



Assessment and Management Tips for Depression Types in General Practice

Presentation, suicide risk and counselling issues

Depression Type?	How Common?	Suicide Risk?	Areas for counselling*?
Non-Melancholic Depression as a Response to Situation			
Acute stress related	Common	Low, but depends on previous coping history.	Supportive Counselling, Problem Solving
Chronic Stress related	Fairly common	Low, unless feeling helpless, trapped.	Problem Solving, IPT, CBT, Solution Focussed Therapy
Non-Melancholic Depression Reflecting Personality Vulnerability			
Anxious worrying	Common, esp in women. May present with health concerns, 'stress', worrying. (Reflects internalised high trait anxiety)	Can be at risk after interpersonal difficulties	Anxiety and Stress Management, Mindfulness can be very helpful in short term and to promote coping, problem solving,
Irritable	Common, Often raised by family and friends rather than patient. (Reflects externalised high trait anxiety)	In externalising, may use alcohol and substances when under stress (which increase risk and impulsivity).	Short term, structured interventions: communication, anger management, relaxation techniques, develop social network. Physical activity.
Social avoidance & Personal reserve	Both fairly common, reflecting shy people and those who don't open up to others	Can be at risk after interpersonal difficulties. (particularly distressed if exploited or ignored)	Assess priorities, encourage action. IPT and especially assertiveness training are useful.
Perfectionistic	Less common, more evident as feature of patient's personal style	Vulnerable when loss of control in life, or devaluing of their work.	Problem Solving, other structured techniques may help Therapeutic alliance crucial.
Sensitivity to rejection	Fairly common	At risk with relationship break-ups, or threatened break-ups.	CBT, communication skills, mindfulness, IPT
Self-critical	Fairly common, reflecting on-going low self-esteem	At risk with increased criticism.	CBT, communication skills, self-esteem building activities.
Self-focussed	Less common but can cause a lot of anxiety for clinician	Related to mood and feelings of powerlessness, increase in frustration about unmet needs	Anger management, appropriate assertion skills, exercise, psychotherapy [CBT, IPT]
Episodic Depression with Psychomotor Change			
Melancholic	Rare in young, except when bipolar or stimulant abuse. More common over 50.	High. Those with good social skills may hide their despair well.	Educate person and family. Treat mood first, then review for possible stressors.
Psychotic Melancholic	Rare in young, except when bipolar or stimulant abuse. More common over 60.	Very high Suspect psychotic thinking in those who are highly agitated.	Educate person and family. Treat mood first, then review. There can be a 'kernel of truth' in delusional thoughts
Bipolar	Not common but may be on the increase. Important to recognise and plan long term	Very high, especially for psychotic or post-manic episodes. Substance and alcohol abuse increases risk to self and others.	Education for person and family. Mood chart helpful. Develop Wellbeing Plan – attention to relapse prevention and crisis management. CBT etc if indicated

Refer to Psychological Tool Kit for relevant depression information sheets for patient and family, 'Identifying Priorities', mood charts, goal setting and problem solving sheets and other short term strategies. Material in the depression section can assist planning and relapse prevention.



Medication issues and other comments

Depression Type?	Will Antidepressants* Help?	Comments
Non-Melancholic Depression as a Response to Situations		
Acute stress related	Not usually required.	Important to identify triggers and issues to work through. Displays acute symptoms of depression and anxiety.
Chronic Stress related	May assist by reducing chronic worrying.	Aim to increase personal effectiveness. Identify levers that can promote change.
Non-Melancholic Depression Reflecting Personality Vulnerability		
Anxious worrying	SSRIs, other newer antidepressants may assist chronic worrying, can elevate low mood and modulate mood.	Check the understandability of patient's concerns. CBT and IPT can also be helpful.
Irritable	SSRIs and other newer antidepressants may modulate mood for some. (Be aware may be 'self-medicating' with alcohol and street drugs)	CBT and IPT helpful if insightful and motivated.
Social avoidance & Personal Reserve	SSRIs and other newer antidepressants can modulate mood, but not commonly effective.	Need to change interpersonal style, enhance social network (eg IPT)
Perfectionistic	Antidepressants not helpful unless marked dip in mood.	Play to strengths: organise structure in treatment plan. Sense of loss of control may occur with relaxation exercises
Sensitivity to rejection	SSRIs may help anxiety/panic attacks. Tends to engage in self-consoling behaviours, may abuse alcohol, BZDs.	Fears abandonment/ base's worth on others' perceptions. Needs to establish good therapeutic alliance.
Self-critical	Not sole treatment: may assist psychotherapy	Requires longer term approach to boosting self-esteem if person motivated to change.
Self-focussed	Antidepressants and mood stabilisers may (rarely) assist, but benefits need to be weighed against problems of deliberate self harm.	Mellow with age (after 30), goal of harm minimisation (esp. DSH and drug abuse), ie, strategies to challenge basis for frustration and/or to more constructively vent their frustrations. CBT, DBT, mindfulness helpful.
Episodic Depressions with Psychomotor Change		
Melancholic	Antidepressants - may require SNRIs, TCAs, MAOIs, augmentation strategies (as only small %age respond to SSRI). Some may require ECT for significant psychomotor change or poor response to antidepressants. Consult prior to ceasing medication.	Sometimes need to persist with several antidepressants to affect improvement. May require psychiatric consultation, especially re long term planning. Review regularly (say 6-monthly) when well to prevent recurrence.
Psychotic Melancholic	Antidepressants, (ideally 'broad spectrum') and antipsychotic as well. Consult prior to ceasing medication. ECT effective for psychomotor change and delusions.	Will require psychiatric consultation to prevent relapse and recurrence. Review regularly (say 6-monthly) when well to prevent recurrence.
Bipolar	Antidepressants and mood stabilisers essential. May require antipsychotic. Consult prior to changing medication.	Develop Wellbeing Plan. Attention to therapeutic alliance, relapse prevention and strategies, regular review. Team approach to management with psychiatrist, GP and patient.

Material on medication dosage and management of effects will assist.