

CHAPTER 20



KEY CONCEPTS

- mania
- mood
- mood disorders
- suicidal behavior

Mood Disorders: Management of Moods and Suicidal Behavior

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LEARNING OBJECTIVES

After studying this chapter, you will be able to:

- Describe the prevalence and incidence of mood disorders and suicide within American society.
- Delineate the clinical symptoms and course of mood disorders and suicidal behavior.
- Analyze the biopsychosocial theories that formulate the education, practice, and research basis in caring for patients who are diagnosed with a mood disorder and who exhibit suicidal behavior.
- Analyze the human responses to mood disorders.
- Discuss the biopsychosocial nursing clinical reasoning processes for patients diagnosed with mood disorders and for those who exhibit suicidal behavior.
- Formulate nursing diagnoses with strategies, interventions, and evaluative approaches that address the cultural needs of persons diagnosed with mood disorders and for those who exhibit suicidal behavior.

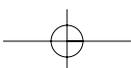
KEY TERMS

- affect • bipolar • cyclothymic disorder • depressive episode • dysthymic disorder • euphoria • expansive mood • hypomanic episode • lability of mood • manic episode • mixed episode • rapid cycling • unipolar

Depression is an overwhelming disorder. Well over 17 million people are affected within the United States alone, and it is projected that depression will overtake cardiovascular disease as the major world-wide health concern by the 21st century. The clinical symptoms and course of depressive phenomena is a complex, dynamic biopsychosocial process involving lifespan and cultural aspects. Unless appropri-

ately treated, depression persists over time, having a significant negative effect on life and increasing the risk of suicide. Psychiatric nurses are uniquely positioned to address this pandemic health concern.

The World Health Organization (WHO) predicts that mood disorders will be the number one public health problem in the 21st century. In the United States, mental disorders account for more than 15% of the disease



burden for all diseases and a little more than the burden for all types of cancer. Mood disorders are associated with high levels of impairment in occupation, social, and physical functioning and cause as much disability and distress to patients as chronic medical disorders (United States Department of Health and Human Services [U.S. DHHS], 1999). Mood disorders often go undetected and untreated. Studies suggest that more than two-thirds of people with bipolar disorder have their disease misdiagnosed (Hirschfeld, Lewis, & Vornik, 2003). The incidence of misdiagnosis is often greater for persons from culturally and ethnically diverse populations, as their explanation of their symptomatology may be expressed using different terminology than do persons who are not from these populations (U.S. Department of Health and Human Services [U.S. DHHS], 2001). Although health care resources are expended on testing for atypical physical symptom patterns, the opportunity to make use of effective pharmaceutical and psychological treatments often is missed. In addition, because suicide is a significant risk in mood disorders, these disorders have a greater impact on premature mortality. Nurses practicing in any health care setting need to develop competence in assessing patients for the presence of a mood disorder and, if suspected, provide appropriate educational and clinical interventions or referral.



KEY CONCEPT Mood is a pervasive and sustained emotion that colors one's perception of the world and how one functions in it. Normal variations in mood occur as responses to specific life experiences. Normal mood variations, such as sadness, euphoria, and anxiety, are time limited and are not associated with significant functional impairment.



KEY CONCEPT Mood disorders, as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision ([DSM-IV-TR]; American Psychiatric Association [APA], 2000), are recurrent disturbances or alterations in mood that cause psychological distress and behavioral impairment.



KEY CONCEPT Suicidal behavior Suicidal behavior is defined as the occurrence of persistent thought patterns and actions that indicate a person is thinking about, planning, or enacting suicide.

The primary alteration is in mood, rather than in thought or perception. Several terms describe **affect** or outward emotional expression (see Chapter 10) including the following:

- *Blunted*: significantly reduced intensity of emotional expression
- *Flat*: absent or nearly absent affective expression

- *Inappropriate*: discordant affective expression accompanying the content of speech or ideation
- *Labile*: varied, rapid, and abrupt shifts in affective expression
- *Restricted or constricted*: mildly reduced in the range and intensity of emotional expression

Normal range of mood or affect varies considerably both within and between different cultures (this issue is addressed in *Ethnic and Cultural Differences*).

Primary mood disorders include both depressive disorders (**unipolar**) and manic-depressive (**bipolar**) disorders. The *DSM-IV-TR* has established specific criteria for diagnostic classification of these disorders, including criteria for severity (a change from previous functioning), duration (at least 2 weeks), and clinically significant distress or impairment. Mood episodes are the “building blocks” for the mood disorder diagnoses. The *DSM-IV-TR* describes four categories of mood episodes: major depressive episode, manic episode, mixed episode, and hypomanic episode. This chapter focuses on the depressive disorders and bipolar disorder. The *DSM-IV-TR* categorizes mood disorders as follows:

- *Depressive disorders*: major depressive disorder, single or recurrent; dysthymic disorder; and depressive disorder not otherwise specified (NOS)
- *Bipolar disorders*: bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder NOS
- *Mood disorder* caused by a general medical condition
- *Substance-induced mood disorder*
- *Mood disorder NOS*

DEPRESSIVE DISORDERS

Clinical Course

The primary *DSM-IV-TR* criterion for major depressive disorder is one or more major depressive episodes. In a major **depressive episode**, either a depressed mood or a loss of interest or pleasure in nearly all activities must be present for at least 2 weeks. Four of seven additional symptoms must be present: disruption in sleep, appetite (or weight), concentration, energy; psychomotor agitation or retardation; excessive guilt or feelings of worthlessness; and suicidal ideation (see Table 20.1). Individuals often describe themselves as depressed, sad, hopeless, discouraged, or “down in the dumps.” If individuals complain of feeling “blah,” having no feelings, or feeling anxious, a depressed mood can sometimes be inferred from their facial expression and demeanor (APA, 2000).

Dysthymic disorder is a milder but more chronic form of major depressive disorder. The *DSM-IV-TR* cri-

Table 20.1



Key Diagnostic Characteristics for Major Depressive Disorder 296.xx
Major depressive disorder, single episode 296.2x
Major depressive disorder, recurrent 296.3x



Diagnostic Criteria and Target Symptoms

- Change from previous level of functioning during a 2-week period
 - Depressed mood
 - Markedly diminished interest or pleasure in all or almost all activities
 - Significant weight loss when not dieting, or weight gain or change in appetite
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue or loss of energy
 - Feelings of worthlessness or excessive or inappropriate guilt
 - Diminished ability to think or concentrate, or indecisiveness
 - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- At least one symptom is depressed mood, or loss of interest or pleasure
- Significant distress or impairment of social, occupational, or other important areas of functioning
- Not a direct physiologic effect of substance or medical condition
- Not better accounted for by bereavement, schizoaffective disorder; not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified

Associated Findings

Associated Behavioral Findings

- Tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain
- Possible panic attacks
- Difficulty with intimate relationships
- Difficulties with sexual functioning
- Marital problems
- Occupational problems
- Substance abuse, such as alcohol
- High mortality rate; death by suicide
- Increased pain and physical illness
- Decreased physical, social, and role functioning
- May be preceded by dysthymic disorder

teria for dysthymic disorder are depressed mood for most days for at least 2 years and two or more of the following symptoms: poor appetite or overeating; insomnia or oversleeping; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions; and feelings of hopelessness. The not otherwise specified (NOS) category includes disorders with depressive features that do not meet strict criteria for major depressive disorder.

Major depressive disorder is commonly a progressive, recurrent illness. With time, episodes tend to occur more frequently, become more severe, and are of a longer duration. About 25% of patients experience a recurrence during the first 6 months after a first episode, and about 50% to 75% have a recurrence within 5 years. The mean age of onset for major depressive disorder is about 40 years; 50% of all patients have an onset between the ages of 20 and 50 years. During a 20-year period, the mean number of episodes is five or six. Symptoms usually develop during a period of days to months. About 50% of patients have significant depressive symptoms before the first identified episode. An untreated episode typically lasts 6 to 13 months, regardless of the age of onset. In one report, only 6% to 14% of depressed suicide victims were adequately treated and only 8% to 17% of all suicide victims were under treatment with prescribed psy-

chiatric medications (Goldsmith, Pellmar, Kleinman, Bunny, 2002).

Depressive Disorders in Special Populations

Children and Adolescents

Depressive disorders in children have manifestations similar to those seen in adults with a few exceptions. In major depressive disorder, children are less likely to experience psychosis, but when they do, auditory hallucinations are more common than delusions. They are more likely to have anxiety symptoms, such as fear of separation, and somatic symptoms, such as stomach aches and headaches. They may have less interaction with their peers and avoid play and recreational activities that they generally have participated in. Mood may be irritable, rather than sad, especially in adolescents. The risk of suicide, which peaks during the mid-adolescent years, is very real in children and adolescents. Mortality from suicide, which increases steadily through the teens, is the third leading cause of death for that age group. Findings from research indicate that deaths due to illegal drug use and automobile accidents may be the outcome of adolescent depression and suicidal ideation (U.S. DHHS, 1999).

Elderly People

Most older patients with symptoms of depression do not meet the full criteria for major depression. However, it is estimated that 8% to 20% of older adults in the community and as many as 37% in primary care settings experience depressive symptoms. Treatment is successful in 60% to 80%, but response to treatment is slower than in younger adults. Depression in elderly people often is associated with chronic illnesses, such as heart disease, stroke, and cancer; symptoms may have a more somatic focus. Depressive symptomatology in this group may be confused with symptoms of dementia or cerebral vascular accidents. Hence, differential diagnosis may be required to ascertain the root and cause of symptoms. Suicide is a very serious risk for the older adult, especially men. People older than age 65 years have the highest suicide rates of any age group. There is a greater likelihood of death in or following a suicide attempt in the elderly. In those 85 years and older, the suicide rate is the highest, at 21 suicides per 100,000 persons (Goldsmith et al., 2002; U.S. DHHS, 1999).

Epidemiology

In any year, approximately 7% of Americans will experience a mood disorder generally recognized as either

depression or mania. This percentage translates into an estimated 11 million people every year. It also appears that the chances of experiencing major depressive disorder are increasing in progressively younger age groups (U.S. DHHS, 1999). Major depressive disorder is twice as common in adolescent and adult women as in adolescent and adult men. Prepubertal boys and girls are equally affected. Major depressive disorders often co-occur with other psychiatric and substance-related disorders. Depression often is associated with a variety of medical conditions, particularly endocrine disorders, cardiovascular disease, neurologic disorders, autoimmune conditions, viral or other infectious diseases, certain cancers, and nutritional deficiencies, or as a direct physiologic effect of a substance (e.g., a drug of abuse, a medication, other somatic treatment for depression, or toxin exposure) (APA, 2000).

Ethnic and Cultural Differences

Prevalence rates are unrelated to race. Culture can influence the experience and communication of symptoms of depression. Persons from culturally and ethnically diverse populations may formulate and describe their depressive symptomatology differently than the language proposed for descriptions of these symptoms in the diagnostic criteria of the *DSM-IV-TR* (2000). For example, expressions like “heart-brokenness” (Native American and Middle Eastern), “brain fog” (persons from the West Indies), “zar” and “running amok” may be used in place of such terms as “depressed, sad, hopeless and discouraged” (APA, 2000).

In some cultures, somatic symptoms, rather than sadness or guilt, may predominate (Baker, 2001). For example, language such as “nervous” may be used by persons from Latino and Mediterranean cultures to describe their depressive symptomatology. Individuals from various Asian cultural groups may have complaints of weakness, tiredness, or imbalance. “Problems of the heart” (in Middle Eastern cultures) or of being “heartbroken” (among Hopi Indians) may be the way that persons from these cultural groups express their depressive experiences. Culturally distinctive experiences need to be assessed in order to ascertain any presence of depressive disorder from a “normal” cultural emotional response (APA, 2002).

Risk Factors

Depression is so common that it is sometimes difficult to identify risk factors. The generally agreed-on risk factors include the following:

- Prior episode of depression
- Family history of depressive disorder
- Lack of social support
- Lack of coping abilities

FAME AND FORTUNE

Wilbur Wright (1867–1912):
Genius Inventor

Public Persona

Of the Wright brothers, Wilbur and Orville, Wilbur Wright is viewed as the real genius and the one who developed intellectual control over the problem of flight. Although his brother, Orville, had inventive skills and was an ideal counterpart, Wilbur was the one who envisioned things that others could not see. Together, the brothers had the skill to build what they imagined. They once built a wagon that reduced the wheel friction so that it could haul 10 times as much as before. In his early teens, Wilbur invented a machine to fold newspapers, and Orville built a small printing press for a newspaper he started.

Personal Realities

Wilbur Wright suffered with depression that started after an injury he sustained when he was hit in the face with a bat during a game. Complications followed from the medication he received, which affected his heart. He then developed an intestinal disorder, which caused him to abandon his college plans and remain secluded for 4 years. He felt that he could never realize his goal of becoming a clergyman. During his poor health and seclusion, he cared for his mother who was ill with tuberculosis that would eventually cause her death. After his mother died, Wilbur emerged from his depression and he and his brother went into the printing business together. Later, they focused on airplanes and flying.

Source: Crouch, T.D. (1990). *The Bishop's Boys: A Life of Wilbur and Orville Wright*. New York: W.W. Norton & Company.

- Presence of life and environmental stressors
- Current substance use and/or abuse
- Medical comorbidity

Etiology

Genetics

Family, twin, and adoption studies demonstrate that genetic influences undoubtedly play a substantial role in the etiology of mood disorders. Major depressive disorder is more common among first-degree biologic relatives of people with this disorder than among the general population. Currently, a major research effort is focusing on developing a more accurate paradigm regarding the contribution of genetic factors to the development of mood disorders (Alda, 2001).

Neurobiologic Hypotheses

Neurobiologic theories of the etiology of depression emerged in the 1950s. These theories posit that major depression is caused by a deficiency or dysregulation in central nervous system (CNS) concentrations of the neurotransmitters norepinephrine, dopamine, and serotonin or in their receptor functions. These hypotheses arose in part from observations that some pharmacologic agents elevated mood, and subsequent studies identified their mechanisms of action. All antidepressants currently available have their therapeutic effects on these neurotransmitters or receptors. Current research focuses on the synthesis, storage, release, and uptake of these neurotransmitters, as well as on postsynaptic events (e.g., second-messenger systems) (Donati & Rasenick, 2003).

Neuroendocrine and Neuropeptide Hypotheses

Major depressive disorder is associated with multiple endocrine alterations, specifically of the hypothalamic–pituitary–adrenal axis, the hypothalamic–pituitary–thyroid axis, the hypothalamic–growth hormone axis, and the hypothalamic–pituitary–gonadal axis. In addition, there is mounting evidence that components of neuroendocrine axes (e.g., neuromodulatory peptides such as corticotropin-releasing factor) may themselves contribute to depressive symptoms. Evidence also suggests that the secretion of these hypothalamic and growth hormones is controlled by many of the neurotransmitters implicated in the pathophysiology of depression (Hanley & Van de Kar, 2003).

Psychoneuroimmunology

Psychoneuroimmunology is a recent area of research into a diverse group of proteins known as *chemical messengers*

between immune cells. These messengers, called cytokines, signal the brain and serve as mediators between immune and nerve cells. The brain is capable of influencing immune processes, and conversely, immunologic response can result in changes in brain activity (Kronfol & Remick, 2000). The specific role of these mechanisms in psychiatric disease pathogenesis remains unknown.

Psychological Theories

Psychodynamic Factors

Most psychodynamic theorists acknowledge some debt to Freud's original conceptualization of the psychodynamics of depression, which ascribes etiology to an early lack of love, care, warmth, and protection and resultant anger, guilt, helplessness, and fear regarding the loss of love. The ensuing conflict between wanting to be loved and fear of rejection engenders pathologic self-punitiveness (also conceptualized as aggression turned inward), self-rejection, low self-esteem, and depressive symptoms (see Chapter 6).

Behavioral Factors

The behaviorists hold that depression occurs primarily as the result of a severe reduction in rewarding activities or an increase in unpleasant events in one's life. The resultant depression then leads to further restriction of activity, thereby decreasing the likelihood of experiencing pleasurable activities, which, in turn, intensifies the mood disturbance.

Cognitive Factors

The cognitive approach maintains that irrational beliefs and negative distortions of thought about the self, the environment, and the future engender and perpetuate depressive affects (see Chapter 6).

Developmental Factors

Developmental theorists posit that depression may be the result of loss of a parent through death or separation or lack of emotionally adequate parenting. These factors may delay or prohibit the realization of appropriate developmental milestones.

Social Theories

Family Factors

Family theorists ascribe maladaptive patterns in family interactions as contributing to the onset of depression, particularly “ambivalent, abusive, rejecting, or highly dependent family relationships” (APA, 2002, p. 495).

Social Factors

Major depression may follow adverse or traumatic life events, especially those that involve the loss of an important human relationship or role in life. Social isolation, deprivation, and financial deprivation are risk factors (APA, 2002).

Interdisciplinary Treatment of Disorder

Although depressive disorders are the most commonly occurring mental disorders, they are usually treated within the primary care setting, not the psychiatric setting. Individuals with depression enter mental health settings when their symptoms become so severe that hospitalization is needed, usually for suicide attempts, or if they self-refer because of incapacitation. Interdisciplinary treatment of these disorders, which are often life-long, needs to include a wide array of health professionals in all areas. The specific goals of treatment are:

- Reduce/control symptoms and, if possible, eliminate signs and symptoms of the depressive syndrome.
- Improve occupational and psychosocial function as much as possible.
- Reduce the likelihood of relapse and recurrence.

Priority Care Issues

The overriding concern for people with mood disorders is safety, because these individuals may experience self-destructive thoughts and suicidal ideations. Hence, the assessment of possible suicide risk should be routinely conducted in any person who is incurring depressive symptomatology (see Chapter 17).

Family Response to Disorder

Depression in one member affects the whole family. Spouses, children, parents, siblings, and friends experience frustration, guilt, and anger when the family member is immobilized and cannot function. It is often hard for others to understand the depth of the mood and how disabling it can be. Financial hardship can occur when the family member cannot go to work and spends days in bed. The lack of understanding and difficulty of living with a depressed person can lead to abuse. Women between the ages of 18 and 45 years constitute the majority of those experiencing depression. This incidence may affect women's ability to not only have a productive life and take care of themselves but to also take care of their children or other family members they may have responsibility for. Moreover, research indicates that the incidence of depression may be higher in children whose mothers incur depression (U.S. DHHS, 2001).

NURSING MANAGEMENT: HUMAN RESPONSE TO DEPRESSIVE DISORDER

The diagnosis of major depressive disorder is made when *DSM-IV-TR* criteria are met. An awareness of the risk factors for depression, a comprehensive and culturally competent biopsychosocial assessment, history of illness, and past treatment are key to formulating a treatment plan and to evaluating outcomes (Taylor, 2003; Warren, 2002). Interviewing a family member or close friend about the patient's day-to-day functioning and specific symptoms may be helpful in determining the course of the illness, current symptoms, and level of functioning.

