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Individual Planning: A Treatment Plan Overview for Individuals with Depression Problems.

A Treatment Plan Overview for Individuals for Adult with Depression.

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms and learning different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations
Course Syllabus:

Introduction and Types of Depression

Adjustment Disorder with Depressed Mood
Persistent Depressive Disorder
Clinical Depression
Postpartum Depression
Bipolar Depression
Psychotic Depression
Seasonal Affective Disorder or Depression

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction and Types of Depression:

Depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors.

Depression can happen at any age, but often begins in adulthood. Depression is now recognized as occurring in children and adolescents, although it sometimes presents with more prominent irritability than low mood. Many chronic mood and anxiety disorders in adults begin as high levels of anxiety in children.
Depression, especially in midlife or older adults, can co-occur with other serious medical illnesses, such as diabetes, cancer, heart disease, and Parkinson’s disease. These conditions are often worse when depression is present. Sometimes medications taken for these physical illnesses may cause side effects that contribute to depression. A doctor experienced in treating these complicated illnesses can help work out the best treatment strategy.

Risk factors include:

- Personal or family history of depression
- Major life changes, trauma, or stress
- Certain physical illnesses and medications

Types of Depression:

Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

Some forms of depression are slightly different, or they may develop under unique circumstances, such as:

- Persistent depressive disorder or Clinical Depression (also called dysthymia) is a depressed mood that lasts for at least two years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for two years to be considered persistent depressive disorder.

- Major Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

- Postpartum depression is much more serious than the "baby blues" (relatively mild depressive and anxiety symptoms that typically clear within two weeks after delivery) that many women experience after giving birth. Women with postpartum depression experience full-blown major depression during pregnancy or after delivery (postpartum
Postpartum depression (PPD) is a type of major depression that occurs during or shortly after childbirth. The feelings of extreme sadness, anxiety, and exhaustion that accompany postpartum depression may make it difficult for these new mothers to complete daily care activities for themselves and/or for their babies.

Psychotic depression occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive &ldquo;theme;&rdquo; such as delusions of guilt, poverty, or illness.

Seasonal affective disorder is characterized by the onset of depression during the winter months, when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression, typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder.

Bipolar disorder is different from depression, but it is included in this list is because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called &ldquo;bipolar depression&rdquo;). But a person with bipolar disorder also experiences extreme high &ndash; euphoric or irritable &ndash; moods called &ldquo;mania&rdquo; or a less severe form called &ldquo;hypomania.&rdquo;

Examples of other types of depressive disorders newly added to the diagnostic classification of DSM-5 include disruptive mood dysregulation disorder (diagnosed in children and adolescents) and premenstrual dysphoric disorder (PMDD).

Depressive episodes symptoms occur most of the day, nearly every day and have occurred for at least two weeks:

- Persistent sad, anxious, or &ldquo;empty&rdquo; mood
- Feelings of hopelessness, or pessimism
- Irritability
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy or fatigue
- Moving or talking more slowly
- Feeling restless or having trouble sitting still
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
Appetite and/or weight changes

Thoughts of death or suicide, or suicide attempts

Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment

Not everyone who is depressed experiences every symptom. Some people experience only a few symptoms while others may experience many. Several persistent symptoms in addition to low mood are required for a diagnosis of major depression, but people with only a few but distressing symptoms may benefit from treatment of their "subsyndromal" depression. The severity and frequency of symptoms and how long they last will vary depending on the individual and his or her particular illness. Symptoms may also vary depending on the stage of the illness.

Adjustment Disorder with Depressed Mood:

It is important to know the difference between adjustment disorder with depressed mood and other depressive disorders is that the adjustment disorder symptoms begin in response to some specific stressful situation or circumstance or a combination of stressors. The stressor could be almost anything. Examples include divorce, financial problems, loss of a job, conflicts in a close friendship, having to move, being diagnosed with a serious disease, being a victim of crime, experiencing a natural disaster.

Adjustment Disorder with Depressed Mood: Adjustment Disorder with Depressed Mood is a common type of adjustment disorder. All adjustment disorders are caused by one or more stressors that negatively impact everyday life. Adjustment disorders are very subjective. An event can no emotional impact on one, but same event may affect the ability to cope at another person. In adjustment disorders, people's reactions and coping mechanisms are very different. It is easy to misread Adjustment Disorder with Depressed Mood reactions with depression.

