Lesson 9
Mood Disorders

Introduction

Mood disorders most commonly referred to include those considered under the depression and the bipolar disorder spectrum. Mood disorders are defined as recurrent alteration or disturbance in mood that cause psychological distress and behavioral impairment (Diagnostic Statistical Manual-IV-Text Revision (DSM-IV-TR), 2000). The DSM-IV-TR describes many types of mood disorders including: major depressive disorder, dysthymic disorder, bipolar disorders, mood disorder caused by a general medical condition, substance induced mood disorder and depressive disorder NOS. Within this unit there is a discussion of depression, bipolar disorder and care of the suicidal person. A general description of the main mood disorders and their treatment will be reviewed. Another focus of this unit will be the latest research and evidence based information on mood disorders in the specific populations of youth and the older adult. Included in this unit will be a discussion of the risk factors, assessment guidelines, and nursing care of the suicidal person.

Learning Outcomes

1. Distinguish the key symptoms of major depressive disorder.
2. Distinguish the key symptoms of bipolar disorder.
3. Review the differences (course, etiology, theories, treatment) of the major mood disorders.
4. Apply the nursing process to persons with a mood disorder.
5. Review mood disorders as they relate to youth populations.
6. Review mood disorders in the geriatric population.
7. Review safety issues important in the care of persons with mood disorders.
8. Discuss assessment and nursing care for persons with suicidal tendencies.

Required Readings


**Topic 1: Mood Disorders**

There are a number of mood disorders listed in the DSM IV. The purpose of this lesson is to focus primarily on two of the most common mood disorders: major depression and bipolar disorder. The other disorders of mood are briefly described below.

- **Dysthymic Disorder**
  - Described as a milder chronic form of depression wherein the person suffers with a depressed mood on most days covering a time span of two years or more. During these two years the symptoms they experience are not absent for longer than 2 consecutive months.

- **Mood disorder caused by a general medical condition**
  - A persistent and prominent mood disturbance with either depressed mood, adhedonia or elevated expansive and irritable mood. There is evidence from the assessment that it is a direct result of a medical condition such as cerebral vascular disease or metabolic endocrine or autoimmune diseases.

- **Substance induced mood disorder**
  - A persistent and prominent mood disturbance with either depressed mood, adhedonia or elevated expansive and irritable mood. Evidence exists that either the symptoms developed during or within a month of substance intoxication or withdrawal from alcohol, hallucinogens, and inhalants for example or that medication is the cause of the mood disturbance.

- **Mood Disorder Not Otherwise Specified (NOS):**
  - This is a mood disorder with depressive symptoms that do not meet the criteria for the number of symptoms or duration of the illness episode for major depression.

- **Cyclothymic disorder**
  - Numerous periods of hypomanic episodes and depressive symptoms (that do not meet the criteria for a major depression) that lasts for longer than two years.

- **Bipolar disorder NOS**
  - This disorder has features of bipolar disorder but they do not meet the specific criteria for any of the bipolar disorders.
Major Depressive Disorder (MDD)


William Stryon, renowned American author speaks eloquently and poignantly about his own battle with depression in his book *Darkness Visible*.

In depression this faith in deliverance, in ultimate restoration, is absent. The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come-not in a day, an hour, a month, or a minute. If there is mild relief, one knows that it is only temporary; more pain will follow. It is hopelessness even more than pain that crushes the soul...I had now reached that phase of the disorder where all sense of hope had vanished, along with the idea of futurity; my brain, in thrall to its outlaw hormones, had become less an organ of thought than an instrument registering, minute by minute, varying degrees of its own suffering. The mornings themselves were becoming bad now as I wandered about lethargic, following my synthetic sleep, but afternoons were still worst, beginning at about three o’clock, when I’d feel the horror, like some poisonous fogbank, roll in upon my mind, forcing me to bed. There I would lie for as long as six hours, stuporous and virtually paralyzed, gazing at the ceiling and waiting for that moment of evening when, mysteriously, the crucifixion would ease up just enough to allow me to force down some food and then, like an automaton, seek an hour or two of sleep again. (Styron, 1990, pp. 58-59, 62)

Depression is the one of the oldest and most common psychiatric disorder. To be diagnosed with depression a person must have five or more symptoms from a list of nine described in the DSM-IV-TR, 2000 and at least one symptom must include depressed mood or loss of pleasure. The symptoms must be present for at least two weeks and be a change from previous functioning.

As seen from the list of symptoms depression is a serious mood disorder which requires treatment. It is more than a low mood or normal sadness. It is more than feeling “blue” or “down”. It is all encompassing and profound and those suffering from it frequently feel it will never resolve. Often it is marked by feeling hopeless and even suicidal. It can range from mild to moderate to severe and be present with, or more commonly without, psychosis.
There are a number of reasons why a person can become depressed. Risk factors include:

- having a first degree relative with depression.
- an episode of depression in the past.
- lack of social support.
- substance abuse.
- childbirth.
- a medical condition, stress, grief.
- chemical changes in the brain.

Depression occurs most often in a person’s prime of life, mid-twenties to mid-thirties, women are twice as likely as men to suffer depression, and for them, depression rates peak in early adolescent and adulthood. Health Canada states that here in Canada the lifetime risk for adults having a major depression is somewhere between 7.9 - 8.6 %. In Canada, approximately 5% of men and 10% of women experience clinical depression at some point in their life (Association of Psychologists of Nova Scotia, (APNS), 2004).

If left untreated, major depression can last from 7 to 24 months. Approximately 50% of persons with a major depression will go on to have another and 25% will have recurring depression (Stuart, 2008). Here are some of the symptoms and behavioral findings you may see in a person with a major depression.

- Intense feelings of sadness, hopelessness, guilt and worthlessness
- Social withdrawal from friends and peers
- Loss of interest in activities you normally enjoy
- Inability to experience pleasure
- Trouble with memory and concentration
- Decline in school or work activity
- Weight loss or weight gain without dieting
- Loss of energy
- Fatigue
- Increased or decreased sleep (insomnia, early morning awakening, difficulty initiation)
- Difficulty making a decision
- Anxiety
- Agitation (psychomotor)
- Psychomotor retardation
- Loss of appetite or increased appetite
- Inattention to grooming, poor hygiene
- Increased alcohol or drug abuse
- Increase in suicidal thoughts or plans or suicide attempts
- Excessive or inappropriate guilt
- Hallucinations or delusions
- Diminished or loss of libido
- Somatic complaints
- Excessive crying
- Feeling numb or empty
(Beech, 2003; Canadian Psychiatric Research Foundation (CPRF), 2004; Mood Disorders Society of Canada, 2011).

What Causes Depression?

A number of theories regarding the causes of depression have been discussed in the literature. The majority that abound can be grouped under four main categories; biological, psychodynamic, cognitive, and social. We will look at each of these in closer detail.

