MOOD DISORDERS

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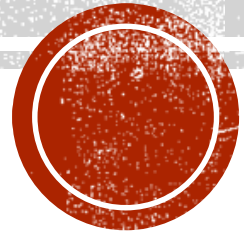


LEARNING OUTCOMES

By The end of Session Learners will learn:

I . Types of Mood Disorders

II. Clinical Descriptions and Epidemiology of Mood Disorders

III. Etiology of Mood Disorders

IV. Treatment of Mood Disorders

V. Nursing Care of patient with mood disorders

MOOD DISORDERS

- Two broad types:
  - Involves only depressive symptoms (Depression)
  - Involves manic symptoms (bipolar disorders)
- DSM-5 depressive disorders:
  - Major depressive disorder
  - Persistent depressive disorder
  - Premenstrual dysphoric disorder
  - Disruptive mood dysregulation disorder
- DSM-5 Bipolar Disorders:
  - Bipolar I disorder
  - Bipolar II disorder
  - Cyclothymia

OVERVIEW OF THE DSM-5 MOOD DISORDERS

DSM-5 Diagnoses

Major Features

Major depressive disorder: Five or more depressive symptoms, including sad mood or loss of pleasure, for 2 weeks

Persistent depressive disorder: Low mood and at least two other symptoms of depression at least half of the time for 2 years

Premenstrual dysphoric disorder:Mood symptoms in the week before menses

Disruptive mood dysregulation disorder:Severe recurrent temper outbursts and persistent negative mood for at least 1 year beginning before age 10

Bipolar I disorder:At least one lifetime manic episode

Bipolar II disorder: At least one lifetime hypomanic episode and one major depressive episode

Cyclothymia:Recurrent mood changes from high to low for at least 2 years, without hypomanic or depressive episodes

CRITERIA FOR PREMENSTRUAL DYSPHORIC DISORDER

- In most menstrual cycles during the past year, at least five of the following symptoms were present in the final week before menses and improved within a few days of menses onset:
  - Affective lability
  - Irritability
  - Depressed mood, hopelessness, or self-deprecating thoughts
  - Anxiety
  - Diminished interest in usual activities
  - Difficulty concentrating
  - Lack of energy
  - Changes in appetite, overeating, or food craving
  - Sleeping too much or too little
  - Subjective sense of being overwhelmed or out of control
  - Physical symptoms such as breast tenderness or swelling, joint or muscle pain, or bloating

EPIDEMIOLOGY AND CONSEQUENCES

- only 20% of individuals with BD who present with a depressive episode are diagnosed within the first year.
- there is an average delay of 6 years between first symptoms and a clinical diagnosis.
- Symptom variation across cultures
  - Latino cultures
    - Complaints of nerves and headaches
  - Asian cultures
    - Complaints of weakness, fatigue, and poor concentration
  - Smaller distance from equator (longer day length) and higher fish consumption associated with lower rates of MDD
- Symptom variation across life span
  - Children
    - Stomach and headaches
  - Older adults
    - Distractibility and forgetfulness
- Co-morbidity
  - 2/3 of those with MDD will also meet criteria for anxiety disorder at some point

BIPOLAR DISORDERS

- Three forms:
  - Bipolar I, Bipolar II, and Cyclothymia
    - Mania defining feature of each
    - Differentiated by severity and duration of mania
  - Usually involve episodes of depression alternating with mania
    - Depressive episode required for Bipolar II, but not Bipolar I
- Mania
  - State of intense elation or irritability
  - Hypomania
    - Symptoms of mania but less intense
    - Does not involve significant impairment, mania does

DSM-5 CRITERIA FOR MANIC AND HYPOMANIC EPISODES

- Distinctly elevated or irritable mood for most of the day nearly every day
- *Abnormally increased activity and energy*
- At least three of the following are *noticeably changed from baseline* (four if mood is irritable):
  - Increase in goal-directed activity or psychomotor agitation
  - Unusual talkativeness; rapid speech
  - Flight of ideas or subjective impression that thoughts are racing
  - Decreased need for sleep
  - Increased self-esteem; belief that one has special talents, powers, or abilities
  - Distractibility; attention easily diverted
  - Excessive involvement in activities that are likely to have undesirable consequences, such as reckless spending, sexual behavior, or driving
- For a manic episode:
  - Symptoms last for 1 week or require hospitalization or include psychosis
  - Symptoms cause significant distress or functional impairment
- For a hypomanic episode:
  - Symptoms last at least 4 days
  - Clear changes in functioning that are observable to others, but impairment is not marked
  - No psychotic symptoms are present