Biologic Domain

Assessment

Because some symptoms of depression are similar to those of some medical problems or side effects of medication therapies, biologic assessment must include a physical systems review and thorough history of medical problems, with special attention to CNS function, endocrine function, anemia, chronic pain, autoimmune illness, diabetes, or menopause. Additional medical history includes surgeries; medical hospitalizations; head injuries; episodes of loss of consciousness; and pregnancies, childbirths, miscarriages, and abortions. A complete list of prescribed and over-the-counter medications should be compiled, including the reason a medication was prescribed or its use discontinued. A physical examination is recommended with baseline vital signs and baseline laboratory tests, including comprehensive blood chemistry panel, complete blood counts, liver function tests, thyroid function tests, urinalysis, and electrocardiograms (Chapter 10). Biologic assessment also includes evaluating the patient for the characteristic neurovegetative symptoms listed below.

• NCLEXNOTE

NCLEXNOTE In determining severity of depressive symptoms, nursing assessment should explore physical changes in appetite and sleep patterns and decreased energy. And considering the possibility of suicide should always be a priority with patients who are depressed. Assessment and documentation of suicide risk should always be included in patient care.

- *Appetite and weight changes:* In major depression, changes from baseline include decrease or increase in appetite with or without significant weight loss or gain (i.e., a change of more than 5% of body weight

in 1 month). Weight loss occurs when not dieting. Older adults with moderate to severe depression need to be assessed for dehydration as well as weight changes.

- *Sleep disturbance*: The most common sleep disturbance associated with major depression is insomnia. *DSM-IV-TR*'s definitions of insomnia are divided into three categories: initial insomnia (difficulty falling asleep); middle insomnia (waking up during the night and having difficulty returning to sleep); or terminal insomnia (waking too early and being unable to return to sleep). Less frequently, the sleep disturbance is hypersomnia (prolonged sleep episodes at night or increased daytime sleep). The individual with either insomnia or hypersomnia complains of not feeling rested upon awakening.
- *Decreased energy, tiredness, and fatigue*: Fatigue associated with depression is a subjective experience of feeling tired regardless of how much sleep or physical activity a person has had. Even the smallest tasks require substantial effort.

• NCLEXNOTE

Remember the three major assessment categories listed above. A question may state several patient symptoms and expect the student to recognize that the patient being described is depressed.

In addition to a physical assessment including weight and appetite, sleep habits, and fatigue factors, an assessment of current medications should be completed. The frequency and dosage of prescribed medication, over-the-counter medication, and use of herbal or culturally related medication treatments should be explored. In depression, the nurse must always assess the lethality of the medication the patient is taking. For example, if a patient has sleeping medications at home, the individual should be further queried about the number of pills in the bottle. Patients also need to be assessed for their use of alcohol, marijuana, and other mood-altering medications, as well as herbal substances because of the potential for drug–drug interactions. For example, patients taking antidepressants that affect serotonin regulation could also be taking St. John's wort (*hypericum perforatum*) to fight depression. The combined drug and herb could interact to cause serotonin syndrome (altered mental status, autonomic dysfunction, and neuromuscular abnormalities).

Nursing Diagnoses for Biologic Domain

There are several nursing diagnoses that could be formulated based on assessment data, including insom-

nia, Imbalanced Nutrition, Fatigue, Self-care Deficit, and Nausea. Other diagnoses that should be considered are Disturbed Thought Processes and Sexual Dysfunction.

Interventions for Biologic Domain

Because weeks or months of disturbed sleep patterns and nutritional imbalance only make depression worse, counseling and education should aim to establish normal sleep patterns and healthy nutrition.

Teaching Physical Care



Encouraging patients to practice positive sleep hygiene and eat well-balanced meals regularly helps the patient move toward remission or recovery. Activity and exercise are also important for improving depressed mood state. Most people find that regular exercise is hard to maintain. People who are depressed may find it impossible. When teaching about exercise, it is important to start with the current level of patient activity and increase slowly. For example, if the patient is spending most of the time in bed, encouraging the patient to get dressed every day and walk for 5 or 10 minutes may be all that patient can tolerate. Gradually, patients should be encouraged to have a regular exercise program and to slowly increase their food intake.

Pharmacologic Interventions

An antidepressant is selected based primarily on an individual patient's target symptoms, genetic responses related to cultural, racial, and ethnic influences and an individual agent's side-effect profile (Warren, in press). Failure to consider these influences may increase the risk of aversive and injurious side effects (Institute of Medicine, 2003; U.S. DHHS, 2001). There are other factors that may influence choice:

- Prior medication response
- Drug interactions and contraindications
- Medication responses in family members
- Concurrent medical and psychiatric disorders
- Patient needs and requirements based on cultural healthcare beliefs and values
- Patient age
- Cost of medication

Medication therapy should be reviewed on a regular basis in order to ascertain whether changes and/or discontinuation of medications might be needed. The treatment and clinical management of psychiatric disorders are divided into the acute phase, continuation phase, maintenance phase, and, when indicated, discontinuation of medication use.

NCLEXNOTE

Patients may be reluctant to take prescribed antidepressant medications or may self-treat depression based on their cultural beliefs and values (U.S. DHHS, 2001). A culturally competent nursing care and teaching plan needs to address the importance for adherence to a medication regimen and emphasize any potential drug–drug interactions.

- *Acute phase.* The primary goal of therapy for the acute phase is symptom reduction or remission. The objective is to choose the right match of medication and dosage for the patient. Careful monitoring and follow-up are essential during this phase to assess patient response to medications, adjust dosage if necessary, identify and address side effects, and provide patient support and education.
- *Continuation phase.* The goal of this treatment phase is to decrease the risk for relapse (a return of the current episode of depression). If a patient experiences a response to an adequate trial of medication, use of the medication generally is continued at the same dosage for at least 4 to 9 months after the patient returns to a clinically well state.
- *Maintenance phase.* For patients who are at high risk for recurrence (see Risk Factors), the optimal duration of maintenance treatment is unknown but is measured in years, and full-dose therapy is required for effective prophylaxis (Schatzberg, Cole, & DeBattista, 2003).
- *Discontinuation of medication use.* The decision to discontinue active treatment should be based on the same factors considered in the decision to initiate maintenance treatment. These factors include the frequency and severity of past episodes, the persistence of dysthymic symptoms after recovery, the presence of comorbid disorders, and patient preference. Many patients continue taking medications for their lifetime.

Administering Antidepressant Medication Therapy

Antidepressant medications have proved effective in all forms of major depression. To date, controlled trials have shown no single antidepressant drug to have greater efficacy in the treatment of major depressive disorder. Antidepressant medications can be grouped as follows:

- Selective serotonin reuptake inhibitors (SSRIs), which currently include escitalopram oxalate (Lexapro), fluoxetine (Prozac), sertraline (Zoloft), fluvoxamine (Luvox), paroxetine (Paxil), and citalopram (Celexa) (see Box 20.1 for more information);

Serotonin norepinephrine reuptake inhibitors (SNRIs), which include venlafaxine (Effexor), nefazodone (Serzone), and duloxetine (Cymbalta);

- Cyclic antidepressants, which include the tricyclic antidepressants (TCAs), and maprotiline (a tetracyclic);
- monoamine oxidase inhibitors (MAOIs), which include phenelzine (Nardil), tranylcypromine (Parnate), and selegiline (Emsam);
- other antidepressants, which include bupropion (Wellbutrin), a norepinephrine dopamine reuptake inhibitor, mirtazapine (Remeron), an α_2 antagonist, and trazadone (Desyrel), a serotonin-2 antagonist/reuptake inhibitor. See Chapter 8 for list of antidepressant medications, usual dosage range, half-life, and therapeutic blood levels. For more information, see Box 20.2.

The first-generation drugs, the TCAs and MAOIs, are being used less often than the second-generation drugs, the SSRIs and atypical antidepressants. Second-generation drugs selectively target the neurotransmitters and receptors thought to be associated with depression and to minimize side effects. The side-effect profiles of the two generations of drugs are significantly different as well (Table 20.2). The efficacy of the MAOIs is well established. Evidence suggests their distinct advantage in treating a specific subtype of depression, so-called atypical depression (characterized by increased appetite, reverse diurnal mood variation, and hypersomnia), depression with panic symptoms, or social phobia (Schatzberg et al., 2003). Given the complexity of their use, MAOIs usually are reserved for patients whose depression fails to respond to other antidepressants or patients who cannot tolerate typical antidepressants.

Monitoring Medications

Patients should be carefully observed when taking antidepressant medications (Box 20.3). In the depths of depression, saving medication for a later suicide attempt is quite common. All of the antidepressants have boxed warnings for suicidality in children and adolescents. During antidepressant treatment, there is ongoing monitoring of vital signs, plasma drug levels as appropriate, liver and thyroid function tests, complete blood counts, and blood chemistry. Responsibilities include ensuring that patients are receiving a therapeutic dosage, helping in the evaluation of compliance, monitoring side effects, and helping to prevent toxicity. (Therapeutic blood levels for antidepressant medications are listed in Chapter 8.) Table 20.3 indicates various pharmacologic and nonpharmacologic interventions for the various side effects of antidepressant

BOX 20.1**Drug Profile: Escitalopram oxalate (Lexapro)****DRUG CLASS:** Antidepressant**RECEPTOR AFFINITY:** A highly selective serotonin reuptake inhibitor with low affinity for 5HT 1-7 or α - and β -adrenergic, dopamine D1-5, histamine H1-3, muscarinic M1-5, and benzodiazepine receptors or for Na⁺, K⁺, Cl⁻, and Ca⁺⁺ ion channels that have been associated with various anticholinergic, sedative, and cardiovascular side effects.**INDICATIONS:** Treatment of major depressive disorder, generalized anxiety disorder.**ROUTES AND DOSAGES:** Available as 5-, 10-, and 20-mg oral tablets.**Adults:** Initially 10 mg once a day. May increase to 20 mg after a minimum of a week. Trials have not shown greater benefit at the 20-mg dose.**Geriatric:** The 10-mg dose is recommended. Adjust dosage related to the drug's longer half-life and the slower liver metabolism of elderly patients.**Renal impairment:** No dosage adjustment is necessary for mild to moderate renal impairment.**Children:** Safety and efficacy not established in this population.**HALF LIFE (PEAK EFFECT):** 27–32 h (4–7 h)**SELECTED ADVERSE REACTIONS:** Most common adverse events include insomnia, ejaculation disorder, diarrhea, nausea, fatigue, increased sweating, dry mouth, somnolence, dizziness, and constipation. Most serious adverse events

include ejaculation disorder in males; fetal abnormalities and decreased fetal weight in pregnant patients; serotonin syndrome if co-administered with MAOIs, St. John's Wort, or SSRIs, including citalopram (Celexa), of which escitalopram (Lexapro) is the active isomer.

BOXED WARNING: Suicidality in children and adolescents.**WARNINGS:** There is potential for interaction with MAOIs. Lexapro should not be used in combination with a MAOI or within 14 days of discontinuing a MAOI.**SPECIFIC PATIENT/FAMILY EDUCATION:**

- Do not take in combination with citalopram (Celexa) or other SSRIs or MAOIs. A 2-week washout period between escitalopram and SSRIs or MAOIs is recommended to avoid serotonin syndrome.
- Families and caregivers should be advised of the need for close observation and communication with the prescriber.
- Notify prescriber if pregnancy is possible or being planned. Do not breast-feed while taking this medication.
- Use caution driving or operating machinery until certain escitalopram does not alter physical abilities or mental alertness.
- Notify prescriber of any OTC medications, herbal supplements, or home remedies being used in combination with escitalopram.
- Ingestion of alcohol in combination with escitalopram is not recommended, although escitalopram does not seem to potentiate mental and motor impairments associated with alcohol.

Source: RX List available at <http://www.rxlist.com/cgi/generic/lexapro.htm>.**BOX 20.2****Drug Profile: Mirtazapine (Remeron)****DRUG CLASS:** Antidepressant**RECEPTOR AFFINITY:** Believed to enhance central noradrenergic and serotonergic activity antagonizing central presynaptic α_2 -adrenergic receptors. Mechanism of action unknown.**INDICATIONS:** Treatment of depression.**ROUTES AND DOSAGE:** Available as 15- and 30-mg tablets.**Adults:** Initially, 15 mg/d as a single dose preferably in the evening before sleeping. Maximum dosage is 45 mg/d.**Geriatric:** Use with caution; reduced dosage may be needed.**Children:** Safety and efficacy not established.**HALF-LIFE (PEAK EFFECT):** 20–40 h (2 h)**SELECTED ADVERSE REACTIONS:** Somnolence, increased appetite, dizziness, weight gain, elevated cholesterol/triglyceride and transaminase levels, malaise, abdominal pain, hypertension, vasodilation, vomiting, anorexia, thirst, myasthenia, arthralgia, hypoesthesia, apathy, depression, vertigo, twitching, agitation, anxiety, amnesia, increased cough, sinusitis, pruritus, rash, urinary tract infection, mania (rare), agranulocytosis (rare).**BOXES WARNING:** Suicidality in children and adolescents.**WARNING:** Contraindicated in patients with known hypersensitivity. Use with caution in the elderly, patients who are breast-feeding, and those with impaired hepatic function. Avoid concomitant use with alcohol or diazepam, which can cause additive impairment of cognitive and motor skills.**SPECIFIC PATIENT/FAMILY EDUCATION:**

- Take the dose once a day in the evening before sleep.
 - Families and caregivers should be advised of the need for dose observation and communication with the prescriber
- Avoid driving or performing tasks requiring alertness.
- Notify prescriber before taking any OTC or other prescription drugs.
- Avoid alcohol or other CNS depressants.
- Notify prescriber if pregnancy is possible or planned.
- Monitor temperature and report any fever, lethargy, weakness, sore throat, malaise, or other "flu-like" symptoms.
- Maintain medical follow-up, including any appointments for blood counts and liver studies.

Table 20.2 Side Effects of Antidepressant Medications

Generic (Trade) Drug Name	Side Effects				
	Anticholinergic	Sedation	Orthostatic Hypotension	Gastrointestinal Distress	Weight Gain
<i>Tricyclics: Tertiary Amines</i>					
Amitriptyline (Elavil)	+4	+4	+2	0	+4
Clomipramine (Anafranil)	+3	+3	+2	+1	+4
Doxepin (Sinequan)	+2	+3	+2	0	+3
Imipramine (Tofranil)	+2	+2	+3	+1	+3
<i>Tricyclics: Secondary Amines</i>					
Amoxapine (Asendin)	+3	+2	+1	0	+1
Desipramine (Norpramin)	+1	+1	+1	0	+1
Nortriptyline (Aventyl, Pamelor)	+2	+2	+1	0	+1
<i>SSRIs</i>					
Fluoxetine (Prozac)	0/+1	0/+1	0/+1	+3	0
Sertraline (Zoloft)	0	0/+1	0	+3	0
Paroxetine (Paxil)	0	0/+1	0	+3	0
Fluvoxamine (Luvox)	0/+1	0/+1	0/+1	+3	0
Citalopram (Celexa)	0/+1	0/+1	0/+1	+3	0
Escitalopram (Lexapro)	0/+1	0/+1	0/+1	+3	0
<i>Atypical: Antidepressants</i>					
Venlafaxine (Effexor)	0	0	0	+3	0
Trazodone (Desyrel)	0	+1	+3	+1	+1
Nefazodone (Serzone)	0/+1	+1	+2	+2	0/+1
Bupropion (Wellbutrin)	+2	+2	+1	0	0/+1
Mirtazapine (Remeron)	+3	+4	+3	+3	+2

0 = absent or rare
 0/+1 = lowest likelihood
 +4 = highest likelihood

medications. See Chapter 8 for diet restrictions for those taking MAOIs. Low doses of selegiline (Emsam), 6 mg/24 hours, do not require diet restriction according to the package insert.

Baseline orthostatic vital signs should be obtained before initiation of any medication, and in the case of medications known to have an impact on vital signs, such as TCAs, MAOIs, or venlafaxine, they should be

monitored on a regular basis. If these medications are administered to children or elderly patients, the dosage should be lowered to accommodate the physiologic state of the individual.

Tools for monitoring medication effects are objective observations, vital signs, the patient's subjective reports, and the administration of rating scales over the course of treatment. Responsibilities include ensuring that

BOX 20.3

Guidelines: Monitoring and Administering Antidepressant Medications

Nurses should do the following in administering/monitoring antidepressant medications:

- Observe the patient for cheeking or saving medications for a later suicide attempt.
- Monitor vital signs: obtain baseline data, before the initiation of medications (such as orthostatic vital signs and temperature).
- Monitor periodically liver and thyroid function tests, blood chemistry, and complete blood count as appropriate and compare with baseline values.
- Monitor patient symptoms for therapeutic response and report inadequate response to prescriber.
- Monitor patient for side effects and report to the prescriber serious side effects or those that are chronic and problematic for the patient. (Table 20.3 indicates pharmacologic and nonpharmacologic interventions for common side effects.)
- Monitor drug levels as appropriate. (Therapeutic drug levels for antidepressants are listed in Chapter 8.)
- Monitor dietary intake as appropriate, especially with regard to MAOI antidepressants.
- Inquire about patient use of other medications, alcohol, "street" drugs, OTC medications, and/or herbal supplements that might alter the desired effects of prescribed antidepressants.

Table 20.3 Interventions to Relieve Side Effects of Antidepressants

Side Effect	Pharmacologic Intervention	Nonpharmacologic Intervention
Dry mouth, caries, inflammation of the mouth	Bethanechol 10–30 mg tid Pilocarpine drops	Sugarless gum Sugarless lozenges 6–8 cups water per day Toothpaste for dry mouth
Nausea, vomiting	Change medication	Take medication with food Soda crackers, toast, tea
Weight gain	Change medication	Nutritionally balanced diet Daily exercise
Urinary hesitation Constipation	Bethanechol 10–30 mg tid Stool softener	6–8 cups water per day Bulk laxative Daily exercise 6–8 cups water per day
Diarrhea Orthostatic hypotension	OTC antidiarrheal	Diet rich in fresh fruits, vegetables, and grains Maintain fluid intake Increase hydration Sit or stand up slowly
Drowsiness	Shift dosing time Lower medication dose Change medication	One caffeinated beverage at strategic time Do not drive when drowsy No alcohol or other recreational drugs Plan for rest time
Fatigue	Lower medication dose Change medication	Daily exercise
Blurred vision	Bethanechol 10–30 mg tid Pilocarpine eyedrops	Temporary use of magnifying lenses until body adjusts to medication
Flushing, sweating	Terazosin 1 mg qd Lower medication dose Change medication	Frequent bathing Lightweight clothing
Tremor	β -blockers Lower medication dose	Reassure patient that tremor may decrease as patient adjusts to medication. Notify caregiver if tremor interferes with daily functioning.

patients are receiving a therapeutic dosage (therapeutic blood levels for antidepressant medications are found in Chapter 8), assessing adherence to the medication regimen, and evaluating compliance.

