Variations in mood are a natural part of life. They indicate that a person is perceiving the world and responding to it. Extremes in mood also are linked with extremes in human experience, such as creativity, madness, despair, ecstasy, romanticism, personal charisma, and interpersonal destructiveness.

Mood is a prolonged emotional state that influences the person’s whole personality and life functioning. It is synonymous with the terms feeling state and emotion. Like other aspects of the personality, emotions or moods serve an adaptive role. The four adaptive functions of emotions are social communication, physiological arousal, subjective awareness, and psychodynamic defense.

CONTINUUM OF EMOTIONAL RESPONSES

Emotions such as fear, joy, anxiety, love, anger, sadness, and surprise are all normal parts of the human experience. The problem arises in trying to evaluate when a person’s mood or emotional state is maladaptive, abnormal, or unhealthy. Grief, for example, is a healthy, adaptive, separating process that attempts to overcome the stress of a loss. Grief work, or mourning, is not a pathological process; it is an adaptive response to a real stressor. The absence of grieving in the face of a loss suggests maladaptation.

The continuum of emotional responses is represented in Figure 18-1. At the adaptive end is emotional responsiveness. This involves the person being affected by and being an active participant in the internal and external worlds. It implies an openness to and awareness of feelings. If used in such a way, feelings provide us with valuable learning experiences. They are barometers that give us feedback about ourselves and our relationships, and they help us function more effectively.

Also adaptive in the face of stress is an uncomplicated grief reaction. Such a reaction implies that the person is facing the reality of the loss and is immersed in the work of grieving.
A maladaptive response is the suppression of emotions. This may be a denial of one's feelings or a detachment from them. A transient suppression of feelings may at times be necessary to cope, as in an initial response to a death or tragedy. However, prolonged suppression of emotion, as in delayed grief reaction, will ultimately interfere with effective functioning.

The most maladaptive emotional responses or severe mood disturbances are recognized by their intensity, pervasiveness, persistence, and interference with social and physiological functioning. These characteristics apply to the clinical states of depression and mania, which complete the maladaptive end of the continuum of emotional responses.

Grief Reactions

Grief is the subjective state that follows loss. It is one of the most powerful emotional states and affects all aspects of a person's life. It forces the person to stop normal activities and focus on present feelings and needs. Most often, it is the response to the loss of a loved person through death or separation, but it also occurs following the loss of something tangible or intangible that is highly regarded. It may be a valued object, a cherished possession, an ideal, a job, or status.

As a response to the loss of a loved one, grief is a universal reaction. As a person's dependence on others grows, the chance increases that the person will at some point face loss, separation, and death, which elicit intense feelings of grief. The capacity to form warm, satisfying relationships with others makes a person vulnerable to sadness, despair, and grief when those relationships are terminated.

As a natural reaction to a life experience, grief is universal; however, the way it is expressed is culturally determined (Clements et al, 2003). It involves stress, pain, suffering, and an impairment of function that can last for days, weeks, or months. Thus understanding the stages of grief and its symptoms is important because of grief's effect on both physical and emotional health (Egan and Arnold, 2003).

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The ability to experience grief is gradually formed in the course of normal development and is closely related to the capacity for developing meaningful relationships. Grief responses may be either uncomplicated or pathological. Uncomplicated grief, an adaptive response, runs a consistent course that is modified by the abruptness of the loss, the person's preparation for the event, and the significance of the lost object. It is a self-limited process of realization; it makes real the fact of the loss.

A maladaptive response to loss implies that something has prevented it from running its normal course. The two types of pathological grief reactions are the delayed grief reaction and the distorted grief reaction. Persistent absence of any emotion may signal an undue delay in the work of mourning or a delayed grief reaction. The delay may occur in the beginning of the mourning process, slow the process once it has begun, or do both. The delay and rejection of grief may occasionally last for years.

The emotions associated with the loss may be triggered by a deliberate recall of circumstances surrounding the loss or by a spontaneous occurrence in the patient's life. A classic example of this is the anniversary reaction, in which the person experiences incomplete or abnormal mourning at the time of the loss, only to have the grieving response recur at anniversaries of the original loss.

The person who does not mourn can experience the pathological grief reaction known as depression, or melancholia (Zisook and Kendler, 2007). It is an abnormal extension or over elaboration of sadness and grief.

Depression

Depression is the oldest and most common psychiatric illness. It was described as early as 1500 BC, and it is as familiar as it is mysterious. The word depression is used in a variety of ways. It can refer to a sign, symptom, syndrome, emotional state, reaction, disease, or clinical entity. In this chapter depression is viewed as a clinical illness that is severe, maladaptive, and incapacitating.

Depression may range from mild and moderate states to severe states with or without psychotic features. Psychotic depression is uncommon, accounting for less than 10% of all depressions. Major depression can begin at any age, although it usually begins in the mid twenties and thirties. Symptoms develop over days to weeks.

Rates of depression have risen markedly over the past decade in the United States, and increases have been noted for most sociodemographic subgroups of the population (Compton et al, 2006). Approximately one of eight adults may experience major depres-
sion in one’s lifetime. It affects 14 million people each year, 70% of whom are women. Complications include significant marital, parental, social, and vocational difficulties. Finally, it has been estimated that depression costs the U.S. economy $43.7 billion in worker absenteeism, lost productivity, and health care.

The lifetime risk for major depression is 7% to 12% for men and 20% to 30% for women. Among women, rates peak between adolescence and early adulthood. This difference holds true across cultures and continents (Box 18-1). Other risk factors include a history of depressive illness in first-degree relatives and a history of major depression.

### Box 18-1 Sociocultural Context of Care

**How Does Culture Impact the Expression and Resolution of Depression?**

As a psychiatric illness, depression exists in all countries across the globe. The World Health Organization has identified depression as the number one psychiatric cause of disability in the world and projected that it would rank second in the world as a cause of disability by 2020. Nonetheless, evidence suggests that culture impacts the symptomatic expression, clinical presentation, and effective resolution of depression.

Specifically, culture has an effect on the neural systems, psychological states, and interpersonal patterns that exist throughout one’s life, and cultural variations in family and child-rearing practices shape one’s view of the world. Culture provides a release for one’s emotional expression and also can influence one’s source of distress, the form of illness experienced, modes of coping with distress, help-seeking behavior, and social response.

In some cultures, disturbances of mood are viewed as normal problems, whereas in others they are repressed or seen as a sign of personal failure or lack of personal strength. This can lead some cultures to deny or minimize this aspect of their personal distress.

In the United States, ethnic minorities have similar rates of mood disorders as do white Americans; but they are less likely to receive appropriate care because of underdiagnosis and undertreatment, and they report higher rates of severe and disabling depression (Ray et al, 2007; Williams et al, 2007). Other barriers to care include lack of insurance, scarcity of minority providers, and distrust of care providers. Clearly, clinicians need to work collaboratively with their patients, as well as with culture brokers and colleagues from other cultural communities, not only to better understand and identify their patients’ problems and eliminate disparities in care, but also to uncover cultural resources that can complement and perhaps supplant conventional treatment.

Most untreated episodes of major depression last 6 to 24 months. Although some people have only a single episode of major depression and return to presymptomatic functioning, it is estimated that more than 50% of those who have one episode will eventually have another, and 25% of patients will have chronic, recurrent depression.

Depression often occurs along with other psychiatric illnesses (Table 18-1). Up to 40% of patients with major depressive disorders have histories of one or more nonmood psychiatric disorders that significantly impair their quality of life (Mittal et al, 2006). These statistics underscore the importance of this health problem and suggest the need for timely diagnosis and treatment. Unfortunately, only one third of all people with depression seek help, are accurately diagnosed, and obtain appropriate treatment (Kessler et al, 2003).

A high incidence of depression is found among all patients hospitalized for medical illnesses, although its intensity and frequency are higher in more severely ill patients. These depressions are largely unrecognized and untreated by general health care providers. Studies suggest that about one third of medical inpatients report mild or moderate symptoms of depression and up to one fourth may have a depressive illness.

Certain medical conditions are often associated with depression, especially diabetes, cancer, stroke, epilepsy, multiple sclerosis, Parkinson disease, cardiac disease, and a variety of endocrine disorders. Thus depression is a common accompaniment of many major medical illnesses, resulting in increased health care use, role impairment, disability, and work absence in persons with chronic physical illness (Stein et al, 2006).

Depressive conditions are highly prevalent in primary care settings. One of every five patients seeing a primary care practitioner has significant symptoms of depression. Yet only about 1 in 100 patients cites depression as a reason for the most recent visit, and health care providers fail to diagnose major depression in their patients up to 50% of the time. Given the prevalence and disability associated with depression, the U.S. Preventive Services Task Force recommends screening adults for depression in primary care settings that have systems in place to ensure accurate diagnosis, effective treatment, and responsive follow-up.

#### Critical Thinking

A patient who just underwent cardiac surgery comes for a follow-up visit and tells the physician he is feeling depressed. He is told that depression is a normal response to cardiac illness and he will get over it in time. Do you agree? If not, what nursing actions are indicated?

