Unit 8 Mood disorder (depression & mania) Suicide



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Mental Health Nursing

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Learning Outcomes

At the end of this presentation, learners will be able to:

1. Understand the concept of mood disorder.
2. Describe the risk factors for and characteristics of mood disorders.
3. Discuss etiologic theories of depression and bipolar disorder.
4. Apply the nursing process and care for clients and families with mood disorders.

What are Mood Disorders?

How to Identify and Understand



Introduction

- **Mood disorders or (affective disorders)** are pervasive alterations in emotions that are manifested by depression, mania, or both.
- **Mood disorders** causes severe and long-term sadness, agitation, or elation, which alter life activities.
- **Mood disorders** are the most common psychiatric diagnoses associated with suicide.

Categories of Mood disorder

- Major depressive disorder
- Bipolar disorder (manic-depressive disorder).

✓**Mania** is a distinct period during which mood is abnormally and persistently elevated, expansive, or irritable.

✓**Hypomania** is a period of abnormally and persistently elevated, expansive, or irritable mood lasting 4 days

- **Note:** The difference between mania and hypomania is that hypomanic episodes do not impair the person's ability to function

Related Disorders

➢**Other disorders classified with similarities to mood disorders include:**

- **1. Persistent depressive (dysthymic) disorder** is a chronic, persistent mood disturbance characterized by symptoms such as insomnia, loss of appetite, decreased energy, low self-esteem, difficulty concentrating, and feelings of sadness and hopelessness that are milder than those of depression.
- **2. Disruptive mood dysregulation disorder** is a persistent angry or irritable mood, punctuated by severe, recurrent temper outbursts that are not in keeping with the provocation or situation, beginning before age 10.

Related Disorders

➢**Other disorders classified with similarities to mood disorders include:**

- **3.Cyclothymic disorder** is characterized by mild mood swings between hypomania and depression without loss of social or occupational functioning.
- **4.Substance-induced depressive or bipolar disorder** is characterized by a significant disturbance in mood that is a direct physiological consequence of ingested substances such as alcohol, other drugs, or toxins.

Related Disorders



➢**Other disorders classified with similarities to mood disorders include:**

- **5. Seasonal affective disorder (SAD)** has two subtypes. In one, most commonly called winter depression or fall-onset SAD, people experience increased sleep, appetite, and carbohydrate cravings; weight gain; interpersonal conflict; irritability; and heaviness in the extremities beginning in late autumn and abating in spring and summer. The other subtype, called spring-onset SAD, is less common, with symptoms of insomnia, weight loss, and poor appetite lasting from late spring or early summer until early fall. SAD is often treated with light therapy.

Related Disorders

➢**Other disorders classified with similarities to mood disorders include:**

- **6. Postpartum or "maternity" blues** is a mild, predictable mood disturbance occurring in the first several days after delivery of a baby. Symptoms include labile mood and affect, crying spells, sadness, insomnia, and anxiety. The symptoms subside without treatment, but mothers do benefit from the support and understanding of friends and family.
- **Postpartum depression** is the most common complication of pregnancy in developed countries (Langan & Goodbred, 2017). The symptoms are consistent with those of depression (described previously), with onset within 4 weeks of delivery.

Related Disorders

➢**Other disorders classified with similarities to mood disorders include:**

- **7. Postpartum psychosis** is a severe and debilitating psychiatric illness, with acute onset in the days following childbirth. Symptoms begin with fatigue, sadness, emotional lability, poor memory, and confusion and progress to delusions, hallucinations, poor insight and judgment, and loss of contact with reality. This medical emergency requires immediate treatment.
- Women who have a history of serious mental illness are at higher risk for a postpartum relapse, even if they were well during pregnancy.