Individualizing dosages is essential for achieving optimal efficacy. When the newer antidepressants are used, this is usually done by fine-tuning medication dosage based on patient feedback. The TCAs, including imipramine (Tofranil), desipramine (Norpramin), amitriptyline (Elavil), and nortriptyline (Pamelor), have standardized valid plasma levels that can be useful in determining therapeutic dosages, although therapeutic plasma levels may vary from individual to individual. Blood samples should be drawn as close as possible to 12 hours away from the last dose. The newer antidepressants do not have established standardized ranges, and optimal dosing is based on efficacy and tolerability.

Monitoring and Managing Side Effects

First-Generation Antidepressants: TCAs and MAOIs. The most common side effects associated with TCAs are the antihistaminic side effects (sedation and weight gain) and anticholinergic side effects (potentia-

tion of CNS drugs, blurred vision, dry mouth, constipation, urinary retention, sinus tachycardia, and decreased memory).

Emergency!



If possible, TCAs should not be prescribed for patients at risk for suicide. Lethal doses of TCAs are only three to five times the therapeutic dose, and more than 1 g of a TCA is often toxic and may be fatal. Death may result from cardiac arrhythmia, hypotension, or uncontrollable seizures.

Serum TCA levels should be evaluated when overdose is suspected. In acute overdose, almost all symptoms develop within 12 hours. Anticholinergic effects are prominent: dry mucous membranes, warm and dry skin, blurred vision, decreased bowel motility, and urinary retention. CNS suppression (ranging from drowsiness to coma) or an agitated delirium may occur. Basic overdose treatment includes induction of emesis, gastric lavage, and cardiorespiratory supportive care. The most common side effects of MAOIs are headache, drowsiness, dry mouth, constipation, blurred vision, and orthostatic hypotension.

Emergency!

If coadministered with food or other substances containing tyramine (e.g., aged cheese, beer, red wine), MAOIs can trigger a hypertensive crisis that may be life threatening. Symptoms include sudden, severe pounding or explosive headache in the back of the head or temples, racing pulse, flushing, stiff neck, chest pain, nausea and vomiting, and profuse sweating.

MAOIs are more lethal in overdose than are the newer antidepressants and thus should be prescribed with caution if the patient's suicide potential is elevated (see Chapter 8). An MAOI generally is given in divided doses to minimize side effects. These drugs are used cautiously in patients who are suicidal because of their relative lethality compared with the newer antidepressants.

Selected adverse effects of MAOIs include headache, drowsiness, dry mouth and throat, insomnia, nausea, agitation, dizziness, constipation, asthenia, blurred vision, weight loss, and postural hypotension. Although priapism was not reported during clinical trials, the MAOIs are structurally similar to trazodone, which has been associated with priapism (prolonged painful erection).

Second-generation Antidepressants: SSRIs and Other Antidepressants. Serotonin syndrome is a potentially serious side effect caused by drug-induced excess of intrasynaptic serotonin (5-hydroxytryptamine [5-HT]; see Chapter 8). First reported in the 1950s, it was relatively rare until the introduction of the SSRIs. Serotonin syndrome is most often reported in patients taking two or more medications that increase CNS serotonin levels by different mechanisms (Nolan & Scoggin, 2001). The most common drug combinations associated with serotonin syndrome involve the MAOIs, the SSRIs, and the TCAs. Although serotonin syndrome can cause death, it is mild in most patients, who usually recover with supportive care alone. Unlike neuroleptic malignant syndrome, which develops within 3 to 9 days after the introduction of neuroleptic medications (see Chapter 18), serotonin syndrome tends to develop within hours or days after initiating or increasing the dose of serotonergic medication or adding a drug with serotomimetic properties. The symptoms include altered mental status, autonomic dysfunction, and neuromuscular abnormalities. At least three of the following must be present for a diagnosis: mental status changes, agitation, myoclonus, hyperreflexia, fever, shivering, diaphoresis, ataxia, and diarrhea. In patients who also have peripheral vascular disease or atherosclerosis, severe vasospasm and hypertension may occur in the presence of elevated serotonin levels. In addition, in a patient who is a slow metabolizer of SSRIs, higher-than-normal levels of these antidepressants may

circulate in the blood. Medications that are not usually considered serotonergic, such as dextromethorphan (Pertussin) and meperidine (Demerol), have been associated with the syndrome (Bernard & Bruera, 2000).

Emergency!

The most important emergency interventions are stopping use of the offending drug, notifying the physician, and providing necessary supportive care (e.g., intravenous fluids, antipyretics, cooling blanket). Severe symptoms have been successfully treated with anti-serotonergic agents, such as cyproheptadine (Sorenson, 2002).

Monitoring for Drug Interactions

Although SSRIs and newer atypical antidepressants produce fewer and generally milder side effects, which improves patient tolerability and compliance, there are some side effects to note. Among the most common are

- insomnia and activation
- headaches
- gastrointestinal symptoms
- weight gain

Sexual side effects, primarily diminished interest and performance, are also reported with some SSRIs, particularly sertraline. The most potentially harmful, but preventable, side effect or interaction of SSRIs is serotonin syndrome (Box 20.4).

BOX 20.4**Emergency: Serotonin Syndrome**

CAUSE: Excessive intrasynaptic serotonin

HOW IT HAPPENS: Combining medications that increase CNS serotonin levels, such as SSRIs + MAOIs; SSRIs + St. John's wort; or SSRIs + diet pills; dextromethorphan or alcohol, especially red wine; or SSRI + street drugs, such as LSD, MDMA, or Ecstasy.

SYMPTOMS: Mental status changes, agitation, ataxia, myoclonus, hyperreflexia, fever, shivering, diaphoresis, diarrhea

TREATMENT: Assess all medication, supplements, foods, and recreational drugs ingested to determine the offending substances.

Discontinue any substances that may be causative factors. If symptoms are mild, treat supportively on outpatient basis with propranolol and lorazepam and follow-up with prescriber.

If symptoms are moderate to severe, hospitalization may be needed with monitoring of vital signs and treatment with intravenous fluids, antipyretics, and cooling blankets.

FURTHER USE: Assess on a case-by-case basis and minimize risk factors for further medication therapy.

The atypical antidepressant nefazodone (once a more popular medication) has been shown to raise hepatic enzyme levels in some patients, potentially leading to hepatic failure. Trazodone administration has been associated with erectile dysfunction and priapism. Bupropion can cause seizures, particularly in patients at risk for seizures. Bupropion has also been associated with the development of psychosis because it is dopaminergic, and its use should be avoided in patients with schizophrenia. Venlafaxine can cause blood pressure to increase, although this side effect appears to be dose related and can be controlled by lowering the dose (APA, 2002).

Potential drug interactions associated with agents that are metabolized by the cytochrome P-450 systems should be considered when children or elderly patients are treated (see Chapter 7). Five of the most important enzyme systems are 1A2, 2D6, 2C9, 2C19, and 3A4. The 1A2 system is inhibited by the SSRI fluvoxamine. Thus, other drugs that use the 1A2 system will no longer be metabolized as efficiently. For example, if fluvoxamine is given with theophylline, the theophylline dosage must be lowered, or else blood levels of theophylline will rise and cause possible side effects or toxic reactions, such as seizures. Fluvoxamine also affects the metabolism of atypical antipsychotics. On the other hand, smoking and caffeine can induce 1A2 system activity. This means that smokers may need to be given a higher dose of medications that are metabolized by this system (Stahl, 2006).

Fluoxetine (Prozac) and paroxetine (Paxil) are potent inhibitors of 2D6. One of the most significant drug

interactions is caused by SSRI inhibition of 2D6 that in turn causes an increase in plasma levels of TCAs. If there is concomitant administration of an SSRI and a TCA, the plasma drug level of TCA should be monitored and probably reduced. In the 3A4 system, some SSRIs (fluoxetine, fluvoxamine, and nefazodone) will raise the levels of alprazolam (Xanax) or triazolam (Halcion) through enzyme inhibition, requiring reduction of dosage of the benzodiazepine. For more information see Table 20.4.

Teaching Points



If depression goes untreated or is inadequately treated, episodes can become more frequent, more severe, longer in duration, and can lead to suicide. Patient education involves explaining this pattern and the importance of continuing medication use after the acute phase of treatment to decrease the risk for future episodes. Patient concerns regarding long-term antidepressant therapy need to be assessed and addressed. All teaching points need to be developed and delivered using a culturally competent approach in order to enhance adherence within patients (U.S. DHHS, 2001; Warren, 2002).

Even after the first episode of major depression, medication should be continued for at least 6 months to 1 year after the patient achieves complete remission of symptoms. If the patient experiences a recurrence after tapering the first course of treatment, the regimen should be reinstated for at least another year, and if the illness reoccurs, medication should be continued indefinitely (Schatzberg et al., 2003).

Table 20.4 Drug-Drug Interactions: Antidepressants

Antidepressant	Other Drug	Effect of Interaction/Treatment
Fluvoxamine	Theophylline	Increased theophylline level: seizures. Tx: Reduce theophylline levels when administering with fluvoxamine.
Fluoxetine, Paroxetine	TCAs Benzodiazepines Phenothiazines	Increased in plasma levels of TCA. Tx: Reduce TCA levels when giving with fluoxetine or paroxetine.
Fluoxetine, Fluvoxamine, Nefazodone	Alprazolam Benzodiazepines	Increased plasma levels of alprazolam. Tx: Reduce dose of alprazolam when administered with benzodiazepines.
Triazolam Nefazodone	Digoxin Benzodiazepines Antihistamines	Increased levels of digoxin, antihistamines, and benzodiazepines. Tx: Reduce dose of nefazodone when giving with these medications.
Fluvoxamine	Caffeine Nicotine	Lowered levels of fluvoxamine. Tx: Increase dose of fluvoxamine in smokers or patients whose coffee, tea, or caffeinated drink intake is high.
SSRIs	Warfarin	Increased prothrombin time, bleeding. Tx: Monitor closely, decrease dose of warfarin if giving with SSRIs.
SSRIs	Lithium TCAs Barbiturates	Increased CNS effects of SSRIs. Tx: Adjust dosage of SSRI.
SSRIs	Phenytoin	Increased serum levels of phenytoin. Tx: Adjust dosage of phenytoin.

Source: Stahl, 2006.

Teaching Points



Patients should be advised not to take the herbal substance St. John's wort if they are also taking prescribed antidepressants. St. John's wort also should not be taken if the patient is taking nasal decongestants, hay fever and asthma medications containing monoamines, amino acid supplements containing phenylalanine, or tyrosine. The combination may cause hypertension.

Other Somatic Therapies

Electroconvulsive Therapy Although its therapeutic mechanism of action is unknown, electroconvulsive therapy (ECT) is an effective treatment for severe depression. It is generally reserved for patients whose disorder is refractory or intolerant to initial drug treatments and who are so severely ill that rapid treatment is required (e.g., patients with malnutrition, catatonia, or suicidality).

ECT is contraindicated for patients with increased intracranial pressure. Other high-risk patients include those with recent myocardial infarction, recent cerebrovascular accident, retinal detachment, or pheochromocytoma (tumor on the adrenal cortex or other tumors) and those at risk for complications of anesthesia. Older age has been associated with a favorable response to ECT. Because depression can increase mortality risk for the elderly, in particular, and some elderly patients do not respond well to medication, effective treatment is especially important for this age group (Blazer, Hybels, & Pieper, 2001).

Interventions for the Patient Undergoing ECT The American Nurses Association (2000) defines the role of the nurse in the care of the patient undergoing ECT to include providing educational and emotional support for the patient and family, assessing baseline or pre-treatment level of function, preparing the patient for the ECT process, and monitoring and evaluating the patient's response to ECT, sharing it with the ECT team, and modifying treatment as needed (see Chapter 8 for more information). The actual procedure, possible therapeutic mechanisms of action, potential adverse effects, contraindications, and nursing interventions are described in detail in Chapter 8.

Light Therapy (Phototherapy) Light therapy is described in Chapter 8. Given current research, light therapy is an option for well-documented mild to moderate seasonal, nonpsychotic, winter depressive episodes in patients with recurrent major depressive or bipolar II disorders, including children and adolescents (Glod & Baisden, 1999; Zahourek, 2000). There is also evidence that light therapy can modestly improve symptoms in nonseasonal depression, especially when administered during the first week of treatment, in the morning, for

those experiencing sleep deprivation (Tuunainen, Kripke, & Endo, 2004).

Psychological Domain

Assessment

The mental status examination is an effective clinical tool to evaluate the psychological aspects of major depression because the focus is on disturbances of mood and affect, thought processes and content, cognition, memory, and attention. The comprehensive mental status examination is described in detail in Chapter 10.

Mood and Affect

The person with depression has a sustained period of feeling depressed, sad, or hopeless and may experience anhedonia (loss of interest or pleasure). The patient may report "not caring anymore" or not feeling any enjoyment in activities that were previously considered pleasurable. In some individuals, this may include decrease in or loss of libido (sexual interest or desire) and sexual function. Depressed mood may be severe enough to provoke thoughts of suicide.

Numerous assessment scales are available for assessing depression. Easily administered self-report questionnaires can be valuable detection tools. These questionnaires cannot be the sole basis for making a diagnosis of major depressive episode, but they are sensitive to depressive symptoms. The following are five commonly used self-report scales:

- General Health Questionnaire (GHQ)
- Center for Epidemiological Studies Depression Scale (CES-D)
- Beck Depression Inventory (BDI)
- Zung Self-Rating Depression Scale (SDS)
- PRIME-MD

Clinician-completed rating scales may be more sensitive to improvement in the course of treatment, assess symptoms in relationship to the *DSM-IV-TR* depressive criteria, and may have a slightly greater specificity than do self-report questionnaires in detecting depression. These include the following:

- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery-Asberg Depression Rating Scale (MADRS)
- National Institute of Mental Health Diagnostic Interview Schedule (DIS)

Thought Content

Depressed individuals often have an unrealistic negative evaluation of their worth or have guilty preoccupations or ruminations about minor past failings. Such individuals often misinterpret neutral or trivial day-to-day

events as evidence of personal defects, and they have an exaggerated sense of responsibility for untoward events. As a result they feel hopeless, helpless, worthless, and powerless. The possibility of disorganized thought processes (e.g., tangential or circumstantial thinking) and perceptual disturbances (e.g., hallucinations, delusions) should also be included in the assessment.

Suicidal Behavior

Patients with major depression are at increased risk for suicide. Suicide risk should be assessed initially and throughout the course of treatment. Suicidal ideation includes thoughts that range from a belief that others would be better off if the person were dead or thoughts of death (passive suicidal ideation) to actual specific plans for committing suicide (active suicidal ideation). The frequency, intensity, and lethality of these thoughts can vary and can help to determine the seriousness of intent. The more specific the plan and the more accessible the means, the more serious is the intent. Risk factors that must be carefully considered are the availability and adequacy of social supports, past history of suicidal ideation or behavior, presence of psychosis or substance abuse, and decreased ability to control suicidal impulses.

Cognition and Memory

Many individuals with depression report impaired ability to think, concentrate, or make decisions. They may appear easily distracted or complain of memory difficulties. In older adults with major depression, memory difficulties may be the chief complaint and may be mistaken for early signs of a dementia (pseudodementia) (APA, 2000). When the depression is fully treated, the memory problem often improves or fully resolves.

Nursing Diagnoses for the Psychological Domain

Nursing diagnoses focusing on the psychological domain for the patient with a depressive disorder are numerous. If patient data lead to the diagnosis of Risk for Suicide, the patient should be further assessed for plan, intent, and accessibility of means. Other nursing diagnoses include Hopelessness, Low Self-Esteem, Ineffective Individual Coping, Decisional Conflict, Spiritual Distress, and Dysfunctional Grieving.

Interventions for the Psychological Domain

Although pharmacotherapy is usually the primary treatment method for major depression, patients also can benefit from psychosocial and psychoeducational treatments. The most commonly used therapies are

described. For patients with severe or recurrent major depressive disorder, the combination of psychotherapy (including interpersonal therapy, cognitive behavioral therapy, behavior therapy, or brief dynamic therapy) and pharmacotherapy has been found to be superior to treatment with a single modality. Adding a course of cognitive behavioral therapy may be an effective strategy for preventing relapse in patients who have had only a partial response to pharmacotherapy alone (APA, 2000). Clinical practice guidelines suggest that the combination of medication and psychotherapy may be particularly useful in more complex situations (e.g., depression in the context of concurrent, chronic general-medical or other psychiatric disorders, or in patients who fail to experience complete response to either treatment alone). Recent studies suggest that short-term cognitive and interpersonal therapies may be as effective as pharmacotherapy in milder depressions. Psychotherapy in combination with medication may also be used to address collateral issues, such as medication adherence or secondary psychosocial problems (Casacalenda, Perry, & Looper, 2002).

• NCLEXNOTE

A cognitive therapy approach is recommended for helping persons restructure the negative thinking processes related to a person's concept of self, others, and the future. This approach should be included in most nursing care plans for patients with depression.

Therapeutic Relationship

One of the most effective therapeutic tools for treating any psychiatric disorder is the therapeutic alliance, a helpful and trusting relationship between clinician and patient. The alliance is built from a number of activities, including the following:

- Establishment and maintenance of a supportive relationship
- Availability in times of crisis
- Vigilance regarding dangerousness to self and others
- Education about the illness and treatment goals
- Encouragement and feedback concerning progress
- Guidance regarding the patient's interactions with the personal and work environment
- Realistic goal setting and monitoring

Interacting with depressed individuals is challenging because they tend to be withdrawn and have difficulty expressing feelings and engaging in interpersonal interactions. The therapeutic alliance may be enhanced through the use of cognitive therapy as well as the nurse's ability to win the patient's trust through the use of culturally competent strategies in the context of empathy (see Box 20.5).

BOX 20.5*Therapeutic Dialogue: Approaching the Depressed Patient*

George Sadder is a 70-year-old retired businessman who has been admitted to a day treatment program because of complaints of stomach pains, insomnia, and hopelessness. He has withdrawn from social activities he previously enjoyed, such as golfing and going out to eat with his wife and friends. This morning he sits in a chair by himself, rather than joining a group activity.

Ineffective Approach

Nurse: "Hi, Mr. Sadder. My name is Sally. How are you feeling today?"

Mr. S: "Lousy, just lousy! I didn't sleep well last night, and my stomach is killing me!"

Nurse: "Oh, that is too bad! Have you had any breakfast?"

Mr. S: "No! Didn't I say that my stomach is killing me?"

Nurse: "Maybe eating breakfast would help your stomach pain."

Mr. S: "You don't know anything about my pain!" (Gets up and walks away.)

Effective Approach

Nurse: "Hi. My name is Sally."

Mr. S: "Hello, Sally. My name is George Sadder."

Nurse: "I'd like to sit down with you, if that is OK."

Mr. S: "If you want, but I am not much of a talker."

Nurse: "That's OK. We can talk or not, whatever you wish."

