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I. Introduction

Clinical Monitoring Form: Users' Guide Edition 2.1 is updated for the latest revision of the Clinical Monitoring Form (CMF). For ease of use and better reliability, CMF 2.1 was reformatted and some under utilized optional fields found on previous versions of the CMF were eliminated. As with prior editions, the changes made to the CMF largely reflect the valuable feedback received from clinicians using the CMF. We hope you will find it a useful reference tool and welcome your comments and suggestions for further improvement.

To get the most out of this guide, you should be familiar with diagnostic nomenclature used in the DSM-IV. Knowledge of the diagnostic criteria for common psychiatric disorders is essential to good clinical care. The determination of clinical state assessed on the CMF, in particular, can not be made without understanding the DSM-IV criteria for the major mood episodes. The CMF now includes some of the key criteria for diagnosis of abnormal mood states, but CMF users are encouraged to deepen their grasp of the diagnostic criteria by reviewing the DSM-IV criteria. With a firm understanding of diagnosis as the starting point, the CMF Users' Guide explains the procedures and conventions you can use to streamline the process of eliciting and recording basic information during routine follow-up visits.

The CMF is not intended to be used as a rating scale or even as a formal diagnostic instrument per se. Instead, it is a clinical assessment and tracking tool, designed to meet the clinical need for time efficient assessment and record keeping as well as the common need of clinicians and researchers for a operationally defined outcome measure. The CMF meets the first need by enlisting the help of the patients, while at the same time providing a series of standards for notation and recording conventions. The second need is met by defining a single summary outcome, which is the Current Clinical Status, that can be used across all phases of bipolar illness.

The goals of the CMF include many of the goals of medical record keeping:

1. Determine the patient's current clinical status and response to treatment.
2. Provide a systematic follow-up to facilitate long term assessment.
3. Track medication use and adverse effects.
4. Assure patients receive high quality care.

By adopting the systematic approach and operational vocabulary presented below, clinicians can achieve these goals for clinical assessment and record keeping with minimal training. The CMF is quite simple; it merely extends the principles used in recording results of physical diagnosis to the psychiatric exam. For instance, after learning what is meant by a grade 2/6 murmur or a +3 reflex, physicians can use these conventions to record and convey meaningful clinical information concisely.

The chronic recurrent nature of mood disorders often requires an iterative approach to treatment over periods of months and years. The unstructured narrative charting techniques typically used in clinical practice are often too cumbersome, too inaccessible or too inadequate to guide this process. By providing a template for the follow-up examination and simple conventions for recording complex clinical observations, the CMF helps the clinician (and eventually the patient) to gather important clinical data systematically and record it in an easily accessible format.

The CMF assumes that clinicians have knowledge of DSM-IV diagnostic criteria. Use of the CMF also requires clinical experience of sufficient range to allow the user to judge symptom severity (e.g., 0= none, 1= mild, 2= moderate, 3= marked, 4= severe).

II. Structure of CMF

The CMF consists of eight parts:

Part	Content/objective	Location
Header	**Identification, date, and administrative fields**	Top
1	**Current Episode Screening Questions:** Assesses abnormal mood states by asking patients the number and severity of days depressed most of the day, days with any anhedonia, days with any period of abnormal mood elevation, days with any period of abnormal or excessive irritability, and days with any period of abnormal or excessive anxiety. The **DSM-IV Current Episode Screening Questions** are intended to allow reliable assessment of DSM criteria. The criteria are provided for categorical scoring in a "no", probable, and "definite" format modified from the SCID current mania and depression modules	Under header
2	**Associated Symptoms for Past Week:** Assesses diagnostic items and common associated features of depression and mood elevation. (Parts 1 and 2 can also be scored as sub-scale severity measures for both depression and mania.). These are the symptoms for both mania and depression as outlined in the DSM-IV.	under Part 1
3	Stressors, medical problems, and common comorbid conditions, additional medical care	under Part 2
4	**Current Treatments** Assesses medication use, adverse effects and compliance	under Part 3
5	**Selected Mental Status**: Evaluation of psychotic features and other mental status items	1st small box on right
6	**Laboratory data** Space in which to record the date and results of the most recent laboratory findings	2nd small box on right
7	**Current Clinical Status and other clinical assessment variables** Contains the single summary item which assigns *one* of eight operational defined clinical states at every visit; CGI score for the week; GAF scores for *both* week and month; Pathway code(s) and phase(s).	the lower right box
8	**Narrative Comments, Summary Assessments and Plan:** Provides space for a narrative to document other pertinent information, CGI, GAF, other assessments, and treatment plan.	bottom

Part 1: Current Episode Screening

The five screening questions assess mood and anxiety focusing on the last 10 days

As you feel appropriate after listening to the spontaneous response to your opening question, begin with either the DSM-IV/SCID screening questions or the questions requesting the number of days depressed, elevated, irritable, and anxious. The questions focus on the past 10 days and allow you to easily score responses as a percentage of days the patient has been depressed, disinterested, elevated, irritable or anxious. Code the percentage of days in each mood state. If the patient reports "5 or 6 days", the CMF coding conventions do not require a determination of which is correct, but record the midpoint (for this example code "55%"). This convention will save a considerable amount of time. You will find it helps to refer to the self-report form fields corresponding to these questions.

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Symptom severity rating (*optional here*) should be rated using a 0-4 scale,
where **0**=none, **1**= Mild, **2**= Moderate, **3**= Marked, and **4**= Severe

Rate severity based on your clinical experience.
When you desire to record a range of severity it is possible to simply use a range to code to the range of severity (i.e., if 5 days moderate and 2 days marked, code "2-3").

DSM-IV (SCID) Current Episode Screening Questions

Generally you will be able to score the DSM criteria accurately based on the patient's response to questions which focus on the past 10 day time interval. For example, if a patient has been depressed fewer than 4 days in the past 10 days, no additional questions are needed to score the DSM depressed mood criteria (nearly everyday in the past 2 weeks). Additional questions are often needed to confidently determine whether the DSM criteria are satisfied. For instance if a patient reports four days of mood elevation, addition questions are needed to determine if the days involved in this sequence meet DSM criteria for hypomania.

The screening questions are scored categorically rather than as a continuous variable.

Checking "**Definite**" indicates the patient definitely meets criteria for this symptom.
Checking "**Probable**" indicates subthreshold/probably meets criteria.
Checking "**No**" indicates that the patient definitely does not meet criteria.

A patient who was depressed for most of the day for only 3 days, definitely does **NOT** meet the DSM criteria (nearly every day) and so would be scored "no" on the depression screening question.

Remember to check off the answer based on all information available to you, not just the patient's subjective answers (e.g., patient's completed Clinical Self-Report Form, etc.).

