Mood Disorders
Affective

- Depression
- Mania
- Other

presented by

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Core Concepts

- **Mood**(Affect)-pervasive/sustained emotion that may have major influence on perception(depression,elation,anger).
- **Depression**-alteration in mood-feelings of (sadness,despair,pessimism).
- **Mania**-alteration in mood-feelings of (inflated self-esteem,hyperactivity,agitation,grandiosity).

Mood Disorders
DSM-IV-TR

- Essential feature of a Mood Disorder is a disturbance of mood, characterized by full or partial Manic or Depression not attributed to another mental disorder.

Mood Disorders Epidemiology Factors

- Gender-depression 2-1women,bipolar =
- Age-depression-women young<age, men opposite. bipolar 1st manic episode early 20"s.
- Social Class
- Race/Culture- depression>whites, more severe in blacks- less likely to be treated.
- Marital Status-depression-single,divorced.
- Seasonality-depression>spring,fall.

Types of Mood Disorder

- Depressive (Unipolar)
  1. Major Depressive Disorder
  2. Dysthymic Disorder
- Mania (Bipolar)
- Other

Depression

- Oldest recognized psychiatric disorder "the common cold of psychiatric disorders".
- 19 million Americans suffer from Major Depression.
- This disorder occurs in all developmental levels.
- Symptoms of depression occur along a continuum from transient to severe.
- *Pathological Depression occurs when ADAPTATION is ineffective.

Major Depressive Disorders **Classified**

- 1.single/recurrent
- 2.mild/moderate/severe
- 3.Psychotic *Features(delusions,hallucinations)
- 4.Catatonic *Features (psychomotor retardation)
- 5.Melancholic *Features (severe form of depressive episode)

Major Depressive Disorders Classified Cont.

- 6. Chronic- last at least 2 years.
- 7. Seasonal-fall/winter months
  (SAD-seasonal affective disorder)
- 8.PostPartum-onset 4weeks postpartum

Depressive Disorders Major Depressive Disorder

- Impaired social/occupational function existing for at least 2weeks.
- No history of Manic Behavior.
- Symptoms not attributed to medical conditions/substance abuse

Major Depressive Disorder

- Feel worthless/guility
- Diminished ability to think/concentrate/indecisive
- Thoughts of death/ideation without specific plan

Major Depressive Disorder **Diagnostic** Criteria (A-E)

- A.

  1. 5>symptoms presented in same 2 wks.

  2. 1 of the symptoms is depressed mood (loss of interest/pleasure).

  3. must interfer with ADL'S

Major Depressive Disorder **Diagnostic Criteria Cont.**

- A. Symptoms related to the 3 previous criteria.

  1.Depressed (SAD) most of the day nearly every day. Child/Adolescent-irritable.
  2.Marked diminished interested in pleasure.
  3.Significant wgt. loss
  4.Insomnia/Hypersomnia
  5.Psychomotor agitation/retardation
  6.Fatigue/loss of energy

Major Depressive Disorder Diagnostic Criteria Cont.

- B.Never a MANIC Episode
- C.Clinically significant distress or impairment
- D.Symptoms have no direct physiological cause
- E.Symptoms longer than 2months,suicidal ideation,psychotic/psychomotor (not related to bereavement)

Depressive Disorders
Dysthymic Disorder

- Feature –chronically depressed mood(2yrs>); most of the day, more days than not .
- **irritable** mood in child/adolescent(1yr>).
- No evidence of psychotic symptoms.
- Milder than major depression "down in the dumps", able to function.

Dysthymic Disorders Classification

- Early onset (before 21yrs.)
- Late onset (21yrs>)

Theories of depression Predisposing Factors

- **Biological** theories:

  1. **Genetics-** no biological marker –hereditary link strongly suggested.

  2.Biochemical/Biogenic Amines-deficiency of neurotransmitters:

  * a.norepinephrine-deals with stress

Theories of Depression Cont. Predisposing Factors

- **Biochemical cont.**

  * b. serotonin-regulates psychobiological factors (mood, anxiety, arousal).

  c. dopamine-exerts strong influence over mood/behavior.

  d.Acetylcholine-excessive in depression, inadequate in mania.