---

### Table 18-1 Comorbidity of Depression and Other Psychiatric Illnesses

<table>
<thead>
<tr>
<th>Comorbid Condition</th>
<th>12-Month Major Depressive Disorder</th>
<th>Lifetime Major Depressive Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use disorder</td>
<td>14%</td>
<td>40%</td>
</tr>
<tr>
<td>Drug use disorder</td>
<td>5%</td>
<td>17%</td>
</tr>
<tr>
<td>Nicotine dependence</td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>36%</td>
<td>40%</td>
</tr>
<tr>
<td>Any personality disorder</td>
<td>38%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Mania**

In addition to severe depression, manic episodes may occur. These episodes, like those of depression, can vary in intensity and the accompanying level of anxiety from moderate manic states to severe and panic states with psychotic features. **Mania** is characterized by an elevated, expansive, or irritable mood. **Hypomania** is a clinical syndrome similar to but not as severe as mania.

In the *Diagnostic and Statistical Manual of Mental Disorders*, ed 4, text revision (DSM-IV-TR; APA, 2000), the major affective disorders are separated into two subgroups—bipolar and depressive disorders—based on whether manic and depressive episodes are involved over time. In this classification, major depression may involve a single episode or a recurrent depressive illness but does not include manic episodes. **When a person has experienced one or more manic episodes, with or without a major depressive episode, the category of bipolar disorder is used.**

Thus a depressive episode with no manic episodes would be classified as a **depressive disorder**. A depressive episode with previous or current manic episodes would be classified as a **bipolar disorder** or manic-depressive illness because the patient experiences both mania and depression.

Although bipolar affective disorders are less common than depressive disorders, it is estimated that 1% of the adult population has bipolar disorder. Risk factors are being female and having a family history of bipolar disorder. The data suggest that people under age 50 years are at higher risk of a first attack, whereas those who already have the disorder face increased risk of a recurrent manic or depressive episode as they grow older.

Studies indicate that 60% to 70% of individuals with bipolar disorder meet diagnostic criteria for a lifetime history of substance abuse or dependence. Thus the risk for alcohol or drug abuse is six to seven times greater than would be expected by chance alone among people with bipolar disorder. Additional facts about depressive and bipolar disorders are presented in Box 18-2.

---

**Box 18-2  Facts About Mood Disorders**

**Major Depressive Disorder**

Major depression is one of the most common clinical problems encountered by primary care practitioners. Major depression accounts for more bed days (people out of work and in bed) than any other “physical” disorder except cardiovascular disorders, and it is more costly to the economy than chronic respiratory illness, diabetes, arthritis, or hypertension.

Psychotherapy alone helps some depressed patients, especially those with mild to moderate symptoms. Depression can be treated successfully by antidepressant medications in 65% of cases. Success rate of treatment increases to 85% when alternative or adjunctive medications are used or psychotherapy is combined with medications.

**Bipolar Disorder**

Bipolar disorder is associated with twice as many lost workdays (65%) compared with major depression (27%) per year. Effective medications, often used in combination with psychotherapy, allow 75% to 80% of manic-depressive patients to lead essentially normal lives.

---

**ASSESSMENT**

**Behaviors**

**Delayed Grief Reaction.** Delayed grief reactions may be expressed by excessive hostility and grief, prolonged feelings of emptiness and numbness, an inability to weep or express emotions, low self-esteem, use of present tense instead of past when speaking of the loss, persistent dreams about the loss, retention of clothing of the deceased, an inability to visit the grave of the deceased, and the projection of living memories onto an object held in place of the lost one. The following clinical example illustrates some of the behaviors associated with a delayed grief reaction.

**CLINICAL EXAMPLE** Ms. G was a 38-year-old married woman with no history of depression. She came to the local community mental health center complaining of severe throbbing headaches, difficulty falling asleep, fitful and disturbing dreams when asleep, and poor appetite. She said she felt “disgusted” with herself and “useless” to her family.

Her family history revealed that she had three children: two boys and a girl. Her eldest son, 20 years old, was attending college out of state, and her daughter, 19 years old, was living with a girlfriend in the same city. Her youngest son was killed in an automobile accident 2 years before at 15 years of age. She described him as her “baby” and expressed much guilt for contributing to his death. She scolded herself for allowing him to drive to the seashore for the weekend with friends and said she now worries a great deal about her other two children. She said she was trying to protect them from the dangers of the world, but they resented her advice and concern.

On questioning by the nurse, Ms. G reported that these feelings of sadness and guilt had emerged in the last month and seemed to be triggered by the graduation of her son’s high school class.

**Selected Nursing Diagnosis**

- Complicated grieving related to son’s death, as evidenced by somatic complaints and feelings of sadness and guilt.

In this example Ms. G was experiencing a delayed grief reaction precipitated by the event of her deceased son’s would-be graduation. She had failed to progress through mourning after her son’s death and was just now beginning grief work.

**Depression.** The behaviors associated with depression vary. Sadness and slowness may predominate, or agitation may occur. The key element of a behavioral assessment is change. Depressed people change their usual patterns and responses. Research indicates that people working through normal mourning respond to their loss with psychological symptoms often indistinguishable from depression, but these symptoms are accepted by them and by those around them as normal. In contrast, patients with depression experience their condition as a change from their usual selves, which often leads them to seek help.

Many behaviors are associated with depression. These can be divided into affective, physiological, cognitive, and behavioral (Box 18-3). The lists in Box 18-3 describe the spectrum of possible behaviors, and not all patients experience all these behaviors.

The most common and central behavior is that of depressive mood. This is not necessarily described by the patient as depression but rather as feeling sad, blue, down in the dumps, unhappy,
or unable to enjoy life. Crying often occurs. On the other hand, some depressed people do not cry and describe themselves as “beyond tears.” The mood disturbance of the depressed patient resembles that of normal unhappiness multiplied in intensity and pervasiveness.

Another mood that often accompanies depression is anxiety: a sense of fear and intense worry. Both depression and anxiety may show diurnal variation, that is, a pattern whereby certain times of the day, such as morning or evening, are consistently worse or better.

Some patients may initially deny their anxious or depressed moods but do identify a variety of somatic complaints. These might include gastrointestinal distress, chronic or intermittent pain, irritability, palpitations, dizziness, appetite change, lack of energy, change in sex drive, or sleep disturbances. The person often focuses on these symptoms because they are more socially acceptable than the profound feeling of sadness, inability to concentrate, or loss of pleasure in usual activities.

In addition, the physical symptoms may help the person with depression explain why nothing is fun anymore. When patients have a range of somatic symptoms, the nurse should carefully evaluate these complaints but also return to the issues of mood and interest, thus considering the possible diagnosis of depression.

Two subgroups of major depressive disorder merit special attention.

**Postpartum onset.** Postpartum mood symptoms are divided into three categories based on severity: blues, depression, and psychosis.

1. **Postpartum blues** are brief episodes, lasting 1 to 4 days, of labile mood and tearfulness that occur in about 50% to 80% of women within 1 to 5 days of delivery. Treatment consists of reassurance and time to resolve this normal response.

2. **Postpartum depression** may occur from 2 weeks to 12 months after delivery but usually occurs within 6 months. The risk of postpartum depression is 10% to 15%, but the rate is higher for people with a history of psychiatric disorders. Treatment with medication and psychotherapy is indicated for postpartum depression (Beck, 2006; Dietz et al, 2007; Jolley and Betrus, 2007; Leahy-Warren and McCarthy, 2007; Logsdon et al, 2007).

3. **Postpartum psychosis** can be divided into depressed and manic types. The incidence of postpartum psychosis is low, and the symptoms typically begin 2 to 3 days after delivery. The period of risk for postpartum psychosis is within the first month after delivery. The prognosis is good for acute postpartum psychosis if treated at its onset. However, many patients subsequently develop a bipolar disorder (Sit et al, 2006). The recurrence rate is 33% to 51%, thus underscoring the important of early intervention.

**Seasonal pattern.** Seasonal affective disorder (SAD) is depression that comes with shortened daylight in winter and fall and disappears during spring and summer. It is characterized by hypersomnia, lethargy and fatigue, increased anxiety, irritability, increased appetite with carbohydrate craving, and often weight gain. It is believed to be related to abnormal melatonin metabolism. It also has been noted that two to three times as many people experience the winter recurrence of seasonal mood symptoms as those who actually exhibit behaviors severe enough to merit clinical diagnosis.

> **Critical Thinking** Conditions of light and darkness have often been noted to affect mood. Evaluate your own environment for exposure to light. Compare it with a hospital environment.

**Suicide.** The potential for suicide should always be assessed in those with severe mood disturbances. Approximately 15% of severely depressed patients commit suicide, and between 25% and 50% of patients with bipolar disorder attempt suicide at least once. Suicide and other self-destructive behaviors are discussed in detail in Chapter 19. The intensity of anger, guilt, and worthlessness may precipitate suicidal thoughts, feelings, or gestures, as illustrated in the following clinical example.

> **CLINICAL EXAMPLE** Mr. W was a 60-year-old man who lived alone. His son and daughter were married and lived in the same state as Mr. W. His wife had died 2 years before, and since that time his children had often asked him to move in with either of them. He consistently refused to do this, believing that he and his children needed privacy in their lives. Six months before, he was diagnosed as having advanced prostatic cancer with metastasis.
After the diagnosis and because of increasing disability, he left his job and began to receive disability compensation. He visited his children and their families about twice each month and kept his regularly scheduled visits with the medical clinic.

