

Workbook

Depression and Bipolar Disorder Workbook

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*A practical guide to
understanding and treating
depression and bipolar
disorder.*



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A Spectrum of Moods

Mood disorders exist on a spectrum from major depressive disorder to full bipolar disorder. In between those extremes are people who have various shades of depression and mania, often overlapping in mixed states.

For most of the 20th century these disorders were all lumped into a single category: Manic-Depressive Illness. The thinking was that there was so much overlap between the manic and depressive extremes that it was difficult to separate them. In 1980, the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) separated them in two: unipolar (Major Depressive Disorder) and bipolar (Bipolar I Disorder).

That left a wide gap in the middle, where about 40% of people with depression also have manic symptoms that don't reach full mania. Subsequent editions of the DSM filled in most of that gap, starting with Bipolar II in 1994 and Major Depression with Mixed Features in 2013.

The current DSM recognizes a spectrum of mood disorders that, as

the DSM-5 chair David Kupfer wrote, form "a continuum, with variable expressions of vulnerability to hypomania or mania."

The table below lists the mood disorders on that continuum in order of increasing manic symptoms. The ones in blue are considered unipolar in DSM-5, while those in yellow/red are in the bipolar section, but where we draw those lines is somewhat arbitrary.

DSM-5 MOOD DISORDERS

Major Depressive Disorder	At least 2 weeks of depression
Persistent Depressive Disorder	At least 2 years of depression (usually life-long)
Depression with Mixed Features	Major depression with ≥ 3 manic symptoms during the episode
Depression with Brief Hypomania	Major Depression with brief (< 4 days) hypomanias
Cyclothymic Disorder	Chronic (≥ 2 years) cycling between brief depressions (< 2 weeks) and hypomania
Bipolar II Disorder	Full depressions (≥ 2 weeks) that cycle with full hypomanias (≥ 4 days)
Bipolar I Disorder	Full mania (usually ≥ 1 week)



The Three Moods

There are three kinds of mood episodes, and the symptom that best distinguishes them is energy:

Depression: low energy

Mania and hypomania: high energy

Mixed: high and low energy overlap

Behaviors also help identify these episodes, and the table at right lists common behaviors you'll see when energy is high, low, or mixed.

Emotions are a less reliable guide to mood because distressful emotions like anxiety and sadness are common to all those episodes. A study from Harvard found that anxiety levels were higher in hypomania than depression.

Hypomania means "mild mania." It has the same symptoms as mania, but those symptoms do not cause life-altering problems.

In mixed states the extremes of high and low energy collide.

Unfortunately, they do not cancel each other out. They make people feel "tired and wired, driven to do something but I don't know what to do, as if I'm being pulled apart inside."

MOOD BEHAVIORS

Depression

LOW ENERGY: Avoidance, slow movements, lack of variety in activities, little social interaction, not taking on risks. Speech is slow and monotonous.

Mania and hypomania

HIGH ENERGY: High activity with little consideration of risks, shifting tasks, hyperactive, very social and reactive to others. Speech is fast and pressured.

Mixed

MIX OF HIGH/LOW ENERGY: Agitated, directionless or destructive activity, such as moving furniture from one room to another, breaking the TV set, pacing in circles. Speech is pressured with a desperate, emotional tone.



Depression

Depression is not the same as sadness. Rather, it is a constricting or "depressing" of emotions. In severe depression, patients may feel empty, unable to cry. The appearance of tears may reflect improvement. Other key symptoms of depression include low motivation and *anhedonia*, the inability to experience positive emotions.

Anhedonia is listed first in the Physician's Health Questionnaire (PHQ-9), a rating scale that translates the nine symptoms of depression into everyday language. To diagnose depression, DSM-5 requires that at least 5 of the symptoms are present most of the day, nearly every day, for at least 2 weeks. At least 1 of those symptoms must be depressed mood or anhedonia (the first 2 items in PHQ-9).

Depression is a common response to stress, so the diagnosis does not hinge on whether it is a "normal" response to life events. Instead, DSM requires that the symptoms cause significant distress or impairment. The last question on the PHQ-9 opens that up, but further discussion is necessary to really figure that one out.