Related Disorders

➢**Other disorders classified with similarities to mood disorders include:**

- **8. Premenstrual dysphoric disorder** is a severe form of premenstrual syndrome and is defined as recurrent, moderate psychological and physical symptoms that occur during the week before menses and resolving with menstruation. Approximately 20% to 30% of premenopausal women are affected by affective and/or somatic symptoms that can cause severe dysfunction in social or occupational functioning, such as labile mood, irritability, increased interpersonal conflict, difficulty concentrating, feeling overwhelmed or unable to cope, and feelings of anxiety, tension, or hopelessness .
- **9. Non-suicidal self-injury** involves deliberate, intentional cutting, burning, scraping, hitting, or interference with wound healing. Some persons who engage in self-injury (sometimes called self-mutilation) report reasons of alleviation of negative emotions, self-punishment, seeking attention, or escaping a situation or responsibility. Others report the influence of peers or the need to “fit in” as contributing factors .

Etiology of Mood Disorders

- psychosocial stressors and interpersonal events appear to trigger certain physiological and chemical changes in the brain, which significantly alter the balance of neurotransmitters.

Biological Theories:

1. Genetic Theories

- First-degree relatives are at risk for **major depressive disorder** twice the risk compared in general population.
- First-degree relatives of people with bipolar disorder have a 3% to 8% risk for developing bipolar disorder compared with a 1% risk in the general population.
- Identical twins are 2 to 4 times higher than fraternal twins to have mood disorders (both twins having the disorder) .

CONT.

2. Neurochemical Theories

Serotonin and norepinephrine are major neurotransmitters implicated with mood disorders. (Serotonin has many roles in behavior: mood, activity, aggressiveness and irritability, cognition, and pain.

- Serotonin deficit is found with depression.
- Norepinephrine levels may be deficient in depression and increased in mania. This catecholamine energizes the body to mobilize during stress and inhibits kindling.
- Kindling is the process by which seizure activity in a specific area of the brain is initially stimulated by reaching a threshold of the cumulative effects of stress,
- It is theorized that kindling may underlie the cycling of mood disorders as well as addiction.
- Anticonvulsants inhibit kindling; this may explain their efficacy in the treatment of the bipolar disorder.
- Dysregulation of acetylcholine and dopamine is also being studied in relation to mood disorders.

CONT.

3. *Neuroendocrine Influences*:

- Mood disturbances have been documented in people with endocrine disorders, such as those of the thyroid, adrenal, parathyroid, and pituitary glands.
- About 40% of clients with depression have increased cortisol secretion.
- About 5% to 10% of people with depression have thyroid dysfunction (elevated thyroid-stimulating hormone).

CONT.

4. Psychodynamic Theory:

- The self-depreciation of people with depression becomes self-reproach and “anger turned inward” related to either a real or perceived loss.
- A person’s ego (or self) aspires to be ideal (i.e., good and loving, superior or strong), and to be loved and worthy, must achieve these high standards. Depression results when, in reality, the person is not able to achieve these ideals all the time.
- The state of depression is like a situation in which the ego is a powerless, helpless child who is victimized by the superego, much like a powerful and sadistic parent who takes delight in torturing the child.
- Most psychoanalytical theories of mania view manic episodes as a “defense” against underlying depression, with the ID taking over the ego and acting as an undisciplined hedonistic being (child).
- Depression is a reaction to a distressing life experience, such as an event with psychic causality.
- Children raised by rejecting or unloving parents are prone to feelings of insecurity and loneliness, making them susceptible to depression and helplessness.
- Depression is a result of specific cognitive distortions in susceptible people. Early experiences shape distorted ways of thinking about oneself, the world, and the future; these distortions involve the magnification of negative events, traits, and expectations and the simultaneous minimization of anything positive.

Major depressive disorder

- MDD typically involves 2 or more weeks of a sad mood or lack of interest in life activities.
- About 20% with MDD patients have delusions and hallucinations (the combination is referred to as psychotic depression).
- Person's sense of helplessness and hopelessness can determine the severity of depression.

