NARAYANA
COLLEGE OF NURSING

UNIT–VII Nursing management of patients with Mood disorders

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Mood Disorders

INTRODUCTION

: We all feel 'blue' from time to time. Sadness is an important part of living. It helps us understand our inner world, communicate with others and gives richness and meaning to our lives. Where the 'normal' sadness that comes from the inevitable losses and frustrations of daily life, parts company with depression as an illness, is the severity, duration and the degree of disability that depression can cause. Depression occurs along a continuum from mild to life threatening. Some mild episodes of depression may resolve with time, aided by making important adjustment to one’s daily routines, and by seeking out the support of others.

Mood Disorders

Disturbances in emotions that cause subjective discomfort, hinders a person's ability to function, or both.

Depression and mania are central to these disorders.

Depression: Emotional state characterized by intense sadness, feelings of futility and worthlessness, and withdrawal from others.

Mania: Emotional state characterized by elevated mood, expansiveness, or irritability, often resulting in hyperactivity.

DEFINITION

Clinical depression (also called major-depressive disorder or unipolar depression) is a common psychiatric disorder, characterized by a persistent lowering of mood, loss of interest in usual activities and diminished ability to experience pleasure.

Depression is a serious, debilitating illness that intensely affects how you feel, think. Depression can last for years and without treatment can cause permanent disability. It is a profoundly painful, distressing disorder that rarely can be overcome without external help, positive self-talk, love and support will lift the dark veil of depression. It is an illness and it needs treatment.

Mood Disorders

Depression occurs ten times as frequently as mania.

Depression is the most common complaint of individuals seeking mental health care.

Epidemiologic catchment area survey:

- 2.3% of adult males and 5% of adult females in the U.S. have a mood disorder in a one-year period.

Mood Disorders

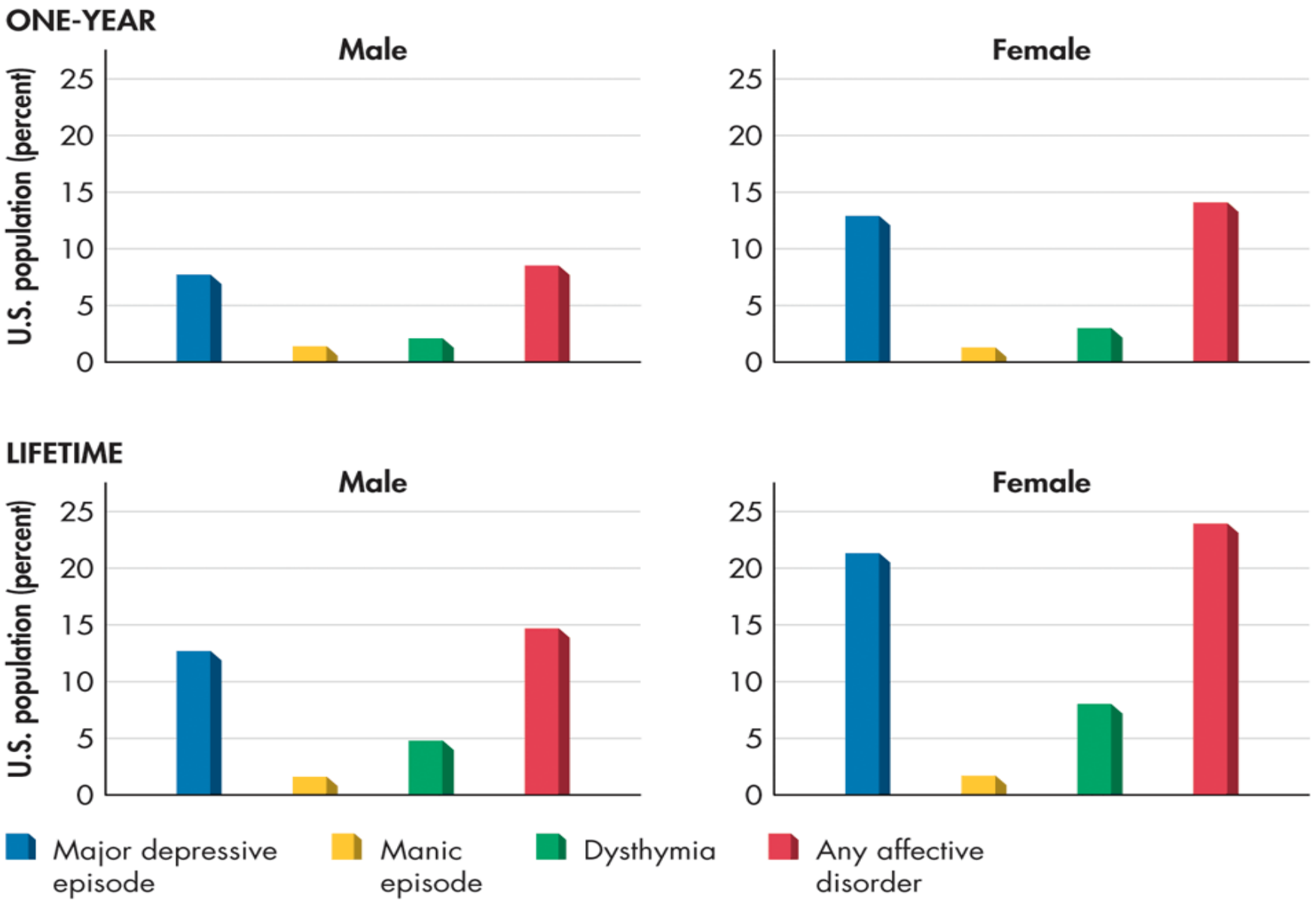
Lifetime prevalence:

- Severe depression: 5-12% of males and 10-25% of females
- Mood disorder: 15% of males and 24% of females

Risk of another episode increases with each episode

- 50% after one episode, 70% after second, 90% after third

One-Year and Lifetime Prevalence Rates of Mood Disorders in the United States



Comparison of Depressive and Bipolar Disorders

Genetic studies:

- Increased incidence of manic disturbances for blood relatives of bipolar patients.
- More evidence of genetic/ psychophysiological influences for bipolar than unipolar disorders.
- Relatives of unipolar patients have a greater probability of having unipolar disorders, but relatives of bipolar patients have a greater probability of having bipolar AND unipolar disorders.

Comparison of Depressive and Bipolar Disorders

Age of onset is earlier for bipolar (early 20s) than unipolar (late 20s).

Psychomotor retardation and risk of suicide greater for bipolar than unipolar.