Biological Theories

Biological theories state that depression is a matter of having the right balance of neurotransmitters in your brain. In depression these neurotransmitters get out of balance. One dominate biological theory is the deregulation hypothesis which claims there is a problem in the neurotransmitter systems (Stuart, 2008). This includes neurotransmitters that are regulated incorrectly, both in the amount and the availability of them; in how sensitive their receptors are in regions of the brain and in how they balance out with other neurotransmitters. This imbalance can be from a number of reasons such as stress or genetics. It is unclear if the chemical changes cause the depression or the depression causes the chemical changes. Discussion exists about what the proper proportions of those neurotransmitters are, which ones play a role in depression, and even if the same ones cause all depressions in all persons. It is widely researched that the two main neurotransmitters implicated in depression are serotonin and norepinephrine. As well there are likely many neurotransmitters as yet unidentified that play a part in depression. What is clear is that depression does cause abnormalities in many body systems. One need only look at the person who is unable to sleep, eat, and move normally.

Biological theories also assert that depression has a genetic component, which predisposes you to develop depression. Several studies have examined the incidence of depression in twins. Research has indicated that up to two thirds of twins are concordant for MDD if one or both of the biologic parents has been diagnosed with MDD (Keltner, Schwecke & Bostrom, 2007).

What is most important to remember when looking at this theory, or any one theory, is the complexity of depression and persons who suffer with it. Different individuals experience depression in different ways. Persons respond to treatment modalities in unique ways as well. In fact, one third of persons do not respond to any of the available medications on the market.

Psychological Theories

Psychological explanations for depression come from many perspectives such as cognitive, behavioral, and interpersonal views. These explanations state that as children, or in the early stages of development, persons experience a loss of a loved one or the inability to attach or bond with a parent. This loss is carried through life and clouds a person’s view of others and themselves. Some refer to this as Object Loss Theory (Stuart, 2008). Developing a depressive way of being, due to negative interpersonal relationships and the lack of any positive reinforcement or loving care in life, is an explanation that is known as the Interpersonal theory, which also comes under the range of psychological theories (Beech, 2003).
theories persons may feel unworthy or incapable of love and this may lead to feelings of self-loathing, low self esteem or intense inner anger. This anger can be turned against themselves and cause depressive states and depression. Some refer to this as Aggression-Turned –Inward Theory (Stuart, 2008). When a person experiences a loss in their adult years they may associate this with the loss in earlier life with those feelings repeating and intensifying, and in turn causing depression. Treatment for depression under this dimension involves psychodynamic and psychotherapy sessions where childhood trauma, ways of viewing self, and dealing with past losses are discussed. It is hoped that insights into these events and thoughts will provide healing. In a person with severe depression this form of therapy may be impossible to do as the person may not have the cognitive capabilities or the motivation. Medication may, and in fact often is, supplemented with psychotherapy in the treatment of depression. Others believe that focusing on past problems can create even more difficulties for the person.

Cognitive Theories

Another well known and popular theory, made widely known through Beck et al’s work, 1979 (as cited in Stuart, 2008) is that depression is caused by cognitive factors. If a person thinks or perceives all stressful situations as negative this may lead to feelings of depression. So it is not so much what is happening at any given time in the person’s world but how the person perceives or thinks about what is happening that is the issue. According to Beck, 1979, (as cited in Stuart 2008) this cognitively distorted thinking is often rooted in childhood loss where a person experienced a traumatic separation or divorce of parents and subsequently tends to view the world in a negative light, and as an unsafe place where bad things will always happen. This negative thinking causes negative reactions in themselves and others which in turn cause depression. Treatment is based on correcting the negative and distorted thinking. Although reported to work well with depression, for those suffering severe depression, medications may need time to “prepare the mind” before the person is able to focus on and change their distorted thinking. (Keltner et al., 2007).

Social or Situational Theories

These theories assert that depression is cause by stressful life events or situations. Loss of loved ones, job loss, loneliness, or extremely difficult life circumstances like the sudden loss of a child could all be included as stressful life events. These major stresses in life precipitate a depression. This theory emphasizes the importance of the world outside of the person and its role in depression, but it does argue that the experience the person is having from the stressful life issues can be internalized into the person’s consciousness. If the person attempts to cope or respond to the situation by accepting or trying to improve the circumstance, and is in turn met with failure, they may begin to feel helpless and overwhelmed. This increases the risk for developing depression.

Another way to visualize the causes of depression and their interrelatedness is by looking at the chart below.
So, what about treatment?

Depression is treatable. It can be successfully treated with a combination of medications and psychotherapy. Research shows the most successful treatment for depression is a combination of both medication and psychotherapy. (Antai-Otong, 2004) Some depressions also can be treated quite well without medication. It is also noted that psychological treatments such as behavioral, cognitive, and interpersonal therapy have less drop out rates of treatment; 10% in psychological therapies compared to 30% in drug treatment. Similarly, cognitive therapy reveals evidence of a lower drop out rate compared to drug therapy (APNS, 2004). Interventions such as exercise, healthy active living, dealing with negative thinking effectively, talking openly, and working through problems are all effective strategies to combat depression.

Ian Beech (2003) states; “The nursing care of someone experiencing depression is a skilled activity that is neither medicine nor psychotherapy, but might take from these and other disciplines to help people” (p. 223).

It is important to note that as a nurse assessing a person with a mood disorder you need to be mindful of assessing both symptoms of depression and mania regardless of the current presenting type. Past histories of hypomania or depressions give important diagnostic clues. A
person may have never been asked before about history and therefore gone unrecognized. A thorough assessment is always required.

Your text book covers the nursing management of persons who have a depressive disorder in detail.


With treatment options under these domains in mind, review the biopsychosocial interventions that are presented in your text.

**Safety Issues with Depression**

**Suicide**

It is well documented that 90% of persons who died by suicide had a mental illness. In depression the estimated life time rate of suicide is between 10-15% (Keltner et al., 2007). Autopsy studies done on persons who completed suicide show the prevalence of depression ranges from 30% to 87% (Foster, Gillespie, McClelland, & Patterson, 1999). In other studies it has been shown that roughly 50% of person who completed suicide were suffering from a major depression at the time, whether it was diagnosed or not. Suicide is a real risk with persons who have depression and must always be assessed for in this population. Suicide risk assessment and subsequent intervention for those with depression must happen on a daily basis while the person is under your care. Special attention should be paid to those persons who are on antidepressants and their energy has returned but their mood has not lifted, thereby enabling them to have the ability to act on their suicidal thoughts.