- ***Symptoms of MDD according to (DSM-V Diagnostic Criteria)***

➢Symptoms of depression include:

- 1. Changes in eating habits resulting in unplanned weight gain or loss.
- 2. Hypersomnia or insomnia
- 3. Impaired concentration, decision-making or problem-solving abilities.
- 4. Inability to cope with daily life
- 5. Feelings of worthlessness, hopelessness, guilt, or despair
- 6. Thoughts of death and/or suicide
- 7. Overwhelming fatigue; and rumination with negative thinking with no hope of improvement.

- **Incidence and Clinical Course for Major depressive disorder**
- Major depression is twice as common in women than men.
- Depression decreases with age in women and increases with age in men.
- About 1.5 to 3 times greater incidence in first-degree relatives than in the general population.
- An untreated episode of depression can last 6 to 24 months before remitting.
- 50 – 60% of people can have another depression episode.
- After the second episode 70% of people with depression will have recurrent episodes.

TREATMENTS OF MDD

- Pharmacological treatment
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Cyclic Antidepressants (Tricyclin and Tetracyclic Antidepressants).
- Atypical Antidepressants.
- Monoamine Oxidase Inhibitors. MAOIs
- Psychotherapy (Interpersonal therapy, Behavioral therapy, Cognitive therapy).
- Electro convulsive therapy CT

DRUG ALERT

➢Serotonin Syndrome

- Serotonin syndrome occurs when there is an inadequate washout period between taking MAOIs and SSRIs or when MAOIs are combined with meperidine.

✓**Symptoms of serotonin syndrome include:**

- Change in mental state: confusion and agitation
- Neuromuscular excitement: muscle rigidity, weakness, sluggish pupils, shivering, tremors, myoclonic jerks, collapse, and muscle paralysis
- Autonomic abnormalities: hyperthermia, tachycardia, tachypnea, hypersalivation, and diaphoresis

DRUG ALERT

➢Overdose of MAOI and Cyclic Antidepressants

- Both the cyclic compounds and MAOIs are potentially lethal when taken in overdose.
- **MAOI Drug Interaction:**

- **Amphetamines**
- **Ephedrine**
- **Fenfluramine**
- **Isoproterenol**
- **Meperidine**
- **Phenylephrine**
- **Phenylpropanolamine**
- **Pseudoephedrine**
- **SSRI antidepressants**
- **Tricyclic antidepressants**
- **Tyramine**

Psychotherapy

- **Interpersonal therapy** focuses on difficulties in relationships, such as grief reactions, role disputes, and role transitions. For example, a person who as a child never learned how to make and trust a friend outside the family structure has difficulty establishing friendships as an adult.
- **Behavior therapy** seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions. It may also focus on improving social skills.
- **Cognitive therapy** focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person's distorted thinking, which, in turn, influences feelings, behavior, and functional abilities.

NURSING INTERVENTIONS

For Depression

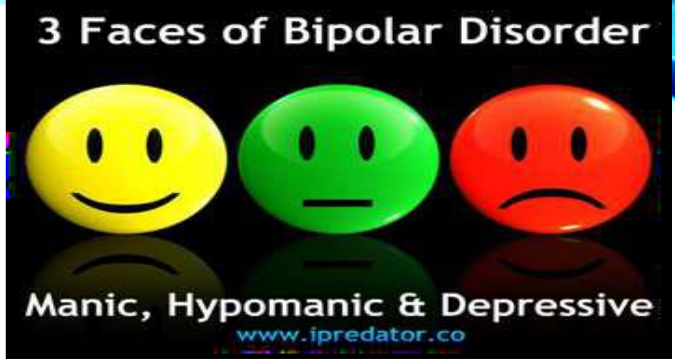
- Provide for the safety of the client and others.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending nondemanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- 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.

CLIENT AND FAMILY EDUCATION

For Depression

- Teach about the illness of depression.
- Identify early signs of relapse.
- Discuss the importance of support groups and assist in locating resources.
- Teach the client and family about the benefits of therapy and follow-up appointments.

