

Mood Disorders NCLEX Review

I. Introduction

Mood disorders, also called affective disorders

- are pervasive *alterations in emotions* that are manifested by depression, mania, or both

II. Categories of Mood Disorders

1. Major Depression (Unipolar Disorder)

- Loss of interest in life and a depressed mood that moves from mild to severe and lasts *at least 2 weeks*

MAJOR SYMPTOMS OF DEPRESSIVE DISORDER

- Depressed mood
- Anhedonia (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

1. Dysthymic disorder

- 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.
- Less severe, chronic depressed mood that fluctuates with a normal mood

1. Bipolar Disorder (Manic-Depressive Disorder)

- Moods alternating between depression and elation; *with periods of normal mood and activity* in between

Categories of Bipolar Disorder

1. Bipolar I – one or more manic episodes and one or more depressive episodes (alternating Mania and Severe Depression with normal mood)
2. Bipolar II – less severe and has one or more hypomanic episodes and one or more depressive episodes (alternating moderate mania and severe depression with normal mood)

Further classification:

1. Mixed – the individual has rapidly alternating moods
2. Manic – the individual is currently in a manic state
3. Depressed – the individual is in the depressed phase, but there is also a history of manic episodes

Assessment of Bipolar Disorder

Mania	Depression
<ul style="list-style-type: none"> • Becomes angry quickly • Delusional self-confidence • Distracted by environmental stimuli • Extroverted personality • Flight of ideas • Grandiose and persecutory delusions • High and unstable affect • Significant decrease in appetite • Inability to eat or sleep because of involvement in more important things • Inability to sleep yet still active • Unlimited energy • Inappropriate affect • Inappropriate dress • Initiation of activity • Pressured speech • Restlessness • Sexually promiscuous • Urgent motor activity 	<ul style="list-style-type: none"> • Increased or decreased appetite • Decrease in activities of daily living • Decreased emotion and physical activity • Easily fatigued • Inability to make decisions • Poor concentration • Internalizing hostility • Introverted personality • Social isolation and withdrawn from groups • Lack of energy • Lack of initiative • Lack of self-confidence and low self-esteem • Lack of sexual interest • Psychomotor retardation • Suicidal thinking

1. Cyclothymic Disorder

- Mood changes between moderate depression and hypomania, do not meet the criteria for bipolar disorder
- The disorder lasts for *at least 2 years*
- *No sign of a normal range* in clients with cyclothymic disorder

1. Seasonal affective disorder (SAD)

- Client exhibits a depressed mood that occurs in the fall and winter
- During spring and summer, the client experiences normal mood or hypomania
- There is a direct correlation with light and production of melatonin in clients with SAD

1. Schizoaffective disorder

- Combination of the signs and symptoms of schizophrenia and those of the mood disorders

Signs and symptoms

1. Delusions
2. Hallucination
3. Disorganized speech
4. Disorganized behavior
5. Negative symptoms

- Anergia – lack of activity
- Anhedonia – loss of pleasure, asocial behavior, attention deficits, avolition, blunted affect

1. Major depressive symptoms or manic symptoms or mixed symptoms

1. Postpartum Depression

- meets all the criteria for a major depressive episode with onset *within 4 weeks of delivery*.

**Postpartum or “maternity” blues - frequent normal experience after delivery of a baby 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 disappear rapidly with no medical treatment

III. Etiology

A. Biological Causative Theories of Depressive Disorders

- Genetic predisposition

First Degree Relatives – twice the risk of developing depression

- Alterations in Neurochemical functioning

B. Psychological Theories

1. Psychoanalytic perspective (Sigmund Freud) – loss of a person or an object triggers the depression

“Depression is an anger turned inward”

Psychoanalysis – helps the client gain insight into the meaning of thoughts, feelings, and actions