The nurses and physicians at the clinic noted that he was “despondent and withdrawn” but thought this was as a normal reaction to his diagnosis and family history. No interventions were implemented based on his emotional needs. A week after attending the clinic for a routine follow-up visit, he went to the cemetery where his wife was buried and at her gravestone shot himself in the head. A groundskeeper of the cemetery heard the shot, discovered what had happened, and called an ambulance. Mr. W was taken to the emergency room of the nearest hospital and, with prompt medical care, survived the suicide attempt.

**Selected Nursing Diagnoses**

- Risk for suicide related to feelings of depression, as evidenced by gunshot to the head.
- Hopelessness related to medical diagnosis of metastatic cancer, as evidenced by withdrawal and dependency.

This example dramatically makes three important points:

1. Medical illness often involves a loss of function, body part, or appearance; thus all patients should be assessed for depression.
2. All people experiencing depression and despair have the potential for suicide; thus all patients should be assessed for suicide.
3. Nurses should intervene with nursing actions that can be preventive, curative, or rehabilitative, based on the nursing assessment and diagnosis.

**Mania.** The essential feature of mania is a distinct period of intense psychophysiological activation. Some behaviors of mania are listed in Box 18-4. The predominant mood is elevated or irritable, accompanied by one or more of the following symptoms: hyperactivity, the undertaking of too many activities, lack of judgment in anticipating consequences, pressured speech, flight of ideas, distractibility, inflated self-esteem, and hypersexuality.

**Behaviors Associated with Mania**

<table>
<thead>
<tr>
<th>Affective</th>
<th>Thoughts of grandiosity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has illusions</td>
</tr>
<tr>
<td></td>
<td>Lack of judgment</td>
</tr>
<tr>
<td></td>
<td>Loose associations</td>
</tr>
</tbody>
</table>

**Behavioral**

- Aggressiveness
- Excessive spending
- Grandiose acts
- Hyperactivity
- Increased motor activity
- Irresponsibility
- Irritability or argumentativeness
- Poor personal grooming
- Provocativeness
- Sexual overactivity
- Increased social activity
- Verbose

If the mood is elevated or euphoric, it can be infectious. Patients report feeling happy, unconcerned, and carefree. Although such experiences seem enviable, the person also has no concern for reality or the feelings of others. Patients may have misperceptions about their power and importance and involve themselves in seemingly senseless and risky enterprises.

Alternatively, the mood may be irritable, especially when plans are blocked. Patients can be argumentative and provoked by seemingly harmless remarks. Self-esteem is inflated during a manic episode, and as activity level increases, feelings about the self become increasingly disturbed. Grandiose symptoms are evident, and the patient is willing to undertake any project possible.

In contrast to depressed patients, manic patients are extremely self-confident, with an ego that knows no bounds; they are “on top of the world.” Accompanying this magical omnipotence and supreme self-esteem is an equally inordinate lack of guilt and shame. Often they deny realistic danger. The patient’s boundless energy, cunning, planning, scheming, and inability to anticipate consequences often lead to irresponsible activities and excessive spending, as well as problems of a sexual, aggressive, or possessive nature.

Manic patients have abundant energy and heightened sexual appetite. Characteristic physical changes are caused by inadequate nutrition, partly because manic patients have no time to eat; serious weight loss is also related to their insomnia and overactivity. Extremely manic patients may become dehydrated and require prompt attention.

In addition to mood alterations, the person with mania may exhibit disturbed speech patterns. As mania intensifies, formal and logical speech is replaced by loud, rapid, and confusing language. This is often referred to as pressured speech. As the activated state increases, speech becomes laced with numerous plays on words and irrelevancies that can escalate to loose associations and flight of ideas (Chapter 6). Some of these behaviors are evident in the next clinical example.

**Clinical Example**

Mr. B was a 30-year-old single man who was admitted to the psychiatric unit of the local community hospital. He had been hospitalized 2 years before for problems related to alcoholism. He was accompanied to the hospital by a friend who lived with him. His friend said that for the past 2 months Mr. B had been “running on 10 cylinders instead of 4.” He slept and ate little and talked constantly, sometimes so fast that no one could understand what he was trying to say. He had redecorated his bedroom in the apartment twice and had gone into debt buying a new wardrobe. His friend brought him in because of his behavior was becoming more erratic and his physical condition was deteriorating.

The nurse who admitted Mr. B asked about his social relationships. He revealed that his girlfriend of 7 years had left him 6 months before for another man. He said that initially he thought she would “see the light,” but she had refused to see him since then. Mr. B said this “upset” him a little at the time, but he was sure it was for the best and there were plenty other women waiting for him.

**Selected Nursing Diagnosis**

- Risk for self-directed violence related to interpersonal rejection, as evidenced by agitated behavior and lack of self-care.
Another behavior found in those with mania is lability of mood with rapid shifts to brief depression. This accounts for patients who alternately laugh and cry. There may be feelings of guilt and thoughts of suicide.

Manic episodes are very likely to recur. About 75% of manic patients have more than one episode, and almost all those with manic episodes also have depressive episodes. However, the duration and severity of the manic episodes vary among patients, as do the intervals between relapses and recurrences.

Finally, disturbances of mood are interrelated with self-esteem problems and disrupted relationships. Multiple aspects of the patient's life are affected, including that of physical health. Hypertensive crises, irritable bowel syndrome, coronary occlusions, rheumatoid arthritis, migraine headaches, and various dermatological conditions can occur with severe mood disturbances.

**Predisposing Factors**

**Genetics.** Both heredity and environment play an important role in severe mood disturbances. Major depression and bipolar disorder are familial disorders, and their familiarity primarily results from genetic influences.

The lifetime risk for mood disorders in the general population is 6%. Family, twin, and adoption studies show that the lifetime risk is 20% for relatives of people with depression and 24% for relatives of people with mania. A person with an identical twin (monozygotic, or MZ) with an affective disorder is two to four times more at risk for the disorder than are fraternal twins (dizygotic, or DZ) or siblings. Thus good evidence exists for the role of genetic factors in mood disorders.

**Object Loss Theory.** The object loss theory of depression refers to traumatic separation of the person from significant objects of attachment. Two issues are important to this theory: loss during childhood as a predisposing factor for adult depressions, and their familiarity primarily results from genetic influences.

The first issue proposes that a child has ordinarily formed a tie to a mother figure by 6 months of age, and if that tie is broken in early life, the child experiences separation anxiety, grief, and mourning. This mourning in the early years often affects later personality development. It can predispose the child to psychiatric illness or be beneficial and help develop resilience.

Another perspective on this theory focuses on the negative impact of maternal depression on infants and children (Swartz et al, 2005; Weissman et al, 2006). This is expressed by the infant as flat affect, lower activity, disengagement, and difficulty in being consoled. Among older children it is seen as sadness, submissive helplessness, and social withdrawal. Older children of depressed parents also have a three to four times higher rate of adjustment problems, including a range of emotional disorders.

These observations lend a different but related view to the object loss theory. They suggest that emotional unavailability may be more stressful to children than physical separation. They also underscore the need for early and aggressive intervention by nurses for parents experiencing depression and for their children.

**Personality Organization Theory.** The personality organization view of depression focuses on the major psychosocial variable of low self-esteem. The patient’s self-concept is an underly-
failure to continue permanently. Thus pessimism dominates their activities, wishes, and expectations.

Depressed people are capable of logical self-evaluation when not in a depressed mood or when only mildly depressed. When depression does occur, after some precipitating life stressors, the negative cognitive set makes its appearance. As depression develops and increases, the negative thinking increasingly replaces objective thinking.

Although the onset of the depression may appear sudden, it develops over weeks, months, or even years, as each life experience is interpreted as further evidence of failure. As a result of this tunnel vision, depressed people become hypersensitive to experiences of loss and defeat and become oblivious to experiences of success and pleasure. They have difficulty acknowledging anger because they think they are responsible for, and deserving of, insults from others and problems encountered in living.

Along with low self-esteem, they experience apathy and indifference. They are drawn to a state of inactivity and withdraw from life. They lack spontaneous desire and wish only to be passive. Because they expect failure, they lack the ordinary energy to even make an effort.

Suicidal wishes can be viewed as an extreme expression of the desire to escape. Suicidal patients see their life as filled with suffering, with no chance of improvement. Given this negative mind set, suicide seems a rational solution. It promises to end their misery and relieve their families of a burden, and they begin to believe that everyone would be better off if they were dead. The more they consider the alternative of suicide, the more desirable it may seem, and as their life becomes more hopeless and painful, the desire to end it becomes stronger.

Naturalistic, clinical, and experimental studies have provided substantial support for this cognitive model of depression. Strong evidence of the efficacy of cognitive therapy as a treatment strategy for depressed patients also exists.

» Critical Thinking Relate the cognitive model of depression to the saying “mind over matter.”