Current Depression

In the past two weeks, has there been a time when you were feeling down or depressed…

Down or depressed mood most of the day, nearly every day for two weeks	**Definite**
Subthreshold/ probably meets DSM-IV criteria for this item	**Probable**
Clearly does not meet DSM-IV criteria for this item	**No**

What about being a lot less interested in most things…

Less interested in most things or unable to enjoy most things usually enjoyed for as long as two weeks most of the day, nearly everyday (note: nearly every day (9 /14 days)	**Definite**
Subthreshold/ probably meets DSM-IV criteria for this item	**Probable**
Clearly does not meet DSM-IV criteria for this item	**No**

Current Mania or Hypomania

In the past week, has there been a period of time when you were feeling so good or so hyper…

If the patient is hyper and not their normal self or so hyper that the patient got into trouble or is reported or observed to display manic behavior (note: rate 3 if clearly unusual behavior but didn't get into trouble because behavior was not observed, e.g. didn't get caught)	**Definite**
Subthreshold/ probably meets DSM-IV criteria for this item	**Probable**
Clearly does not meet DSM-IV criteria for this item	**No**

What about a period of time when you were so irritable that you would shout at people…

If clearly abnormal irritability with behavioral manifestations (e.g. starts fights/arguments)	**Definite**
Subthreshold/probably meets DSM-IV criteria for this item	**Probable**
Clearly does not meet DSM-IV criteria for this item	**No**

Once you have covered these sections, complete the DSM-IV/SCID current mood modules by asking about associated symptoms in the tables for depression and mood elevation.

Associated Symptoms Past Week

Inquire about each item beginning with your standard (SCID type) question for screening. Suggestions for wording are provided with the anchor points outlined below. These sample questions have been satisfactory for clinical use, but the exact wording is less important than consistency and being sure patients understand the point of your question. Formulating an equivalent question of your own is acceptable so long as you are comfortable with the phrasing and you judge that patients are generally responding appropriately. Ask follow-up questions as necessary to determine whether that item meets the DSM-IV symptom criteria. Note: The CMF coding is modified to allow tracking of absolute symptom severity.

Symptoms of insufficient severity to meet DSM-IV/SCID criteria are coded using fractions.
If a symptom meets DSM-IV criteria, it is coded at least '1' and is given a plus or minus sign to indicate the direction of deviation from normal. In all cases, you are rating symptom severity relative to the normal, euthymic state.

0 **None or usual**		
Decreased	from **Normal, Euthymic State**	**Increased**
-1/4	*Questionable, Slight or Rare Symptom* *(occurred once or twice) but not clinically significant*	+1/4
-1/2	*Clearly present Symptom but subthreshold for DSM-IV* **Mild**	+1/2
-1	**Moderate** *Clearly present and fulfills DSM-IV criteria*	**+1**
-1.5	**Marked**	+1.5
-2	**Severe**	+2

This scale is intended to provide a means of tracking symptom intensity and use of intermediate scores such as 1.5 are encouraged. The scores of + 2 or –2 indicate the extreme of common symptoms, but are not reserved for the worst imaginable case.

Summary of Symptom Scoring:
For each item below, descriptors and examples are provided for scores with absolute values of ¼, ½, 1, 1.5, and 2. Please use your best clinical judgement to select the score which best corresponds to the definitions provided below.

NOTE: Two symptoms are grouped within one column (Guilt/Self-Esteem, Concentration/Distraction, PMA/PMR, and Goal-Directed Activity/PMA), because for diagnositic purposes the DSM counts them as one symptom even if both are present. For example, if a patient has a +1 for guilt and a –1 for self-esteem, the whole column would be counted as one symptom, not two. Also, when determining the count of symptoms reaching criteria for diagnosis of depression, hypomania, mania, or mixed episodes do not sum across the column: a +1/2 for PMA and +1/2 for PMR do not amount to a symptom reaching threshold.

Nearly every day ³ about 70% of days (e.g. ³ 5 in past week, ³ 9 in past 2wks)
Fleeting = < 1 minute, Brief period: 1-15 minutes, Persistent period = ³ 15 minutes

CMF/ADE-Depression Items

Note: To count toward the clinical status of depression, DSM-IV requires associated symptoms be present nearly every day and to be of moderate severity or above.

Rate Depression ³1 if DSM Screening Question above = definite

Depression	'ersistently feels "depressed", "sad", down", "blue" or equivalent dysphoria	
0	**Not depressed**	
	Frequency	**Intensity**
+¼	**Any**	**Any dysphoria = questionable, mild, or rare e.g. significantly depressed, sad, or cried, once or twice this week.**
+½		
+1 Moderate	**Nearly every day**	**Depressed/dysphoric most of the day (Score if DSM screening question above is rated "definite"**
+1.5		
+2 Much more/less	**Nearly everyday**	**Constant/unremitting intense dyphoria**
Use zero or positive numbers only.		

Sleep: *What has your sleep been like this week?*
Indicate Range (i.e. 4 – 5) hours,
Indicate presence of each item "+" / "-": DFA, MCA, EMA, DGOOB, Naps (located to right of symptoms; definitions of abbreviations can be found in the Appendix)

Sleep	)isturbance in quality or amount of sleep which may include early bedtime, napping, difficulty ling asleep, midcycle awakening, early morning awakening, and/or difficulty getting out of bed.	
0	**Sleeping normally every night.**	
	Frequency	**Duration**
±¼	**Any**	**Any sleep disturbance = questionable, mild, or rare g. once or twice this week, needed a brief nap, or significant insomnia/hypersominia.**
±½		
±1 Moderate	**Nearly every day**	³ **1 hr/d deviation from normal. either an increase or decrease**
±1.5		
±2 Much more/less	**Nearly everyday**	³ **Sleep increase 50% ABOVE NORMAL or decrease below 50% of Normal.**
If disturbance is in both directions, assign the sign based on which ever predominates.		

Interest: *This week have you been able to enjoy pleasant things that happened?*
Indicate presence of anhedonia "+" / "-"

Interest	Loss of motivation or connectedness with others. Loss of interest in or diminished capacity for enjoyment of pleasurable activities (sex, work, recreation or hobbies). Feels s/he has to push self to work or activities even if has enough energy to accomplish the activity.	
0	**Enjoys activities as usual.**	
	Frequency	**Intensity**
-¼	**Any**	**Any decreased interest = questionable, mild, or rare (e.g. one or two activities less pleasurable, but able to enjoy most things).**
-½		
-1 Moderate	**Nearly every day persistent**	**Loss of interest or capacity to enjoy most things.**
		Reports disinterest/decreased motivation but able to enjoy some activities when engaged under favorable conditions.
-1.5		
-2 Much less	**Nearly everyday** persistent	**Emotionally constricted, can't cry, could not respond to very favorable stimuli.**
Positive numbers are used to indicate a greater interest than normal (e.g. hypersexuality) but do not count toward the diagnosis of depression.		