Areas important to assess regarding suicide in the person who is depressed include; the person`s risk factors for suicide; the person’s protective factors against suicide; the person’s suicidal thoughts (the content, intensity, frequency and duration); the person’s suicidal plan (SLAP, specificity, lethality, access to lethal means, and proximity of rescue). Plans for ensuring the safety of the person at risk for suicide is paramount, whether that means constant observation, close observation, and/or frequent re-assessment. Talking to the person openly and honestly about their suicidal thoughts, intent, and plan is very important. This will not “put the idea in their head”. In fact, it often gives the person permission and relief to discuss a topic they may feel much shame and angst about. Being available to listen to the person’s pain with empathy and concern, without trying to “fix it”, is an intervention nurses can do with the person who is depressed and considering suicide.

*More information on suicide will be discussed later in the lesson.*
Depression with postpartum Onset

A depressive episode lasting longer than 2 weeks and beginning within a 4 week period after the birth of a child, although it can start later. The incidence of postpartum depression has been reported to be 13 – 15%. It is considered to be a dangerous depression in that it causes misery and robs women of time with their infants (Wylie, Martin, Marland, Martin, & Rankin 2011).

Postpartum depression sometimes gets lumped under a variety of post partum disorders and postpartum mood symptoms. These include maternity blues or the baby blues, postpartum panic disorder, postpartum obsessive-compulsive disorder, postpartum bipolar II disorder, postpartum posttraumatic stress disorder, postpartum psychosis (Beck, 2006). It is postpartum psychosis which is the most serious of the spectrum of postpartum disorders and the one which demands an extra focus on safety.

Postpartum psychosis is a psychiatric emergency that warrants immediate hospitalization and treatment. Mothers with psychosis are at times a danger to themselves and to their children, and if not hospitalized should be in the care of a responsible adult 24 hours a day. They should never be left alone. Postpartum psychosis is associated with high suicide and infanticide rates. The good news is that this more rare form of postpartum mood disorder has a low incidence rate. Approximately one to two postpartum women out of 1000 will develop the disorder, or well under 1% of the population (Beck, 2006). This disorder may include symptoms of postpartum depression but characteristically psychosis is present and delusion and/or hallucinations are evident. Often these delusions are centered on the infant, such as uncommon concern over the babies’ health or that the baby is possessed by Satan. Command hallucinations to kill the infant can be present which adds to the urgent need for treatment and seriousness of the disorder. Other symptoms these moms may experience include extreme agitation, confusion, inability to eat or sleep, rapid mood swings and exhilaration.

Often moms will not tell you specifically that they are suffering. The belief that all new moms should be happy sets up a stigma that can cause the mom to feel ashamed about disclosing their unhappiness. Be alert to assess any mother in the early postpartum period and up to one year postpartum who presents with depressive symptoms and or psychosis. Knowing your risk factors and screening for them with specifically developed tools and inventories for women who may develop postpartum depression is a valuable skill if you are working with this population. (Beck, 2006)

Other areas of safety in regards to caring for the person with depression include:

- Serotonin Syndrome
- Overdoses with Trycyclic antidepressants (TCA)
- MAOI’s hypertensive crisis
- Toxicity with MAOI’s and TCA’s
Children with Depression

Depression in youth is a sad reality in today’s society. It is especially difficult and heartbreaking to see a young person suffer with such a debilitating disorder during what should be the most carefree and innocent time in their life. Statistics show depression affects up to 8% of adolescent, but can also show up in children as well. If a young person has a parent or a sibling with depression they have a 15% chance of also becoming depressed, and girls with a mother who has depression have a 40% risk of being depressed. The lifetime prevalence of major depression among adolescents is between 15-20% (Boydston, 2011). In recent years there has been an increase in the reporting of depressive symptoms among young people but despite this, depression often goes undiagnosed in youth. This could be partly due to their symptoms appearing to others as the “normal” moodiness and irritability of adolescence (CPRF, 2004).

There is a growing prevalence of mood disorders, as well as anxiety and suicide in this population. It is very important to ensure that youth are viewed from a holistic perspective; to not just assist and care for their mental health issues but to help them in their personhood as teens make the transition from child to adult. It is easy for youth to fall through the cracks during this transition. Therefore there needs to be a seamless transition from youth to adult services for this population, and from hospital-based to community settings for care. This population may first be diagnosed with depression in their teens but quite likely could end up having to deal with a recurrent depression into adulthood. (Canadian Collaborative Mental Health Initiative, 2006).

Untreated depression in adolescents has been noted to be associated with the following problems:

- School drop out
- Teen pregnancy
- Substance abuse
- Risky sexual behavior
- Risk for sexually transmitted disease
- Suicide

Risk factors for major depression in teens include:

- Family history of depression in a close relative
- A previous depression
- History of anxiety disorder or ADHD
- Losses early in life
- Learning difficulties
- Dysfunctional family or conflict with caregiver
- Problems with peers
- Academic problems
- Negative interpretation of life events
- Negative coping style
- Chronic illness
Lesson 9

- Cigarette smoking
- Hormonal changes due to puberty

(CPRF, 2004, Boydston, 2011)

Some of the warning signs, symptoms and behaviors you may see in a young person who is depressed include:

- Sad or anxious mood lasting more than 2 weeks
- Irritability or crankiness
- Agitation, combativeness or aggression
- Loss of interest in sports, video games, or activities with friends
- Decrease in school grades, missed assignments, absenteeism
- Persistent boredom
- Talk of running away from home or attempts to do so
- Wanting to stay home
- Social isolation
- Staying up watching TV late at night, refusal to wake in am
- Failure to gain weight as normal
- Anorexia or bulimia
- Frequent complaints of physical illness such as stomachache and headache
- Preoccupation with nihilistic song lyrics
- Overly quiet, not wanting to talk to anyone
- Voiced hopelessness and negative outlook on life
- Loss of confidence
- Sleep disturbance
- Lack of energy or excessive fatigue
- Addictive behaviors such as smoking, alcohol and/or drug abuse
- Suicidal writing or notes, or suicidal actions and gestures