**Learned Helplessness-Hopelessness Model.** Helplessness is a “belief that no one will do anything to aid you,” and hopelessness is a belief that neither “you nor anyone else can do anything.” This theory proposes that it is not trauma itself that produces depression, but the belief that one has no control over the important outcomes in life and therefore refrains from adaptive responses (Seligman, 1975).

Learned helplessness is both a behavioral state and a personality trait of one who believes that control over reinforcers in the environment has been lost. These negative expectations lead to hopelessness, passivity, and an inability to assert oneself.

People resistant to depression have high self-efficacy and have experienced mastery in life. Their childhood experiences proved to them that their actions were effective in producing gratification and removing annoyances. In contrast, those susceptible to depression have low self-efficacy and have had lives without mastery. Their experiences caused them to believe that they were helpless and incapable of influencing their sources of suffering, and they developed no coping responses against failure.

This model has been revised to include the hopelessness theory of depression (Abramson et al., 1989). It suggests that inferred negative consequences and negative characteristics about the self contribute to the formation of hopelessness, and in turn the symptoms of hopelessness contribute to depression. Hopelessness theory thus is very similar to the cognitive model of depression.

**Behavioral Model.** The behavioral model views people as being capable of exercising control over their own behavior (Lewinsohn et al., 1979). They do not merely react to external influences. They select, organize, and transform incoming stimuli. Thus people are not viewed as powerless objects controlled by their environments; nor are they absolutely free to do whatever they choose. Rather, people and their environment affect each other.

The concept of reinforcement is crucial to this view of depression. Person-environment interactions with positive outcomes provide positive reinforcement. Such interactions strengthen the person’s behavior. Little or no rewarding interaction with the environment causes the person to feel sad. Thus the key assumption in this model is that a low rate of positive reinforcement is the antecedent of depressive behaviors.

Two elements of this model are important. One is that the person may fail to produce appropriate responses that will initiate positive reinforcement. The other is that the environment may fail to provide reinforcement and thus worsen the patient’s condition. This occurs because depressed patients are often deficient in the social skills needed to interact with others effectively. In turn, other people find the behavior of depressed people distancing, negative, or offensive and therefore often avoid them as much as possible.

Depression is likely to occur if positively reinforcing events are absent, particularly those that fall into the following categories:

- Competence experiences
- Rewarding social interaction
- Enjoyable outdoor activities
- Solitude
- Positive sexual experiences

These may be described as “being with friends,” “being relaxed,” “doing my job well,” “being sexually attractive,” and “doing things my own way.”

Depression also occurs in the presence of certain punishing events, particularly those that fall into three categories:

- Marital or interpersonal discord
- Work or school hassles
- Negative reactions from others

The behavioral model of depression emphasizes an active approach to the person and relies heavily on an interactional view of personality. Treatment is aimed at helping the person increase the quantity and quality of positively reinforcing interactions and decrease aversive interactions.

» Critical Thinking How many positive reinforcing events have you experienced this month? How many punishing events? Relate these to your overall mood.

**Biological Model.** The biological model explores chemical changes in the body during depressed states. Whether these chemical changes cause depression or are a result of depression is not yet understood. However, significant abnormalities can be seen in
many body systems during a depressive illness, including electrolyte disturbances, especially of sodium and potassium; neurophysiological alterations; dysfunction and faulty regulation of autonomic nervous system activity; adrenocortical, thyroid, and gonadal changes; and neurochemical alterations in the neurotransmitters, especially in the biogenic amines, which act as central nervous system and peripheral neurotransmitters.

The biogenic amines include three catecholamines—dopamine, norepinephrine, and epinephrine—as well as serotonin and acetylcholine. No single biochemical model adequately explains the affective disorders.

Endocrine system. Some symptoms of depression that suggest endocrine changes are decreased appetite, weight loss, insomnia, diminished sex drive, gastrointestinal disorders, and variations of mood. Assay techniques have detected alterations of hormone activity concurrent with depression. Mood changes also have been observed with a variety of endocrine disorders, including Cushing disease, hyperthyroidism, and estrogen therapy. Further support for this theory is evident in the high incidence of depression during the postpartum period, when hormonal levels change.

Current study of neuroendocrine factors in affective disorders emphasizes the disinhibition of the hypothalamic-pituitary-adrenal (HPA) axis and the hypothalamic-pituitary-thyroid (HPT) axis. Two tests based on the neuroendocrine theory and performed clinically may prove to be useful in diagnosing affective illnesses. The first is the corticotropin-releasing factor stimulation test, which evaluates the pituitary’s ability to respond to corticotropin-releasing hormone (CRH) and secrete sufficient amounts of adrenocorticotropic hormone (ACTH) to induce normal adrenal activity.

The second test is the thyroid-releasing hormone (TRH) infusion test, which differs from CRH infusion by assessing the pituitary’s ability to secrete sufficient amounts of thyroid-stimulating hormones (TSHs) to produce normal thyroid activity. These tests may be helpful in differentiating unipolar from bipolar depression and mania from schizophrenic psychosis.

Cortisol. Many depressed patients exhibit hypersecretion of cortisol. This has been used in the dexamethasone suppression test (DST). (Dexamethasone is an exogenous steroid that suppresses the blood level of cortisol.) The DST is based on the observation that, in patients with biological depression, late-afternoon cortisol levels are not suppressed after a single dose of dexamethasone. However, many physical illnesses and some medications can interfere with the test results.

Neurotransmission. One of the dominant theories in the neurobiology of mood disorders is the dysregulation hypothesis, which proposes that a problem exists in several of the neurotransmitter systems. Specifically, substantial evidence exists for the abnormal regulation of the serotonin (5-HT) neurotransmitter system (Figure 18-2). This dysregulation is in either the amount or the availability of 5-HT, in the sensitivity of its receptors in relevant regions of the brain, and in its balance with other neurotransmitters and brain chemicals.

Behavior. 5-HT has an important role in brain functions, such as aggression, mood, anxiety, psychomotor activity, irritability, appetite, sexual activity, sleep/wakefulness, circadian and seasonal rhythms, neuroendocrine function, body temperature, cognitive function, and pain perception, processes that are abnormal in people with depression.

Biochemistry. Research has shown that there is decreased 5-HT availability in patients with depression—too little 5-HT, its

![Figure 18-2 The serotonin neurotransmitter system implicated in depression.](image-url)
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precursor (tryptophan), or its major metabolite (5-HIAA) in the cerebrospinal fluid or blood of people with depression and in the postmortem brains of depressed people who died of other causes and in people who committed suicide.

**Neuroendocrine.** 5-HT has an important role in the secretion of growth hormone, prolactin, and cortisol, all of which are found to be abnormal in people with depression.

**Treatment.** Most clinically effective biological antidepressant agents, such as drugs and electroconvulsive therapy (ECT), have been found to enhance the neurotransmission of 5-HT, although the mechanisms of actions differ from each other.

**Brain imaging.** Computed tomography (CT) and magnetic resonance imaging (MRI) studies find various abnormalities in the structure of brains in people with mood disorders. MRI studies of depressed patients show a decrease in the size of the hippocampus, supporting the hypothesis that increased levels of stress hormones are associated with damage to the hippocampus (a limbic structure involved in learning and memory).

MRI studies also show that brain structures responsible for human mood are larger in bipolar patients compared with controls. Specifically, the amygdala (the limbic structure responsible for modulating feelings of aggression, anger, love, and shyness) is especially large, perhaps accounting for some of the heightened emotionality and problematic behaviors seen in manic patients.

Positron emission tomography (PET) studies of mood disorders consistently show decreased frontal lobe brain metabolism (hypometabolism), which is generally more pronounced on the left hemisphere in depression and on the right hemisphere in mania. This means that the frontal lobes, which have an important role in intellectual and emotional activities, are not using as much glucose as they should (Figure 18-3).

Prefrontal cortex hypometabolism affects the function of many brain structures connected with it by way of the 5-HT system. It is hypothesized that these interconnections facilitate the varied symptoms of depression (Table 18-2). Also, the amygdala shows increased blood flow, which is associated with intrusive ruminations in people with severe recurrent depression and a family history of mood disorders.

Several important implications of viewing depression as a brain-based illness of the prefrontal cortex are noted:

- Cognitive and interpersonal therapies may be viewed as prefrontal rehabilitation because they substitute for, then gradually bring back on line, some of the behaviors and cognitions compromised by prefrontal cortex (PFC) hypoactivity.
- Viewing depression as a disease with identified regional brain dysfunction helps destigmatize depression and re-integrate mood disorders into general health care.
- Changes in brain metabolism identified by neuroimaging studies may help with the understanding of how psychosocial stressors such as grief (a hyperactivity in the PFC) may evolve into the clinical syndrome of depression (a hypoactivity in the PFC).

**Biological rhythms.** Mood disorders show periodic variations in physiological and psychological functions. Affective illnesses are usually recurrent, with episodes often occurring and remitting spontaneously. Two subtypes of mood disorders are specifically cyclical in nature: rapid cycling bipolar disorder and depressive disorder with seasonal patterns. In the first, cycles may endure for days, weeks, months, or years. In seasonal affective disorder (SAD), cycles occur annually in the same season each year, as people react to changes in environmental factors, such as climate, latitude, or light.