TYPES OF BIPOLAR DISORDERS

- Bipolar I
  - At least one episode or mania
- Bipolar II
  - At least one major depressive episode with at least one episode of hypomania
- Cyclothymic disorder (Cyclothymia)
  - Milder, chronic form of bipolar disorder
    - Lasts at least 2 years in adults, 1 year in children/adolescents
  - Numerous periods with hypomanic and depressive symptoms
    - Does not meet criteria for mania or major depressive episode
    - Symptoms do not clear for more than 2 months at a time
    - Symptoms cause significant distress or impairment

TYPES OF BIPOLAR DISORDERS

- . **Substance-Induced Bipolar Disorder**
  - A disturbance of mood (depression or mania) that is considered to be the direct result of the physiological effects of a substance (e.g., ingestion of or withdrawal from a drug of abuse or a medication or other treatment).

TYPES OF BIPOLAR DISORDERS

- **Bipolar Disorder Associated with Another Medical Condition**

  Characterized by an abnormally and persistently elevated, expansive, or irritable mood and excessive activity or energy that is judged to be the result of direct physiological effects of another medical condition.

CRITERIA FOR PERSISTENT DEPRESSIVE DISORDER

- Depressed mood for at least 2 years; 1 year for children/adolescents

- PLUS 2 other symptoms:
  - Poor appetite or overeating
  - Sleeping too much or too little
  - Poor self-esteem
  - Trouble concentrating or making decisions
  - Feelings of hopelessness

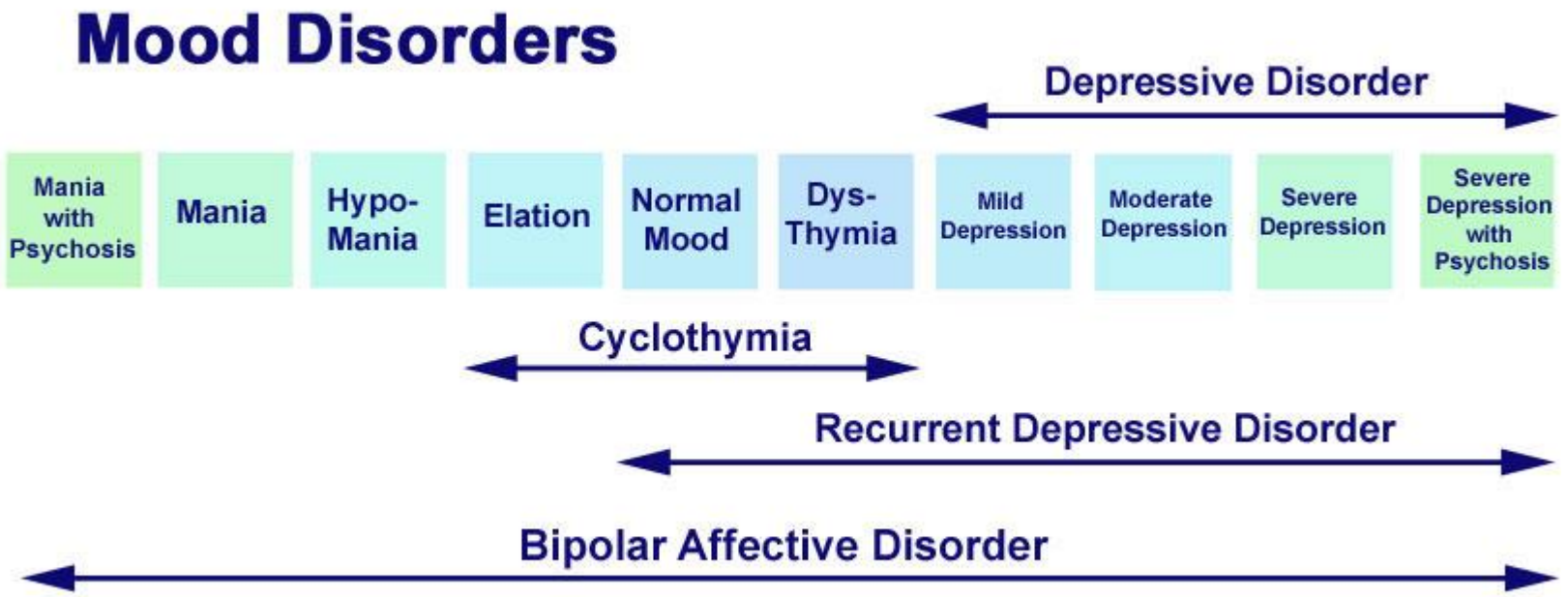
- Symptoms do not clear for more than 2 months at a time

