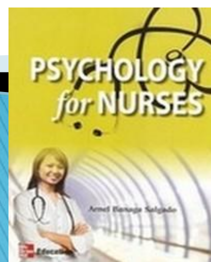
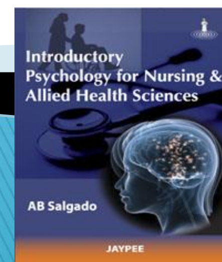
Mood Disorders

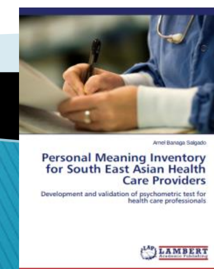
DR. ARNEL BAÑAGA SALGADO
H/P No.: 056-88-27-333
URL: www.ifeet.org
Doctor of Psychology (Clinical Psychology)
FPM (PhD) Psychology
Doctor of Science (D.Sc.)
Doctor of Education (Ed.D.)
Master of Arts in Nursing (RP)
Master of Arts in Teaching - Psychology (PNU)
Registered Nurse (RP, Mal, UAE)
Licensed Teacher (RP)
Certificate in Teaching,
Bachelor of Science in Nursing (BSN)

Author of



McGraw-Hill





Learning Objectives

- Describe the signs and symptoms of depressive and bipolar disorders
- Discuss the various aetiological theories of mood disorders
- Formulate the nursing diagnosis for depressive and manic phases of mood disorder and include the outcome criteria
- Discuss various intervention strategies for depressive and manic phases
- Discuss long-term management of mood disorders

Introduction

- Mood disorders are a group of disorders in which disturbance of mood is the prominent feature.
- Kraepelin (1896) was the first one to divide the functional psychosis into two broad categories—dementia praecox and manic-depressive insanity (MDI).
- These disorders have earlier been referred to as affective disorders.

MOOD RANGE

DEPRESSED

MANIC

Severe Moderate Mild Normal Hypomanic Euphoric

BIPOLAR

Cyclothymic Disorder

Unipolar Disorder (Major Depression)

Dysthymic Disorder

Introduction (cont.)

- Mood disorders can be classified into two major syndromes namely depression and mania.
  - People who suffer from manic illness will invariably have depression as well at some time in life and this type is known as bipolar mood disorder.
  - Major depressive disorder is characterized by repeated episodes of depression only.
  - Dysthymia is a chronic depressive syndrome for a duration of 2 years or more but depressive symptoms are not as severe as in depressive disorder.

Dr. Arnel Banaga Salgado

Depressive Disorder

Epidemiology

Prevalence of depressive disorder	:	2 to 5% and life time prevalence varies between 10 and 20%
Gender	:	Male : Female–1:2
Age of onset	:	Is becoming lower, with more of young people getting the illness
Lifetime prevalence of dysthymia	:	3%— It is more common in women, younger than 65, single, unemployed and persons from low socio-economic status.

Comorbidity

- Symptoms of anxiety are common in depressive disorder.
- Depressive features are quite frequent in :
  - generalized anxiety disorder, panic disorder, obsessive–compulsive disorder, schizophrenia, schizoaffective disorder, eating disorder, substance abuse disorder and personality disorder.

Comorbidity (cont.)

- The incidence of depressive disorder is quite high in medical illnesses such as :
  - chorea, Parkinson's disease, epilepsy, stroke, migraine, myocardial infarction, endocrinal disorders, viral infections and rheumatoid arthritis.

Aetiology

A. Biological Factors

i. Genetics

- Heredity— 50–70% of first degree relatives of clients

ii. Neurobiological studies

- Abnormalities in various neurotransmitters
- Decrease in norepinephrine at various nerve terminals
- Low levels of serotonin (in the post-synaptic cleft) in the brain

Aetiology (cont.)

- Low levels of 5-hydroxy-indole-acetic acid (5-HIAA) in the CSF

iii. Neurophysiological abnormalities

- Sleep EEG shows decreased slow-wave sleep, shortened REM latency and longer REM periods than seen in normal subjects
- MRI studies show an increased number of focal signal hyper-intensities in white matter in depressed clients

Aetiology (cont.)

B. Psychological Factors

Psychoanalysts say depression is seen as a reaction to the loss of an 'object', (even a loss of self-esteem). Mania, on the other hand serves as a defense against depression.

Behaviourists suggest that people develop a behavioural syndrome called 'learned helplessness' when faced with an uncontrollable situation.

Aetiology (cont.)

C. Cognitive theories

- Aaron Beck, a cognitive theorist suggested that 'depressive cognitions' were the cause of depressed mood, or were powerful factors in aggravating and maintaining the disturbed mood.

