

15

Mood Disorders



Key Terms

- anergia
- anhedonia
- electroconvulsive therapy (ECT)
- euthymic
- flight of ideas
- hypertensive crisis
- hypomania
- kindling
- labile emotions
- latency of response
- mania
- mood disorders
- pressured speech
- psychomotor agitation
- psychomotor retardation
- ruminate
- seasonal affective disorder (SAD)
- suicidal ideation
- suicide
- suicide precautions

Learning Objectives

After reading this chapter, you should be able to:

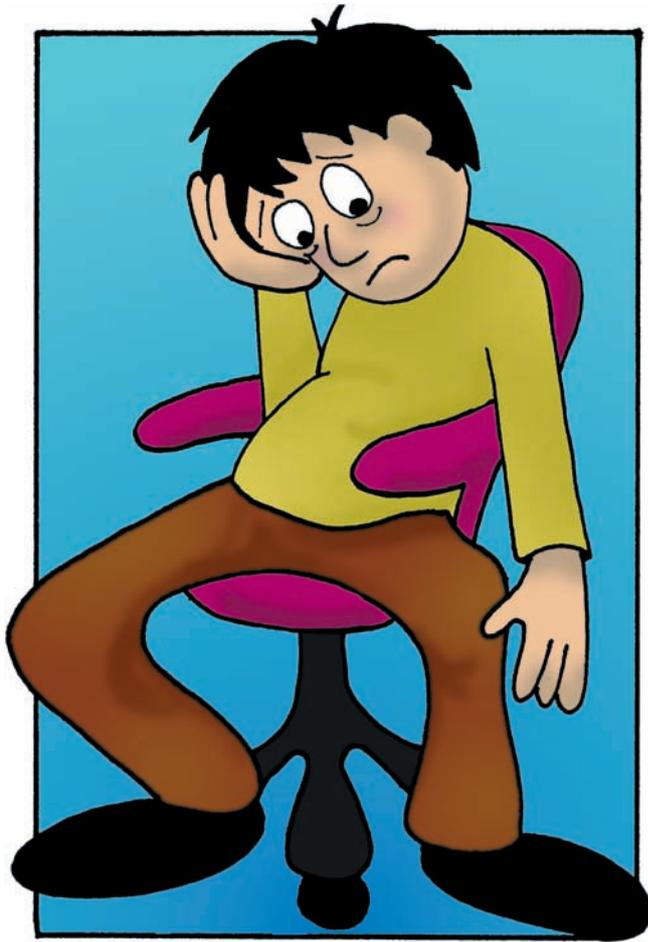
1. Discuss etiologic theories of depression and bipolar disorder.
2. Describe the risk factors for and characteristics of mood disorders.
3. Apply the nursing process to the care of clients and families with mood disorders.
4. Provide education to clients, families, caregivers, and community members to increase knowledge and understanding of mood disorders.
5. Identify populations at risk for suicide.
6. Apply the nursing process to the care of a suicidal client.
7. Evaluate your feelings, beliefs, and attitudes regarding mood disorders and suicide.

EVERYONE OCCASIONALLY FEELS sad, low, and tired, with the desire to stay in bed and shut out the world. These episodes often are accompanied by **anergia** (lack of energy), exhaustion, agitation, noise intolerance, and slowed thinking processes, all of which make decisions difficult.

Work, family, and social responsibilities drive most people to proceed with their daily routines, even when nothing seems to go right and their irritable mood is obvious to all. Such “low periods” pass in a few days, and energy returns. Fluctuations in mood are so common to the human condition that we think nothing of hearing someone say, “I’m depressed because I have too much to do.” Everyday use of the word *depressed* doesn’t actually mean that the person is clinically depressed but, rather, that the person is just having a bad day. Sadness in mood also can be a response to misfortune: death of a friend or relative, financial problems, or loss of a job may cause a person to grieve (see Chapter 12).

At the other end of the mood spectrum are episodes of exaggeratedly energetic behavior. The person has the sure sense that he or she can take on any task or relationship. In an elated mood, stamina for work, family, and social events is untiring. This feeling of being “on top of the world” also recedes in a few days to a **euthymic** mood (average affect and activity).

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Anergia

Happy events stimulate joy and enthusiasm. These mood alterations are normal and do not interfere meaningfully with the person's life.

Mood disorders, also called affective disorders, are pervasive alterations in emotions that are manifested by depression, mania, or both. They interfere with a person's life, plaguing him or her with drastic and long-term sadness, agitation, or elation. Accompanying self-doubt, guilt, and anger alter life activities, especially those that involve self-esteem, occupation, and relationships.

From early history, people have suffered from mood disturbances. Archeologists have found holes drilled into ancient skulls to relieve the "evil humors" of those suffering from sad feelings and strange behaviors. Babylonians and ancient Hebrews believed that overwhelming sadness and extreme behavior were sent to people through the will of God or other divine beings. Biblical notables King Saul, King Nebuchadnezzar, and Moses suffered overwhelming grief of heart, unclean spirits, and bitterness of soul, all of which are symptoms of depression. Abraham Lincoln and Queen Victoria had recurrent episodes of depression. Other famous people with mood disorders were writers Virginia Woolf, Sylvia Plath, and Eugene O'Neill; composer George Frideric Handel; musician Jerry Garcia; artist

Vincent Van Gogh; philosopher Frederic Nietzsche; television commentator and host of *60 Minutes* Mike Wallace; and actress Patty Duke.

Until the mid-1950s, no treatment was available to help people with serious depression or mania. These people suffered through their altered moods, thinking they were hopelessly weak to succumb to these devastating symptoms. Family and mental health professionals tended to agree, seeing sufferers as egocentric or viewing life negatively. Although there are still no cures for mood disorders, effective treatments for both depression and mania are now available.

Mood disorders are the most common psychiatric diagnoses associated with suicide; depression is one of the most important risk factors for it (Sudak, 2005). For that reason, this chapter focuses on major depression, bipolar disorder, and suicide. It is important to note that clients with schizophrenia, substance use disorders, antisocial and borderline personality disorders, and panic disorders also are at increased risk for suicide and suicide attempts.

CATEGORIES OF MOOD DISORDERS

The primary mood disorders are major depressive disorder and bipolar disorder (formerly called manic-depressive illness). A major depressive episode lasts at least 2 weeks, during which the person experiences a depressed mood or loss of pleasure in nearly all activities. In addition, four of the following symptoms are present: changes in appetite or weight, sleep, or psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. These symptoms must be present every day for 2 weeks and result in significant distress or impair social, occupational, or other important areas of functioning (American Psychiatric Association [APA], 2000). Some people also have delusions and hallucinations; the combination is referred to as psychotic depression.

Bipolar disorder is diagnosed when a person's mood cycles between extremes of mania and depression (as described previously). **Mania** is a distinct period during which mood is abnormally and persistently elevated, expansive, or irritable. Typically, this period lasts about 1 week (unless the person is hospitalized and treated sooner), but it may be longer for some individuals. At least three of the following symptoms accompany the manic episode: inflated self-esteem or grandiosity; decreased need for sleep; **pressured speech** (unrelenting, rapid, often loud talking without pauses); **flight of ideas** (racing, often unconnected, thoughts); distractibility; increased involvement in goal-directed activity or psychomotor agitation; and excessive involvement in pleasure-seeking activities with a high potential for painful consequences (APA, 2000). Some people also exhibit delusions and hallucinations during a manic episode.

Hypomania is a period of abnormally and persistently elevated, expansive, or irritable mood lasting 4 days and including three or four of the additional symptoms described earlier. The difference is that hypomanic episodes do not impair the person's ability to function (in fact, he or she may be quite productive), and there are no psychotic features (delusions and hallucinations). A mixed episode is diagnosed when the person experiences both mania and depression nearly every day for at least 1 week. These mixed episodes often are called rapid cycling. For the purpose of medical diagnosis, bipolar disorders are described as follows:

- Bipolar I disorder—one or more manic or mixed episodes usually accompanied by major depressive episodes.
- Bipolar II disorder—one or more major depressive episodes accompanied by at least one hypomanic episode.

People with bipolar disorder may experience a euthymic or normal mood and affect between extreme episodes, or they may have a depressed mood swing after a manic episode before returning to a euthymic mood. For some, euthymic periods between extremes are quite short. For others, euthymia lasts months or even years.

RELATED DISORDERS

Other disorders classified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (APA, 2000) as mood disorders but with symptoms that are less severe or of shorter duration include the following:

- Dysthymic disorder is characterized by at least 2 years of depressed mood for more days than not with some additional, less severe symptoms that do not meet the criteria for a major depressive episode.
- Cyclothymic disorder is characterized by 2 years of numerous periods of both hypomanic symptoms that do not meet the criteria for bipolar disorder.
- Substance-induced mood disorder is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiologic consequence of ingested substances such as alcohol, other drugs, or toxins.
- Mood disorder due to a general medical condition is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiologic consequence of a medical condition such as degenerative neurologic conditions, cerebrovascular disease, metabolic or endocrine conditions, autoimmune disorders, human immunodeficiency virus (HIV) infections, or certain cancers.

Other disorders that involve changes in mood include the following:

- **Seasonal affective disorder (SAD)** has two subtypes. In one, most commonly called winter depression or fall-onset SAD, people experience increased sleep, appetite,



Seasonal affective disorder

and carbohydrate cravings; weight gain; interpersonal conflict; irritability; and heaviness in the extremities beginning in late autumn and abating in spring and summer. The other subtype, called spring-onset SAD, is less common, with symptoms of insomnia, weight loss, and poor appetite lasting from late spring or early summer until early fall. SAD is often treated with light therapy (Rastad, Ulfberg, & Lindberg, 2008).

- Postpartum or “maternity” blues are a frequent normal experience after delivery of a baby. They are characterized by labile mood and affect, crying spells, sadness, insomnia, and anxiety. Symptoms begin approximately 1 day after delivery, usually peak in 3 to 7 days, and subside rapidly with no medical treatment (Sit, Rothschild, & Wisner, 2006).
- Postpartum depression meets all the criteria for a major depressive episode, with onset within 4 weeks of delivery.
- Postpartum psychosis is a psychotic episode developing within 3 weeks of delivery and beginning with fatigue, sadness, emotional lability, poor memory, and confusion and progressing to delusions, hallucinations, poor insight and judgment, and loss of contact with reality. This medical emergency requires immediate treatment (Sit et al., 2006).

ETIOLOGY

Various theories for the etiology of mood disorders exist. The most recent research focuses on chemical biologic imbalances as the cause. Nevertheless, psychosocial stressors and interpersonal events appear to trigger certain physiologic and chemical changes in the brain, which significantly alter the balance of neurotransmitters (Akiskal, 2005). Effective treatment addresses both the biologic and psychosocial components of mood disorders. Thus, nurses need a basic knowledge of both perspectives when working with clients experiencing these disorders.

Biologic Theories

Genetic Theories

Genetic studies implicate the transmission of major depression in first-degree relatives, who are at twice the risk for developing depression compared with the general population (APA, 2000). First-degree relatives of people with bipolar disorder have a 3% to 8% risk for developing bipolar disorder compared with a 1% risk in the general population. For all mood disorders, monozygotic (identical) twins have a concordance rate (both twins having the disorder) two to four times higher than that of dizygotic (fraternal) twins. Although heredity is a significant factor, the concordance rate for monozygotic twins is not 100%, so genetics alone do not account for all mood disorders (Kelsoe, 2005).

Markowitz and Milrod (2005) discussed indications of a genetic overlap between early-onset bipolar disorder and early-onset alcoholism. They noted that people with both problems have a higher rate of mixed and rapid cycling, poorer response to lithium, slower rate of recovery, and more hospital admissions. Mania displayed by these clients involves more agitation than elation; clients may respond better to anticonvulsants than to lithium.

Neurochemical Theories

Neurochemical influences of neurotransmitters (chemical messengers) focus on serotonin and norepinephrine as the two major biogenic amines implicated in mood disorders. Serotonin has many roles in behavior: mood, activity, aggressiveness and irritability, cognition, pain, biorhythms, and neuroendocrine processes (i.e., growth hormone, cortisol, and prolactin levels are abnormal in depression). Deficits of serotonin, its precursor tryptophan, or a metabolite (5-hydroxyindole acetic acid, or 5-HIAA) of serotonin found in the blood or cerebrospinal fluid occur in people with depression. Positron emission tomography demonstrates reduced metabolism in the prefrontal cortex, which may promote depression (Tecott & Smart, 2005).

Norepinephrine levels may be deficient in depression and increased in mania. This catecholamine energizes the body to mobilize during stress and inhibits kindling. **Kindling** is the process by which seizure activity in a specific area of the brain is initially stimulated by reaching a

threshold of the cumulative effects of stress, low amounts of electric impulses, or chemicals such as cocaine that sensitize nerve cells and pathways. These highly sensitized pathways respond by no longer needing the stimulus to induce seizure activity, which now occurs spontaneously. It is theorized that kindling may underlie the cycling of mood disorders as well as addiction. Anticonvulsants inhibit kindling; this may explain their efficacy in the treatment of bipolar disorder (Akiskal, 2005).

Dysregulation of acetylcholine and dopamine also is being studied in relation to mood disorders. Cholinergic drugs alter mood, sleep, neuroendocrine function, and the electroencephalographic pattern; therefore, acetylcholine seems to be implicated in depression and mania. The neurotransmitter problem may not be as simple as underproduction or depletion through overuse during stress. Changes in the sensitivity as well as the number of receptors are being evaluated for their roles in mood disorders (Tecott & Smart, 2005).

Neuroendocrine Influences

Hormonal fluctuations are being studied in relation to depression. Mood disturbances have been documented in people with endocrine disorders such as those of the thyroid, adrenal, parathyroid, and pituitary glands. Elevated glucocorticoid activity is associated with the stress response, and evidence of increased cortisol secretion is apparent in about 40% of clients with depression, with the highest rates found among older clients. Postpartum hormone alterations precipitate mood disorders such as postpartum depression and psychosis. About 5% to 10% of people with depression have thyroid dysfunction, notably an elevated thyroid-stimulating hormone. This problem must be corrected with thyroid treatment, or treatment for the mood disorder is affected adversely (Thase, 2005).

Psychodynamic Theories

Many psychodynamic theories about the cause of mood disorders seemed to “blame the victim” and his or her family (Markowitz & Milrod, 2005):

- Freud looked at the self-depreciation of people with depression and attributed that self-reproach to anger turned inward related to either a real or perceived loss. Feeling abandoned by this loss, people became angry while both loving and hating the lost object.
- Bibring believed that one’s ego (or self) aspired to be ideal (i.e., good and loving, superior or strong) and that to be loved and worthy, one must achieve these high standards. Depression results when, in reality, the person was not able to achieve these ideals all the time.
- Jacobson compared the state of depression with a situation in which the ego is a powerless, helpless child victimized by the superego, much like a powerful and sadistic mother who takes delight in torturing the child.

- Most psychoanalytical theories of mania view manic episodes as a “defense” against underlying depression, with the id taking over the ego and acting as an undisciplined hedonistic being (child).
- Meyer viewed depression as a reaction to a distressing life experience such as an event with psychic causality.
- Horney believed that children raised by rejecting or unloving parents were prone to feelings of insecurity and loneliness, making them susceptible to depression and helplessness.
- Beck saw depression as resulting from specific cognitive distortions in susceptible people. Early experiences shaped distorted ways of thinking about one’s self, the world, and the future; these distortions involve magnification of negative events, traits, and expectations and simultaneous minimization of anything positive.

CULTURAL CONSIDERATIONS

Other behaviors considered age appropriate can mask depression, which makes the disorder difficult to identify and diagnose in certain age groups. Children with depression often appear cranky. They may have school phobia, hyperactivity, learning disorders, failing grades, and anti-social behaviors. Adolescents with depression may abuse substances, join gangs, engage in risky behavior, be under-achievers, or drop out of school. In adults, manifestations of depression can include substance abuse, eating disorders, compulsive behaviors such as workaholism and gambling, and hypochondriasis. Older adults who are cranky and argumentative may actually be depressed.

Many somatic ailments (physiologic ailments) accompany depression. This manifestation varies among cultures

and is more apparent in cultures that avoid verbalizing emotions. For example, Asians who are anxious or depressed are more likely to have somatic complaints of headache, backache, or other symptoms. Latin cultures complain of “nerves” or headaches; Middle Eastern cultures complain of heart problems (Andrews & Boyle, 2007).