Guilt: *Have there been times you were down on yourself? Did you feel as if you were a bad person or that you deserved to suffer?*

Guilt	Self-reproach, feels s/he has let people down, Present illness is a punishment. Delusions of guilt. Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.	
0	**No excessive self blame or guilty preoccupation**	
	Frequency	**Intensity**
+¼	**Any**	**Questionable, mild, or rare self deprecatory thoughts.**
+½		
1 Moderate	**Nearly every day persistent periods**	**Self deprecatory thoughts (not limited to inability to function due to illness).**
		Ideas of guilt or ruminations over past errors or sinful deeds
+1.5		
+ 2 **Much more**	Nearly every day, frequent periods of persistent	**Frequency = nearly every day persistent. Intensity: Ideas of guilt or ruminations over past errors or sinful deeds.**
Use zero or positive numbers only.		

Self Esteem: *How was your self esteem or self confidence compared to usual?*

Self Esteem /Self confidence	Feels inferior, defective, incompetent, inadequate.	
0	**Normal self esteem / self confidence.**	
	Frequency	**Intensity**
-¼	**Any**	**Questionable, mild, or rare; feels down on self, lacks self confidence.**
-½		
-1 Moderate	**Nearly every day persistent**	**Feels inferior to most others (not limited to inability to function due to mood disorder).**
		Stops work or social activities due to expectation of failure.
-1.5		
-2 Much Less	**Nearly every day persistent**	**Worthlessness--? delusional**
Positive numbers are used to indicate a greater than normal self esteem (e.g., grandiosity) but do not count toward the diagnosis of depression.		

Note: Usually rating made here will be the same as that made for the mood elevation self esteem item, but when both increased self esteem and decreased self esteem are present, indicate decrease here and increase under mood elevation.

Energy: *How was your energy level this week? Were there things which you should have done and didn't because you didn't have enough energy or were simply too tired? For example?*

Energy	Fatigue, Decreased energy, feels tired or tires easily.	
0	**Usual energy level**	
	Frequency	**Intensity**
-¼	**Any**	**Sufficient energy to carry out all activities but occasionally tired or feels some tasks are harder to complete or more draining than usual.**
-½		
-1 Moderate	**Nearly every day, most of the day**	**Lack of energy interferes with at least some activity at work, home, or socially (not due to lack of motivation).**
		Too tired to complete necessary or pleasant tasks.
-1.5		
-2	**Nearly everyday, most of the day**	**Lethargic Stays in bed**
Positive numbers are used to indicate a greater than normal energy level but do not count toward the diagnosis of depression		

Concentration/Distractibility: *How is your concentration? Have you been able to read the newspaper (watch TV)? Do you find there are times when you are easily distracted? Is it hard to focus in the first place, or do you find youe your attention id constantly drawn away by other thoughts or things going on around you?*

Concentration	Inability to concentrate, inability to focus on a task, difficulty making decisions.	
0	**Enjoys activities at usual**	
	Frequency	**Intensity**
-¼	**Any**	**Impairment in concentration rare, questionable, or limited to unpleasant or unusually demanding difficult tasks.**
-½		
-1 Moderate	**nearly every day, most of the day**	**Reports inability to read newspaper or follow a television show.**
		Finds it difficult to collect thoughts in conversation.
		Stopped worked or unable to function in role at home due to impaired concentration.
-1.5		
-2 Much less	**Nearly everyday, constantly**	**Clear cognitive impairment evident during casual interaction.**
Positive numbers may be used to indicate a greater than normal capacity to concentrate but do not count toward the diagnosis of depression.		

Distractible	Unable to maintain focus of attention easily distracted by external or internal stimuli.	
0	**No evidence of distractibility.**	
	Frequency	**Intensity**
+¼	**Any**	**Generally able to maintain focus despite occasional subjective or objective distraction due to extraneous worries, environmental stimuli.**
+½		
+1 Moderate	**nearly every day, most of the day**	**Reports decreased ability to complete tasks due to distractibility.**
		Able to complete tasks but requires a great effort.
+1.5		
+2 Much more	**Nearly everyday, constantly**	**Evidence of distractibility obvious in most conversations, and present at interview.**
Use only zero or positive numbers		

Appetite: *How was your appetite this week?*

Appetite	Disturbance of appetite (increased or decreased from normal appetite).	
0	**Appetite normal.**	
	Frequency	**Intensity**
±¼	**Any**	**Questionable, mild, or rare increase or decrease in appetite.**
±½		
± 1 Moderate	**Nearly every day**	**Decreased consumption (e.g. intake reduced » 25%) Requires encouragement to eat**
		Increased consumption / craving food or seeks food in addition to usual meals.
±1.5		
±2 Much more/less	**Nearly every day persistent**	**Weight Loss/gain >5pounds or 2kg in past 2 weeks. Eating < »50% and or > »50% of usual consumption.**
Count all days with appetite disturbance toward frequency rating and use appropriate sign to indicate predominant direction of change		

Psychomotor Retardation (PMR)/Psychomotor Agitation (PMA): *Were there times you were moving or thinking more slowly than usual (or feeling like molasses in January)? If I had been with you would I have noticed something was wrong? What about the opposite, so fidgety or agitated it was hard for you to stay still?*

Psychomotor Retardation	**Slowness of thought and speech; impaired ability to concentrate; decreased motor activity, lassitude.**	
0	**No evidence of motor, speech or cognitive slowing.**	
	Frequency	**Intensity**
+¼	**Any**	**Subjective slowing of thoughts, speech or movement or rare objective evidence of retardation.**
+½		
+1 Moderate	**Nearly every day , at least intermittent periods occur through most of the day**	**Slowness of thought or movement observable by others.**
		Increase speech latency.
+1.5		
+2 Much more	**Nearly every day persistent**	**Slowness of thought or movement that impedes function to a marked degree. Must be visible at interview?**
Use only zero or positive numbers		

Psychomotor Agitation	Fidgetiness, Playing with hands, hair, etc. Moving about, can't sit still, purposeless activity. Hand-wringing, nail biting, hair pulling, biting of lips.	
0	**No evidence of motor agitation**	
	Frequency	**Intensity**
+¼	Any	Restlessness, fidgets, purposeless movement, pacing.
+½		
1 Moderate	**Nearly every day , at least intermittent periods occur through most of the day**	**Difficulty remaining still or purposeless movement observable by others (appears agitated not simply busy).**
+1.5		
+2 Much more	**Nearly every day persistent**	**Pacing or unable to sit still when necessary.**
Use only zero or positive numbers		

Suicidal Ideation (SI): *Were there times when you were feeling so bad that you felt life was not worth living? What about actually thinking about suicide or harming yourself?* Narrative note required if code ≥1/4. If passive or active suicidal ideation document details and plan for safety.