BIPOLAR DISORDER



- **Bipolar disorder** involves extreme mood swings from episodes of mania to episodes of depression.
- Clients are euphoric, grandiose, energetic, and sleepless during manic episodes and sad, helplessness, and hopelessness during depressive episode.
- A diagnosis of bipolar disorder may not be made until the person experiences both episodes (manic & depression).
- Bipolar disorder occurs almost equally among men and women, but higher among educated people.

Bipolar disorder

Incidence and Clinical Course of Bipolar disorder :

- The mean age for a first manic episode is the early 20s.
- Manic episodes typically begin suddenly, with rapid escalation of symptoms over a few days.
- Symptoms of mania last from a few weeks to several months.
- Symptoms of manic episode tend to be briefer and to end more suddenly than depressive episodes

Bipolar disorder

➢**Symptoms of Mania (Manic Episode) according to (DSM-IV Diagnostic Criteria) :**

1. Heightened, grandiose, or agitated mood
2. Exaggerated self-esteem
3. Sleeplessness
4. Flight of ideas and pressured speech
5. Reduced ability to filter out extraneous stimuli; easily distractible
6. Increased number of activities with increased energy
7. Multiple, grandiose, high-risk activities, using poor judgment, with severe consequences

Bipolar disorder

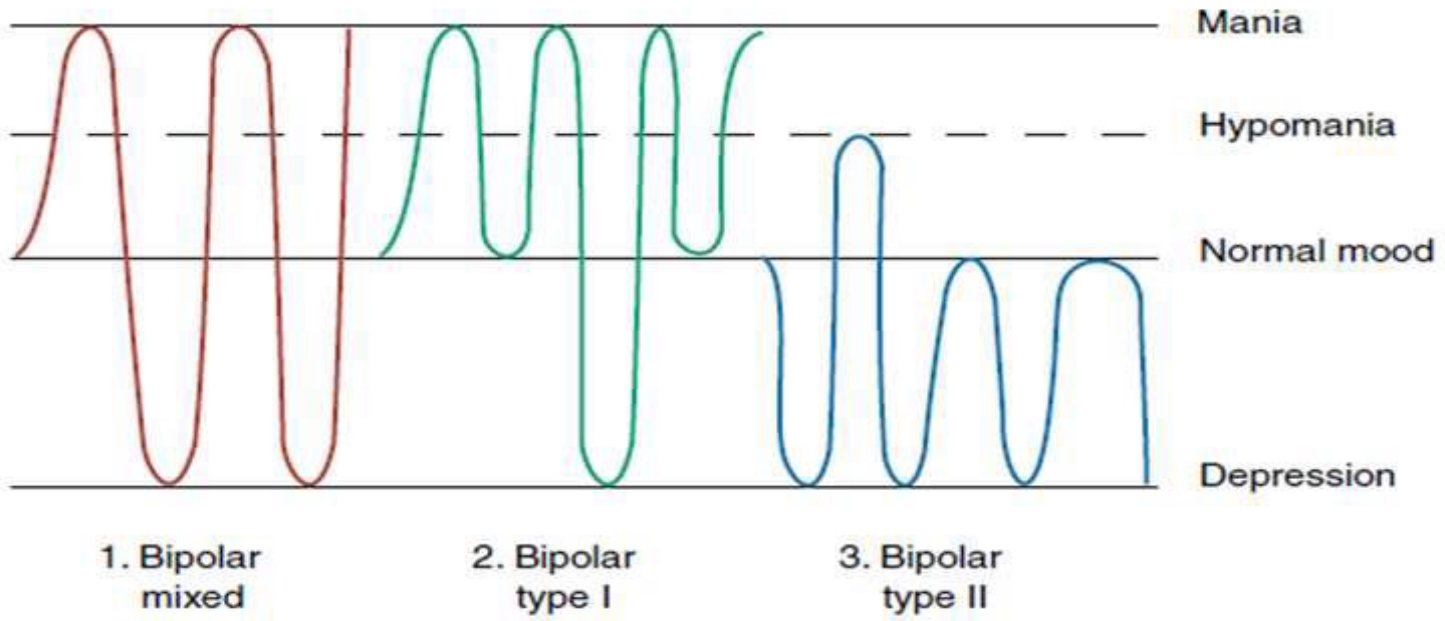
Description of Bipolar Disorder (For the purpose of medical diagnosis)

