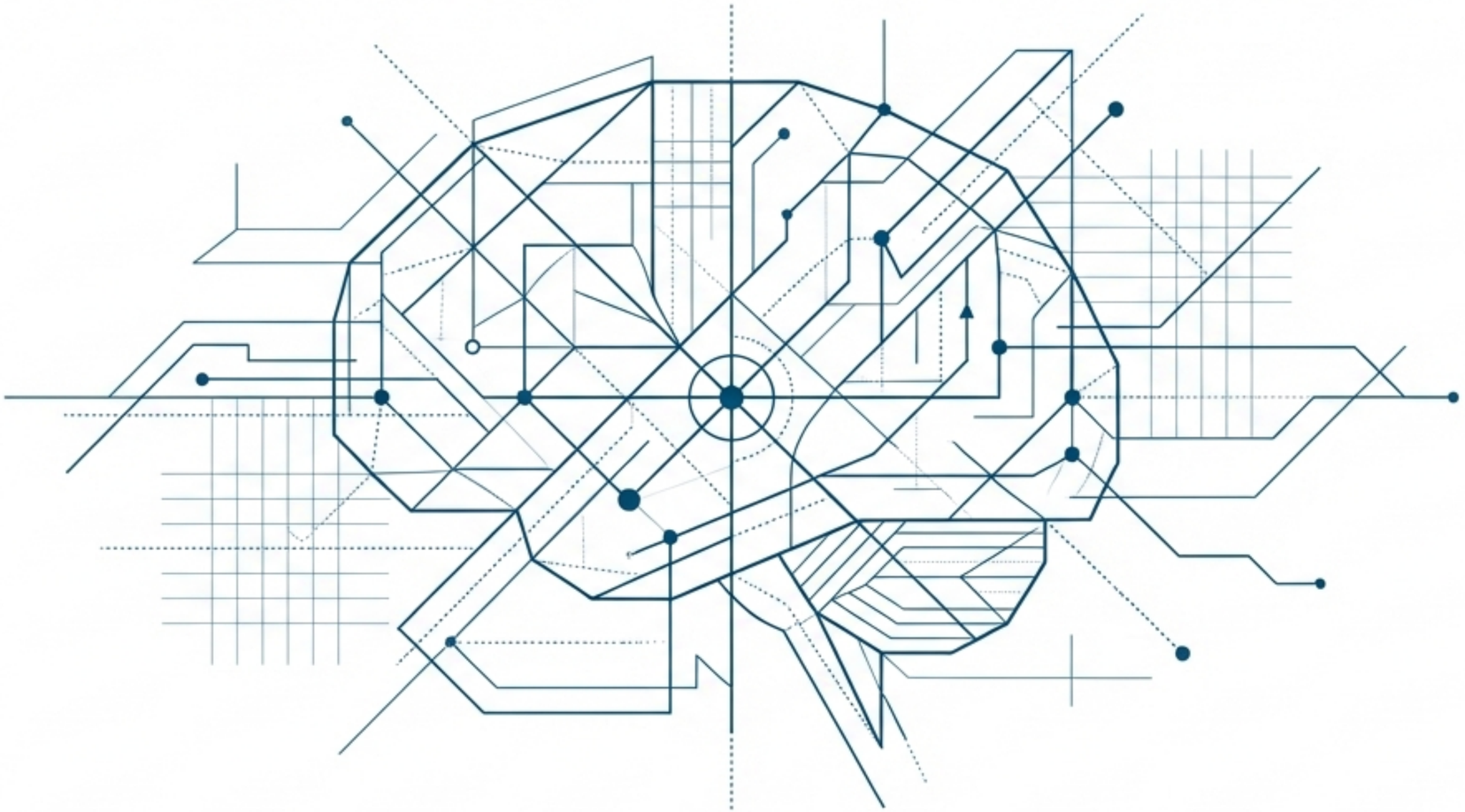


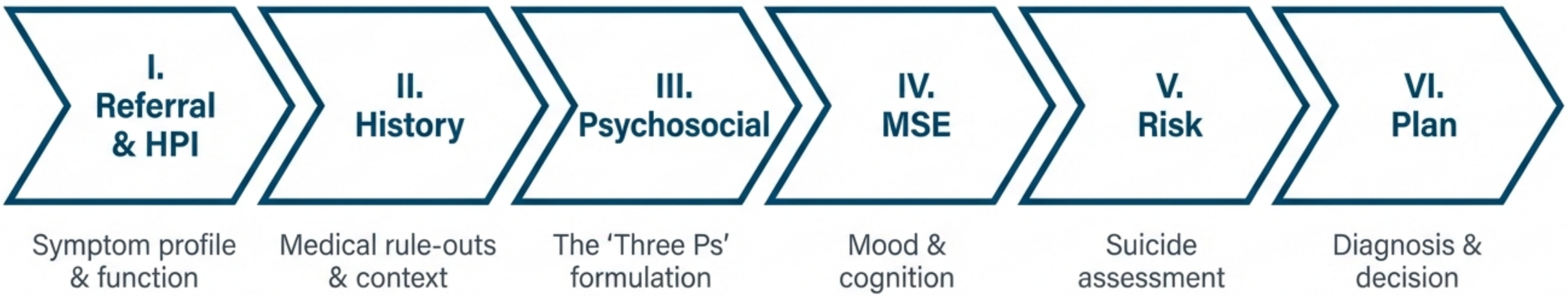
# The Anatomy of Depression Assessment

## A Clinical Protocol