Suicidal Ideation	Weary of life, would be better or dead, morbid preoccupation, thoughts of harming self, plans for self-destruction, urge to end life. **Use narrative note if code > 1/4. If passive or active suicidal ideation, document details and plan for safety.**	
0	**No SI / no morbid preoccupation**	
	Frequency	**Intensity**
+¼	**Rare fleeting**	**LNWL**
		Passive SI (Thoughts of death **without** plan for self destruction, no action or urge to act)
+½	Several days, fleeting	LNWL
		Passive SI (Thoughts of death **without** plan for self destruction, no action or urge to act)
		Active SI (Suicidal thoughts with plan for self destruction but no action or urge to act
	Several days, persistent periods	**Passive SI** (Thoughts of death **without** plan for self destruction, no action or urge to act)
+1 Moderate	**nearly every day, persistent most of the day**	**LNWL**
	nearly every day any period of persistent	**Passive SI** (Thoughts of death without plan for self destruction, no action or urge to act)
	several days, brief	**Active SI** (Suicidal thoughts with plan for self destruction but no action or urge to act
+1.5	>1 Persistent period	**Active SI** (Thoughts of death with plan for self destruction but no action or urge to act)
+2 Much more	nearly every day, persistent	**Active SI** (Thoughts of death with plan for self destruction but no action or urge to act)
	Any	Active SI with urges to harm self or has been self destructive (not superficial gesture)
Use only "0" or positive numbers		

If Suicidal Ideation is coded > 0, circle the appropriate abbreviation to the right of the symptoms.

CMF/ADE-Mood Elevation Items

Note: To count toward the clinical status of hypomania or mania, DSM-IV criteria requires these items be "present to a significant degree". Therefore, use your clinical judgement to determine the clinical significance of symptoms that occur during the week being rated.

Self-Esteem/Self-Confidence: *Have there been times when you were feeling more self confident than usual or like you were special, more talented, more attractive or smarter than usual? Have there been any times when your thoughts were grandiose?*

Self Esteem /Self confidence	Inflated self confidence, feels more attractive, more talented and/ or able to do much more than usual, grandiosity.	
0	**No excessive self blame or guilty preoccupation**	
	Frequency	**Intensity**
+¼	**Any**	**Mild, rare or questionable Some exaggerated sense of abilities.**
+½		
+1 Moderate	**Present to a significant degree 4-7 days**	**Clearly inflated estimate of capabilities. (Pt. still within his/her domain of competence, but is unlikely to perform at self-reported level).**
		Actual performance may be improved but assessment of the achievement or self is excessively positive
+1.5		
+2 Much more	**Nearly every day persistent**	**Grossly excessive ideas of worth, abilities--? To delusional degree. Unquestionably beyond areas of competence and capabilities.**
Negative numbers are used to indicate a lower than normal level of self esteem (e.g. worthlessness) but do not count toward the diagnosis of mania or hypomania.		

Note: Usually rating made here will be the same as that made for the depression self esteem item, but when both increased self esteem and decreased self esteem are present, indicate increase here and decrease under depression.

Need for sleep: *Have there been nights were you got less sleep than usual and found you didn't really miss it?* (Do not count simple insomnia)

Need for Sleep	Rate subjective need for sleep and ability to function with decreased sleep compared to normal sleep requirement or 5 hrs which ever is greater.	
0	**Usual need for sleep**	
	Frequency	**Intensity**
-¼	**Any**	**Mild rare or questionable decrease need for sleep without commensurate impact on function.**
-½		
- 1 Moderate	**Present to a significant degree (>33% of) 4-7 days**	**Sleep time reduced by ³ 1.5 hrs without commensurate impact on next day function (e.g. usually requires 7 hrs but sleeping 5 hrs without day time drowsiness).**
-1.5		
-2 Much less	**Nearly every day persistent**	**Sleep reduced by > 5hrs from usual or sleeping < 2 hrs sleep/day.**
Positive numbers are used to indicate a greater than normal need for sleep, but do not count toward the diagnosis of mania, or hypomania.		

Talking: *Were there any times you were more talkative than usual, or you found you said much more than you intended? Any time that you spoke faster than usual?*

Talking	**Rate amount and rate of speech.**	
0	**Normal rate and quantity of speech.**	
	Frequency	**Intensity**
+¼	**Any**	**Others note talkativeness but not out of character or bothersome.**
+½		
+1 Moderate	**Present to a significant degree 4-7 days, at least intermittent periods occur on > 1 day**	**People complain of excessive talking. Pt uncharacteristically cuts others off.**
		Pressured speech (described or observed)
		Conversation Seeking (eg long distance phone calls)
		Communicatio n reveals more than intended
+1.5		
+2 Much more	**Nearly every day consistently**	Hard for others to get a word in. Virtually incessant talking.
Negative numbers are used to indicate when patient is less talkative than normal, but do not count toward the diagnosis of mania, or hypomania.		

Flight of Ideas/Racing Thoughts: *Did you find that you had more ideas than usual? Were there times when your thoughts seemed to be racing through your head?*

FOI/Racing Thoughts	Rate of thought subjectively racing. Increase in train of productive, novel, and/or unrelated ideation.	
0	**none**	
	Frequency	**Intensity**
+¼	**Any**	**Pt describes mild degree of thinking fast.**
+½		
+1 Moderate	**To a significant degree over 4-7 days**	**Ideas race, come tumbling out. Pt may experience as pleasurable or not.**
		Rapid train of thoughts (not limited to depressive ruminations)
+1.5		
+2 Much more	**Nearly every day persistent**	**Speech cannot keep up w/ pressured thoughts.**
Only "0" or positive numbers are used.		

Distractibility: *Did you find you were easily distracted?*

Distractible	Unable to maintain focus of attention easily distracted by external or internal stimuli.	
0	**No evidence of distractibility**	
	Frequency	**Intensity**
+¼	**Any**	**Generally able to maintain focus despite occasional subjective or objective distraction due to extraneous worries, environmental stimuli.**
+½		
+1 Moderate	**nearly every day, most of the day**	**Reports decreased ability to complete tasks due to distractibility**
		Able to complete tasks but requires a great effort.
+1.5		
+2 Much more	**Nearly everyday** .	**Evidence of distractibility obvious in most conversations. Can't stay on a topic, even to complete most sentences and thoughts.**
Negative numbers can be used to indicate an improvement over normal (e.g. patient describes thoughts are much sharper with greater ability to focus during hypomanic episodes), but do not count toward the diagnosis of depression, hypomania, mania or mixed episodes.		

