**Acharya’s N.R. School of nursing **

Soladevanahalli, Bangalore -90

**Subject – Mental Health and Psychiatric Nursing**

**Unit – Mental disorders and Nursing Interventions**

**Mood Disorders**

Mood disorders are characterized by a disturbance of mood, accompanied by a full / partial manic / depressive syndrome, which is not due to any other physical or mental disorders.

**Classification –**

 According to ICD -10 mood disorders are classified as

* Manic episodes
* Depressive episodes
* Bipolar mood disorders
* Recurrent depressive disorders
* Persistent mood disorders
* Other mood disorders

**Causes –**

* **Biological theories –**
* **Genetic hypnosis :**

The life time risk for the first degree relatives of patients with bipolar mood disorders is 25 % and normal controls is 7%.the lifetime risk for the children of one parent with mood disorders is 27% and both the parents with mood disorders is 74%.

* **Bio chemical theories :**

A deficiency of norepienphrine and serotonin has been found in depressed patients and they are elevated in mania.

* **Psychosocial theories –**
* **Psychoanalytic theory :**

According to Freud depression results due to loss of a loved object and fixation in the oral sadistic phase of development.

* **Behavioral theory :**

This theory of depression connects depressive phenomena to the experience of uncontrollable events. According to this model, depression is conditioned by repeated losses in the past.

* **Cognitive theory :**

According to this theory depression is due to negative cognition which includes - negative expectations of the environment, self, future.

* **Sociological theory :**

Stressful life events eg – death, marriage, financial loss before the onset of the diseases / a relapse probably have a formative effect.

**MANIC EPISODES**

 Mania refers to a syndrome in which the central features are over – activity, mood change and self – important ideas.

**Classification of mania –**

* Hypomania
* Mania without psychotic symptoms
* Mania with psychotic symptoms
* Manic episode unspecified

**Clinical features –**

1. Elevated, expansive / irritable mood
* Euphoria
* Elation
* Exaltation
* Ecstasy
1. Psychomotor activity
* Over activeness
* restlessness
1. Speech and thought
* Flight of ideas
* Pressure of speech
* Delusion of grandeur
* Delusion of persecution
* distractibility
1. Other features
* Increased sociability
* Impulsive behavior
* Disinhibition
* Poor judgment
* Decreased need for sleep
* Decreased intake of food
* Decreased attention and concentration

**Treatment –**

1. **Pharmacotherapy:**
* Litium – 900 to 2100 mg / day
* Carbamazepine – 600 to 1800 mg / day
* Sodium valproate – 600 to 2600 mg / day
1. **ECT:**
2. **Psychosocial treatment:**
* Family and marital therapy

**Nursing diagnosis –**

1. High risk for injury related to extreme hyper activity and impulsive behavior, evidenced by lack of control over purposeless and potentially injurious moments
2. High risk for violence, self – directed / directed at others related to manic excitement, delusional thinking and hallucinations
3. Nutritional status altered, less than body requirements related to refusal / inability to sit still long enough to eat, evidenced by weight loss, amenorrhea
4. Impaired social interaction related to egocentric and evidenced by inability to develop satisfying relationships and manipulation of others for own desires
5. Self esteem disturbance related to unmet dependency needs, lack of positive feedback, unrealistic self – expectations
6. Altered family processes related to euphoric mood and grandiose ideas, manipulative behavior, refusal to accept responsibility for own actions

**DEPRESSIVE EPISODE**

 Depression is a widespread mental health problem affecting many people.

**Classification –**

* Mild depression
* Moderate depression
* Severe depression
* Severe depression with psychotic symptoms

**Clinical features –**

1. Depressed mood
* Sadness of mood
* Loss of pleasure
1. Depressive cognitions
* Hopelessness
* Helplessness
* Unreasonable guilt
* Self - blame
1. Suicidal thoughts
* Hopelessness
* Suicidal thoughts
1. Psychomotor activity
* Anxiety
* Restlessness
1. Psychotic features
* Delusion
* Hallucination
1. Somatic symptoms of depression
* Decreased appetite / weight
* Lack of interest
1. Other features
* Difficulties in thinking and concentration
* Poor memory
* Menstrual and sexual disturbance

**Treatment –**

1. **Pharmacotherapy**

Antidepressants - Imipramine

1. **ECT**
2. **Psychosocial treatment**
* Cognitive therapy
* Supportive psychotherapy
* Group therapy
* Family therapy
* Behavior therapy

**OTHER MOOD DISORDERS**

1. **Bipolar mood disorders**

This is characterized by recurrent episodes of mania and depression in the same patient at different times.

**Classification of bipolar mood disorders**

* Bipolar I
* Bipolar II
1. **Recurrent depressive disorders**

This disorder is characterized by recurrent depressive episodes. The current episode is specified as mild, moderate, severe and severe with psychotic symptoms.

1. **Persistent mood disorders**

These disorders are characterized by persistent mood symptoms that last for more than 2 years.