Treatment

Psychotherapy, cognitive behavioral therapy (CBT), and interpersonal therapy (IPT) have all been found to reduce the symptoms of mild to moderate depression in young people. Psychotherapy is at times a first line treatment for youth with depression, and this population responds well to it. It is important to keep in mind as well that response rates to these types of treatment are very much tied to the type and severity of the depressive illness. CBT and IPT may include offering the person and their family education about depression. Having the person self monitor their mood and thoughts. Teaching the person to focus on acquiring skills such as realistic thinking to replace the depressive and negative thinking, problem solving and coming up with better solutions and coping skills, and setting realistic goals that can be reached. Lifestyle changes also help to elevate depression such as activity and exercise which create mood enhancing hormones in the body. A healthy diet and staying clear of drug and alcohol is also important. Massage, relaxation therapy, and holistic and natural therapies are also types of treatment used in mood disorders. It is imperative that the family and individual be informed about the best choices and the most effective ones that will work for each unique person seeking treatment.
For youth and teenagers struggling with a severe depression medication may be the answer and is often the first line of treatment. Up to 50% of teens diagnosed with depression are prescribed antidepressants if it is severe and goes on for a long time. Recent research has shown that in youth with moderate to severe depression antidepressants work best if combined with cognitive behavioral therapy compared to either treatment alone, (Bujoreanu, Benhayon, Szigethy, 2011). Selective Serotonin Reuptake Inhibitors (SSRI’s) are the drugs of first choice when medication is the therapy option. Controversy and conflicting results exists in the literature regarding the risk for suicide in young people using SSRI’s. Studies first came out in England stating that for many of the SSRI’s the benefits did not outweigh the risks. Health Canada issued a warning in May of 2004 regarding the behavioral and emotional changes, including risk for self harm, in persons under 18 taking these medications. Risk is highest during the initial treatment with SSRI’s, especially in the first 10 to 30 days. The nurse should watch for and teach the parents to observe and report any symptoms such as increased suicidal ideation, impulsivity, aggression or anxiety (Bujoreanu, et al, 2011; Health Canada, 2004).

**Depression in the older adult**

Depression is the most common mental health disorder in the older adult. It is also the most treatable. Depression in the older person can be caused by genetic factors, psychosocial stress, medications, and physiological effects from diseases. In the community setting prevalence of depression ranges from 5-17% of persons. In an acute care hospital 10% of older adult populations are diagnosed with major depression and need treatment. Up to 40% present with some depressive symptoms. Medications that the older person is more likely to be prescribed can cause depression. These include antihypertensive, cardiovascular agents, analgesics, and sedatives to name a few. As well, an older person who may have a specific medical condition is also more likely to become depressed. Some of these conditions include cancer, coronary artery disease, Parkinson’s, dementia, stroke and diabetes. All of these factors must be brought to mind when assessing for depression in the older person (Miller, 2012).

Some risk factors for depression the older adult include:

- Previous depression
- Family history of depression
- Prior suicide attempts
- Female
- Recent loss of a spouse
- Medical co-morbidity
- Little social support
- Stressful life event, like death of someone close or divorce

Older persons often experience more than one of the risk factors for depression simultaneously. Older persons who care for their relatives or companions who have dementia are very vulnerable to becoming depressed as well. Detecting depression in older persons may be more of a challenge and numerous factors may interfere in uncovering it. The older person’s views, attitudes and knowledge on depression may make it hard for them to seek help; they may present with somatic complaints instead of mood symptoms, or they may fear antidepressants.
Depression in the older adult may manifest differently than in the general population. Often sad mood is not the prominent symptom. Here are some symptoms to watch for in the older adult:

- Somatic complaints rather than mood symptoms dominate
- Deny a sad mood
- Apathy
- Withdrawal
- Weight loss
- Sleep disturbance
- Loss of self esteem
- Inability to concentrate with impairment of memory
- Feelings of guilt and worthlessness are less common

(Miller, 2012)

In a study done by Ugarriza, (2002) older women were asked about their experience with depression. The majority stated their depression was a result of changes in their health, such as illness and loss of function, and the second most common reason was death of a loved one - usually a husband. These women opted for treatment for their depression, ranging from medications, ECT, supportive care and psychotherapies. The author concluded treatment centers in community setting such as churches, social and civic institutions and the like, where the focus of treatment could be on older women’s loss of role functioning and health, would be an ideal option for community mental health nurses to practice and offer consultation and care.

As one common treatment for depression in the elderly includes the use of SSRI's, as they have a greater safety margin than other antidepressant medications. The common side effects of SSRI's that usually subside with a few weeks include sedation, agitation, GI upset, sexual dysfunction, and weight loss. One side effect that is noted more often in the elderly is that of hyponatremia. This is a decrease of sodium in the blood and early symptoms include thirst, anorexia, muscle cramps, headaches, and mild lethargy. The risk of hyponatremia occurs most often after the first month of treatment (Bowen, 2009).

**Bipolar Disorders**


“I suffered tremendous loss because of my reluctance to come forward for help and not recognizing what was happening to me. I was very lonely, a long tunnel of darkness, trying to manage my symptoms on my own was terrifying. I was in a very very dark place, finally, my mind let go of me. It was never talked about in those days and barely recognized, no matter what sector of society you lived in. And so, in the public eye and under public scrutiny, I tried to manage as best I could. I was forced to cope with these mood swings in secret. They thought I
Lesson 9

Margaret Trudeau speaks to the media in May, 2006 about her bipolar illness. (CanWest News Service; Ottawa Citizen, 2006; Globe and Mail, 2006)

Bipolar disorder or bipolar affective disorder (commonly known in the past as manic-depression) is a chronic recurrent mood disorder where a person experiences unusual shifts in moods, energy, and ability to function. Moods can vary from deep depression to extreme euphoria and mania. Bipolar disorder affects approximately 3% of the population of Canada, and the onset tends to be in late adolescents or early 20’s, with the average age of onset around 28. It has become more commonly recognized that some persons develop bipolar in childhood, although the actual numbers are unknown. Bipolar symptoms are more severe than the normal ups and downs of mood, and can swing from serious depression to excessive highs such as mania or hypomania. For 90% of the persons who have a bipolar illness the symptoms will reoccur. The disorder strikes men and women equally, however, it is often seen that with men the illness first manifests as a manic episode and in women it is first seen as depression. Some studies show that bipolar affects persons of a higher socioeconomic status more frequently. The cause of Bipolar is unknown; there is no test and no cure. Generally most of the literature attributes cause to genetics. Those persons with a parent who has bipolar illness have a 25% chance of developing it as well. Those persons with both parents having bipolar illness see the rate go up to 50-75%. (CPRF, 2004; Keltner et al., 2007; Stuart, 2008; Organization for Bipolar Affective Disorders (OBAD), 2005)

The course of Bipolar I involves recurrent bouts of depression and mania. If a person never develops mania but has more than one episode of hypomania and depression then they have Bipolar II. Between episodes most people will have periods of normal mood and no symptoms, however, one third of persons with bipolar will have residual symptoms and a small percentage will have persistent chronic symptoms despite treatment.

Without treatment the course of bipolar illness tends to worsen and over time a person may have more severe episodes of both mania and depression and more frequent rapid cycling than during the early start of the illness. (National Institute of Mental Health [NIMH], 2001) Other problems often seen in conjunction with bipolar illness are marital conflict, chronic unemployment, a 75-80% risk of alcohol or drug abuse, and suicide.