MAJOR DEPRESSIVE DISORDER

Major depressive disorder typically involves 2 or more weeks of a sad mood or lack of interest in life activities with at least four other symptoms of depression such as anhedonia and changes in weight, sleep, energy, concentration, decision making, self-esteem, and goals. Major depression is twice as common in women and has a 1.5 to 3 times greater incidence in first-degree relatives than in the general population. Incidence of depression decreases with age in women and increases with age in men. Single and divorced people have the highest incidence. Depression in prepubertal boys and girls occurs at an equal rate (Kelsoe, 2005).

Onset and Clinical Course

An untreated episode of depression can last 6 to 24 months before remitting. Fifty to sixty percent of people who have one episode of depression will have another. After a second episode of depression, there is a 70% chance of recurrence. Depressive symptoms can vary from mild to severe. The degree of depression is comparable with the person’s sense of helplessness and hopelessness. Some people with severe depression (9%) have psychotic features (APA, 2000).



CLINICAL VIGNETTE: DEPRESSION

“Just get out! I am not interested in food,” said Chris to her husband Matt, who had come into their bedroom to invite her to the dinner he and their daughters had prepared. “Can’t they leave me alone?” thought Chris to herself as she miserably pulled the covers over her shoulders. Yet she felt guilty about the way she’d snapped at Matt. She knew she’d disparaged her family’s efforts to help, but she couldn’t stop.

Chris was physically and emotionally exhausted. “I can’t remember when I felt well . . . maybe last year sometime, or maybe never,” she thought fretfully. She’d always worked hard to get things done; lately, she could not do anything at all except complain. Kathy, her 13-year-old, accused her of hating everything and everybody, including her family. Linda, 11 years old, said, “Everything has to be your way, Mom. You snap at us for every little thing. You never listen anymore.” Matt had long ago withdrawn from her moodiness,

acid tongue, and disinterest in sex. One day, she overheard Matt tell his brother that Chris was “crabby, agitated, and self-centered and if it wasn’t for the girls, I don’t know what I’d do. I’ve tried to get her to go to a doctor, but she says it’s all our fault; then she sulks for days. What is our fault? I don’t know what to do for her. I feel as if I am living in a minefield and never know what will set off an explosion. I try to remember the love we had together, but her behavior is getting old.”

Chris has lost 12 pounds in the past 2 months, has difficulty sleeping, and is hostile, angry, and guilty about it. She has no desire for any pleasure. “Why bother? There is nothing to enjoy. Life is bleak.” She feels stuck, worthless, hopeless, and helpless. Hoping against hope, Chris thinks to herself, “I wish I were dead. I’d never have to do anything again.”

DSM-IV-TR DIAGNOSTIC CRITERIA: Symptoms of Major Depressive Disorder

- Depressed mood
- Anhedonism (decreased attention to and enjoyment from previously pleasurable activities)
- Unintentional weight change of 5% or more in a month
- Change in sleep pattern
- Agitation or psychomotor retardation
- Tiredness
- Worthlessness or guilt inappropriate to the situation (possibly delusional)
- Difficulty thinking, focusing, or making decisions
- Hopelessness, helplessness, and/or suicidal ideation

Adapted from *DSM-IV-TR*, 2000.

Treatment and Prognosis

Psychopharmacology

Major categories of antidepressants include cyclic antidepressants, monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and atypical antidepressants. Chapter 2 details biologic treatments. The choice of which antidepressant to use is based on the client's symptoms, age, and physical health needs; drugs that have or have not worked in the past or that have worked for a blood relative with depression; and other medications that the client is taking.

Researchers believe that levels of neurotransmitters, especially norepinephrine and serotonin, are decreased in depression. Usually, presynaptic neurons release these neurotransmitters to allow them to enter synapses and link with postsynaptic receptors. Depression results if too few neurotransmitters are released, if they linger too briefly in synapses, if the releasing presynaptic neurons reabsorb them too quickly, if conditions in synapses do not support linkage with postsynaptic receptors, or if the number of postsynaptic receptors has decreased. The goal is to increase the efficacy of available neurotransmitters and the absorption by postsynaptic receptors. To do so, antidepressants establish a blockade for the reuptake of norepinephrine and serotonin into their specific nerve terminals. This permits them to linger longer in synapses and to be more available to postsynaptic receptors. Antidepressants also increase the sensitivity of the postsynaptic receptor sites (Rush, 2005).

In clients who have acute depression with psychotic features, an antipsychotic is used in combination with an antidepressant. The antipsychotic treats the psychotic features; several weeks into treatment, the client is reassessed

to determine whether the antipsychotic can be withdrawn and the antidepressant maintained.

Evidence is increasing that antidepressant therapy should continue for longer than the 3 to 6 months originally believed necessary. Fewer relapses occur in people with depression who receive 18 to 24 months of antidepressant therapy. As a rule, the dosage of antidepressants should be tapered before being discontinued.

Selective Serotonin Reuptake Inhibitors. SSRIs, the newest category of antidepressants (Table 15.1), are effective for most clients. Their action is specific to serotonin reuptake inhibition; these drugs produce few sedating, anticholinergic, and cardiovascular side effects, which make them safer for use in older adults. Because of their low side effects and relative safety, people using SSRIs are more apt to be compliant with the treatment regimen than clients using more troublesome medications. Insomnia decreases in 3 to 4 days, appetite returns to a more normal state in 5 to 7 days, and energy returns in 4 to 7 days. In 7 to 10 days, mood, concentration, and interest in life improve.

Fluoxetine (Prozac) produces a slightly higher rate of mild agitation and weight loss but less somnolence. It has a half-life of more than 7 days, which differs from the 25-hour half-life of other SSRIs.

Cyclic Antidepressants. Tricyclics, introduced for the treatment of depression in the mid-1950s, are the oldest antidepressants. They relieve symptoms of hopelessness, helplessness, anhedonia, inappropriate guilt, suicidal ideation, and daily mood variations (cranky in the morning and better in the evening). Other indications include panic disorder, obsessive-compulsive disorder, and eating disorders. Each drug has a different degree of efficacy in blocking the activity of norepinephrine and serotonin or increasing the sensitivity of postsynaptic receptor sites. Tricyclic and heterocyclic antidepressants have a lag period of 10 to 14 days before reaching a serum level that begins to alter symptoms; they take 6 weeks to reach full effect. Because they have a long serum half-life, there is a lag period of 1 to 4 weeks before steady plasma levels are reached and the client's symptoms begin to decrease. They cost less primarily because they have been around longer and generic forms are available.

Tricyclic antidepressants are contraindicated in severe impairment of liver function and in myocardial infarction (acute recovery phase). They cannot be given concurrently with MAOIs. Because of their anticholinergic side effects, tricyclic antidepressants must be used cautiously in clients who have glaucoma, benign prostatic hypertrophy, urinary retention or obstruction, diabetes mellitus, hyperthyroidism, cardiovascular disease, renal impairment, or respiratory disorders (Table 15.2).

Overdosage of tricyclic antidepressants occurs over several days and results in confusion, agitation, hallucinations, hyperpyrexia, and increased reflexes. Seizures, coma, and cardiovascular toxicity can occur with ensuing tachycardia, decreased output, depressed contractility, and atrioventricular block. Because many older adults have

Table

15.1 SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI) ANTIDEPRESSANTS

Generic (Trade) Name	Side Effects	Nursing Implications
Fluoxetine (Prozac)	Headache, nervousness, anxiety, sedation, tremor, sexual dysfunction, anorexia, constipation, nausea, diarrhea, and weight loss	Administer in AM (if nervous) or PM (if drowsy). Monitor for hyponatremia. Encourage adequate fluids. Report sexual difficulties to physician.
Sertraline (Zoloft)	Dizziness, sedation, headache, insomnia, tremor, sexual dysfunction, diarrhea, dry mouth and throat, nausea, vomiting, and sweating	Administer in PM if client is drowsy. Encourage use of sugar-free beverages or hard candy. Drink adequate fluids. Monitor hyponatremia; report sexual difficulties to physician.
Paroxetine (Paxil)	Dizziness, sedation, headache, insomnia, weakness, fatigue, constipation, dry mouth and throat, nausea, vomiting, diarrhea, and sweating	Administer with food. Administer in PM if client is drowsy. Encourage use of sugar-free hard candy or beverages. Encourage adequate fluids.
Citalopram (Celexa)	Drowsiness, sedation, insomnia, nausea, vomiting, weight gain, constipation, and diarrhea	Monitor for hyponatremia. Administer with food. Administer dose at 6 PM or later. Promote balanced nutrition and exercise.
Escitalopram (Lexapro)	Drowsiness, dizziness, weight gain, sexual dysfunction, restlessness, dry mouth, headache, nausea, and diarrhea	Check orthostatic blood pressure. Assist client to rise slowly from sitting position. Encourage use of sugar-free beverages or hard candy. Administer with food.

concomitant health problems, cyclic antidepressants are used less often in the geriatric population than newer types of antidepressants that have fewer side effects and less drug interactions.

Tetracyclic Antidepressants. Amoxapine (Asendin) may cause extrapyramidal symptoms, tardive dyskinesia, and neuroleptic malignant syndrome. It can create tolerance in 1 to 3 months. It increases appetite and causes weight gain and cravings for sweets.

Maprotiline (Ludiomil) carries a risk for seizures (especially in heavy drinkers), severe constipation and urinary retention, stomatitis, and other side effects; this leads to poor compliance. The drug is started and withdrawn gradually. Central nervous system depressants can increase the effects of this drug.

Atypical Antidepressants. Atypical antidepressants are used when the client has an inadequate response to or side effects from SSRIs. Atypical antidepressants include venlafaxine (Effexor), duloxetine (Cymbalta), bupropion (Wellbutrin), nefazodone (Serzone), and mirtazapine (Remeron) (Table 15.3).

Venlafaxine blocks the reuptake of serotonin, norepinephrine, and dopamine (weakly). Duloxetine selectively blocks both serotonin and norepinephrine. Bupropion modestly

inhibits the reuptake of norepinephrine, weakly inhibits the reuptake of dopamine, and has no effects on serotonin. Bupropion is marketed as Zyban for smoking cessation.

Nefazodone inhibits the reuptake of serotonin and norepinephrine and has few side effects. Its half-life is 4 hours, and it can be used in clients with liver and kidney disease. It increases the action of certain benzodiazepines (alprazolam, estazolam, and triazolam) and the H₂ blocker terfenadine. Remeron also inhibits the reuptake of serotonin and norepinephrine, and it has few sexual side effects; however, its use comes with a higher incidence of weight gain, sedation, and anticholinergic side effects (Facts and Comparisons, 2009).

Monoamine Oxidase Inhibitors. MAOIs are used infrequently because of potentially fatal side effects and interactions with numerous drugs, both prescription and over-the-counter preparations (Table 15.4). The most serious side effect is **hypertensive crisis**, a life-threatening condition that can result when a client taking MAOIs ingests tyramine-containing foods (see Chapter 2, Box 2.1) and fluids or other medications. Symptoms are occipital headache, hypertension, nausea, vomiting, chills, sweating, restlessness, nuchal rigidity, dilated pupils, fever, and motor agitation. These can lead to hyperpyrexia, cerebral hemorrhage,


Table 15.2 TRICYCLIC ANTIDEPRESSANT MEDICATIONS

Generic (Trade) Name	Side Effects	Nursing Implications
Amitriptyline (Elavil)	Dizziness, orthostatic hypotension, tachycardia, sedation, headache, tremor, blurred vision, constipation, dry mouth and throat, weight gain, urinary hesitancy, and sweating	Assist client to rise slowly from sitting position. Administer at bedtime. Encourage use of sugar-free beverages and hard candy. Ensure adequate fluids and balanced nutrition. Encourage exercise. Monitor cardiac function.
Amoxapine (Asendin)	Dizziness, orthostatic hypotension, sedation, insomnia, constipation, dry mouth and throat, and rashes	Assist client to rise slowly from sitting position. Administer at bedtime if client is sedated. Ensure adequate fluids. Encourage use of sugar-free beverages and hard candy. Report rashes to physician.
Doxepin (Sinequan)	Dizziness, orthostatic hypotension, tachycardia, sedation, blurred vision, constipation, dry mouth and throat, weight gain, and sweating	Assist client to rise slowly from sitting position. Administer at bedtime if client is sedated. Ensure adequate fluids and balanced nutrition. Encourage use of sugar-free beverages and hard candy. Encourage exercise.
Imipramine (Tofranil)	Dizziness, orthostatic hypotension, weakness, fatigue, blurred vision, constipation, dry mouth and throat, and weight gain	Assist client to rise slowly from sitting or supine position. Ensure adequate fluids and balanced nutrition. Encourage use of sugar-free beverages and hard candy. Encourage exercise.
Desipramine (Norpramine)	Cardiac dysrhythmias, dizziness, orthostatic hypotension, excitement, insomnia, sexual dysfunction, dry mouth and throat, and rashes	Monitor cardiac function. Assist client to rise slowly from sitting position. Administer in AM if client is having insomnia. Encourage sugar-free beverages and hard candy. Report rashes or sexual difficulties to physician.
Nortriptyline (Pamelor)	Cardiac dysrhythmias, tachycardia, confusion, excitement, tremor, constipation, and dry mouth and throat	Monitor cardiac function. Administer in AM if stimulated. Ensure adequate fluids. Encourage use of sugar-free beverages and hard candy. Report confusion to physician.

and death. The MAOI–tyramine interaction produces symptoms within 20 to 60 minutes after ingestion. For hypertensive crisis, transient antihypertensive agents, such as phentolamine mesylate, are given to dilate blood vessels and decrease vascular resistance (Facts and Comparisons, 2009).

There is a 2- to 4-week lag period before MAOIs reach therapeutic levels. Because of the lag period, adequate washout periods of 5 to 6 weeks are recommended between the times that the MAOI is discontinued and another class of antidepressant is started.

Other Medical Treatments and Psychotherapy

Electroconvulsive Therapy. Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select

groups, such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT with no harm to the fetus. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication.

ECT involves application of electrodes to the head of the client to deliver an electrical impulse to the brain; this causes a seizure. It is believed that the shock stimulates brain chemistry to correct the chemical imbalance of depression. Historically, clients did not receive any anesthetic or other medication before ECT, and they had full-blown grand mal seizures that often resulted in injuries


Table 15.3 ATYPICAL ANTIDEPRESSANTS

Generic (Trade) Name	Side Effects	Nursing Implications
Venlafaxine (Effexor)	Increased blood pressure and pulse, nausea, vomiting, headache, dizziness, drowsiness, dry mouth, and sweating; can alter many lab tests, e.g., AST, ALT, alkaline phosphatase, creatinine, glucose, and electrolytes	Administer with food. Ensure adequate fluids. Give in PM. Encourage use of sugar-free beverages or hard candy.
Duloxetine (Cymbalta)	Increased blood pressure and pulse, nausea, vomiting, drowsiness or insomnia, headache, dry mouth, constipation, lowered seizure threshold, and sexual dysfunction	Administer with food. Ensure adequate fluids. Encourage use of sugar-free beverages or hard candy. Give with food.
Bupropion (Wellbutrin)	Nausea, vomiting, lowered seizure threshold, agitation, restlessness, insomnia, may alter taste, blurred vision, weight gain, and headache	Administer dose in AM. Ensure balanced nutrition and exercise.
Nefazodone (Serzone)	Headache; dizziness; drowsiness; alters results of AST, ALT, LDH, cholesterol, glucose, and hematocrit	Administer before meal (food inhibits absorption). Monitor liver and kidney functions.
Mirtazapine (Remeron)	Sedation, dizziness, dry mouth and throat, weight gain, sexual dysfunction, and constipation	Administer in PM. Encourage use of sugar-free beverages and hard candy. Ensure adequate fluids and balanced nutrition. Report sexual difficulties to physician.

ALT, alanine aminotransferase; AST, aspartate aminotransferase; LDH, lactate dehydrogenase.


Table 15.4 MONOAMINE OXIDASE INHIBITOR (MAOI) ANTIDEPRESSANTS

Generic (Trade) Name	Side Effects	Nursing Implications
Isocarboxazid (Marplan) Phenelzine (Nardil) Tranlycypromine (Parnate)	Drowsiness, dry mouth, overactivity, insomnia, nausea, anorexia, constipation, urinary retention, and orthostatic hypotension	Assist client to rise slowly from sitting position. Administer in AM. Administer with food. Ensure adequate fluids. Perform essential teaching on importance of low-tyramine diet.

ranging from biting the tongue to breaking bones. ECT fell into disfavor for a period and was seen as “barbaric.” Today, although ECT is administered in a safe and humane way with almost no injuries, there are still critics of the treatment.