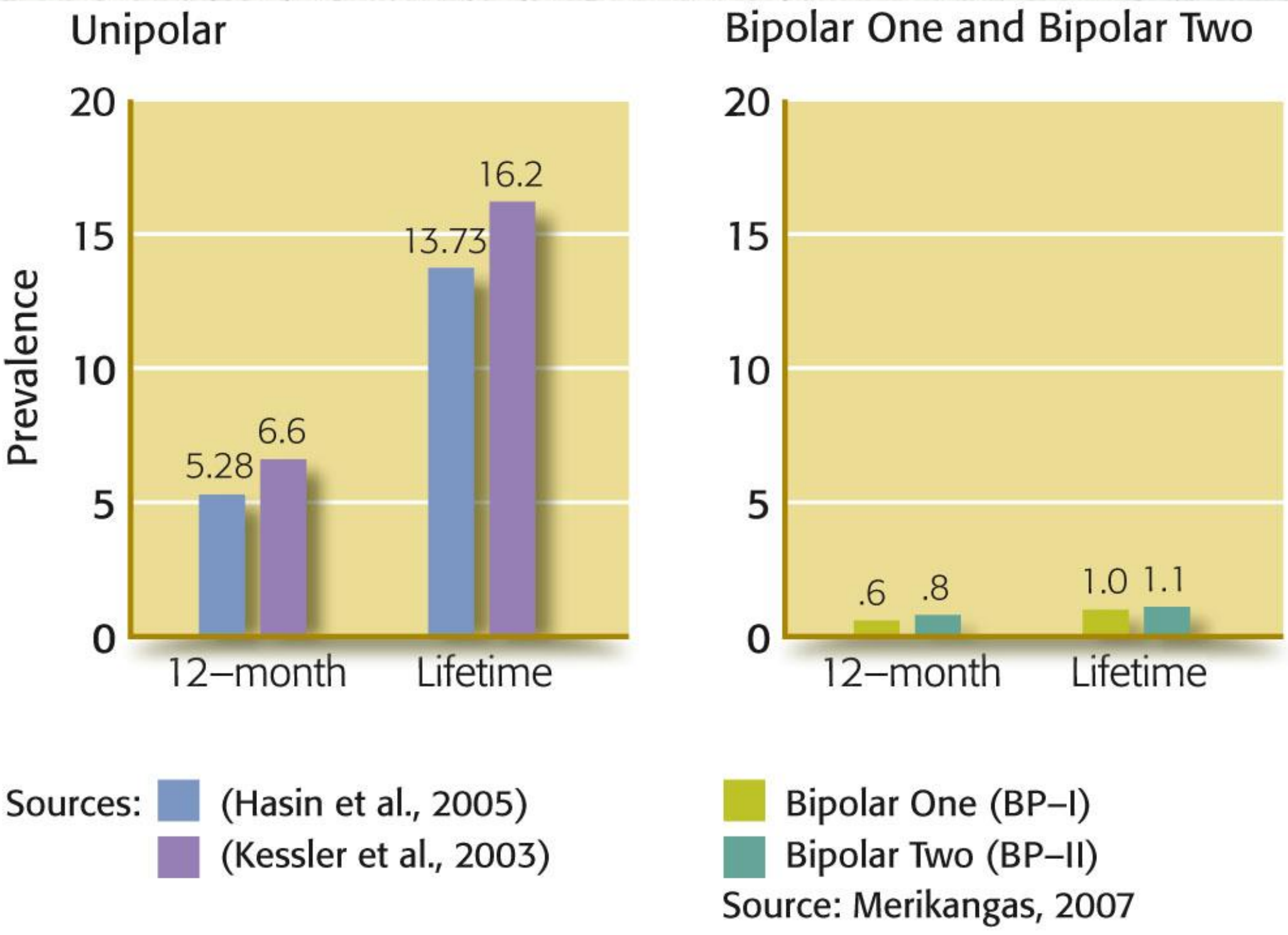
Unipolars are more likely to exhibit anxiety.

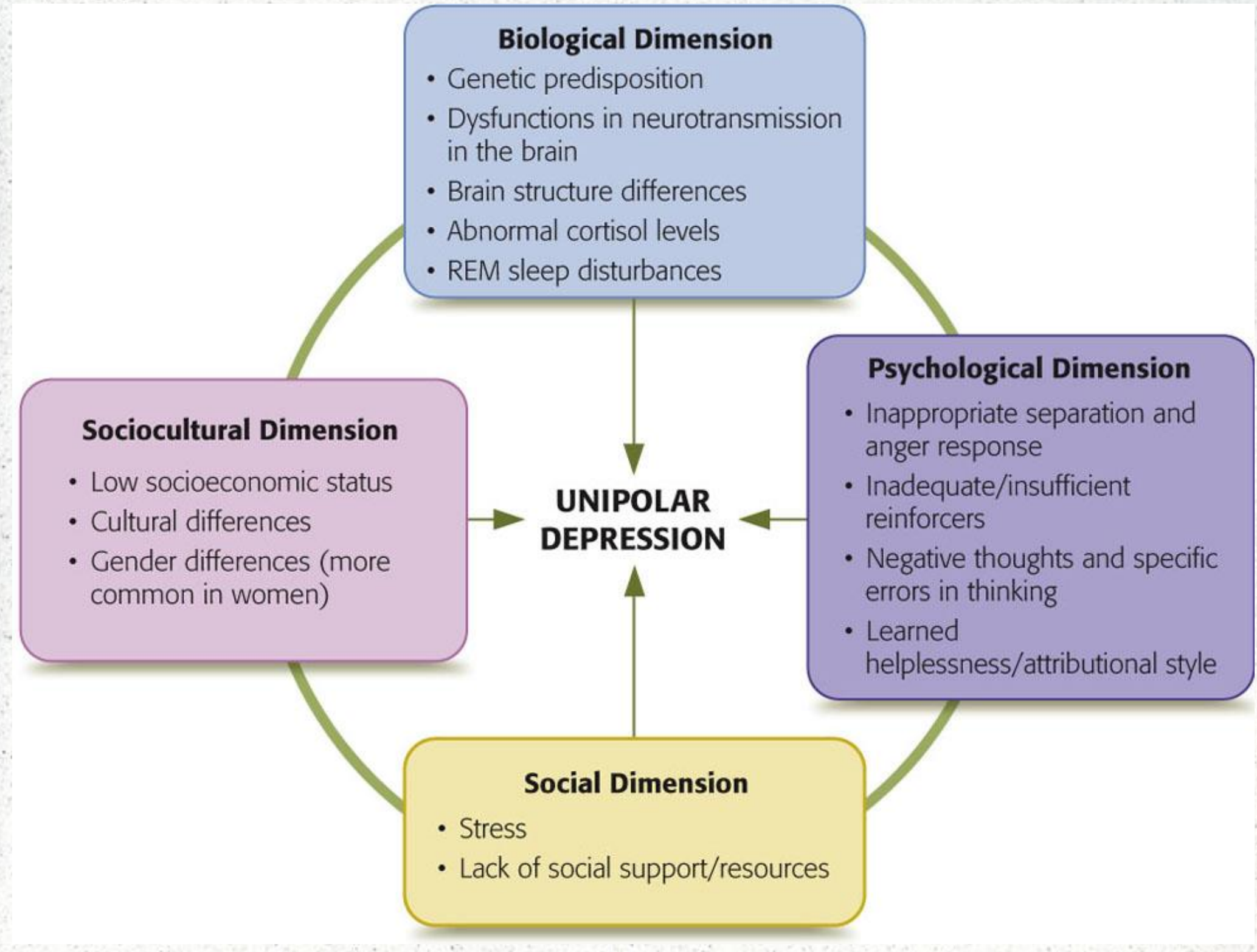
Comparison of Depressive and Bipolar Disorders

Bipolar patients respond to lithium.

Prevalence differences:

- 1-2% of adult population has experienced bipolar disorder.
- 8-19% of adult population has experienced major depressive disorder.
- No gender differences in bipolar I disorder.
- Women are more likely than men to experience major depression and bipolar II disorder.


Unipolar
Bipolar One and Bipolar Two
Prevalence
20
15
10
5
0
5.28
6.6
13.73
16.2
.6
.8
1.0
1.1
12–month
Lifetime
12–month
Lifetime
Sources:
(Hasin et al., 2005)
(Kessler et al., 2003)
Bipolar One (BP–I)
Bipolar Two (BP–II)
Source: Merikangas, 2007


Biological Dimension
• Genetic predisposition
• Dysfunctions in neurotransmission in the brain
• Brain structure differences
• Abnormal cortisol levels
• REM sleep disturbances
Psychological Dimension
• Inappropriate separation and anger response
• Inadequate/insufficient reinforcers
• Negative thoughts and specific errors in thinking
• Learned helplessness/attributional style
Sociocultural Dimension
• Low socioeconomic status
• Cultural differences
• Gender differences (more common in women)
UNIPOLAR DEPRESSION
Social Dimension
• Stress
• Lack of social support/resources

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Psychodynamic: Focus on separation and anger ("symbolic loss")

Cognitive: Low self-esteem, stable and enduring cognitive styles:

Negative thoughts and errors in thinking

Beck: Depression is a disturbance in thinking, not mood.

Schemas set people up for depression.

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Cognitive:

- Depressed people operate from a primary triad of negative self-views, present experiences, and future expectations.
  - Four errors in logic typify this negative schema:
    - Arbitrary inference
    - Selected abstraction
    - Overgeneralization
    - Magnification/ minimization

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Behavioral: Separation or loss, but reduced reinforcement is the cause and leads to less activity; secondary gain from reinforcement of inactivity.