Theories of Depression Cont. Predisposing Factors

- **Neuroendocrine**
  1.Hypothalamic/Pituitary/Adenocortical Axis.
  2.Hypothalamic/Pituitary/Thyroid Axis.

- **Physiological Influences**
  1.secondary depression due to non-mood disorders
  2.Adverse effects of meds.
  3.Electrolytes,hormones,nutrition,neuro or other physiological conditions.

Theories of Depression **Psychosocial**

- **Psychoanalytical theory-unconscious** conflict (mourning, melancholia).Central theme of loss and aggression.
- **Learning theory** –"learned helplessness". Repeated failure to control life leading to feelings of helplessness and dependence on others a possible predisposition for depression.
- **Object Loss theory-abandoned/separated** in first 6months . Absence of attachment leads to feelings of helplessness/despair=depression due to loss.

Theories of Depression **Psychosocial Cont.**

- **Cognitive** theory- negative cognitive distortion (negative expectations of : envirorment, self, future). Not viewed as Affective.
- **The Transactional Model-** the combined effect of genetic, biochemical, psychosocial influences the individual's susceptibility to depression.

Developmental Implications

- **Childhood** –tantrums,failure to thrive-<age 3; accident prone, phobias, excessive self approach- 3-5yrs.; clinging, physical complaints, aggression behavior,-6-8yrs.; morbid thoughts, excessive worrying-9-12yrs..
- *Common denominator = LOSS
- TX: emotional support, family counseling, medication, alleviate symptoms, strengthen coping skills.

Developmental Implications Cont.

- **<u>ADOLESCENTS</u> -*BEHAVIORAL changes lasting several weeks.**
  (sadness, loneliness,anxiety,delinquency,sexual acting out, substance abuse, anger, apathy).
- *Perception of Abandonment by parents or peers can precipitate SUICIDE .(3rd leading cause of death in 15-24yr olds)
- TX:psychosocial interventions, antidepressant .

Developmental Disorders Cont.

- **<u>Senescence</u>- (**Low self-esteem, helplessness, hopelessness).Symptoms of depression often confused with dementia.
- Bereavement Overload.
- Highest % of suicides among the elderly.
- TX: antidepressants, electroconvulsive therapy, psychotherapy (behavioral, group, cognitive, family).

Nursing Process-Assessment Areas

- **Affect**- sadness, despair.
- **Thought Process-** suicidal ideation, poor judgement, memory, concentration.
- **Feelings-** Guilt, help/hopelessness, anger.
- **Physical Behavior-** Poor ADL's,< appetite, wgt loss, sleep disturbance, fatigue (vegetative state)
- **Communications-** impaired

Nursing Process/Assessment
Continuum of Depression

- **Transient**- not necessarily dysfunctional.
  - a. Affective-"blues"
  - b.Behavioral- some crying.
  - c.Cognitive- trouble getting mind off disappointment.
  - d.Physiological- sad, listless, tired.

Nursing Process/Assessment
Continuum of Depression Cont.

- **Mild**-normal grieving.
  - a. Affective- anger, anxiety.
  - b. Behavioral- tearful, regressive.
  - c. Cognitive- preoccupied with loss.
  - d. Physiological- anorexia, insomnia

Nursing Process/Assessment
Continuum of Depression Cont.

- **Moderate**-associated with Dysthymic Disorder.
  - a. Affective- helpless, powerless.
  - b. Behavioral-slow movement, limited communication, slumped.
  - c.Cognitive- retarded thinking, difficulty concentrating
  - d.Physiological- anorexia or overeating, h/a, sleep disturbance.

Nursing Process/Assessment Continuum of Depression Cont.

- **Severe-** major depression or bipolar depression.
  a. Affective- total despair, worthlessness, flat affect.
  b.Behavioral- psychomotor retardation, no communications,fetal position.
  c. Cognitive- Delusional thinking,confusion, suicidal thought.
  d. Physiological- slow-down entire body

Nursing Diagnosis (NANDA) examples

- Risk for violence (self-directed)
- Powerlessness
- Self care deficit
- Low self esteem

Planning(NOC)

- Safety
- Promote self- esteem
- Assist with grieving process
- Assist confronting anger turned to self.
- Ensure basic needs are met-ADL'S

Nursing Intervention(NIC) Depression

- Provide for the safety of the client and others.
- Begin a therapeutic relationship by spending non-demanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.