Symptoms of Adjustment Disorder with Depressed Mood: The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), identifies Adjustment Disorder with Depressed Mood as one of six types of adjustment disorders. When someone experiences adjustment disorder, the diagnosis is categorized by type according to the person's unique symptoms, and additional problems, and is not given a Adjustment Disorder with Depressed Mood alone.
Adjustment disorder with depressed mood is diagnosed when someone’s symptoms are primarily depressive in nature. Reaction to different life change or another type of stressor can lead to a subjective and very personal experience of depression. The symptoms of adjustment disorder with depressed mood can include

- Low mood, sadness
- Increased tearfulness, frequent crying spells
- Sense of hopelessness
- Decreased self-esteem
- Anhedonia-loss of a sense of pleasure
- Lack of motivation
- Feeling of loneliness and isolation
- Suicidal ideation or behavior

Difference between Adjustment Disorder with Depressed Mood and Major Depression:

Is not easy to differentiate adjustment disorder with depressed mood from depressive disorders. The symptoms are very similar that at times adjustment disorder with depression is referred to as situational depression.

The key to distinguishing between adjustment disorder with depressed mood and major depression or other depressive disorders is the word "situational." Adjustment disorder with depressed mood is conditional and triggers by a particular situation, a life change such as divorce, death of loved or any other stressor. The stressor can be of any severity, but it causes major disruption to the person’s life. When the disruption is experienced as depression, it is called adjustment disorder with depressed mood.
It is important to note that when depressive symptoms occur without a stressor or before a stressor has occurred, the diagnosis is no longer adjustment disorder with depressed mood, but another depressive disorder such as major depressive disorder. Life is very unpredictable and sometimes multiple stressors build up slowly over time developing ongoing depressive symptoms. In such cases, the level and length of the depressive symptoms can provide a clue. The more symptoms of depression a person has and the longer they last, the more likely it is that a person is experiencing another depressive disorder rather than adjustment disorder with depressed mood.

Adjustment Disorder with Depressed Mood is temporary and treatable. Adjustment disorder with depressed mood can be overcome over a period of adjustment. Treatment involves addressing the stressor as well as treating the symptoms, in this case, the symptoms of depression.

Once the stressor is removed and the person has learned to adjust to and cope with it, adjustment disorder with depressed mood usually subsides within six months. Adjustment disorder with depressed mood won’t forever negatively impact a person’s life.

Persistent Depressive Disorder:

Persistent depressive disorder, also called dysthymia, is a form of chronic depression, with symptoms less severe but longer lasting than other forms of depression. It is a new diagnosis that combines two earlier diagnoses: dysthymia and chronic major depressive episode. Since symptoms are less acute than major depressive disorder, it may go unnoticed for some time.

Symptoms of persistent depressive disorder:

Irritability or a depressed mood most of the time for more than a year
Inability to take pleasure and perform well in the activities of daily life
Behavior problems
Poor performance at school
Low self-esteem
Difficulty interacting with other children in social situations
Poor appetite or overeating
Trouble sleeping
Persistent tiredness or lack of energy
Hopelessness
Trouble concentrating
Difficulty making decisions

Treatment and Prognosis: Treatment for persistent depressive disorder include medications and psychotherapy. A combination of the two is believed to be the most effective treatment. Psychotherapy includes cognitive behavioral therapy and interpersonal therapy. Medications include selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants (TCAs).

Clinical Depression:

Depression ranges in seriousness from mild, temporary episodes of sadness to severe, persistent depression. Clinical depression is the more-severe form of depression, also known as major depression or major depressive disorder. It isn't the same as depression caused by a loss, such as the death of a loved one, or a medical condition, such as a thyroid disorder.

To diagnose clinical depression, many doctors use the symptom criteria for major depressive disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association.