- Bipoloar disorders are not present

EPIDEMIOLOGY AND CONSEQUENCES

- Depression is common
  - Lifetime prevalence (Kessler et al., 2005):
    - 16.2% MDD
    - 2.5% Dysthymia
  - Twice as common in women as in men
  - Three times as common among people in poverty

INTENSITY OF MOOD DISORDER



PREDISPOSING FACTORS OF MOOD DISORDERS

- **Biological Theories**
  - Genetics
    - Twin and family studies
    - Other genetic studies
  - Biochemical influences for bipolar disorder
    - Possible excess of norepinephrine , dopamine and Decrease in **acetylcholine**
      Biochemical influences in depression:
    - Deficiency of norepinephrine, serotonin, and dopamine has been implicated.
    - Excessive cholinergic transmission may also be a factor.
    - Depression due to **Neuroendocrine Disturbances**
  - Increased cortisol
  - Possible diminished release of thyroid-stimulating hormone

TABLE 26–1 Assigning Nursing Diagnoses to Behaviors Commonly Exhibited by Individuals Experiencing a Manic Episode

BEHAVIORS	NURSING DIAGNOSES
Extreme hyperactivity; increased agitation and lack of control over purposeless and potentially injurious movements	Risk for injury
Manic excitement, delusional thinking, hallucinations, impulsivity	Risk for violence: Self-directed or other-directed
Loss of weight, amenorrhea, refusal or inability to sit still long enough to eat	Imbalanced nutrition: Less than body requirements
Delusions of grandeur and persecution; inaccurate interpretation of the environment	Disturbed thought processes*
Auditory and visual hallucinations; disorientation	Disturbed sensory perception*
Inability to develop satisfying relationships, manipulation of others for own desires, use of unsuccessful social interaction behaviors	Impaired social interaction
Difficulty falling asleep, sleeping only short periods	Insomnia

*These diagnoses have been retired from the NANDA-I list of approved diagnoses. They are used in this instance because they are most compatible with the identified behaviors.

OUTCOMES CRITERIA

- **The Client**:
  - Exhibits no evidence of physical injury
  - Has not harmed self or others
  - Is no longer exhibiting signs of physical agitation
  - Eats a well-balanced diet with snacks to prevent weight loss and maintain nutritional status
  - Verbalizes an accurate interpretation of the environment
  - Verbalizes that hallucinatory activity has ceased and demonstrates no outward behavior indicating hallucinations

OUTCOMES CRITERIA CONT:

- **The Client *(cont.):***
  - Accepts responsibility for own behaviors
  - Does not manipulate others for gratification of own needs
  - Interacts appropriately with others
  - Is able to fall asleep within 30 minutes of retiring
  - Is able to sleep 6 to 8 hours per night

PLANNING/IMPLEMENTATION

- Protection from injury due to hyperactivity
- Protection from harm to self or others
- Restoration of nutritional status
- Progression toward resolution of the grief process
- Improvement in interactions with others
- Acquiring sufficient rest and sleep

CLIENT/FAMILY EDUCATION

- **Nature of the Illness**
  - Cyclic nature of the illness
  - Symptoms of depression
  - Symptoms of mania
- **Management of the Illness**
  - Medication management
  - Anger management

CLIENT/FAMILY EDUCATION *(CONT.)*

- **Support Services**
  - Support groups
  - Individual psychotherapy
  - Legal/financial assistance

EVALUATION

Evaluation of the effectiveness of the nursing interventions is measured by fulfillment of the outcome criteria:

I. Has the client avoided personal injury?

II. Has violence to client or others been prevented?

III. Has agitation subsided?

IV. Have nutritional status and weight been stabilized?

V. Have delusions and hallucinations ceased?

VI. Is the client able to make decisions about own self-care?

VII. Is behavior socially acceptable?

VIII. Is the client able to sleep 6 to 8 hours per night and awaken feeling rested?

IX. Does the client understand the importance of maintenance medication therapy?

PSYCHOLOGICAL TREATMENT OF MOOD DISORDERS

- Cognitive therapy
  - Monitor and identify automatic thoughts
    - Replace negative thoughts with more neutral or positive thoughts
- Mindfulness-based cognitive therapy (MBCT)
  - Strategies, including meditation, to prevent relapse
- Behavioral activation (BA) therapy
  - Increase participation in positively reinforcing activities to disrupt spiral of depression, withdrawal, and avoidance
- Behavioral couples therapy(criticism, contempt, defensiveness and stonewalling)
  - Enhance communication and satisfaction

  Family-focused treatment (FFT)
    - Educate family about disorder, enhance family communication, improve problem solving

EXAMPLE OF COGNITIVE THERAPY'S THOUGHT MONITORING/CHALLENGING

Table 5.6 An Example of Daily Thought Monitoring, a Strategy Commonly Used in Cognitive Therapy

Date and Time	Situation *What was happening?*	Negative emotion *Note type of emotion (e.g., sad, nervous, angry) and the intensity of the emotion (0–100)*	Automatic negative thought	How much did you believe this initial thought (0–100)?	Alternative thought *Is there another view of the situation?*	Re-rate your belief in the initial thought	Outcome *Note type of emotion felt and emotion intensity (0–100) after considering the alternative*
Tuesday morning	I made a mistake on a report at work.	Sad–90 Embarrassed–80	I always mess things up. I'm never going to be good at anything.	90	My boss didn't give me enough time to prepare the report. I could have done a better job with more time.	50	Relief–30 Sad–30
Wednesday dinner	Eating dinner at a restaurant. An old friend from high school was at the next table and didn't recognize me.	Sad–95	I'm a nobody.	100	I've changed my hair drastically since then. Many people don't recognize me, but maybe she would have been happy to see me if I had reminded her of who I was.	25	Sad–25
Thursday breakfast	My husband left for work without saying goodbye to me.	Sad–90	Even the people I love don't seem to notice me.	100	I know that he had a huge presentation and he gets stressed.	20	Sad–20

TREATMENT MODALITIES FOR MOOD DISORDERS

- **The Recovery Model**
  - Learning how to live a safe, dignified, full, and self-determined life in the face of the enduring disability which may, at times, be associated with serious mental illness.

THE RECOVERY MODEL *(CONT.)*

- Client identifies goals.
- Client and clinician develop a treatment plan.
- Client and clinician work on strategies to help the individual manage the illness.
- Clinician serves as support person to help the individual achieve the previously identified goals.

THE RECOVERY MODEL *(CONT.)*

Although there is no cure for bipolar disorder, recovery is possible in the sense of learning to prevent and minimize symptoms, and to successfully cope with the effects of the illness on mood, career, and social life.

TREATMENT MODALITIES FOR MOOD DISORDERS

- **Electroconvulsive Therapy**
  - Episodes of mania may be treated with ECT when:
    - Client does not tolerate medication.
    - Client fails to respond to medication.
    - Client's life is threatened by dangerous behavior or exhaustion.

TREATMENT MODALITIES FOR MOOD DISORDERS

- **For mania:**
  - Lithium carbonate
  - Anticonvulsants (eg,valporic acid,carbamazepine)

  Verapamil calcium channel blocker used as a mood stabilizer also.