Goal Directed Activity: *Did you have difficulty making new plans or get new projects started? Were you so active that people worried about you taking on so much, or did you find you were so active that you really didn't get much done?*

Goal Directed Activity	**Plans, projects, purposeful activites**	
0	**No evidence of motor, speech or cognitive slowing**	
	Frequency	**Intensity**
+¼	**Any**	**Initiated one or more new projects**
+½		
+1 Moderate	**nearly every day, at least intermittent periods**	**Initiated new projects requiring commitment of > 8hrs/wk of activity or > 5% of expected annual income**
		Engages in multiple creative, self improvement or home improvement projects (cleaning, writing, decorating, remodeling) in the absence of external requirements
+1.5		
+2 Much more	nearly every day persistent	Projects required total work effort beyond 10/d or must work after 9 p.m.
Negative numbers are used to indicate when a patient is less engaged in goal directed activities (e.g. stopped work, chores, or hobbies) , but do not count toward the diagnosis of mania, or hypomania.		

Psychomotor Agitation (PMA): *Were there times you were so fidgety or agitated it was hard for you to stay still?*

Psychomotor Agitation	Fidgetiness, Playing with hands, hair, etc., Moving about, can't sit still, Purposeless activity Hand-wringing, nail biting, hair pulling, biting of lips.	
0	**No evidence of motor agitation**	
	Frequency	**Intensity**
+¼	**Any**	**Restlessness, purposeless movement, pacing.**
+½		
+1 Moderate	**nearly every day , at least intermittent periods occur through most of the day**	**Difficulty remaining still or purposeless movement observable by others (appears agitated not simply busy).**
	nearly every day	**Pacing or unable to sit still when necessary.**
+1.5		
+2 Much more	**nearly every day persistent**	**Pacing or unable to sit still when necessary. Observable at interview.**
Use only zero or positive numbers		

High Risk Behavior: *Did you do anything that was unusual for you or that other people might think was excessive, foolish, or risky? Did you do anything which would have caused a problem if you were caught?*

Risk taking	Excessive, foolish or risky behaviors, that could have serious consequences for self or others (whether or not patient is caught).	
0	**No risk taking**	
	Frequency	**Intensity**
¼	**Any**	**Questionable, mild, rare. risk taking/ increased pleasure seeking**
½		
1 Moderate	**To a significant degree during a 4-7 period**	**Exhibits behaviors others recognize as foolish, excessive or risky (gambling, bad investments, inappropriate sexual advances, and/or reckless driving that would have negative consequences /penalties if caught)**
		Definitely hazardous behavior: social, sexual, financial. Likely to have adverse consequences. Outside of normal risk tolerance for pt.
1.5		
2 Much more	**Persistent**	**Extremely hazardous behaviors: highly likely to result in life threatening physical injury, enduring financial or social catastrophe.**
Negative numbers are used to indicate when a patient is more risk avoidant than usual (e.g. decides not to drive, agrees to abstain from alcohol, or pulls back on investments) but do not count toward the diagnosis of mania, or hypomania.		

Part 3: Stressors, Medical Problems and other Comorbid Conditions

New Major Stressor: Record, if it seems important to the patient (Also use for DSM-IV Axis IV)

Caffeine - estimate cups/day (c/d) based on 6 ounces of coffee

Nicotine - packs per day (ppd); if patient indicates smoking a pipe, cigar or chewing tobacco, you should estimate 1 pipe, I cigar or 1 tobacco chew equaling 5 cigarettes in a pack. For example, if a patient has 1 cigar per day, ppd nicotine should be recorded as '.25'.

Onset of Menses: Code first day of menstruation and circle whether it came on 'early', 'late' or 'NA' if menses is not applicable (e.g., patient is man, patient is post-menopausal woman).

Alcohol and substance abuse - Circle Y or N to indicate whether DSM-IV criteria is met; Optional: indicate level of use for alcohol and recreational drug use

Headaches, binge/purge and panic attacks – Circle Y if present at all during the past week or N if not.

Significant Medical Illness - Circle Y if there was a new onset medical illness or exacerbation of chronic condition during the past week (Also use for DSM IV Axis III). Circle N if none present. If Y is circled, indicate the illness.

Additional Psych tx (Additional psychiatric treatment) and Additional Gen Med (Additional General Medical Treatment) – If present, circle the type of care provided: OP (operation), ER (Emergency Room) or Hosp (Hospitalization).

Part 4: Current Medications, Compliance, and Adverse Effects

Standing Medications: Indicate drug, milligrams/24 hrs as prescribed, and total mg missed in last 7 days.

PRN Medication: Indicate drug, usual mg dose and enter PRN into space for mg missed in 7 last days.

Adverse Effects of Medications: Begin by asking a nonleading question, e.g. "Have you been having side effects from your medication?" Follow-up as necessary to determine the severity of each spontaneously reported adverse effect.

Additional specific enquiry should be made in two circumstances:

1. The patient previously reported an adverse effect but has not reported it at this visit, (eg headache). Ask the patient if the symptom (headache) is still a problem.
2. Any observable sign not spontaneously reported (e.g. tremor, akathasia, slurred speech).

Psychosocial Interventions, ECT and Other: Indicate number of visits for the past month.

Noncompliance: Indicate significant if missed (25% of prescribed psychotropic in the absence of an adverse effect or reasonable administrative issue (misunderstood directions, or couldn't obtain drug due to cost, weather, or other circumstance outside patients control.). Record any concomitant non-psychotropic medications.

Rate Adverse effect severity: 0=None,1= Mild, 2=Moderate,3= Marked, and 4=Severe

Part 5: Mental Status: Selected Symptoms of Disordered Thinking

PI = paranoid ideation

IOR = ideas of reference

OC = True Obsessions or compulsions (but criteria for OCD not required)

Clarify as with OCD what are true OCD symptoms versus ruminations associated with depression or mania. Compulsive behaviors associated with mania do not meet OCD when they result from special significance assigned to a person, object or act (i.e., a person arranges all objects in a room in a ritualistic way because by sorting objects in this manner they will discover a cure for cancer)

Other pertinent mental status items may be written in this space or in the narrative below.
Rate Mental Status items severity: 0=None, 1= Mild, 2=Moderate, 3= Marked, and 4=Severe

Part 6: Laboratory Data (Optional)

Record date and result of most recent lab studies.
If necessary, note if result was obtained outside of steady state, at peak, etc.