Signs and symptoms of clinical depression may include:

Feelings of sadness, tearfulness, emptiness or hopelessness
Angry outbursts, irritability or frustration, even over small matters
Loss of interest or pleasure in most or all normal activities, such as sex, hobbies or sports
Sleep disturbances, including insomnia or sleeping too much
Tiredness and lack of energy, so even small tasks take extra effort
Reduced appetite and weight loss or increased cravings for food and weight gain
Anxiety, agitation or restlessness
Slowed thinking, speaking or body movements
Feelings of worthlessness or guilt, fixating on past failures or self-blame
Trouble thinking, concentrating, making decisions and remembering things
Frequent or recurrent thoughts of death, suicidal thoughts, suicide attempts or suicide
Unexplained physical problems, such as back pain or headaches

Symptoms are usually severe enough to cause noticeable problems in relationships with others or in day-to-day activities, such as work, school or social activities.

Clinical depression can affect people of any age, including children. However, clinical depression symptoms, even if severe, usually improve with psychological counseling, antidepressant medications or a combination of the two.

Postpartum Depression:

With postpartum depression, feelings of sadness and anxiety can be extreme and might interfere with a woman’s ability to care for herself or her family.

What is postpartum depression? Postpartum depression is a mood disorder that can affect women after childbirth. Mothers with postpartum depression experience feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for them to complete daily care activities for themselves or for others.

What causes postpartum depression? Postpartum depression does not have a single cause, but likely results from a combination of physical and emotional factors. Postpartum
depression does not occur because of something a mother does or does not do.

After childbirth, the levels of hormones (estrogen and progesterone) in a woman’s body quickly drop. This leads to chemical changes in her brain that may trigger mood swings. In addition, many mothers are unable to get the rest they need to fully recover from giving birth. Constant sleep deprivation can lead to physical discomfort and exhaustion, which can contribute to the symptoms of postpartum depression.

What are the symptoms of postpartum depression? Some of the more common symptoms a woman may experience include:

- Feeling sad, hopeless, empty, or overwhelmed
- Crying more often than usual or for no apparent reason
- Worrying or feeling overly anxious
- Feeling moody, irritable, or restless
- Oversleeping, or being unable to sleep even when her baby is asleep
- Having trouble concentrating, remembering details, and making decisions
- Experiencing anger or rage
- Losing interest in activities that are usually enjoyable
- Suffering from physical aches and pains, including frequent headaches, stomach problems, and muscle pain
- Eating too little or too much
- Withdrawing from or avoiding friends and family
- Having trouble bonding or forming an emotional attachment with her baby
- Persistently doubting her ability to care for her baby
- Thinking about harming herself or her baby.

How can a woman tell if she has postpartum depression? Only a health care provider can diagnose a woman with postpartum depression. Because symptoms of this condition are broad and may vary between women, a health care provider can help a woman figure out
whether the symptoms she is feeling are due to postpartum depression or something else. A woman who experiences any of these symptoms should see a health care provider right away.

How is postpartum depression different from the "baby blues"? The "baby blues" is a term used to describe the feelings of worry, unhappiness, and fatigue that many women experience after having a baby. Babies require a lot of care, so it's normal for mothers to be worried about, or tired from, providing that care. Baby blues, which affects up to 80 percent of mothers, includes feelings that are somewhat mild, last a week or two, and go away on their own.

With postpartum depression, feelings of sadness and anxiety can be extreme and might interfere with a woman's ability to care for herself or her family. Because of the severity of the symptoms, postpartum depression usually requires treatment. The condition, which occurs in nearly 15 percent of births, may begin shortly before or any time after childbirth, but commonly begins between a week and a month after delivery.

Are some women more likely to experience postpartum depression? Some women are at greater risk for developing postpartum depression because they have one or more risk factors, such as:

Symptoms of depression during or after a previous pregnancy

Previous experience with depression or bipolar disorder at another time in her life

A family member who has been diagnosed with depression or other mental illness

A stressful life event during pregnancy or shortly after giving birth, such as job loss, death of a loved one, domestic violence, or personal illness

Medical complications during childbirth, including premature delivery or having a baby with medical problems

Mixed feelings about the pregnancy, whether it was planned or unplanned

A lack of strong emotional support from her spouse, partner, family, or friends

Alcohol or other drug abuse problems.

Postpartum depression can affect any woman regardless of age, race, ethnicity, or economic status.

