

Mood Disorders

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Objectives:

By the end of the session the student will be able to :

Discuss etiological theories of mood disorders.

Identify special treatment measures for mood disorders.

Explain characteristics of depressive and manic disorders.

List at least nursing diagnoses appropriate for clients who experience mood disorders.

Describe nursing care goals & strategies for intervening with clients who experience mood disorders.

Outline:

Classification..

Etiology.

Epidemiology.

Special treatment measures.

Depressive reactions & Manic reactions.

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Mood disorder

A mood disorder is a severe disturbance in AFFECT manifested by extreme sadness or euphoria.

Mood changes

- 1- Unipolar: only episodes of DEPRESSION.
- 2- Bipolar: MANIA alternating with depression.

DSM-VI-R medical diagnoses

- 1- Bipolar disorders, including manic and depressive disorders and cyclothymiacs.
- 2- Depressive disorders, including major depression and dysthymia.

Etiology

A- Genetic

Transmitted by the X-linked dominant gene.

B- Biological

Electrolyte metabolism: disturbance in the distribution of sodium and potassium

Catecholamine deficiency or excess in the central nervous system

Biological rhythm disturbance

Serotonin, nor epinephrine disturbance

**C- Aggression-turned-inward theory
(Sigmund Freud)**

D- Object-loss theory.

E- Cognitive model (Aaron Beck)

Depression resulting from

1- Negative view of self .

2- Negative cognitive set.

**3- View of adverse event as a personal shortcoming:
expectations of failure.**

F-Learned helplessness

G- Behavioral model (P. Lewiston)

**1- Depression caused by person-behavior-environment
interaction.**

**2- Low rate of positive: reinforcement or lack of rewarding
interactions**

H- Sociological theories and stress factors .

1- Loss.

2- Major life events.

3- Role strain.

4- Change in familiar environment .

5- Change in economic conditions or coping resources.

6- Physiologic changes.

V- Special treatment measures

A- Electroconvulsive therapy (ECT)

B- Antidepressant medication

C- Lithium therapy

D- Group and individual therapies .

E- Phototherapy.

F- Sleep manipulation .



Depression



Assessment: characteristics of severe depression

- 1- Intense, pervasive , and persistent depression .
- 2- Altered reality orientation .
- 3- Affective changes:

despair and hopelessness, worthlessness, helplessness, loneliness.

- 4- Cognitive changes:

confusion ,indecisiveness, self-blame and self-deprecation, wish to die, possible delusions or hallucinations.

Cont. assessment

5- Behavioral changes:

psychomotor retardation ; agitation,
slow responses, neglect appearance, **social withdrawal.**

6- Physiologic changes:

constipation, urine retention, amenorrhea, lack of sexual interest, impotence, marked weight loss, insomnia .

Nursing goals

1- Promote adequate nutrition, hydration, elimination, rest, sleep, and activity.

2- Stop withdrawn behavior.

3- Prevent the client from self-harm.

4- Decrease disorientation, ruminations, hallucinations, and delusions.

5- Promote feelings of self-worth and articulation of feelings

intervention physical needs.

- 1- Monitor and record nutritional intake.**
- 2- Weigh the client daily.**
- 3- Encourage small, frequent high-fiber meals**
- 4- Teach methods to help the client relax and sleep.**
- 5- Assist the client in getting out of bed and taking care of personal hygiene**
- 6- Encourage exercise to prevent constipation :**
- 9- Observe for medication compliance and side effects.**

Nursing intervention : Behavioral needs

1- Mobilize the client to productive activity by assigning therapeutic tasks

.

2- Provide opportunities for increased involvement in activities.

3- Select activities that ensure success and accomplishment.

4- Provide opportunities for exercise.

Nursing interventions : Cognitive needs

- 1- Increase self-esteem and sense of control over behavior.
- 2- Modify negative expectations and explore the extent of negative thinking.
- 3- Substitute positive thoughts for negative .
- 4- Establish realistic goals.



Nursing interventions: Emotional needs

- 1- Slowly and cautiously make the client aware of unconscious feelings.**
- 2- Plan activities that allow for physical sublimation of aggressive feelings .**
- 3- Talk about the universality of feelings.**
- 4- Encourage constructive expression when the client discusses anger .**
- 5- Provide hope .**

Nursing interventions: Spiritual needs

- 1- Assess the client's loss of belief.**
- 2- Help the client explore spiritual beliefs or a meaningful philosophy of life.**
- 3- Arrange for a spiritual advisor to visit, if appropriate .**

Manic reactions

Assessment: Characteristics

- 1- Condition that usually develops more rapidly than depressive reactions.
- 2- Failure to view behavior as inappropriate.
- 3- Maladaptive defense against depression.



Assessment : Physical manifestations

- 1- Deteriorated physical appearance .
- 2- Increased energy: feeling of being “charged up ”.
- 3- Increased sexual interest and activity.
- 4- Decreased sleep disturbance.

Assessment : Emotional manifestations

- 1- Mood lability: euphoria.
- 2- Feelings of grandiosity .
- 3- Inflated sense of self-worth

Assessment : Cognitive manifestations

- 1- Difficulty concentrating.
- 2- Flight of ideas.
- 3- Delusions of grandeur.
- 4- Impaired judgment

Assessment : Behavioral manifestations

1- Hyperactivity.

2- Impulsiveness, lack of inhibition, recklessness.

3- Increased social contacts.

4- Hyper sexuality .

5- Verbosity: often rhyming and punning.

6- Bizarre and eccentric appearance.

Nursing care goals

- 1- Prevent the client from self-harm.**
- 2- Decrease disorientation, delusions, bizarre behavior and dress, sexual acting-out, hyperactivity, restlessness, agitation.**
- 3- Promote rest, sleep, and a nutritious diet.**
- 4- Assist with activities of daily living.**
- 5- Provide emotional support.**
- 6- Promote medication compliance.**

Nursing interventions: Physical needs

- 1- Decrease environmental stimuli**
- 2- Offer finger foods.**
- 3- Encourage short rest periods.**
- 4- Enforce minimal standards of personal hygiene.**
- 5- Monitor medications .**

Nursing interventions: Behavioral needs

- 1- Suggest sedentary activities, and offer motor activities in moderation.**
- 2- Define and explain acceptable behaviors, then set limits.**
- 3- Negotiate limits on demanding, manipulative behaviors.**
- 4- Avoid frustrating the client unnecessarily.**

Nursing interventions: Cognitive needs

1. Safeguard the client from physical risks.
- 2- Discourage the client from expensive purchases.
- 3- Help the client identify behaviors that lead to a manic episode.
- 4- Explore effects of behavior on others.
- 5- Intervene when the client has DELUSIONS.
- 6- Increase the client's self-esteem.

Nursing interventions : Emotional needs

- 1- Help the client become aware of underlying anger.
- 2- Verbally acknowledge resistance to therapy.
- 3- Teach the client to make decisions and accept responsibility



Nursing interventions: Spiritual needs

Help the client explore a meaningful philosophy of life.
Arrange for a spiritual advisor to visit, if appropriate.