- Lewinsohn suggests 3 sets of variable that help or hinder access to positive reinforcement
  - Number of potentially reinforcing events/activities
  - Availability of reinforcements
  - Individual's instrumental behavior

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Cognitive-learning approaches:

Learned Helplessness: The belief that one is helpless and unable to affect outcomes in one's life.

Seligman: Belief in one's own helplessness

Attributional Style: People who feel helpless make speculations (causal attributions) about why they are helpless.

Internal/external, stable/unstable, global/specific

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Cognitive-learning approaches:

Response Styles: People have consistent styles of responding to depressed moods that affect the course of depression.

Ruminative Responses: Dwelling on why one feels bad, considering possible consequences of symptoms, and expressing how badly one feels.

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Cognitive-learning:

Diathesis-Stress: Vulnerability (negative cognitions or pessimistic attributional styles) in the presence of stress (negative life events) results in depression.

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

- Sociocultural: Culture, social experiences, and psychosocial stressors (including stress and gender)
  - Social support: Acts as a buffer against depression
  - Stress and depression:
    - Diathesis: Individual genetic, constitutional, or social conditions may produce vulnerability to developing depression.
    - Chronic stress more strongly related to depression than acute stress

The Etiology of Mood Disorders
Psychological or Sociocultural Approaches to Depression

Gender and depression:

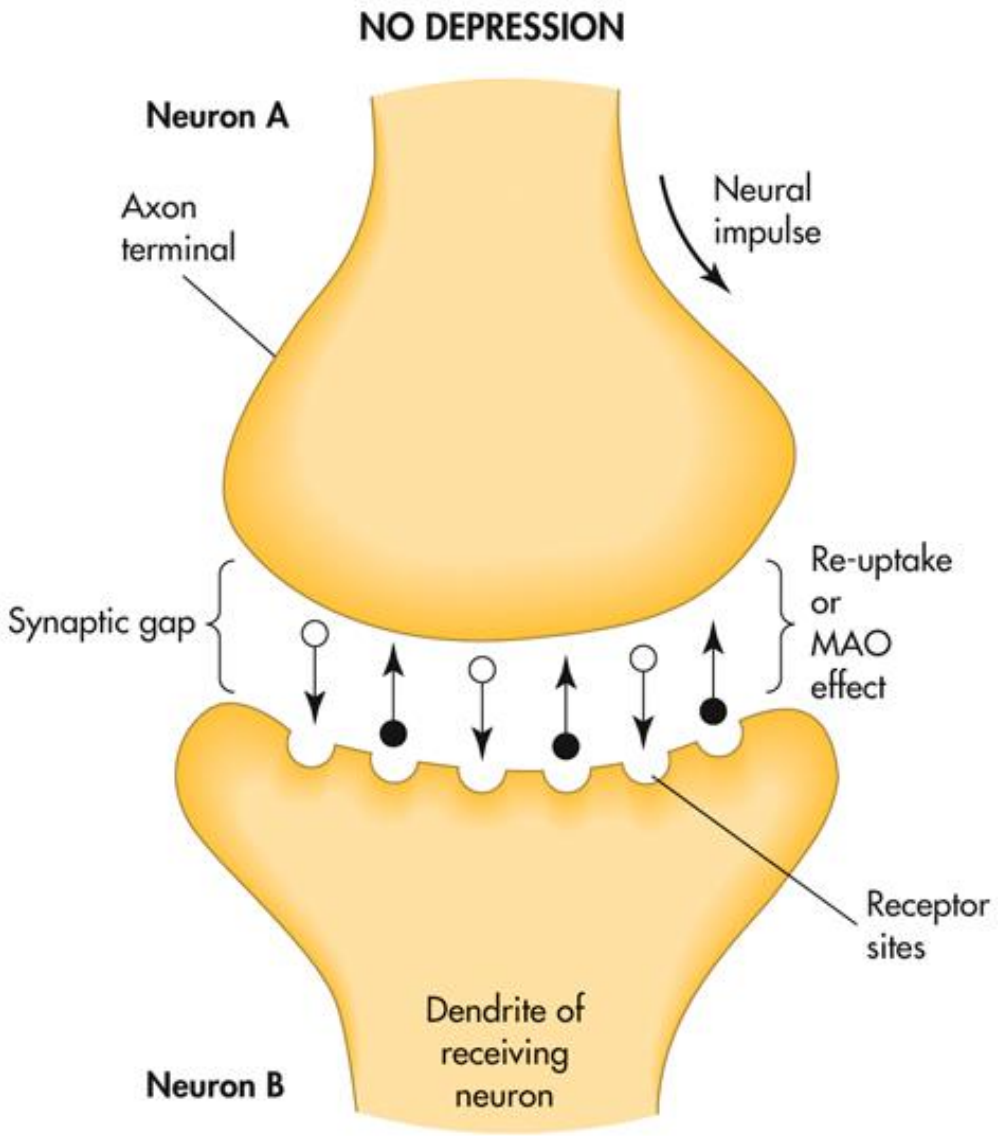
- Universally, women are twice as likely as men to develop major depression.
  - Women are more likely to seek treatment or report their depression to others.
  - Possible diagnostic bias
  - Depression may take other forms in men.
  - Possible biological factors
  - Traditional gender roles
  - Response styles (women ruminate)

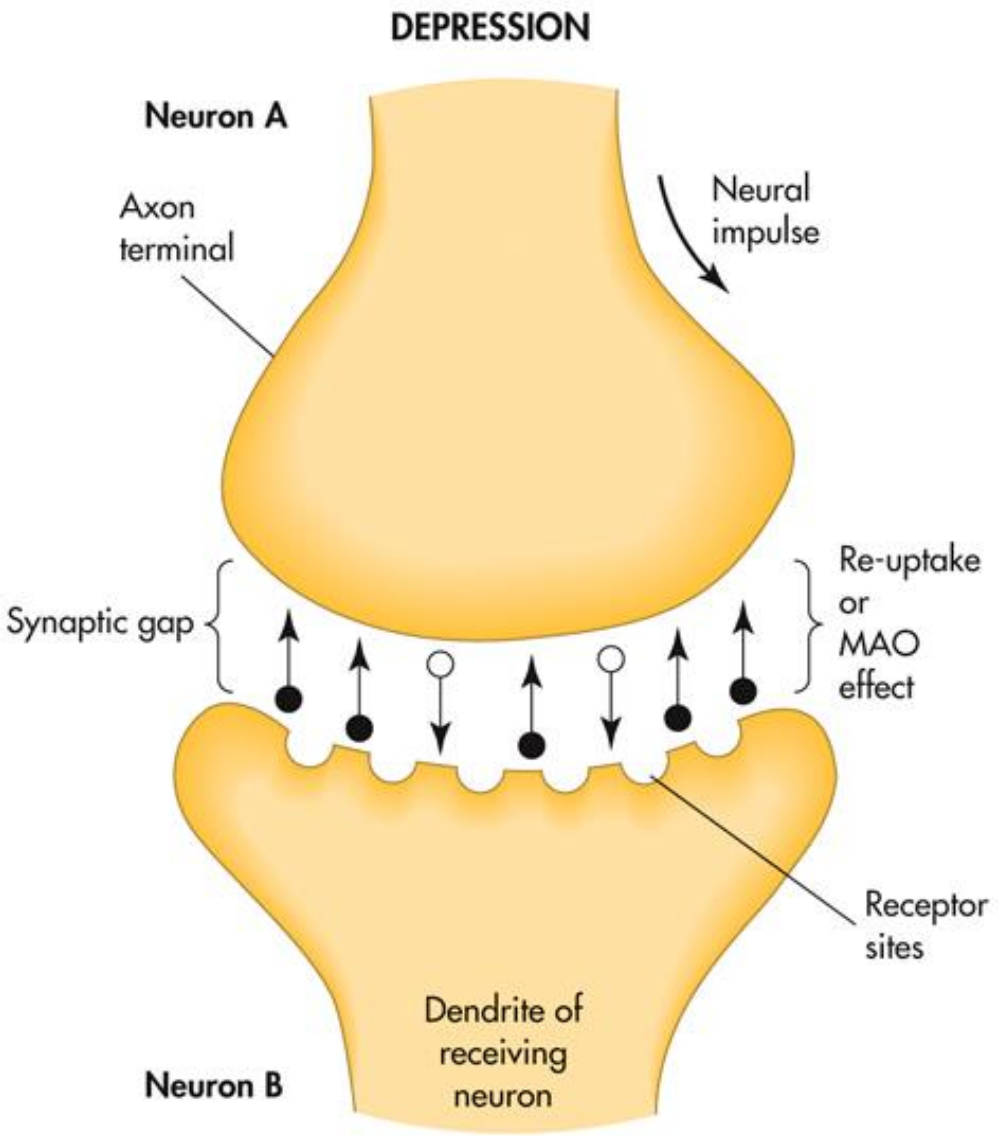
The Etiology of Mood Disorders
Biological Perspectives on Mood Disorders