2. Cognitive Perspective – depression is the outcome when an individual perceives all stressful situations as negative

Cognitive Therapy – helps the client learn how to perceive the world in a positive light and teach them how to relearn thinking and decision making based on positive rather than negative processing

3. *Behavioral Perspective* – when feelings of helplessness, unworthiness, and powerlessness are the norm during the developmental years; the individual finds most of life outcomes as negative

IV. Nursing Interventions

A. Interventions for Depressed Clients

- Assess for homicidal and suicidal ideation
- Provide safety from suicidal actions

- Assist with activities of daily living
- Use gentle encouragement to participate in activities of daily living and unit therapies
- Do not push decision making or making complex choices or decisions that client is not ready to make
- Monitor sleep patterns
- Monitor nutritional intake and weight
- Monitor for general hygiene and self-care deficits; deficits may indicate worsening depression.
- Provide achievable activities in which client can achieve success (focus on strengths).
- Remind client of times when he or she felt better and was successful
- Spend time with client to communicate client's value.
- Respond to anger therapeutically.

NOTE! Monitor a depressed client closely for signs of suicidal ideation. If the client presents with increased energy, *monitor closely* because it could mean that the client now has the energy to perform the suicide act.

B. Interventions for Mania

- Constant supervision
- Remove hazardous objects from the environment.
- Assess the client closely for fatigue.
- Use comfort measures to promote sleep.
- Provide frequent rest periods.
- Monitor the client's sleep patterns.
- Provide a private room if possible.
- Administer a hypnotic or sedative medication as prescribed.
- Encourage the client to ventilate feelings.
- Use calm, slow interactions.
- Help the client focus on one topic during the conversation.
- distract the client from grandiose thinking.
- Present reality to the client.
- Do not argue with the client.
- Limit group activities and assess the client's tolerance level
- Solitary activities may be necessary
- Provide high-calorie finger foods and fluids
- Supervise the client's choice of clothing
- Reduce environmental stimuli.
- Set limits on inappropriate behaviors
- Provide physical activities and outlets for tension.
- Avoid competitive games
- Provide gross motor activities such as walking
- Provide structured activities or one-to-one activities with the nurse.

C. Dealing with Inappropriate Behaviors associated with Bipolar Disorder

Aggressive Behavior

- Assist client in identifying feelings of frustration and aggression.
- Encourage client to talk out instead of acting out feelings of frustration
- Assist client in identifying precipitating events or situations that lead to aggressive behavior
- Describe the consequences of the behavior on self and others
- Assist in identifying previous coping mechanisms
- Assist client in problem-solving techniques to cope with frustration or aggression.

De-escalation Techniques

- Maintain safety for client, other clients, and self
- Maintain large personal space and use a nonaggressive posture
- Use a calm approach and communicate with a calm, clear tone of voice (be assertive, not aggressive).
- Determine what client considers to be his or her need
- Avoid verbal struggles.
- Provide client with clear options that deal with client's behavior
- Assist client with problem solving and decision making regarding options.

Manipulative Behavior

- Set clear, consistent, realistic, and enforceable limits, and communicate expected behaviors
- Be clear about consequences associated with exceeding set limits and follow through with consequences in a nonpunitive manner, if necessary
- Discuss client's behavior in a nonjudgmental and nonthreatening manner
- Avoid power struggles with client (avoid arguing with client)
- Assist client in developing means of setting limits on own behavior.
- When becoming intrusive, set and maintain boundaries while interacting with others; *maintain distance of 2 to 3 ft. at all times*

IV. Psychopharmacology

A. Antidepressant Drugs

1. Selective serotonin reuptake inhibitors (SSRIs)

- The SSRIs block the reuptake of serotonin and intensify the transmission at Serotonergic synapses
- First-line treatment because of fewer sedating, anticholinergic, and cardiovascular side effects
- Several weeks before full therapeutic effect is seen; usually, the effect can be seen *after 1 to 3 weeks*

Side-effects:

- Insomnia – medication should be taken in the morning
- Diarrhea
- Nausea
- Sexual Dysfunction (decreased libido)

Nursing Responsibilities:

- The potential for medication interactions is high, and complete medication assessments must be obtained and evaluated; *inquire about the use of herbal therapies*, especially St. John's wort.
- Monitor vital signs because SSRIs can potentially lower or elevate blood pressure.
- If *priapism* (painful, prolonged penile erection) occurs, the medication is *withheld* and the physician is notified.
- Educate the client about the potential for *discontinuation syndrome* if medication is stopped abruptly rather than tapered; the syndrome is characterized by gastrointestinal distress, behavioral or perceptual oddities, movement problems, and sleep disturbances.
- Be aware of the potential for *serotonin syndrome*, characterized by elevated temperature, muscle rigidity, and elevated creatinine phosphokinase levels; *this risk is greatly increased when SSRIs are given with monoamine oxidase inhibitors (MAOIs)*. This medication combination needs to be avoided.
- Instruct the client that over-the-counter (OTC) cold medicines can increase the likelihood of serotonin syndrome.
- Monitor white blood cell and neutrophil counts; the medication may be discontinued if levels decrease below normal.
- Monitor weight.
- Initiate safety precautions, particularly if dizziness occurs
- Instruct the client to avoid alcohol.
- Monitor the suicidal client, especially during improved mood and increased energy levels.

2. Tricyclic Antidepressants (TCAs)

Examples:

Amitriptyline (Elavil); Clomipramine (Anafranil); Desipramine (Norpramin); Doxepin (Sinequan); Imipramine (Tofranil); Nortriptyline (Aventyl HCl, Pamelor); Protriptyline (Vivactil); Trimipramine (Surmontil)

- Block the reuptake of norepinephrine (and serotonin) at the presynaptic neuron
- Initial Mechanism: *1-3 weeks*; maximum therapeutic response: *6-8 weeks*
- May reduce effectiveness of antihypertensive agents
- Concurrent use with alcohol or antihistamines can cause CNS depression
- Concurrent use with MAOIs can cause *hypertensive crisis*
- Cardiac toxicity can occur, and all clients should receive an electrocardiogram (ECG) before treatment and periodically thereafter
- *Overdose is life-threatening*, necessitating immediate treatment (tachycardia, intraventricular blocks, complete atrioventricular block, and ventricular fibrillation; hypothermia; flushing; dry mouth; dilation of the pupils; confusion, agitation, and hallucinations; and seizures followed by coma)

Actions to Take for a Tricyclic Antidepressant Overdose

- Check airway and maintain a patent airway.
- Administer oxygen
- Check vital signs
- Obtain an electrocardiogram
- Prepare for gastric lavage with activated charcoal
- Prepare to administer physostigmine (a cholinesterase inhibitor) and antidysrhythmic medications
- Document the event, actions taken, and the client's response.

Side effects

- Anticholinergic effects: Dry mouth, difficulty voiding, dilated pupils and blurred vision, decreased gastrointestinal motility, constipation
- Photosensitivity
- Cardiovascular disturbances such as tachycardia or dysrhythmias, orthostatic hypotension
- Sedation
- Seizures (with bupropion)
- Weight gain
- Anxiety, restlessness, irritability
- Decreased or increased libido with ejaculatory and erection disturbances

Nursing Responsibilities:

- Monitor the suicidal client, especially during improved mood and increased energy levels.
- Assess for urinary retention
- Administer the entire daily oral dose at one time, preferably at bedtime.
- Instruct the client to avoid alcohol and nonprescription medications to prevent adverse medication interactions
- Instruct the client to avoid driving and other activities requiring alertness until the response

is known; sedation is expected in early therapy and may subside with time.

- When the medication is discontinued by the physician, it should be tapered gradually.
- The potential for medication interactions with OTC cold medication exists.
- Caution the client about photosensitivity and to take measures to prevent exposure to sunlight
- Encourage oral hygiene and the use of hard candies and mouth rinses to relieve dry mouth.