D. Social and environmental factors

- Adverse childhood experiences lead to depressive disorder in adult life.

Aetiology (cont.)

- Depression is more common in divorced men.
- Women, who were caring for 3 or more children under the age of 11, unemployed and without a confiding relationship, were at high risk of having depression.
- High rates of depression are seen in clients with chronic or painful physical illnesses.

Course and Prognosis

- Depressive episodes usually last for 6 months.
- Episodes of recurrent depressive disorder are usually shorter (4–16 weeks).
- Risk of recurrence: 60% would have another episode within 20 years.

Course and Prognosis (cont.)

- The inter-episodic interval usually becomes shorter with increasing number of recurrences.
- The presence of residual symptoms such as somatic symptoms and poor sleep increases the risk of recurrence.
- In 10–20% of cases, depressive episodes run a chronic course with persistent symptoms lasting more than 2 years.

Course and Prognosis (cont.)

- The death rate in clients with depressive disorder is higher than the general population.
- The causes of death are usually suicide, psychoactive substance abuse, cardiac and respiratory diseases.
- About 11–17% of clients with severe depression eventually commit suicide.

Course and Prognosis (cont.)

- Clients with younger age of onset and acute onset of illness show better recovery.
- Insidious onset, late age of onset, poor social support, presence of residual symptoms and co-morbid alcohol abuse are associated with poor outcome.

Nursing Assessment

- Somatic symptoms (e.g. headache, back pain and gastrointestinal upsets) are common presentations of depression and are often missed (masked depression).
- Assessment for suicide potential should be done to ensure the safety of the patient.
- Key features of depressive disorder:
  - Lowering of mood
  - Reduced levels of energy and activity

Nursing Assessment (cont.)

- Sustained and persistent low/depressed mood
- Anhedonia (not able to enjoy anything)
- Loses interest in all activities including work and family
- Loss of appetite and weight loss
- Disturbed sleep
- Loss of libido
- Psychomotor retardation

Nursing Assessment (cont.)

- Difficulty in paying attention/concentrating
- Gloomy view of self, future and the world around
- Suicidal ideas and plans
- Delusions of poverty, nihilism and personal inadequacy
- Hallucinations (auditory, olfactory and visual

In severe forms of the illness, incongruent psychotic symptoms and catatonic symptoms may be present.

Nursing Assessment (cont.)

- Melancholia— also known as 'biological depression' and refers to the typical syndrome of depression mentioned.
- Symptoms of melancholia are somatic, e.g. depressed mood, anhedonia, loss of emotional reactivity, loss of appetite and weight, etc.
- In some patients, the mood, though depressed, is reactive and the patient is able to enjoy certain activities.

Nursing Assessment (cont.)

- This presentation is known as 'atypical depression'. Symptoms include depressed mood accompanied by irritability, disturbed sleep, overeating, weight gain and feels better in the morning.
- Dysthymia (neurotic depression) is characterized by the presence of chronic, low-grade depressive symptoms.
- Full depressive episodes may be superimposed on dysthymia and this is known as 'double depression'.

Nursing Assessment (cont.)

- Risk factors for depressive disorder:
  - Past history of depressive disorder
  - Family history of depressive disorder
  - Lack of social support
  - Presence of stressors
  - Comorbid substance abuse disorders
  - Presence of medical comorbidity

Nursing Diagnoses for Depression

- Risk of suicide
- Disturbed thought processes
- Hopelessness
- Helplessness
- Decisional conflict
- Chronic low self-esteem
- Ineffective coping
- Impaired social interaction
- Social isolation
- Self-care deficit
- Impaired nutrition
- Disturbed sleep pattern

The nursing diagnosis of risk for suicide is always kept in mind

Nursing Outcome Criteria

- Outcome criteria are identified after discussion with the client and family, whenever possible.
- The indicators of outcome should be realistic, measurable and tailor-made according to the level of pre-morbid functioning and the needs of a client.

Nursing Outcome Criteria for Depression

Nursing outcome	Goals
Risk for suicide	Reports of suicidal ideas and plans Recognizes the thinking process Refrains from harming self Verbalizes need for assistance
Disturbed thought process (ideas of hopelessness, helplessness and and powerlessness)	Reports of negative thoughts Recognizes distorted thoughts and beliefs. Tries to control these thoughts
Chronic low self-esteem	Able to substitute negative thoughts with positive and realistic thoughts

Nursing Outcome Criteria for Depression (cont.)