People who are depressed or manic have certain characteristic changes in biological rhythms and related physiology. For instance, body temperature and certain hormones reach their peak earlier than normal; some depressed patients are more sensitive to the absence of sunlight than nondepressed people; and many depressed people experience circadian rhythm disturbances, such as diurnal variation and early-morning awakening. Sleep loss for individuals with bipolar disorder can trigger mania (Umlauf and Shattell, 2005).

The neurotransmitter **melatonin (a synthesis of serotonin in the pineal gland)**, which is secreted with darkness and suppressed with bright light, is believed to regulate hypothalamic hormones involved in the generation of circadian rhythms and the synchronization of such rhythms to variations in environmental light. The

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**Figure 18-3** Positron emission tomography (PET) scan of glucose use in depressed subject *(figure on left)* showing frontal hypometabolism *(left side of figure)*. This improves after treatment with antidepressant medication *(figure on right)*; note increased glucose metabolism in frontal lobe *(left side of figure).*
human sleep cycle appears to be linked to the timing of human circadian rhythms and to malfunctions in the brain's ability to follow environmental cues, such as light and darkness; to unusual environmental situations, such as long, dark winters in northern latitudes; or to disturbances in the intensity of the circadian rhythm, such as those caused by sleep problems, body temperature changes, mood cycling, and endocrine system (hormones such as cortisol and thyrotropin) abnormalities.

Sleep problems associated with depression have to do with the timing of rapid eye movement (REM) sleep. Sleep electroencephalogram (EEG) studies are abnormal in 90% of depressed patients. Normally on falling asleep, the brain cycles through each stage of sleep for 60 to 90 minutes before it reaches stage 5, or REM (dream sleep). The time between the initiation of sleep and the occurrence of the first REM period is called REM latency.

Depressed patients reach REM too early in the night (in just 5 to 30 minutes); spend less time in the more refreshing slow-wave stages of sleep (stages 3 and 4); spend too much time in REM sleep (up to twice as long as the first REM period in nondepressed people); and have increased periods of either very light sleep or awakenings during the night (Figure 18-4). This explains why depressed patients complain of feeling tired and unrefreshed after a night’s sleep. They experience a decrease in total sleep time, an increase in the percentage of dream time, difficulty in falling asleep, and an increased number of spontaneous awakenings.

Kindling. When an animal’s brain is given intermittent and repeated stimulation by low-level electrical impulses or low-dose chemicals such as cocaine, the result is an increased responsiveness to stable, low doses of the stimulation over time, resulting eventually in seizures. A similar response can be elicited by environmental stimulation. This sensitizing phenomenon is known as kindling.

Table 18-2 Prefrontal Cortex and Serotonin Interconnections: Implications in Depression

<table>
<thead>
<tr>
<th>Interconnected Brain Structures</th>
<th>Hypothesized Role of These Interconnections in Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefrontal Cortex</td>
<td>Covering the frontal lobes, it is unique within the CNS for its strong interconnections with all other areas of the brain; it receives information that has already been processed by other sensory areas and then merges this information with other emotional, historical, or relevant information, thus attending to both feelings and intellect.</td>
</tr>
<tr>
<td>Limbic System Structures</td>
<td>The prefrontal cortex modulates limbic system activities (emotional and instinctive) by way of the following three structures.</td>
</tr>
<tr>
<td>Hippocampus</td>
<td>Major importance in cognitive function, including memory.</td>
</tr>
<tr>
<td>Amygdala</td>
<td>Major importance in modulating feelings such as aggression, anger, love, and shyness.</td>
</tr>
<tr>
<td>Cingulate gyrus</td>
<td>Involved in motivation and interest.</td>
</tr>
<tr>
<td>Brainstem</td>
<td>Responsible for regulating the general state of arousal and tone of brain function; also the location of structures that manufacture various neurotransmitters, such as serotonin (5-HT), norepinephrine (NE), and dopamine (DA).</td>
</tr>
<tr>
<td>Raphe Nuclei</td>
<td>Located in the brainstem, they manufacture 5-HT; they also modulate excessive stimuli and the organization and coordination of appropriate responses to these stimuli.</td>
</tr>
<tr>
<td>Hypothalamus</td>
<td>This interconnection allows for direct prefrontal input into neuroendocrine function by way of the hypothalamic-pituitary axis.</td>
</tr>
<tr>
<td>Suprachiasmatic Nucleus</td>
<td>Located in the hypothalamus, it regulates circadian (24-hour) rhythms and circannual rhythms; thus it is also implicated in seasonal affective disorder.</td>
</tr>
</tbody>
</table>

CNS, Central nervous system.

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awake</td>
<td>Awake</td>
</tr>
<tr>
<td>Stage 1 and REM</td>
<td>Stage 1 and REM</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Stage 2</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Stage 4</td>
</tr>
</tbody>
</table>

Delta sleep

Hours 1 2 3 4 5 6 7 8

Figure 18-4 A, Normal sleep architecture. B, Depressed sleep architecture. Green areas indicate rapid eye movement (REM) sleep.

Ultimately the animal becomes so sensitive that seizures continue to occur spontaneously after the stimulation is discontinued, demonstrating “behavioral sensitization.” It is theorized that kindling underlies the addictive disorders and the cycling and recurrent psychiatric disorders.

Theoretically, psychosocial stressors in genetically vulnerable individuals may precipitate early episodes of mania and depression,
but later episodes can occur in the absence of any apparent external stimulus and with greater frequency and intensity over time. Additional evidence of a role for kindling in mood disorders is that many of the neurotransmitters implicated in the mood disorders inhibit kindling. Drugs used to treat bipolar disorder also affect kindling; lithium blocks behavioral sensitization, and the anticonvulsants block kindling itself. Thus the effect of the environment on a vulnerable brain is the focus of ongoing research on these disorders.

The puzzle of the biology of mood disorders has many different pieces; as yet an all-inclusive hypothesis has not been formulated. It is likely, however, that mood disorders occur because integrated control systems are disrupted, as evidenced by dysregulation in neurotransmitter systems and by the fact that the brain mechanisms that control hormonal balance and biological rhythms are implicated in mood disorders.

What is clear is that the etiologies are diverse, so the treatments must be both diverse and specific to the biopsychosocial context of the individual patient. Kindling and behavioral sensitization research suggests that early detection, aggressive treatment of acute episodes, and adequate long-term prophylactic treatment might inhibit or even prevent a progressively deteriorating course of illness. Some of the biological bases of depression are shown in Figure 18-5.

**Critical Thinking** A pastor preaches about how depression results from "poor moral character" and "personal weakness." How would you respond?

**Precipitating Stressors**

Disturbances of mood can be a specific response to stress. There are two major types of stress. The first is the stress of **major life events** that is evident to other people. The second type is the **minor stress or irritations of daily life** that a person may feel but may not be as obvious to others. These are the small disappointments, frustrations, criticisms, and arguments that occur on a daily basis. However, when accumulated over time and in the absence of compensating positive events, they can precipitate depression.

**Work and family life stress can be major or minor.** Stressors that may produce disturbances of mood include loss of attachment, major life events, role strain, and physiological changes.

**Loss of Attachment.** Loss in adult life can precipitate depression. The loss may be real or imagined and may include the loss of love, a person, physical functioning, status, or self-esteem. Many losses take on importance because of their symbolic meaning, which makes the reactions to them appear out of proportion to reality. In this sense, even an apparently pleasurable event, such as moving to a new home, may involve the loss of old friends, warm memories, and neighborhood associations. Loss of hope is another significant stressor often overlooked. Because of the actual and symbolic issues involved in loss, the patient’s perception is of primary importance.

The intensity of grief becomes meaningful only when the person understands earlier losses and separations. People reacting to a recent loss often behave as they did in previous separations. The intensity of the present reaction therefore becomes more understandable with the realization that the reaction is to earlier losses as well. By definition loss is negative, a deprivation. The ability to sustain, integrate, and recover from loss is a sign of personal maturity and growth.

An uncomplicated grief reaction is the process of normal mourning or simple bereavement. **Mourning** includes a complex sequence of psychological processes. It is accompanied by anxiety, anger, pain, despair, and hope. The sequence is not a smooth, unvarying course. It is filled with turmoil, regressions, and potential problems (Clements et al, 2004). Certain factors have been identified that influence the outcome of mourning (Box 18-5).

These factors should be assessed by the nurse for each person experiencing a loss. Two of the factors—the **nature of the relationship with the lost person or object and the mourner’s perception of the preventability of the loss**—have been identified as prime predictors of the intensity and duration of the bereavement. Concurrent crises, the circumstances of the loss, and a pathological relationship with the lost person or object are other factors that contribute to a failure to resolve grief.
Inhibiting factors. Loss of a loved one is a major stressor that precipitates grief reactions. Most people resolve this loss through simple bereavement and do not experience pathological grief or depression. However, various internal and external factors can inhibit mourning.

An external factor may be the immersion of the mourner in practical, necessary tasks that accompany the loss but are not directly connected to the emotional fact of the loss. These tasks may include funeral arrangements, unfinished business of the deceased, or a search for immediate employment. All these tasks foster denial of the loss. Denial also may be encouraged by cultural norms that minimize or negate the finality of the loss. The U.S. norm of “courage in the face of adversity” can prevent an open display of grief.