Part 7: Assignment of Clinical Status

This rating is critical - it directs much of what happens in the treatment**.**

Definitions for Assignment of Clinical Status

If DSM-IV Criteria for Current Episode: Positive		
	Associated Symptoms of Mania or Depression	**Assigned status**
Major depression	≥ 5 moderate	**Depression**
Mania	≥ 3 moderate †	**Mania**
Hypomania	≥ 3 moderate †	**Hypomania**
Major depression and mania	≥ 3 moderate for mania and ≥ 5 moderate for depression	**Mixed** *

† For mania and hypomania, ≥4 moderate symptoms are needed if mood is only irritable, not elevated.
*Include as Mixed clinical status when mood abnormally high or low nearly everyday, but does not meet criteria for mania or depression. (e.g. In past 10 day depressed 5days and mood elevated 3 days if also meets associated feature criteria for mixed)

If DSM-IV Criteria for Current Episode: Negative		
"Recovered" from last acute episode	Associated Symptoms **of Mania or Depression**	Assigned status
No	≥ 3 moderate symptoms	**Continued Symptomatic**
No	≤ 2 moderate symptoms †	**Recovering**
Yes, if "recovering" ≥ 8 consecutive weeks	≤ 2 moderate symptoms †	**Recovered**
Yes	≥ 3 moderate symptoms †	**Roughening**

† If a symptom is greater than moderate in severity (marked or severe), you would round up the symptoms. In the instance of 'recovered', one moderate symptom and one more than moderate symptom, or two more than moderate symptoms would count as roughening, rather than 'recovered', especially if one of the symptoms was a new symptom that the patient was experiencing. Similarly, in the case of 'recovering' if there is a moderate symptom and a more than moderate symptom, or two more than moderate symptoms, the patient would be considered 'continued symptomatic'. In the instance of 'roughening', a patient could have two more than moderate symptoms and be considered 'roughening' if these were new symptoms that the patient was experiencing.

REMEMBER: ONLY ***ONE*** **CLINICAL STATUS** MAY BE RECORDED.

Clinical Global Impression, SEVERITY OF ILLNESS (CGI)

Considering your total clinical experience with this particular population, how mentally ill is the patient at this time? Remember to rate this according to the past week.

1=Normal, not at all ill
2=Borderline mentally ill
3=Mildly ill
4= Moderately ill
5= Markedly ill
6= Severely ill
7= Among the most extremely ill

Global Assessment of Functioning (GAF) Scale (DSM -IV=Axis V) for past week AND month

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health and illness. Do not include impairment in functioning due to physical (or environmental) limitations.

100 ↑ 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought our by others because of his or her many positive qualities. No symptoms.
90 ↑ 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 ↑ 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
70 ↑ 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 ↑ 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational or school functioning (e.g., few friends, conflicts with peers or co-workers).
50 ↑ 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).
40 ↑ 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas such as work or school, family relations, judgement, thinking or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing school).
30 ↑ 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).
20 ↑ 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 ↑ 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

Part 8: Narrative Comments and Plan

Record any additional information regarded as clinically pertinent.
Should include treatment plan and recommended time for follow-up.

III. Phases of Treatment: Explanation

Acute Phase:
The acute phase begins when the patient meets criteria for an episode (depression, mania, hypomania, or mixed), and treatment is initiated. Each individual acute treatment trial is carried out to one of three endpoints:

1) Discontinuation because the patient is unable to tolerate adverse effects of treatment;
2) Discontinuation because the patient has failed to respond to a maximal trial of the treatment (including, if warranted, augmentation strategies);
3) The patient has improved during this treatment.

Problems during the acute phase include treatment intolerance, inadequate dosage, partial response, and non-response. Treatments are adjusted or replaced as necessary to manage these problems until the acute symptoms remit ending the acute phase.

Continuation Phase:
Remission of acute symptoms defines the beginning of the continuation phase, but relapse with full or partial return of symptoms is the most frequently encountered problem during the continuation phase. Successful acute therapies are therefore continued at full dosage for a period of time to prevent relapse. With the remission of symptoms, the continuation phase is also a time when denial of illness fosters noncompliance.

The length of the continuation phase is based on the clinician's estimate of the period necessary to exceed the likely (natural) duration of episode in the absence of treatment. Whether the estimated duration of the continuation phase is determined on the basis of the patient's prior episodes or based on a more general estimate of the likely duration of depressive or manic episodes, the purpose of the continuation phase is to avoid relapse. This is most often accomplished by continuing treatment at the levels required to induce remission but may also involve titration of the dosage. Some treatment responsive patients may benefit by dose reduction during the continuation phase if medication side effects substantially negate the gains due to remission of mood symptoms. A larger group will intermittently experience significant symptoms during the continuation phase (continued symptomatic) which, while not fulfilling criteria for an acute depressive episode, may warrant an increase in antidepressant (or antimanic) treatments.

The continuation phase ends and the discontinuation phase or maintenance phase begins when the patient is declared to have recovered from the acute episode.

Maintenance Phase/Discontinuation Phase:
The maintenance phase follows a decision to discontinue a treatment and involves monitoring for recurrence while gradually tapering medication. A decision to redirect the therapeutic focus away from treatment of the acute episode toward maintaining recovery or preventing the recurrence of future acute episodes launches the maintenance phase. Many patients experience intermittent subsyndromal symptoms (roughening) during the maintenance/discontinuation phase. The significance of roughening depends on whether it is the harbinger of an impending acute episode or is merely a brief period of mild symptoms with little clear relation to the patient's mood disorder. Studies of such interepisode symptoms suggest that roughening with features of depression often resolve without intervention. Symptoms of hypomania carry a higher risk of evolving into full affective episodes.

The occurrence of symptoms meeting criteria for an acute episode would be considered a recurrence (new episode) requiring reintroduction of acute treatments.

How long should maintenance therapy continue? There is considerable debate as to when lifetime prophylaxis should be recommended. This complex debate need not impede most routine treatment since in many important areas there is broad consensus among experts. Expert consensus supports at least one year of prophylaxis following the first manic episode and any subsequent manic episode. There is also general agreement that patients with three or more episodes warrant long term maintenance therapy.

For STEP-BD at least one pathway should be indicated on every CMF, as well as the current phase for that pathway (A=Acute, C=Continuation, M=Maintenance, T=Termination). When a pathway is indicated on the CMF, this means that the patient is being treated with regard to that pathway during the visit. Even though a patient may be in several pathways at one time, the current CMF should indicate current treatment focus. When the patient exits/terminates a pathway, that is indicated on the CMF by circling "T" for termination.