Nursing Intervention (NIC) Depression

- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects.

Bipolar Illness Definition of Terms

- **Bipolar I (Mania)-Full syndrome of manic or mixed.**
- **Bipolar II (hypomania)-recurrent bouts of major depression with episodes of hypomania.**
- **Cyclothmia-chronic mood disturbance(2yrs>)insufficient severity/duration to meet criteria of Bipolar I or II.**

Theories of Bipolar Disorders Mania

Biological
1. **Genetic** (vulnerability),
2. **Biochemical** (norepinephine,dopamine),
3. **Biological** (electrolytes)
4. **Physiological** (neuroanatomical, medication).

- Psychosocial –questionable. Viewed as disease of brain.
- Transactional Model–interaction between generic, biological, psychosocial.

Bipolar Disorder Developmental Implications

- Child/Adolescents- difficult diagnosis recommend FIND (CABF)
  - F-Frequency (most days)
  - I-Intensity 1domain severe,2>moderate
  - N-Number (3-4x day)
  - D-Duration (4hrs>day)

Bipolar Disorder Developmental Implications Cont.

- Child/Adolescent
  1. Euphoric/ irritable/ grandiosity
  2. Decreased need for sleep/ pressured speech.
  3. Racing thoughts/ distractibility.
  4. Pleasure-seeking/ Risk taking activities.
  5. Psychosis –Hallucinations/ delusions.

*Suicide Risk: rage, aggression, self-injurious behavior

Developmental Implications Cont.

- Child/Adolescent- Treatment Strategies:

A. Psychopharmacology: Librium, Divalproex, Carbamazepine, Atypical antipsychotics.

*ADHD- most common comorbid condition. ADHD Agents may >mania-only give after bipolar symptoms controlled.

Developmental Implications Cont.

- Child/Adolescent Treatment Cont.

B.Family Interventions: education, problem-solving, communication skills.

Symptoms of Mania on a Continuum

Stage I Hypomania
Stage II Acute mania
Stage III Delirious Mania

Stage I Hypomania

- **Mood**- cheerful/expansive, underlying irritability, very volatile and fluctuating.
- **Cognitive/Perception**-ideas of worth/ability, flighty, rapid flow of ideas, easily distracted.
- **Activity/Behavior**- extrovert, lacks depth, talkative,laughs, loud, inappropriate, increased libido, anorexia, wgt. loss, inappropriate behavior.

*Does not require hospitalization usually

Stage II Acute Mania

- **Mood-**Euphoria/elation "high", labile mood changes,
- **Cognitive/Perception-"**flight of ideas", disorganized,incoherent,hallucinations/delusions.
- **Activity/Behaviors-**psychomotor activity excessive, sexual interest>,poor impulsive control,excessive spending,flamboyant ,bizarre disorganized.
- *Usually requires hospitalization.

Stage III Delirious Mania

- Mood: <u>labile</u>, panic, anxiety.
- **Cognitive/Perception:** confusion, stupor,extremely distractible/incoherent.
- **Activity/Behavior**: psychomotor frenzied, agitated, purposeless movement, exhaustion, injury to self/others, death without interventions.

* At risk for injury to self/others

Nursing Diagnoses (NANDA)

- Risk for injury
- Risk for Violence towards self/others
- Altered thought process

Planning (NOC)

- Outcome related to Nsg DX
- Primary-achieve state of equilibrium
- Secondary-stabilize the melieu

Intervention (NIC) Mania(Safety)

- Set limits on client's behavior when needed.
- Reminded the client to respect distance between self and others.
- Use short, simple sentences to communicate.
- Clarify the meaning of client's communication.
- Frequently provide finger foods that are high in calories and protein.

Intervention (NIC)Cont.