3. Monoamine Oxidase Inhibitors (MAOIs)

- Inhibit the *enzyme monoamine oxidase*, which is present in the brain, blood platelets, liver, spleen, and kidneys
- Monoamine oxidase metabolizes amines, norepinephrine, and serotonin, so the concentration of these amines increases with MAOIs
- Clients who have depression and have not responded to other antidepressant therapies, including electroconvulsive therapy, are given MAOIs.
- Concurrent use with amphetamines, antidepressants, dopamine, epinephrine, guanethidine, levodopa, methyl dopa, nasal decongestants, norepinephrine, reserpine, tyramine-containing foods, or vasoconstrictors may cause hypertensive crisis
- Concurrent use with opioid analgesics may cause hypertension or hypotension, coma, or seizures

Side effects

1. Orthostatic hypotension
2. Restlessness
3. Insomnia
4. Dizziness
5. Weakness, lethargy
6. Gastrointestinal upset
7. Dry mouth
8. Weight gain
9. Peripheral edema
10. Anticholinergic effects
11. CNS stimulation (anxiety, agitation, mania)
12. Delay in ejaculation

Nursing Responsibilities:

- Monitor blood pressure frequently for hypertension.
- Monitor for signs of hypertensive crisis.
- If palpitations or frequent headaches occur, withhold the medication and notify the physician.
- Administer with food if gastrointestinal distress occurs.

- Instruct the client that the medication effect may be noted during the first week of therapy, but maximum benefit may take 3 weeks.
- Instruct the client to report headache, neck stiffness, or neck soreness immediately.
- Instruct the client to change positions slowly to prevent orthostatic hypotension.
- Instruct the client to avoid caffeine or OTC preparations such as weight-reducing pills or medications for hay fever and colds.
- Monitor for client compliance with medication administration
- Instruct the client to carry a Medic-Alert card indicating that an MAOI medication is being taken
- Avoid administering the medication in the evening because insomnia may result.
- When the medication is discontinued by the physician, it should be discontinued gradually.
- Instruct the client to *avoid foods that require bacteria or molds for their preparation or preservation and foods that contain tyramine*

Tyramine-Rich foods to avoid when on MAOI:

- all cheeses except cream or cottage
- meats and fish: aged/cured
- fruits and vegetables: broad bean pods, tofu, soybean extracts
- alcohol: draft beer
- other: sauerkraut, soy sauce, yeast extracts, soups (especially miso)
- Avocados
- Bananas Beef or chicken liver
- Brewer's yeast
- Broad beans
- Caffeine, such as in coffee, tea, or chocolate
- Figs
- Meat extracts and tenderizers
- Overripe fruit
- Papaya
- Pickled herring
- Raisins
- Red wine and sherry
- Sausage, bologna, pepperoni, salami
- Sour cream
- Yogurt

B. Mood Stabilizers

1. Lithium

- Drug of choice for controlling manic episodes in clients with bipolar disorder
- Affect cellular transport mechanism and enhance serotonin or g-aminobutyric acid (GABA) function, or both, which are associated with mood
- *The therapeutic dose is only slightly less than the amount producing toxicity*

- Therapeutic range: 0.8 – 1.4, in book of Saunders: 0.6 to 1.2 mEq/L
- Toxic level: 1.5 and greater
- Anti-manic effects: 5 – 7 days after initial doses; Full effect: 2-3 weeks

Side-effect (therapeutic levels)

- Fine hand tremors
- Gastrointestinal upset
- Thirst
- Muscle weakness

Adverse Effect (Toxicity)

- Persistent GI upset
- Coarse hand tremor
- Confusion
- Hyperirritability of muscles
- ECG changes
- Sedation
- Incoordination

Nursing Responsibilities:

- Monitor the suicidal client, especially during improved mood and increased energy levels.
- Administer the medication with food to minimize gastrointestinal irritation.
- Instruct the client to avoid excessive amounts of coffee, tea, or cola, which have a diuretic effect.
- Do not administer diuretics while the client is taking lithium.
- Instruct the client to avoid alcohol.
- Instruct the client to avoid OTC medications.
- Instruct the client that he or she may take a missed dose within 2 hours of the scheduled time; otherwise, the client should skip the missed dose and take the next dose at the scheduled time.
- Instruct the client not to adjust the dosage without consulting the physician because lithium should be tapered and not discontinued abruptly
- Instruct the client about the signs and symptoms of lithium toxicity
- Instruct the client to notify the physician if polyuria, prolonged vomiting, diarrhea, or fever occurs
- Instruct the client that the therapeutic response to the medication is noted in 1 to 3 weeks
- Monitor the ECG, renal function tests, and thyroid tests (ensure that these tests are performed before the start of therapy).
- Instruct the client to take the medication with food or milk to decrease gastrointestinal upset
- Monitor weight.
- Instruct clients to maintain a constant sodium intake; sodium depletion will decrease renal excretion of lithium, which will cause the drug to accumulate and lead to lithium toxicity

Interventions for lithium toxicity

1. Withhold lithium and notify the physician.
2. Monitor vital signs and level of consciousness.
3. Monitor cardiac status.
4. Prepare to obtain samples monitoring lithium, electrolyte, blood urea nitrogen, and creatinine levels and complete blood cell count.
5. Monitor for suicidal tendencies and institute suicide precautions.

2. Carbamazepine (Tegretol) and valproic acid (Depakote)

- Anti-convulsants with mood-stabilizing properties
- Treat bipolar disorders; usually reserved for clients who cannot tolerate lithium or who haven't responded to lithium
- *Risk for Agranulocytosis* while taking these medications; Baseline and periodic laboratory testing also must also be done to monitor for suppression of white blood cells.
- Clients taking carbamazepine need to have drug serum levels checked regularly to monitor for toxicity and to determine if the drug has reached therapeutic levels, which are generally 4 to 12 mcg per ml;
- For Valproic acid, therapeutic levels are monitored periodically to remain at 50 to 125 mcg per ml, as are baseline and ongoing liver function tests including serum ammonia levels and platelet and bleeding time

C. Other Treatment:

1. Electroconvulsive therapy (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.
- Treat depression in clients who do not respond to antidepressants or those who experience intolerable side-effects at therapeutic doses
- 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
- series of 6 to 15 treatments scheduled 3 times a week
- minimum of 6 treatments is needed to see sustained improvement in depressive symptoms
- Maximum benefit is achieved in 12 to 15 treatments

Client Preparations (Before Procedure)

- NPO after midnight, removes any fingernail polish, and voids just prior to the procedure
- IV is started for the administration of medication
- short-acting anesthetic is administered (i.e. Propofol) so client is not awake during the procedure
- muscle relaxant (i.e. succinylcholine), relaxes all muscles to reduce greatly the outward signs of the seizure (e.g., clonic-tonic muscle contractions) thus preventing injury
- The client receives oxygen and is assisted to breathe with an ambu bag

Client Preparations (After Procedure)

- Vital signs are monitored, and the client is assessed for the return of a gag reflex.
- the client may be mildly confused or disoriented briefly: initiate safety precaution and re-orient the client
- short-term memory loss may also be experienced – temporary;
- Headaches are treated symptomatically.

2. Psychotherapy

- A combination of psychotherapy and medications is considered the most effective treatment for depressive disorders

- Interpersonal therapy
 - focuses on difficulties in relationships such as grief reactions, role disputes, and role transitions
- Behavior therapy
 - seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions
 - 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
 - focuses on the person's distorted thinking that in turn influences feelings, behavior, and functional abilities