Clients usually receive a series of 6 to 15 treatments scheduled thrice a week. Generally, a minimum of six treatments are needed to see sustained improvement in depressive symptoms. Maximum benefit is achieved in 12 to 15 treatments.

Preparation of a client for ECT is similar to preparation for any outpatient minor surgical procedure: The client receives nothing by mouth (or, is NPO) after midnight, removes any fingernail polish, and voids just before the procedure. An intravenous line is started for the administration of medication.

Initially, the client receives a short-acting anesthetic so he or she is not awake during the procedure. Next, he or she receives a muscle relaxant/paralytic, usually succinylcholine, which relaxes all muscles to reduce greatly the outward

Drug Alert !



Serotonin Syndrome

Serotonin syndrome occurs when there is an inadequate washout period between taking MAOIs and SSRIs or when MAOIs are combined with meperidine. Symptoms of serotonin syndrome include:

- Change in mental state: confusion and agitation
- Neuromuscular excitement: muscle rigidity, weakness, sluggish pupils, shivering, tremors, myoclonic jerks, collapse, and muscle paralysis
- Autonomic abnormalities: hyperthermia, tachycardia, tachypnea, hypersalivation, and diaphoresis

Drug Alert !



Overdose of MAOI and Cyclic Antidepressants

Both the cyclic compounds and MAOIs are potentially lethal when taken in overdose. To decrease this risk, depressed or impulsive clients who are taking any antidepressants in these two categories may need to have prescriptions and refills in limited amounts.

Drug Alert !



MAOI Drug Interactions

There are numerous drugs that interact with MAOIs. The following drugs cause potentially fatal interactions:

- Amphetamines
- Ephedrine
- Fenfluramine
- Isoproterenol
- Meperidine
- Phenylephrine
- Phenylpropanolamine
- Pseudoephedrine
- SSRI antidepressants
- Tricyclic antidepressants
- Tyramine

signs of the seizure (e.g., clonic–tonic muscle contractions). Electrodes are placed on the client's head: one on either side (bilateral) or both on one side (unilateral). The electrical stimulation is delivered, which causes seizure activity in the brain that is monitored by an electroencephalogram, or

EEG. The client receives oxygen and is assisted to breathe with an Ambu bag. He or she generally begins to waken after a few minutes. Vital signs are monitored, and the client is assessed for the return of a gag reflex.

After ECT treatment, the client may be mildly confused or briefly disoriented. He or she is very tired and often has a headache. The symptoms are just like those of anyone who has had a grand mal seizure. In addition, the client will have some short-term memory impairment. After a treatment, the client may eat as soon as he or she is hungry and usually sleeps for a period. Headaches are treated symptomatically.

Unilateral ECT results in less memory loss for the client, but more treatments may be needed to see sustained improvement. Bilateral ECT results in more rapid improvement but with increased short-term memory loss.

The literature continues to be divided about the effectiveness of ECT. Some studies report that ECT is as effective as medication for depression, whereas other studies report only short-term improvement. Likewise, some studies report that memory loss side effects of ECT are short lived, whereas others report they are serious and long term (Fenton, Fasula, Ostroff, & Sanacora, 2006; Ross, 2006).

ECT is also used for relapse prevention in depression. Clients may continue to receive treatments, such as one per month, to maintain their mood improvement. Often, clients are given antidepressant therapy after ECT to prevent relapse. Studies have found maintenance ECT to be effective in relapse prevention (Frederikse, Petrides, & Kellner, 2006).

Psychotherapy. A combination of psychotherapy and medications is considered the most effective treatment for depressive disorders. There is no one specific type of therapy that is better for the treatment of depression (Rush, 2005). The goals of combined therapy are symptom remission, psychosocial restoration, prevention of relapse or recurrence, reduced secondary consequences such as marital discord or occupational difficulties, and increasing treatment compliance.

Interpersonal therapy focuses on difficulties in relationships, such as grief reactions, role disputes, and role transitions. For example, a person who, as a child, never learned how to make and trust a friend outside the family structure has difficulty establishing friendships as an adult. Interpersonal therapy helps the person to find ways to accomplish this developmental task.

Behavior therapy seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions. It also may focus on improving social skills.

Cognitive therapy focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person's distorted thinking, which, in turn, influences feelings, behavior, and functional abilities. Table 15.5 describes the cognitive distortions that are the focus of cognitive therapy.

Table

15.5 DISTORTIONS ADDRESSED BY COGNITIVE THERAPY

Cognitive Distortion	Definition
Absolute, dichotomous thinking	Tendency to view everything in polar categories, i.e., all or none, black or white
Arbitrary inference	Drawing a specific conclusion without sufficient evidence, i.e., jumping to (negative) conclusions
Specific abstraction	Focusing on a single (often minor) detail while ignoring other, more significant aspects of the experience, i.e., concentrating on one small (negative) detail while discounting positive aspects
Overgeneralization	Forming conclusions based on too little or too narrow experience, i.e., if one experience was negative, then all similar experiences will be negative
Magnification and minimization	Over- or undervaluing the significance of a particular event, i.e., one small negative event is the end of the world or a positive experience is totally discounted
Personalization	Tendency to self-reference external events without basis, i.e., believing that events are directly related to one's self, whether they are or not

Investigational Treatments. Other treatments for depression are being tested. These include transcranial magnetic stimulation (TMS), magnetic seizure therapy, deep brain stimulation, and vagal nerve stimulation. TMS is the closest to approval for clinical use. These novel brain-stimulation techniques seem to be safe, but their efficacy in relieving depression needs to be established (Eitan & Lerer, 2006).

APPLICATION OF THE NURSING PROCESS: DEPRESSION

Assessment

History

The nurse can collect assessment data from the client and family or significant others, previous chart information, and others involved in the support or care. It may take several short periods to complete the assessment because clients who are severely depressed feel exhausted and overwhelmed. It can take time for them to process the question asked and to formulate a response. It is important that the nurse does not try to rush clients because doing so leads to frustration and incomplete assessment data.

To assess the client's perception of the problem, the nurse asks about behavioral changes: when they started, what was happening when they began, their duration, and what the client has tried to do about them. Assessing the history is important to determine any previous episodes of depression, treatment, and client's response to treatment. The nurse also asks about family history of mood disorders, suicide, or attempted suicide.

General Appearance and Motor Behavior

Many people with depression look sad; sometimes they just look ill. The posture often is slouched with head down, and they make minimal eye contact. They have

psychomotor retardation (slow body movements, slow cognitive processing, and slow verbal interaction). Responses to questions may be minimal, with only one or two words. **Latency of response** is seen when clients take up to 30 seconds to respond to a question. They may answer some questions with "I don't know" because they are simply too fatigued and overwhelmed to think of an answer or respond in any detail. Clients also may exhibit signs of agitation or anxiety such as wringing their hands and having difficulty sitting still. These clients are said to have **psychomotor agitation** (increased body movements and thoughts), which includes pacing, accelerated thinking, and argumentativeness.

Mood and Affect

Clients with depression may describe themselves as hopeless, helpless, down, or anxious. They also may say they are a burden on others or are a failure at life, or they may make other similar statements. They are easily frustrated, are angry with themselves, and can be angry with others (APA, 2000). They experience **anhedonia**, losing any sense of pleasure from activities they formerly enjoyed. Clients may be apathetic, that is, not caring about self, activities, or much of anything.

Their affect is sad or depressed or may be flat with no emotional expressions. Typically, depressed clients sit alone, staring into space or lost in thought. When addressed, they interact minimally with a few words or a gesture. They are overwhelmed by noise and people who might make demands on them, so they withdraw from the stimulation of interaction with others.

Thought Process and Content

Clients with depression experience slowed thinking processes: their thinking seems to occur in slow motion. With



Nursing Care Plan | Depression

Nursing Diagnosis

Ineffective Coping: *Inability to form a valid appraisal of the stressors, inadequate choices of practiced responses, and/or inability to use available resources.*

ASSESSMENT DATA

- Suicidal ideas or behavior
- Slowed mental processes
- Disordered thoughts
- Feelings of despair, hopelessness, and worthlessness
- Guilt
- Anhedonia (inability to experience pleasure)
- Disorientation
- Generalized restlessness or agitation
- Sleep disturbances: early awakening, insomnia, or excessive sleeping
- Anger or hostility (may not be overt)
- Rumination
- Delusions, hallucinations, or other psychotic symptoms
- Diminished interest in sexual activity
- Fear of intensity of feelings
- Anxiety

EXPECTED OUTCOMES

Immediate

The client will

- Be free from self-inflicted harm
- Engage in reality-based interactions
- Be oriented to person, place, and time
- Express anger or hostility outwardly in a safe manner, e.g., talking with staff members

Stabilization

The client will

- Express feelings directly with congruent verbal and nonverbal messages
- Be free from psychotic symptoms
- Demonstrate functional level of psychomotor activity

Community

The client will

- Demonstrate compliance with and knowledge of medications, if any
- Demonstrate an increased ability to cope with anxiety, stress, or frustration
- Verbalize or demonstrate acceptance of loss or change, if any
- Identify a support system in the community

IMPLEMENTATION

Nursing Interventions (* denotes collaborative interventions)

Provide a safe environment for the client.

Continually assess the client's potential for suicide. Remain aware of this suicide potential at all times.

Observe the client closely, especially under the following circumstances:

- After antidepressant medication begins to raise the client's mood.
- Unstructured time on the unit or times when the number of staff on the unit is limited.
- After any dramatic behavioral change (sudden cheerfulness, relief, or giving away personal belongings).

Rationale

Physical safety of the client is a priority. Many common items may be used in a self-destructive manner. Depressed clients may have a potential for suicide that may or may not be expressed and that may change with time.

You must be aware of the client's activities at all times when there is a potential for suicide or self-injury. Risk for suicide increases as the client's energy level is increased by medication, when the client's time is unstructured, and when observation of the client decreases. These changes may indicate that the client has come to a decision to commit suicide.

(continued)

Nursing Care Plan | *Depression, cont.*

IMPLEMENTATION

Nursing Interventions (* denotes collaborative interventions)

Reorient the client to person, place, and time as indicated (call the client by name, tell the client your name, tell the client where he or she is, and so forth).

Spend time with the client.

If the client is ruminating, tell him or her that you will talk about reality or about the client's feelings, but limit the attention given to repeated expressions of rumination.

Initially assign the same staff members to work with the client whenever possible.

When approaching the client, use a moderate, level tone of voice. Avoid being overly cheerful.

Use silence and active listening when interacting with the client. Let the client know that you are concerned and that you consider the client a worthwhile person.

Be comfortable sitting with the client in silence. Let the client know you are available to converse, but do not require the client to talk.

When first communicating with the client, use simple, direct sentences; avoid complex sentences or directions.

Avoid asking the client many questions, especially questions that require only brief answers.

Do not cut off interactions with cheerful remarks or platitudes (e.g., "No one really wants to die," or "You'll feel better soon."). Do not belittle the client's feelings. Accept the client's verbalizations of feelings as real, and give support for expressions of emotions, especially those that may be difficult for the client (like anger).

Encourage the client to ventilate feelings in whatever way is comfortable—verbal and nonverbal. Let the client know you will listen and accept what is being expressed.

Allow (and encourage) the client to cry. Stay with and support the client if he or she desires. Provide privacy if the client desires and it is safe to do so.

Interact with the client on topics with which he or she is comfortable. Do not probe for information.

Rationale

Repeated presentation of reality is concrete reinforcement for the client.

Your physical presence is reality.

Minimizing attention may help decrease rumination.

Providing reinforcement for reality orientation and expression of feelings will encourage these behaviors.

The client's ability to respond to others may be impaired. Limiting the number of new contacts initially will facilitate familiarity and trust.

However, the number of people interacting with the client should increase as soon as possible to minimize dependency and to facilitate the client's abilities to communicate with a variety of people.

Being overly cheerful may indicate to the client that being cheerful is the goal and that other feelings are not acceptable.

The client may not communicate if you are talking too much. Your presence and use of active listening will communicate your interest and concern.

Your silence will convey your expectation that the client will communicate and your acceptance of the client's difficulty with communication.

The client's ability to perceive and respond to complex stimuli is impaired.

Asking questions and requiring only brief answers may discourage the client from expressing feelings.

You may be uncomfortable with certain feelings the client expresses. If so, it is important for you to recognize this and discuss it with another staff member rather than directly or indirectly communicating your discomfort to the client. Proclaiming the client's feelings to be inappropriate or belittling them is detrimental.

Expressing feelings may help relieve despair, hopelessness, and so forth. Feelings are not inherently good or bad. You must remain nonjudgmental about the client's feelings and express this to the client.

Crying is a healthy way of expressing feelings of sadness, hopelessness, and despair. The client may not feel comfortable crying and may need encouragement or privacy.

Topics that are uncomfortable for the client and probing may be threatening and discourage communication. After trust has been established, the client may be able to discuss more difficult topics.

(continued)

Nursing Care Plan | *Depression, cont.*

IMPLEMENTATION

Nursing Interventions (* denotes collaborative interventions)

Teach the client about the problem-solving process: explore possible options, examine the consequences of each alternative, select and implement an alternative, and evaluate the results.

Provide positive feedback at each step of the process. If the client is not satisfied with the chosen alternative, assist the client to select another alternative.

Rationale

The client may be unaware of a systematic method for solving problems. Successful use of the problem-solving process facilitates the client's confidence in the use of coping skills.

Positive feedback at each step will give the client many opportunities for success, encourage him or her to persist in problem solving, and enhance confidence. The client also can learn to “survive” making a mistake.

Adapted from Schultz, J. M., & Videbeck, S. L. (2009). *Lippincott's manual of psychiatric nursing care plans* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.

severe depression, they may not respond verbally to questions. Clients tend to be negative and pessimistic in their thinking, that is, they believe that they will always feel this bad, things will never get any better, and nothing will help. Clients make self-deprecating remarks, criticizing themselves harshly and focusing only on failures or negative attributes. They tend to **ruminate**, which is repeatedly going over the same thoughts. Those who experience psychotic symptoms have delusions; they often believe they are responsible for all the tragedies and miseries in the world.

Often clients with depression have thoughts of dying or committing suicide. It is important to assess suicidal ideation by asking about it directly. The nurse may ask, “Are you thinking about suicide?” or “What suicidal thoughts are you having?” Most clients readily admit to suicidal thinking. Suicide is discussed more fully later in this chapter.

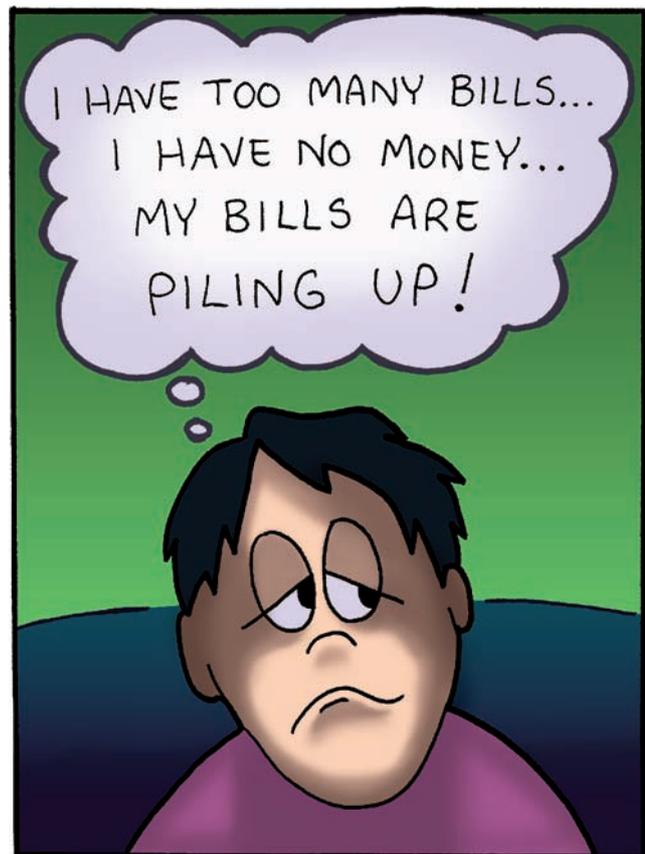
Sensorium and Intellectual Processes

Some clients with depression are oriented to person, time, and place; others experience difficulty with orientation, especially if they experience psychotic symptoms or are withdrawn from their environment. Assessing general knowledge is difficult because of their limited ability to respond to questions. Memory impairment is common. Clients have extreme difficulty concentrating or paying attention. If psychotic, clients may hear degrading and belittling voices or they may even have command hallucinations that order them to commit suicide.