Role of heredity:

- Adoption studies: Incidence of mood disorders is higher among biological families than among adoptive families.
- Twin studies: Concordance rates are higher for monozygotic twins than for dizygotic twins (especially for bipolar disorders), although non-genetic factors also have an influence.
- Polygenetic interactions

The Catecholamine Hypothesis: A Proposed Connection Between Neurotransmitters and Depression





Etiology of Mood Disorders
Neurotransmitters and Mood Disorders

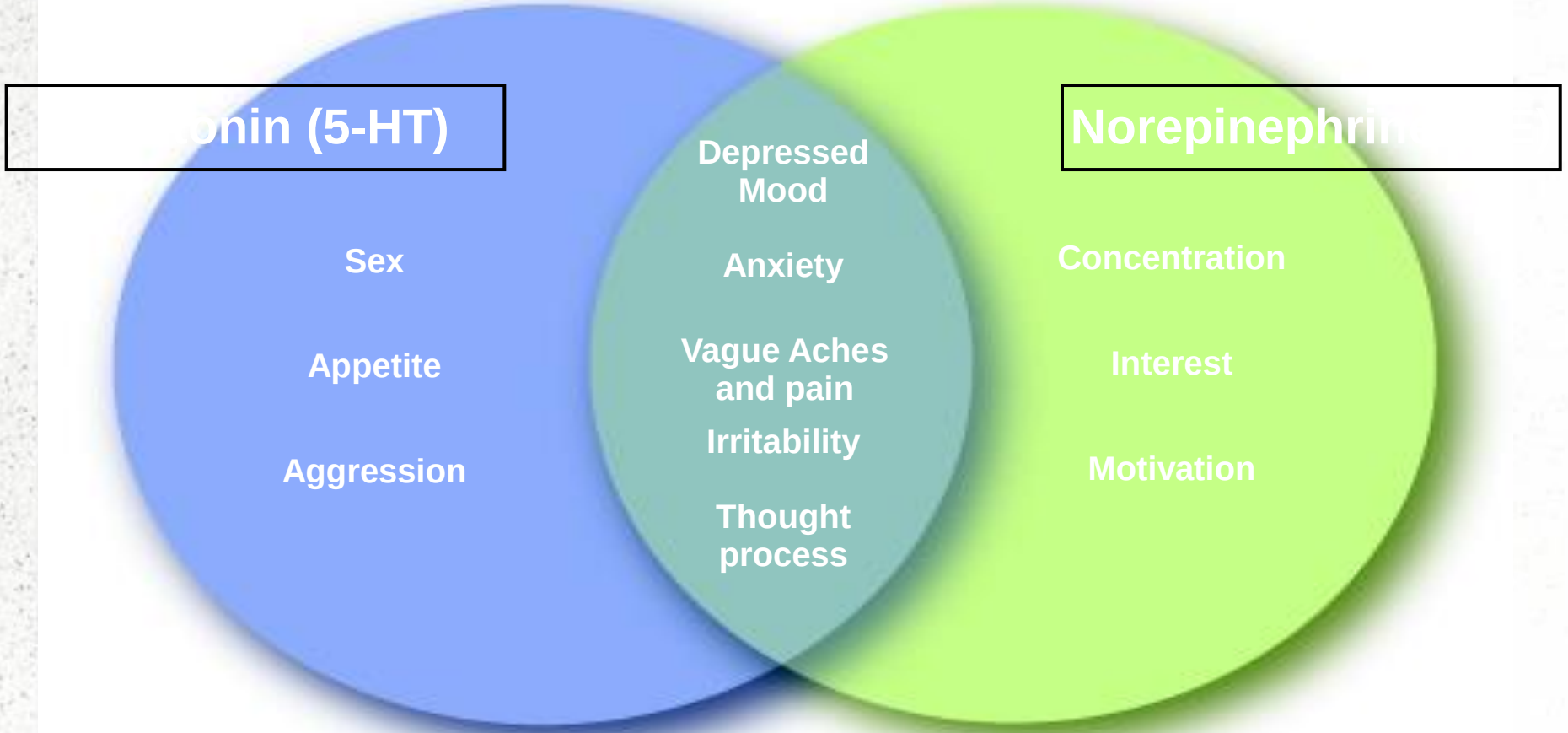
Neurotransmitters: Chemical substances that are released by axons of sending neurons and that are involved in the transmission of neural impulses to the dendrites of receiving neurons.

Catecholamine Hypothesis: Depression results from a deficit of specific neurotransmitters, mania is caused by too much.

Neurotransmitters are broken down or chemically depleted by MAOs.

Neurotransmitters are reabsorbed by the releasing neuron in the reuptake process.

Etiology of Mood Disorders
Neurotransmitters and Mood Disorders



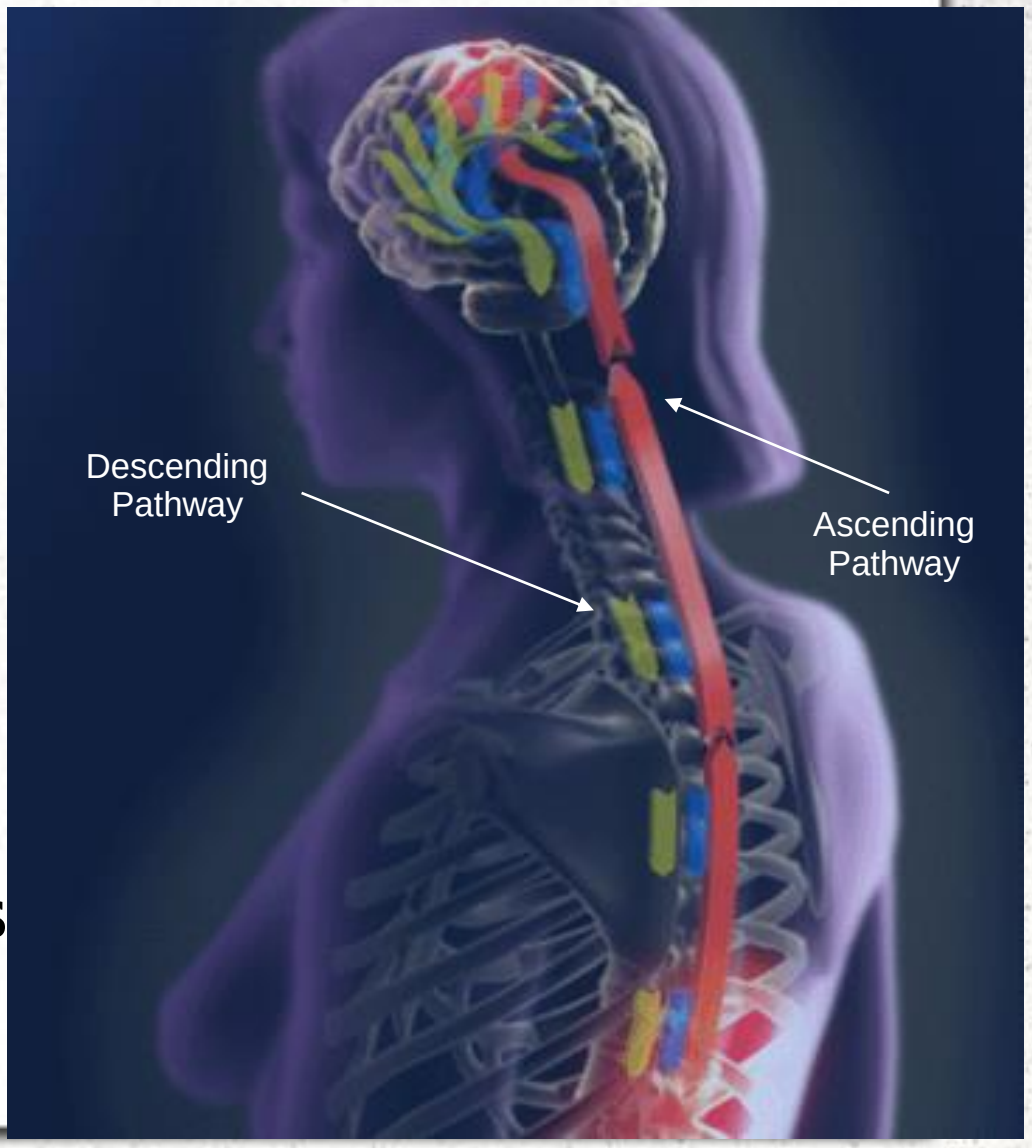
- Both serotonin and norepinephrine mediate a broad spectrum of depressive symptoms