  Antipsychotics
  - First generation (haloperidol)
  - second generation (olanzapine, clozapine)
  - Benzodiazepine (lorazepam,clonazepam)

TREATMENT MODALITIES FOR MOOD DISORDERS

- **Mood-Stabilizing Agents *(cont.)***
  - **Action:**
    - **Lithium**
      - May modulate the effects of certain neurotransmitters such as norepinephrine, serotonin, dopamine, glutamate, and GABA, thereby stabilizing symptoms associated with bipolar disorder
  - **The action of anticonvulsants, verapamil, and atypical antipsychotics in the treatment of bipolar disorder is not fully understood.**

CLIENT/FAMILY EDUCATION

- Side effects
  - Monitor for side effects of **lithium:**
    - Drowsiness, dizziness, headache
    - Dry mouth, thirst, GI upset, nausea/vomiting
    - Fine hand tremors
    - Hypotension, arrhythmias, pulse irregularities
    - Polyuria, dehydration
    - Weight gain
    - Potential for toxicity

CLIENT/FAMILY EDUCATION *(CONT.)*

- Lithium toxicity
  - Therapeutic range
    - 1.0 to 1.5 mEq/L (acute mania)
    - 0.6 to 1.2 mEq/L (maintenance)
  - Initial symptoms of toxicity include
    - Blurred vision, ataxia, tinnitus, persistent nausea and vomiting, and severe diarrhea
  - Ensure that client consumes adequate sodium and fluid in diet

CLIENT/FAMILY EDUCATION *(CONT.)*

- Side effects *(cont.)*
  - Monitor for side effects of **anticonvulsants** (eg,valporic acid,carbamazepine):
    - Nausea and vomiting
    - Drowsiness, dizziness
    - Blood dyscrasias
    - Prolonged bleeding time (with valproic acid)
    - Decreased efficacy of oral contraceptives (with topiramate)
    - Risk of suicide with all antiepileptic drugs (FDA warning, December 2008)

CLIENT/FAMILY EDUCATION *(CONT.)*

- Side effects *(cont.)*
  - Monitor for side effects of **verapamil:**
    - Drowsiness, dizziness
    - Hypotension, bradycardia
    - Nausea
    - Constipation

CLIENT/FAMILY EDUCATION *(CONT.)*

- Side effects *(cont.)*
  - Monitor for side effects of **antipsychotics:**
    - Drowsiness, dizziness
    - Dry mouth, constipation
    - Increased appetite, weight gain
    - Extrapyramidal symptoms
    - Hyperglycemia and diabetes

EXTRAPYRAMIDAL MOTOR DISTURBANCES

Due to *blockade of D_2 receptors in* Corpus striatum

Early reactions: 1. Dystonia (within days) (spasm of muscle s cause twisting or abnormal postures)

2. Parkinsonism,

3. Akathisia (weeks) (hypersensitivity of the receptor) (patient cannot sit still)

***Treatment*: Centrally acting anticholinergics.**

4. Neuroleptic malignant syndrome

(extreme rigidity, fever & unstable BP)

***Treatment*: Stop drug, give dantrolene (muscle relexant)**

Late reactions

1. Tardive dyskinesia *is due to* upregulation of receptors.(months to occur) it may be irreversible.

- **No effective treatment.**
- ***Prevention*: Prescribe at lowest doses possible.**

Observe drug free holidays.

switch to atypical drug.

CLIENT/FAMILY EDUCATION *(CONT.)*

- **Lithium**
  - Take the medication regularly.
  - Do not skimp on dietary sodium.
  - Drink 6 to 8 glasses of water each day.
  - Notify physician if vomiting or diarrhea occur.
  - Have serum lithium level checked every 1 to 2 months or as advised by physician.

CLIENT/FAMILY EDUCATION *(CONT.)*

- **Lithium *(cont.)***
  - Notify physician if any of the following symptoms occur:
    - Persistent nausea and vomiting
    - Severe diarrhea
    - Ataxia
    - Blurred vision
    - Tinnitus
    - Excessive output of urine
    - Increasing tremors
    - Mental confusion

CLIENT/FAMILY EDUCATION *(CONT.)*

- **Verapamil**
  - Do not discontinue the drug abruptly.
  - Rise slowly from sitting or lying position to prevent sudden drop in blood pressure.
  - Report the following symptoms to physician:
    - Irregular heart beat, chest pain
    - Shortness of breath, pronounced dizziness
    - Swelling of hands and feet
    - Profound mood swings
    - Severe and persistent headache

ANTIPSYCHOTICS
CLIENT/FAMILY EDUCATION *(CONT.)*

- Do not discontinue drug abruptly.
- Use sunblock lotion when outdoors.
- Rise slowly from a sitting or lying position.
- Avoid alcohol and over-the-counter medications.
- Continue to take the medication, even if feeling well and as though it is not needed. Symptoms may return if medication is discontinued.