PHQ-9 SCORING

0-4	No depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Rating Depression: PHQ-9

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add each column _____

Total score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat difficult

Very
difficult

Extremely
difficult



Depression in Therapy

SYMPTOM	DEFINITION	INTERVENTION
Avoidance	Engaging in actions with the goal of reducing aversive internal experiences like anxiety	Behavioral activation, value-based action, mindfulness
Anhedonia	Inability to experience pleasure or reward	Clients are more likely to persevere in the absence of rewards if they connect their actions to personal values
Global, abstract thinking	A focus on depressive beliefs rather than the concrete details of events in their lives	Functional analysis helps clients find more effective ways to influence their world by recalling events in detail and identifying cause-effect
Rumination	Repetitive, negative thinking that does not lead to action or solutions. Usually it focuses on the past, future, self, and existential themes	Shift from unsolvable to solvable problems with concrete solutions that can be put into action
Threat signals	Tendency to perceive everyday situations as threatening; neutral faces as angry or critical	Spend 1 hour/day in a non-threatening environment without retreating to bed (nature, animals, music)
Rejection sensitivity	Tendency to perceive rejection in neutral social encounters and react intensely to them (eg, waiting for a friend to return a text)	CBT, testing the evidence, psychoeducation, mindfulness, cognitive defusion
Overeating	Usually with carbs, fats, and comfort foods	Protein 30-60 min before meals lowers appetite (eg nuts, protein shake). Healthy fats lower sugar cravings (avocado, yogurt, olives)
Fatigue	Common in <i>atypical depression</i> , which causes oversleeping, overeating, heavy feelings in limbs, and rejection sensitivity	Sunlight, morning lightbox, brisk walking, Mediterranean diet
Insomnia	Trouble falling asleep (initiation insomnia), staying asleep (middle insomnia), early awakening (terminal insomnia), and oversleeping (hypersomnia)	CBT-insomnia improves symptoms better than sleep medication and also treats depression
Sleep inertia	Waking up with a groggy, slowed, disoriented sensation that can persist for several hours	Brisk awakening, dawn simulator



Situational Analysis

Chronic depression has a unique psychology, requiring a unique approach in therapy. These clients live in their head; in their emotions and interpretations; in the past. They feel like passive players in their own lives. Things happen to them, but they don't cause anything to happen. The stories they relate in therapy are a disjointed mix of past and present, facts and emotions.

That disengagement from the world makes it hard for them to learn and change. Situational analysis addresses this problem. Clients learn to observe their lives like a news reporter, with concrete details and a clear sequence of events. From that vantage point they can clarify their goals and figure out more effective ways to achieve them.

The technique was developed by James McCullough as part of the Cognitive Behavioral Analysis System of Psychotherapy (CBASP), an evidence-based therapy for chronic depression. Dr. McCullough summed his approach up this way, "If you don't like the way you feel, you need to change the way you act."

Tell a story about a recent interaction you had with another person. Describe the event like a news report.

Describe the facts What happened? What did you do? What was said? What were your emotions and perceptions? What did it mean to you?