Etiology of Mood Disorders
Neurotransmitters and Mood Disorders

Dysregulation of Serotonin (5HT) and Norepinephrine (NE) in the brain are strongly associated with depression.

Dysregulation of 5HT and NE in the spinal cord may explain an increased pain perception among depressed patients.

Imbalances of 5HT and NE may explain the presence of both emotional and physical symptoms of depression.



The Etiology of Mood Disorders
Neurotransmitters and Mood Disorders

Low norepinephrine levels related to inaction.

Other possible neurotransmission issues:

- Blunted receptor response
- Dysregulation in neurotransmission

Neuroendocrine abnormalities:

- Depression is linked with high levels of cortisol (hormone secreted by adrenal cortex).
- Dexamethasone suppression test (DST) measures cortisol levels.

The Etiology of Mood Disorders
Neurotransmitters and Mood Disorders

REM sleep disturbances:

- Depression is linked to relatively rapid onset of and increase in REM sleep.
- May be connected to severe life stress

Etiology of Mood Disorders
Evaluating Causation Theories

Longitudinal/prospective studies allow more insight into links between life experiences and depression.

Technological advances in identifying biological markers and processes in mood disorders.

Increased attention to viewing depression as a heterogeneous collection of disorders.

Many theories are too simplistic or too complex, hard to test empirically, don’t account for relevant variables, or are too limited.

Range of mood stages result from interaction between environmental and biological factors.

The Grief Response

Characteristics

Persists > 6 months after loss

Sense of disbelief regarding the death

Persistent, intense longing for deceased

Preoccupation with the deceased

Recurrent intrusive images of the dying person

Abnormal avoidance of painful reminders of the death

Individuals may report anger, bitterness related to the deatl

Estrangement from friends and relatives

Cannot find satisfaction in ongoing life

Many Variables Affect the Grief Experience

Sociocultural norms

Relationship/attachment to the deceased

Timing of the death

If the deceased is a child

Circumstances of the death: murder, suicide, accident, etc.

Quality/extent of preparation for death

Perceptions of the death as comfortable, peaceful, accepted: ("…a good death")

Resiliency/coping abilities of those grieving

Appropriate supports for those grieving

The 5 Stages of Grief

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

Stage 1: Denial

Refusing to believe a probable death will occur.

You can help others face it by being available for them to talk instead of forcing them to talk about it.

Stage 2: Anger

Once the diagnosis is accepted as true, anger and hostile feelings like the following can occur:

-Anger at God for not allowing them to see their kids grow up

-Anger at the doctors

-Anger at the family

-Try not to take it personally. They have a right to be angry so allow them to express themselves so they can move on in the grieving process.

Stage 3: Bargaining

They dying person may start to negotiate with God i.e. “I’ll live a healthier life,” “I’ll be a nicer person,” “I was angry so let me ask nicely to please let me live.”

They may negotiate with the doctor by saying, “How can I get more time so I can live in my dream home, and so on.

There is a deep sense of yearning at this stage to be well again.

Stage 4: Depression

When reality sets in about their near death, bargaining turns into depression.

Fear of the unknown

Guilt for demanding so much attention and depleting the family income occurs.

Be available to listen instead of cheering them up, or rambling, repetitive talk.

Distraction like talk about sports, etc., is good but don’t ignore the situation.

Stage 5: Acceptance

When the dying have enough time and support, they can often move into acceptance.

There is an inner peace about the upcoming death.

The dying person will want someone caring, and accepting by their side.

Classification of Mood Disorders

Depressive Disorders (also called unipolar disorders because no mania is exhibited):

- Major depressive disorders
- Dysthymic disorder
- Depressive disorders not otherwise specified

Classification of Mood Disorders

Bipolar Disorders: Characterized by one or more manic or hypomanic episodes and usually by one or more depressive episodes.

- Bipolar disorder I
- Bipolar disorder II
- Cyclothymic disorder

Mood Episodes

- Building blocks of mood disorders
- Not diagnosable
- Helps in understanding mood disorders
- Manic episode
  - Mood is persistently elevated, irritable, and expansive.
  - Leads to impaired functioning.

At least 3 of the following

Pressured speech, psychomotor agitation, flight of ideas, decreased need for sleep, increased involvement in goal orientated activities, distractibility, inflated self-esteem, grandiosity.

High risk activities

Lasting at least 1 week.

Mood Episodes

- Hypomanic episode
  - Similar to manic
  - symptoms are less severe but still interfere with functioning.
  - distinct period of persistently expansive, irritable, elevated mood
  - Lasting at least 4 days but less than 1 week.
  - At least 3 of the following
    - Pressured speech
    - Increased goal-oriented activities
    - Psychomotor agitation
    - Distractibility
    - Decreased need for sleep
    - Grandiosity
    - Risk taking

Mood Episodes

- Major Depressive Episode
  - Depressed mood 2 weeks
  - Or loss of pleasure
    - At least 4, 2 weeks
      - Sleep disturbance
      - Appetite disturbance
      - Fatigue
      - Psychomotor activity change
      - Concentration issues
      - Worthlessness
      - Guilt
      - Suicide ideation
      - Irritable mood

Mixed episode

Alternating sadness, irritability, and euphoria

Lasts at least 1 week

Meet criteria for manic and depressive episodes

Depressive Disorders

- AKA unipolar disorders
- Prevalence
  - 2-6% of children
  - 25% of those over 65
  - 10-25% of adults
    - Common cold of MH
- Depressive Disorders
  - Major Depressive Disorder
  - Dsthymic disorder

Depressive Disorder Not Otherwise Specified

World Health Organization: 120 million ppl depressive disorders

USA 30 million ppl

16% will have

Less than 25% have proper access to care.

50-80% go undiagnosed

70% will relapse

Depressive Disorders

- 296.2x Major Depressive Disorder, Single Episode

  A) Presence of a single Major Depressive Episode

  B) Not better accounted for by Schizoaffective Disorder not superimposed on Schizophrenia, Schizophreniform Disorder, Delusion Disorder, or Psychotic Disorder NOS

  C) There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, **Note**: This exclusion does not apply if all of the manic-like , mixed-like, or hypomanic-like episodes are substance or treatment induced or a re due to the direct physiological effects of a general medical condition.

Depressive Disorders

- 296.3x Major Depressive Disorder, Recurrent

  A) Presence of two or more major Depressive Episodes. (at least 2 months apart)

  B) Not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusion Disorder, or Psychotic Disorder Not Otherwise Specified.