Judgment and Insight

Clients with depression experience impaired judgment because they cannot use their cognitive abilities to solve problems or to make decisions. They often cannot make decisions or choices because of their extreme apathy or their negative belief that it “doesn't matter anyway.”

Insight may be intact, especially if clients have been depressed previously. Others have very limited insight and



Rumination

are totally unaware of their behavior, feelings, or even their illness.

Self-Concept

Sense of self-esteem is greatly reduced; clients often use phrases such as “good for nothing” or “just worthless” to

describe themselves. They feel guilty about not being able to function and often personalize events or take responsibility for incidents over which they have no control. They believe that others would be better off without them, a belief which leads to suicidal thoughts.

Roles and Relationships

Clients with depression have difficulty fulfilling roles and responsibilities. The more severe the depression, the greater the difficulty. They have problems going to work or school; when there, they seem unable to carry out their responsibilities. The same is true with family responsibilities. Clients are less able to cook, clean, or care for children. In addition to the inability to fulfill roles, clients become even more convinced of their “worthlessness” for being unable to meet life responsibilities.

Depression can cause great strain in relationships. Family members who have limited knowledge about depression may believe clients should “just get on with it.” Clients often avoid family and social relationships because they feel overwhelmed, experience no pleasure from interactions, and feel unworthy. As clients withdraw from relationships, the strain increases.

Physiologic and Self-Care Considerations

Clients with depression often experience pronounced weight loss because of lack of appetite or disinterest in eating. Sleep disturbances are common: either clients cannot sleep, or they feel exhausted and unrefreshed no matter how much time they spend in bed. They lose interest in sexual activities, and men often experience impotence. Some clients neglect personal hygiene because they lack the interest or energy. Constipation commonly results from decreased food and fluid intake as well as from inactivity. If fluid intake is severely limited, clients also may be dehydrated.

Depression Rating Scales

Clients complete some rating scales for depression; mental health professionals administer others. These assessment tools, along with evaluation of behavior, thought processes, history, family history, and situational factors, help to create a diagnostic picture. Self-rating scales of depressive symptoms include the Zung Self-Rating Depression Scale and the Beck Depression Inventory. Self-rating scales are used for case finding in the general public and may be used over the course of treatment to determine improvement from the client’s perspective.

The Hamilton Rating Scale for Depression (Table 15.6) is a clinician-rated depression scale used like a clinical interview. The clinician rates the range of the client’s behaviors such as depressed mood, guilt, suicide, and insomnia. There is also a section to score diurnal variations, depersonalization (sense of unreality about the self), paranoid symptoms, and obsessions.

Data Analysis

The nurse analyzes assessment data to determine priorities and to establish a plan of care. Nursing diagnoses commonly established for the client with depression include the following:

- Risk for Suicide
- Imbalanced Nutrition: Less Than Body Requirements
- Anxiety
- Ineffective Coping
- Hopelessness
- Ineffective Role Performance
- Self-Care Deficit
- Chronic Low Self-Esteem
- Disturbed Sleep Pattern
- Impaired Social Interaction

Outcome Identification

Outcomes for clients with depression relate to how the depression is manifested—for instance, whether or not the person is slow or agitated, sleeps too much or too little, or eats too much or too little. Examples of outcomes for a client with the psychomotor retardation form of depression include the following:

- The client will not injure himself or herself.
- The client will independently carry out activities of daily living (showering, changing clothing, grooming).
- The client will establish a balance of rest, sleep, and activity.
- The client will establish a balance of adequate nutrition, hydration, and elimination.
- The client will evaluate self-attributes realistically.
- The client will socialize with staff, peers, and family/friends.
- The client will return to occupation or school activities.
- The client will comply with antidepressant regimen.
- The client will verbalize symptoms of a recurrence.

Intervention

Providing for Safety

The first priority is to determine whether a client with depression is suicidal. If a client has suicidal ideation or hears voices commanding him or her to commit suicide, measures to provide a safe environment are necessary. If the client has a suicide plan, the nurse asks additional questions to determine the lethality of the intent and plan. The nurse reports this information to the treatment team. Health care personnel follow hospital or agency policies and procedures for instituting **suicide precautions** (e.g., removal of harmful items, increased supervision). A thorough discussion is presented later in the chapter.



Table 15.6 HAMILTON RATING SCALE FOR DEPRESSION

For each item select the “cue” that best characterizes the patient.

- 1: Depressed mood (sadness, hopeless, helpless, worthless)
- 0 Absent
 - 1 These feeling states indicated only on questioning
 - 2 These feeling states spontaneously reported verbally
 - 3 Communicates feeling states nonverbally—i.e., through facial expression, posture, voice, and tendency to weep
 - 4 Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication
- 2: Feelings of guilt
- 0 Absent
 - 1 Self-reproach, feels he has let people down
 - 2 Ideas of guilt or rumination over past errors or sinful deeds
 - 3 Present illness is a punishment. Delusions of guilt
 - 4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations
- 3: Suicide
- 0 Absent
 - 1 Feels life is not worth living
 - 2 Wishes he were dead or any thoughts of possible death to self
 - 3 Suicide ideas or gesture
 - 4 Attempts at suicide (any serious attempt rates 4)
- 4: Insomnia early
- 0 No difficulty falling asleep
 - 1 Complains of occasional difficulty falling asleep—i.e., more than ¼ hour
 - 2 Complains of nightly difficulty falling asleep
- 5: Insomnia middle
- 0 No difficulty
 - 1 Patient complains of being restless and disturbed during the night
 - 2 Waking during the night—any getting out of bed rates 2 (except for purpose of voiding)
- 6: Insomnia late
- 0 No difficulty
 - 1 Waking in early hours of the morning but goes back to sleep
 - 2 Unable to fall asleep again if gets out of bed
- 7: Work and activities
- 0 No difficulty
 - 1 Thoughts and feelings of incapacity, fatigue or weakness related to activities, work, or hobbies
 - 2 Loss of interest in activity, hobbies, or work—either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
 - 3 Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least 3 hours a day in activities (hospital job or hobbies) exclusive of ward chores
 - 4 Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted
- 8: Retardation (slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
- 0 Normal speech and thought
 - 1 Slight retardation at interview
 - 2 Obvious retardation at interview
 - 3 Interview difficult
 - 4 Complete stupor
- 9: Agitation
- 0 None
 - 1 “Playing with” hands, hair, etc.
 - 2 Hand wringing, nail biting, hair pulling, biting of lips
- 10: Anxiety psychic
- 0 No difficulty
 - 1 Subjective tension and irritability
 - 2 Worrying about minor matters
 - 3 Apprehensive attitude apparent in face or speech
 - 4 Fears expressed without questioning
- 11: Anxiety somatic
- 0 Absent Physiologic concomitants of anxiety, such as:
 - 1 Mild Gastrointestinal—dry mouth, wind, indigestion, diarrhea, cramps, belching
 - 2 Moderate Cardiovascular—palpitations, headaches
 - 3 Severe Respiratory—hyperventilation, sighing
 - 4 Incapacitating Urinary frequency Sweating
- 12: Somatic symptoms gastrointestinal
- 0 None
 - 1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
 - 2 Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for GI symptoms
- 13: Somatic symptoms general
- 0 None
 - 1 Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability
 - 2 Any clear cut symptom rates 2
- 14: Genital symptoms
- 0 Absent Symptoms such as:
 - 1 Mild Loss of libido
 - 2 Severe Menstrual disturbances
- 15: Hypochondriasis
- 0 Not present
 - 1 Self-absorption (bodily)
 - 2 Preoccupation with health
 - 3 Frequent complaints, requests for help, etc.
 - 4 Hypochondriacal delusions

(continued)


Table 15.6 HAMILTON RATING SCALE FOR DEPRESSION (Continued)

<p>16: Loss of weight</p> <p>A: When rating by history</p> <p>0 No weight loss</p> <p>1 Probable weight loss associated with present illness</p> <p>2 Definite (according to patient) weight loss</p> <p>B: On weekly ratings by ward psychiatrist, when actual weight changes are measured</p> <p>0 Less than 1 pound weight loss in week</p> <p>1 Greater than 1 pound weight loss in week</p> <p>2 Greater than 2 pounds weight loss in week</p> <p>17: Insight</p> <p>0 Acknowledges being depressed and ill</p> <p>1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.</p> <p>2 Denies being ill at all</p> <p>18: Diurnal variation</p> <table border="0"> <thead> <tr> <th>AM</th> <th>PM</th> <th>If symptoms are worse in the</th> </tr> </thead> <tbody> <tr> <td>0 0</td> <td>Absent</td> <td>morning or evening, note which</td> </tr> <tr> <td>1 1</td> <td>Mild</td> <td>it is and rate severity of variation</td> </tr> <tr> <td>2 2</td> <td>Severe</td> <td></td> </tr> </tbody> </table> <p>19: Depersonalization and derealization</p> <p>0 Absent</p> <p>1 Mild Such as:</p> <p>2 Moderate Feeling of unreality</p> <p>3 Severe Nihilistic ideas</p> <p>4 Incapacitating</p> <p>20: Paranoid symptoms</p> <p>0 None</p> <p>1 Suspiciousness</p> <p>3 Ideas of reference</p> <p>4 Delusions of reference and persecution</p>	AM	PM	If symptoms are worse in the	0 0	Absent	morning or evening, note which	1 1	Mild	it is and rate severity of variation	2 2	Severe		<p>21: Obsessional and compulsive symptoms</p> <p>0 Absent</p> <p>1 Mild</p> <p>2 Severe</p> <p>22: Helplessness</p> <p>0 Not present</p> <p>1 Subjective feelings that are elicited only by inquiry</p> <p>2 Patient volunteers his helpless feelings</p> <p>3 Requires urging, guidance, and reassurance to accomplish ward chores or personal hygiene</p> <p>4 Requires physical assistance for dress, grooming, eating, bedside tasks, or personal hygiene</p> <p>23: Hopelessness</p> <p>0 Not present</p> <p>1 Intermittently doubts that "things will improve" but can be reassured</p> <p>2 Consistently feels "hopeless" but accepts reassurances</p> <p>3 Expresses feelings of discouragement, despair, pessimism about future, which cannot be dispelled</p> <p>4 Spontaneously and inappropriately perseverates "I'll never get well" or its equivalent</p> <p>24: Worthlessness (ranges from mild loss of esteem, feelings of inferiority, self-depreciation to delusional notions of worthlessness)</p> <p>0 Not present</p> <p>1 Indicates feelings of worthlessness (loss of self-esteem) only on questioning</p> <p>2 Spontaneously indicates feelings of worthlessness (loss of self-esteem)</p> <p>3 Different from 2 by degree. Patient volunteers that he is "no good," "inferior," etc.</p> <p>4 Delusional notions of worthlessness—i.e., "I am a heap of garbage" or its equivalent</p>
AM	PM	If symptoms are worse in the											
0 0	Absent	morning or evening, note which											
1 1	Mild	it is and rate severity of variation											
2 2	Severe												

Reprinted with permission from Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, 23, 56.

Promoting a Therapeutic Relationship

It is important to have meaningful contact with clients who have depression and to begin a therapeutic relationship regardless of the state of depression. Some clients are quite open in describing their feelings of sadness, hopelessness, helplessness, or agitation. Clients may be unable to sustain a long interaction, so several shorter visits help the nurse to assess status and to establish a therapeutic relationship.

The nurse may find it difficult to interact with these clients because of empathy with such sadness and depression. The nurse also may feel unable to "do anything" for clients with limited responses. Clients with psychomotor retardation (slow speech, slow movement, slow thought processes) are very noncommunicative or may even be mute. The nurse can sit with such clients for a few minutes at intervals

throughout the day. The nurse's presence conveys genuine interest and caring. It is not necessary for the nurse to talk to clients the entire time; rather, silence can convey that clients are worthwhile even if they are not interacting.



"My name is Sheila. I'm your nurse today. I'm going to sit with you for a few minutes. If you need anything, or if you would like to talk, please tell me."

After time has elapsed, the nurse would say the following:



"I'm going now. I will be back in an hour to see you again."

NURSING INTERVENTIONS

for Depression

- Provide for the safety of the client and others.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending nondemanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects.

It is also important that the nurse avoids being overly cheerful or trying to “cheer up” clients. It is impossible to coax or to humor clients out of their depression. In fact, an overly cheerful approach may make clients feel worse or convey a lack of understanding of their despair.

Promoting Activities of Daily Living and Physical Care

The ability to perform daily activities is related to the level of psychomotor retardation. To assess ability to perform activities of daily living independently, the nurse first asks the client to perform the global task. For example,



“Martin, it’s time to get dressed.” (global task)

If a client cannot respond to the global request, the nurse breaks the task into smaller segments. Clients with depression can become overwhelmed easily with a task that has several steps. The nurse can use success in small, concrete steps as a basis to increase self-esteem and to build competency for a slightly more complex task the next time.

If clients cannot choose between articles of clothing, the nurse selects the clothing and directs clients to put them on. For example,



“Here are your gray slacks. Put them on.”

This still allows clients to participate in dressing. If this is what clients are capable of doing at this point, this activity will reduce dependence on staff. This request is

concrete, and if clients cannot do this, the nurse has information about the level of psychomotor retardation.

If a client cannot put on slacks, the nurse assists by saying,



“Let me help you with your slacks, Martin.”

The nurse helps clients to dress only when they cannot perform any of the above steps. This allows clients to do as much as possible for themselves and to avoid becoming dependent on the staff. The nurse can carry out this same process with clients when they eat, take a shower, and perform routine self-care activities.

Because abilities change over time, the nurse must assess them on an ongoing basis. This continual assessment takes more time than simply helping clients to dress. Nevertheless, it promotes independence and provides dynamic assessment data about psychomotor abilities.

Often, clients decline to engage in activities because they are too fatigued or have no interest. The nurse can validate these feelings yet still promote participation. For example,



“I know you feel like staying in bed, but it is time to get up for breakfast.”

Often, clients may want to stay in bed until they “feel like getting up” or engaging in activities of daily living. The nurse can let clients know they must become more active to feel better rather than waiting passively for improvement. It may be helpful to avoid asking “yes-or-no” questions. Instead of asking, “Do you want to get up now?” the nurse would say, “It is time to get up now.”

Reestablishing balanced nutrition can be challenging when clients have no appetite or don’t feel like eating. The nurse can explain that beginning to eat helps stimulate appetite. Food offered frequently and in small amounts can prevent overwhelming clients with a large meal that they feel unable to eat. Sitting quietly with clients during meals can promote eating. Monitoring food and fluid intake may be necessary until clients are consuming adequate amounts.

Promoting sleep may include the short-term use of a sedative or giving medication in the evening if drowsiness or sedation is a side effect. It is also important to encourage clients to remain out of bed and active during the day to facilitate sleeping at night. It is important to monitor the number of hours clients sleep as well as whether they feel refreshed on awakening.

Using Therapeutic Communication

Clients with depression are often overwhelmed by the intensity of their emotions. Talking about these feelings

can be beneficial. Initially, the nurse encourages clients to describe in detail how they are feeling. Sharing the burden with another person can provide some relief. At these times, the nurse can listen attentively, encourage clients, and validate the intensity of their experience. For example,



Nurse: “How are you feeling today?” (broad opening)

Client: “I feel so awful . . . terrible.”

Nurse: “Tell me more. What is that like for you?” (using a general lead; encouraging description)

Client: “I don’t feel like myself. I don’t know what to do.”

Nurse: “That must be frightening.” (validating)

It is important at this point that the nurse does not attempt to “fix” the client’s difficulties or offer clichés such as “Things will get better” or “But you know your family really needs you.” Although the nurse may have good intentions, remarks of this type belittle the client’s feelings or make the client feel more guilty and worthless.

As clients begin to improve, the nurse can help them to learn or rediscover more effective coping strategies such as talking to friends, spending leisure time to relax, taking positive steps to deal with stressors, and so forth. Improved coping skills may not prevent depression but may assist clients to deal with the effects of depression more effectively.

Managing Medications

The increased activity and improved mood that antidepressants produce can provide the energy for suicidal clients to carry out the act. Thus, the nurse must assess suicide risk even when clients are receiving antidepressants. It is also important to ensure that clients ingest the medication and are not saving it in attempt to commit suicide. As clients become ready for discharge, careful assessment of suicide potential is important because they will have a supply of antidepressant medication at home. SSRIs are rarely fatal in overdose, but cyclic and MAOI antidepressants are potentially fatal. Prescriptions may need to be limited to only a 1-week supply at a time if concerns linger about overdose.