How is postpartum depression treated?
There are effective treatments for postpartum depression. A woman’s health care provider can help her choose the best treatment, which may include:

Counseling/Talk Therapy: This treatment involves talking one-on-one with a mental health professional (a counselor, therapist, psychologist, psychiatrist, or social worker).

Two types of counseling shown to be particularly effective in treating postpartum depression are:

Cognitive behavioral therapy (CBT), which helps people recognize and change their negative thoughts and behaviors; and

Interpersonal therapy (IPT), which helps people understand and work through problematic personal relationships.

Medication: Antidepressant medications act on the brain chemicals that are involved in mood regulation. Many antidepressants take a few weeks to be most effective. While these medications are generally considered safe to use during breastfeeding, a woman should talk to her health care provider about the risks and benefits to both herself and her baby.

These treatment methods can be used alone or together.

Bipolar Disorder:

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.

There are four basic types of bipolar disorder; all of them involve clear changes in mood, energy, and activity levels. These moods range from periods of extremely elated, and energized behavior (known as manic episodes) to very sad, or hopeless periods (known as depressive episodes). Less severe manic periods are known as hypomanic episodes.

Bipolar I Disorder- defined by manic episodes that last at least 7 days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks. Episodes of depression
with mixed features (having depression and manic symptoms at the same time) are also possible.

Bipolar II Disorder- defined by a pattern of depressive episodes and hypomanic episodes, but not the full-blown manic episodes described above.

Cyclothymic Disorder (also called cyclothymia)- defined by numerous periods of hypomanic symptoms as well numerous periods of depressive symptoms lasting for at least 2 years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for a hypomanic episode and a depressive episode.

Other Specified and Unspecified Bipolar and Related Disorders- defined by bipolar disorder symptoms that do not match the three categories listed above.

Signs and Symptoms: People with bipolar disorder experience periods of unusually intense emotion, changes in sleep patterns and activity levels, and unusual behaviors. These distinct periods are called "mood episodes." Mood episodes are drastically different from the moods and behaviors that are typical for the person. Extreme changes in energy, activity, and sleep go along with mood episodes.

People having a manic episode may:

Feel very "up," "high," or elated
Have a lot of energy
Have increased activity levels
Feel "jumpy" or "wired"
Have trouble sleeping
Become more active than usual
Talk really fast about a lot of different things
Be agitated, irritable, or "touchy"
Feel like their thoughts are going very fast
Think they can do a lot of things at once
Do risky things, like spend a lot of money or have reckless sex
People having a depressive episode may:

Feel very sad, down, empty, or hopeless
Have very little energy
Have decreased activity levels
Have trouble sleeping, they may sleep too little or too much
Feel like they can’t enjoy anything
Feel worried and empty
Have trouble concentrating
Forget things a lot
Eat too much or too little
Feel tired or “slowed down”
Think about death or suicide

Diagnosis: Proper diagnosis and treatment help people with bipolar disorder lead healthy and productive lives. Talking with a doctor or other licensed mental health professional is the first step for anyone who thinks he or she may have bipolar disorder. The doctor can complete a physical exam to rule out other conditions. If the problems are not caused by other illnesses, the doctor may conduct a mental health evaluation or provide a referral to a trained mental health professional, such as a psychiatrist, who is experienced in diagnosing and treating bipolar disorder.

Note for Health Care Providers: People with bipolar disorder are more likely to seek help when they are depressed than when experiencing mania or hypomania. Therefore, a careful medical history is needed to ensure that bipolar disorder is not mistakenly diagnosed as major depression. Unlike people with bipolar disorder, people who have depression only (also called unipolar depression) do not experience mania. They may, however, experience some manic symptoms at the same time, which is also known as major depressive disorder with mixed features.

Psychotic Depression:
Psychotic depression, also known as depressive psychosis, is a major depressive episode that is accompanied by psychotic symptoms. It can occur in the context of bipolar disorder or major depressive disorder. It can be difficult to distinguish from schizoaffective disorder, a diagnosis that requires the presence of psychotic symptoms for at least two weeks without any mood symptoms present. Conversely, psychotic depression requires that the psychotic features occur only during episodes of major depression. Diagnosis using the DSM-IV involves meeting the criteria for a major depressive episode, along with the criteria for the "psychotic features" specifier.