- Mixed episodes of mania and depression
- Bipolar I disorder: one or more manic accompanied by major depressive episodes.
- Bipolar II disorder: one or more major depressive episodes accompanied by at least one hypomanic episode



Bipolar disorder

- **Mood Cycles of Bipolar Disorder**



1. Bipolar mixed—Cycles alternate between periods of mania, normal mood, depression, normal mood, mania, and so forth.

2. Bipolar type I—Manic episodes with at least one depressive episode.

3. Bipolar type II—Recurrent depressive episodes with at least one hypomanic episode.

Figure 15-1. Graphic depiction of mood cycles.

Bipolar disorder

Treatment:

1) Psychopharmacological

- Lithium
- The response rate in acute mania to lithium therapy is 70% to 80%.
- Lithium reduces the degree and frequency of bipolar cycle or eliminating manic episodes.
- Anticonvulsant Drugs (Carbamazepine, Gabapentin, & Clonazepam)
- They are helpful in stabilizing the moods of people with bipolar illness.
- The drugs raise the brain's threshold for dealing with stimulation (internal or external).

Bipolar disorder

Treatment:

2) Psychotherapy

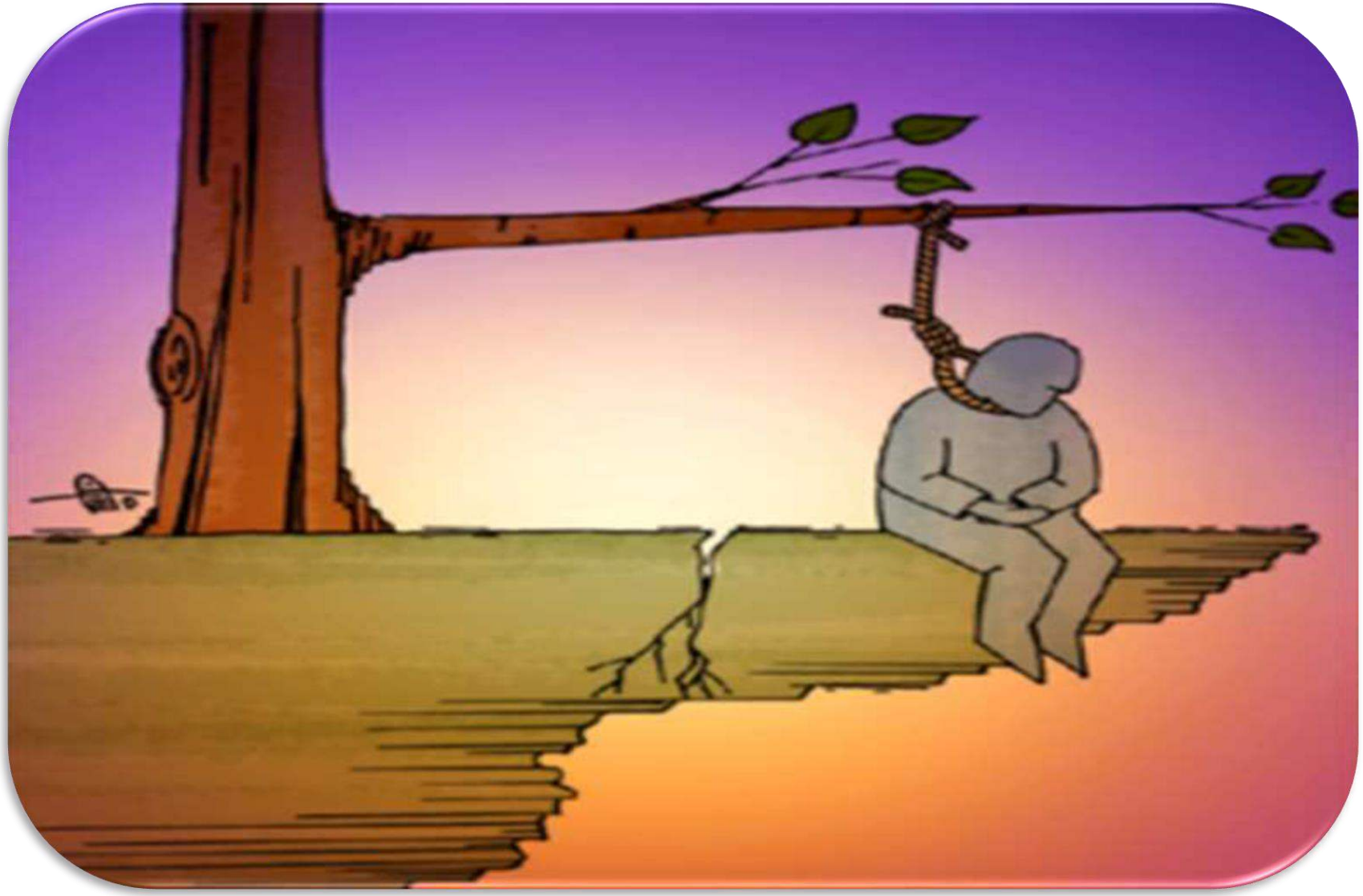
- Psychotherapy is useful in the mildly depressive or the bipolar cycle.
- Psychotherapy is not useful during acute manic stages because the person's attention span is brief or momentary.
- A combination of psychotherapy with medication can reduce the risk of suicide in people with mood disorder.