Mr. S: (Patient winces)

Nurse: "You just winced. Are you in pain?"

Mr. S: "Yes, my stomach has been killing me lately."

Nurse: "What do you usually do to ease the pain?"

Mr. S: "I usually take an antacid with my meals but forgot this morning."

Nurse: "I'll see if I can get some for you now."

Mr. S: "Thanks. When my stomach settles down, maybe we can talk."

Nurse: "That would be fine. I'll check back with you in a few minutes."

Critical Thinking Challenge

- What ineffective techniques did the nurse use in the first scenario and how did they impair communication?
- What effective techniques did the nurse use in the second scenario and how did they facilitate communication?

• NCLEXNOTE

Establishing the patient–nurse relationship with a person who is depressed requires an empathic, quiet approach that is grounded in the nurse's understanding of the cultural needs of the patient.

Cognitive Therapy

Cognitive therapy has been successful in reducing depressive symptoms during the acute phase of major depression (APA, 2002) (see Chapter 11). This therapy uses techniques, such as thought stopping and positive self-talk, to dispel irrational beliefs and distorted attitudes. In one study, remission rates after cognitive therapy were comparable to those after pharmacotherapy (Casacalenda et al., 2002). The use of cognitive therapy in the acute phase of treatment combined with medication has grown in the past few years and now may be considered as first-line treatment for mildly to moderately depressed outpatients.

Behavior Therapy

Behavior therapy has been effective in the acute treatment of patients with mild to moderately severe depression, especially when combined with pharmacotherapy. Therapeutic techniques include activity scheduling, self-control therapy, social skills training, and problem solving. The efficacy of behavior therapy in the continuation and maintenance phase of depression has not been subjected to controlled studies

(APA, 2002). Behavior therapy techniques are described in Chapter 10.

Interpersonal Therapy

Interpersonal therapy seeks to recognize, explore, and resolve the interpersonal losses, role confusion and transitions, social isolation, and deficits in social skills that may precipitate depressive states (APA, 2002). It maintains that losses must be mourned and related affects appreciated, that role confusion and transitions must be recognized and resolved, and that social skills deficits must be overcome to acquire social supports. Some evidence in controlled studies suggests that interpersonal therapy is more effective in reducing depressive symptoms with certain populations, such as depressed patients with human immunodeficiency virus infection, and less successful with patients who have personality disorders (APA, 2002) (see Chapter 22).

Family and Marital Therapy

Patients who perceive high family stress are at risk for greater future severity of illness, higher use of health services, and higher health care expense. Marital and family problems are common among patients with mood disorders; comprehensive treatment requires that these problems be assessed and addressed. They may be a consequence of the major depression but may also predispose persons to develop depressive symptoms and/or inhibit recovery and resilience processes. Research suggests that marital and family therapy may

reduce depressive symptoms and the risk for relapse in patients with marital and family problems (Thase, 2000). The depressed spouse's depression has marked impact on the marital adjustment of the nondepressed spouse. It is recommended that treatment approaches be designed to help couples be supportive of each other, to adapt, and to cope with the depressive symptoms within the framework of their ongoing marital relations (Mead, 2002). Many family nursing interventions (discussed in detail in Chapter 13) may be used by the psychiatric nurse in providing targeted family-centered care. These include:

- Monitoring patient and family for indicators of stress.
- Teaching stress management techniques.
- Counseling family members on coping skills for their own use.
- Providing necessary knowledge of options and support services.
- Facilitating family routines and rituals.
- Assisting family to resolve feelings of guilt.
- Assisting family with conflict resolution.
- Identifying family strengths and resources with family members.
- Facilitating communication among family members.

Group Therapy

The role of group therapy in treating depression is based on clinical experience, rather than on systematic controlled studies. It may be particularly useful for depression associated with bereavement or chronic medical illness. Individuals may benefit from the example of others who have dealt successfully with similar losses or challenges. Survivors can gain self-esteem as successful role models for new group members. Medication support groups can provide information to the patient and to family members regarding prognosis and medication issues, thereby providing a psychoeducational forum.

Teaching Patients and Families



Patients with depression and their significant others often incorrectly believe that their illness is their own fault and that they should be able to “pull themselves up by their boot straps and snap out of it.” Persons from some cultural groups believe that the symptoms of depression may be a result of someone placing a hex on the affected person because the person has done something evil (Warren, in press). It is vital to be culturally competent to be effective in teaching patients and their families about the treatment modalities for depression.

Patients need to know the full range of suitable treatment options before consenting to participate in treat-

BOX 20.6

Psychoeducation Checklist: Major Depressive Disorder

When caring for the patient with a major depressive disorder, be sure to include the following topic areas in the teaching plan:

- Psychopharmacologic agents, including drug action, dosing frequency, and possible adverse effects
- Risk factors for recurrence, signs of recurrence
- Adherence to therapy and treatment program
- Nutrition
- Sleep measures
- Self-care management
- Goal setting and problem solving
- Social interaction skills
- Follow-up appointments
- Community support services

ment. The nurse can provide opportunities for them to question, discuss, and explore their feelings about past, current, and planned use of medications and other treatments (ANA, 2000). Developing strategies to enhance adherence and to raise awareness of early signs of relapse can be important aids to increasing treatment efficacy (see Box 20.6).

Social Domain

Assessment

Social assessment focuses on the individual's developmental history, family psychiatric history, patterns of relationships, quality of support system, education, work history, and impact of physical or sexual abuse on interpersonal function (see Chapter 10). Including a family member or close friend in the assessment process can be helpful. Changes in patterns of relating (especially social withdrawal) and changes in level of occupational functioning are commonly reported and may represent a significant deterioration from baseline behavior. Increased use of “sick days” may occur. The family's level of support and understanding of the disorder also need to be assessed. For people who are depressed, special attention should be given to the individual's spiritual dimension and religious background (see Box 20.7).

Nursing Diagnoses for the Social Domain

Nursing diagnoses common for the social domain include Ineffective Family Coping, Ineffective Role Performance, Interrupted Family Processes, and Caregiver Role Strain (if the patient is also a caregiver).

BOX 20.7**Using Reflection: Assessment of Spiritual Distress**

Incident: A patient expresses extreme guilt over a childhood incident involving a teenage pregnancy that resulted in her child being anonymously adopted. The child is now an adult and is trying to contact her. She tells the nurse that she has committed an unforgivable sin.

Reflection: The nurse listened for several minutes and reflected on the meaning of the patient's statements and observed how distraught the patient appeared. The nurse then asked the patient if she would want to see the hospital chaplain for further clarification. The patient was greatly relieved and requested help from a chaplain.

Interventions for the Social Domain

Individuals experiencing depression have often withdrawn from daily activities, such as engaging in family activities, attending work, and participating in community activities. During hospitalization, patients often withdraw to their rooms and refuse to participate in unit activity. Nurses are challenged to help the patient balance the need for privacy with the need to return to normal social functioning. Depressed patients should never be approached in an overly enthusiastic manner; that approach will irritate them and block communication. On the other hand, patients should be encouraged to set realistic goals to reconnect with their families and communities. Explain to patients that attending social activities, even though they do not feel like it, will promote the recovery process and help patients achieve those goals.

Milieu Therapy

While hospitalized, milieu therapy (see Chapter 10) helps depressed patients maintain socialization skills and continue to interact with others. When depressed, people are often unaware of the environment and withdraw into themselves. On a psychiatric unit, depressed patients should be encouraged to attend and participate in unit activities. These individuals have a decreased energy level and thus may be moving more slowly than others; however, their efforts should be praised.

Safety. In many cases, patients are commonly admitted to the psychiatric hospital because of a suicide attempt. Suicidality should continually be evaluated, and the patient should be protected from self-harm (see Chapter 17). During the depths of depression, patients may not have the energy to complete a suicide. As patients begin to feel better and have increased energy, they may be at a greater risk for suicide. If a previously depressed patient appears to become energized overnight, he or she may have made a decision to commit suicide and

thus may be relieved that the decision is finally made. The nurse may misinterpret the mood improvement as a positive move toward recovery; however, this patient may be very intent on suicide. These individuals should be carefully monitored to maintain their safety.

Other Interventions

Nurses are exceptionally well positioned to engage patients and their families in the active process of improving daily functioning, increasing knowledge and skill acquisition, and increasing independent living. Consumer-oriented support groups can help to enhance the self-esteem and the support network of participating patients and their families. Advice, encouragement, and the sense of group camaraderie may make an important contribution to recovery (APA, 2000). Organizations providing support and information include the Depression and Bipolar Support Network (DBSA), National Alliance for the Mentally Ill (NAMI), and the Mental Health Association and Recovery, Inc. (a self-help group).

Interventions for Family Members 

The family needs education and support during and after the treatment of family members. Because major depressive disorder is a recurring disorder, the family needs information about specific antecedents to a family member's depression and what steps to take. For example, one patient may routinely become depressed during the fall of each year, with one of the first symptoms being excessive sleepiness. For another patient, a major loss, such as a child going to college or the death of a pet, may precipitate a depressive episode. Families of elderly patients need to be aware of the possibility of depression and related symptoms, often occurring after the deaths of friends and relatives. Families of children who are depressed often misinterpret depression as behavior problems.

 **MVIEWING GUIDES**

Evaluation and Treatment Outcomes

The major goals of treatment are to help the patient to be as independent as possible and to achieve stability, remission, and recovery from major depression. It is often a lifelong struggle for the individual. Ongoing evaluation of the patient's symptoms, functioning, and quality of life should be carefully documented in the patient's record in order to monitor outcomes of treatment.

Continuum of Care

Individuals with depressive disorders may initially present in inpatient and outpatient medical and primary

care settings, emergency rooms, and inpatient and outpatient mental health settings. Nurses should be able to recognize depression in these patients and make appropriate interventions or referrals. The continuum of care beyond these settings may include partial hospitalization or day treatment programs; individual, family, or group psychotherapy; home visits, and ethnopsychopharmacotherapy. Although most patients with major depression are treated in outpatient settings, brief hospitalization may be required if the patient is suicidal or psychotic.

Nurses working on inpatient units provide a wide range of direct services, including administering and monitoring medications and target symptoms, conducting psychoeducational groups, and more generally, structuring and maintaining a therapeutic environment. Nurses providing home care have an excellent opportunity to detect undiagnosed depressive disorders and make appropriate referrals.

Nursing practice requires a coordinated, ongoing interaction among patients, families, and providers to deliver comprehensive services. This includes using the complementary skills of both psychiatric and medical care colleagues for forming overall goals, plans, and decisions and for providing continuity of care as needed (ANA, 2000). Collaborative care between the primary care provider and mental health specialist is also key to achieving remission of symptoms and physical well-being, restoring baseline occupational and psychosocial functioning, and reducing the likelihood of relapse or recurrence (Fig. 20.1).

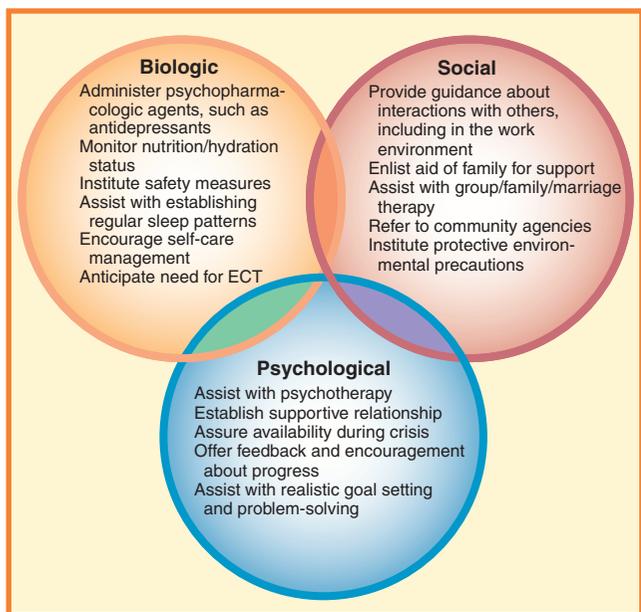


FIGURE 20.1. Biopsychosocial interventions for patients with major depressive disorder (ECT, electroconvulsive therapy).

BIPOLAR DISORDERS (MANIC-DEPRESSIVE DISORDERS)

Diagnostic Criteria

Bipolar disorder is distinguished from depressive disorders by the occurrence of manic or hypomanic (i.e., mildly manic) episodes in addition to depressive episodes. The *DSM-IV-TR* divides bipolar disorders into three major groups: bipolar I (periods of major depressive, manic, or mixed episodes); bipolar II (periods of major depression and hypomania); and **cyclothymic disorder** (periods of hypomanic episodes and depressive episodes that do not meet full criteria for a major depressive episode) (Table 20.5). These are described later. The specifiers describe either the most recent mood episode or the course of recurrent episodes; for example, “bipolar disorder I, most recent episode manic, severe with psychotic features.”



KEY CONCEPT Mania is primarily characterized by an abnormally and persistently elevated, expansive, or irritable mood for a duration of at least 1 week (or less, if hospitalized).

A **manic episode** is a distinct period (of at least 1 week, or less, if hospitalized) during which there is an abnormally and persistently elevated, expansive, or irritable mood (APA, 2000). Elevated mood is characterized as **euphoria** (exaggerated feelings of well-being) or elation, during which the person may describe feeling “high,” “ecstatic,” “on top of the world,” or “up in the clouds.” **Expansive mood** is characterized by inappropriate lack of restraint in expressing one’s feelings and frequently overvaluing one’s own importance. Expansive qualities include an unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. Manic episodes can also consist of irritable mood, in which the person is easily annoyed and provoked to anger, particularly when the person’s wishes are challenged or thwarted. In addition, manic episodes can consist of alterations between euphoria and irritability (**lability of mood**). To meet full *DSM-IV-TR* criteria, three (or four if the mood is irritable) of seven additional symptoms must be present: inflated self-esteem or grandiosity; decreased need for sleep; being more talkative or having pressured speech; flight of ideas or racing thoughts; distractibility; increase in goal-directed activity or psychomotor agitation; and excessive involvement in pleasurable activities that have a high potential for painful consequences. The disturbance must be severe enough to cause marked impairment in social activities, occupational functioning, and interpersonal relationships or to require hospitalization to prevent self-harm.

During a manic episode, decreased need to sleep is accompanied by increased energy and hyperactivity. The individual often remains awake for long periods at night

Table 20.5


Key Diagnostic Characteristics of Bipolar I Disorder 296.xx

- 296.0x—Bipolar I, single manic episode
- 296.40—Bipolar I, most recent episode hypomanic
- 296.4x—Bipolar I, most recent episode manic
- 296.6x—Bipolar I, most recent episode mixed
- 296.5x—Bipolar I, most recent episode depressed
- 296.7—Bipolar I, most recent episode unspecified


Diagnostic Criteria and Target Symptoms

- Presence of one or more manic episodes or mixed episodes, including one or more major depressive episodes

Manic episode

- Abnormally and persistently elevated, expansive, or irritable mood for at least 1 week
- Persistence of inflated self-esteem and grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas or racing thoughts
- Distractibility
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities with high potential for painful results (such as unrestrained buying sprees, foolish business investments)
- Marked impairment in occupational functioning or in usual social activities or relationships; possible hospitalization to prevent harm; psychotic features

Major depressive episode (symptoms appear nearly every day)

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all or most all activities for most of the day
- Significant weight loss when not dieting; weight gain or increase or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to concentrate or indecisiveness
- Recurrent thoughts of death, suicidal ideation without a specific plan, suicide attempt or specific plan for committing suicide
- Not bereavement
- Clinically significant distress or impairment in social, occupational, or other important areas of functioning

Mixed episode

- Criteria for both manic and major depressive episodes nearly every day for at least 1 week
- Hospitalization to prevent harm; psychotic features

Hypomanic episode

- Distinct period of persistently elevated, expansive, or irritable mood through at least 4 days
- Clearly different from usual nondepressed mood
- Same symptoms as that for manic episode but does not cause impairment in social or occupational functioning or necessitate hospitalization

Associated Findings
Associated Behavioral Findings
Manic episode

- Resistive to efforts for treatment
- Disorganized or bizarre behavior
- Change in dress or appearance
- Possible gambling and antisocial behavior

Major depressive episode

- Tearfulness, irritability
- Obsessive rumination
- Anxiety
- Phobia
- Excessive worry over physical symptoms
- Complaints of pain
- Possible panic attacks
- Difficulty with intimate relationships
- Marital, occupational, or academic problems
- Substance abuse
- Increased use of medical services
- Attempted or complete suicide attempts

Mixed episode

- Similar to those for manic and depressive episodes

Hypomanic episodes

- Sudden onset with rapid escalation within 1–2 d
- Possibly precede or are followed by major depressive episode

Associated Physical Examination Findings
Manic episode

- Mean age of onset for first manic episode after age 21–30 yrs
- Possible child abuse, spouse abuse, or other violent behavior during severe manic episodes
- Associated problems involving school truancy, school failure, occupational failure, divorce, or episodic antisocial behavior

(Continued on following page)

<p>Table 20.5</p> 	<p>Key Diagnostic Characteristics of Bipolar I Disorder 296.xx</p> <p>296.0x—Bipolar I, single manic episode 296.40—Bipolar I, most recent episode hypomanic 296.4x—Bipolar I, most recent episode manic 296.6x—Bipolar I, most recent episode mixed 296.5x—Bipolar I, most recent episode depressed 296.7—Bipolar I, most recent episode unspecified (Continued)</p> 	
Diagnostic Criteria and Target Symptoms	Associated Findings	
<ul style="list-style-type: none"> • Unequivocal change in function, uncharacteristic of person when asymptomatic • Change observable by others • Not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization; no psychotic features • Episode not better accounted for by other disorders such as schizoaffective disorder and not superimposed on schizophrenia, schizophreniform, delusional, or psychotic disorders • Not a direct physiologic effect of substance or other medical condition 	<p>Associated Laboratory Findings</p> <p>Manic episodes</p> <ul style="list-style-type: none"> • Polysomnographic abnormalities • Increased cortisol secretion • Absence of dexamethasone nonsuppression • Possible abnormalities with norepinephrine, serotonin, acetylcholine, dopamine, or GABA neurotransmitter <p>Major depressive episode</p> <ul style="list-style-type: none"> • Sleep electroencephalogram abnormalities • Possible abnormalities with norepinephrine, serotonin, acetylcholine, dopamine, or GABA neurotransmitter systems 	

or wakes up several times full of energy. Increased motor activity and agitation, which may be purposeful at first (e.g., cleaning the house), may deteriorate into inappropriate or disorganized actions. The individual may get involved unrealistically in several new endeavors that may entail overspending or sexual encounters or drug or alcohol use, or high-risk activities such as driving too fast or taking up dangerous sports (see Box 20.8). The individual becomes overly talkative, feels pressured to continue talking, and at times is difficult to interrupt. Thoughts become disorganized and skip rapidly among topics that often have little relationship to each other. This decreased logical connection between thoughts is termed *flight of ideas*. Patients with mania have inflated self-esteem, which may range from unusual self-confidence to grandiose delusions. Other psychiatric disorders can have symptoms that mimic a manic episode. Schizophrenia, schizoaffective disorder, anxiety disorders, some personality disorders (borderline personality disorder and histrionic personality disorder), substance abuse involving stimulants, and adolescent conduct disorders should be ruled out when making a diagnosis of mania. The *DSM-IV-TR* criteria for a **mixed episode** are met when the criteria for both a manic episode and a major depressive episode are met and are present for at least 1 week. Individuals who are having a mixed episode usually exhibit high anxiety, agitation, and irritability. The criteria for a **hypomanic episode** are the same as for a manic episode, except that the time criterion is at least 4 days, rather than 1 week, and no marked impairment in social or occupational functioning is present.