IV. CMF/ADE Abbreviations

CVA: Cerebrovascular accident
DFA: Difficulty falling asleep
DGOOB: Difficulty getting out of bed
DM: Diabetes Mellitus
DTR: Deep tendon reflex
EBT: Early bedtime
EMA: Early morning awakening
EPS: Extra pyramidal symptoms
FOI: Flight of ideas
FTUCVD: Full-term Uncomplicated Vaginal Delivery
GAD: Generalized Anxiety Disorder
HAs: Headaches
HPI: History of present illness
HT: Head trauma
IBD: Irritable Bowel Disease
IOR: Ideas of reference
LNWL: Life not worth living
LOA: Looseness of association
LOC: Loss of consciousness
MCA: Mid-cycle awakening
MS: Multiple Sclerosis
OBC: Oral birth control
OCD: Obsessive-Compulsive Disorder
PI: Paranoid ideation
PMA: Psychomotor agitation
PMR: Psychomotor retardation
PTSD: Post Traumatic Stress Disorder
PUD: Peptic Ulcer Disease
SI: Suicidal ideation
SLE: Systemic lupus erythmatosis
Sxs: Symptoms
SZ: Seizures
Tx: Treatment

Phase
(located at bottom right of CMF: circle one)

A: Acute
C: Continuation
M: Maintenance
T: Termination

V. CMF Pathway Codes

Each patient is enrolled in at least one standard care or randomized care pathway. The pathway(s) should be indicated in the box(es) provided in the bottom right-hand corner of the CMF. Each pathway is indicated on the CMF by a unique 3-character code.

Randomized Care Pathway codes:	***CMF code***
Acute Depression	RAD
Refractory Depression	RRD
Relapse Prevention	RRP

Standard Care Pathway codes:	***CMF code***
Acute Depression	SAD
Refractory Depression	SRD
Relapse Prevention	SRP
Refractory Mania/Mixed	SRM
Secondary Mood Elevation	SME
Rapid Cycling	SRC
Acute Mania/Mixed	SAM
Comorbid: Substance Abuse	SSA
Comorbid: ADHD	SHD
Comorbid: OCD	SOC
Comorbid: Panic Disorder	SPA
Comorbid: GAD	SGA
Comorbid: PTSD	SPT
Comorbid: Social phobia	SSP
Comorbid: Bulimia	SBL

NOTE: A patient can be treated for more than one pathway. Even though the CMF only contains two areas for pathway code, it is entirely possible that a patient is treated in more than two pathways, e.g., Acute mania, substance abuse and PTSD. In a case such as this, simply attach an additional CMF to the back of the completed CMF.

VI. Using the CMF

Conducting a follow-up interview using the CMF.

Given the clinical needs and regulatory responsibilities incumbent upon clinicians managing bipolar patients, it is difficult to imagine conducting and recording a follow-up visit in less than 6o minutes. Patients realize better care can be obtained when their doctor understands as much as possible about their lives and the symptoms they suffer. Doctors attempt to provide this understanding, but also bear responsibility for monitoring their patient's medical condition and response to treatment, while titrating medication, monitoring labs and maintaining rapport. Meeting these expectations within a brief visit can strain both doctor and patient. When doctors and patient collaborate, however, a great deal can be accomplished within the 15-30 minutes usually allotted for a routine follow-up visit.

The use of the CMF and its companion self report forms facilitate the collaboration needed to provide high quality follow-up visits. The vast majority of patients (but not all) will find the consistency of being asked familiar questions at each visit establishes a comforting routine (similar to a routine physical exam) and actually increases the time available for unstructured communication. Clinicians generally find the routine increases their clinical sensitivity as well as improving time efficiency. The key to developing the rapport necessary for this collaboration is often achieved by a simple discussion with the patient in which the process and their role in the collaboration is made explicit.

Before the interview:

Nearly all patients are happy to provide updates of routine information using a self report form. Much of the information needed to complete the CMF can be gathered before the visit by teaching patients how to keep a simple daily mood chart and providing in the waiting room a self report form that collects information linked to the CMF fields. These forms, developed as companions to the CMF, are provided in appendices.

Starting the interview:

After greeting the patient, inquire about the waiting room self report form and mood chart, if the patient has not brought them into the office. Begin the interview with an open ended question asking the patient how they have been since you last saw them. This overview often provides considerable specific clinical information, but when it does not, feel free to inquire specifically about the patients current mood state. A glance at the self report forms often enables the clinician to quickly formulate the approach most appropriate for a session. The information provided will also be useful in efficiently gathering clinical information. For each of the CMF parts below, it is often easiest to start by confirming the routine information obtained from the companion forms and then clarify any discrepancies.

VII. Tables

Table 1. Modified Summary of DSM-IV Episodes

Acute Episodes with Elevated Mood			
Episode Type	Predominant Mood State	Symptom Threshold	Requires ≥3 Associated Features in presence of euphoric or expansive mood. If only irritable, ≥4 Associated Features are required.
Mania	High, euphoric, expansive, irritable	Present to a significant degree through at least 1 week, or any duration if hospitalized	1. Increased self esteem/grandiosity 2. Decreased need for sleep 3. More talkative 4. Racing thought/flight of ideas 5. Distractible 6. Increase goal directed activities/ Psychomotor agitation 7. Risk taking
Hypomania	High, euphoric, expansive, irritable	Present to a significant degree through at least 4 days	1. Increased self esteem/grandiosity 2. Decreased need for sleep 3. More talkative 4. Racing thoughts/flight of ideas 5. Distractible 6. Increased goal directed activities/ Psychomotor agitation 7. Risk taking
Mixed	Both elevated and depressed	At least 1 week during which symptoms satisfying criteria for depression are present most of the day/nearly every day and symptoms meeting criteria for mania are present to a significant degree.	

Acute Episodes with Depressed Mood			
Episode Type	Predominant Mood State	Symptom Threshold	Associated Features, Requires 5 in absence including either depressed mood or diminished interest/anhendonia
Depression	Low, dysphoric, sad, disinterested	Present most of the day/nearly every day through at least 2 weeks	1. Depressed mood 2. Sleep disturbance 3. Diminished interest/anhedonia 4. Inappropriate Guilt/low self esteem 5. Decreased energy/ fatigue 6. Inability to concentrate/make simple decisions 7. Appetite disturbance 8. Psychomotor retardation/agitation 9. Suicidal ideation/morbid preoccupation
Mixed	Both elevated and depressed	At least 1 week during which symptoms satisfying criteria for depression are present most of the day/nearly every day and symptoms meeting criteria for mania are present to a significant degree.	

