

Introduction to the Black Dog Institute Model

Our Hierarchical Model

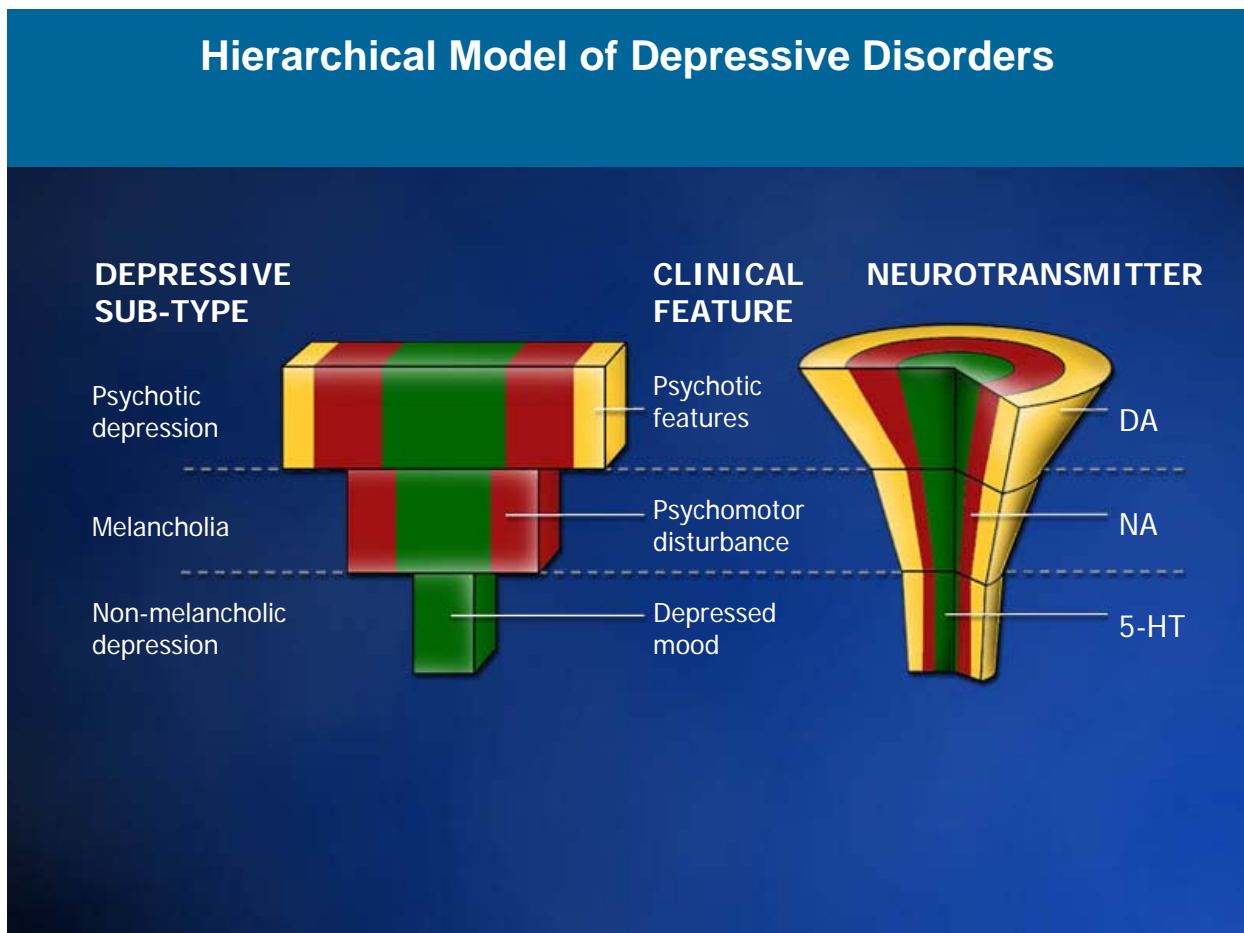
The North American DSM-IV classification system views depression as a single entity and differentiates conditions based on severity and duration. (Major depression – severe and present for more than two weeks; dysthymia – moderate and present for more than 2 years).

The Black Dog Institute believes this severity-based approach is unhelpful both in theory and practice (and is rarely used in other disciplines!). An alternative hierarchical model has been developed at the Institute that assumes there are three subtypes. There are 2 distinct categories of essentially biological conditions (melancholic and psychotic depression) which have identifiable defining features, and a residual group of quite varying conditions (non-melancholic depression). This last is therefore associated with varying presentations reflecting the contribution of life event stressors and personality style.

In all three groups there is a mood disorder component, the key features of which include a depressed mood, decline in self esteem, and self-criticism, with the mood state present for at least 2 weeks and cause social impairment.

The key feature which defines melancholic depression is observable psychomotor disturbance (PMD) – i.e. retardation and/or agitation together with a cognitive processing difficulty.

In psychotic depression, the PMD is generally more severe and combined with psychotic features such as delusions, hallucinations and/or over-valued ideas.



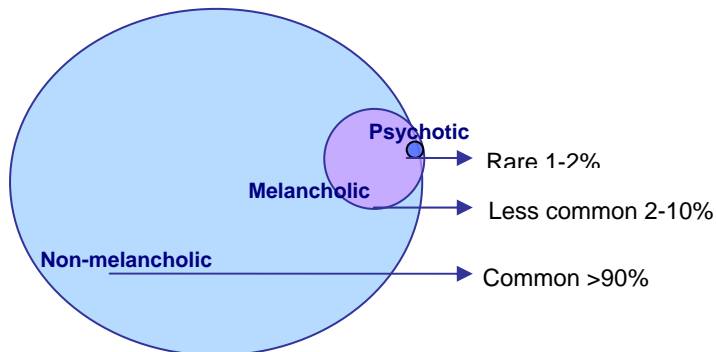
Based on research and clinical findings of response to treatment we suggest that the non-melancholic depressions are principally underpinned by serotonergic dysfunction (affecting sleep, appetite, anxiety, irritability, and mood). For the specific features (such as psychomotor change) evident in melancholic depression and the psychotic features in psychotic depression, there are additional noradrenergic and dopaminergic contributions respectively.



An understanding of this model helps to make logical and appropriate treatment decisions.

Depressive Disorders in General Practice

The following diagram represents the prevalence of each type of depressive disorder generally seen in general practice.



Sub-typing algorithm

| | | |
|---|---|--|
| Is the patient depressed? | ⇒ | Pursue depressed mood, self-criticism and loss of self-esteem |
| Does the patient have clinical depression? | ⇒ | Pursue severity and duration of symptoms, and impaired functioning |
| Does the patient have psychotic depression? | ⇒ | Pursue psychotic features (e.g. delusions, over-valued ideas of guilt) Is there severe PMD? |
| Does the patient have melancholic depression? | ⇒ | In addition to severely depressed mood, PMD should be evident |
| Does the patient have a non-melancholic depression? | ⇒ | No psychotic features or PMD and should not have a bipolar history |



Useful References

Parker, G (2004), **Dealing with Depression: A Common Sense Guide to Mood Disorders**. (Second Edition) Allen & Unwin. *A comprehensive overview of depression from an Australian perspective.*

Parker, G (2002), **The Depressions**. Australian Doctor (25th October 2002) *provides a summary of the BDI approach to depression types and management approaches.*