The *DSM-IV-TR* criteria for cyclothymic disorder are the presence for at least 2 years of numerous periods

with hypomanic symptoms and numerous periods with depressive symptoms that do not meet full criteria for a major depressive episode.

M^UVIE viewing GUIDES

Secondary Mania

Mania can be caused by medical disorders or their treatments or by certain substances of abuse (e.g., certain metabolic abnormalities, neurologic disorders, CNS tumors, and medications) (Strakowski & Sax, 2000).

Rapid Cycling Specifier

Rapid cycling can occur in both bipolar I and bipolar II disorders. In its most severe form, rapid cycling includes

BOX 20.8

Clinical Vignette: The Manic Patient

Mr. Bell was a day trader on the stock market. Initially he was quite successful and, as a result, upgraded his lifestyle with a more expensive car, a larger, more luxurious house, and a boat. When the stock market declined dramatically, Mr. Bell continued to trade, saying that if he could just find the “right” stock he could earn back all of the money he had lost. He spent his days and nights in front of his computer screen, taking little or no time to eat or sleep. He defaulted on his mortgage and car and boat payments and was talking nonstop to his wife. She brought him to the hospital for evaluation.

What Do You Think?

- What behavioral symptoms of mania does Mr. Bell exhibit?
- What cognitive symptoms of mania does Mr. Bell exhibit?

continuous cycling between subthreshold mania and depression or hypomania and depression (Suppes et al., 2001). The essential feature of rapid cycling is the occurrence of four or more mood episodes that meet criteria for manic, mixed, hypomanic, or depressive episode during the previous 12 months.

The *DSM-IV-TR* criteria for cyclothymic disorder are at least 2 years of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet full criteria for a major depressive episode.

Clinical Course

Bipolar disorder is a chronic, cyclic disorder. There is general agreement that later episodes of illness occur more frequently than earlier episodes, and increased frequency of episodes or more continuous symptoms have been reported in patients who experienced onset at an earlier age and who have a significant family history of illness. Some patients may have unpredictable and variable symptoms of the illness (Suppes et al., 2001). An additional feature of bipolar disorder is rapid cycling. Mixed states have been associated with increased suicidal ideation compared with pure mania (Maser et al., 2002). Bipolar disorder can lead to severe functional impairment as manifested by alienation from family, friends, and coworkers; indebtedness; job loss; divorce; and other problems of living (Rothbaum & Astin, 2000).

Bipolar Disorder In Special Populations

Children and Adolescents

Bipolar disorder in children has been recognized only recently. Although it is not well studied, depression usually appears first. Somewhat different than in adults, the hallmark of childhood bipolar disorder is intense rage. Children may display seemingly unprovoked rage episodes for as long as 2 to 3 hours. The symptoms of bipolar disorder reflect the developmental level of the child. Children younger than 9 years exhibit more irritability and emotional lability; older children exhibit more classic symptoms, such as euphoria and grandiosity. The first contact with the mental health system often occurs when the behavior becomes disruptive, possibly 5 to 10 years after its onset. These children often have other psychiatric disorders, such as attention deficit hyperactivity disorder and conduct disorder (Mohr, 2001) (see Chapter 29).

Elderly People

Geriatric patients with mania demonstrate more neurologic abnormalities and cognitive disturbances (confusion and disorientation) than do younger patients. It generally

was believed that the incidence of mania decreases with age because this population was thought to consist of only those individuals who had a diagnosis in younger years and managed to survive into old age. Recently, late-onset bipolar disorder was identified when researchers found evidence of an increased incidence of mania with age, especially in women after age 50 years and in men in the eighth and ninth decades. Late-onset bipolar disorder is more likely related to secondary mania and consequently has a poorer prognosis because of comorbid medical conditions (Kilbourne, 2005).

Epidemiology

Distribution and Age of Onset

Bipolar disorder has a lifetime prevalence of 0.4% to 1.6% in the general adult population (APA, 2000). Most patients with bipolar disorder experience significant symptoms before age 25 years (Suppes et al., 2001). The estimated mean age of onset is between 21 and 30 years. Nearly 20% of patients with bipolar disorder diagnosed demonstrated symptoms before the age of 19 years (Mohr, 2001). Estimates of the prevalence of mania in elderly psychiatric patients are as high as 19%, with prevalence in nursing home patients estimated at about 10% (McDonald, 2000).

Gender, Ethnic, and Cultural Differences

Although no significant gender differences have been found in the incidence of bipolar I and II diagnoses, gender differences have been reported in phenomenology, course, and treatment response. In addition, some data show that female patients with bipolar disorder are at greater risk for depression and rapid cycling than are male patients, whereas male patients are at greater risk for manic episodes (Grunze, Amann, Dittmann, & Walden, 2002; Yildiz & Sachs, 2003). No significant differences have been found based on race or ethnicity (APA, 2000).

Comorbidity

The two most common comorbid conditions are anxiety disorders (most prevalent: panic disorder and social phobia) and substance use (most commonly alcohol and marijuana). Individuals with a comorbid anxiety disorder are more likely to experience a more severe course. A history of substance use further complicates the course of illness and results in less chance for remission and poorer treatment compliance (Sajatovic, Blow, & Ignacio, 2006).

Etiology

Current theories of the etiology of mood disorders are associated with chronic abnormalities of neurotransmis-

sion, which are thought to result in compensatory but maladaptive changes in brain regulation. In addition, use of controlled structural and functional imaging studies of patients with mood disorders have generated hypotheses that dysfunction of the CNS is associated with specific structural brain abnormalities and functional CNS alterations (Sheline, 2003).

Chronobiologic Theories

Sleep disturbance is an important aspect of depression and mania. Sleep patterns appear to be regulated by an internal biologic clock center in the hypothalamus. Artificially induced sleep deprivation is known to precipitate mania in some patients with bipolar disorder (Grunze et al., 2002). Because a number of neurotransmitter and hormone levels follow circadian patterns, sleep disruption may lead to biochemical abnormalities that affect mood. Seasonal changes in light exposure also trigger affective episodes in some patients, typically depression in winter and hypomania in the summer in the northern hemisphere (Lewy, Lefler, Emens, & Bauer, 2006).

Sensitization and Kindling Theory

Sensitization (increase in response with repetition of the same dose of drug) and the related phenomenon of kindling (subthreshold stimulation of a neuron generates an action potential; see Chapter 7) refer to animal models. Repeated chemical or electrical stimulation of certain regions of the brain produces stereotypical behavioral responses or seizures. The amount of the chemical or electricity required to evoke the response or seizure decreases with each experience. These phenomena have been used as models to explain why, over time, affective episodes, particularly those seen in patients with bipolar

disorder, recur in shorter and shorter cycles and with less relation to environmental precipitants. It is hypothesized that repeated affective episodes might be accompanied by progressive alteration of brain synapses that lower the threshold for future episodes and increase the likelihood of illness. The kindling theory also helps explain the value of using antiseizure medication, such as carbamazepine and valproic acid, for mood stabilization.

Genetic Factors

First-degree biologic relatives of individuals with bipolar I disorder have elevated rates of bipolar I disorder (4% to 24%), bipolar II disorder (1% to 5%), and major depressive disorder (4% to 24%) (APA, 2000). Results from family, adoption, and twin studies indicate that bipolar disorder is highly heritable (McCuffin et al., 2003). Nevertheless, the mode of transmission and its genetic relationship to other mood disorders have not been definitively identified.

Psychological and Social Theories

Most psychological and social theories of mood disorders focus on loss as the cause of depression in genetically vulnerable individuals. Mania is considered to be a biologically rooted condition, but when viewed from a psychological perspective, mania is usually regarded as a condition that arises from an attempt to overcompensate for depressed feelings, rather than a disorder in its own right. It is now generally accepted that environmental conditions contribute to the timing of an episode of illness, rather than cause the illness (Johnson, Andersson-Lundman, Aberg-Wistedt, & Mathe, 2000).

Interdisciplinary Treatment of Disorders

Patients with bipolar disorder have a complex set of issues and likely will be treated by an interdisciplinary team. Nurses, physicians, social workers, psychologists, and activity therapists all have valuable expertise for patients with bipolar disorder. For children with bipolar disorder, school teachers and counselors are included in the team. For elderly patients, the primary care physician becomes part of the team. An important treatment goal is to minimize and prevent either manic or depressive episodes, which tend to accelerate over time. The fewer the episodes, the more likely the person can live a normal, productive life. Another important goal is to help the patient and family to learn about the disorder and manage it throughout a lifetime.

Priority Care Issues

During a manic episode, protection of the patient is a priority. It is during a manic episode that poor judgment and impulsivity result in risk-taking behaviors that can have

FAME AND FORTUNE

Virginia Woolf (1882–1941):
British Novelist

Public Persona

Virginia Woolf, an early feminist and accomplished novelist, came from a long line of writers with a history of mental illness on both sides of the family. Many believe that Virginia Woolf suffered from bipolar disorder. Unfortunately, there was little treatment in her time.

Personal Realities

She experienced mood swings most of her life and had her first mental breakdown at age 13 following her mother's death. She had several more episodes in which she heard voices and once threw herself out of a window. During periods of remission, Woolf was very creative and productive. During her last episode of illness, she committed suicide at the age of 59.

Source: Virginia Woolf, http://www.online-literature.com/virginia_woolf/

dire consequences for the patient and family. For example, one patient withdrew all the family money from the bank and gambled it away. Risk for suicide is always a possibility. During a depressive episode, the patient may feel that life is not worth living. During a manic episode, the patient may believe that he or she has supernatural powers, such as the ability to fly. As patients recover from a manic episode, they may be so devastated by the consequences of impulsive behavior and poor judgment during the episode that suicide seems like a reasonable option.

Family Response to Disorder

Bipolar disorder can devastate families, who often feel that they are on an emotional merry-go-round, particularly if they have difficulty understanding the mood shifts. A major problem for family members is dealing with the consequences of impulsive behavior during manic episodes, such as excessive debt, assault charges, and sexual infidelities.

NURSING MANAGEMENT: HUMAN RESPONSE TO BIPOLAR DISORDER

The nursing care of patients with bipolar disorder is one of the most interesting yet greatest challenges in psychiatric nursing. In general, the behavior of patients with bipolar disorder is normal between mood episodes. The ideal nursing care occurs during a period of time when the nurse can see the patient in the acute illness phase and in remission. Nursing care of bipolar depression should be approached in a manner similar to that used for major depressive disorder, as described previously.

Biologic Domain

Assessment

With regard to the biologic domain, the assessment emphasis is on evaluating symptoms of mania and, most particularly, changes in sleep patterns. The assessment should follow the guidelines in Chapter 10. In the manic phase of bipolar disorder, the patient may not sleep, resulting in irritability and physical exhaustion. Because eating habits usually change during a manic or depressive episode, the nurse should assess changes in diet and body weight. Because patients with mania may experience malnutrition and fluid imbalance, laboratory studies, such as thyroid function, should be completed. Abnormal thyroid functioning can be responsible for the mood and behavioral disturbances. During a manic phase, patients often become hypersexual and engage in risky sexual practices. Changes in sexual practices should be explored.

Pharmacologic Assessment

When a patient is in a manic state, the previous use of antidepressants should be assessed because a manic episode may be triggered by antidepressant use. In such cases, use of antidepressants should be discontinued. Many times, manic or depressive episodes occur after patients stop taking their mood stabilizer, at which time the reason for stopping the medication should be explored. Patients may stop taking their medications because of side effects or because they no longer believe they have a mental disorder. Special attention should also focus on the use of alcohol and other substances. Usually, a drug screen is ordered to determine current use of substances.

Nursing Diagnoses for Biologic Domain

Among nursing diagnoses in this domain are Insomnia; Sleep Deprivation; Imbalanced Nutrition; Hypothermia, Deficient Fluid Volume; and Noncompliance if patients have stopped taking their medication. If patients are in the depressive phase of illness, the previously discussed diagnoses for depression should be considered.

Interventions for Biologic Domain

Physical Care

In a state of mania, the patient's physical needs are rest, adequate hydration and nutrition, and re-establishment of physical well-being. Self-care has usually deteriorated. For a patient who is unable to sit long enough to eat, snacks and high-energy foods should be provided that can be eaten while moving. Alcohol should be avoided. Sleep hygiene is a priority but may not be realistic until medications take effect. Limiting stimuli can be helpful in decreasing agitation and promoting sleep.

• NCLEXNOTE

Protection of patients with mania is always a priority. Ongoing assessment should focus on irritability, fatigue, and potential for harming self or others.

Teaching Points

Once the patient's mood stabilizes, the nurse should focus on monitoring changes in physical functioning in sleep or eating behavior and teaching patients to identify antecedents to mood episodes. A regular sleep routine should be maintained if possible. High-risk times for manic episodes, such as changes in work schedule (day to night), should be avoided if possible. Patients should be taught to monitor the amount of their sleep each night and report decreases in sleep of more than 1 hour per night because this may be a precursor to a manic episode.

Intervention With Mood Stabilizers

Pharmacotherapy is essential in bipolar disorder to achieve two goals: rapid control of symptoms and prevention of future episodes or, at least, reduction in their severity and frequency. Pharmacotherapy continues through the various phases of bipolar disorder:

- **Acute phase.** The goal of treatment in the acute phase is symptom reduction and stabilization. Therefore, for the first few weeks of treatment, mood stabilizers may need to be combined with antipsychotics or benzodiazepines, particularly if the patient has psychotic symptoms, agitation, or insomnia. If the clinical situation is not an emergency, patients usually start on a low dose and gradually increase the dose until maximum therapeutic benefits are achieved. Once stabilization is achieved, the frequency of serum level monitoring should be every 1 to 2 weeks during the first 2 months and every 3 to 6 months during long-term maintenance. Medications most commonly used for mood stabilization in bipolar disorder are discussed here and in Chapter 8.
- **Continuation phase.** The treatment goal in this phase is to prevent relapse of the current episode or cycling into the opposite pole. It lasts about 2 to 9 months after acute symptoms resolve. The usual pharmacologic procedure in this phase is to continue the mood stabilizer while closely monitoring the patient for signs or symptoms of relapse.
- **Maintenance phase.** The goal of treating this phase is to sustain remission and to prevent new episodes. The great weight of evidence favors long-term prophylaxis against recurrence after effective treatment of acute episodes. It is recommended that long-term or lifetime prophylaxis with a mood stabilizer be instituted after two manic episodes or after one severe manic episode or if there is a family history of bipolar disorder.
- **Discontinuation.** Like the course of major depressive disorder, the course of bipolar disorder typically is recurrent and progressive. Therefore, the same issues and principles regarding the decision to continue or discontinue pharmacotherapy apply.

The mainstays of somatic therapy are the mood-stabilizing drugs. The three agents that show significant efficacy in controlled trials are lithium carbonate (Lithium), divalproex sodium (Depakote), and carbamazepine (Tegretol) (Table 20.6). Both lithium and divalproex sodium have U.S. Food and Drug Administration (FDA) approval for treating acute bipolar I mania, as do most of the atypical antipsychotics.

Lithium Carbonate Lithium is the most widely used mood stabilizer (see Box 20.9). Combined response rates from five studies demonstrate that 70% of patients experienced at least partial improvement with

Table 20.6 Mood Stabilizing Medications

Generic (Trade) Drug Name	Usual Dosage Range (daily)	Half-life (h)
Lithium (Eskalith, Lithane)	600–1,800 mg	17–36
Divalproex sodium (Depakote)	15–60 mg/kg	6–16
Carbamazepine (Tegretol)	200–1,200 mg	25–65
Olanzapine (Zyprexa)	5–20 mg	21–54
Risperidone (Risperdal)	1–6 mg	20

lithium therapy. However, for most patients, lithium is not a fully adequate treatment for all phases of the illness, and particularly during the acute phase, supplemental use of antipsychotics and benzodiazepines is often beneficial. During acute depressive episodes, supplemental use of antidepressants is most often indicated (Keck et al., 2000). Because of its significant side-effect burden (Table 20.7), lithium is poorly tolerated in at least one third of treated patients and has the narrowest gap between therapeutic and toxic concentrations of any routinely prescribed psychotropic agent (Belmaker & Yaroslavsky, 2000). Predictors of poor response to lithium in acute mania include a history of poor response, rapid cycling, dysphoric symptoms, mixed symptoms of depression and mania, psychiatric comorbidity, and medical comorbidity (Alda & Grof, 2000).

• NCLEXNOTE

Reviewing blood levels of lithium carbonate and divalproex sodium are ongoing nursing assessments for patients receiving these medications. Side effects of mood stabilizers vary.

Lithium is a salt, and the interaction between lithium levels and sodium levels in the body and the relationship between lithium levels and fluid volume in the body remain crucial issues in its safe, effective use. The higher the sodium levels are in the body, the lower the lithium level will be, and vice versa. Thus, changes in dietary sodium intake can affect lithium blood levels that, in turn, may affect therapeutic results or increase the incidence of side effects. The same applies to fluid volume. If body fluid decreases significantly because of a hot climate, strenuous exercise, vomiting, diarrhea, or drastic reduction in fluid intake, then lithium levels can rise sharply, causing an increase in side effects, progressing to lethal lithium toxicity. Persons from African descent may not therapeutically respond to lithium because they may develop toxic symptoms more rapidly than persons from other cultural groups due to their chemical sensitivity to salt and sodium pump irregular-

BOX 20.9**Drug Profile: Lithium (Eskalith)****DRUG CLASS:** Mood stabilizer**RECEPTOR AFFINITY:** Alters sodium transport in nerve and muscle cells, increases norepinephrine uptake and serotonin receptor sensitivity, slightly increases intraneuronal stores of catecholamines, delays some second messenger systems. Mechanism of action is unknown.**INDICATIONS:** Treatment and prevention of manic episodes in bipolar affective disorder.**ROUTES AND DOSAGE:** 150-, 300-, and 600-mg capsules. Lithobid, 300-mg slow-release tablets; Eskalith CR, 450-mg controlled-release tablets; Lithium citrate, 300-mg/5 mL liquid form.**Adult:** In acute mania, optimal response is usually 600 mg tid or 900 mg bid. Obtain serum levels twice weekly in acute phase. Maintenance: Use lowest possible dose to alleviate symptoms and maintain serum level of 0.6–1.2 mEq/L. In uncomplicated maintenance obtain serum levels every 2–3 months. Do not rely on serum levels alone. Monitor patient side effects.**Geriatric:** Increased risk for toxic effects, use lower doses, monitor frequently.**Children:** Safety and efficacy in children younger than 12 y has not been established.**HALF-LIFE (PEAK EFFECT):** mean, 24 h (peak serum levels in 1–4 h). Steady state reached in 5–7 d.**SELECT ADVERSE REACTIONS:** Weight gain.**WARNING:** Avoid use during pregnancy or while breastfeeding. Hepatic or renal impairments increase plasma concentration.**SPECIFIC PATIENT/FAMILY EDUCATION:**

- Avoid alcohol or other CNS depressant drugs.
- Notify prescriber if pregnancy is possible or planned. Do not breast-feed while taking this medication.
- Notify prescriber before taking any other prescription, OTC medication, or herbal supplements.
- May impair judgment, thinking, or motor skills; avoid driving or other hazardous tasks.
- Do not abruptly discontinue use.

ities (Herrera, Lawson, & Sramek, 1999); anticonvulsant agents may be more appropriate. However, the key is to start the dose low and increase slowly in order to maximize the therapeutic response and avoid overshooting the therapeutic window. See Table 20.8 for lithium interactions with other drugs. See Chapter 8 for further discussion of lithium's possible mechanisms of action, pharmacokinetics, side effects, and toxicity.