Nursing outcome	Goals
Impaired nutrition	Meals and fluids taken in small amounts Accepts meals and fluids adequately Asks for the food or drinks he likes Gains weight
Self-care deficit	Accepts help offer to shave, brush, bath and change dress Asks for help to maintain personal hygiene Appears clean and well groomed

Nursing Care Plan and Implementation

- The nursing care plan for the clients with depression targets the symptoms a client has and the intervention strategies should be suited to the phase of the depressive disorder.
- There are three phases in the treatment and recovery process from the depressive disorder:
    i. Acute phase (6–12 weeks)
    ii. Continuation phase (3–9 months)
    iii. Maintenance phase (1 or more years)

Nursing Care Plan and Implementation (cont.)

i. Acute phase (6-12 weeks)

- The main aim of treatment is symptom reduction or remission and restoration of psychosocial functioning.
- Hospitalization should be considered if the symptoms are severe or the client is suicidal.

Nursing Care Plan and Implementation (cont.)

- Once safety is ensured, the next objective is to choose the right antidepressant and to adjust its dosage.
- Regular follow-ups are necessary to monitor the response to the antidepressants and the side effects.
- The client is provided with supportive psychotherapy and education.

Nursing Care Plan and Implementation (cont.)

ii. Continuation phase (3–9 months)

- The goal of treatment is to minimize the risk of relapse (a return of the current episode of depression).
- This is achieved by:
  - continuing the medication at the same dose at which the client has shown adequate response, at least for the next 6–7 months.
  - psychotherapy for depression and psycho-education along with the medication.

Nursing Care Plan and Implementation (cont.)

iii. Maintenance phase (1 or more years)

- To prevent recurrence in the clients who are at high risk, the antidepressants and/or mood stabilizers such as lithium carbonate or lamotrigine are continued for years.
- The decision to discontinue the medications is governed by the same factors considered in the decision to initiate maintenance treatment.

Nursing Care Plan and Implementation (cont.)

Somatic Treatment

- Pharmacotherapy
  - Treatment for depressive disorder with/without psychotic features
  - Maintenance therapy
- Electroconvulsive therapy (ECT)
  - Effective treatment for severe depression

Nursing Care Plan and Implementation (cont.)

- Light therapy
  - Treatment option for seasonal, non-psychotic and winter depressive episodes
- Transcranial Magnetic Stimulation (TMS)
  - Treatment for severe, recurrent and treatment-resistant depression

Nursing Care Plan and Implementation (cont.)

Psychosocial Interventions

- Clients with recurrent depressive disorder show better outcomes with a combination of antidepressants and psychotherapy as compared to treatment with a single modality.
- Types of interventions
    i. Cognitive Behaviour Therapy
    ii. Interpersonal Therapy (IPT)
    iii. Milieu Therapy
    iv. Self-care Activities
    v. Psychoeducation.

Evaluation

- Frequent evaluation of short-term indicators and outcome goals is done.
- The efficacy of the treatment can be judged by:
  - assessment of presence or absence of suicidal ideas, negative thoughts (worthlessness, hopelessness and of helplessness), self-care deficits, sleep and appetite changes and social interactions.
  - If the indictors have not been met, it is important that the nursing care plan is reassessed and reformulated.

Bipolar Disorder

- Bipolar disorder is a chronic, recurrent illness characterized by:
  - episodes of mania,
  - hypomania,
  - depression and
  - concurrent mania and depression (mixed episodes)

with periods of normal mood and functioning in between the episodes.

Classification of Bipolar Disorders

Bipolar I disorder	: Depressive episodes alternating with at least one episode of mania
Bipolar II disorder	: Depressive episode alternating with episodes of hypomania
Cyclothymia	: Hypomanic episodes alternating with depressive episodes that do not fulfil the criteria for major depressive episodes and the illness at least of 2 years in duration
Rapid cycling mood disorder	: Four or more mood episodes in a 12-month period

Epidemiology

- Lifetime prevalence vary from 0.3 to 1.5%
- More common in women than in men (M:F 2:3)
- Age of onset—15 to 50 years with a mean of 21 years
- The first episode in males is likely to be a manic episode, whereas in females the disorder usually starts with a depressive episode
- Cyclothymia usually starts in adolescence or early adulthood
- There is a 15%–50% risk that an individual with cyclothymia will subsequently develop bipolar I or II disorder

Comorbidity

- Substance-use disorders are common in persons with bipolar disorder.
- Such clients experience more mixed or dysphoric mania and rapid cycling. Compliance with medication also tends to be poorer.
- Other comorbid psychiatric disorders include personality disorders, anxiety disorders and eating disorders.

Aetiology

i. Genetics:

- Bipolar disorder is seven times more common in the first degree relatives of bipolar clients.
- Children of a parent with bipolar disorder have a 50% chance of developing the illness.
- The concordance rate for monozygotic twins is 33–90% as compared to that of about 20% for dizygotic twins.