Cyclothymia refers to persistent instability in mood in which there are numerous periods of mild elation / mild depression

Dysthymia (neurotic / reactive depression) is a chronic, mild depressive state persisting for months / years.

**NURSING DIAGNOSIS –**

1. High risk for self – directed related to depressed mood, feeling of worthlessness and anger directed inward on the self
2. Dysfunctional grieving related to real / perceived loss, evidenced by denial of loss, inappropriate expression of anger, inability to carry out activities of daily living
3. Powerlessness related to dysfunctional grieving process, life style of helplessness, evidenced by feelings of lack of control over life situation, over dependence on others to fulfill needs
4. Self – esteem disturbance related to learned helplessness, impaired cognition, negative view of self, evidenced by expression of worthlessness, sensitivity to criticism, negative and pessimistic outlook
5. Altered communication process related to depressive cognitions, evidenced by being unable to interact with others, withdrawn, expressing fear of failure / rejection
6. Altered sleep and rest, related to depressed mood and depressive cognitions evidenced by difficulty in falling asleep, early morning awakening, verbal complaints of not feeling well – being
7. Altered nutrition, less than body requirement related to depressed mood, lack of appetite / lack of interest in food, evidenced by weight loss, poor muscle tone, pale conjunctiva, poor skin turgor
8. Self – care deficit related to depressed mood, feelings of worthlessness, evidenced by poor personal hygiene and grooming

**Bipolar Versus Unipolar**



1. **Bipolar**
* Results from disturbances in the areas of the brain that regulate mood
* It involves periods of excitability (mania) alternating with periods of depression
* This may affects men and women equally
* Usually appears between ages 15 – 25

**Cause**

* Unknown
* It occurs more often in relatives of people with bipolar disorder

**Symptoms**

**Manic Phase**

1. Agitation or irritation
2. Elevated mood (hyperactivity, increased energy, lack of self-control, racing thoughts)
3. Inflated self-esteem (delusions of grandeur, false beliefs in special abilities)
4. Little need for sleep
5. Over-involvement in activities
6. Poor temper control
7. Reckless behavior (binge eating, drinking, and/or drug use, impaired judgment, sexual promiscuity, spending sprees)
8. Tendency to be easily distracted

**Depressed Phase**

1. Difficulty concentrating, remembering, or making decisions
2. Eating disturbances
3. Fatigue or listlessness
4. Feelings of worthlessness, hopelessness and/or guilt
5. Loss of self-esteem
6. Persistent sadness and thoughts of death
7. Sleep disturbances
8. Suicidal thoughts
9. Withdrawal from activities that were once enjoyed

**Medical Intervention**

* Proper History Taking and Observation
* Antipsychotic medications (such as lithium and mood stabilizers or antidepressant for depressive phase)
* Electroconvulsive therapy (ECT)

**Nursing Interventions**

1. Provide a calm environment
2. Giving health teachings about regular exercise, and proper diet
3. Explain to patient that getting enough sleep helps keep a stable mood
4. **Unipolar**
* Another name for major depressive disorder
* Occurs when a person experiences the symptoms for longer than a two-week period

**Causes**

* The biopsychosocial model proposes that biological, psychological, and social factors all play a role in causing depression
* The diathesis–stress model specifies that depression results when a preexisting vulnerability, or diathesis, is activated by stressful life events

**Symptoms**

1. Depressed mood
2. A lack of interest in activities normally enjoyed
3. Changes in weight and sleep
4. Fatigue
5. Feelings of worthlessness and guilt
6. Difficulty concentrating
7. Has thoughts of death and suicide

**Medical Interventions**

* Antidepressants
* Tricyclic antidepressants
* Monoamine oxidase inhibitors
* Selective serotonin re-uptake inhibitors
* Electroconvulsive therapy

**Nursing Interventions**

1. Interpersonal Therapy
2. Psychotherapy
3. Encourage client to have a regular exercise
4. Cognitive behavioral therapy
5. Behavioral modification therapy

**Difference between Bipolar and Unipolar Disorder**

|  |  |  |
| --- | --- | --- |
|  | **UNIPOLAR** | **BIPOLAR** |
| **Gender and Age of Onset** | Affects women more often than men, appears later in life | Affects men and woman equally, average age of onset suspected to be 18 years |
| **Sleep** | Generally insomnia, difficulty falling asleep or waking repeatedly during the night | Generally hypersomnia, excessive tiredness and difficulty waking in the morning |
| **Appetite** | Often has a loss of appetite and diminished interest in eating | Often binge-eating and cravings for carbohydrates, may alternate with loss of appetite |
| **Activity Level** | Agitated, pacing and restlessness are more common | Inactivity, somnolence, a slowing down of movements (psychomotor retardation) more common |
| **Mood** | Sadness, hopelessness, feelings of worthlessness | Same as for unipolar, although guilt is often much more prominent |
| **Other** | Episodes often last longer, sometimes more responsive to treatment | Risk of drug abuse and suicide higher than in unipolar depression |

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*