Emergency!

If symptoms of moderate or severe toxicity (e.g., cardiac arrhythmias, blackouts, tremors, seizures) are noted, withhold additional doses of lithium, immediately obtain a blood sample to analyze the lithium level,

Table 20.7 Lithium Blood Levels and Associated Side Effects

Plasma Level	Side Effects or Symptoms of Toxicity
<1.5 mEq/L Mild side effects	Metallic taste in mouth Fine hand tremor (resting) Nausea Polyuria Polydipsia Diarrhea or loose stools Muscular weakness or fatigue Weight gain Edema
1.5–2.5 mEq/L Moderate toxicity	Memory impairments Severe diarrhea Dry mouth Nausea and vomiting Mild to moderate ataxia Incoordination Dizziness, sluggishness, giddiness, vertigo Slurred speech Tinnitus Blurred vision Increasing tremor Muscle irritability or twitching Asymmetric deep tendon reflexes Increased muscle tone
>2.5 mEq/L Severe toxicity	Cardiac arrhythmias Blackouts Nystagmus Coarse tremor Fasciculations Visual or tactile hallucinations Oliguria, renal failure Peripheral vascular collapse Confusion Seizures Coma and death

and push fluids if the patient can take fluids. Contact the physician for further direction about relieving the symptoms. Mild side effects tend to subside or can be managed by nursing measures (see Table 20.9).

Divalproex sodium

Divalproex sodium (Depakote), an anticonvulsant, has a broader spectrum of efficacy and has about equal benefit for patients with pure mania as for those with other forms of bipolar disorder (i.e., mixed mania, rapid cycling, comorbid substance abuse, and secondary mania). Moreover, in one large placebo-controlled study, patients taking divalproex sodium experienced a longer period of stable mood than did patients taking lithium or placebo (Bowden et al., 2000). Whereas divalproex is usually initiated at 250 mg twice a day or lower, in the inpatient setting, it can be initiated in an oral loading dose using 20 to 30 mg/kg body weight (see Box 20.10). This may speed the reduction of manic symptoms and diminish the need for antipsychotics

Table 20.8 Lithium Interactions With Medications and Other Substances

Substance	Effect of Interaction
Angiotensin-converting enzyme inhibitors, such as: <ul style="list-style-type: none"> • Captopril • Lisinopril • Quinapril 	Increases serum lithium; may cause toxicity and impaired kidney function
Acetazolamide	Increases renal excretion of lithium, decreases lithium levels
Alcohol	May increase serum lithium level
Caffeine	Increases lithium excretion, increases lithium tremor
Carbamazepine	Increases neurotoxicity, despite normal serum levels and dosage
Fluoxetine	Increases serum lithium levels
Haloperidol	Increases neurotoxicity, despite normal serum levels and dosage
Loop diuretics, such as furosemide	Increases lithium serum levels, but may be safer than thiazide diuretics; potassium-sparing diuretics (amiloride, spirolac-tone) are safest
Methyldopa	Increases neurotoxicity without increasing serum lithium levels
Nonsteroidal antiinflammatory drugs, such as: <ul style="list-style-type: none"> • Diclofenac • Ibuprofen • Indomethacin • Piroxicam 	Increases serum lithium levels by 30%–60% in 3–10 d Aspirin and sulindac do not appear to have the same effect
Osmotic diuretics, such as: <ul style="list-style-type: none"> • Urea • Mannitol • Isosorbide 	Increases renal excretion of lithium and decreases lithium levels
Sodium chloride	High sodium intake decreases lithium levels; low sodium diets may increase lithium levels and lead to toxicity
Thiazide diuretics, such as: <ul style="list-style-type: none"> • Chlorothiazide • Hydrochlorothiazide 	Promotes sodium and potassium excretion; increases lithium serum levels; may produce cardiotoxicity and neurotoxicity
Tricyclic antidepressants	Increases tremor; potentiates pharmacologic effects of tricyclic antidepressants

early in the course of therapy (Hirschfeld, Baker, Wozniak, Tracy, & Sommerville, 2003). Baseline liver function tests and a complete blood count with platelets should be obtained before starting therapy, and patients with known liver disease should not be given divalproex sodium. There is a boxed warning for hepatotoxicity. Optimal blood levels appear to be in the range of 50 to 150 ng/mL. Levels may be obtained weekly until the patient is stable, and then every 6 months. Divalproex sodium is associated with increased risk for birth defects. Cases of life-threatening pancreatitis have been reported in adults and children receiving valproate, either initially or after several years of use. Some cases were described as hemorrhagic, with a rapid progression from onset to death. If pancreatitis is diagnosed, valproate use should be discontinued.

Carbamazepine

Carbamazepine, an anticonvulsant, also has mood-stabilizing effects. Data from various studies suggest that it may be effective in patients who experience no response to lithium. In addition, patients with secondary mania appear to be more responsive to carbamazepine than to lithium (Strakowski & Sax, 2000). Carbamazepine is

metabolized by CYP3A4 and induces CYP1A2 and 3A4. The most common side effects of carbamazepine are dizziness, drowsiness, nausea, and vomiting, which may be avoided with slow incremental dosing. Carbamazepine has a boxed warning for aplastic anemia and agranulocytosis, but frequent clinically unimportant decreases in white blood cell counts occur. Estimates of the rate of severe blood dyscrasias vary from one in 10,000 patients treated to a more recent estimate of one in 125,000 (Schatzberg et al., 2003). Mild, nonprogressive elevations of liver function test results are relatively common. Carbamazepine is associated with increased risk for birth defects.

In patients older than 12 years, carbamazepine is begun at 200 mg once or twice a day. The dosage is increased by no more than 200 mg every 2 to 4 days, to 800 to 1,000 mg a day, or until therapeutic levels or effects are achieved. It is important to monitor for blood dyscrasias and liver damage. Liver function tests and complete blood counts with differential are minimal pretreatment laboratory tests and should be repeated about 1 month after initiating treatment, and at 3 months, 6 months, and yearly. Other yearly tests should include electrolytes, blood urea nitrogen, thy-

Table 20.9 Interventions for Lithium Side Effects

Side Effect	Intervention
Edema of feet or hands	Monitor intake and output, check for possible decreased urinary output. Monitor sodium intake. Patient should elevate legs when sitting or lying. Monitor weight.
Fine hand tremor	Provide support and reassurance, if it does not interfere with daily activities. Tremor worsens with anxiety and intentional movements; minimize stressors. Notify prescriber if it interferes with patient's work and compliance will be an issue. More frequent smaller doses of lithium may also help.
Mild diarrhea	Take lithium with meals. Provide for fluid replacement. Notify prescriber if becomes severe; may need a change in medication preparation or may be early sign of toxicity.
Muscle weakness, fatigue, or memory and concentration difficulties	Provide support and reassurance; this side effect will usually pass after a few weeks of treatment. Short-term memory aids such as lists or reminder calls may be helpful. Notify prescriber if becomes severe or interferes with the patient's desire to continue treatment.
Metallic taste	Suggest sugarless candies or throat lozenges. Encourage frequent oral hygiene.
Nausea or abdominal discomfort	Consider dividing the medication into smaller doses, or give it at more frequent intervals. Give medication with meals.
Polydipsia Polyuria	Reassure patient that this is a normal mechanism to cope with polyuria. Monitor intake and output. Provide reassurance and explain nature of side effect. Also explain that this causes no physical damage to kidneys.
Toxicity	Withhold medication. Notify prescriber. Use symptomatic treatments.

roid function tests, urinalysis, and eye examinations. Carbamazepine levels are measured monthly until the patient is on a stable dosage. Studies suggest that blood levels in the range of 8 to 12 ng/mL correspond to ther-

apeutic efficacy. See Table 20.10 for carbamazepine's interactions with other drugs. See Chapter 8 for further discussion of carbamazepine's possible mechanisms of action, pharmacokinetics, side effects, and toxicity.

BOX 20.10**Drug Profile: Divalproex Sodium (Depakote)**

Drug Class: Antimania agent

Receptor Affinity: Thought to increase level of inhibitory neurotransmitter, GABA, to brain neurons. Mechanism of action is unknown.

Indications: Mania, epilepsy, migraine.

Routes and Dosage: Available in 125-mg delayed-release capsules, and 125-, 250-, and 500-mg enteric-coated tablets.

Adult Dosage: Dosage depends on symptoms and clinical picture presented; initially, the dosage is low and gradually increased depending on the clinical presentation.

Half-Life (Peak Effect): 6–16 h (1–4 h)

Select Adverse Reactions: Sedation, tremor (may be dose related), nausea, vomiting, indigestion, abdominal cramps, anorexia with weight loss, slight elevations in liver enzymes, hepatic failure, thrombocytopenia, transient increases in hair loss.

Boxed Warning: Hepatotoxicity, teratogenicity, pancreatitis

Warning: Use cautiously during pregnancy and lactation. Contraindicated in patients with hepatic disease or significant hepatic dysfunction. Administer cautiously with salicylates; may increase serum levels and result in toxicity.

Specific Patient/Family Education:

- Take with food if gastrointestinal upset occurs.
- Swallow tablets or capsules whole to prevent local irritation of mouth and throat.
- Notify prescriber before taking any other prescription or OTC medications or herbal supplements.
- Avoid alcohol and sleep-inducing or OTC products.
- Avoid driving or performing activities that require alertness.
- Do not abruptly discontinue use.
- Keep appointments for follow-up, including blood tests to monitor response.

Table 20.10 Selected Medication Interactions With Carbamazepine

Interaction	Drug Interacting With Carbamazepine
Increased carbamazepine levels	Erythromycin
	Cimetidine
	Propoxyphene
	Isoniazid
	Calcium-channel blockers (Verapamil)
	Fluoxetine
	Danazol
	Diltiazem
Decreased carbamazepine levels	Phenobarbital
	Primidone
Drugs whose levels are decreased by carbamazepine	Phenytoin
	Oral contraceptives
	Warfarin, oral anticoagulants
	Doxycycline
	Theophylline
	Haloperidol
	Divalproex sodium
	Tricyclic antidepressants
	Acetaminophen—increased metabolism, but also increased risk for hepatotoxicity

Emergency!

Both valproate and carbamazepine may be lethal if high doses are ingested. Toxic symptoms appear in 1 to 3 hours and include neuromuscular disturbances, dizziness, stupor, agitation, disorientation, nystagmus, urinary retention, nausea and vomiting, tachycardia, hypotension or hypertension, cardiovascular shock, coma, and respiratory depression.

Lamotrigine

Lamotrigine (Lamictal) is recently approved by the FDA for the maintenance treatment of bipolar disorder (www.FDA.gov). It may be particularly effective for rapid cycling and in the depressed phase of bipolar illness. If lamotrigine is given with valproic acid (Depakote), the dose should be reduced. Depakote decreases the clearance of lamotrigine. Lamotrigine does have a “boxed warning” for skin rash. Nurses should be especially vigilant for the appearance of any skin rash. If a rash does appear, it is most likely benign. However, it is not possible to predict whether the rash is benign or serious (Stevens-Johnson syndrome).

Other Anticonvulsants

In small clinical trials, case reports, and anecdotal evidence, newer anticonvulsants also show promise as mood stabilizers. Initial evidence suggests that gabapentin (Neurontin) may be effective for acute mania, mood stabilization, and rapid cycling. Topiramate (Topamax)

has been used mostly as add-on therapy in mixed patient samples with refractory mood disorders. A characteristic of topiramate is that it is more associated with weight loss than weight gain. Controlled trials are needed to evaluate further the efficacy of these and other anticonvulsants (Schatzberg et al., 2003).

Intervention With Antidepressants

Acute bipolar depression has received little scientific study in comparison with unipolar depression. Antidepressant drugs may cause either a switch to mania or a mixed state or may induce rapid cycling. Unfortunately, lithium or anticonvulsants are not as effective against depression as they are against mania. However, in a few patients, lithium or anticonvulsants can be used alone with good antidepressant effects. The most common treatment of bipolar depression is an antidepressant combined with a mood stabilizer to “protect” the patient against a manic switch. The antidepressant agents are the same as those used in unipolar illness, although they are sometimes given in lower dosages and for shorter periods of time as a precaution.

Intervention With Antipsychotics

Antipsychotics are prescribed for patients who experience psychosis as a part of bipolar disorder. If patients cannot tolerate mood stabilizers, antipsychotics may be given, instead of antidepressants, to stabilize the moods. Generally, the antipsychotic dosage is lower than what is prescribed for patients with schizophrenia.

Administering and Monitoring Medication

During acute mania, patients may not believe that they have a psychiatric disorder and refuse to take medication. Because their energy is still high, they can be very creative in avoiding medication. Once patients begin to take medications, symptom improvement should be evident. If a patient is very agitated, a benzodiazepine may be given for a short period.

Monitoring and Managing Side Effects

It is unlikely that patients will take only one medication; they may receive several. In some instances, one agent will be used to augment the effects of another, such as supplemental thyroid hormone to boost antidepressant response in depression. Possible side effects for each medication should be listed and cross-referenced. When a side effect appears, the nurse should document the side effect and notify the prescriber so that further evaluation can be made. In some instances, medications should be changed.

Monitoring for Drug Interactions

It is a well-established practice to combine mood stabilizers with antidepressants or antipsychotics. The previ-

ously discussed drug interactions should be considered when caring for a person with bipolar disorder. A big challenge is monitoring alcohol, drugs, over-the-counter medications, and herbal supplements. A complete list of all medications should be maintained and evaluated for any potential interaction (see Table 20.4 for specific drug interactions).

Teaching Points



For patients who are taking lithium, it is important to explain that a change in salt intake can affect the therapeutic blood level. If there is a reduction in salt intake, the body will naturally retain lithium to maintain homeostasis. This increase in lithium retention can lead to toxicity. Once stabilized on a lithium dose, salt intake should remain constant. This is fairly easy to do, except during the summer, when excessive perspiration can occur. Patients should increase salt intake during periods of perspiration, increased exercise, and dehydration. Most mood stabilizers and antidepressants can cause weight gain. Patients should be alerted to this potential side effect and should be instructed to monitor any changes in eating, appetite, or weight. Weight reduction techniques may need to be instituted. Patients also should be clearly instructed to check with the nurse or physician before taking any over-the-counter medication, herbal supplements, or any other complementary and alternative treatment approaches (Leininger & McFarland, 2006; Spector, 2004).

Other Somatic Interventions: Electroconvulsive Therapy

ECT may be a treatment alternative for patients with severe mania who exhibit unremitting, frenzied physical activity. Other indications for ECT are acute mania that is unresponsive to antimanic agents or high suicide risk. ECT is safe and effective in patients receiving antipsychotic drugs. Use of valproate or carbamazepine will elevate the seizure threshold, requiring some adjustments in treatment.

Psychological Domain

Assessment

The assessment of the psychological domain should follow the process explained in Chapter 10. Individuals with bipolar disorder can usually participate fully in this part of the assessment.

Mood

By definition, bipolar disorder is a disturbance of mood. If the patient is depressed, using an assessment tool for depression may help determine the severity of depres-

sion. If mania predominates, evaluating the quality of the mood (elated, grandiose, irritated, or agitated) becomes important. Usually, mania is determined by clinical observation.

Cognition

In a depressive episode, the individual may not be able to concentrate enough to complete cognitive tasks, such as those called for in the Mini Mental State Exam (MMSE). During the acute phase of a manic or depressive episode, mental status may be abnormal, and in a manic phase, judgment is impaired by extremely rapid, disjointed, and distorted thinking. Moreover, feelings such as grandiosity can interfere with normal executive functioning.

Thought Disturbances

Psychosis commonly occurs in patients with bipolar disorder, especially during acute episodes of mania. Auditory hallucinations and delusional thinking are part of the clinical picture. In children and adolescents, psychosis is not so easily disclosed.

Stress and Coping Factors

Stress and coping are critical assessment areas for a person with bipolar disorder. A stressful event often triggers a manic or depressive episode. In some instances, there are no particular stresses that preceded the episode, but it is important to discuss the possibility. Determining the patient's usual coping skills for stresses lays the groundwork for developing interventional strategies. Negative coping skills, such as substance use or aggression, should be identified because these skills need to be replaced with positive coping skills.

Risk Assessment

Patients with bipolar disorder are at high risk for injury to self and others, with 10% to 15% of patients completing suicide. Child abuse, spouse abuse, or other violent behaviors may occur during severe manic episodes; thus, patients should be assessed for suicidal or homicidal risk (APA, 2000). The risk of relapse and poorer treatment outcomes are associated with obesity. Preventing and treating obesity in patients with bipolar disorder could decrease the morbidity and mortality related to physical illness, enhance psychological well-being, and possibly improve the course of the disorder (Fagiolini, Kupfer, Houck, Novick, & Frank, 2003).

