, hopelessness, unworthiness and pessimism. Combined with behavioural activation it is referred to as cognitive behaviour therapy (CBT).

Interpersonal therapy is a short-term therapy focusing on the interpersonal issues associated with grief and loss, role transition (e.g. retirement) and role disputes. CBT and brief interpersonal or dynamic psychotherapies are effective in the treatment of depression [NICE, 2004; ICSI, 2008].
Antidepressants

Antidepressants are indicated for adults with moderate to severe depression, when there is evidence of melancholic depression (with anhedonia, psychomotor retardation), when counselling or psychotherapy has not been totally effective, or when the past history of the person suggests their depression is usually responsive to medication.

Patients should be reviewed weekly until significant response is achieved to ensure engagement in treatment and to address side-effects (ICSI, 2008). Once begun, medication dose should be increased, changed or augmented if there is no partial response by four to six weeks or full remission by 10 to 12 weeks. Specialist psychiatric advice is appropriate when changing or combining drugs.

Antidepressants should be continued for at least four to nine months after depressive symptoms have remitted. Patients who have two or more episodes in a five-year period may be considered for continuing maintenance antidepressant therapy (AHCPR, 1993). Some form of psychological therapy, in addition to medication, will improve recovery and reduce relapse. For adolescents with depression, antidepressants can be used if indicated but, because of safety concerns, are not considered first-line treatment (beyondblue 2010).

Collaborative care

The term collaborative care is used to describe a systematic multidisciplinary approach to patient care. Using a care manager, who is frequently a nurse or psychologist, it facilitates communication between the primary and secondary health care systems and the patient. While not adding any active therapeutic ingredient, it facilitates optimal care through better communication and collaborations, and more active monitoring and follow-up. Early research of collaborative care models suggest that they do produce short- and long-term benefits in patient outcomes (Gilbody et al. 2006).
Resources to give to patients

*beyondblue* provides resources on depression and anxiety, free of charge, to the Australian community. We have an extensive catalogue of resources for the people who experience depression and anxiety, their partners, family and friends, and for health professionals who work in mental health.

**Depression and anxiety: An information booklet**

This 60-page information booklet aims to provide clear and comprehensive information about depression and anxiety, including what the conditions are, common symptoms and how to recognise them, how to get help for yourself or for someone you know, and how to stay well.

**A guide to what works for depression booklet**

This is a comprehensive review of all known treatments for depression – including medical, psychological, complementary and lifestyle interventions.

**Getting help – How much does it cost? fact sheet**

The cost of getting treatment for depression, anxiety or a related disorder from a health professional varies. This fact sheet looks at the government rebates available to help pay part of the cost of psychological treatments.

Visit [www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources) or call the *beyondblue* support service on 1300 22 4636 to download or order these and other resources.

**Beating the blues: A self help approach to overcoming depression**

By Susan Tanner and Jillian Ball

Based on cognitive behaviour therapy (CBT), this book takes readers through a step-by-step therapy program for overcoming both low moods and more serious depression.

**Blue Pages**


Provides information on treatments for depression, screening tests for depression and anxiety, a depression search engine, and links to other helpful resources.
Resources for General Practitioners


Davies, J (2003). *A Manual of Mental Health Care in General Practice*. Canberra: Commonwealth Department of Health and Ageing. Written specifically for General Practitioners, this is a comprehensive guide to treatments and diagnosis of mental illness.


Clinical Practice Guidelines

*beyondblue* has led the development of NHMRC-approved Clinical Practice Guidelines for the treatment of depression in pregnant women, mothers and young people. The *beyondblue* Clinical Practice Guidelines draw on the latest high quality research evidence to provide Recommendations and Good Practice Points that can be used to identify, treat and manage depression, anxiety and related disorders.

- Clinical practice guidelines: Depression in adolescents and young adults
- Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals

*beyondblue* has also produced several companion documents to support the Clinical Practice Guidelines. To download the Clinical Practice Guidelines and companion documents visit www.beyondblue.org.au/resources or call the *beyondblue* support service on 1300 22 4636.
## Assessing the severity of depression

<table>
<thead>
<tr>
<th>Symptom cluster</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mood</strong></td>
<td>• Lowered mood</td>
<td>• Reduced pleasure in things</td>
<td>• No pleasure in things</td>
</tr>
<tr>
<td></td>
<td>• Reduced joy</td>
<td>• Reduced interest in things</td>
<td>• No interest in things</td>
</tr>
<tr>
<td></td>
<td>• Crying</td>
<td>• Reduced reactivity of mood</td>
<td>• No reactivity of mood</td>
</tr>
<tr>
<td></td>
<td>• Anxiety</td>
<td>• Reduced interest in things</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Irritability</td>
<td>• Reduced reactivity of mood</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Depressive thought</strong></td>
<td>• Loss of confidence</td>
<td>• Feeling worthless or a failure</td>
<td>• Hopeless, see no future</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pessimism about things generally</td>
<td>• Self-reproach, guilt, shame</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Consider illness a punishment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Paranoid or nihilistic delusions</td>
</tr>
<tr>
<td><strong>Cognition</strong></td>
<td>• Minor forgetfulness or lack of concentration</td>
<td>• Indecisiveness</td>
<td>• Unable to make decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Forgetfulness</td>
<td>• Slowed thinking, seems cognitively impaired</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(pseudodementia)</td>
</tr>
<tr>
<td>Symptom cluster</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
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| **Somatic**     | - Low drive  
- Loss of interest in food  
- Lowered libido  
- Mild initial insomnia; wake one to two times a night |
|                 | - Low energy, drive  
- Eat with encouragement; mild weight loss  
- Loss of libido  
- Initial insomnia, wake several times a night |
|                 | - No energy, drive  
- Unable to eat; severe weight loss  
- No libido  
- Psychomotor retardation or agitation  
- Sleep only a few hours |
| **Social**      | - Mild social withdrawal |
|                 | - Apathy and social withdrawal  
- Work impairment |
|                 | - Apathy and social withdrawal  
- Marked work impairment  
- Poor self-care |
| **Suicidality** | - Life not enjoyable  
- Helplessness |
|                 | - Hopelessness  
- Life not worth living  
- Thoughts of death or suicide |
|                 | - Evidence of intent to suicide (plans, attempts) |
A guide to undertaking a suicide risk assessment