Mourning may be inhibited when the bereaved lack support from their social network. Nonsupportiveness suppresses grieving when significant others inhibit mourners’ expression of sadness, anger, and guilt; block their review of the lost relationship; and attempt to orient them too quickly to the future. Finally, the widespread use of tranquilizers and antidepressant medications may suppress normal grief and encourage pathological reactions.

Internal factors that inhibit mourning are often fostered by a society that encourages the control and concealment of feelings. Crying, for example, may be seen as weakness, especially in men. Grief and anger are particularly repressed in U.S. society, and this repression may create many emotional problems.

Finally, the relationship between loss and depression is complex:

- Loss and separation events are possible precipitating stressors of depression.
- Loss and separation are not present in all depressions.
- Not all people who experience loss and separation develop depressions.
- Loss and separation are not specific to depression but may act as precipitating events for a variety of psychiatric and medical illnesses.
- Loss and separation may result from depression.

Life Events. Adverse life events can precipitate depression. Such events include loss of self-esteem, interpersonal problems, socially undesirable occurrences, and major life disruptions. Events perceived as undesirable are most often the precipitants of depression (Patton et al, 2003).

Exit events (separations and losses) more often than entrance events (additions and introductions) are followed by worsening of psychiatric symptoms, physical health changes, impairment of social role performance, and depressive illnesses. The concept of exit events overlaps with the psychiatric concept of loss.

Certain types of events also may prove to be more important than others. For example, childhood physical and sexual abuse has been found to be associated with high depressive symptoms in women. In addition, the presence of multiple family disadvantages, such as marital or family disruption, parental physical illness, poor physical care of child and home, social dependence, family overcrowding, and poor parenting in early life, has been found to be associated with depression in adulthood.

Any conclusions about life events should be made with caution. All people experience stressful life events, but not all people become depressed. This suggests that specific events can contribute only partially to the development of depression.

Role Strain. In analyzing social role stressors, much of the literature focuses on women. This reflects the predominance of depression among women and the increasing interest in gender socialization processes and women’s changing roles.

Role strain in marriage emerges as a major stressor related to depression for both men and women. Research also suggests that being married has a protective effect for males but a detrimental effect for females.

Another role-related risk factor for women is exposure to chronic stressors, such as those experienced in their role as caregivers. These present specific psychosocial and biological challenges, including the following:

- The perinatal period, with its subsequent sleep-disrupting infant care demands, which comes immediately after hormonal, biochemical, and social disruptions associated with pregnancy
- The predominantly female caretaking role for spouses and parents with age- or Alzheimer-related dementias, which can cause the same sleep disruption experienced by mothers of infants
- Achievement-motivated women who take needed time from sleep in order to juggle full-time family and social roles in addition to work and educational commitments
- Shift work that does not follow a forward rotation (days to evenings to nights) with adequate adjustment for each shift change

If these special stressors for women are combined with other rhythm-disrupting processes, such as seasonal light changes, and other risk factors for depression, such as family history and inadequate support systems and primary relationships, a woman has a gender- and role-based risk for depression.

Critical Thinking Describe how the early socialization of young girls in contemporary society might affect their cognitive and emotional coping responses. Compare this with the experiences of young boys.

Physiological Changes. Mood states are affected by a wide variety of physical illnesses and medications (Table 18-3). Drug-induced depressions can follow treatment with antihypertensive drugs, particularly reserpine, and the abuse of addictive substances, such as amphetamines, barbiturates, cocaine, and alcohol.

Depression also may occur secondary to medical illnesses, such as viral infections, nutritional deficiencies, endocrine disorders, anemias, and central nervous system disorders, such as multiple sclerosis, tumors, and cerebrovascular disease. Most chronic debilitating illnesses, whether physical or psychiatric, are accompanied by depression.

The depressions of the elderly are particularly complex because the differential diagnosis often involves organic brain damage and clinical depression. People with early signs of senile brain changes, vascular disease, or other neurological diseases
of aging may be more at risk for depression than the general population.

In the United States there has been a tendency to overdiagnose arteriosclerosis and senility in people over age 65 years, without recognizing that depression may manifest itself by a slowing of psychomotor activity. Lowered intellectual function and a loss of interest in sex, hobbies, and activities may be taken as signs of brain disease instead of depression.

Mania also can be a secondary reaction to taking drugs, particularly steroids, amphetamines, and tricyclic antidepressants. It can be triggered by infections, neoplasms, and metabolic disturbances. The evidence that mania can result from pharmacological, structural, and metabolic disturbances suggests that mania, like depression, is a clinical syndrome with multiple causes. The diversity of causes probably involves more than one pathophysiological pathway and challenges any one model of causation, whether biochemical, psychological, genetic, or structural.

### Table 18-3 Physical Illness and Medications Associated with Depressive and Manic States

<table>
<thead>
<tr>
<th>Physical Illness</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>Amphetamines</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>Cocaine</td>
</tr>
<tr>
<td>Nutritional</td>
<td>Methylphenidate</td>
</tr>
<tr>
<td>Pernicious anemia</td>
<td>Monoamine oxidase inhibitors</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Steroids</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Thyroid hormones</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>Tricyclic antidepressants</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td></td>
</tr>
<tr>
<td>Hepatic encephalopathy</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Alpha-methyl dopa</td>
<td></td>
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<tr>
<td>Amphetamine withdrawal</td>
<td></td>
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<tr>
<td>Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td>Cycloserine</td>
<td></td>
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<tr>
<td>Glucocorticoids</td>
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<tr>
<td>Levodopa</td>
<td></td>
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<tr>
<td>Neuroleptics</td>
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<tr>
<td>Physostigmine</td>
<td></td>
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<tr>
<td>Propranolol</td>
<td></td>
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<tr>
<td>Reserpine</td>
<td></td>
</tr>
<tr>
<td>Sedative-hypnotics</td>
<td></td>
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<tr>
<td>Steroidal contraceptives</td>
<td></td>
</tr>
</tbody>
</table>

### Appraisal of Stressors

Debate continues over the nature of depression, that is, whether depression is a single illness with different signs and symptoms or whether several different forms of the disease exist. It is clear, however, that a complex interactive effect exists among predisposing and precipitating factors that are biological and psychosocial in origin (Kendler et al, 2006). This underscores the importance of one’s appraisal of one’s life situation and related stressors. Table 18-4 summarizes these major theories of causation.

### Coping Resources

Personal resources include one’s socioeconomic status (income, occupation, social position, education), family (nuclear, extended), social support networks, and secondary organizations provided by the broader social environment (Box 18-6). The far-ranging effects
Box 18-6 A Family Speaks

It’s hard for me to imagine how life could be so bad that my beautiful and loving 22-year-old daughter couldn’t get out of bed in the morning and cried most of the day. It all started when she quit college and returned home and told us about the biggest mistake she had made in her life. While at school, she accidentally got pregnant and then had an abortion. Since that event, she said she had felt worthless, immoral, and extremely guilty.

We talked about it, and I suggested that she get help. She saw two different mental health professionals but dropped out of therapy with each one after only a couple of visits. Then one of my friends recommended a nurse who specialized in working with women with depression. My daughter saw her twice each week initially, then once each week, and finally monthly. My daughter was able to open up to this nurse, and together they worked at changing my daughter’s negative thoughts, feelings, and behaviors. She kept a diary and began to call friends and socialize once again.

Today, 8 months later, my daughter has a job and is going to college part-time in the evenings. Sometimes when I look at her, she seems like a different person to me—so much more grown up and mature. I’m sorry for her pain, but I know that now she is a stronger and wiser person for having endured it.

Box 18-7 Risk Factors for Depression

- Prior episodes of depression
- Family history of depression
- Prior suicide attempts
- Female gender
- Age at onset less than 40 years
- Postpartum period
- Medical comorbidity
- Lack of social support
- Stressful life events
- Personal history of sexual abuse
- Current substance abuse

of poverty, discrimination, inadequate housing, and social isolation cannot be ignored or taken lightly. Thus nursing interventions that foster the person’s ability to develop capacities for coping with life’s disruptions are very important. The risk factors for depression are listed in Box 18-7.

Coping Mechanisms

Uncomplicated grief reactions can be normal mourning or simple bereavement. Mourning includes all the psychological processes set in motion by the loss. Mourning begins with the introjection of the lost object. In grieving the person’s feelings are directed toward a mental image of the loved one. Thus the mechanism of introjection serves as a buffering mechanism.

Through reality testing the person realizes that the loved person or object no longer exists, and then the emotional investment is withdrawn. The ultimate outcome is that reality wins out, but this is accomplished slowly over time. When the mourning work is completed, the ego becomes free to invest in new objects.

A delayed grief reaction uses the defense mechanisms of denial and suppression in an attempt to avoid intense distress. Specific defenses used to block mourning are repression, suppression, denial, and dissociation. Denial of the loss results in profound feelings of guilt, anger, and despair that focus on the person’s own unworthiness.