Bipolar disorder 1 and Bipolar II disorders each have a number of separate criteria sets. To see a synopsis of this criteria refer to your text book. Below is a visual representation comparing the differences in various bipolar disorders on a mood continuum. (Keltner et al., 2007)
Bipolar I disorder is characterized by periods of major depression, mania and mixed episodes combined. It is defined by the person having more than one manic episode.

Mania is a period of abnormally and persistently elevated, irritable or expansive mood, lasting more than one week. Here are some of the symptoms and behavioral characteristics you may see in a person who is experiencing mania.

- Inflated self-esteem
- Grandiosity
- Increased energy
- Decreased need for sleep
- Talkative
- Flight of ideas
- racing thoughts
- racing thoughts
- poor judgment
- overestimation of abilities
- Distractibility
- Impulsivity
- Increase in goal directed activity
- Psychomotor agitation
- Increased sex drive
- Increased use of alcohol and drugs
- Hypersensitivity to criticism
- Fanciful ideas
- Unrealistic schemes
- Increased spending
- Lack of shame or guilt
- Involvement in pleasurable activities
- Anger
- Anorexia
- Hallucination and delusions
- Suicidal thinking
- Flamboyant dress and make-up
- Rapid mood changes
- Intrusive, demanding, domineering
- Resistive to efforts for treatment

One can see from this list that mania can cause a number of problems in a family and in a person’s own life. Often the onset of mania is a time described as wonderful - a great feeling that the person does not want to end. But as the mania progresses the symptoms and their manifestation take the person down a road where the consequences for them and their family are great.

One such problem is the cost of bipolar illness to the person, their families, and to society. Baldassano (2004) discusses:

- Lifetime costs of bipolar illness ranged from 24-40 billion dollars including lost wages, caregiver costs, hospitalization costs and lost productivity due to suicide.

- In 1990, persons with bipolar disorder accounted for 289 million days of absenteeism.

- For those who were hospitalized, six months after a manic episode 43% remained unemployed. And of the 80% of those who recovered symptomatically, only 20% were functioning at expected levels.

- Other hidden costs may include personal financial burdens after a person has spent excessively during a manic phase, as well as, the costs of substance abuse and reckless or fast driving.

- The ultimate cost of course is death by suicide, 25-50% of persons with bipolar will attempt suicide and sadly between 15-19% will actually go on to complete suicide.
“The World Health Organization identified bipolar disorder as the world’s sixth leading cause of disability-adjusted life years among people aged 15-4 years” (Yatham, et al, 2005, pg. 7).

**Causes of Bipolar Illness**

**Biological**

Neurotransmitter and structural hypothesis: Like with depression, it is surmised that biology plays a part in bipolar disorder. Different researchers have claimed that manic episodes seem to be related to the excessive quantities of dopamine, norepinephrine, and serotonin, and the imbalances between the cholinergic and noradrenergic systems (Keltner et al., 2007; Austin & Boyd 2010). Some studies show that biological changes such as more lesions in certain areas of the brains of those with bipolar illness may be a cause (Keltner et al., 2007). A recent study has focused on mood disorders being related on the spectrum of chromosome 22. This presents much future possibility for observation and study (OBAD, 2005). The theories of Sensitization and Kindling as well as sleep disturbances are described in your text. All come under a general heading of biological theories. It also seems very clear from the literature that genetics plays a role in the cause of bipolar disorder. Having an identical twin with bipolar disorder gives you a 40-70% chance of having the disorder yourself. This tell us that the etiology of bipolar disorder is not just about biology, for identical twins share the same gene’s and if bipolar was “all in the gene’s” then both twins would always be affected equally. Many studies quote conflicting numbers regarding the risk of having bipolar if a first degree relative has it, with statistics ranging from 5-30% if one parent has bipolar, to 50-75% if both parents have bipolar. (Keltner et al., 2007; & NIMH, 2001) Yatham et al, 2005 claims an 8-18 times increase in developing bipolar II disorder if you have a positive family history among a first degree relative compared to those with no family history. When all the evidence is in it becomes clear that genetics does play a role in developing this disorder.

**Psychological theories**

In the past many developmental theories posited that experiencing dysfunction in the family in the early stages of life sets one up for developing mania later in life. The conflicts between independence and dependence and the opposite and conflicting events of a mother’s approval/dissapproval set in the context of broken down family dynamics has been determined as a factor causing manic behaviour. Although some theories may seem more believable than others many clinicians today believe family dynamics play a key role in the development of bipolar. (Keltner et al., 2007) Family dynamics may indeed unmask or trigger bipolar disorder but does not on its own cause the disorder.

Another theory states that mania is a defense or denial against depression.
Treatment

Bipolar disorder is a long term illness and there is no cure, however, it can be effectively treated. The person with bipolar illness requires a long term multidisciplinary management plan focusing on medication, psychoeducational, psychosocial and psychotherapeutic modalities. It is important that persons with bipolar disorders stay on their treatment regime, even when they are well, to prevent a relapse or a worsening recurrent episode. Staying on treatment is strongly recommended and indicated. Even persons with severe mood swings can be stabilized if they receive the proper treatment. Most often, treatment consists of using a mood stabilizer such as lithium or an antiepileptic medication. Milieu management, cognitive psychotherapeutic management, behavioral therapy, and social rhythm therapy, which focus on regular routines of eating sleeping and working, have all been used in the treatment of bipolar illness. Psychoeducation and psychosocial treatment have proven effective as well. Treatment works best if it is continuous rather than sporadic. Your text covers treatment and nursing management of the person with bipolar disorder very well.


Caring for the family

Family members can often be bewildered by their loved one who is ill and acting in a manner not typical. They are often left totally devastated when their loved one has been diagnosed with bipolar illness. Spouses can be overwhelmed by financial concerns or relationship problems brought on secondary to the person’s behavior. These problems can then affect every aspect of family life, making for a strained relationship with the person who is already suffering with a bipolar illness. In one study which looked at the burden experienced by family members and caregivers dealing with a loved one with bipolar disorder, 7% said they had moderate to great distress in at least one burden domain (Baldassano, 2004). Also, they reported poorer physical health, less activity and greater use of health services compared to those who did not have a family member with bipolar (Baldassano, 2004). It has been shown that caregiver or family burden has a negative clinical outcome, therefore, in order to work for a more positive outcome for all involved we must direct our attention to the family as well as the person diagnosed.

One effective way to cope with this burden felt by families is through psychoeducation. Psychoeducation for family members reduces the perception of burden significantly. Family focused therapy has been shown to reduce emotional burdens for the family and for the person who is ill. The role of the therapist is to facilitate communication and provide skills for family members to use that are unique to their situation. Family therapy can help alleviate stress and restore a sense of normalcy through education and support. Not surprisingly, in a one year follow up with families who had the therapy, there was noted more positive nonverbal interaction and less hostile verbal interactions with their loved ones. Also, for the person with
bipolar who attended family therapy, they showed less mood disordered symptoms and greater adherence to their medication (Baldassano, 2004; OBAD, 2005).