Suicide risk assessment can be considered in three hierarchical steps.

1. The risk of suicide is related in the first place to the severity of depression (see Appendix 1) and, in particular, to the degree of:
   • anhedonia – the loss of ability to experience pleasure
   • persistent helplessness and resulting hopelessness
   • shame and/or guilt.

2. If any of these are evident, other demographic and situational factors become important:
   • male
   • divorced
   • living alone
   • concomitant physical illness
   • heavy alcohol use.

3. If there is concern, questions about suicide should be asked in a graded order, such as illustrated here:
   a. Have you felt at times like giving up, that life is not worth living? How often have you felt that way?
   b. Have you contemplated death or thought about killing yourself? How often have you had those thoughts?
   c. Have you thought about how you might kill yourself if you were to do that? (Think about access to means in the answer to this question)
   d. What has stopped you?
   e. Do you feel you are likely to suicide now?
   f. Have you ever actually tried to suicide (either recently or in the past)?
Appendix 3

ICD-10\(^1\) description of mania (manic episode)

Mood is elevated out of keeping with the individual’s circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech and a decreased need for sleep. Normal social inhibitions are lost, attention cannot be sustained and there is often marked distractibility. Self-esteem is inflated and grandiose or over-optimistic ideas are freely expressed. Perceptual disorders may occur, such as the appreciation of colours as especially vivid (and usually beautiful), a preoccupation with fine details of surfaces or textures and subjective hyperacusis. The individual may embark on extravagant and impractical schemes, spend money recklessly or become aggressive, amorous or facetious in inappropriate circumstances. In some manic episodes, the mood is irritable and suspicious rather than elated.

ICD-10\(^1\) description of a depressive episode

In typical depressive episodes, the individual suffers from:

1. depressed mood
2. loss of interest and enjoyment
3. reduced energy leading to increased fatiguability and diminished activity.

Other common symptoms are:

4. reduced concentration and attention
5. reduced self-esteem and self-confidence
6. ideas of guilt and unworthiness
7. bleak and pessimistic views of the future
8. ideas or acts of self-harm or suicide
9. disturbed sleep
10. diminished appetite.

In ICD-10\(^1\), a mild depressive episode requires the presence of at least four symptoms, including at least one of one to three; a moderate depressive episode requires six or seven symptoms; a severe depressive episode is defined by the presence of at least eight symptoms.

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Appendix 4

Symptoms of the melancholic sub-type (ICD-10\(^1\) somatic syndrome)

- Marked loss of interest or pleasure
- Loss of emotional reactivity
- Waking early in the morning, two hours before usual time
- The feeling of depression is worse in the morning
- Evident psychomotor retardation of agitation
- Marked loss of appetite
- Significant weight loss (5 per cent or more in the past month)
- Loss of libido

A formal diagnosis of somatic syndrome in ICD-10\(^1\) requires four or more of the above.


Depression is categorised by:
- symptom type
- context (stressor, no stressor, bereavement)
- severity
- duration.

Distress / Depression symptoms

Depressive reaction

Anxiety
Stressed and worried

Hopelessness depression
Can't cope, despairing, demoralised, given up

Grief/Loss
Normal (feelings of loss, pangs of grief, pining)

Grief/Loss
Complicated (feelings of loss, pangs of grief, pining)

Anxious depression
Mixed anxiety and depression

Melancholic depression
Unipolar/bipolar depression
Anhedonia, absence of joy, no interest or drive, slowed up

Chronic depression
Chronic sadness or misery
Recurrent depressive episodes

Treatment is determined by:
- the way we understand the depression (type, context)
- severity
- preferences for treatment
- availability of resources.

Information, mobilising support, self-help, behavioural activation

Grief counselling / Problem solving therapy

Cognitive, interpersonal or dynamic psychotherapy

Medication

Psychiatrist advice

Collaborative care
Hope. Recovery. Resilience. Find out more at www.beyondblue.org.au
Where to find more information

beyondblue
www.beyondblue.org.au
Learn more about anxiety, depression and suicide prevention, or talk through your concerns with our Support Service. Our trained mental health professionals will listen, provide information, advice and brief counselling, and point you in the right direction so you can seek further support.

1300 22 4636
Email or chat to us online at www.beyondblue.org.au/getsupport

Lifeline
www.lifeline.org.au
13 11 14
Access to crisis support, suicide prevention and mental health support services.

Head to Health
headtohealth.gov.au
Head to Health can help you find free and low-cost, trusted online and phone mental health resources.

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