DIAGNOSIS

The diagnosis of mood disturbances depends on an understanding of many interrelated concepts, including anxiety and self-concept. One task of the nurse in formulating a diagnosis is to determine whether the patient is experiencing primarily a state of anxiety or depression. It is often difficult to distinguish between the two because they may coexist in one patient and are manifested by similar behaviors. The differences between anxiety and depression are presented in Chapter 15 (see Table 15-3).

Figure 18-6 presents the Stuart Stress Adaptation Model with the continuum of emotional responses. The maladaptive responses are a result of anxiety, hostility, self-devaluation, and guilt. This model suggests that nursing care should be centered on increasing self-esteem and encouraging expression of emotions.

Nursing Diagnoses

The primary NANDA International (NANDA-I) nursing diagnoses related to maladaptive emotional responses are complicated grieving, hopelessness, powerlessness, spiritual distress, risk for suicide, and risk for self-directed violence. Nursing diagnoses related to the range of possible maladaptive responses are identified in the Medical and Nursing Diagnoses box (Box 18-8). Examples of expanded nursing diagnoses are presented in the Detailed Diagnoses table (Table 18-5).
Two major categories of mood or affective disorders are identified in the Diagnostic and Statistical Manual of Mental Disorders, ed 4, text revision (DSM-IV-TR): bipolar disorders and depressive disorders. Primary DSM-IV-TR diagnoses include bipolar I and II disorders, cyclothymic disorder, major depressive disorder, and dysthymic disorder (APA, 2000).

- **Cyclothymia** is a disorder resembling bipolar disorder with less severe symptoms, characterized by repeated periods of nonpsychotic depression and hypomania for at least 2 years.
• **Dysthymia** is a milder form of depression lasting 2 or more years. It is a chronic condition, and many patients with dysthymia eventually develop major depressive episodes.

The specific disorders are described in the Detailed Diagnoses table (see Table 18-5). Diagnostic criteria for a major depressive episode and a manic episode are listed in Box 18-9.

**OUTCOMES IDENTIFICATION**

The *expected outcome* when working with a patient with a maladaptive emotional response is as follows: The patient will be emotionally responsive and return to a preillness level of functioning.

Goals of nursing care for patients with severe mood disturbance have the following aims:

- To allow recognition and continuous expression of feelings, including denial, hopelessness, anger, guilt, blame, helplessness, regret, hope, and relief, within a supportive therapeutic atmosphere
- To allow for gradual analysis of stressors while strengthening the patient’s self-esteem
- To increase the patient’s sense of identity, control, awareness of choices, and responsibility for behavior
- To encourage healthy interpersonal ties with others
- To promote understanding of maladaptive emotions and to acquire adaptive coping responses to stressors

Specific short-term goals should be developed based on the behaviors of the patient, present areas of difficulty, and relevant stressors. Goal setting should involve a holistic view of the patient and the patient’s world.

Goals will most likely need to be developed regarding the patient’s self-concept, physical status, behavioral performance, expression of emotions, and relationships. All these areas can directly relate to the mood disturbance. The patient’s participation in setting these goals can be a significant first step in regaining mastery over life.

Outcome indicators related to grief resolution from the Nursing Outcome Classification (NOC) project are presented in Box 18-10 (Moorhead et al, 2008).

**PLANNING**

In planning care the nurse’s priorities are the reduction and ultimate removal of the patient’s maladaptive emotional responses, restoration of the patient’s occupational and psychosocial functioning, improvement in the patient’s quality of life, and minimization...
of the likelihood of relapse and recurrence (Keller, 2003). Treatment consists of three phases: acute, continuation, and maintenance (Figure 18-7).

**Acute Treatment Phase**

The goal of acute treatment is to eliminate the symptoms. If patients improve with treatment, they are said to have had a therapeutic response. A successful acute treatment brings patients back to an essentially symptom-free state and to a level of functioning comparable with that before the illness. This phase usually lasts 6 to 12 weeks, and if patients are symptom free at the end of that time, they are then in remission.

**Continuation Treatment Phase**

The goal of continuation treatment is to prevent relapse, which is the return of symptoms, and to promote recovery. The risk of relapse is very high in the first 4 to 6 months after remission, and one of the greatest mistakes in the treatment of mood disorders is the failure to continue a successful treatment for a long enough time. This phase usually lasts 4 to 9 months.

**Maintenance Treatment Phase**

The goal of maintenance treatment is to prevent recurrence, or a new episode of illness. This concept is commonly accepted for bipolar illness, but it is now seen as important for major depressive...

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**Box 18-9 Diagnostic Criteria for Major Depressive and Manic Episodes**

**Major Depressive Episode**

At least five of the following (including one of the first two) must be present most of the day, almost every day, for at least 2 weeks:

- Depressed mood
- Loss of interest or pleasure
- Weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness
- Impaired concentration
- Thoughts of death or suicide

**Manic Episode**

At least three of the following must be present to a significant degree for at least 1 week:

- Grandiosity
- Decreased need for sleep
- Pressured speech
- Flight of ideas
- Distractibility
- Psychomotor agitation
- Excessive involvement in pleasurable activities without regard for negative consequences


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**Box 18-10 NOC Outcome Indicators for Grief Resolution**

- Resolves feelings about loss
- Expresses spiritual beliefs about death
- Verbalizes reality of loss
- Verbalizes acceptance of loss
- Participates in planning funeral
- Discusses unresolved conflict(s)
- Reports absence of somatic distress
- Reports decreased preoccupation with loss
- Maintains personal grooming and hygiene
- Reports adequate sleep
- Reports adequate nutrition intake
- Seeks social support
- Shares loss with significant others
- Progresses through stages of grief
- Expresses positive expectations about the future


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![Figure 18-7](image-url) The phases of treatment for mood disorders. (From Kupfer DJ: *J Clin Psychiatry* 53[suppl]:28, 1991.)
disorder as well. Studies point out the effectiveness of both pharmacological and cognitive behavioral maintenance therapy in preventing new episodes or lengthening the interval between them. In the maintenance phase, patients may be on medication indefinitely.

Understanding the phases of treatment for mood disorders is critically important. The nurse should discuss them with the patient and family so that they may join in the therapeutic alliance and have clear expectations about the goals and course of treatment.

Critical Thinking Your patient tells you she stopped taking her medicine after 2 months because she was feeling better. What would you tell her, based on your understanding of the treatment phases of depression?

IMPLEMENTATION

Maladaptive emotional responses may emerge at unpredicted moments, can vary in intensity from mild to severe, and can be transitory, recurrent, or stable conditions. Episodes of depression and mania can occur in any setting and can arise in conjunction with existing medical problems. Also, the treatment of mood disturbances can take place in various settings: at home, at an outpatient facility, or in a hospital.

The best treatment setting for the patient depends on the severity of the illness, available support systems, and resources of the treatment center. In timing intervention, remember that help given when maladaptive patterns are developing is likely to be more acceptable and effective than help given after these patterns have been established. Thus early diagnosis and treatment are associated with more positive outcomes.

Practice guidelines have been developed for the treatment of mood disorders (APA, 2005a, 2005b). Research has found that the nature of the therapeutic alliance, social support, and medication adherence have a significant impact on treatment outcomes in mood disorders (Altman et al, 2006). Empirically validated treatments for major depressive disorder and bipolar disorder are summarized in Table 18-6 (Nathan and Gorman, 2007).

The nursing interventions described for severe mood disturbances are based on a multicausal, integrative model of affective disorders. Such a model dismisses the notion of one cause or one cure. Rather, it proposes that affective problems have many causes and dimensions that affect all aspects of a person’s life. Thus a single approach to nursing care would be inadequate.

Nursing interventions must reflect the complex, multicausal nature of the model and address all maladaptive aspects of a person’s life. Intervening in as many areas as possible should have the maximum effect in modifying maladaptive responses and alleviating severe mood disturbances (Schramm et al, 2007). The ultimate aim of these nursing interventions is to teach the patient coping responses and increase the satisfaction gained from interaction with the world.

Environmental Interventions

Environmental interventions are useful when the patient’s environment is highly dangerous, impoverished, aversive, or lacking in personal resources. In caring for the patient with a severe mood disorder, highest priority should be given to the potential for suicide. Hospitalization is definitely indicated when suicide is deemed to be a risk. In the presence of rapidly progressing symptoms and in the absence of support systems, hospitalization is strongly indicated. Nursing care in this case means protecting

<table>
<thead>
<tr>
<th>Table 18-6 Summarizing the Evidence on Mood Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorder</strong></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td><strong>Disorder</strong></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
</tr>
</tbody>
</table>

patients and assuring them that they will not be allowed to harm themselves. Specific interventions for suicidal patients are described in Chapter 19.

Depressed patients must always be assessed for possible suicide. **They are at particular risk when they appear to be coming out of their depression** because they may then have the energy and opportunity to kill themselves. Acute manic states are also life threatening. These patients show poor judgment, excessive risk taking, and an inability to evaluate realistic danger and the consequences of their actions. In an acute manic episode, immediate measures must be instituted to prevent death.

Another environmental intervention involves changing the physical or social setting by helping the patient move to a new environment. Sometimes a change in the general pattern of living is indicated, such as taking a leave of absence from work, working at a different job, socializing with a new peer group, or leaving a family setting. Changes such as these decrease the immediate stress and mobilize additional support.