  C)There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, **Note**: Does not apply if episodes are substance or treatment induced or a re due to the direct physiological effects of a general medical condition.

Depressive Disorders

- Major Depressive Disorder
  - Depressed mood most of the day nearly everyday
  - Must effect social, occupational, educational, or other important functioning.
  - Risk factors
    - Biological relative who has depression.
    - Stressful early life
    - Traumatic events

Depressive Disorders

- 300.4 Dysthymic Disorder

  A) Depressed Mood most of the day, more days than not for at least 2 years.

  B) Two (or more) of the following: appetite disturbance, sleep disturbance, fatigue, low self-esteem, poor concentration or difficulty making decisions, and hopelessness

  C) never without the symptoms for more than 2 months at a time.

  D) No Major Depressive Episode during the 2 years

  E) No Manic, Mixed, or Hypomanic. No Cyclothymic Disorder.

  F) No Schizophrenia or Delusional Disorder.

  G) Significant distress in social, occupation, etc. functioning

Depressive Disorders

- Dysthymic Disorder
  - Chronic course
  - Thought not as severe, same consequences.
  - Can occur in children
    - differs from adults
    - Mood is often irritable
    - Agitation, pessimism, low self-esteem.
    - Duration of 1 year
    - Impaired school and social functioning.

Diagnosis can change to major depressive disorder.

Double depression: full criteria for Dysthymic Disorder & later meets the criteria for Major depressive disorder.

“mood disorder that can act like personality disorder”

Depressive Disorders

- Depressive Disorder NOS
  - Premenstrual dysphoric disorder: most menstrual cycles: depressed mood, anxiety, affective lability, decreased interest in activities. Stops by onset of menses. absent 1 week
  - Minor depressive disorder: episodes of at least 2 weeks of depressive symptoms, less than the five MDD symptoms
  - Recurrent brief depressive disorder: depressive episodes from 2 days to 2 weeks, at least once a month for 12 months.
  - Postpsychotic depressive disorder of Schizophrenia: occurs in residual phase of Schizophrenia
  - During Delusional Disorder, Psychotic Disorder NOS, or active phase of Schizophrenia

Depressive Disorders

- Depressive Disorder Not Otherwise Specified
  - Symptoms interfere with functioning
  - Does not meed criteria for other disorders
  - Characterized by low mood, low self-esteem, loose of pleasure in activities
  - Not related to medical condition or substance abuse

Bipolar Disorders

- AKA manic depression. bipolar affective disorder
- severe recurrent
- mood switches from depression to mania
- Prevalence
  - 3-5% of U.S. Population
- suicide rate 60 times higher than general population

High hospitalization, comorbidity, disability, morbidity

Risk taking

Majority are unable to maintain long term remission.

with good med maintenance 75% will relapse within 5 years

Bipolar Disorders

- Responsible for 5-15% of new & longer psychiatric hospitalization
- Must have manic symptom(s)
- Even if client presents only manic assumed depression will follow.
- Depressive phase indistinguishable from MDD.
- Depression is leading cause of impairment and death.

Bipolar disorders include

- Bipolar I
- Bipolar II
- Cyclothymia
- Bipolar disorder not otherwise specified

Bipolar Disorders

- 296.0x Bipolar I Disorder, Single Manic Episode

  A) Presence of only one Manic Episode and no past Major Depressive Episodes. **Note**: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms

  B) Symptoms is not better accounted for by Schizoaffective Disorder, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS

Bipolar Disorders

- 296.40 Bipolar I Disorder, Most Recent Episode _____

  A) Currently in a _____ Episode

  B)At least one Manic, Major Depressed, or Mixed Episode

  C) Symptoms cause significant distress or impairment in social, occupational, or other functioning.

  D)The symptoms are not better accounted for by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

  E)The Symptoms are not better accounted for by a substance or general medical condition.

Bipolar Disorders

- 296.89 Bipolar II Disorder (Recurrent Major Depressive Episodes With Hypomanic Episodes)

  A) Presence/ history of one or more Major Depressive Episodes

  B) Presence/ history of at least one Hypomanic Episode.

  C)There has never been a Manic or Mixed.

  D) Symptoms not accounted for by Schizoaffective Disorder ,Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS

  E) The symptoms cause clinically significant distress or impairment in social occupational.

Bipolar Disorders

- Bipolar II Disorder
  - Manic or Mixed Episode rules out this disorder
  - Presence of a Hypomanic Episode defferinates between the two conditions.
  - Symptoms must cause impairment
    - Sometimes hypomanic symptoms may not cause impairment
  - More common in women
    - Women with the disorder are at risk for developing episodes during postpartum.

Bipolar Disorders

- 301.13 Cyclothymic Disorder

  A) For at least 2 years, the presence of numerous periods of hypomanic symptoms & periods with depressive symptoms.

  B) not without symptoms for more than 2 months at a time.

  C) No Major Depressive Episode, Manic Episode, or Mixed Episode during the 2 years.

  D) The symptoms are not accounted for by Schizoaffective Disorder, Schizoprenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.

  E) not due to substance use or medical condition.

  F) The symptoms cause clinically significant distress.

Bipolar Disorders

- Cyclothymic Disorder
  - Milder symptoms
  - Considered a chronic condition
  - Symptoms more consistent
  - Clients with only depressive symptoms should not be diagnosed with Cyclothymic Disorder.

Bipolar Disorders

- Bipolar Disorder Not Otherwise Specified
  - Disorders with bipolar features not meeting criteria Examples:
    1. Rapid alternation (over days) between manic and depressive symptoms that meet symptom criteria but not minimal duration for Manic, Hympmanic or Major Depressive Episodes.
    2. Recurrent Hypomanic Episodes without depressive symptoms.
    3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder NOS.
    4. Hypomanic Episodes, along with chronic depressive symptoms, that are too infrequent for Cyclothymic Disorder
    5. When the clinician believes Bipolar Disorder is present but is unable to determine rule out medical condition or substance.

Other Mood Disorders

Mood Disorder Due to General Medical Condition: Characterized by depressed mood and/or elevated or irritable mood as a direct result of a general medical condition.

Substance-Induced Mood Disorder: Prominent and persistent disturbance of mood attributable to use of a substance or cessation of substance use.

Rapid Assessment Instruments

- Beck Depression Inventory -II (BDI-II)
  - By Arron T. Beck, Robert A. Steer, Gregory K. Brown
  - Published by Pearson
  - 5 mins to administer
  - Self report
  - Ages 13-80
  - English and Spanish
  - assesses depression
  - 21 items

Asks about symptoms over last two weeks as in DSM-IV

Scoring

0-13 minimal

14-19 mild

20-28 moderate

29-63 severe

Reliability: Coefficient Alpha = .92.

Rapid Assessment Instruments

- The Mood Disorder Questionnaire
  - By Hirschfeld, Williams, Spitzer, Calabrese, et al. (2000)
  - 13-item checklist
  - designed to help determine if a client is likely to have BD.
  - Screening instrument
  - Good sensitivity and specificity
    - Correctly identify 7 out of 10 patients with BD
    - 9 of 10 without BD will be correctly screened out.

Rapid Assessment Instruments

- Semantic Deferential Feelings and Mood Scales (SDFMS)
  - Maurice Lorr and Richard A Wunderlich
  - Measures mood states
  - 35 items
  - On a one-to-five scale which mood is closer
  - Has five factors A= elated-depressed, B= relaxed – anxious, C= confident- unsure, D= energetic – fatigued, & E= good natured- grouchy
  - Reliability coefficients of .74

Rapid Assessment Instruments

- Beck Hopelessness Scale
  - By Aaron Beck
  - Published by Pearson
  - 5-10 mins to administer
  - Ages 17-80 years
  - English or Spanish
  - predicts eventual suicide
  - measures three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations.

Self- report measure

20 true or false items

Scoring

Overlay

0-3 normal

4-8 mild

9-14 moderate

Over 14 severe

Beck: 9 or above

Rapid Assessment Instruments

- Beck Scale for Sucide Ideation (BSS)
  - By Aaron Beck
  - Published by Pearson
  - 5-10 mins to complete
  - Self-report
  - For 17 years and older
  - English and Spanish
  - patient's suicidal intent
  - Five Screening Items, 21 Test Items
  - Five screening items reduce the length and the intrusiveness for patients who are nonsuicidal.