for Diagnosis, Formulation, and Management

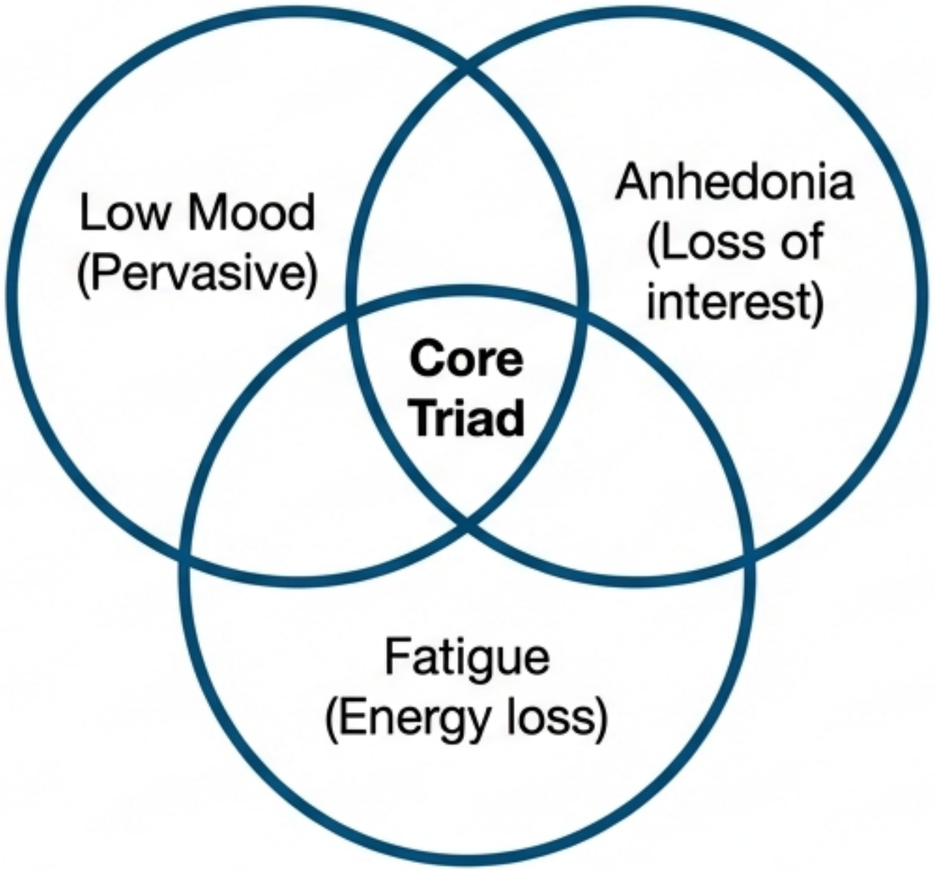
Clinical Reference Guide | Professional Education Series

