UNIPOLAR 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.

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LONG-TERM GOALS

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

2. Recognize, accept, and cope with feelings of depression.
3. Develop healthy thinking patterns and beliefs about self, others, and the world that lead to the alleviation and help prevent the relapse of depression.
4. Develop healthy interpersonal relationships that lead to the alleviation and help prevent the relapse of depression.
5. Appropriately grieve the loss in order to normalize mood and to return to previously adaptive level of functioning.

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SHORT-TERM OBJECTIVES

1. Describe current and past experiences with depression including their impact on functioning and attempts to resolve it. (1, 2)

2. Complete psychological testing to assess the depth of depression, the need for anti-depressant medication, and suicide prevention measures. (3)

THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings of depression; express empathy and build rapport while identifying primary cognitive, behavioral, interpersonal, or other contributors to depression.
2. Assess current and past mood episodes including their features, frequency, severity, and duration (e.g., clinical interview supplemented by the *Inventory to Diagnose Depression*).
3. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., *Beck Depression Inventory-II*; the *Beck Hopelessness Scale*); evaluate results and give feedback to the client; readminister as indicated to assess treatment progress.

3. Verbalize any history of past and present suicidal thoughts and actions. (4)

4. State no longer having thoughts of self-harm. (5, 6)

5. Complete a medical evaluation to assess for possible contribution of medical or substance-related conditions to the depression. (7)

6. Disclose any history of substance use that may contribute to and complicate the treatment of unipolar depression. (8)

7. 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. (9, 10, 11, 12)

4. 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).

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

6. Arrange for hospitalization, as necessary, when the client is judged to be a danger to self.

7. Refer the client to a physician for a medical evaluation to rule out general medical or substance-related causes of the depression.

8. 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*).

9. 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).

10. 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).

11. 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.

12. 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).

8. Cooperate with a medication evaluation by a physician. (13, 14)

13. Evaluate the client's need and desire for psychotropic medication and, if indicated, arrange for a medication evaluation by a physician.

14. Monitor and evaluate the client's psychotropic medication compliance, effectiveness, and side effects; communicate with prescribing physician.

9. Verbalize an accurate understanding of depression. (15, 16)

15. Consistent with the treatment model, discuss how cognitive, behavioral, interpersonal, and/or

	other factors (e.g., family history) contribute to depression.
	16. Assign the client to read chapters, books, treatment manuals, or other resources that convey psychoeducational concepts regarding depression.
10. Verbalize an understanding of the rationale for treatment of depression. (17, 18)	17. Consistent with the treatment model, discuss how change in cognitive, behavioral, interpersonal, and other factors can help the client alleviate depression and return to previous level of effective functioning.
	18. Assign the client to read chapters, books, or use other resources to help the client learn more about the therapy and its rationale.
11. Identify and replace thoughts and beliefs that support depression. (19, 20, 21, 22, 23)	19. Conduct Cognitive-Behavioral Therapy (see *Cognitive Behavior Therapy* by Beck; *Overcoming Depression* by Gilson, et al.), beginning with helping the client learn the connection among cognition, depressive feelings, and actions.
	20. Assign the client to self-monitor thoughts, feelings, and actions in daily journal (e.g., "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma; "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts.

21. Assign "behavioral experiments" in which depressive automatic thoughts are treated as hypotheses/prediction, reality-based alternative hypotheses/prediction are generated, and both are tested against the client's past, present, and/or future experiences.

22. Facilitate and reinforce the client's shift from biased depressive self-talk and beliefs to reality-based cognitive messages that enhance self-confidence and increase adaptive actions (see "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Explore and restructure underlying assumptions and beliefs reflected in biased self-talk that may put the client at risk for relapse or recurrence.

12. Learn and implement behavioral strategies to overcome depression. (24, 25)

24. Engage the client in "behavioral activation," increasing his/her activity level and contact with sources of reward, while identifying processes that inhibit activation (see *Behavioral Activation for Depression* by Martell, Dimidjian, and Herman-Dunn; or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, role reversal, as needed, to facilitate activity in the client's daily life; reinforce success.

25. Assist the client in developing skills that increase the likelihood of deriving pleasure from

	behavioral activation (e.g., assertiveness skills, developing an exercise plan, less internal/more external focus, increased social involvement); reinforce success.
13. Identify important people in life, past and present, and describe the quality, good and poor, of those relationships. (26)	26. Conduct Interpersonal Therapy (see *Interpersonal Psychotherapy of Depression* by Klerman et al.), beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships; develop a case formulation linking depression to grief, interpersonal role disputes, role transitions, and/or interpersonal deficits).
14. Verbalize an understanding and resolution of current interpersonal problems. (27, 28, 29, 30)	27. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.
	28. For interpersonal disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.
	29. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role,

and taking steps to gain mastery over the new role.

30. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

15. Learn and implement problem-solving and decision-making skills. (31, 32)

31. Conduct Problem-Solving Therapy (see *Problem-Solving Therapy* by D'Zurilla and Nezu) using techniques such as psychoeducation, modeling, and role-playing to teach client problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

32. Encourage in the client the development of a positive problem orientation in which problems and solving them are viewed as a natural part of life and not something to be feared, despaired, or avoided.

16. Learn and implement conflict resolution skills to resolve interpersonal problems. (33, 34)

33. Teach conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use psychoeducation, modeling, role-playing, and rehearsal to work through several current conflicts; assign homework exercises; review and repeat so as

to integrate their use into the client's life.

34. Help the client resolve depression related to interpersonal problems through the use of reassurance and support, clarification of cognitive and affective triggers that ignite conflicts, and active problem-solving (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Learn and implement relapse prevention skills. (35, 36, 37)

35. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a rather common, temporary setback that may involve, for example, reexperiencing a depressive thought and/or urge to withdraw or avoid (perhaps as related to some loss or conflict) and a relapse as a sustained return to a pattern of depressive thinking and feeling usually accompanied by interpersonal withdrawal and/or avoidance.

36. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

37. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse and rehearsing the use of skills learned during therapy to manage them.

18. Implement mindfulness techniques for relapse prevention. (38, 39)

38. Use mindfulness meditation and cognitive therapy techniques to help the client learn to recognize and regulate the negative thought processes associated

with depression and to change his/her relationship with these thoughts (see *Mindfulness-Based Cognitive Therapy for Depression* by Segal, Williams, and Teasdale).

39. Work to increase the client's new sense of well-being by building his/her personal strengths evident in their progress through therapy (or assign "Acknowledging My Strengths" and/or "What Are My Good Qualities?" in the *Adult Psychotherapy Homework Planner* by Jongsma).

19. Participate in couples therapy to decrease depression and improve the relationship. (40)

40. Conduct Behavioral Couples Therapy using behavioral interventions focused on exchanges between partners including assertive communication, and problem-solving/conflict resolution; focus on consistent use of respectful assertive communication, increasing caring exchanges between partners, and fostering collaborative problem-solving (see *Integrative Couples Therapy* by Jacobson and Christensen).

20. Verbalize an understanding of healthy and unhealthy emotions with the intent of increasing the use of healthy emotions to guide actions. (41)

41. Use a process-experiential approach consistent with Emotion-Focused Therapy to create a safe, nurturing environment in which the client can process emotions, learning to identify and regulate unhealthy feelings and to generate more adaptive ones that then guide actions (see *Emotion-Focused Therapy for Depression* by Greenberg and Watson).

21. Verbalize insight into how past relationships may be influencing

42. Conduct Brief Psychodynamic Therapy for depression to help

current experiences with depression. (42, 43, 44, 45)	the client increase insight into the role that past relational patterns may be influencing current vulnerabilities to depression; identify core conflictual themes; process with the client toward making changes in current relational patterns (see *Supportive-Expressive Dynamic Psychotherapy of Depression* by Luborsky et al.). 43. Explore experiences from the client's childhood that contribute to current depressed state. 44. Encourage the client to share feelings of anger regarding pain inflicted on him/her in childhood that contributed to current depressed state. 45. Explain a connection between previously unexpressed (repressed) feelings of anger (and helplessness) and current state of depression.
22. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (46)	46. 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 (or assign "Developing Noncompetitive Values" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Read books on overcoming depression. (47)

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

47. Recommend that the client read self-help books consistent with the therapeutic approach used in therapy to help supplement therapy and foster better understanding of it (e.g., *A Cognitive Behavioral Workbook for Depression: A Step-by-Step Program* by Knaus; *Solving Life's Problems* by Nezu, Nezu, and D'Zurilla; *The Interpersonal Solution to Depression: A Workbook for Changing How You Feel by Changing How You Relate* by Pettit and Joiner; *The Mindfulness and Acceptance Workbook for Depression* by Strosahl and Robinson); process material read.

48. Assign the client to write at least one positive affirmation statement daily regarding himself/herself and the future (or assign "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:	309.0	Adjustment Disorder With Depressed Mood
	300.4	Dysthymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	310.1	Personality Change Due to Axis III Disorder
	311	Depressive Disorder NOS
	V62.82	Bereavement
	_____	_____
	_____	_____
Axis II:	301.9	Personality Disorder NOS
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
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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
309.0	F43.21	Adjustment Disorder, With Depressed Mood
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
300.4	F34.1	Persistent Depressive Disorder
301.13	F34.0	Cyclothymic Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
310.1	F07.0	Personality Change Due to Another Medical Condition
V62.82	Z63.4	Uncomplicated Bereavement

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.