2. The story should have beginning, a middle, and an end.

3. How did it turn out? What was the actual outcome?

4. How did you want it to turn out? What was your desired outcome?

5. How did your actions and your interpretations influence the outcome?



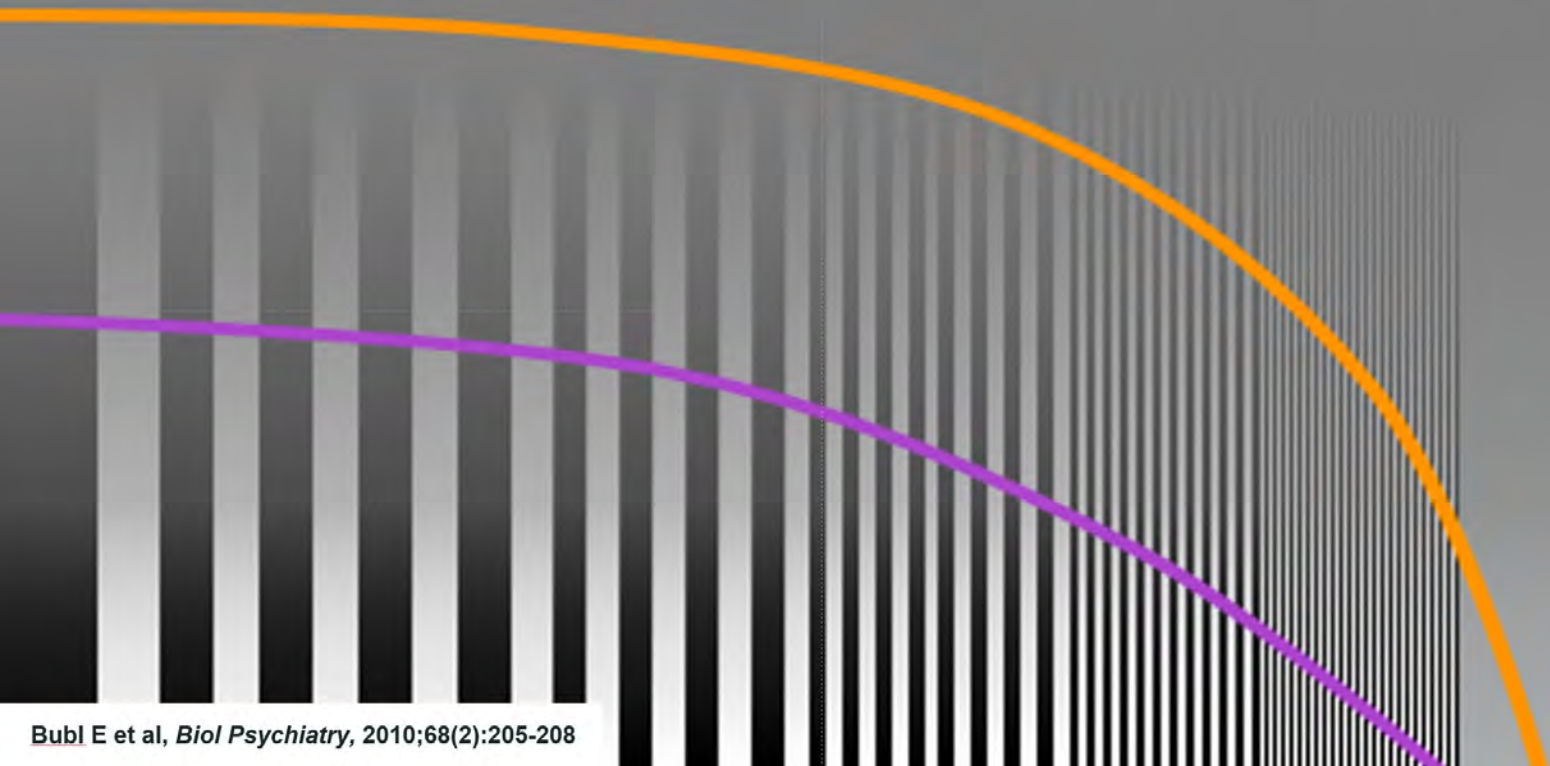
Depressive Vision

Many things get in the way of situational analysis. Clients may not know what they want from the situation, or may go into it with goals that are vague or outside their control ("I just want everyone to like me" or "I want to feel better").

To analyze situations, clients need to be able to tell the difference between one outcome and another, and notice how small changes in their own behavior can influence those actions.

Depression, however, blurs distinctions, painting everything with a drab sameness. It does this at every level, from higher order cognition to sensory perception. In the picture below, the colored lines are cut-offs where people are no longer able to distinguish the subtle shades of gray above the line. In depression, the eyes cut off at the blue line, far below the yellow line for healthy volunteers.

Depression impairs ability to distinguish shades of gray



Bubl E et al, *Biol Psychiatry*, 2010;68(2):205-208



Counter-transference in Chronic Depression

Chronic depression is slow to change. That can leave the therapist feeling helpless, defeated, and dreading the appointment. Watch out for common counter-transference reactions like anger and withdrawal. These show up in subtle ways:

Anger

Assigning too much homework, challenging the patient excessively

Withdrawal

Daydreaming during session, suggesting the client should transfer to someone with more experience.



02 Causes of Depression

People become depressed for many reasons, often more than one. Ideally, we would find the cause and address it, but this is difficult. Fortunately, the brain is adaptive and most people respond to therapeutic interventions even when they are unrelated to the cause.

Chronic stress is more likely to cause depression than acute stress. Acute stress motivates people to rise up and try harder, behaviors that are the opposite of depression. This is why some clients with depression actually improve when, for example, their child gets diagnosed with diabetes. It focuses their mind and motivates action.

Depression sets in when that action results in repeated failure. Typically this takes about 3-9 months. It's not the problem that causes depression, but the lack of success in solving it. Ideally, a therapist would guide these clients to move on from those defeat scenarios and turn their attention toward problems that are more in their power to solve.

Sounds like a reasonable strategy, but two things get in the way. First, the problem may have an emotional pull that is hard for the client to let go of.

For example, a 52 year old woman whose 26 year old daughter has cut off their relationship.

Second, the depressed mind is a magnet for unsolvable problems. These tendency, called rumination, causes clients to bang their head against the proverbial wall, dwelling on questions that can't be answered ("Am I good enough?") and problems that can't be solved ("I want tell my boss what I really think of her, but I don't want to upset her.")

Therapists can fall into this ruminative trap if they mistake what the client is depressed about with what is causing their depression. Often, what clients say they are "depressed about" is what they ruminate about during depression and not what caused it.

For example, a client said he was "depressed about the disconnection in my marriage." However, before the depression he saw this as a minor problem in an otherwise healthy marriage. On the other hand, he had stopped exercise 3 months earlier, and when he got back into it the routine the depression resolved and he no longer ruminated about his marriage.

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