- Promote rest and sleep.
- Protect the client's dignity when inappropriate behaviors occur.
- Channel client's need for movement into socially acceptable motor activities,

Treatment Modalities Mood Disorders

- Psychopharmacology
  - Depression (pp.552-553)
  - Mania (pp.553-554)

*Note clinical pearls

- Psychotherapy
  - Individual/Group/Family
  - Cognitive- Change "automatic thoughts"

Treatment Modalities Cont.

- Transcranial Magnetic Stimulation(TMS)
- Light Therapy for depression (SAD)
- Family Intervention
  - family support- to prevent relapse,
  - family focused psycho-educational treatment (FFT).

Treatment Modalities Cont.

- Electroconvulsive Therapy (ECT)
  1. Introduction of Grand Mal Seizure.
  2. Often used when medication fails.
  3. Uses: severe depression, acutely suicidal, acute mania, psychotic symptoms.

*Absolute contraindication: increased intracranial pressure. High risk: CVA,MI,Aneurysm,>BP,CHF. (Review Chpt 22.)

Teaching
Mood Disorders

- Nature of Illness
  - Symptoms
  - Possible causes
- Management of Illness
  - Medication management
  - Other treatments
- Supportive Services
  - Suicide/Crisis hotline
  - Support group
  - Legal/Finanicial assistence

Suicide

- Suicide is a behavior.
- 95% suicides are committed by individuals who have a diagnosed mental illness.
- Leading cause of deaths in America:
  1. 3rd for ages 15-24.
  2. 5th for ages 25-44.
  3. 8th for ages 45-64.

  Elderly rate very high.

Risk Factors for Suicide

- **Marital status-2X** >in single/divorced.
- **Gender**-women attempt more often, men succeed more often due to lethal methods.
- **Age**- >particularly among men. White men older than 80yrs. are at greastest risk(age, gender, race).
- **Socioeconomic** status-highest/lowest social class >rates

Risk Factors Cont. Suicide

- **Ethnicity**- whites, native americans, african americans, hispanic americans ,asian americans.
- **Religion**- affliation <u>decreases</u> suicide risk.
- **Other risk-** mood disorders most commonly followed by substance related, schizophrenia, personality disorders, anxiety disorders.

Risk factors Cont. suicide

- Painful, disabling disease.
- Family history.
- Previous attempted suicides.
- Loss of loved one.
- Finanical burden, loss of job.

Theories of Suicide

- A. **Psychological**: anger turned inward, hopelessness, guilt, desperation, hx. aggression/violence, shame, developmental stressors.
- B.**Biological:**

  a. Genetics—studies suggest existence of genetic predisposition toward suicidal behavior.

  b. Neurochemical-< in serotonin levels.

Theories of Suicide Cont.

- C. **Sociological:** Durkheim's 3 categories of suicide:

  a. egoistic suicide-does not feel a part of any cohesive group (family,peers).

  b. altruistic-excess integration into a group will sacrifice life for group.

  c. anomic-disruption relatedness to group (divorce).

Nursing Assessment

- a. demographics.
- b. presenting symptoms/medical/psychiatric.
- c. suicidal assessment : seriousness of intent, existence of plan, availability and lethality of the method, verbal/behavioral clues.
- d. analysis of crisis : stressors, history, life-stage issues.
- e. coping strategies: support, religion

Suicidal Interventions

- **Primary:** Activities that provide support, education, information to prevent suicide. (schools, conferences).
- **Secondary:** Treatment of actual suicide crisis. (hot-lines, hospitals).
- **Tertiary:** Working with family/friends of suicide victim.

Nursing Diagnosis

- Risk for Suicide
- Hopelessness
- Review Chpt.18-- Nursing Process

Nursing Intervention (NIC) Suicide

- Ask client directly: do you want to harm yourself?, Do you have a plan?,Do you have the means (gun)?
- Safe environment: eliminate harmful objects.
- Contract not to harm self. Tell staff if feeling suicidal.
- Close Observation. Possibly 1:1. Make rounds at frequent, irregular , intervals.

Nursing Interventions(NIC) Hopelessness

- Encourage client to explore feelings.
- Provide expressions of hope.
- Identify stressors.
- Discuss the current crisis in the clients life.
- Help the client identify areas in of control.
- Medication: 3 day supply at a time etc.
- Remember when depression begins to lift client may act on Suicidal thoughts.