❑Nursing Intervention for Mania:

1. Provide for client's physical safety and those around.
2. Set limits on client's behavior when needed.
3. Remind the client to respect distances between self and others.
4. Use short, simple sentences to communicate.
5. Clarify the meaning of client's communication.
6. Frequently provide foods that are high in calories and protein.
7. Promote rest and sleep.
8. Protect the client's dignity when inappropriate behavior occurs.
9. Channel client's need for movement into socially acceptable motor activities.

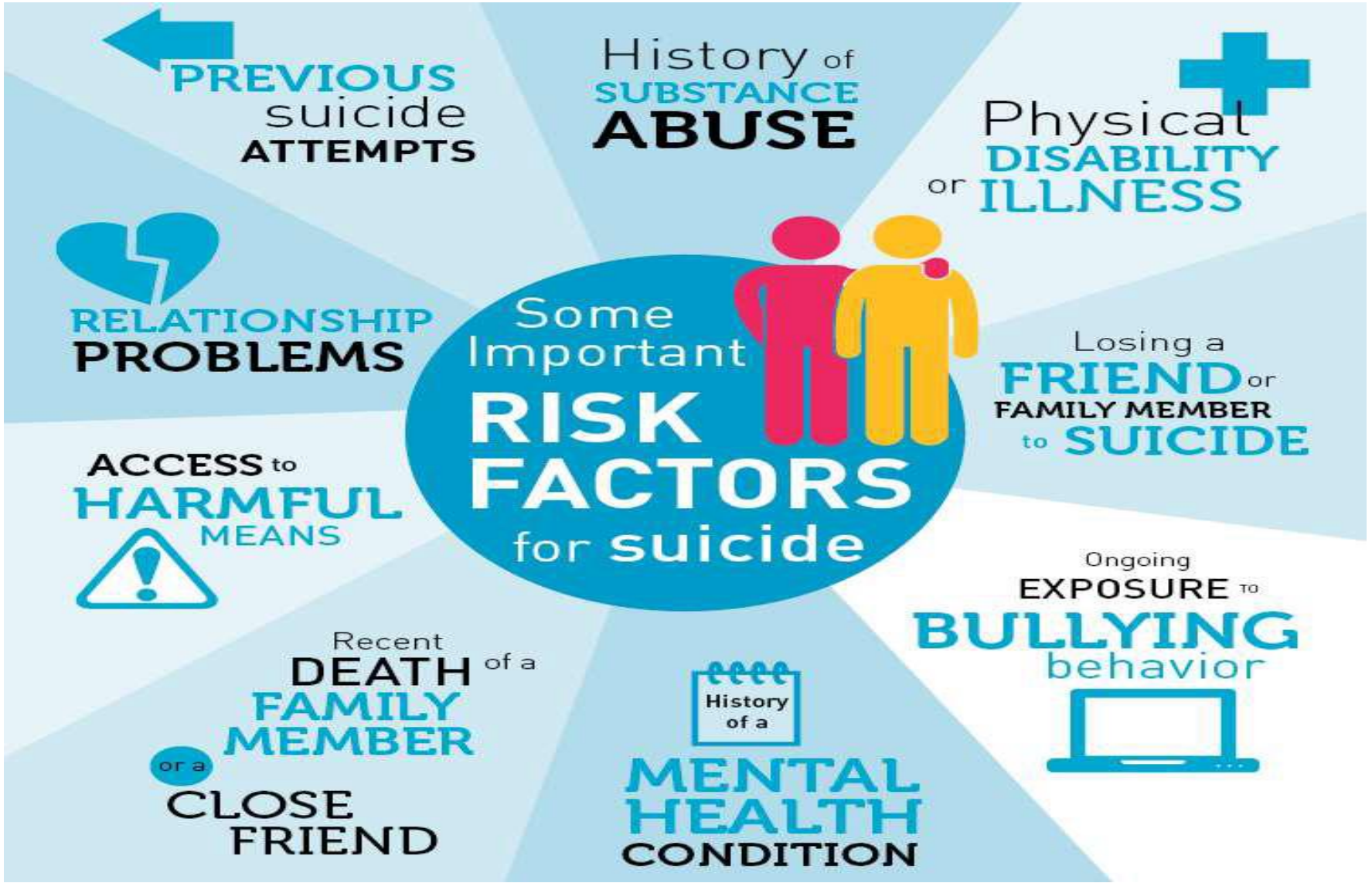
Suicide



Suicide

- Suicide is the intentional act of killing oneself, and is common in people with mood disorders.
- Suicide is the second leading cause of death (after accidents) among people 15 to 24 years of age.
- Men commit suicide three times the rate of women.
- Women attempt suicide four times higher than men.
- Men choose methods like (shooting, hanging, or jumping from a high place)
- Women more likely to choose less sever method of suicide, such as overdose on medication.

Risk Factors for Suicide



Suicide Assessment :

- The first 2 years after an attempt represent the highest risk period, especially the first 3 months.
- Those with a relative who committed suicide are at increased risk for suicide.
- Antidepressant treatment actually can give clients with depression the energy to act on suicidal ideation.



Suicide Assessment :

➢Suicide Assessment: Lethality Assessment

- Lethality means the person admits to having a “death wish” or suicidal thoughts.
- The danger to life usually associated with a suicide method or action.

➢Warning of Suicidal Intent :

- Sending signals to others by talking about suicide and their thought of harming themselves.
- Suicidal people have mixed feelings (ambivalence) about their wish to die, wish to kill others, or to be killed.



Suicide

➢**Nursing Intervention:**

- Assume authoritative role to maintain client safety.
- Provide a Safe Environment
- Create a Support System

Suicide

➢ **Myths about Suicide:**

- People who talk about suicide never commit suicide.
- Suicidal people only want to hurt themselves, not others.
- There is no way to help someone who wants to kill himself or herself.
- Do not mention the word suicide to a person you suspect to be suicidal, because this could give him or her the idea to commit suicide.
- Ignoring verbal threats of suicide or challenging a person to carry out his or her suicide plans will reduce the individual's use of these behaviors.

➢ Antidepressants and Suicide Risk

Depressed clients who begin taking an antidepressant may have a continued or increased risk for suicide in the first few weeks of therapy. They may experience an increase in energy from the antidepressant but remain depressed.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