Symptoms: Individuals with psychotic depression experience the symptoms of a major depressive episode, along with one or more psychotic symptoms, including delusions and/or hallucinations. Delusions can be classified as mood congruent or incongruent, depending on whether or not the nature of the delusions is in keeping with the individual's mood state. Common themes of mood congruent delusions include guilt, persecution, punishment, personal inadequacy, or disease. Half of patients experience more than one kind of delusion. Delusions occur without hallucinations in about one-half to two-thirds of patients with psychotic depression. Hallucinations can be auditory, visual, olfactory (smell), or haptic (touch), and are congruent with delusional material. Affect is sad, not flat. Severe anhedonia, loss of interest, and psychomotor retardation are typically present.

Causes of Psychotic Depression: Psychotic symptoms tend to develop after an individual has already had several episodes of depression without psychosis. However, once psychotic symptoms have emerged, they tend to reappear with each future depressive episode. The prognosis for psychotic depression is not considered to be as poor as for schizoaffective disorders or primary psychotic disorders. Still, those who have experienced a depressive episode with psychotic features have an increased risk of relapse and suicide compared to those without psychotic features, and they tend to have more pronounced sleep abnormalities.

The families of those who have experienced psychotic depression are at increased risk for both psychotic depression and schizophrenia.

Most patients with psychotic depression report having an initial episode between the ages of 20 and 40. As with other depressive episodes, psychotic depression tends to be episodic, with symptoms lasting for a certain amount of time and then subsiding. While psychotic depression can be chronic (lasting more than years), most depressive episodes last less than months. Unlike psychotic disorders such as schizophrenia and schizoaffective disorder, patients with psychotic depression generally function well between episodes, both socially and professionally.

Differential diagnosis: Psychotic symptoms are often missed in psychotic depression, either
because patients do not think their symptoms are abnormal or they attempt to conceal their symptoms from others. On the other hand, psychotic depression may be confused with schizoaffective disorder. Due to overlapping symptoms, differential diagnosis includes also dissociative disorders.

There are a number of biological features that may distinguish psychotic depression from non-psychotic depression. The most significant difference may be the presence of an abnormality in the hypothalamic pituitary adrenal axis (HPA). The HPA axis appears to be dysregulated in psychotic depression, with dexamethasone suppression tests demonstrating higher levels of cortisol following dexamethasone administration (i.e. lower cortisol suppression). Those with psychotic depression also have higher ventricular-brain ratios than those with non-psychotic depression.

Treatment: Several treatment guidelines recommend either the combination of a second-generation antidepressant and atypical antipsychotic or tricyclic antidepressant monotherapy or electroconvulsive therapy (ECT) as the first-line treatment for unipolar psychotic depression.

Pharmaceutical treatments can include tricyclic antidepressants, atypical antipsychotics, or a combination of an antidepressant from the newer, more well tolerated SSRI or SNRI categories and an atypical antipsychotic. Olanzapine may be an effective monotherapy in psychotic depression, although there is evidence that it is ineffective for depressive symptoms as a monotherapy; and olanzapine/fluoxetine is more effective. Quetiapine monotherapy may be particularly helpful in psychotic depression since it has both antidepressant and antipsychotic effects and a reasonable tolerability profile compared to other atypical antipsychotics. The current drug-based treatments of psychotic depression are reasonably effective but can cause side effects, such as nausea, headaches, dizziness, and weight gain. Tricyclic antidepressants are particularly dangerous in overdose due to their potential to cause potentially-fatal cardiac arrhythmias. In the context of psychotic depression, the following are the most well-studied antidepressant/antipsychotic combinations

Seasonal Affective Disorder:

Overview: Seasonal Affective Disorder (SAD) is a type of depression that comes and goes with the seasons, typically starting in the late fall and early winter and going away during the spring and summer. Depressive episodes linked to the summer can occur, but are much less common than winter episodes of SAD.