An important component of client care is management of side effects. The nurse must make careful observations and ask clients pertinent questions to determine how they are tolerating medications. Tables 15.1 through 15.4 give specific interventions to manage side effects of antidepressant medications.

Clients and family must learn how to manage the medication regimen because clients may need to take these medications for months, years, or even a lifetime. Education promotes compliance. Clients must know how often they need to return for monitoring and diagnostic tests.

Providing Client and Family Teaching

Teaching clients and family about depression is important. They must understand that depression is an illness, not a

CLIENT FAMILY EDUCATION

for Depression

- Teach about the illness of depression.
- Identify early signs of relapse.
- Discuss the importance of support groups and assist in locating resources.
- Teach the client and family about the benefits of therapy and follow-up appointments.
- Encourage participation in support groups.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.

lack of willpower or motivation. Learning about the beginning symptoms of relapse may assist clients to seek treatment early and avoid a lengthy recurrence.

Clients and family should know that treatment outcomes are best when psychotherapy and antidepressants are combined. Psychotherapy helps clients to explore anger, dependence, guilt, hopelessness, helplessness, object loss, interpersonal issues, and irrational beliefs. The goal is to reverse negative views of the future, improve self-image, and help clients gain competence and self-mastery. The nurse can help clients to find a therapist through mental health centers in specific communities.

Support group participation also helps some clients and their families. Clients can receive support and encouragement from others who struggle with depression, and family members can offer support to one another. The National Alliance for the Mentally Ill is an organization that can help clients and families connect with local support groups.

Evaluation

Evaluation of the plan of care is based on achievement of individual client outcomes. It is essential that clients feel safe and do not experience uncontrollable urges to commit suicide. Participation in therapy and medication compliance produce more favorable outcomes for clients with depression. Being able to identify signs of relapse and to seek treatment immediately can significantly decrease the severity of a depressive episode.

BIPOLAR DISORDER

Bipolar disorder involves extreme mood swings from episodes of mania to episodes of depression. (Bipolar disorder was formerly known as manic-depressive illness.) During manic phases, clients are euphoric, grandiose, energetic, and sleepless. They have poor judgment and rapid thoughts, actions, and speech. During depressed phases, mood, behavior, and



CLINICAL VIGNETTE: MANIC EPISODE

“Everyone is stupid! What is the matter? Have you all taken dumb pills? Dumb pills, rum pills, shlummy shlum lum pills!” Mitch screamed as he waited for his staff to snap to attention and get with the program. He had started the Pickle Barn 10 years ago and now had a money-making business canning and delivering gourmet pickles.

He knew how to do everything in this place and, running from person to person to watch what each was doing, he didn’t like what he saw. It was 8 AM, and he’d already fired the supervisor, who had been with him for 5 years.

By 8:02 am, Mitch had fired six pickle assistants because he did not like the way they looked. Then, Mitch threw pots and paddles at them because they weren’t leaving fast enough. Rich, his brother, walked in during this melee and quietly asked everyone to stay, then invited Mitch outside for a walk.

“Are you nuts?” Mitch screamed at his brother. “Everyone here is out of control. I have to do everything.” Mitch was trembling, shaking. He hadn’t slept in 3 days and didn’t

need to. The only time he’d left the building in these 3 days was to have sex with any woman who had agreed. He felt euphoric, supreme, able to leap tall buildings in a single bound. He glared at Rich. “I feel good! What are you bugging me for?” He slammed out the door, shrilly reciting, “Rich and Mitch! Rich and Mitch! Pickle king rich!”

“Rich and Mitch, Rich and Mitch. With dear old auntie, now we’re rich.” Mitch couldn’t stop talking and speed walking. Watching Mitch, Rich gently said, “Aunt Jen called me last night. She says you are manic again. When did you stop taking your lithium?”

“Manic? Who’s manic? I’m just feeling good. Who needs that stuff? I like to feel good. It is wonderful, marvelous, stupendous. I am not manic,” shrieked Mitch as he swerved around to face his brother. Rich, weary and sad, said, “I am taking you to the emergency psych unit. If you do not agree to go, I will have the police take you. I know you don’t see this in yourself, but you are out of control and getting dangerous.”

thoughts are the same as in people diagnosed with major depression (see previous discussion). In fact, if a person’s first episode of bipolar illness is a depressed phase, he or she might be diagnosed with major depression; a diagnosis of bipolar disorder may not be made until the person experiences a manic episode. To increase awareness about bipolar disorder, health care professionals can use tools such as the Mood Disorder Questionnaire (Box 15.1).

Bipolar disorder ranks second only to major depression as a cause of worldwide disability. The lifetime risk for bipolar disorder is at least 1.2%, with a risk of completed suicide for 15%. Young men early in the course of their illness are at highest risk for suicide, especially those with a history of suicide attempts or alcohol abuse as well as those recently discharged from the hospital (Rihmer & Angst, 2005).

Whereas a person with major depression slowly slides into depression that can last for 6 months to 2 years, the person with bipolar disorder cycles between depression and normal behavior (bipolar depressed) or mania and normal behavior (bipolar manic). A person with bipolar mixed episodes alternates between major depressive and manic episodes interspersed with periods of normal behavior. Each mood may last for weeks or months before the pattern begins to descend or ascend once again. Figure 15.1 shows the three categories of bipolar cycles.

Bipolar disorder occurs almost equally among men and women. It is more common in highly educated people. Because some people with bipolar illness deny their mania, prevalence rates may actually be higher than reported.

Onset and Clinical Course

The mean age for a first manic episode is the early 20s, but some people experience onset in adolescence, whereas others start experiencing symptoms when they are older than 50 (APA, 2000). Currently, debate exists about whether or not some children diagnosed with attention deficit hyperactivity disorder actually have a very early onset of bipolar disorder. Manic episodes typically begin suddenly, with rapid escalation of symptoms over a few days, and they last from a few weeks to several months. They tend to be briefer and to end more suddenly than depressive episodes. Adolescents are more likely to have psychotic manifestations.

The diagnosis of a manic episode or mania requires at least 1 week of unusual and incessantly heightened, grandiose, or agitated mood in addition to three or more of the following symptoms: exaggerated self-esteem; sleeplessness; pressured speech; flight of ideas; reduced ability to filter extraneous stimuli; distractibility; increased activities with increased energy; and multiple, grandiose, high-risk activities involving poor judgment and severe consequences, such as spending sprees, sex with strangers, and impulsive investments (APA, 2000).

Clients often do not understand how their illness affects others. They may stop taking medications because they like the euphoria and feel burdened by the side effects, blood tests, and physicians’ visits needed to maintain treatment. Family members are concerned and exhausted by their loved ones’ behaviors; they often stay up late at night for fear the manic person may do something impulsive and dangerous.

Box 15.1 MOOD DISORDER QUESTIONNAIRE

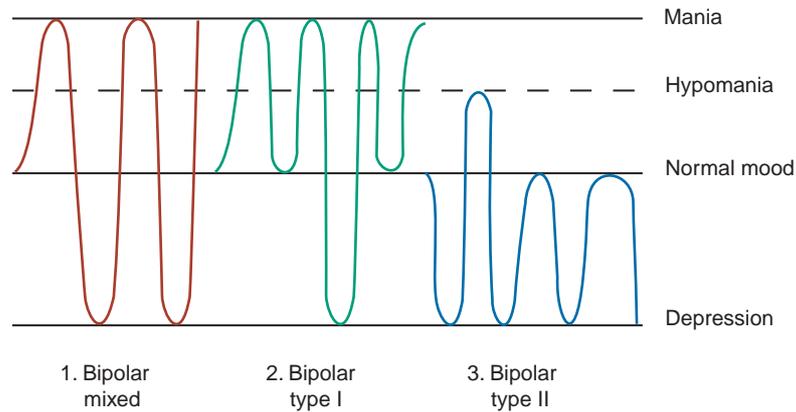
The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of bipolar disorder but is not meant to be a substitute for a full medical evaluation. Bipolar disorder is complex and **an accurate, thorough diagnosis can be made through a personal evaluation by your doctor**. However, a positive screening may suggest that you might benefit from seeking such an evaluation from your doctor. Regardless of the questionnaire results, if you or your family has concerns about your mental health, please contact your physician and/or other health care professional.

When completed, you may want to print out your responses.

Instructions: Please answer each question as best you can.

- | | YES | NO | |
|---|--|---|--|
| 1. Has there ever been a period of time when you were not your usual self and . . . | | | |
| . . . you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were so irritable that you shouted at people or started fights or arguments? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you felt much more self-confident than usual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you got much less sleep than usual and found you didn't really miss it? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were much more talkative or spoke much faster than usual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . thoughts raced through your head or you couldn't slow your mind down? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were so easily distracted by things around you that you had trouble concentrating or staying on track? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you had much more energy than usual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were much more active or did many more things than usual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you were much more interested in sex than usual? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | <input type="checkbox"/> | <input type="checkbox"/> | |
| . . . spending money got you or your family into trouble? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. How much of a problem did any of these cause you—like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only. | | | |
| <input type="checkbox"/> No problem | <input type="checkbox"/> Minor problem | <input type="checkbox"/> Moderate problem | <input type="checkbox"/> Serious problem |
| 4. Have any of your blood relatives (children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Has a health care professional ever told you that you have manic-depressive illness or bipolar disorder? | <input type="checkbox"/> | <input type="checkbox"/> | |

From Hirschfeld, R. M. A., Williams, J. B., Spitzer, R. L., et al. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire. *American Journal of Psychiatry*, 157(11), 1873–1875.



1. Bipolar mixed—Cycles alternate between periods of mania, normal mood, depression, normal mood, mania, and so forth.

2. Bipolar type I—Manic episodes with at least one depressive episode.

3. Bipolar type II—Recurrent depressive episodes with at least one hypomanic episode.

Figure 15-1. Graphic depiction of mood cycles.

DSM-IV-TR DIAGNOSTIC CRITERIA: Typical Symptoms of Mania

- Heightened, grandiose, or agitated mood
- Exaggerated self-esteem
- Sleeplessness
- Pressured speech
- Flight of ideas
- Reduced ability to filter out extraneous stimuli; easily distractible
- Increased number of activities with increased energy
- Multiple, grandiose, high-risk activities, using poor judgment, with severe consequences

Adapted from *DSM-IV-TR*, 2000.

Treatment

Psychopharmacology

Treatment for bipolar disorder involves a lifetime regimen of medications: either an antimanic agent called lithium or anticonvulsant medications used as mood stabilizers (see Chapter 2). This is the only psychiatric disorder in which medications can prevent acute cycles of bipolar behavior. Once thought to help reduce manic behavior only, lithium and these anticonvulsants also protect against the effects of bipolar depressive cycles. If a client in the acute stage of mania or depression exhibits psychosis (disordered thinking as seen with delusions, hallucinations, and illusions), an antipsychotic agent is administered in addition to the

bipolar medications. Some clients keep taking both bipolar medications and antipsychotics.

Lithium. Lithium is a salt contained in the human body; it is similar to gold, copper, magnesium, manganese, and other trace elements. Once believed to be helpful for bipolar mania only, investigators quickly realized that lithium also could partially or completely mute the cycling toward bipolar depression. The response rate in acute mania to lithium therapy is 70% to 80%. In addition to treating the range of bipolar behaviors, lithium also can stabilize bipolar disorder by reducing the degree and frequency of cycling or eliminating manic episodes (Freeman, Wiegand, & Gelenberg, 2006).

Lithium not only competes for salt receptor sites but also affects calcium, potassium, and magnesium ions as well as glucose metabolism. Its mechanism of action is unknown, but it is thought to work in the synapses to hasten destruction of catecholamines (dopamine, norepinephrine), inhibit neurotransmitter release, and decrease the sensitivity of postsynaptic receptors (Facts and Comparisons, 2009).

Lithium's action peaks in 30 minutes to 4 hours for regular forms and in 4 to 6 hours for the slow-release form. It crosses the blood–brain barrier and placenta and is distributed in sweat and breast milk. Lithium use during pregnancy is not recommended because it can lead to first-trimester developmental abnormalities. Onset of action is 5 to 14 days; with this lag period, antipsychotic or antidepressant agents are used carefully in combination with lithium to reduce symptoms in acutely manic or acutely depressed clients. The half-life of lithium is 20 to 27 hours (Facts and Comparisons, 2009).

Anticonvulsant Drugs. Lithium is effective in about 75% of people with bipolar illness. The rest do not respond or

have difficulty taking lithium because of side effects, problems with the treatment regimen, drug interactions, or medical conditions such as renal disease that contraindicate use of lithium. Several anticonvulsants traditionally used to treat seizure disorders have proved helpful in stabilizing the moods of people with bipolar illness. These drugs are categorized as miscellaneous anticonvulsants. Their mechanism of action is largely unknown, but they may raise the brain's threshold for dealing with stimulation; this prevents the person from being bombarded with external and internal stimuli (Table 15.7).

Carbamazepine (Tegretol), which had been used for grand mal and temporal lobe epilepsy as well as for trigeminal neuralgia, was the first anticonvulsant found to have mood-stabilizing properties, but the threat of agranulocytosis was of great concern. Clients taking carbamazepine need to have drug serum levels checked regularly to monitor for toxicity and to determine whether the drug has reached therapeutic levels, which are generally 4 to 12 µg/mL (Ketter, Wang & Post, 2006). Baseline and periodic laboratory testing must also be done to monitor for suppression of white blood cells.

Valproic acid (Depakote), also known as divalproex sodium or sodium valproate, is an anticonvulsant used for

simple absence and mixed seizures, migraine prophylaxis, and mania. The mechanism of action is unclear. Therapeutic levels are monitored periodically to remain at 50 to 125 µg/mL, as are baseline and ongoing liver function tests, including serum ammonia levels and platelet and bleeding times (Bowden, 2006).

Gabapentin (Neurontin), lamotrigine (Lamictal), and topiramate (Topamax) are other anticonvulsants sometimes used as mood stabilizers, but they are used less frequently than valproic acid. Value ranges for therapeutic levels are not established.

Clonazepam (Klonopin) is an anticonvulsant and a benzodiazepine (a schedule IV controlled substance) used in simple absence and minor motor seizures, panic disorder, and bipolar disorder. Physiologic dependence can develop with long-term use. This drug may be used in lithium or other mood stabilizers but is not used alone to manage bipolar disorder.

Psychotherapy

Psychotherapy can be useful in the mildly depressive or normal portion of the bipolar cycle. It is not useful during acute manic stages because the person's attention span is brief and he or she can gain little insight during times of

Table

15.7 ANTICONVULSANTS USED AS MOOD STABILIZERS

Generic (Trade) Name	Side Effects	Nursing Implications
Carbamazepine (Tegretol)	Dizziness, hypotension, ataxia, sedation, blurred vision, leukopenia, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Report rashes to physician.
Divalproex (Depakote)	Ataxia, drowsiness, weakness, fatigue, menstrual changes, dyspepsia, nausea, vomiting, weight gain, and hair loss	Monitor gait and assist as necessary. Provide rest periods. Give with food. Establish balanced nutrition.
Gabapentin (Neurontin)	Dizziness, hypotension, ataxia, coordination, sedation, headache, fatigue, nystagmus, nausea, and vomiting	Assist client to rise slowly from sitting position. Provide rest periods. Give with food.
Lamotrigine (Lamictal)	Dizziness, hypotension, ataxia, coordination, sedation, headache, weakness, fatigue, menstrual changes, sore throat, flu-like symptoms, blurred or double vision, nausea, vomiting, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Provide rest periods. Monitor physical health. Give with food. Report rashes to physician.
Topiramate (Topamax)	Dizziness, hypotension, anxiety, ataxia, incoordination, confusion, sedation, slurred speech, tremor, weakness, blurred or double vision, anorexia, nausea, and vomiting	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Orient client. Protect client from potential injury. Give with food.
Oxcarbazepine (Trileptal)	Dizziness, fatigue, ataxia, confusion, nausea, vomiting, anorexia, headache, tremor, confusion, and rashes	Assist client to rise slowly from sitting position. Monitor gait and assist as necessary. Give with food. Orient client and protect from injury. Report rashes to physician.

accelerated psychomotor activity. Psychotherapy combined with medication can reduce the risk for suicide and injury, provide support to the client and family, and help the client to accept the diagnosis and treatment plan.

APPLICATION OF THE NURSING PROCESS: BIPOLAR DISORDER

The focus of this discussion is on the client experiencing a manic episode of bipolar disorder. The reader should review the Application of the Nursing Process: Depression section to examine nursing care of the client experiencing a depressed phase of bipolar disorder.