# A comprehensive record is a narrative of distress, not a checklist

The goal of this protocol is to move beyond simple symptom counting to a holistic diagnostic formulation that informs a Shared Decision management plan.



# Establishing the baseline symptom profile




Duration requirement: ≥ 2 weeks

## The Spectrum of Distress

- Emotional
- Cognitive
- Behavioral
- Somatic (Physical complaints)

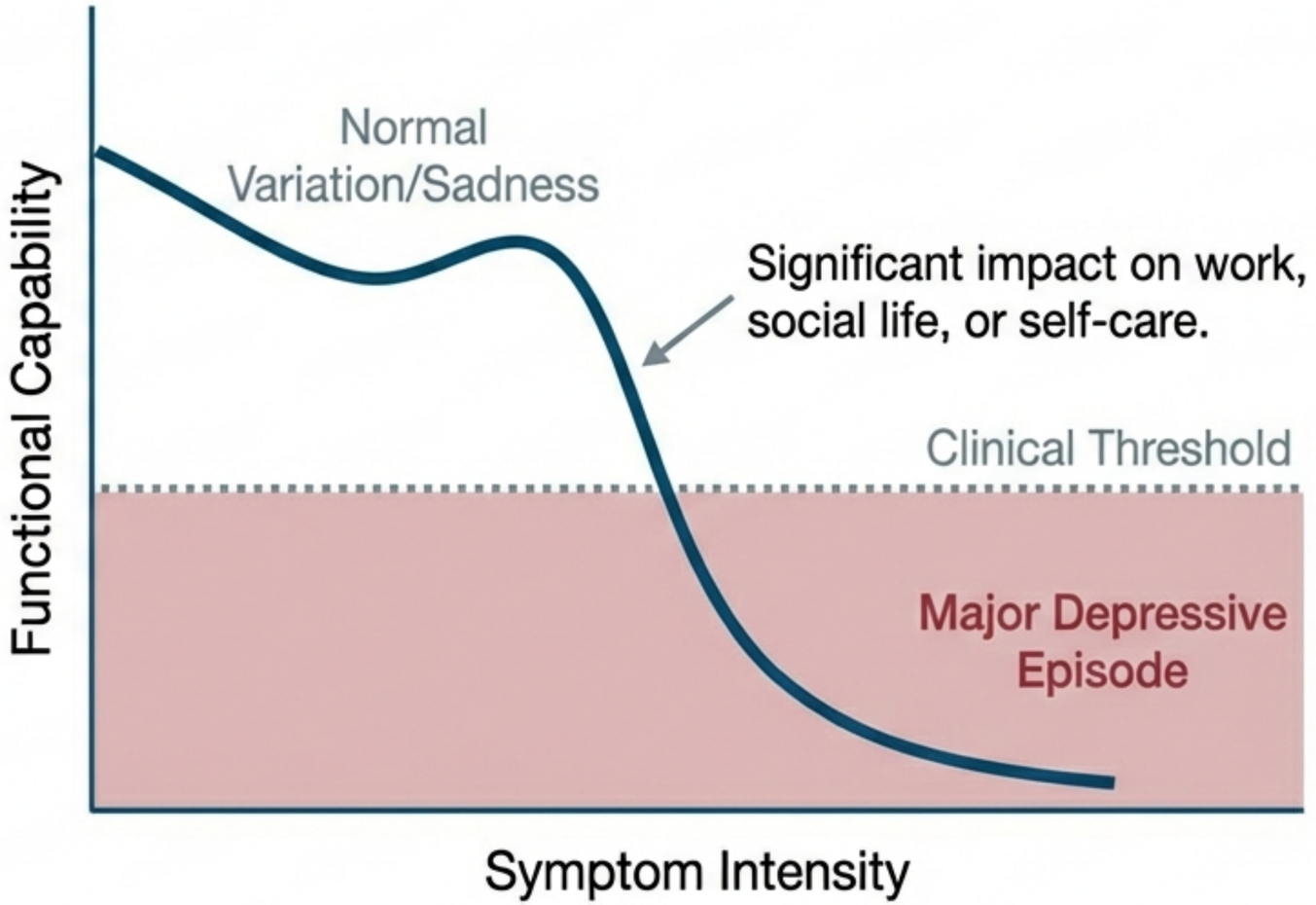
### Clinical Pearl

Cultural expressions of distress vary widely. Be alert for religious themes or strictly somatic presentations (e.g., pain, gastrointestinal issues) that mask emotional pain.

# Functional impairment distinguishes disorder from variation

The presence of symptoms alone is insufficient for diagnosis. The record must document the specific impact on social and occupational functioning.

This assesses the threshold between normal mood variation and clinical depression.



# Constructing the medical and psychiatric backdrop

## The Rule of Comorbidity

**67%**

Anxiety Disorders

**25%**

Substance Use Disorders

## Medical Rule-Outs

- ☑ Complete Blood Count (CBC) - Rule out Anemia
- ☑ Thyroid Stimulating Hormone (TSH) - Rule out Hypothyroidism
- ☑ Medication Review - Identify depressogenic drugs

## Prior History

Evaluate previous trials for:

- Specific agent & dose
- Duration & compliance
- Side effect profile

# The ‘Three Ps’ framework connects life events to pathology

| 1. Predisposing | 2. Precipitating | 3. Perpetuating |
| --- | --- | --- |
| Historical vulnerabilities.<br>• Family history, early childhood trauma, genetics. | The “Why Now?” trigger.<br>• Bereavement, job loss, financial crisis, acute illness. | Maintenance factors.<br>• Ongoing conflict, isolation, lack of social support, unemployment. |

## Personality Factors

Assess for Neuroticism or Low Self-Directedness. These traits predict treatment response and influence the therapeutic alliance.