Signs and Symptoms: Seasonal Affective Disorder (SAD) is not considered as a separate disorder. It is a type of depression displaying a recurring seasonal pattern. To be diagnosed with SAD, people must meet full criteria for major depression coinciding with specific seasons (appearing in the winter or summer months) for at least 2 years. Seasonal depressions must be much more frequent than any non-seasonal depressions.
Symptoms of Major Depression, (Must Meet Criteria for Major Depression):

- Feeling depressed most of the day, nearly every day
- Feeling hopeless or worthless
- Having low energy
- Losing interest in activities you once enjoyed
- Having problems with sleep
- Experiencing changes in your appetite or weight
- Feeling sluggish or agitated
- Having difficulty concentrating
- Having frequent thoughts of death or suicide.

Symptoms of the Winter Pattern of SAD include:

- Having low energy
- Hypersomnia
- Overeating
- Weight gain
- Craving for carbohydrates
- Social withdrawal (feel like “hibernating”)

Symptoms of the less frequently occurring summer seasonal affective disorder include:
Poor appetite with associated weight loss
Insomnia
Agitation
Restlessness
Anxiety
Episodes of violent behavior

Risk Factors: Attributes that may increase your risk of SAD include:

Being female. SAD is diagnosed four times more often in women than men.

Living far from the equator. SAD is more frequent in people who live far north or south of the equator. For example, 1 percent of those who live in Florida and 9 percent of those who live in New England or Alaska suffer from SAD.

Family history. People with a family history of other types of depression are more likely to develop SAD than people who do not have a family history of depression.

Having depression or bipolar disorder. The symptoms of depression may worsen with the seasons if you have one of these conditions (but SAD is diagnosed only if seasonal depressions are the most common).

Younger Age. Younger adults have a higher risk of SAD than older adults. SAD has been reported even in children and teens.

The causes of SAD are unknown, but research has found some biological clues:

People with SAD may have trouble regulating one of the key neurotransmitters involved in mood, serotonin. One study found that people with SAD have 5 percent more serotonin transporter protein in winter months than summer months. Higher serotonin transporter protein leaves less serotonin available at the synapse because the function of the transporter is to recycle neurotransmitter back into the presynaptic neuron.

People with SAD may overproduce the hormone melatonin. Darkness increases production of melatonin, which regulates sleep. As winter days become shorter, melatonin production increases, leaving people with SAD to feel sleepier and more lethargic, often with delayed
circadian rhythms.

People with SAD also may produce less Vitamin D. Vitamin D is believed to play a role in serotonin activity. Vitamin D insufficiency may be associated with clinically significant depression symptoms.

There are four major types of treatment for SAD:

Medication

Light therapy

Psychotherapy

Vitamin D

These may be used alone or in combination.

Medication: Selective Serotonin Reuptake Inhibitors (SSRIs) are used to treat SAD. The FDA has also approved the use of bupropion, another type of antidepressant, for treating SAD.

As with other medications, there are side effects to SSRIs. Talk to your doctor about the possible risks of using this medication for your condition. You may need to try several different antidepressant medications before finding the one that improves your symptoms without causing problematic side effects.

Light Therapy: Light therapy has been a mainstay of treatment for SAD since the 1980s. The idea behind light therapy is to replace the diminished sunshine of the fall and winter months using daily exposure to bright, artificial light. Symptoms of SAD may be relieved by sitting in front of a light box first thing in the morning, on a daily basis from the early fall until spring. Most typically, light boxes filter out the ultraviolet rays and require 20-60 minutes of exposure to 10,000 lux of cool-white fluorescent light, an amount that is about 20 times greater than ordinary indoor lighting.

Psychotherapy: Cognitive behavioral therapy (CBT) is type of psychotherapy that is effective for SAD. Traditional cognitive behavioral therapy has been adapted for use with SAD (CBT-SAD). CBT-SAD relies on basic techniques of CBT such as identifying negative thoughts and replacing them with more positive thoughts along with a technique called
behavioral activation. Behavioral activation seeks to help the person identify activities that are engaging and pleasurable, whether indoors or outdoors, to improve coping with winter.

Vitamin D: At present, vitamin D supplementation by itself is not regarded as an effective SAD treatment. The reason behind its use is that low blood levels of vitamin D were found in people with SAD. The low levels are usually due to insufficient dietary intake or insufficient exposure to sunshine. However, the evidence for its use has been mixed. While some studies suggest vitamin D supplementation may be as effective as light therapy, others found vitamin D had no effect.

Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. this may include:

- issues with family of origin,
- current stressors,
- present and past emotional status,
- present and past social networks,
- present and past coping skills,
- present and past physical health,
- self-esteem,
- interpersonal conflicts
- financial issues
- cultural issues
There are different sources of data that may be obtained from a:

- clinical interview,
- Gathering of social history,
- physical exam,
- psychological testing,
- contact with client's or patient's significant others at home, school, or work.

The integration of all this data is very critical for the clinician's effect in treatment. It is important to understand the client's or patient's present awareness and the basis of the client's struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There are 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

**Step 1, Problem Selection and Definition:**

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client's or patient's own prioritization of the problems presented. The client's or patient's cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client's or
patient’s needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

***For a full listing of Goals and Strategies aligned next to each other, check the Apps for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps, and Download the Free Demo***

Behavioral Definitions for Individuals with Depression Problems:

A. Poor concentration and indecisiveness.
B. Social withdrawal or low self-esteem.
C. Suicidal thoughts and/or gestures.
D. Feelings of hopelessness, worthlessness, or inappropriate guilt.
E. Loss of appetite or sleeplessness or hypersomnia.
F. Depressed affect or unresolved grief issues.
G. Diminished interest in or enjoyment of activities or lack of energy.
H. Psychomotor agitation or retardation.
I. Mood-related hallucinations or delusions.
J. History of chronic or recurrent depression for which client has taken antidepressant medication, been hospitalized, had outpatient treatment.
Step 2, Long Term Goal Development:

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

Long Term Goals for Individuals with Depression Problems:

A. Alleviate depressed mood and return to previous level of normal functioning.

B. Encourage patient recognize, accept, and cope with feelings of depression.

C. Establish healthy cognitive patterns and beliefs about self and the world that lead to alleviation of depression symptoms.

D. Encourage patient during the grieving process to normalize mood and to return to previous level of functioning.

Step 3 and 4, Objective or Short Term Goal Construction and Strategies to Accomplish Goals:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurables objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously
stated in non measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal "13. Increase positive self-descriptive statements." Can be restated as; "By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem". Remember, that it must be stated in a way one can measure effectiveness.

It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

Strategies or Interventions:

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client’s needs and presenting problem.
An example of a short term goals and its aligned strategies:

Short Term Goal Goal 1:
Explore any history of suicide attempts and any current suicidal urges.

Therapeutic Interventions For Goal 1:
Assess prior history and current state of suicidal urges and behaviors.
Encourage client verbalize not longer having thoughts of self-harm, and complete an written agreement to not self harm.
Continuously monitor suicide potential and intent.
Refer and arrange for hospitalization if client is judged to be harmful to self.

Short Term Goal Goal 2:
Implement behavioral strategies to control and overcome depression.

Therapeutic Interventions For Goal 2:
Implement coping strategies such as less internal focus on the present behaviors, physical exercise, increase social involvement, increase need for sharing with others, more controlled anger expression, and greater assertiveness; and reinforce these behaviors throughout therapy.
Increase positive behavioral activities that have are stronger likelihood for pleasure and social contact that increases self confidence, and use rehearsal, role playing and role reversal to practice adopting these activities into daily life.
Teach self-reliance where the client learns to assume a higher responsibility to establish routine activities that increase self-esteem such as cooking, going out with others, shopping, and reinforce these activities throughout therapy.
Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. It is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.

DSM V Code Paired with ICD_9-CM Codes (Parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Possible Diagnostic Suggestions for Adults Suffering Depression Issues:

__. (__.__) Major Depressive Disorder
__. (__.__) Single episode
296.21 (F32.0) Mild
296.22 (F32.1) Moderate
296.23 (F32.2) Severe
296.24 (F32.3) With psychotic features
296.25 (F32.4) In partial remission
296.26 (F32.5) In full remission
296.20 (F32.9) Unspecified

__. (__.__) Recurrent episode
296.31 (F33.0) Mild
296.32 (F33.1) Moderate
296.33 (F33.2) Severe
296.34 (F33.3) With psychotic features
296.35 (F33.41) In partial remission
296.36 (F33.42) In full remission
296.30 (F33.9) Unspecified