Assessment

History

Taking a history with a client in the manic phase often proves difficult. The client may jump from subject to subject, which makes it difficult for the nurse to follow. Obtaining data in several short sessions, as well as talking to family members, may be necessary. The nurse can obtain much information, however, by watching and listening.

General Appearance and Motor Behavior

Clients with mania experience psychomotor agitation and seem to be in perpetual motion; sitting still is difficult. This continual movement has many ramifications: clients can become exhausted or injure themselves.

In the manic phase, the client may wear clothes that reflect the elevated mood: brightly colored, flamboyant, attention-getting, and perhaps sexually suggestive. For example, a woman in the manic phase may wear a lot of jewelry and hair ornaments, or her makeup may be garish and heavy, whereas a male client may wear a tight and revealing muscle shirt or go bare-chested.

Clients experiencing a manic episode think, move, and talk fast. Pressured speech, one of the hallmark symptoms, is evidenced by unrelentingly rapid and often loud speech without pauses. Those with pressured speech interrupt and cannot listen to others. They ignore verbal and nonverbal cues indicating that others wish to speak, and they continue with constant intelligible or unintelligible speech, turning from one listener to another or speaking to no one at all. If interrupted, clients with mania often start over from the beginning.

Mood and Affect

Mania is reflected in periods of euphoria, exuberant activity, grandiosity, and false sense of well-being. Projection of an all-knowing and all-powerful image may be an unconscious defense against underlying low self-esteem. Some clients manifest mania with an angry, verbally aggressive tone and are sarcastic and irritable, especially when others set limits on their behavior. Clients' mood is quite labile, and they may alternate between periods of loud laughter and episodes of tears.

Thought Process and Content

Cognitive ability or thinking is confused and jumbled with thoughts racing one after another, which is often referred to as flight of ideas. Clients cannot connect concepts, and they jump from one subject to another. Circumstantiality and tangentiality also characterize thinking. At times, clients may be unable to communicate thoughts or needs in ways that others understand.

These clients start many projects at one time but cannot carry any to completion. There is little true planning, but clients talk nonstop about plans and projects to anyone and everyone, insisting on the importance of accomplishing these activities. Sometimes they try to enlist help from others in one or more activities. They do not consider risks or personal experience, abilities, or resources. Clients start these activities as they occur in their thought processes. Examples of these multiple activities are going on shopping sprees, using credit cards excessively while unemployed and broke, starting several business ventures at once, having promiscuous sex, gambling, taking impulsive trips, embarking on illegal endeavors, making risky investments, talking with multiple people, and speeding (APA, 2000).

Some clients experience psychotic features during mania; they express grandiose delusions involving importance, fame, privilege, and wealth. Some may claim to be the president, a famous movie star, or even God or a prophet.

Sensorium and Intellectual Processes

Clients may be oriented to person and place but rarely to time. Intellectual functioning, such as fund of knowledge, is difficult to assess during the manic phase. Clients may claim to have many abilities they do not possess. The ability to concentrate or to pay attention is grossly impaired. Again, if a client is psychotic, he or she may experience hallucinations.

Judgment and Insight

People in the manic phase are easily angered and irritated and strike back at what they perceive as censorship by others because they impose no restrictions on themselves. They are impulsive and rarely think before acting or speaking, which makes their judgment poor. Insight is limited because they believe they are "fine" and have no problems. They blame any difficulties on others.

Self-Concept

Clients with mania often have exaggerated self-esteem; they believe they can accomplish anything. They rarely discuss their self-concept realistically. Nevertheless, a false sense of well-being masks difficulties with chronic low self-esteem.

Roles and Relationships

Clients in the manic phase rarely can fulfill role responsibilities. They have trouble at work or school (if they are even attending) and are too distracted and hyperactive to

pay attention to children or activities of daily living. Although they may begin many tasks or projects, they complete few.

These clients have a great need to socialize but little understanding of their excessive, overpowering, and confrontational social interactions. Their need for socialization often leads to promiscuity. Clients invade the intimate space and personal business of others. Arguments result when others feel threatened by such boundary invasions. Although the usual mood of manic people is elation, emotions are unstable and can fluctuate (**labile emotions**) readily between euphoria and hostility. Clients with mania can become hostile to others whom they perceive as standing in way of desired goals. They cannot postpone or delay gratification. For example, a manic client tells his wife, “You are the most wonderful woman in the world. Give me \$50 so I can buy you a ticket to the opera.” When she refuses, he snarls and accuses her of being cheap and selfish and may even strike her.

Physiologic and Self-Care Considerations

Clients with mania can go days without sleep or food and not even realize they are hungry or tired. They may be on the brink of physical exhaustion but are unwilling or unable to stop, rest, or sleep. They often ignore personal hygiene as “boring” when they have “more important things” to do. Clients may throw away possessions or destroy valued items. They may even physically injure themselves and tend to ignore or be unaware of health needs that can worsen.

Data Analysis

The nurse analyzes assessment data to determine priorities and to establish a plan of care. Nursing diagnoses commonly established for clients in the manic phase are as follows:

- Risk for Other-Directed Violence
- Risk for Injury
- Imbalanced Nutrition: Less Than Body Requirements
- Ineffective Coping
- Noncompliance
- Ineffective Role Performance
- Self-Care Deficit
- Chronic Low Self-Esteem
- Disturbed Sleep Pattern

Outcome Identification

Examples of outcomes appropriate to mania are as follows:

- The client will not injure self or others.
- The client will establish a balance of rest, sleep, and activity.
- The client will establish adequate nutrition, hydration, and elimination.

- The client will participate in self-care activities.
- The client will evaluate personal qualities realistically.
- The client will engage in socially appropriate, reality-based interaction.
- The client will verbalize knowledge of his or her illness and treatment.

Intervention

Providing for Safety

Because of the safety risks that clients in the manic phase take, safety plays a primary role in care, followed by issues related to self-esteem and socialization. A primary nursing responsibility is to provide a safe environment for clients and others. The nurse assesses clients directly for suicidal ideation and plans or thoughts of hurting others. In addition, clients in the manic phase have little insight into their anger and agitation and how their behaviors affect others. They often intrude into others’ space, take others’ belongings without permission, or appear aggressive in approaching others. This behavior can threaten or anger people who then retaliate. It is important to monitor the clients’ whereabouts and behaviors frequently.

The nurse also should tell clients that staff members will help them control their behavior if clients cannot do so alone. For clients who feel out of control, the nurse must establish external controls empathetically and nonjudgmentally. These external controls provide long-term comfort to clients, although their initial response may be aggression. People in the manic phase have labile emotions; it is not unusual for them to strike staff members who have set limits in a way clients dislike.

These clients physically and psychologically invade boundaries. It is necessary to set limits when they cannot set limits on themselves. For example, the nurse might say,

NURSING INTERVENTIONS

for Mania

- Provide for client’s physical safety and those around.
- Set limits on client’s behavior when needed.
- Remind the client to respect distances between self and others.
- Use short, simple sentences to communicate.
- Clarify the meaning of client’s communication.
- Frequently provide finger foods that are high in calories and protein.
- Promote rest and sleep.
- Protect the client’s dignity when inappropriate behavior occurs.
- Channel client’s need for movement into socially acceptable motor activities.



“John, you are too close to my face. Please stand back 2 feet.”

or



“It is unacceptable to hug other clients. You may talk to others, but do not touch them.”

When setting limits, it is important to clearly identify the unacceptable behavior and the expected, appropriate behavior. All staff must consistently set and enforce limits for those limits to be effective.

Meeting Physiologic Needs

Clients with mania may get very little rest or sleep, even if they are on the brink of physical exhaustion. Medication may be helpful, though clients may resist taking it. Decreasing environmental stimulation may assist clients to relax. The nurse provides a quiet environment without noise, television, or other distractions. Establishing a bedtime routine, such as a tepid bath, may help clients to calm down enough to rest.

Nutrition is another area of concern. Manic clients may be too “busy” to sit down and eat, or they may have such poor concentration that they fail to stay interested in food for very long. “Finger foods” or things clients can eat while moving around are the best options to improve nutrition. Such foods also should be as high in calories and protein as possible. For example, celery and carrots are finger foods, but they supply little nutrition. Sandwiches, protein bars, and fortified shakes are better choices. Clients with mania also benefit from food that is easy to eat without much preparation. Meat that must be cut into bite sizes or plates of spaghetti are not likely to be successful options. Having snacks available between meals, so clients can eat whenever possible, is also useful.

The nurse needs to monitor food and fluid intake and hours of sleep until clients routinely meet these needs without difficulty. Observing and supervising clients at meal times are also important to prevent clients from taking food from others.

Providing Therapeutic Communication

Clients with mania have short attention spans, so the nurse uses clear, simple sentences when communicating. They may not be able to handle a lot of information at once, so the nurse breaks information into many small segments. It helps to ask clients to repeat brief messages to ensure they have heard and incorporated them.

Clients may need to undergo baseline and follow-up laboratory tests. A brief explanation of the purpose of each test allays anxiety. The nurse gives printed information to

reinforce verbal messages, especially those related to rules, schedules, civil rights, treatment, staff names, and client education.

The speech of manic clients may be pressured: rapid, circumstantial, rhyming, noisy, or intrusive with flights of ideas. Such disordered speech indicates thought processes that are flooded with thoughts, ideas, and impulses. The nurse must keep channels of communication open with clients, regardless of speech patterns. The nurse can say,



“Please speak more slowly. I’m having trouble following you.”

This puts the responsibility for the communication difficulty on the nurse rather than on the client. This nurse patiently and frequently repeats this request during conversation because clients will return to rapid speech.

Clients in the manic phase often use pronouns when referring to people, making it difficult for listeners to understand who is being discussed and when the conversation has moved to a new subject. While clients are agitatedly talking, they usually are thinking and moving just as quickly, so it is a challenge for the nurse to follow a coherent story. The nurse can ask clients to identify each person, place, or thing being discussed.

When speech includes flight of ideas, the nurse can ask clients to explain the relationship between topics—for example,



“What happened then?”

or



“Was that before or after you got married?”

The nurse also assesses and documents the coherence of messages.

Clients with pressured speech rarely let others speak. Instead, they talk nonstop until they run out of steam or just stand there looking at the other person before moving away. Those with pressured speech do not respond to others’ verbal or nonverbal signals that indicate a desire to speak. The nurse avoids becoming involved in power struggles over who will dominate the conversation. Instead, the nurse may talk to clients away from others so there is no “competition” for the nurse’s attention. The nurse also sets limits regarding taking turns speaking and listening as well as giving attention to others when they need it. Clients with mania cannot have all requests granted immediately even though that may be their desire.

Promoting Appropriate Behaviors

These clients need to be protected from their pursuit of socially unacceptable and risky behaviors. The nurse can direct their need for movement into socially acceptable, large motor activities such as arranging chairs for a community meeting or walking. In acute mania, clients lose the ability to control their behavior and engage in risky activities. Because acutely manic clients feel extraordinarily powerful, they place few restrictions on themselves. They act out impulsive thoughts, have inflated and grandiose perceptions of their abilities, are demanding, and need immediate gratification. This can affect their physical, social, occupational, or financial safety as well as that of others. Clients may make purchases that exceed their ability to pay. They may give away money or jewelry or other possessions. The nurse may need to monitor a client's access to such items until his or her behavior is less impulsive.

In an acute manic episode, clients also may lose sexual inhibitions, resulting in provocative and risky behaviors. Clothing may be flashy or revealing, or clients may undress in public areas. They may engage in unprotected sex with virtual strangers. Clients may ask staff members or other clients (of the same or opposite sex) for sex, graphically describe sexual acts, or display their genitals. The nurse handles such behavior in a matter-of-fact, nonjudgmental manner. For example,



“Mary, let's go to your room and find a sweater.”

It is important to treat clients with dignity and respect despite their inappropriate behavior. It is not helpful to

“scold” or chastise them; they are not children engaging in willful misbehavior.

In the manic phase, clients cannot understand personal boundaries, so it is the staff's role to keep clients in view for intervention as necessary. For example, a staff member who sees a client invading the intimate space of others can say,



“Jeffrey, I'd appreciate your help in setting up a circle of chairs in the group therapy room.”

This large motor activity distracts Jeffrey from his inappropriate behavior, appeals to his need for heightened physical activity, is noncompetitive, and is socially acceptable. The staff's vigilant redirection to a more socially appropriate activity protects clients from the hazards of unprotected sex and reduces embarrassment over such behaviors when they return to normal behavior.

Managing Medications

Lithium is not metabolized; rather, it is reabsorbed by the proximal tubule and excreted in the urine. Periodic serum lithium levels are used to monitor the client's safety and to ensure that the dose given has increased the serum lithium level to a treatment level or reduced it to a maintenance level. There is a narrow range of safety among maintenance levels (0.5 to 1 mEq/L), treatment levels (0.8 to 1.5 mEq/L), and toxic levels (1.5 mEq/L and above). It is important to assess for signs of toxicity and to ensure that clients and their families have this information before discharge (Table 15.8).

Table 15.8 SYMPTOMS AND INTERVENTIONS OF LITHIUM TOXICITY

Serum Lithium Level	Symptoms of Lithium Toxicity	Interventions
1.5–2 mEq/L	Nausea and vomiting, diarrhea, reduced coordination, drowsiness, slurred speech, and muscle weakness	Withhold next dose; call physician. Serum lithium levels are ordered and doses of lithium are usually suspended for a few days or the dose is reduced.
2–3 mEq/L	Ataxia, agitation, blurred vision, tinnitus, giddiness, choreoathetoid movements, confusion, muscle fasciculation, hyperreflexia, hypertonic muscles, myoclonic twitches, pruritus, maculopapular rash, movement of limbs, slurred speech, large output of dilute urine, incontinence of bladder or bowel, and vertigo	Withhold future doses, call physician, stat serum lithium level. Gastric lavage may be used to remove oral lithium; IV containing saline and electrolytes used to ensure fluid and electrolyte function and maintain renal function.
3.0 mEq/L and above	Cardiac arrhythmia, hypotension, peripheral vascular collapse, focal or generalized seizures, reduced levels of consciousness from stupor to coma, myoclonic jerks of muscle groups, and spasticity of muscles	All preceding interventions plus lithium ion excretion is augmented with use of aminophylline, mannitol, or urea. Hemodialysis may also be used to remove lithium from the body. Respiratory, circulatory, thyroid, and immune systems are monitored and assisted as needed.

Older adults can have symptoms of toxicity at lower serum levels. Lithium is potentially fatal in overdose.

Clients should drink adequate water (approximately 2 L/day) and continue with the usual amount of dietary table salt. Having too much salt in the diet because of unusually salty foods or the ingestion of salt-containing antacids can reduce receptor availability for lithium and increase lithium excretion, so the lithium level will be too low. If there is too much water, lithium is diluted and the lithium level will be too low to be therapeutic. Drinking too little water or losing fluid through excessive sweating, vomiting, or diarrhea increases the lithium level, which may result in toxicity. Monitoring daily weights and the balance between intake and output and checking for dependent edema can be helpful in monitoring fluid balance. The physician should be contacted if the client has diarrhea, fever, flu, or any condition that leads to dehydration.

Thyroid function tests usually are ordered as a baseline and every 6 months during treatment with lithium. In 6 to 18 months, one third of clients taking lithium have an increased level of thyroid-stimulating hormone, which can cause anxiety, labile emotions, and sleeping difficulties. Decreased levels are implicated in fatigue and depression.

Because most lithium is excreted in the urine, baseline and periodic assessments of renal status are necessary to assess renal function. The reduced renal function in older adults necessitates lower doses. Lithium is contraindicated in people with compromised renal function or urinary retention and those taking low-salt diets or diuretics. Lithium also is contraindicated in people with brain or cardiovascular damage.

Providing Client and Family Teaching

Educating clients about the dangers of risky behavior is necessary; however, clients with acute mania largely fail to heed such teaching because they have little patience or capacity to listen, understand, and see the relevance of this information. Clients with euphoria may not see why the behavior is a problem because they believe they can do anything without impunity. As they begin to cycle toward normalcy, however, risky behavior lessens, and they become ready and able for teaching.

Manic clients start many tasks, create many goals, and try to carry them out all at once. The result is that they cannot complete any. They move readily between these goals while sometimes obsessing about the importance of one over another, but the goals can quickly change. Clients may invest in a business in which they have no knowledge or experience, go on spending sprees, impulsively travel, speed, make new “best friends,” and take the center of attention in any group. They are egocentric and have little concern for others except as listeners, sexual partners, or the means to achieve one of their poorly conceived goals.

