BIPOLAR DISORDER—DEPRESSION

BEHAVIORAL DEFINITIONS

1. Depressed or irritable mood.
2. Decrease or loss of appetite.
3. Diminished interest in or enjoyment of activities.
4. Psychomotor agitation or retardation.
5. Sleeplessness or hypersomnia.
6. Lack of energy.
7. Poor concentration and indecisiveness.
8. Social withdrawal.
9. Suicidal thoughts and/or gestures.
10. Feelings of hopelessness, worthlessness, or inappropriate guilt.
11. Low self-esteem.
12. Unresolved grief issues.
13. Mood-related hallucinations or delusions.
14. History of chronic or recurrent depression for which the client has taken antidepressant medication, been hospitalized, had outpatient treatment, or had a course of electroconvulsive therapy.
15. History of at least one hypomanic, manic, or mixed mood episode.

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LONG-TERM GOALS

1. Alleviate depressive symptoms and return to previous level of effective functioning.

2. Develop healthy thinking patterns and beliefs about self, others, and the world that lead to the alleviation and help prevent the relapse of depression.
3. Develop healthy interpersonal relationships that lead to the alleviation and help prevent the relapse of depression.
4. Appropriately grieve the loss in order to normalize mood and to return to previously adaptive level of functioning.
5. Normalize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
6. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.
7. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation and help prevent the relapse of mood episodes.
8. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment.

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SHORT-TERM OBJECTIVES

1. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings; express empathy and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Assess presence, severity, and impact of past and present mood episodes on social, occupational, and interpersonal functioning; supplement with semi-structured inventory, if desired (e.g., *Montgomery-Asberg Depression Rating Scale, Inventory to Diagnose Depression*).

2. Complete psychological testing to assess the nature and impact of mood problems. (3)

3. Arrange for the administration of an objective instrument(s) for evaluating relevant features of the bipolar disorder such as symptoms, communication patterns with family/significant others, expressed emotion (e.g., *Beck Depression Inventory–II* and/or *Beck Hopelessness Scale; Perceived Criticism Measure*); evaluate results and process feedback with the client or client and family; readminister as indicated to assess treatment response.

3. Disclose any history of substance use that may contribute to and complicate the treatment of bipolar depression. (4)

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an

anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Verbalize any history of past and present suicidal thoughts and actions. (9)

9. Assess the client's history of suicidality and current state of suicide risk (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).

6. State no longer having thoughts of self-harm. (10, 11)

10. Continuously assess and monitor the client's suicide risk.

11. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.

7. Cooperate with a medical/ psychiatric evaluation for

12. Arrange for an evaluation with a psychiatrist to determine

medication needs to stabilize symptoms. (12)

appropriate pharmacotherapy (e.g., lithium carbonate, Depakote, Lamictal). EBT

8. Take prescribed medications as directed. (13, 14) EBT

13. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness. EBT

14. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in psychotherapy. EBT

9. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (15) EBT

15. Provide psychoeducation to the client and family using all modalities necessary, including reviewing the signs, symptoms, and phasic relapsing nature of the client's mood episodes; destigmatize and normalize. EBT

10. Verbalize an understanding of the causes for, symptoms of, and treatment of mixed and/or depressive bipolar episodes. (16, 17) EBT

16. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to stresses that are manageable and the need for medication compliance. EBT

17. Provide the client with a rationale for treatment involving ongoing medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse. EBT

11. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (18, 19) EBT

18. Educate the client about the importance of medication compliance; teach him/her the risk for relapse when medication is discontinued and work toward a commitment to prescription adherence. EBT

19. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (see "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB

EB 12. Attend group psychoeducational sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (20, 21)

20. Conduct or refer the client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development of bipolar disorder, its biological and psychological treatment (see the *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta). EB

21. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation. EB

EB 13. Client and family members verbalize an understanding of bipolar disorder, factors that influence it, the role of medication and therapy. (22)

22. Conduct Family-Focused Treatment with the client and significant others beginning with psychoeducation emphasizing the biological nature of bipolar disorder, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, and early episode intervention (see *Bipolar*

Disorder by Miklowitz and Goldstein).

14. Family members implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (23, 24, 25, 26, 27)

23. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client's relapse.

24. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills, including: offering positive feedback, active listening, making positive requests of others for behavior change, and giving constructive feedback in an honest and respectful manner while reducing negative expressed emotion.

25. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills, including: defining the problem constructively and specifically; brainstorming solution options; evaluating options; choosing an option and implementing a plan; evaluating the results; and adjusting the plan.

27. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in

session toward effective use; problem-solve obstacles; (see "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session. EBT

EBT 15. Develop a "relapse drill" in which roles, responsibilities, and a course of action is agreed upon in the event that signs of relapse emerge. (28)

28. Help the client and family draw up a "relapse drill" detailing roles and responsibilities (e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client's physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan. EBT

EBT 16. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (29, 30, 31)

29. Use cognitive therapy techniques to explore and educate the client about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). EBT

30. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases in the self-talk, alternatives (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement. EBT

31. Teach the client cognitive-behavioral coping and relapse prevention skills including delaying impulsive actions, structured scheduling of daily

activities, keeping a regular sleep routine, avoiding unrealistic goal striving, using relaxation procedures, identifying and avoiding episode triggers such as stimulant drug use, alcohol consumption, breaking sleep routine, or exposing self to high stress (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.). EBT

EBT 17. Maintain a pattern of regular rhythm to daily activities. (32, 33, 34, 35)

32. Conduct Interpersonal and Social Rhythm Therapy beginning with the assessment of the client's daily activities using an interview and the Social Rhythm Metric (see *Treating Bipolar Disorder* by Frank). EBT

33. Assist the client in establishing a more routine pattern of daily activities such as sleeping, eating, solitary and social activities, and exercise; use and review a form to schedule, assess, and modify these activities so that they occur in a predictable rhythm every day. EBT

34. Teach the client about the importance of good sleep hygiene (see "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly (see the Sleep Disturbance chapter in this *Planner*). EBT

35. Engage the client in a balanced schedule of "behavioral activation" by scheduling rewarding activities while not over-stimulating; (see "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework*

Planner by Jongsma); use activity and mood monitoring to facilitate an optimal balance of activity; reinforce success.

18. Discuss and resolve troubling personal and interpersonal issues. (36, 37, 38)

36. Conduct the interpersonal component of Interpersonal and Social Rhythm Therapy beginning with the assessment the client's current and past significant relationships; assess for themes related to grief, interpersonal role disputes, interpersonal role transitions, and interpersonal skills deficits (see *Treating Bipolar Disorder* by Frank).

37. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, and social skills deficits; provide support and strategies for resolving identified interpersonal issues.

38. Establish a "rescue protocol" with the client and significant others to identify and manage clinical deterioration; include medication use, sleep pattern restoration, maintaining a daily routine and conflict-free social support.

19. Participate in periodic "maintenance" sessions. (39)

39. Hold periodic "maintenance" sessions within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to improvement.

20. Increase understanding of bipolar illness by reading a book on the disorder. (40)

40. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder*

Survival Guide by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More* by White and Preston); review and process concepts learned through the reading.

21. Differentiate between real and imagined losses, rejections, and abandonments. (41, 42, 43)

41. Pledge to be there consistently to help, listen to, and support the client.

42. Explore the client's fears of abandonment by sources of love and nurturance.

43. Help the client differentiate between real and imagined, actual and exaggerated losses.

22. Verbalize grief, fear, and anger regarding real or imagined losses in life. (44, 45, 46)

44. Probe real or perceived losses in the client's life.

45. Review ways for the client to replace the losses and put them in perspective.

46. Probe the causes for the client's low self-esteem and abandonment fears in the family-of-origin history.

23. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (47)

47. Conduct Acceptance and Commitment Therapy (see *ACT for Depression* by Zettle) including mindfulness strategies to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one's experience rather than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her goals and values and commit to behaving accordingly).

24. Increasingly verbalize hopeful and positive statements regarding self, others, and the future (48, 49)

48. Assign the client to write at least one positive affirmation statement daily regarding himself/herself and the future (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

49. Teach the client more about depression and how to recognize and accept some sadness as a normal variation in feeling.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	301.13	Cyclothymic Disorder
	295.70	Schizoaffective Disorder
	296.80	Bipolar Disorder NOS
	310.1	Personality Change Due to Axis III Disorder
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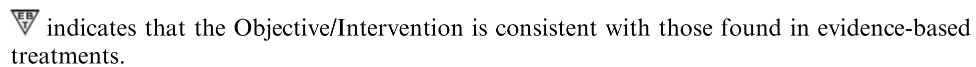
Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F31.1x	Bipolar I Disorder, Manic
296.89	F31.81	Bipolar II Disorder
301.13	F34.0	Cyclothymic Disorder
295.70	F25.1	Schizoaffective Disorder, Depressive Type
296.80	F31.9	Unspecified Bipolar and Related Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.


indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.