Self-help support groups for persons with bipolar and their families are very helpful and can be excellent resources. Two well known groups include the National Alliance for the mentally Ill (NAMI) and The Depression and Bipolar Support Alliance (DBSA). They can be accessed online and are based in America. Here in Canada we have the Canadian Mental Health Association (CMHA) and many other excellent online resources for person with bipolar and their families.

**Safety Issues in Bipolar disorder**

**Suicide**

The risk of suicide for those with bipolar illness is real. The rates of suicide attempts for those with this illness are estimated between 25-50%, which translates to 15-20 times greater than that of the general population. And the lifetime risk of death by suicide with people who suffer from bipolar disorder is estimated between 15 and 19% (Baldassano, 2004, Sajatovic, 2002, Yatham, 2005). You may remember from your previous lesson on assessing risk for suicide that roughly half of those persons who complete suicide have a mood disorder. Most suicides in persons with bipolar take place during the depressive phase, but it can also happen in mixed states. Suicidal thoughts and attempts tend to happen more in the manic phase. Risk for suicide appears to be higher if the person has a co-morbid problem such as substance abuse or during the earlier course of the illness. (Baldassano, 2004, NIMH, 2001) Do not be afraid to ask the person if they are considering suicide. Keep the lines of communication open, this is especially important for the family members as well. Often in a depressed state or a manic state the person’s judgment and thinking are impaired and they may see no other option other than suicide. It is important to talk about this and seek help if this is the case. Always take every threat of suicide seriously.

Be aware also of the different age groups and how risk affects them. Assess for risk factors, being mindful of those that place youth at a higher risk. If the young person is presenting with suicidal behaviors or intent and there are risk factors present, then a plan must be put in place to evaluate if they are safe and what level of support they would require to maintain that safety. Support from the family is essential as well. In children with bipolar illness there is a high risk of suicidal ideation, intent, attempts, and plans during the depressed or mixed episode and when psychotic. Other factors that place a young person at higher risk are co-morbid disruptive disorders, impulsivity, or substance abuse. (Kowatch, Fristad, Birmaher, Wagner, Findling, Hellander et al, 2005)

The older adult population may be at a high risk of suicide as well. Sajatovic (2002) writes “suicide in elderly bipolar individuals has not been studied prospectively. The observed mortality rate for elderly bipolar patients appears greater than the base rate for this age group in the community, and the mortality rate of geriatric manic patients appears to exceed that of geriatric depressed patients” (P.130).
Other possible safety issues to be aware and alert for in the person with bipolar illness include:

- Lithium Toxicity
- Rash with Lamotrigine
- Drug interactions
- Risk of hurting self or others in manic episode

**Bipolar in children**


At one time it was thought that bipolar disorder in children was rare. Today it has become increasingly evident that indeed bipolar commonly presents in childhood and the adolescent years. However, there is much debate about the diagnosis and course of the disorder in children and adolescents. The trouble with bipolar in children is that it is quite difficult to diagnosis. Symptoms do not often present the same, and other disorders often co-exist or are confused with bipolar such as attention deficit hyperactivity disorder (ADHD), conduct disorder, or oppositional defiant disorder.

When looking at the symptoms of mania in the DSM-IV-TR, (2000) it is evident that difficulty exists when applying the criteria to children and adolescents. Many young persons have frequent daily mood swings which have been occurring for months or years, so identifying when the episode began or ended is difficult. As well Kowatch et al (2005) states “Children with BPDs often present with a mixed dysphoric picture characterized by frequent short periods of intense mood lability and irritability rather than classic mania” (p.214).

Because many factors can cloud the presentation and make diagnosis difficult a thorough assessment is a must. Ideally this assessment should gather information from parents, teachers, and key persons from the school systems such as resource teachers and coaches. Siblings and the young person themselves should also be interviewed. Information on a timeline of how long the symptoms have been present, when they started, and their duration is valuable to have. As well, a mood chart is an important tool to have the child or parents fill out prior to coming for assessment. Also, any medical records, treatments and laboratory tests should be reviewed. All this information can be used to help get a clear picture of the person’s symptoms. The assessment and interview is best performed by a clinician who is experienced in mood disorders and who works with children and adolescents (Kowatch et al, 2005).

What is clear is that bipolar disorder in childhood and adolescence impacts significantly on the person’s psychological and psychosocial development. Early detection and treatment are important so the person can return to successful functioning in their families’, school, and peer groups. Early detection and treatment and eliminating or reducing the many negative outcomes that are seen with this disorder is the goal (Singh, 2008).
Bipolar in the older adult

The changing demographics of an aging population as well as higher standards in the management and treatment of bipolar illness has led to a growing awareness of bipolar disorder in the older adult. Bipolar in the older adult has been described as a significant public health problem that causes functional impairment and increased use of the health care system. In the older adult, bipolar disorder accounts for 5-19% of mood disorder presentations. This is probably underestimated due to historically poor reporting from non hospital base facilities that treat this population as well as the fact that older adult tends to under report psychiatric symptoms. Some reports in the literature say that mania decreases with age while others state the prevalence of mania in the older adult is as high as 19%. Still other reports show an increase in new onset mania in the older adult. (Sajatovic, 2002)

Mania in the older adult population may look different depending on gender; women tend to peak with mania in their 30’s with a smaller increase in their late forties. Men, may peak again in their 80’s or 90’s.

Factors of importance in bipolar illness in the older adult

Age of onset

For the older adult, mania may be experienced for the first time; it may change from a life long illness of depression to a manic presentation, or be long standing with the mania having developed earlier in adulthood. (Sajatovic, 2005). Luggen (2005) suggests that if the first episode appears late in life than there is a 70% chance there is some neurological problem.

Symptoms

The presentation of symptoms in late onset bipolar illness is generally different from early onset in the following ways:

- Manic symptoms are fewer and milder
- Mixed mania, dysphoric and agitated states
- Cognitive symptoms that mimic dementia
- Lower familiar rate
- More medical and neurological co-morbidity
- May be caused by organic or neurologic causes
- Persecutory delusions that are non mood congruent
- Irritable behavioral characteristics
- More treatment resistant
- Higher rate of mortality

(Luggen, 2005)
Secondary mania

Mania caused by medical or neurologic factors, such as right sided central nervous system lesions, occurs more often in the older adult and is under recognized and under treated in the clinical setting. As a result this condition is not well investigated as there is little data available. Secondary mania is more difficult to treat and does not respond as well to lithium. The older adults’ presentation of mania such as confusion, disorientation and distractibility is often easily mistaken as dementia and delirium, so bipolar is often not diagnosed or treated (Sarajovic, 2005).