Bipolar I Disorder

Specify: Current or most recent episode manic
296.41 (F31.1 1) Mild
296.42 (F31.12) Moderate
296.43 (F31.13) Severe

296.44 (F31.2) With psychotic features
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified

296.40 (F31.0) Current or most recent episode hypomanic
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified

Current or most recent episode depressed
296.51 (F31.31) Mild
296.52 (F31.32) Moderate
296.53 (F31.4) Severe

296.54 (F31.5) With psychotic features
296.55 (F31.75) In partial remission
296.56 (F31.76) In full remission
296.50 (F31.9) Unspecified

296.7 (F31.9) Current or most recent episode unspecified
296.89 (F31.81) Bipolar II Disorder
Specify current or most recent episode: Hypomanic, Depressed
Specify course if full criteria for a mood episode are not currently met: In partial remission, in full remission
Specify severity if full criteria for a mood episode are not currently met:
Mild, Moderate, Severe

301.13 (F34.0) Cyclothymic Disorder
Specify if: With anxious distress

Substance/Medication-Induced Bipolar and Related Disorder
293.83 Bipolar and Related Disorder Due to Another Medical Condition
Specify if:
(F06.33) With manic features
(F06.33) With manic- or hypomanic-like episode
(F06.34) With mixed features

296.89 (F31.89) Other Specified Bipolar and Related Disorder
296.80 (F31.9) Unspecified Bipolar and Related Disorder

301.6 (F60.7) Dependent Personality Disorder
301.82 (F60.6) Avoidant Personality Disorder
Overall Integration of a Treatment Plan:

Choose one presenting problem. This problem must be identified through the assessment process.

Select at least 1 to 3 behavioral definitions for the presenting problem. If a behavior definition is not listed feel free to define your own behavioral definition.

Select at least one long-term goal for the presenting problem.

Select at least two short-term goals or objectives. Add a Target Date or the number of sessions required to meet this short term goals. If none is listed feel free to include your own.

Based on the short-term goals selected previously choose relevant strategies or interventions related to each short term goal. If no strategy or intervention is listed feel free to include your own.

Review the recommended diagnosis listed. Remember, these are only suggestions. Complete the diagnosis based on the client's assessment data.

Sample Treatment Plan:

***For a full listing of Goals and Strategies aligned next to each other, check the Apps for Windows or Apple PC and Android Devices, under the main menu Windows-Apple Apps, and Download the Free Demo***

Behavioral Descriptors of Problem:
1. Feelings of hopelessness, worthlessness, or inappropriate guilt.

2. Diminished interest in or enjoyment of activities or lack of energy.

Long Term Goals:

1. Encourage client recognize, accept, and cope with feelings of depression.

2. Establish healthy cognitive patterns and beliefs about self and the world that lead to alleviation of depression symptoms.

Short Term Goal Goal 1:

Explore any history of suicide attempts and any current suicidal urges.

Therapeutic Interventions For Goal 1:

Assess prior history and current state of suicidal urges and behaviors.

Encourage client verbalize not longer having thoughts of self-harm, and complete an written agreement to not self harm.

Continuously monitor suicide potential and intent.

Refer and arrange for hospitalization if client is judged to be harmful to self.
Short Term Goal Goal 2:

Implement behavioral strategies to control and overcome depression.

Therapeutic Interventions For Goal 2:

Implement coping strategies such as less internal focus on the present behaviors, physical exercise, increase social involvement, increase need for sharing with others, more controlled anger expression, and greater assertiveness; and reinforce these behaviors throughout therapy.

Increase positive behavioral activities that have are stronger likelihood for pleasure and social contact that increases self confidence, and use rehearsal, role playing and role reversal to practice adopting these activities into daily life.

Teach self-reliance where the client learns to assume a higher responsibility to establish routine activities that increase self-esteem such as cooking, going out with others, shopping, and reinforce these activities throughout therapy.

Diagnostic Suggestions:

296.22 (F32.1) Major Depressive Disorder - Moderate

301.82 (F60.6) Avoidant Personality Disorder