CLIENT FAMILY EDUCATION

for Mania

- Teach about bipolar illness and ways to manage the disorder.
- Teach about medication management, including the need for periodic blood work and management of side effects.
- For clients taking lithium, teach about the need for adequate salt and fluid intake.
- Teach the client and family about signs of toxicity and the need to seek medical attention immediately.
- Educate the client and family about risk-taking behavior and how to avoid it.
- Teach about behavioral signs of relapse and how to seek treatment in early stages.

Education about the cause of bipolar disorder, medication management, ways to deal with behaviors, and potential problems that manic people can encounter is important for family members. Education reduces the guilt, blame, and shame that accompany mental illness; increases client safety; enlarges the support system for clients and the family members; and promotes compliance. Education takes the “mystery” out of treatment for mental illness by providing a proactive view: this is what we know, this is what can be done, and this is what you can do to help.

Family members often say they know clients have stopped taking their medication when, for example, clients become more argumentative, talk about buying expensive items that they cannot afford, hotly deny anything is wrong, or demonstrate any other signs of escalating mania. People sometimes need permission to act on their observations, so a family education session is an appropriate place to give this permission and to set up interventions for various behaviors.

Clients should learn to adhere to the established dosage of lithium and not to omit doses or change dosage intervals; unprescribed dosage alterations interfere with maintenance of serum lithium levels. Clients should know about the many drugs that interact with lithium and should tell each physician they consult that they are taking lithium. When a client taking lithium seems to have increased manic behavior, lithium levels should be checked to determine whether there is lithium toxicity. Periodic monitoring of serum lithium levels is necessary to ensure the safety and adequacy of the treatment regimen. Persistent thirst and diluted urine can indicate the need to call a physician and have the serum lithium level checked to see if the dosage needs to be reduced.

Clients and family members should know the symptoms of lithium toxicity and interventions to take, including backup plans if the physician is not immediately available. The nurse should give these in writing and explain them to clients and family.

Evaluation

Evaluation of the treatment of bipolar disorder includes but is not limited to the following:

- Safety issues
- Comparison of mood and affect between start of treatment and present
- Adherence to treatment regimen of medication and psychotherapy
- Changes in client's perception of quality of life
- Achievement of specific goals of treatment including new coping methods

SUICIDE

Suicide is the intentional act of killing oneself. Suicidal thoughts are common in people with mood disorders, especially depression. Each year, more than 30,000 suicides are reported in the United States; suicide attempts are estimated to be 8 to 10 times higher. In the United States, men commit approximately 72% of suicides, which is roughly three times the rate of women, although women are four times more likely than men to attempt suicide. The higher suicide rates for men are partly the result of the method chosen (e.g., shooting, hanging, jumping from a high place). Women are more likely to overdose on medication. Men, young women, whites, and separated and divorced people are at increased risk for suicide. Adults older than age 65 years compose 10% of the population but account for 25% of suicides. Suicide is the second leading cause of death (after accidents) among people 15 to 24 years of age, and the rate of suicide is increasing most rapidly in this age group (Andreasen & Black, 2006).

Clients with psychiatric disorders, especially depression, bipolar disorder, schizophrenia, substance abuse, posttraumatic stress disorder, and borderline personality disorder, are at increased risk for suicide (Rihmer, 2007). Chronic medical illnesses associated with increased risk for suicide include cancer, HIV or AIDS, diabetes, cerebrovascular accidents, and head and spinal cord injury. Environmental factors that increase suicide risk include isolation, recent loss, lack of social support, unemployment, critical life events, and family history of depression or suicide. Behavioral factors that increase risk include impulsivity, erratic or unexplained changes from usual behavior, and unstable lifestyle (Smith et. al., 2008).

Suicidal ideation means thinking about killing oneself. Active suicidal ideation is when a person thinks about and seeks ways to commit suicide. Passive suicidal ideation is

when a person thinks about wanting to die or wishes he or she were dead but has no plans to cause his or her death. People with active suicidal ideation are considered more potentially lethal.

Attempted suicide is a suicidal act that either failed or was incomplete. In an incomplete suicide attempt, the person did not finish the act because (1) someone recognized the suicide attempt as a cry for help and responded or (2) the person was discovered and rescued (Sudak, 2005).

Suicide involves ambivalence. Many fatal accidents may be impulsive suicides. It is impossible to know, for example, whether the person who drove into a telephone pole did this intentionally. Hence, keeping accurate statistics on suicide is difficult. There are also many myths and misconceptions about suicide of which the nurse should be aware. The nurse must know the facts and warning signs for those at risk for suicide as described in Box 15.2.

Assessment

A history of previous suicide attempts increases risk for suicide. The first 2 years after an attempt represent the highest risk period, especially the first 3 months. Those with a relative who committed suicide are at increased risk for suicide: the closer the relationship, the greater the risk. One possible explanation is that the relative's suicide offers a sense of "permission" or acceptance of suicide as a method of escaping a difficult situation. This familiarity and acceptance also is believed to contribute to "copycat suicides" by teenagers, who are greatly influenced by their peers' actions (Sudak, 2005).

Many people with depression who have suicidal ideation lack the energy to implement suicide plans. The natural energy that accompanies increased sunlight in spring is believed to explain why most suicides occur in April. Most suicides happen on Monday mornings, when most people return to work (another energy spurt). Research has shown that antidepressant treatment actually can give clients with depression the energy to act on suicidal ideation (Sudak, 2005).

Warnings of Suicidal Intent

Most people with suicidal ideation send either direct or indirect signals to others about their intent to harm themselves. The nurse *never* ignores any hint of suicidal ideation regardless of how trivial or subtle it seems and the client's intent or emotional status. Often, people contemplating suicide have ambivalent and conflicting feelings about their desire to die; they frequently reach out to others for help. For example, a client might say,



"I keep thinking about taking my entire supply of medications to end it all" (direct) or "I just can't take it anymore" (indirect).

BOX 15.2 MYTHS AND FACTS ABOUT SUICIDE

Myths

People who talk about suicide never commit suicide.

Suicidal people only want to hurt themselves, not others.

There is no way to help someone who wants to kill himself or herself.

Do not mention the word *suicide* to a person you suspect to be suicidal, because this could give him or her the idea to commit suicide.

Ignoring verbal threats of suicide or challenging a person to carry out his or her suicide plans will reduce the individual's use of these behaviors.

Once a suicide risk, always a suicide risk.

Facts

Suicidal people often send out subtle or not-so-subtle messages that convey their inner thoughts of hopelessness and self-destruction. Both subtle and direct messages of suicide should be taken seriously with appropriate assessments and interventions.

Although the self-violence of suicide demonstrates anger turned inward, the anger can be directed toward others in a planned or impulsive action.

Physical harm: Psychotic people may be responding to inner voices that command the individual to kill others before killing the self. A depressed person who has decided to commit suicide with a gun may impulsively shoot the person who tries to grab the gun in an effort to thwart the suicide.

Emotional harm: Often, family members, friends, health care professionals, and even police involved in trying to avert a suicide or those who did not realize the person's depression and plans to commit suicide feel intense guilt and shame because of their failure to help and are "stuck" in a never-ending cycle of despair and grief. Some people, depressed after the suicide of a loved one, will rationalize that suicide was a "good way out of the pain" and plan their own suicide to escape pain. Some suicides are planned to engender guilt and pain in survivors, e.g., as someone who wants to punish another for rejecting or not returning love.

Suicidal people have mixed feelings (ambivalence) about their wish to die, wish to kill others, or to be killed. This ambivalence often prompts the cries for help evident in overt or covert cues. Intervention can help the suicidal individual get help from situational supports, choose to live, learn new ways to cope, and move forward in life.

Suicidal people have already thought of the idea of suicide and may have begun plans. Asking about suicide does not cause a nonsuicidal person to become suicidal.

Suicidal gestures are a potentially lethal way to act out. Threats should not be ignored or dismissed, nor should a person be challenged to carry out suicidal threats. All plans, threats, gestures, or cues should be taken seriously and immediate help given that focuses on the problem about which the person is suicidal.

When asked about suicide, it is often a relief for the client to know that his or her cries for help have been heard and that help is on the way.

Although it is true that most people who successfully commit suicide have made attempts at least once before, most people with suicidal ideation can have positive resolution to the suicidal crisis. With proper support, finding new ways to resolve the problem helps these individuals become emotionally secure and have no further need for suicide as a way to resolve a problem.

Box 15.3 SUICIDAL IDEATION: CLIENT STATEMENTS AND NURSE RESPONSES

Client Statement

"I just want to go to sleep and not think anymore."

"I want it to be all over."

"It will just be the end of the story."

"You have been a good friend."

"Remember me."

"Here is my chess set that you have always admired."

"If there is ever any need for anyone to know this, my will and insurance papers are in the top drawer of my dresser."

"I can't stand the pain anymore."

"Everyone will feel bad soon."

"I just can't bear it anymore."

"Everyone would be better off without me."

Nonverbal change in behavior from agitated to calm, anxious to relaxed, depressed to smiling, hostile to benign, from being without direction to appearing to be goal directed

Nurse Responses

"Specifically just how are you planning to sleep and not think anymore?"

"By 'sleep,' do you mean 'die'?"

"What is it you do not want to think of anymore?"

"I wonder if you are thinking of suicide."

"What is it you specifically want to be over?"

"Are you planning to end your life?"

"How do you plan to end your story?"

"You sound as if you are saying good-bye. Are you?"

"Are you planning to commit suicide?"

"What is it you really want me to remember about you?"

"What is going on that you are giving away things to remember you by?"

"I appreciate your trust. However, I think there is an important message you are giving me. Are you thinking of ending your life?"

"How do you plan to end the pain?"

"Tell me about the pain."

"Sounds like you are planning to harm yourself."

"Who is the person you want to feel bad by killing yourself?"

"What is it you cannot bear?"

"How do you see an end to this?"

"Who is one person you believe would be better off without you?"

"How do you plan to eliminate yourself, if you think everyone would be better off without you?"

"What is one way you perceive others would be better off without you?"

"You seem different today. What is this about?"

"I sense you have reached a decision. Share it with me."

Box 15.3 provides more examples of client statements about suicide and effective responses from the nurse.

Asking clients directly about thoughts of suicide is important. Psychiatric admission assessment interview forms routinely include such questions. It is also standard practice to inquire about suicide or self-harm thoughts in any setting where people seek treatment for emotional problems.

Risky Behaviors

A few people who commit suicide give no warning signs. Some artfully hide their distress and suicide plans. Others act

impulsively by taking advantage of a situation to carry out the desire to die. Some suicidal people in treatment describe placing themselves in risky or dangerous situations such as speeding in a blinding rainstorm or when intoxicated. This "Russian roulette" approach carries a high risk for harm to clients and innocent bystanders alike. It allows clients to feel brave by repeatedly confronting death and surviving.

Lethality Assessment

When a client admits to having a "death wish" or suicidal thoughts, the next step is to determine potential

lethality. This assessment involves asking the following questions:

- Does the client have a plan? If so, what is it? Is the plan specific?
- Are the means available to carry out this plan? (For example, if the person plans to shoot himself, does he have access to a gun and ammunition?)
- If the client carries out the plan, is it likely to be lethal? (For example, a plan to take 10 aspirin is not lethal, while a plan to take a 2-week supply of a tricyclic antidepressant is.)
- Has the client made preparations for death, such as giving away prized possessions, writing a suicide note, or talking to friends one last time?
- Where and when does the client intend to carry out the plan?
- Is the intended time a special date or anniversary that has meaning for the client?

Specific and positive answers to these questions all increase the client's likelihood of committing suicide. It is important to consider whether or not the client believes her or his method is lethal even if it is not. Believing a method to be lethal poses a significant risk.

Outcome Identification

Suicide prevention usually involves treating the underlying disorder, such as mood disorder or psychosis, with psychoactive agents. The overall goals are first to keep the client safe and later to help him or her to develop new coping skills that do not involve self-harm. Other outcomes may relate to activities of daily living, sleep and nourishment needs, and problems specific to the crisis such as stabilization of psychiatric illness/symptoms.

Examples of outcomes for a suicidal person include the following:

- The client will be safe from harming self or others.
- The client will engage in a therapeutic relationship.
- The client will establish a no-suicide contract.
- The client will create a list of positive attributes.
- The client will generate, test, and evaluate realistic plans to address underlying issues.

Intervention

Using an Authoritative Role

Intervention for suicide or suicidal ideation becomes the first priority of nursing care. The nurse assumes an authoritative role to help clients stay safe. In this crisis situation, clients see few or no alternatives to resolve their problems. The nurse lets clients know their safety is the primary concern and takes precedence over other needs or wishes. For example, a client may want to be alone in her room to think privately. This is not allowed while she is at increased risk for suicide.

Providing a Safe Environment

Inpatient hospital units have policies for general environmental safety. Some policies are more liberal than others, but all usually deny clients access to materials on cleaning carts, their own medications, sharp scissors, and penknives. For suicidal clients, staff members remove any item they can use to commit suicide, such as sharp objects, shoelaces, belts, lighters, matches, pencils, pens, and even clothing with drawstrings.

Again, institutional policies for suicide precautions vary, but usually staff members observe clients every 10 minutes if lethality is low. For clients with high potential lethality, one-to-one supervision by a staff person is initiated. This means that clients are in direct sight of and no more than 2 to 3 feet away from a staff member for all activities, including going to the bathroom. Clients are under constant staff observation with no exceptions. This may be frustrating or upsetting to clients, so staff members usually need to explain the purpose of such supervision more than once.

No-suicide or no-self-harm contracts have been used with suicidal clients. In such contracts, clients agree to keep themselves safe and to notify staff at the first impulse to harm themselves (at home, clients agree to notify their caregivers; the contract must identify backup people in case caregivers are unavailable). These contracts, however, are not a guarantee of safety, and their use has been sharply criticized (McMyler & Prymachuk, 2008). At no time should a nurse assume that a client is safe based on a single statement by the client. Rather a complete assessment and a thorough discussion with the client are more reliable.

Creating a Support System List

Suicidal clients often lack social support systems such as relatives and friends or religious, occupational, and community support groups. This lack may result from social withdrawal, behavior associated with a psychiatric or medical disorder, or movement of the person to a new area because of school, work, or change in family structure or financial status. The nurse assesses support systems and the type of help each person or group can give a client. Mental health clinics, hotlines, psychiatric emergency evaluation services, student health services, church groups, and self-help groups are part of the community support system.

The nurse makes a list of specific names and agencies that clients can call for support; he or she obtains client consent to avoid breach of confidentiality. Many suicidal people do not have to be admitted to a hospital and can be treated successfully in the community with the help of these support people and agencies.

Family Response

Suicide is the ultimate rejection of family and friends. Implicit in the act of suicide is the message to others that their help was incompetent, irrelevant, or unwelcome.

Some suicides are done to place blame on a certain person—even to the point of planning how that person will be the one to discover the body. Most suicides are efforts to escape untenable situations. Even if a person believes love for family members prompted his or her suicide—as in the case of someone who commits suicide to avoid lengthy legal battles or to save the family the financial and emotional cost of a lingering death—relatives still grieve and may feel guilt, shame, and anger.

Significant others may feel guilty for not knowing how desperate the suicidal person was, angry because the person did not seek their help or trust them, ashamed that their loved one ended his or her life with a socially unacceptable act, and sad about being rejected. Suicide is newsworthy, and there may be whispered gossip and even news coverage. Life insurance companies may not pay survivors' benefits to families of those who kill themselves. Also, the one death may spark “copycat suicides” among family members or others, who may believe they have been given permission to do the same. Families can disintegrate after a suicide.

Nurse's Response

When dealing with a client who has suicidal ideation or attempts, the nurse's attitude must indicate unconditional positive regard not for the act but for the person and his or her desperation. The ideas or attempts are serious signals of a desperate emotional state. The nurse must convey the belief that the person can be helped and can grow and change.

Trying to make clients feel guilty for thinking of or attempting suicide is not helpful; they already feel incompetent, hopeless, and helpless. The nurse does not blame clients or act judgmentally when asking about the details of a planned suicide. Rather, the nurse uses a nonjudgmental tone of voice and monitors his or her body language and facial expressions to make sure not to convey disgust or blame.

Nurses believe that one person can make a difference in another's life. They must convey this belief when caring for suicidal people. Nevertheless, nurses also must realize that no matter how competent and caring interventions are, a few clients will still commit suicide. A client's suicide can be devastating to the staff members who treated him or her, especially if they have gotten to know the person and his or her family well over time. Even with therapy, staff members may end up leaving the health care facility or the profession as a result.