Aetiology (cont.)

ii. Neurobiological studies

- Show abnormalities in various neurotransmitters.
- An increase in the levels of dopamine and noradrenaline in the brain can cause mania.
- Drugs like cocaine and L-dopa exacerbate mania.

Course and Prognosis

- The length of manic episodes varies from 3 to 13 months.
- The duration of each episode and inter-episodic interval stabilizes after the 4th or 5th episode, especially in untreated clients.
- Prognosis is much better with treatment.
- Subsequent depressive episodes are very frequent.

Course and Prognosis (cont.)

- Recovery from manic episodes is quite high, with only a small proportion becoming chronic.
- Bipolar disorder is also associated with high morbidity in terms of loss of job, decreased productivity, increased divorce rates and interpersonal problems.

Nursing Assessment Characteristic Features of Mania

i. **Elated, cheerful or irritable mood**

ii. **Increased self-esteem**

- over familiarity
- grandiose ideas and plans
- uninhibited behaviour

iii. **Increased energy**

- overactivity
- subjective sense of wellness
- subjective sense of racing thoughts
- talkativeness

Nursing Assessment Characteristic Features of Mania (cont.)

iv. **Distractibility**
   - moving from one topic/task to another

v. **Impaired judgement**
   - reckless driving
   - sexual promiscuity
   - squandering money
   - impractical plans

vi. **Marked functional impairment (personal, social, vocational)**

Nursing Assessment
Characteristic Features of Mania (cont.)

Hypomania

- More common than mania
- Similar to mania but is milder, briefer and psychotic symptoms are absent
- No impairment of functioning and usually does not require treatment

Nursing Assessment Characteristic Features of Mania (cont.)

Cyclothymia

- Is a condition of persistent unstable mood with frequent mood swings of mild depression and mild elation causing no functional impairment
- Episodes are brief and unrelated to life events
- Superimposed on this chronic instability one may have fullblown manic or depressive episode as well

Nursing Diagnoses for Mania

- Risk for injury
- Risk for other directed violence
- Disturbed thought process
- Impaired verbal communication
- Impaired social interaction
- Ineffective coping
- Disturbed nutrition
- Imbalanced nutrition
- Self-care deficit
- Caregiver role strain

Nursing Outcome Criteria

Nursing outcome indicators and goals would depend upon the phase of mania.

Acute Phase	Continuation Phase	Maintenance Phase
– Aggression self control	– Compliance behaviour	– Compliance behaviour
– Distorted thoughts self control	– Knowledge of disease process	– Knowledge of disease process
– Overactivity self control	– Social support	– Social support
– Hydration Sleep	– Consequences of substance abuse	– Participation in psychoeducational programmes

Planning and Implementation

- The plan of care and interventions is tailored according to the phase of illness and the needs of the client.
- Other comorbid conditions need appropriate treatment.
- There are three phases in the treatment and recovery process from the manic episode.

Planning and Implementation (cont.)

i. **Acute phase (1–4 months)**

- The main aim of treatment in the acute phase is symptom reduction and stabilization.

  a. Treatment of manic episode
  - Pharmacotherapy
  - ECT, has been shown to be one of the best treatments for acute mania, though it is used with reservations

  b. Treatment of depressive episode
  - Pharmacotherapy
  - Psychological interventions

Planning and Implementation (cont.)

ii. Continuation phase (4–9 months)

- The treatment goal in this phase is to prevent relapse of the current episode or a switch into the opposite pole.
- Pharmacotherapy in the form of mood stabilizers (therapeutic or prophylactic) is continued.
- Regular follow up is advised while closely monitoring the client for the signs of relapse and side effects of medication.

Planning and Implementation (cont.)

iii. Maintenance phase

- The main goal of treatment in this phase is to maintain the remission and to prevent future episodes.
- Young age of onset, male gender, positive family history of bipolar disorder and severity of episodes are the factors which would decide the need for prophylactic treatment.
- Lithium carbonate remains the drug of choice as it is effective in preventing both manic and depressive episodes.

Other Interventions Used in the Management of Bipolar Disorder

- Milieu therapy
- Psychological treatment
- Psychoeducation

Evaluation

- The efficacy of treatment can be judged by the improvement in behaviour, mood, thought process and judgement of the client.
- Improvement in risk for injury, sleep pattern and compliance with the treatment plan are other indicators of the success of nursing care plan.
- Long-term outcomes include clear understanding about the illness and need for treatment, compliance with treatment, resuming work, good interpersonal relationships and improved coping skills.