# The Mental Status Examination: From reporting to observation

## Core Observations


**Mood:** Pervasive inner tone

**Affect:** Outward reactivity

**Thought Content:** Assessment for guilt, worthlessness, and helplessness.

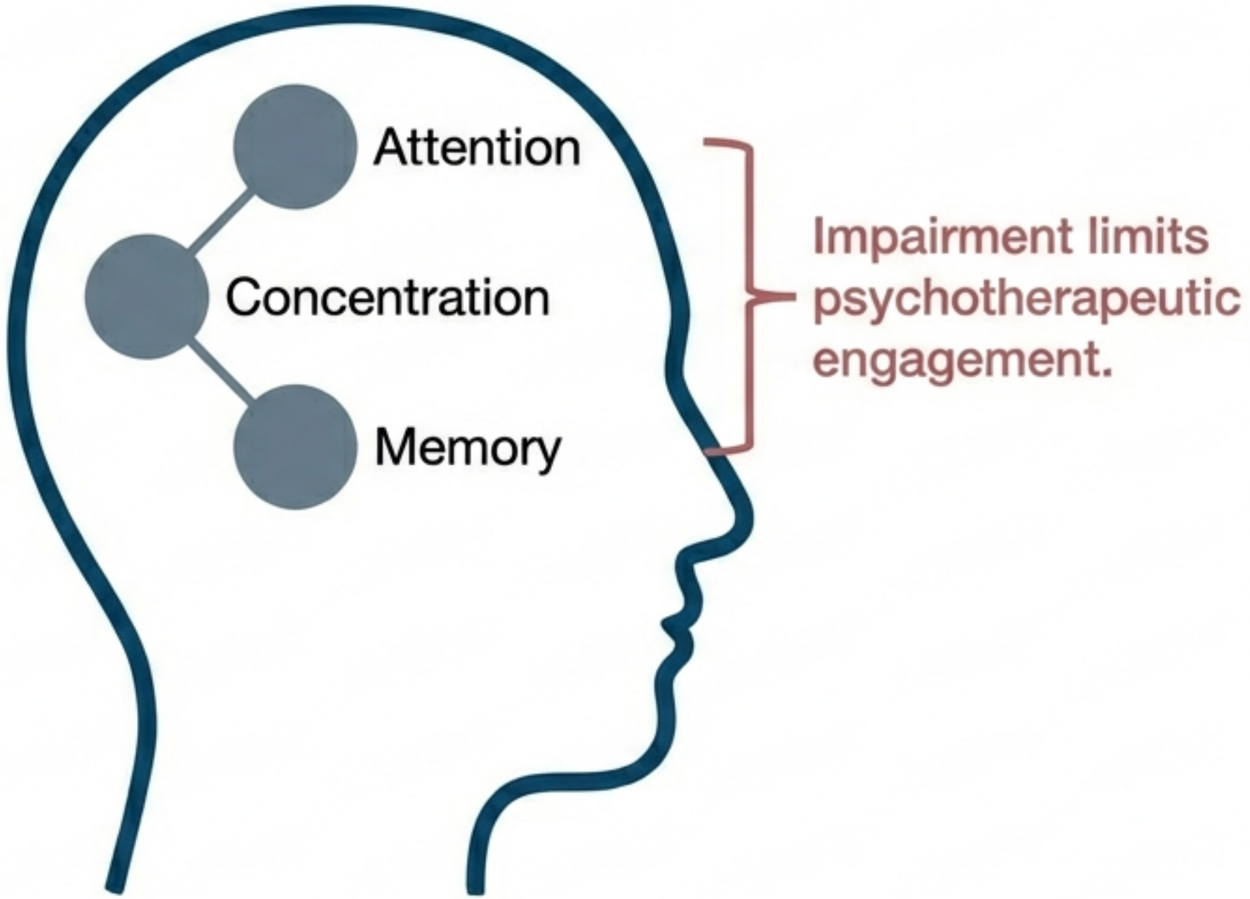
## Red Flag Specifiers

**Psychosis:** Screen for delusions (fixed false beliefs) or hallucinations.

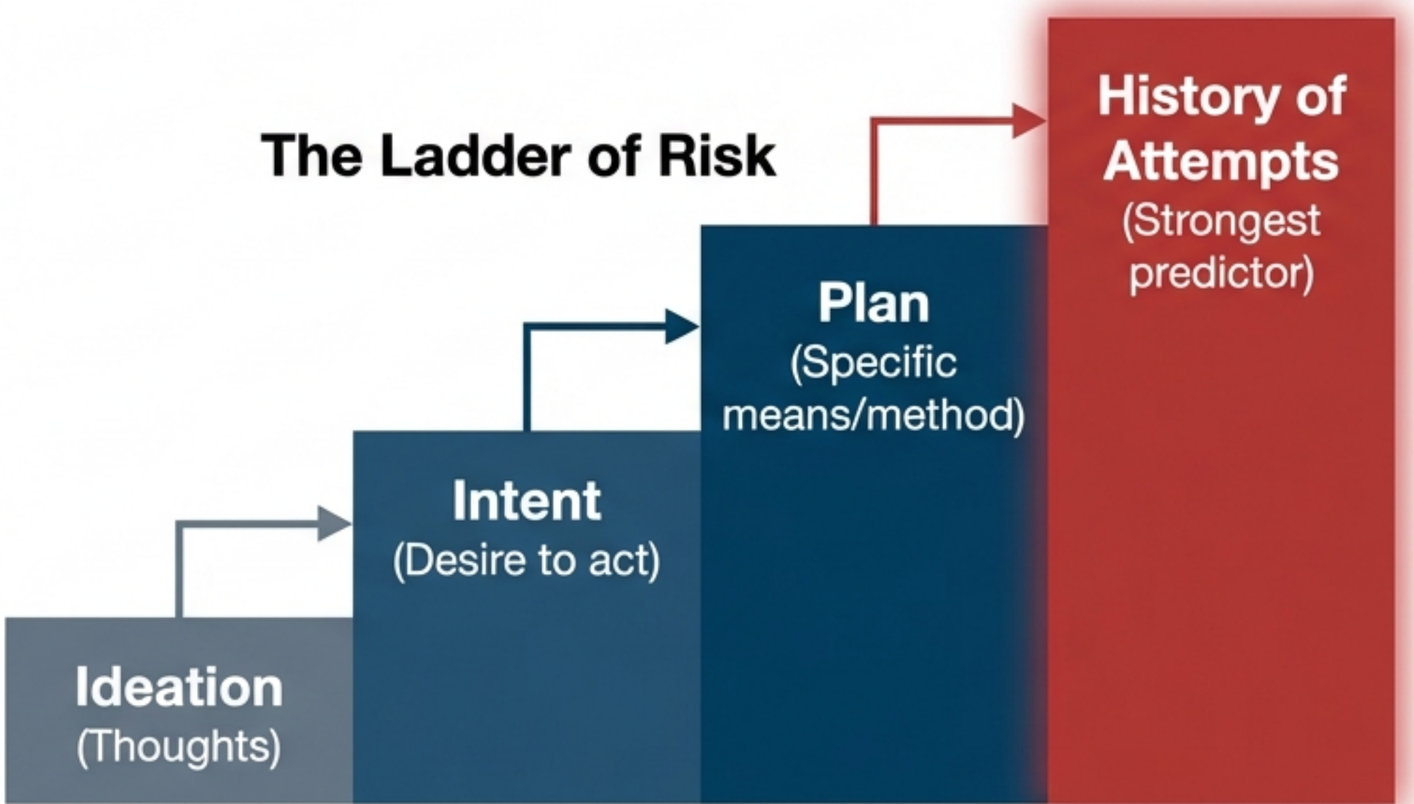
**Melancholia:** Screen for profound anhedonia, early morning awakening, and excessive guilt.

# Evaluating cognitive deficits within the MSE

Depression is not merely an emotional disorder; it is a cognitive state that compromises executive function. Deficits here directly impact the patient's ability to ability to engage in therapy.



# Risk assessment is mandatory for every patient




## Safety Planning & Triage

Disposition (Inpatient vs. Outpatient) is determined by:

- Hopelessness
- Social Support availability

**Err on the side of caution.**

# Quantifying severity and finalizing the diagnosis

## Severity

Objectify the subjective using validated scales (PHQ-9, HAM-D, MADRS).


## The Critical Differential

### Rule Out Bipolar Disorder

Before diagnosing Unipolar Depression, explicitly check for history of Mania or Hypomania.

Distinguish from normal grief/bereavement.

# Management relies on shared decision-making


**The primary modality choice—Psychotherapy vs. Pharmacotherapy—must reflect this synthesis.**

# Clinical Cheat Sheet: The Assessment Protocol

## The Core Triad (2+ Weeks)

- Low Mood + Anhedonia + Fatigue
- Check Functional Impairment.

## The "Three Ps" Formulation

1. Predisposing (History/Genetics)
2. Precipitating (Triggers)
3. Perpetuating (Maintenance factors)

## Workup & Safety

- Labs: CBC, TSH
- Risk Ladder: Ideation > Intent > Plan > Attempts

## Red Flags

- History of Mania (Bipolar)
- Psychotic Features
- High Anxiety Comorbidity

Standardized Scales: PHQ-9, HAM-D, MADRS.