Treatment of Depression

- Medical
  - antidepressants
  - electroconvulsive therapy (ECT)
- Psychosocial
  - cognitive-behavioral therapy
  - interpersonal therapy

Antidepressant Medication

most meds increase levels of serotonin and/or norepinephrine

- result in down-regulation of these systems

take 2-8 weeks to work

effective

- 65-70% of those on meds improve, vs. 25-30% of those taking placebos
- however, 40% will stop taking drugs due to side effects

relapse rate after going off medications is high (50%)

Types of Antidepressants

tricyclics

MAO inhibitors

SSRIs

others

Tricyclics

block reuptake of norepinephrine and (to a lesser extent) serotonin

examples:

- amitriptyline (Elavil)
- imipramine (Tofranil)

side effects:

- dry mouth, constipation, blurred vision, weight gain, orthostatic hypotension

are likely to be lethal if taken in overdose

MAO Inhibitors

block enzyme (monoamine oxidase) which breaks down norepinephrine and serotonin (monoamines)

examples:

- phenelzine (Nardil)
- tranylcypromine (Parnate)

problem:

- dangerously interact with many other drugs (nasal decongestants, SSRIs) and with foods containing tyramine (smoked meats, ages cheeses, beer)
- can produce hypertensive crisis

SSRIs

selectively inhibit reuptake of serotonin

side effects:

- physical agitation, insomnia, gastrointestinal upset, and sexual dysfunction (low desire)

examples

- fluoxetine (Prozac)
- paroxetine (Paxil)
- sertraline (Zoloft)

are less likely to be lethal if taken in overdose

Other Antidepressants

bupropion (Wellbutrin)

- blocks reuptake of dopamine

venlaxafine (Effexor) and nefazodone (Serzone)

- inhibit reuptake of serotonin and norepinephrine

Electroconvulsive Therapy

used for depression that doesn't respond to other treatments

effective

exact mechanism of action is unknown

receive treatments every other day for total of 6-10 treatments

side effects: short-term memory loss

Cognitive-Behavioral Therapy

- focuses on changing dysfunctional beliefs associated with depression
- clients do homework
  - monitor and log thought processes
  - engage in hypothesis testing
- important to reactivate client
- 10-20 weekly sessions
- effective

Interpersonal Psychotherapy

focuses on resolving problems in client's existing interpersonal relationships and forming new ones

4 major areas

- dealing with interpersonal role disputes (marital conflict, conflict with friends)
- adjusting to the loss of a relationship (death, divorce)
- acquiring new relationships (getting married or establishing professional relationships)
- identifying and correcting deficits in social skills

Interpersonal Psychotherapy (continued)

15-20 weekly sessions

effective

Comparing Treatments

- studies compare CBT and IPT to antidepressant meds and other control conditions
- results
  - CBT, IPT, and meds are equally effective
  - CBT, IPT, and meds are more effective than
    - placebo conditions
    - brief psychodynamic treatments
    - other control conditions
- 50-70% of people benefit from treatment to a significant extent, compared to 30% in placebo or control conditions

Combined Treatments

Meds work more quickly

Psychosocial treatments

- Increase long-range social functioning
- Prevent relapse

Treatment of Bipolar Disorder

lithium is best known treatment

not sure how it works

side effects

- excessive thirst and urination, eventual damage to kidneys and thyroid

blood levels must be carefully monitored

effective

- 30-60% respond well initially

Treatment of Bipolar Disorder (continued)

other approaches include anticonvulsant medications

- example: valproate (Depakote)

psychosocial treatment

- family therapy: increase medication compliance, educate family about symptoms, help family develop new coping skills and communication styles
- decreases relapse

List of Nursing Diagnosis

Risk for suicide related to depressed mood, feelings of worthlessness & hopelessness as evidenced by anger turned inward on self

Low self esteem related to self-negating comments as evidenced by expressions of worthlessness

Risk for injury related to increased agitation as evidenced by extreme hyperactivity

Risk for self or other directed violence related to manic excitement as evidenced by delusional thinking and hallucinations

Interventions 1

Inquire about suicidal thoughts, plans, means

Make environmental safe

Short-term verbal or written contract

Close observation

Frequent rounds at irrgular intervals

Encourage open, honest feelings

Interventions 2

Spend time with client and develop trust

Focus on strengths, minimize failures

Encourage group attendance

Assist with behaviors requiring change

Teach assertiveness and effective communication

Interventions 3

Reduce stimuli

Assign private room

Remove hazardous objects from area

Stay with client when she is agitated

Provide physical activities

Interventions 4

Observe client q 15 min

Remove sharps, belts, & other dangerous objects from environment

Maintain calm attitude

Tranquilizers as ordered

Mechanical restraints if necessary

DISORDER

-2016

Subjects

- The Definition of Bipolar Disorder.
- Symptoms of Bipolar Disorder.
- Types of Bipolar Disorder.
- Etiology of Bipolar Disorder.
- Who is at risk?
- Bipolar Disorder SAD.
- Prevalence & Epidemiology.
- Suicide Risk.
- Treatment of Bipolar Disorder.

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.

BIPOLAR DISORDER

characterized by mood swings from profound depression to extreme euphoria (mania), with intervening periods of normalcy. Psychotic symptoms may or may not be present.

- Bipolar mood or affective disorder is characterized by recurrent episodes of mania and depression in the same patient at different times.
- Earlier known as manic depressive psychosis (MDP)

CLASSIFICATION

F31.0 Bipolar affective disorder,

current episode hypomania.

F31.1- Bipolar affective disorder,

current episode mania without psychotic symptoms

F31.2- Bipolar affective disorder,

current episode mania with psychotic symptoms

F31.3- Bipolar affective disorder,

current episode Mild or moderate depression

F31.4- Bipolar affective disorder,

current episode severe depression without psychotic symptoms

F31.4- Bipolar affective disorder,

current episode severe depression with psychotic symptoms

Types of Bipolar

- Bipolar disorder usually lasts a lifetime. Episodes of mania and depression typically come back over time. Between episodes, many people with bipolar disorder are free of symptoms, but some people may have lingering symptoms.

- There are four basic types of bipolar disorder.

Types of Bipolar

1. **Bipolar I Disorder** is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.

2. **Bipolar II Disorder** is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.

Types of Bipolar

3. **Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.
4. **Cyclothymic Disorder, or Cyclothymia**, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years.

Types

- Bipolar I: Characterized by episodes of severe mania and severe depression.
- Bipolar II: Characterized by episodes of hypomania (not requiring hospitalization) and severe depression.

Etiology

- Etiology is not known.
- ***Theories:***
- Genetic hypothesis
- Biochemical theories
- Neuroendocrine theories
- Sleep studies
- Brain imaging

Genetic hypothesis

- The life-time risk for the first degree relatives getting bipolar disorder is 25%.
- Children with one parent having bipolar disorder has a risk of 27% of life time risk, children with both parents having bipolar disorder is 74%.
- The risk in monozygotic twins is 65% and dizygotic twins is 20%.

Biochemical theories

- Catecholamine's abnormality (norepinephrine, dopamine and serotonin) in one or more sites at brain.
- Acetyl choline and GABA may also play a role.
- The effects of antidepressants and mood stabilizers also provide additional evidence.

Neuroendocrine theories

- Mood symptoms are prominently present in endocrine disorders like hypothyroidism, Cushing's disease, and Addison's disease.

Sleep studies

- In depression, decreased REM latency (i.e., the time between falling asleep and the first REM period is decreased).
- Increased duration of the first REM period.
- Delayed sleep onset.

Brain imaging

- CT scan, MRI scan of brain, PET scan and SPECT have yielded inconsistent, but suggestive findings.
- Findings include ventricular dilatation, white matter hyper-intensities, and changes in the blood flow and metabolism in prefrontal cortex, anterior cingulate cortex, and caudate.