Nursing Diagnoses for the Psychological Domain

Nursing diagnoses associated with the psychological domain of bipolar disorder include Disturbed Sensory

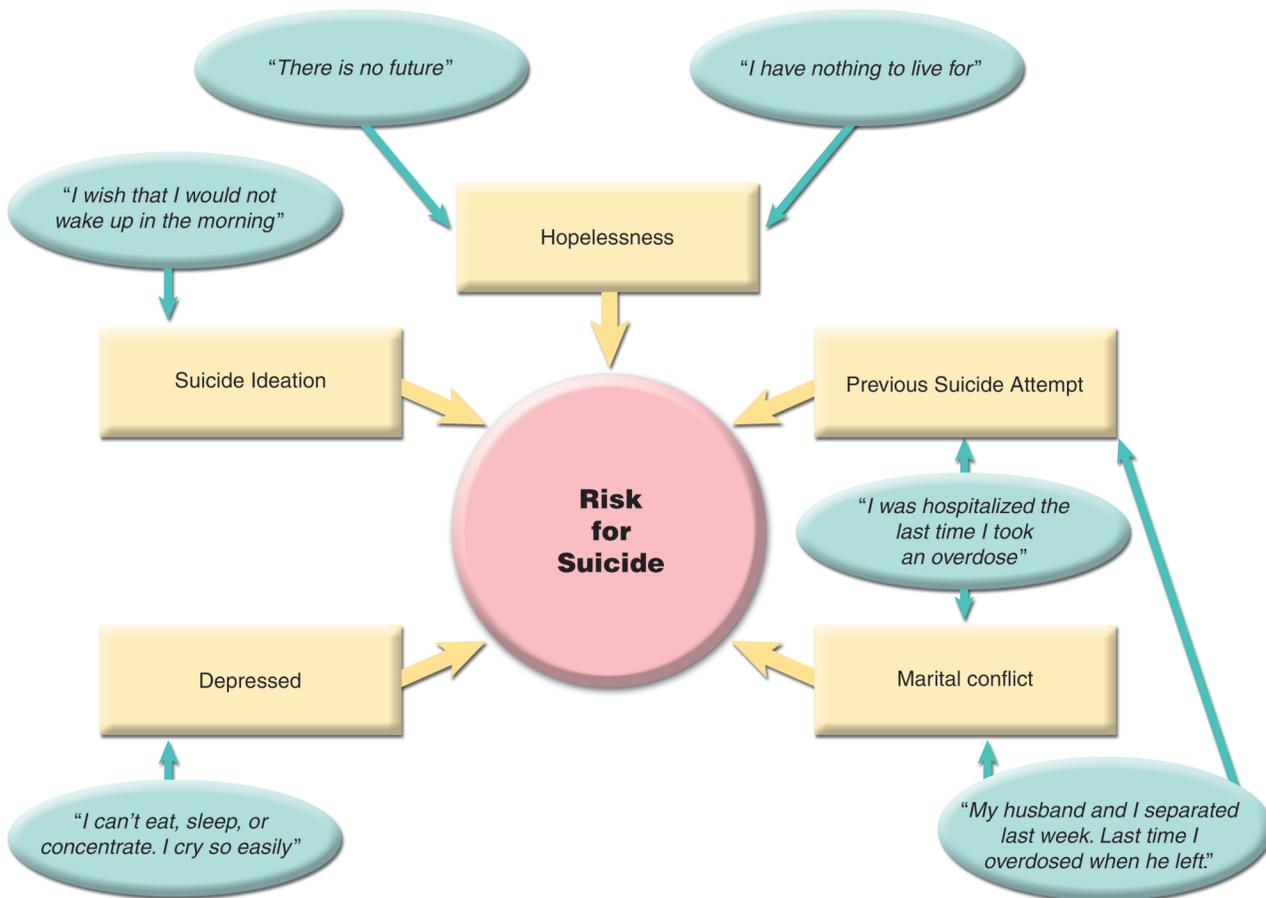


FIGURE 20.2. Nursing diagnosis concept map: risk for Suicide.

Perception; Disturbed Thought Processes; Defensive Coping; Risk for Suicide; Risk for Violence; and Ineffective Coping (see Figure 20.2).

Interventions for the Psychological Domain

Pharmacotherapy is the primary treatment for bipolar disorder but is often unsuccessful unless adjunctive psychosocial interventions are included in the treatment plan. Integration of psychotherapeutic techniques with pharmacotherapy is strongly recommended by clinicians and patients (Thase & Sachs, 2000). The most common psychotherapeutic approaches include psychoeducation, individual cognitive-behavioral therapy, individual interpersonal therapy, and adjunctive therapies, such as those for substance use (Rothbaum & Astin, 2000).

Several risk factors associated with bipolar disorders make patients more vulnerable to relapses and resistant to recovery. Among these are high rates of nonadherence to medication therapy, obesity, marital conflict, separation, divorce, unemployment, and underemployment. The goals of psychosocial interventions are to address risk factors and associated features that are

difficult to address with pharmacotherapy alone. Particularly important are improving medication adherence, decreasing the number and length of hospitalizations and relapses, enhancing social and occupational functioning, improving quality of life, increasing the patient and family's acceptance of the disorder, and reducing the suicide risk (Rothbaum & Astin, 2000).

Psychoeducation

Psychoeducation is designed to provide information on bipolar disorder and successful treatment and recovery and usually focuses on medication adherence. The nurse can provide information about the illness and obstacles to recovery. Helping the patient to recognize warning signs and symptoms of relapse and to cope with residual symptoms and functional impairment are important interventions. Resistance to accepting the illness and to taking medication, the symbolic meaning of medication taking, and worries about the future can be discussed openly. In the interest of improved medication adherence, listening carefully to the patient's concerns about the medication, dosing schedules and dose changes, and side effects are helpful



Nursing Care Plan 20.1

The Patient With Bipolar Disorder

JR, a 43-year-old, single woman, lives in a metropolitan city and works for a large travel agency booking corporate business trips. She has a history of alcohol abuse that began when she was in high school. Initially, she relied on alcohol for stress reduction but gradually began abusing it. Her mother, grandfather, and sister all committed suicide within the past several years. JR's father has remarried and moved out of the area. JR has one brother whom she sees occasionally.

Three years ago, JR left her husband after 15 years of an unhappy marriage and moved into a small condominium in a less affluent neighborhood. She began having symptoms of bipolar mixed disorder at that time, when she sold all her clothes, bleached her hair blonde, and began cruising the bars. She would consume excessive amounts of alcohol and often end up spending the night with a stranger. At first her behavior was attributed to her recent divorce. When she began missing work and charging excessively on her credit cards, her friends and two children

became concerned and convinced her to seek help for her behavior.

JR received a diagnosis of manic episode, and treatment with lithium carbonate was initiated. Her mood stabilized briefly, but she had two more manic episodes within the next 18 months. Shortly after her last manic episode, she became severely depressed and attempted suicide. TCAs and MAOIs were tried, but she discontinued taking them after a significant weight gain. Once her depression lifted, her mood was stable for several months.

About 2 months ago, JR began missing work again because of depression. She refused to take any antidepressants and just wanted to “wait it out.” She often boasted that her one success in life was helping people travel and have a good time. Last week she was told that her position was being eliminated because of a company issue. Now she believes that she is a failure as a wife, as an employee, and as a woman. She became despondent and finally took an overdose to “end it all.”

Setting: Intensive Care Psychiatric Unit In A General Hospital

Baseline Assessment: JR is a 43-year-old single woman transferred from ICU after a 3-day hospitalization following a suicide attempt with an overdose of multiple prescriptions and alcohol. She had her first manic episode 3 years before, and subsequently has had symptoms of a mixed bipolar mood disorder most of the time. Medication with lithium carbonate has not protected her from mood swings, and prior trials of TCAs and MAOIs have been unsuccessful. She is currently depressed, with pressured speech, agitation, irritability, sensory overload, inability to sleep, and anorexia.

Associated Psychiatric Diagnosis

Axis I: Bipolar I disorder, most recent episode mixed, severe, without psychotic features
 Axis II: Deferred (none apparent in her history and she is currently too ill for personality disorder to be assessed)
 Axis III: Hypothyroidism
 Axis IV: Social problems (very poor marriage of 15 years, death by suicide of mother, grandfather, one sister)
 Axis V: GAF = Current 50
 Potential 85

Medications

Lithium carbonate 300 mg tid × 2 years
 L-thyroxine 0.1 mg q AM × 1 d
 Clonazepam 0.5 mg bid for sleep and agitation
 Carbamazepine added on transfer to be titrated up to 400 mg tid

Nursing Diagnosis 1: Risk Suicide

Defining Characteristics

Attempts to inflict life-threatening injury to self
 Expresses desire to die
 Poor impulse control
 Lack of support system

Related Factors

Feelings of helplessness and hopelessness secondary to bipolar disorder
 Depression
 Loss secondary to finances/job, divorce

Outcomes

Initial

1. Develop a no self-harm contract.
2. Remain free from self-harm.
3. Identify factors that led to suicidal intent and methods for managing suicidal impulses if they return.
4. Accept treatment of depression by trying the SSRI antidepressants.

Discharge

5. Discuss the complexity of bipolar disorder.
6. Identify the antecedents to depression.

Continued



Nursing Care Plan 20.1 (Continued)

Interventions

Interventions	Rationale	Ongoing Assessment
Initiate a nurse–patient relationship by demonstrating an acceptance of JR as a worthwhile human being through the use of nonjudgmental statements and behavior.	A sense of worthlessness often underlies suicide ideation. The positive therapeutic relationship can maintain the patient's dignity.	Assess the stages of the relationship and determine whether a therapeutic relationship is actually being formed. Identify indicators of trust.
Initiate suicide precautions per hospital policy.	Safety of the individual is a priority with people who have suicide ideation (see Chapter 36).	Determine intent to harm self—plan and means.
Obtain a no self-harm contract.	A contract can help the patient resist suicide by providing a way of resisting impulses.	Determine patient's ability to commit to a contract.

Evaluation

Outcomes	Revised Outcomes	Interventions
Has not harmed self, denies suicidal thought/intent after realizing that she is still alive.	Absence of suicidal intent will continue.	Discontinue suicide precautions; maintain ongoing assessment for suicidality.
Made a no self-harm contract with nurse, agrees to keep it after discharge.	Maintain a no self-harm contract with outpatient mental health provider.	Support and reinforce this contract.
JR agreed to try to treat her depression by initiating treatment with Prozac.		

Nursing Diagnosis 2: Chronic Low Self-Esteem

Defining Characteristics

Long-standing self-negating verbalizations
 Expressions of shame and guilt
 Evaluates self as unable to deal with events
 Frequent lack of success in work and relationships
 Poor body presentation (eye contact, posture, movements)
 Nonassertive/passive

Related Factors

Failure to stabilize mood
 Unmet dependency needs
 Feelings of abandonment secondary to separation from significant other
 Feelings of failure secondary to loss of job, relationship problems
 Unrealistic expectations of self

Outcomes

Initial

1. Identify positive aspects of self.
2. Modify excessive and unrealistic expectations of self.

Discharge

3. Verbalize acceptance of personal limitations.
4. Report freedom from most symptoms of depression.
5. Begin to take verbal and behavioral risks.

Interventions

Interventions	Rationale	Ongoing Assessment
Enhance JR's sense of self by being attentive, validating your interpretation of what is being said or experienced, and helping her verbalize what she is expressing nonverbally.	By showing respect for the patient as a human being who is worth listening to, the nurse can support and help build the patient's sense of self.	Determine whether patient confirms interpretation of situation and if she can verbalize what she is expressing nonverbally.
Assist to reframe and redefine negative statements ("not a failure, but a setback").	Reframing an event positively rather than negatively can help the patient view the situation in an alternative way.	Assess whether the patient can actually view the world in a different way.
Problem solve with patient about how to approach finding another job.	Work is very important to adults. Losing a job can decrease self-esteem. Focusing on the possibility of a future job will provide hope for the patient.	Assess the patient's ability to problem solve. Determine whether she is realistic in her expectations.

Continued



Nursing Care Plan 20.1 (Continued)

Interventions

Interventions	Rationale	Ongoing Assessment
Encourage positive physical habits (healthy food and eating patterns, exercise, proper sleep). Teach patient to validate consensually with others.	A healthy lifestyle promotes well-being, increasing self-esteem. Low self-esteem is generated by negative interpretations of the world. Through consensual validation, the patient can determine whether others view situations in the same way.	Determine JR's willingness to consider making lifestyle changes. Assess JR's ability to participate in this process.
Teach esteem-building exercises (self-affirmations, imagery, use of humor, meditation/prayer, relaxation). Assist in establishing appropriate personal boundaries.	There are many different approaches that can be practiced to increase self-esteem. In an attempt to meet their own needs, people with low self-esteem often violate other people's boundaries and allow others to take advantage of them. Helping patients establish their own boundaries will improve the likelihood of needs being met in an appropriate manner.	Assess JR's energy level and ability to focus on learning new skills. Assess JR's ability to understand the concept of boundary violation and its significance.
Provide an opportunity within the therapeutic relationship to express thoughts and feelings. Use open-ended statements and questions. Encourage expression of both positive and negative statements. Use movement, art, and music as means of expression.	The individual with low self-esteem may have difficulty expressing thoughts and feelings. Providing them with several different outlets for expression helps to develop skills for expressing thoughts and feelings.	Monitor thoughts and feelings that are expressed in order to help the patient examine them.
Explore opportunities for positive socialization.	Individuals with low self-esteem may be in social situations that reinforce negative valuation of self. Helping patient identify new positive situations will give other options.	Assess whether the new situations are potentially positive or are a re-creation of other negative situations.
JR began to identify positive aspects of self as she began to modify excessive and unrealistic expectations of self.	Strengthen ability to affirm positive aspects and examine expectations related to work and relationships.	Refer to mental health clinic for cognitive-behavioral psychotherapy with a feminist perspective.
She verbalized that she would probably never work for the company again and that it would never be the same. She verbalized that she would need more assertiveness skills in her relationships.	Identify important aspects of job so that she can begin looking for a job that had those characteristics.	Attend a women's group that focuses on assertiveness skills.
As JR's mood improved, she was able to sleep through the night, and she began eating again—began feeling better about herself.	Maintain a stable mood to promote positive self-concept.	Monitor mood and identify antecedents to depression.

Nursing Diagnosis 3: Ineffective Individual Coping

Defining Characteristics	Related Factors
Verbalization in inability to cope or ask for help Reported difficulty with life stressors Inability to problem solve Alteration in social participation Destructive behavior toward self Frequent illnesses Substance abuse	Altered mood (depression) caused by changes secondary to body chemistry (bipolar disorder) Altered mood caused by changes secondary to intake of mood-altering substance (alcohol) Unsatisfactory support system Sensory overload secondary to excessive activity Inadequate psychological resources to adapt to changes in job status

Continued



Nursing Care Plan 20.1 (Continued)

Outcomes

Initial

1. Accept support through the nurse–patient relationship.
2. Identify areas of ineffective coping.
3. Examine the current efforts at coping.
4. Identify areas of strength.
5. Learn new coping skills.

Discharge

6. Practice new coping skills.
7. Focus on strengths.

Interventions

Interventions	Rationale	Ongoing Assessment
Identify current stresses in JR's life, including her suicide attempt and the bipolar disorder.	When areas of concern are verbalized by the patient, she will be able to focus on one issue at a time. If she identifies the mental disorder as a stressor, she will more likely be able to develop strategies to deal with it.	Determine whether JR is able to identify problem areas realistically. Continue to assess for suicidality.
Identify JR's strengths in dealing with past stressors.	By focusing on past successes, she can identify strengths and build on them in the future.	Assess if JR can identify any previous successes in her life.
Assess current level of depression using Beck's Depression Inventory or a similar one and intervene according to assessed level.	Severely depressed or suicidal individuals need assistance with decision making, grooming and hygiene, and nutrition.	Continue to assess for mood and suicidality.
Assist JR in discussing, selecting, and practicing positive coping skills (jogging, yoga, thought stopping).	New coping skills take a conscious effort to learn and will at first seem strange and unnatural. Practicing these skills will help the patient incorporate them into her coping strategy repertoire.	Assess whether JR follows through on learning new skills.
Educate regarding the use of alcohol and its relationship to depression.	Alcohol is an ineffective coping strategy because it actually exacerbates the depression.	Assess for the patient's willingness to address her drinking problem.
Assist patient in coping with bipolar disorder, beginning with education about it.	A mood disorder is a major stressor in a patient's life. To manage the stress, the patient needs a knowledge base.	Determine JR's knowledge about bipolar disorder.
Administer lithium as ordered (give with food or milk). Reinforce the action, dosage, and side effects. Review laboratory results to determine whether lithium is within therapeutic limits. Assess for toxicity. Recommend a normal diet with normal salt intake; maintenance of adequate fluid intake.	Lithium carbonate is effective in the treatment of bipolar disorder but must be managed. Patient should have a thorough knowledge of the medication and side effects.	Assess for target action, side effects, and toxicity.
Administer carbamazepine as ordered, to be titrated up to 400 mg tid. Observe for presence of hypersensitivity to the drug. Teach about action, dosage, and side effects. Emphasize the possibility of drug interaction with alcohol, some antibiotics, TCAs, and MAOIs.	Carbamazepine can be effective in bipolar disorder. However, it can increase CNS toxicity when given with lithium carbonate.	Assess for target action, side effects, and toxicity.
Administer thyroid supplement as ordered. Review laboratory results of thyroid functioning. Discuss the symptoms of hypothyroidism and how they are similar to depression. Emphasize the importance of taking lithium and L-thyroxine. Explain about the long-term effects of lithium on thyroid functioning.	Hypothyroidism can be a side effect of lithium carbonate and also mimics symptoms of depression.	Determine whether patient understands the relationship between thyroid dysfunction and lithium carbonate.

Continued



Nursing Care Plan 20.1 (Continued)

Evaluation

Outcomes	Revised Outcomes	Interventions
Clonazepam 0.5 mg bid for sleep and agitation. JR easily engaged in a therapeutic relationship. She examined the areas in her life where she coped ineffectively. She identified her strengths and how she coped with stressors and especially her illness in the past. She is willing to try antidepressants again, in hopes of not having the weight gain. She learned new problem-solving skills and reported that she learned a lot about her medication. She is committed to complying with her medication regimen. She identified new coping skills that she could realistically do. She will focus on strengths.	<p>Establish a therapeutic relationship with a therapist at the mental health clinic.</p> <p>Continue to view illness as a potential stressor that can disrupt life.</p> <p>Continue to practice new coping skills as stressful situations arise.</p>	<p>Refer to mental health clinic.</p> <p>Seek advice immediately if there are any problems with medications.</p> <p>Discuss with therapist the outcomes of using new coping skills. Attend Alcoholics Anonymous if alcohol is used as a stress reliever.</p>

(see Box 20.11). Health teaching and weight management should be a component of any psychoeducation program. In addition to individual variations in body weight, many of the medications (divalproex sodium, lithium, antidepressants, olanzapine) are associated with weight gain. Monitoring weight and developing individual weight management plans can reduce the risk of relapse and increase the possibility of medication adherence.

Psychotherapy

Long-term psychotherapy may help prevent both mania and depression by reducing the stresses that trigger episodes and increasing the patient's acceptance of the need for medication. Patients should be encouraged to keep their appointments with the therapist, be honest and open, do the assigned homework, and give the therapist feedback on how the treatment is working (Kahn, Ross, Printz, & Sachs, 2000).