Table 2. Summary of Unipolar and Bipolar Disorders

	Mania	Hypomania	Abnormal mood elevation with subthreshold symptoms	Major Depression
Unipolar Disorders				
Major Depression	Never	Never	Never	Yes
Dysthymic Disorder -index 1-2 yr period	Never	Never	Never	No, but feels chronically sad or down
Bipolar Disorders				
Bipolar I	Yes	Yes	Usually some	Usually
Bipolar II	**Never**	Yes	Usually some	Yes
Cyclothymia -index 1-2 yr period	No	Possibly	Frequent	No, but often feels sad or down
Bipolar NOS	Never	Possibly	At least once or hypomania	Usually but not required

Table 3. Protective and Risk Factors in Bipolar Disorder

Protective Factors	Risk Factors

• Use of mood stabilizing medications
• Abstinence from alcohol
• Abstinence from recreational drugs
• Structured Schedule
  • Regular Awakening and sleep times
  • Schedule of recurring social activity
  • Cues to avoid missing medication
• Support System
  • Professionals
  • Family
  • Friends
  • Self help groups
• Psychotherapy
• Harm reduction Planning
  • Learn Early warning signs
  • Empower executive function surrogate
  • Redundant contingency plans
	• Alcohol
	• Recreational drugs
	• Abrupt discontinuation of medications
	  • Mood Stabilizers
	  • Antidepressants
	  • Anxiolytics
	• Antidepressant Medication
	• Sleep disruption
	  • Intentional
	  • Unintentional
	  • Sleep Apnea
	  • Pregnancy
	• Loss of Supports
	• Cognitive distortions
	• Interpersonal conflict
	• Role Transition
	• Negative expressed emotion
	• East-West Travel
	• Stress

Table 4. Summary of Clinical Status Trajectories

Assigned at last visit (in past 8 wks)	No Change	Subthreshold for acute episode with: New acute episode	> 2 symptoms moderate	≤ 2 symptoms moderate	Not permitted
Depression	Depression	Hypomania Mania Mixed	Continued symptomatic	Recovering	**Recovered** Roughening
Hypomania	Hypomania	Depression Mania Mixed	Continued symptomatic	Recovering	**Recovered** Roughening
Mania	Mania	Depression Hypomania Mixed	Continued symptomatic	Recovering	**Recovered** Roughening
Mixed	Mixed	Depression Hypomania Mania	Continued symptomatic	Recovering	**Recovered** Roughening
Continued Symptomatic	Continued symptomatic	Depression Hypomania Mania Mixed	Continued symptomatic	Recovering	**Recovered** Roughening
Recovering	**Recovering or Recovered**	Depression Hypomania Mania Mixed	Continued symptomatic	Recovering	Roughening
Recovered	Recovered	Depression Hypomania Mania Mixed	**Roughening***	**Recovered**	Continued symptomatic, Recovering
Roughening	Roughening	Depression Hypomania Mania Mixed	**Roughening***	**Recovered**	Continued symptomatic, Recovering

* Roughening is defined as the occurrence of subsyndromal symptomatology after a patient has met criteria for recovery (8 consecutive weeks with no more than 2 moderate symptoms). Operationally, a patient would only be considered to have roughening if they experience a change in their symptoms which includes the occurrence of 2 new symptoms and/or significant worsening of residual symptoms.

VIII. CMF Example

General: Patient reports feeling more confused and agitated over the past 10 days. Review of his mood state over the last 10 days reveals 5 days where he was depressed most of the day. He additionally reports he feels the depression was severe. He reports 0 days for mood elevation. The patient states he has felt irritable every day of the past 10, and reports the irritability was "not too bad." He has not felt anxiety during any of the past 10 days.

The patient's clinical status on the last visit (2 weeks ago) was Hypomania. He had been treated based on the acute treatment guidelines for mania in the Standard Care Pathway.

Patient is currently on 1200 mg of Gabapentin (300 mg in the AM, 900 mg before bed), 1.5 mg of Klonopin (.5 mg in the AM, 1 mg before bed), and .5 mg of risperidone (.5 mg before bed) daily. Patient reports missing one bedtime dose of Gabapentin. He endorsed having moderate constipation and marked headaches due to his medication.

Since his last visit two weeks ago:

- He has had no days when his mood was normal.
- There were no new stressors in his life.
- He drank four cups of coffee each day.
- He smoked about 1 pack of cigarettes a day.
- He had no instances of alcohol abuse.
- He had no instances of substance abuse.
- He has had a few headaches, but no migraines.
- He did not binge/purge or have any panic attacks.
- He has not needed to seek treatment for either psychiatric or medical issues, and has not had any significant medical illnesses.

Ratings for the symptoms assessed for the previous week:

Sleep: The patient reports sleeping 5-6 hours per night. This is less than his normal 7-8 hours. He reports that his sleep has been less than normal every night in the past week. He has trouble falling asleep, but once asleep he stays asleep. He does not have trouble getting out of bed in the morning. The Gold Standard rating is **-1.**

Interest: He states he is able to put on a front for his kids, but in reality his interest and pleasure if less than normal. He also states this is not severe and that there are some things he looks forward to. As a result, the Gold Standard rating for interest was **-1**.

Guilt: He denies guilty thoughts so this Gold Standard rating was **0.**

Self-esteem: The patient reports his self-esteem is a little better, but probably not normal. Better for this patient meant not as low, so Gold Standard score is **– ¼.**

Energy: He reports having low energy and that he feels he has to push himself to get moving. Physically, he states, he can't do things because he is too tired. The Gold Standard is **– 1**.

Concentration: Gold standard rating of **–** ½ was assigned because the patient reports his concentration is impaired. He is able to read the paper but jumps around.

Distractibility: Gold standard rating of **0** was given for distractibility, because the patient denies feeling distracted.

Appetite: He reports that his appetite was still high but he is trying to control it by eating only the minimal amount. While the amount he eats is below normal, his appetite is higher than normal so the Gold Standard rating is ¼.

Psychomotor agitation: He reports no agitation so the Gold Standard rating is **0**.

Psychomotor retardation: The Gold Standard rating of **0** is given as the patient feels this symptom is not present.

Suicidal ideation: Absent therefore the Gold Standard score was **0**.

On symptoms of mood elevation:
Inflated self-esteem or grandiosity: The patient reports that he has gained confidence but he has not had any grandiose feelings therefore the Gold Standard score was **0**

Need for sleep: The patient feels as though he needs more sleep so the Gold Standard assigned was **1**.

Talking: The patient states that he is overly talkative during some part of every day. Therefore, the Gold Standard assigned was ½.

Racing Thought and FOI: He denies racing thoughts, but reports having a lot of ideas. These ideas, however, don't interfere with each other. The Gold Standard is ½.

Distractible: He denies being distractible. The Gold Standard score for this item is **0**.

Goal directed activity: The Gold Standard was **0** because he does not report any impairment in the ability to get things done.

Agitation: He reports no agitation so the Gold Standard rating is **0**

High Risk behaviors: The patient denies any risky behaviors, and the Gold Standard rating here is a **0**.

Other associated Symptoms: There are no associated symptoms, and they are all rated 0 – that is diurnal variation, paranoid ideation, ideas of reference, loose associations, delusions, hallucinations, bingeing/ purging, panic attacks, OCD, internalized anxiety, and social phobia.

Clinical status = "Continued Symptomatic." Since that patient is DSM-IV negative but had 3 symptoms, all of which were moderate, he is assigned the status "continued symptomatic."