Legal and Ethical Considerations

Assisted suicide is a topic of national legal and ethical debate, with much attention focusing on the court decisions related to the actions of Dr. Jack Kevorkian, a physician who has participated in numerous assisted suicides.

Oregon was the first state to adopt assisted suicide into law and has set up safeguards to prevent indiscriminate assisted suicide. Many people believe it should be legal in any state for health care professionals or family to assist those who are terminally ill and want to die. Others view suicide as against the laws of humanity and religion and believe that health care professionals should be prosecuted if they assist those trying to die. Groups, such as the Hemlock Society, and people, such as Dr. Kevorkian, are lobbying for changes in laws that would allow health care professionals and family members to assist with suicide attempts for the terminally ill. Controversy and emotion continue to surround the issue.

Often, nurses must care for terminally or chronically ill people with a poor quality of life, such as those with the intractable pain of terminal cancer or severe disability or those kept alive by life-support systems. It is not the nurse's role to decide how long these clients must suffer. It is the nurse's role to provide supportive care for clients and family as they work through the difficult emotional decisions about if and when these clients should be allowed to die; people who have been declared legally dead can be disconnected from life support. Each state has defined legal death and the ways to determine it.

Elder Considerations

Sakauye (2008) reports that depression is common among the elderly and is markedly increased when elders are medically ill. Elders tend to have psychotic features, particularly delusions, more frequently than younger people with depression. Suicide among persons older than age 65 is doubled compared with suicide rates of persons younger than 65. Late-onset bipolar disorder is rare.

Elders are treated for depression with ECT more frequently than younger persons. Elder persons have increased intolerance of side effects of antidepressant medications and may not be able to tolerate doses high enough to effectively treat the depression. Also, ECT produces a more rapid response than medications, which may be desirable if the depression is compromising the medical health of the elder person. Because suicide among the elderly is increased, the most rapid response to treatment becomes even more important (Sakauye, 2008).

COMMUNITY-BASED CARE

Nurses in any area of practice in the community frequently are the first health care professionals to recognize behaviors consistent with mood disorders. In some cases, a family member may mention distress about a client's withdrawal from activities; difficulty thinking, eating, and sleeping; complaints of being tired all the time; sadness; and agitation (all symptoms of depression). They might also mention cycles of euphoria, spending binges, loss of inhibitions, changes in sleep and eating patterns, and loud clothing styles and colors (all symptoms of the manic phase

Drug Alert !



Antidepressants and Suicide Risk

Depressed clients who begin taking an antidepressant may have a continued or increased risk for suicide in the first few weeks of therapy. They may experience an increase in energy from the antidepressant but remain depressed. This increase in energy may make clients more likely to act on suicidal ideas and able to carry them out. Also, because antidepressants take several weeks to reach their peak effect, clients may become discouraged and act on suicidal ideas because they believe the medication is not helping them. For these reasons, it is extremely important to monitor the suicidal ideation of depressed clients until the risk has subsided.

of bipolar disorder). Documenting and reporting such behaviors can help these people to receive treatment. Estimates are that nearly 40% of people who have been diagnosed with a mood disorder do not receive treatment (Akiskal, 2005). Contributing factors may include the stigma still associated with mental disorders, the lack of understanding about the disruption to life that mood disorders can cause, confusion about treatment choices, or a more compelling medical diagnosis; these combine with the reality of limited time that health care professionals devote to any one client.

People with depression can be treated successfully in the community by psychiatrists, psychiatric advanced practice nurses, and primary care physicians. People with bipolar disorder, however, should be referred to a psychiatrist or psychiatric advanced practice nurse for treatment. The physician or nurse who treats a person with bipolar disorder must understand the drug treatment, dosages, desired effects, therapeutic levels, and potential side effects so that he or she can answer questions and promote compliance with treatment.

MENTAL HEALTH PROMOTION

Many studies have been conducted to determine how to prevent mood disorders and suicide, but prediction of suicide risk in clinical practice remains difficult. Programs that use an educational approach designed to address the unique stressors that contribute to the increased incidence of depressive illness in women have had some success. These programs focus on increasing self-esteem and reducing loneliness and hopelessness, which in turn decrease the likelihood of depression.

Efforts to improve primary care treatment of depression have built upon a chronic illness care model that includes

patient self-management, or helping people be better prepared to deal with life issues and changes. This includes having a partnership with their provider, having a crisis or relapse prevention plan, creating a social support network, and making needed behavioral changes to promote health (Bachman, Swensen, Reardon, & Miller, 2006).

Because suicide is a leading cause of death among adolescents, prevention, early detection, and treatment are very important. Strengthening protective factors (those factors associated with a reduction in suicide risk) would improve the mental health of adolescents. Protective factors include close parent–child relationships, academic achievement, family-life stability, and connectedness with peers and others outside the family. School-based programs can be universal (general information for all students) or indicated (targeting young people at risk). Indicated or selective programs have been more successful than universal programs (Horowitz & Garber, 2006; Rapee et al., 2006). Likewise, screening for early detection of risk factors such as family strife, parental alcoholism or mental illness, history of fighting, and access to weapons in the home can lead to referral and early intervention.

SELF-AWARENESS ISSUES



Nurses working with clients who are depressed often empathize with them and also begin to feel sad or agitated. They may unconsciously start to avoid contact with these clients to escape such feelings. The nurse must monitor his or her feelings and reactions closely when dealing with clients with depression to be sure he or she fulfills the responsibility to establish a therapeutic nurse–client relationship.

People with depression are usually negative, pessimistic, and unable to generate new ideas easily. They feel hopeless and incompetent. The nurse easily can become consumed with suggesting ways to fix the problems. Most clients find some reason why the nurse's solutions will not work: "I have tried that," "It would never work," "I don't have the time to do that," or "You just don't understand." Rejection of suggestions can make the nurse feel incompetent and question his or her professional skill. Unless a client is suicidal or is experiencing a crisis, the nurse does not try to solve the client's problems. Instead, the nurse uses therapeutic techniques to encourage clients to generate their own solutions. Studies have shown that clients tend to act on plans or solutions they generate rather than those that others offer (Schultz & Videbeck, 2009). Finding and acting on their own solutions gives clients renewed competence and self-worth.

Working with clients who are manic can be exhausting. They are so hyperactive that the nurse may feel spent or tired after caring for them. The nurse may feel frustrated because these clients engage in the same behaviors repeatedly, such as being intrusive with others, undressing,

singing, rhyming, and dancing. It takes hard work to remain patient and calm with the manic client, but it is essential for the nurse to provide limits and redirection in a calm manner until the client can control his or her own behavior independently.

Some health care professionals consider suicidal people to be failures, immoral, or unworthy of care. These negative attitudes may result from several factors. They may reflect society's negative view of suicide: many states still have laws against suicide, although they rarely enforce these laws. Health care professionals may feel inadequate and anxious dealing with suicidal clients, or they may be uncomfortable about their own mortality. Many people have had thoughts about "ending it all," even if for a fleeting moment when life is not going well. The scariness of remembering such flirtations with suicide causes anxiety. If this anxiety is not resolved, the staff person can demonstrate avoidance, demeaning behavior, and superiority to suicidal clients. Therefore, to be effective, the nurse must be aware of his or her own feelings and beliefs about suicide.

Points to Consider When Working with Clients with Mood Disorders

- Remember that clients with mania may seem happy, but they are suffering inside.
- For clients with mania, delay client teaching until the acute manic phase is resolving.
- Schedule specific, short periods with depressed or agitated clients to eliminate unconscious avoidance of them.
- Do not try to fix a client's problems. Use therapeutic techniques to help him or her find solutions.
- Use a journal to deal with frustration, anger, or personal needs.
- If a particular client's care is troubling, talk with another professional about the plan of care, how it is being carried out, and how it is working.

Critical Thinking Questions

1. Is it possible for someone to make a "rational" decision to commit suicide? Under what circumstances?
2. Are laws ethical that permit physician-assisted suicide? Why or why not?
3. A person with bipolar disorder frequently discontinues taking medication when out of the hospital, becomes manic, and engages in risky behavior such as speeding, drinking and driving, and incurring large debts. How do you reconcile the client's right to refuse medication with public or personal safety? Who should make such a decision? How could it be enforced?

KEY POINTS



- Studies have found a genetic component to mood disorders. The incidence of depression is up to three times greater in first-degree relatives of people with diagnosed depression. People with bipolar disorder usually have a blood relative with bipolar disorder.
- Only 9% of people with mood disorders exhibit psychosis.
- Major depression is a mood disorder that robs the person of joy, self-esteem, and energy. It interferes with relationships and occupational productivity.
- Symptoms of depression include sadness, disinterest in previously pleasurable activities, crying, lack of motivation, asocial behavior, and psychomotor retardation (slowed thinking, talking, and movement). Sleep disturbances, somatic complaints, loss of energy, change in weight, and a sense of worthlessness are other common features.
- Several antidepressants are used to treat depression. SSRIs, the newest type, have the fewest side effects. Tricyclic antidepressants are older and have a longer lag period before reaching adequate serum levels; they are the least expensive type. MAOIs are used least: Clients are at risk for hypertensive crisis if they ingest tyramine-rich foods and fluids while taking these drugs. MAOIs also have a lag period before reaching adequate serum levels.
- People with bipolar disorder cycle between mania, normalcy, and depression. They also may cycle only between mania and normalcy or between depression and normalcy.
- Clients with mania have a labile mood, are grandiose and manipulative, have high self-esteem, and believe they are capable of anything. They sleep little, are always in frantic motion, invade others' boundaries, cannot sit still, and start many tasks. Speech is rapid and pressured, reflects rapid thinking, and may be circumstantial and tangential with features of rhyming, punning, and flight of ideas. Clients show poor judgment with little sense of safety needs and take physical, financial, occupational, or interpersonal risks.
- Lithium is used to treat bipolar disorder. It is helpful for bipolar mania and can partially or completely eradicate cycling toward bipolar depression. Lithium is effective in 75% of clients but has a narrow range of safety; thus, ongoing monitoring of serum lithium levels is necessary to establish efficacy while preventing toxicity. Clients taking lithium must ingest adequate salt and water to avoid overdosing or underdosing because lithium salt uses the same postsynaptic receptor sites as sodium chloride does. Other antimanic drugs include sodium valproate, carbamazepine, other anticonvulsants, and clonazepam, which is also a benzodiazepine.
- For clients with mania, the nurse must monitor food and fluid intake, rest and sleep, and behavior, with a



INTERNET RESOURCES

RESOURCES

- American Association of Suicidology
- Suicide Prevention Resource Center
- Depression Information and Support
- Depression Issues
- National Institute of Mental Health Suicide Research Consortium
- Postpartum Depression Resources
- SAD Association

INTERNET ADDRESS

<http://www.suicidology.org/web/guest/home>
<http://www.sprc.org>
<http://www.depression.about.com>
<http://www.bipolardepressioninfo.com>
<http://www.depressionissues.com>

<http://www.squidoo.com/postpartum>
<http://babyparenting.about.com/b/a/132722.htm>
<http://www.sada.org.uk/>

focus on safety, until medications reduce the acute stage and clients resume responsibility for themselves.

- Suicidal ideation means thinking of suicide.
- People with increased rates of suicide include single adults, divorced men, adolescents, older adults, the very poor or very wealthy, urban dwellers, migrants, students, whites, people with mood disorders, substance abusers, people with medical or personality disorders, and people with psychosis.
- The nurse must be alert to clues to a client's suicidal intent—both direct (making threats of suicide) and indirect (giving away prized possessions, putting his or her life in order, making vague good-byes).
- Conducting a suicide lethality assessment involves determining the degree to which the person has planned his or her death, including time, method, tools, place, person to find the body, reason, and funeral plans.
- Nursing interventions for a client at risk for suicide involve keeping the person safe by instituting a no-suicide contract, ensuring close supervision, and removing objects that the person could use to commit suicide.

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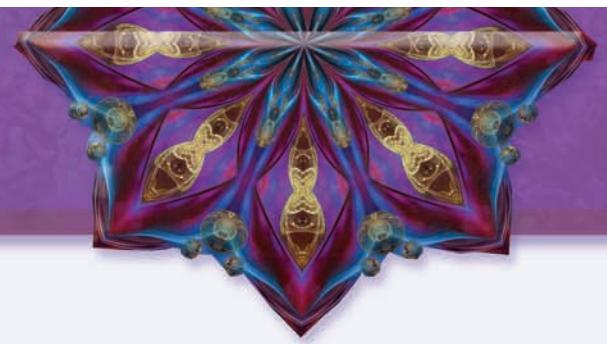
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Chapter Study Guide



MULTIPLE-CHOICE QUESTIONS

Select the best answer for each of the following questions.

- The nurse observes that a client with bipolar disorder is pacing in the hall, talking loudly and rapidly, and using elaborate hand gestures. The nurse concludes that the client is demonstrating which of the following?
 - Aggression
 - Anger
 - Anxiety
 - Psychomotor agitation
- A client with bipolar disorder begins taking lithium carbonate (lithium), 300 mg four times a day. After 3 days of therapy, the client says, "My hands are shaking." The best response by the nurse is
 - "Fine motor tremors are an early effect of lithium therapy that usually subsides in a few weeks."
 - "It is nothing to worry about unless it continues for the next month."
 - "Tremors can be an early sign of toxicity, but we'll keep monitoring your lithium level to make sure you're okay."
 - "You can expect tremors with lithium. You seem very concerned about such a small tremor."
- What are the most common types of side effects from SSRIs?
 - Dizziness, drowsiness, and dry mouth
 - Convulsions and respiratory difficulties
 - Diarrhea and weight gain
 - Jaundice and agranulocytosis
- The nurse observes that a client with depression sat at a table with two other clients during lunch. The best feedback the nurse could give the client is:
 - "Do you feel better after talking with others during lunch?"
 - "I'm so happy to see you interacting with other clients."
 - "I see you were sitting with others at lunch today."
 - "You must feel much better than you were a few days ago."
- Which of the following typifies the speech of a person in the acute phase of mania?
 - Flight of ideas
 - Psychomotor retardation
 - Hesitant
 - Mutism
- What is the rationale for a person taking lithium to have enough water and salt in his or her diet?
 - Salt and water are necessary to dilute lithium to avoid toxicity.
 - Water and salt convert lithium into a usable solute.
 - Lithium is metabolized in the liver, necessitating increased water and salt.
 - Lithium is a salt that has greater affinity for receptor sites than sodium chloride.
- Identify the serum lithium level for maintenance and safety.
 - 0.1 to 1.0 mEq/L
 - 0.5 to 1.5 mEq/L
 - 10 to 50 mEq/L
 - 50 to 100 mEq/L
- A client says to the nurse, "You are the best nurse I've ever met. I want you to remember me." What is an appropriate response by the nurse?
 - "Thank you. I think you are special too."
 - "I suspect you want something from me. What is it?"
 - "You probably say that to all your nurses."
 - "Are you thinking of suicide?"
- A client with mania begins dancing around the day room. When she twirled her skirt in front of the male clients, it was obvious she had no underpants on. The nurse distracts her and takes her to her room to put on underpants. The nurse acted as she did to:
 - Minimize the client's embarrassment about her present behavior.
 - Keep her from dancing with other clients.
 - Avoid embarrassing the male clients who are watching.
 - Teach her about proper attire and hygiene.

MULTIPLE-RESPONSE QUESTIONS

Select all that apply.

1. Which of the following would indicate an increased suicidal risk?
 - a. An abrupt improvement in mood.
 - b. Calling family members to make amends.
 - c. Crying when discussing sadness.
 - d. Feeling overwhelmed by simple daily tasks.
 - e. Statements such as “I’m such a burden for everyone.”
 - f. Statements such as “Everything will be better soon.”
2. Which of the following activities would be appropriate for a client with mania?
 - a. Drawing a picture
 - b. Modeling clay
 - c. Playing bingo
 - d. Playing table tennis
 - e. Stretching exercises
 - f. Stringing beads

CLINICAL EXAMPLE

June, 46 years old, is divorced with three children: 10, 13, and 16 years of age. She works in the county clerk’s office and has called in sick four times in the past 2 weeks. June has lost 17 pounds in the past 2 months, is spending a lot of time in bed, but still feels exhausted “all the time.” During the admission interview, June looks overwhelmingly sad, is tearful, has her head down, and makes little eye contact. She answers the nurse’s questions with one or two words. The nurse considers postponing the remainder of the interview because June seems unable to provide much information.

1. What assessment data are crucial for the nurse to obtain before ending the interview?
2. Identify three nursing diagnoses on the basis of the available data.
3. Identify a short-term outcome for each of the nursing diagnoses.
4. Discuss nursing interventions that would be helpful for June.