BOX 20.11

Psychoeducation Checklist: Bipolar I Disorder

When caring for the patient with a bipolar I disorder, be sure to include the following topic areas in the teaching plan:

- Psychopharmacologic agents, including drug action, dosage, frequency, and possible adverse effects
- Medication regimen adherence
- Strategies to decrease agitation and restlessness
- Safety measures
- Self-care management
- Follow-up laboratory testing
- Support services

Social Domain

Assessment

One of the tragedies of bipolar disorder is its effect on social and occupational functioning. Cultural views of mental illness influence the patient's acceptance of the disorder. During illness episodes, patients often behave in ways that jeopardize their social relationships. Losing a job and going through a divorce are common events. When performing an assessment of social function, the nurse should identify changes resulting from a manic or depressive episode.

Nursing Diagnoses for the Social Domain

Nursing diagnoses for adults can include Ineffective Role Performance; Interrupted Family Processes; Impaired Social Interaction; Impaired Parenting; and Compromised Family Coping. The diagnoses for children and adolescents can include Delayed Growth and Development and Caregiver Role Strain in family coping with a member with a bipolar disorder.

Interventions for the Social Domain

Interventions focusing on the social domain are integral to nursing care for all ages. During mania, patients usually violate others' boundaries. Roommate selection for patients requiring hospital admittance needs to be carefully considered. If possible, a private room is ideal because patients with bipolar disorder tend to irritate others, who quickly tire of the intrusiveness. These patients may miss the cues indicating anger and aggression from others. The nurse should protect the manic patient from self-harm, as well as harm from other patients.

Support groups are helpful for people with this disorder. Participating in groups allows the person to meet others with the same disorder and learn management and preventive strategies. Support groups also are helpful in dealing with the stigma associated with mental illnesses.

Family Interventions



Marital and family interventions are often needed at different periods in the life of a person with bipolar disorder. For the family with a child with this disorder, additional parenting skills are needed to manage the behaviors. The goals of family interventions are to help the family understand and cope with the disorder. Interventions may range from occasional counseling sessions to intensive family therapy.

Family psychoeducation strategies have been shown to be particularly useful in decreasing the risk of relapse and hospitalization. In a study of 53 patients with mania, half were assigned to a 9-month family-focused psychoeducational group and half to individually focused treatment. Those in family-focused treatment were less likely to be rehospitalized (Rea et al., 2003). For more information see Box 20.12.

Evaluation and Treatment Outcomes

Desired treatment outcomes are stabilization of mood and enhanced quality of life. Primary tools for evaluating outcomes are nursing observation and patient self-report (see Nursing Care Plan 20.1 and Interdisciplinary Treatment Plan 20.1).

Continuum of Care

Inpatient Management

Inpatient admission is the treatment setting of choice for patients who are severely psychotic or who are an

immediate threat to themselves or others. In acute mania, nursing interventions focus on patient safety because patients are prone to injury due to hyperactivity and often are unaware of injuries they sustain. Distraction may also be effective when a patient is talking or acting inappropriately. Removal to a quieter environment may be necessary if other interventions have not been successful, but the patient should be carefully monitored. Because during acute mania, patients are often impulsive, disinhibited, and interpersonally inappropriate, the nurse should avoid direct confrontations or challenges.

Medication management (Fig. 20.3), including control of side effects and promotion of self-care, are major nursing responsibilities during inpatient hospitalization. Nurses should be familiar with drug–drug interactions (Table 20.4) and with interventions to help control side effects.

Intensive Outpatient Programs

Intensive outpatient programs for several weeks of acute-phase care during a manic or depressive episode are used when hospitalization is not necessary or to prevent or shorten hospitalization. These programs are usually called *partial hospitalization* or *day hospitalization*. Close medication monitoring and milieu therapies that foster restoration of a patient's previous adaptive abilities are the major nursing responsibilities in these settings.

Setting up frequent office visits and crisis telephone calls are additional nursing interventions that can help to shorten or prevent hospitalization during the acute phase of a manic episode. Family sessions or psychoeducation that includes the patient are alternatives. Severely and persistently ill patients may need ongoing intensive treatment, but the frequency of visits can be decreased for patients whose conditions stabilize and who enter the continuation or the maintenance phase of treatment.

BOX 20.12

Research for Best Practice: Help for Families Affected by Bipolar Disorder

Rea, M. M., Tompson, M. C., Miklowitz, D. J., Goldstein, M. J., Hwang, S., & Mintz, J. (2003). Family-focused treatment versus individual treatment for bipolar disorder: results of a randomized clinical trial. *Journal of Consulting Clinical Psychology, 71*(3), 482–492.

The Question: Is family-focused treatment as effective or more or less effective than individual treatment for bipolar disorder?

Methods: A qualitative study of families' responses to severe mental illness involved 29 participants representing 17 families who were interviewed three times in 2 years. Interviews were analyzed using a comparative technique that described families' responses to these mental illnesses. Living with ambiguity of mental illness was the central concern.

Findings: These families attempted to live normally and sought to control the impact of the illness. The family goals included managing crises, containing and controlling symptoms, and crafting a notion of "normal." The strategies that the families used were being vigilant, setting limits on patients, invoking logic, dealing with sense of loss, seeing patients' strengths, and taking on roles. This study revealed that families were profoundly affected by the social contexts of mental illness.

Implications for Nursing: Families are the informal caregivers and develop their own strategies for dealing with family members with mental illnesses. Including families in psychoeducation programs can facilitate a partnership with the family and allow sharing of successful strategies.

INTERDISCIPLINARY TREATMENT PLAN 20.1

Patient With Bipolar Disorder Community Mental Health Center Treatment Program for JR, a 43-year-old Female

<i>Admission Date:</i>	<i>Date of This Plan:</i>	<i>Type of Plan: Check Appropriate Box</i>
		<input type="checkbox"/> Initial <input type="checkbox"/> Master <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other

Treatment Team Present:

M. Jones, MD; S. Smith, RNC; T. Thompson, PhD (psychologist); G. Bond, LCSW (social worker); V. Stevens, BA (rehabilitation counselor)

DIAGNOSIS (DSM-IV-TR):

AXIS I: Bipolar I
 AXIS II: Deferred
 AXIS III: Hypothyroidism
 AXIS IV: Social Problems
 AXIS V:
 Current GAF: 50
 Highest Level GAF This Past Year: 85

ASSETS (MEDICAL, PSYCHOLOGICAL, SOCIAL, EDUCATIONAL, VOCATIONAL, RECREATIONAL):

1. Controls illness through medication and monthly visits for brief counseling and stress management.
2. Lives independently in apartment.
3. Works at a library and has good relationships with boss and coworkers.
4. Easily makes friends.

MASTER PROBLEM LIST

Prob No.	Date	Problem	Code	Change	
				Code	Date
1	1/12/08	Ineffective coping: Does not want to go to work because of intense grief for mother's death.		R	2/12/08
2	1/12/08	Mood disturbance. Patient is very depressed, not eating or sleeping.		R	4/14/08
3	6/12/08	Mood changes with the seasons. Needs monitoring of mood.		T	
4	6/12/08	Interpersonal issues interfering with ability to work at library.		T	

CODE T = Problem must be addressed in treatment.
 N = Problem noted and will be monitored.
 X = Problem noted, but deferred/inactive/no action necessary.
 O = Problem to be addressed in aftercare/continuing care.
 I = Problem incorporated into another problem.
 R = Resolved.

INDIVIDUAL TREATMENT PLAN PROBLEM SHEET

<i>#1 Problem/Need:</i>	<i>Date Identified</i>	<i>Problem Resolved/Discontinuation Date</i>
	1/12/08	Ongoing

Cyclic mood changes, usually according to the season.
 Medication needs to be re-evaluated and adjusted according to mood changes. Stress is often the precipitant to mood changes. Needs updating on information about bipolar disorder.

(Continued on following page)

INTERDISCIPLINARY TREATMENT PLAN 20.1 (Continued)					
Patient With Bipolar Disorder		Community Mental Health Center Treatment Program for JR, a 43-year-old Female			
<i>Objective(s)/Short-Term Goals:</i>		<i>Target Date</i>		<i>Achievement Date</i>	
1. Monitor mood changes. 2. Adjust medications as needed.		Every 3 months			
<i>Treatment Interventions:</i>		<i>Frequency</i>		<i>Person Responsible</i>	
1. Evaluate mood changes.		Every 3 months or as needed.		RN	
2. Adjust medications.		Every 3 months or as needed.		MD	
3. Medication education.		Weekly class.		RN	
4. Stress management techniques.		Weekly class for 6 weeks.		Psychologist	
<i>Responsible QMHP</i>		<i>Patient or Guardian</i>		<i>Staff Physician</i>	
Signature	Date	Signature	Date	Signature	Date

Spectrum of Care

In today's health care climate, with efforts to reduce hospitalization, most patients with bipolar disorder are treated as outpatients. Hospitalizations are usually brief, and treatment focuses on restabilization. Patients with mood disorders are likely to need long-term medication regimens and supportive psychotherapy to function in the community. Therefore, medication regimens and additional treatment planning need to be tailored to individual needs. Patients need extended and continued

follow-up to monitor medication trials and side effects, reinforce self-care management, and provide continued psychosocial support.

Mental Health Promotion

Mental health promotion activities should be the focus during remissions. During this period, patients have an opportunity to learn new coping skills that promote positive mental health. Stress management and relaxation techniques can be practiced for use when needed. A plan for managing emerging symptoms can also be developed during this period.

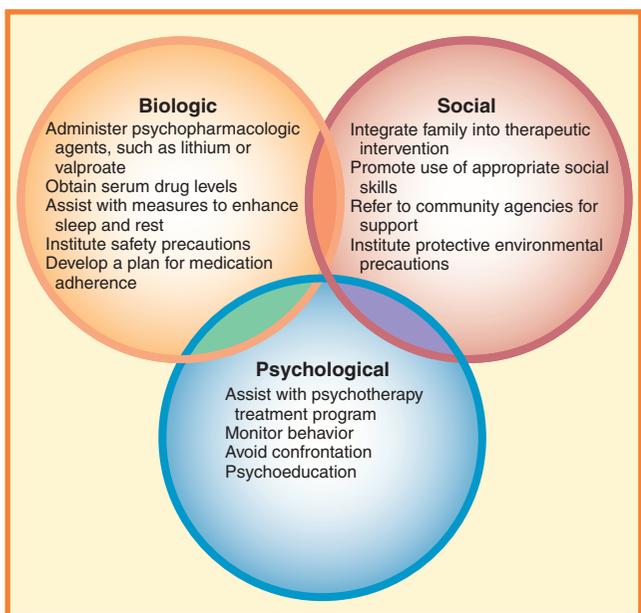


FIGURE 20.3. Biopsychosocial interventions for patients with bipolar I disorder.

SUMMARY OF KEY POINTS

- Mood disorders are characterized by persistent or recurring disturbances in mood that cause significant psychological distress and functional impairment. Moods can be broadly categorized as manic or dysphoric (typified by exaggerated feelings of elation or irritability) or depressive or dysthymic (typified by feelings of sadness, hopelessness, loss of interest, and fatigue).
- Primary mood disorders include both depressive disorders (unipolar depression) and manic-depressive disorders (bipolar disorders).
- Genetics undoubtedly plays a role in the etiology of mood disorders. Risk factors include family history of mood disorders, prior mood episodes, lack of social support, stressful life events, substance use, and medical problems, particularly chronic or terminal illnesses.

● The recommended depression treatment guidelines include antidepressant medication, alone or with psychotherapeutic management or psychotherapy; electroconvulsive therapy for severe depression; or light therapy (phototherapy) for patients with seasonal depressive symptoms.

● Nurses must be knowledgeable regarding culturally competent strategies related to the use of antidepressant medications, pharmacologic therapeutic effects and associated side effects, toxicity, dosage ranges, and contraindications. Nurses must also be familiar with electroconvulsive therapy protocols and associated interventions. Patient education and the provision of emotional support during the course of treatment are also nursing responsibilities.

● Many symptoms of depression, such as weight and appetite changes, sleep disturbance, decreased energy, and fatigue, are similar to those of medical illnesses. Assessment includes a thorough medical history and physical examination to detect or rule out medical or psychiatric comorbidity.

● Biopsychosocial assessment includes assessing mood, speech patterns, thought processes and thought content, suicidal or homicidal thoughts, cognition and memory, and social factors, such as patterns of relationships, quality of support systems, and changes in occupational functioning. Several self-report scales are helpful in evaluating depressive symptoms.

● Establishing and maintaining a therapeutic nurse–patient relationship is key to successful outcomes. Nursing interventions that foster the therapeutic relationship include being available in times of crisis; providing understanding and education to patients and their families regarding goals of treatment; providing encouragement and feedback concerning the patient's progress; providing guidance in the patient's interpersonal interactions with others and work environment; and helping to set and monitor realistic goals.

● Psychosocial interventions for mood disorders include self-care management, cognitive therapy, behavior therapy, interpersonal therapy, patient and family education regarding the nature of the disorder and treatment goals, marital and family therapy, and group therapy that includes medication maintenance support groups and other consumer-oriented support groups.

● Bipolar disorders are characterized by one or more manic episodes or mixed mania (co-occurrence of manic and depressive states) that cause marked impairment in social activities, occupational functioning, and interpersonal relationships and may require hospitalization to prevent self-harm.

● Manic episodes are periods in which the individual experiences abnormally and persistently elevated,

expansive, or irritable mood characterized by inflated self-esteem, decreased need to sleep, excessive energy or hyperactivity, racing thoughts, easy distractibility, and inability to stay focused. Other symptoms can include hypersexuality and impulsivity.

● Similar to treatment of major depressive disorder, pharmacotherapy is the cornerstone of treatment of bipolar illness, but adjunctive psychosocial interventions are needed as well. Pharmacologic therapy includes treatment with mood stabilizers alone or in combination with antipsychotics or benzodiazepines if psychosis, agitation, or insomnia are present and antidepressants for unremitted depression. Electroconvulsive therapy is a valuable alternative for patients with severe mania that does not respond to other treatment.

● Recent major advances in bipolar disorder treatment research validate the efficacy of integrated psychosocial and pharmacologic treatment involving family or couples therapies, psychoeducational programs, and individual cognitive-behavioral or interpersonal therapies.

CRITICAL THINKING CHALLENGES

- 1 Describe how you would do a suicide assessment on a patient in a physician's office who comes in distraught and expressing concerns about her ability to cope with her current situation.
- 2 Describe how you would approach the patient described in the previous thinking challenge if you determined that she was suicidal.
- 3 Discuss difficulties in the differential diagnosis of bipolar disorder in the manic phase and other medical and/or psychiatric disorders. List the information you would use to rule out the other diagnosis when dealing with a patient who appears to have mania.
- 4 Describe how you would approach a patient who is expressing concern that the diagnosis of bipolar disorder will negatively affect his/her social and work relationships.
- 5 Your depressed patient does not seem inclined to talk about his/her depression. Describe the measures you would take to initiate a therapeutic relationship with him/her.
- 6 Your patient with mania is experiencing physical hyperactivity that is interfering with his/her sleep and nutrition. Describe the actions you would take to meet the patient's needs for nutrition and rest.
- 7 Prepare a hypothetical discussion with a patient with potential bipolar disorder concerning the advantages/disadvantages of lithium versus divalproex sodium for treatment of bipolar disorder.

- 8 Prepare a hypothetical discussion with a depressed patient with potential unipolar disorder concerning the advantages and disadvantages of each of the major classifications of antidepressants.
- 9 Think about all of the above situations and relate them to persons from culturally and ethnically diverse populations (e.g., African, Latino, or Asian descent; Jewish or Jehovah Witness religions; across the life-span individuals from children to elderly populations).

MOVIES

About Schmidt. 2002. This movie is about a 67-year-old man, Warren Schmidt, played by Jack Nicholson, who retires from his job as an insurance company executive. He experiences work withdrawal and a lack of direction for his retirement. His wife, Helen, irritates him, and he has no idea what to do to fill his days. While watching television one day he is moved to sponsor a child in Africa with whom he begins a long, one-sided correspondence. When his wife dies unexpectedly, he is initially numb, then sad, and finally angry when he discovers that she had an affair with his best friend many years ago. He is estranged from his only daughter, Jeanie, whose wedding to Randall, a man he feels is beneath her, is imminent. The movie follows Warren as he searches for connection and meaning in his life.

SIGNIFICANCE: Warren Schmidt demonstrates a common phenomenon among the elderly when they retire. He also shows the impact of grief superimposed on initial dysthymia or depression.

VIEWING POINTS: Look for the changes in Schmidt's manifestations of depression in different situations. Note how he experiences the various stages of grieving. What do you think about Schmidt's search for significance and meaning in his life?

Dead Poet's Society. 1989. This film portrays John Keating, played by Robin Williams, as a charismatic English teacher in a conservative, New England prep school for boys in 1959. John brings his love of poetry to the students and encourages them to follow their dreams and talents and make the most of every day. His efforts put him at odds with administration of the school, particularly the headmaster, played by Norman Lloyd, as well as Tom Perry, the father of one of his students, played by Kurtwood Smith. Tom's son, Neil, played by Robert Sean Leonard, chooses to act in a school play despite the objection of his father to any extracurricular activities. When Neil cannot reconcile his love of theater and his father's expectations that he pursue a career in

medicine, he kills himself. John Keating blames himself for the death, as does the school administration. He is fired by the administration but has a moment of pride when his students demonstrate their ability to think and act for themselves.

SIGNIFICANCE: This film accurately portrays the sensitivity of adolescents and their longing for worthwhile role models. It also shows adolescent growth and development in a realistic manner. It demonstrates the combination of factors that accompany a decision to commit suicide. We can see how Neil feels caught between his desires and the demands of his father. In the cultural context of the late 1950s, few children or adolescents dared to challenge or defy their parents, especially such a domineering man as Tom Perry.

VIEWING POINTS: Look for the differences in Neil's behavior with his peers and his father or other adults besides Mr. Keating. What, if any, clues do you get that Neil might attempt suicide? What actions by any of the main characters might have prevented his suicide?

Mr. Jones. 1993. This film is about a musician, Mr. Jones, played by Richard Gere, and his psychiatrist. In his manic state, Mr. Jones is a charismatic, charming individual who persuades a contractor to hire him, proceeds to the roof of the building, and prepares to fly off the roof. He withdraws large sums of money from the bank. He knows that he has bipolar disorder but refuses to take his medication because of the side effects. He has episodes of depression during which he becomes suicidal. Once hospitalized, he struggles with trying to find a life on medication.

SIGNIFICANCE: Viewers can gain insight into the impact of mental illness on the promising career of a classical musician. This film illustrates the ways in which interpersonal relationships are affected by a psychiatric disorder. Unfortunately, the unethical romantic relationship between Mr. Jones and his psychiatrist detracts from the quality of the film's content.

VIEWING POINTS: Why does the diagnosis of paranoid schizophrenia not fit Mr. Jones' clinical picture in the admitting room? Identify the antecedents to the manic and depressive episodes. At what point is the physician-patient relationship first compromised? Are there early warning signs that should have alerted the psychiatrist that she was violating professional boundaries?

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