Clinical features

Depression Form:

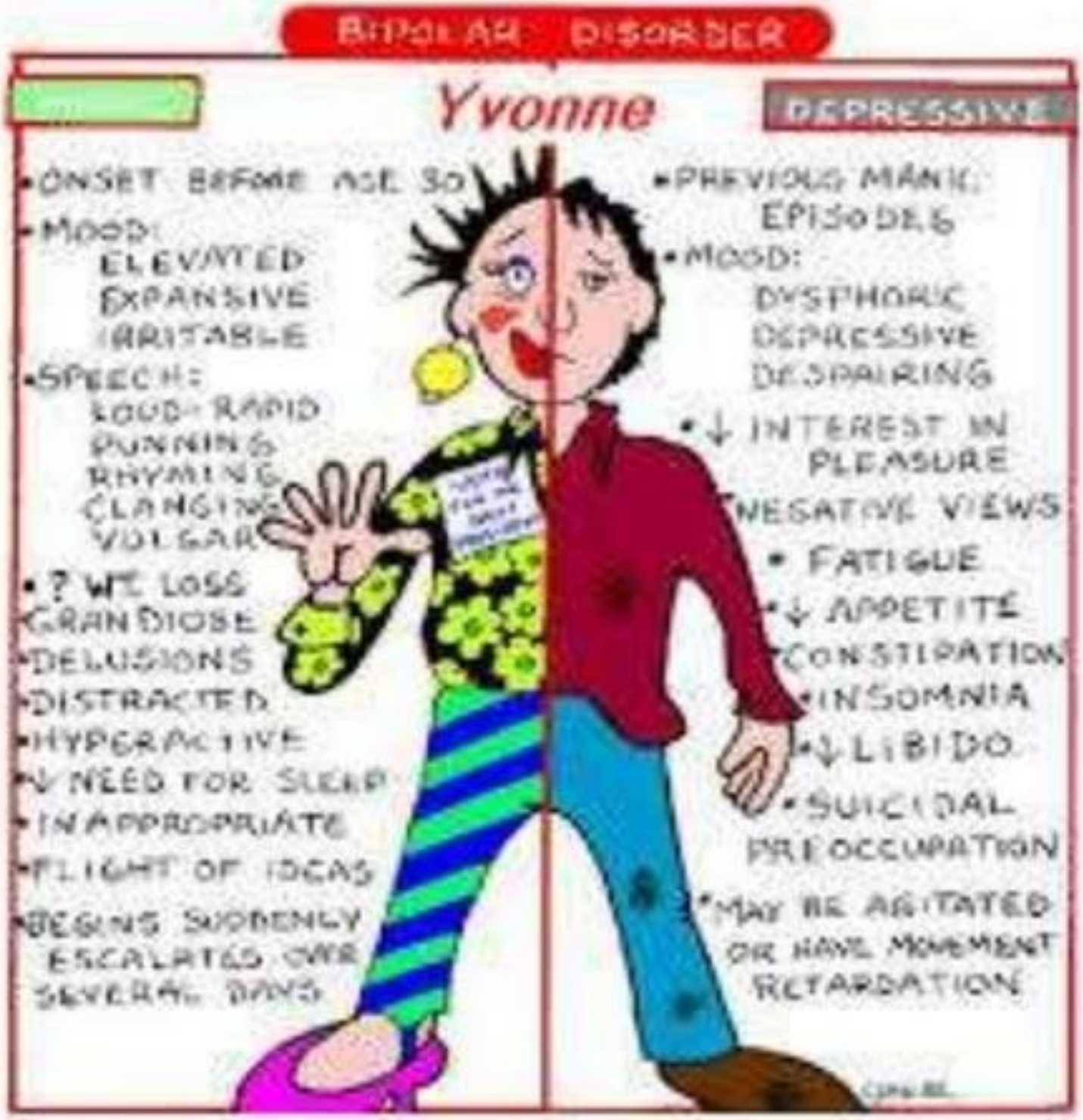
- constantly feeling sad or worthless
- sleeping too much or too little
- feeling tired and having little energy
- appetite and weight changes
- problems focusing
- thoughts of suicide

Manic Form:

- increase in energy level
- less need for sleep
- easily distracted
- nonstop talking
- increased self confidence
- focused on getting things done, but does not accomplish much
- is involved in risky activities even though bad things may happen

Clinical features (Contd.)

- A current episode can be
- Hypomanic
- Manic without psychotic symptoms
- Manic with psychotic symptoms
- Mild or moderate depression
- Severe depression without psychotic symptoms
- Severe depression psychotic symptoms
- Mixed or
- In remission


BIPOLAR DISORDER
Yvonne
DEPRESSIVE
•ONSET BEFORE AGE 30
•MOOD:
ELEVATED
EXPANSIVE
IRRITABLE
•SPEECH:
LOUD- RAPID
PUNNING
RHYMING
CLANGING
VULGAR
• ? WT LOSS
GRANDIOSE
•DELUSIONS
•DISTRACTED
•HYPERACTIVE
↓ NEED FOR SLEEP
•INAPPROPRIATE
•FLIGHT OF IDEAS
•BEGINS SUDDENLY
ESCALATES OVER
SEVERAL DAYS
•PREVIOUS MANIC
EPISODES
•MOOD:
DYSPHORIC
DEPRESSIVE
DESPAIRING
• ↓ INTEREST IN
PLEASURE
NEGATIVE VIEWS
• FATIGUE
• ↓ APPETITE
CONSTIPATION
•INSOMNIA
• ↓ LIBIDO
• SUICIDAL
PREOCCUPATION
•MAY BE AGITATED
OR HAVE MOVEMENT
RETARDATION

Course of the disorder

- Earlier age of onset
- Average manic episodes last for 3-4 months, a depressive episode lasts for 4-6 months
- With rapid institution of treatment symptoms of mania are controlled within 2 weeks and of depression within 6-8 weeks
- Rapid cyclers
- Ultra rapid cyclers
- Increased mortality almost 2 times the normal population

Prognostic factors

- **Good prognostic factors**
- Acute or abrupt onset
- Typical clinical features
- Severe depression
- Well adjusted premorbid personality
- Good response to treatment

- **Poor prognostic factors**
- Co-morbid medical disorders, personality disorders or alcohol dependence
- Double depression
- Catastrophic stress or chronic ongoing stress
- Unfavourable early environment
- Marked hypochondriacal features, or mood incongruent psychotic features
- Poor drug compliance

Management

- Antidepressants
- ECT
- Lithium
- Antipsychotics
- Other mood stabilizers

Antidepressants

Antidepressant	Equivalent dose to 25mg imipramine	Usual therapeutic range (mg/day)
Imipramine	25	150-300
Amitryptyline	25	150-300
Nortryptyline	25	150-300
Clomipramine	25	75-250
Fluoxetine	-	10-60
Paroxetine	-	10-40
Sertraline	-	50-200
Escitalopram	-	10-20
Mirtazepine	-	15-45

Lithium

- Drug of choice for manic episode and preventing further episodes in bipolar disorder.
- 1-2 week period lag before appreciable improvement.
- Usual dose 900-1500mg of $LiCO_3$ per day.
- Low therapeutic index.
- Plasma levels >2mEq/L is toxic and 2.5-3mEq/L may be lethal.

Lithium (Contd.)

- Acute symptoms of toxicity are muscle twitchings, drowsiness, delirium, coma and convulsions, vomiting, severe diarrhoea, albuminuria, hypotension, cardiac arrythmia.
- Before starting lithium therapy CBC, ECG, urine routine, RFT, TFT should be done.

Antipsychotics

- Risperidone, olanzepine, quetipine, haloperidol and chlorpromazine can be used.
- Indications:
- Acute manic episode
- Delusional depression

Other mood stabilizers

- Sodium valproate (1000-3000mg/day)
- Carbamazepine (600-1600mg/day) and oxcarbazepine
- Lorazepam and clonazepam
- Topiramate
- Lamotrigine
- T3 and T4 as adjuncts in rapid cyclers.

THANK YOU