Co-morbidity

In the older adult it is unclear how common co-morbidity with other disorders is, but if present, it complicates the picture and could be made worse by medical and physical problems. Medical co-morbidity is more common in the older adult with bipolar, especially stroke, CNS lesions, diabetes, and adverse drug reactions. Some reports suggest cognitive impairment and dementia is present at a greater rate in the older adult with bipolar compared to those without (Sarajovic, 2005).

Response to treatment

Compared to the younger person, medication is likely to be started lower and titrated slower in the older person. They are also more likely to be bothered by side effects associated with their medications and to be on medications for other medical problems, thus increasing the likelihood of drug-drug interactions. In persons over the age of 70, Lithium is more likely to cause side effects, therefore, anticonvulsants, specifically Valproate and Carbamazapine are more commonly used with older adults with bipolar. In this population there is a lack of research on response to treatment in “real world” settings where medical problems, medication, and psychosocial issues related to this age complicate and affect treatment response. (Sarajovic, 2005)

Psychotherapeutic treatments such as CBT, family therapy and group therapy appear to be helpful with the older adult; however, it can be complicated by the person’s cognitive, physical, and psychological processes.

Instructional Activity # 1

You are working on a psychiatric unit and have been assigned a person with bipolar disorder. The psychiatrist has just ordered lithium treatment for this person and is about to have his first dose.
Topic 2: Care of the Suicidal Person

Suicide or completed suicide is defined as the act of intentionally ending one’s life. This purposeful taking of one’s life arouses many intense and complex feelings in others. A suicide attempt includes all willful, self-inflicted life threatening attempts that has not resulted in death. Suicidal ideation means that a person is thinking about self harm and may voice the thoughts which can be considered as a suicidal threat. A suicidal gesture includes a self-directed harmful action that does not result in injury or harm. A person who makes a suicidal gesture usually does not intend to end his/her life and does not expect to die as a result of the action. Generally, however, this behavior was carried out with the intention to convince others of the wish to die. All attempts, threats or gestures should be taken seriously. (Fortinash & Holoday Worret, 2011)

Suicide occurs in all age groups, social classes, and cultures. Suicide is the 5th leading cause of death in Canada. Statistics Canada (2007) indicate that suicide is the leading cause of death for males aged 25 – 29 years and 40 – 49 years and for females aged 30 – 34 years. Males tend to have higher rates of completed suicide (three times that of females) and is it theorized that one reason might be because the method chosen is more lethal. Females on the other hand are four times more likely to attempt suicide than males.

Suicide is the second leading cause of death for ages 10 – 24 years. More teenagers die from suicide than any other causes. As reported by the Public Health Agency of Canada (2000) suicide is the 2nd leading cause of death for males aged 15 – 24 years.

Suicide is also high among older adults with the ratio of attempts to completion being 4:1. The statistics for Aboriginal people indicate that it is the leading cause of death for those up to the age 44 years. It should also be noted that in all age groups many that attempt and/or complete
suicide have a psychiatric disorder. This however does not mean that all persons who attempt or commit suicide have a mental illness.

**Etiology**

There are three main theoretical perspectives as to the cause of suicidal behavior. These include biologic, psychologic, and sociologic factors.

- A synopsis of the biologic factors includes:
  - The neurotransmitters, mainly serotonin, dopamine, norepinephrine, and GABA, are linked to emotional responses
  - Serotonin plays a major part in the regulation of mood and influences the occurrence of depression and suicide
  - Genetic influences have been found as researchers believe they have found a specific gene that predisposes a person to suicide
  - The dimensions of depression are correlated with changes in specific brain structure.

- A synopsis of psychologic factors includes:
  - Self-directed aggression
  - Hopelessness
  - Unresolved interpersonal conflicts
  - Negativistic thinking patterns
  - A reduction in positive reinforcement
  - Difficulty with problem solving

- A synopsis of sociologic factors includes:
  - Isolation and alienation from social groups
  - Biopsychosocial influences.

  (Fortinash & Holoday Worret, 2012, p. 505)

While these factors are studied in isolation it is believed that the convergence of the biologic, psychologic, sociologic and spiritual factors can be directly linked to suicidal behavior. Review Figure 19.1, p. 347 in your text to see the depicted interrelationship among these four perspectives.

**Risk Factors**

When completing a comprehensive assessment of a person who may have depression or suicidal intentions identified risk factors can lead you to explore suicidal ideation in depth. These factors are:

1. Age. Persons aged 15 – 24 years and older adults who are 65 and older with those over 85 being more vulnerable.

2. Sex. Men have a greater incidence for completed suicides while women have a greater incidence of attempts.
3. Race and ethnicity. Suicide rates for whites is higher than non-whites. However Aboriginal males, particularly younger males are a high risk.

4. Physical and emotional symptoms. High indicators are serious depression, significant changes in weight, serious sleep disturbances, extreme fatigue and loss of energy, anger, self-deprecation, feelings of hopelessness, preoccupation with themes of death and dying.

5. Suicide plan. A clear plan, including the lethality of the planned method indicates a high risk.

6. History of previous attempts. The majority of people who have completed suicides have attempted before.

7. Social supports and resources. A real or perceived lack of support increases the risk.

8. Recent losses. Real or perceived losses, separations, and abandonment are considered as high risk factors. Included in this factor is unresolved grief.

9. Medical problems. People who have terminal illnesses or suffer from painful and debilitating conditions are a particular concern for suicide risk.

10. Alcohol and other drugs. Drugs lower inhibitions and increase depression.


**Assessment Guide**

In order to provide the best nursing care and ensure the safety for persons who are suicidal comprehensive assessments need to be completed. Not just one problem area necessarily indicates a person is suicidal but a combination of factors should be considered. However a nurse should not ignore the one problem area.

For a complete discussion on what is involved in this assessment:


Other components of this assessment include:

- Observable behavior of the person. A calm person may be highly suicidal whereas an agitated person is not always in danger. Decreased agitation, restlessness, and a brighter affect in the calm person may signal an intended attempt. Some persons may show withdrawal, apathy, irritability, and immobility that intensify with intent. Persons
will attempt suicide even while in hospital so nurses need to continue observation of persons’ behavior, affect, and interactions with others. Increased risk times are when the energy level of a depressed person starts to lift or when discharge is about to occur.

- History of the person. As well as determining why a person is feeling suicidal, the nurses needs to assess for self-defeating coping patterns and past experiences that have negatively affected the person’s self-esteem.

- Information from friends and family. Interview the family both with and without the patient. Families who are angry, disgusted, or frustrated with the self-destructive person may actually provoke the person to complete a plan for suicide.

- History of suicidal gestures and attempts. People who have used this coping strategy in the past will consider it again.

- Mental status examination. Disturbances in concentration, orientation, and memory may indicate organic brain syndromes or MDD, which reduce the persons impulse control and increase the chance for self-harm. Disturbances in thought processes may include command hallucinations that tell them to kill themselves.

- Physical examination. Include assessment for signs of substance abuse.

- Nurses intuition. Often a nurse will feel uneasy or anxious about a particular patient. These feelings are said to come from having had experiences with other patients in the past who committed suicide.

Remember when completing an assessment and asking about the plan the person has for carrying out the act of suicide, be sure to question about the intended method and its availability. The more lethal and available the method the higher the risk.

**Nursing Interventions**


During the nursing assessment the nurse’s interest, concern, and exploration should include the beginning of the therapeutic relationship with the person who is suicidal. An investigation of the purpose and meaning of the self-harm behaviors can help the nurse determine specific interventions to promote change. Safety measures should be the first priority.
Suicide Risks for Youth

Suicide is a risk that must be addressed with any young person who has a depression. Suicide before adolescence is rare. Youth suicide has declined in recent years; however, it remains the third leading cause of death in this age group. Those persons aged 15-24 account for 14% of all suicides. As well, mental illness and depression in particular are linked to suicide making assessment all the more important.

Risk factors for youth include:

- Coming from a single parent family especially if the dad is missing
- Being male
- Age 16 and over
- Having experienced a recent suicide of a loved one, friend or idol
- Having issues with sexual identity
- Writing, thinking, or talking about death and dying
- Having experienced bullying or public humiliation
- Have attempted with a lethal method
- Living alone,
- Living in poverty,
- Previous suicide attempts,
- Antisocial personality traits,
- Physical or sexual abuse,
- Interpersonal problems or psychosocial stressors,
- Recent dramatic personality change,
- Psychiatric disorders, and
- Substance abuse disorders.

The most significant factors of attempted suicide in youth are:

- previous suicide attempts
- mood disorders (such as Depression)
- alcohol and drug abuse
- aggressive disruptive behaviour
Adolescents are more likely to attempt suicide, and the rates are quoted to be as high as 200 attempts to one completed suicide. There is also a link between youth suicide, cluster suicide in small communities, and in contagion suicides where the suicide is widely advertised (e.g., the suicide of a popular celebrity figure like Kurt Cobain. (Bourget, Gagne, & Turmel, 2002). As in other age groups, females attempt more often than males. Aboriginals have higher rates of youth suicide than non-aboriginals youth in the Canadian population. Although much media focus is on youth suicides, this age group is well below the national average. Whenever possible, assessment of youth and adolescents should always be done by a clinician skilled in interviewing and working with this population. Assessment should draw on numerous collateral sources respecting individual confidentiality issues.

A young person, who appears to have an undiagnosed mood disorder, should be given a comprehensive evaluation and assessment by a trained professional such as a psychiatrist who works in a setting that specializes with youth. Establishing their risk for suicide is also of utmost importance. Care for the young person with depression should be offered in a seamless continuum from inpatient services to community services and as the person transitions from youth to adolescence to adulthood. One such area, where much potential lies for prevention in depression of children, is in the schools. Here they can play a huge part in promoting or inhibiting the emotional health of children. Parks & Herman, (2003) conclude; “Schools hold promise as sites for sustainable prevention programming if successful interventions can be wedded to the daily practices of school personnel. However, successful school programming cannot occur in isolation. Community-school linkages are needed to foster resilience and competence in children across the multiple systems where they live and play (p.4)

Many excellent resources exist for parents of youth who have depression as well as for the young person themselves. One such excellent online resource is:

http://www.cmha.ca

**Suicide Risks for the Elderly**

Suicide in elders is considered to be a serious problem across the world. Even though suicide rates are high for younger people the death rates for the elderly are consistently higher. In the United States there are 16.4/100,000 people 75 years and older. Almost three quarters of older adults treated in emergency rooms had a history of depression (Miller, 2012).

The most predictable symptomatic behavior is that of an attempt. Other behavior that should be considered seriously include: carelessness about medication; tidying up personal affairs; lack
of interest in taking care of themselves and normal activities that used to give them pleasure; visits to the physician with vague complaints; and searching for some religion or church.

Contributing to an elder’s sadness and melancholy are often the events that are occurring in their lives. Retirement can result in older people becoming isolated if they no longer have their social connections. Also death of a spouse or close friends or the diagnosis of a serious illness can contribute to the sadness and eventual suicide attempt. Behaviors that may be seen include tension, impulsivity, changes in eating and sleeping, to name a few. (de Souza Minayo & Cavalcante, 2010)

**Instructional Activity # 2**

List the outcomes and nursing interventions for the nursing diagnosis Risk for Self Harm.

___________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Summary**

Mood disorders are a common psychiatric diagnosis that may present differently among all age groups of our population. Mood disorders range from the lows of major depression to the highs of mania. Treatment considerations vary from the biological to psychological to psychosocial domains, and are adapted specifically to meet the needs of the youth, adolescent, adult, and the older adult. As a psychiatric nurse you will encounter many persons with depression and bipolar illness in the clinical setting and this chapter guides your practice by offering special considerations regarding treatment and safety concerns when caring for them.
Answer Key:

Instructional Activity # 1

Teaching points include:
- maintain normal salt intake
- avoid excessive exercise, extreme heat, anything that increases perspiration and leads to dehydration
- report any feelings of fever, vomiting, diarrhea
- avoid alcohol or other CNS depressant drugs
- for women inform physician is planning a pregnancy, breast feeding
- do not take any over the counter medications or herbal supplements without checking with physician first
- do not discontinue abruptly
- according to protocols of the institution, how much fluid intake
- as mental status improves and is nearing discharge moderate to severe side effects and when to have routine blood tests to ensure therapeutic level of treatment

Mild side effects include:
- thirst
- metallic taste
- polyuria
- polydipsia
- fine hand tremors
- drowsiness
- mild diarrhea or loose stools
- possibly headache
- weight gain
- muscle weakness or fatigue
- edema
- memory impairments
- nausea

Instructional Activity # 3

Nursing Diagnosis: Risk for self-harm

Outcomes:
- Will not harm self
- Contract no harm contract
- Comply with unit regulations
- Participate in program activities
• Achieve a balance in activities of daily living

Interventions:
1. Initiate a therapeutic nurse-patient relationship
2. Initiate suicide precautions as per hospital protocols. This usually includes vigilant observation and may be referred to as constant or close observation.
3. Ongoing assessment of ideation, mood, energy levels.
4. Watch for any energy increase as if still suicidal and has energy at a higher risk for making an attempt at suicide action. Danger times include after receiving medications 9 – 14 days or if receiving bilateral ECT after 3 – 4.
5. Obtain no harm contract
References


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695748/