**Nurse-Patient Relationship**

**Depressed Patients.** Depressed patients resist involvement through withdrawal and nonresponsiveness. Because of their negative views, they tend to remain isolated, verbalize little, think that they are unworthy of help, and form dependent attachments.

In working with depressed patients the nurse's approach should be quiet, warm, and accepting. The nurse should demonstrate honesty, empathy, and compassion. Admittedly, it is not always easy to give warm, personal care to a person who is unresponsive and detached. The nurse may feel angry, resent the patient's helplessness, or fear rejection. Patience and a belief in the potential of each person to grow and change are needed. If this is calmly communicated, both verbally and nonverbally, in time the patient may begin to respond.

Nurses should avoid assuming an overaggressive or lighthearted approach with the depressed person. Comments such as “You have so much to live for,” “Cheer up—things are sure to get better,” or “You shouldn’t feel so depressed” convey little understanding of and respect for the patient’s feelings. They will create more distance and block the formation of a relationship.

Also, nurses should not sympathize with the patient. Subjective overidentification by nurses can cause them to experience similar feelings of hopelessness and helplessness and can seriously limit their ability to provide therapy.

**Rapport is best established with the depressed patient through shared time, even if the patient talks little, and through supportive companionship.** The very presence of the nurse indicates belief that the patient is a valuable person. The nurse should adjust to the depressed patient’s pace by speaking more slowly and allowing more time to respond. The patient should be addressed by name, talked with, and listened to. By studying the patient’s life and interests, the nurse might select topics that lay the foundation for more meaningful discussions.

**Manic Patients.** In contrast, elated patients may be very talkative and need simple explanations and concise, truthful answers to questions. Although manic patients may appear willing to talk, they often resist involvement through manipulation, testing limits, and superficiality. Their hyperactivity, short attention span, flight of ideas, poor judgment, lack of insight, and rapid mood swings all present special problems to the nursing staff.

Manic patients can be very disruptive to a hospital unit and resist engagement in therapy. They may dominate group meetings or therapy sessions by their excessive talking and manipulate staff or patient groups. By identifying a vulnerable area in another person or a group’s area of conflict, manic patients are able to exploit others. This provokes defensive and angry responses. Nurses are particularly susceptible to these feelings because they often have the most contact with patients and the responsibility for maintaining the psychiatric unit. When anger is generated, therapeutic care breaks down. Thus the maneuvers of manic patients act as diversionary tactics. By alienating themselves, patients can avoid exploring their own problems.

It is important for nurses to understand how manic patients are able to manipulate others and their reasons for doing so. The treatment plan for these patients should be thorough, well coordinated, and consistently implemented. **Constructive limit setting on manic patients’ behavior is an essential part of the plan.** The entire treatment team must be consistent in their expectations of these patients, and progressive limits must be set as situations arise. Other patients also may be encouraged to carry out the agreed limits. Pressure applied by peers can sometimes be more effective than pressure applied by the staff. Frequent staff meetings are recommended to improve communication, share in understanding the manic patient’s behavior, and ensure steady progress.

One goal of nursing care is to increase the patient’s self-control, and this should be kept in mind when setting limits. Patients need to see that they can monitor their own behavior and that the staff is there to help them. Also, the nurse should point out the many positive aspects of their behavior. The ability to be outgoing, expressive, and energetic is a coping strength that can be maximized.

**Physiological Treatments**

Physiological treatments include physical care, psychopharmacology, and somatic therapies. They begin with a thorough physical examination and health history to identify health problems and current treatments or medications that may be affecting the patient’s mood. The indications for physiological treatment include symptoms that will respond to physiological measures, greater severity of illness, suicidal potential, and need for speed in recovery.

**Depressed Patients.** When depressed, the patient may forget to attend to physical well-being or may not be capable of self-care. The more severe the depression, the more important is the physical care. For example, the nurse may need to monitor the diet of a patient who has no appetite and consequently has lost weight. Staying with the patient during meals, arranging for preferred foods, and encouraging frequent small meals may be helpful. Recording intake and output and weighing the patient daily will help evaluate this need.

Sleep disturbances typically occur. It is best to plan activities according to each patient’s energy levels; some feel best in the...
morning and others in the evening. A scheduled rest period may be helpful, but patients should not be encouraged to take frequent naps or remain in bed all day. Patients with depression experience less stage III and IV sleep, and because these stages depend on the period of wakefulness, napping may worsen sleep disturbances. For many patients, eating regularly, staying active during waking hours, and cutting back on caffeine (especially late in the day) may promote more normal sleep patterns.

The patient’s physical appearance may be neglected, and all movements may be slowed. Nurses may have to help with bathing or dressing. They should do this matter-of-factly, explaining that help is being offered because the patient is unable to do it independently right now. Cleanliness and interest in appearance can be noticed and praised. Nurses must allow patients to help themselves whenever possible. Often nurses might rush the patient or do a task themselves to save time, but this does not facilitate the patient’s recovery and should be avoided.

**Psychopharmacology.** Antidepressant medications are the drug of choice to treat patients with depression. They are particularly indicated in severe and recurrent depression. Most practice guidelines emphasize that benzodiazepines use be minimized (Valenstein et al., 2004). Many antidepressant medications are available (Table 18-7), and new ones are released each year. Antidepressant medications are equally effective in treating depression, and their overall success rate is 60% to 80%.

Despite the treatment success achieved with these drugs, antidepressant drugs have limitations. Their therapeutic effects usually begin only after 2 to 6 weeks. They also have side effects that can deter some patients from maintenance. In addition, early discontinuation of antidepressant therapy is widespread in the treatment of depression, especially among socioeconomically disadvantaged patients (Olfson et al., 2006). Thus patient education is essential.

Another major problem with some antidepressant medications is their toxicity. **Tricyclic antidepressants are lethal at high doses,** which makes them particularly dangerous for people most in need of them: suicidal patients. In contrast, the newer selective serotonin reuptake inhibitor (SSRI) antidepressants are safer in the event of an overdose. Current research does not indicate a significant risk of suicide after starting treatment with the newer antidepressant drugs (Simon et al., 2006; Howland, 2007a).

It is difficult to predict who will respond to which drug. Fortunately, those who do not benefit from one antidepressant often do well when switched to another. Antidepressant medications are discussed in detail in Chapter 26.

> **Critical Thinking** What would you say to a patient who tells you that she doesn’t want to take medicines for her depression because they are addictive?

**Somatic therapies.** Electroconvulsive therapy (ECT) is used with depressed patients, particularly those with recurrent depressions and those resistant to drug therapy. ECT is regarded by many as a specific therapy for patients with severe depressions characterized by somatic delusions and delusional guilt, accompanied by a lack of interest in the world, suicidal ideation, and weight loss.

Sleep deprivation therapy also may be effective in treating depression. Research indicates that depriving some depressed patients of a night’s sleep will improve their clinical condition. How sleep deprivation works is not known, and the duration of improvement varies.

Another physiological treatment is phototherapy, or light therapy, in which patients are exposed to bright artificial light for a specified amount of time each day. Phototherapy appears to be effective in the short-term treatment of patients with mild to moderate seasonal affective disorder (SAD).

Finally, three new treatments still being researched are transcranial magnetic stimulation (TMS), vagal nerve stimulation (VNS), and deep brain stimulation (DBS). These somatic therapies are described in detail in Chapter 27.

**Manic Patients.** Manic patients primarily need protection from themselves. They may be too busy to eat or take care of themselves. Eating problems can be handled in the same way as with depressed patients. Manic patients may sleep very little, so rest periods should be encouraged, along with baths, soft music, and whirlpools. These patients also may need help in selecting clothes and maintaining hygiene. Setting limits and using firm actions are effective in physical care.

**Psychopharmacology.** For many years lithium has been considered the drug of choice in the treatment of mania, and it has been shown to reduce the risk of relapse in bipolar disorder. Lithium’s neuroprotective (reducing neurotoxicity) and neurotropic (promoting neurogenesis) cellular effects suggest that it may be “brain healthy” for patients with mood disorders (Geddes et al., 2004; Howland, 2007b). Care must be taken regarding the narrow therapeutic index of lithium, which requires frequent checks of blood levels and careful patient monitoring.

Anticonvulsants, calcium channel blockers, and atypical antipsychotic medications have added to the treatment alternatives for bipolar disorder (Chou and Fazzio, 2006) (Table 18-8).

Caution must be used when prescribing antidepressants to patients with bipolar disorder because they may be switched into mania by these drugs. A detailed discussion of mood-stabilizing medications is presented in Chapter 26.

Unfortunately, nonadherence is a major problem among patients with bipolar disorder, and it limits the effectiveness of the medications (Sajatovic et al., 2007). This underscores again the importance of the provider-patient alliance in identifying treatment goals and strategies.

> **Critical Thinking** Your patient with bipolar disorder tells you that she has stopped taking her medication because she misses the highs that she used to feel and the extra energy she used to have. What would your educational approach be to help her comply with treatment?

**Expressing Feelings**

Affective interventions are necessary because patients with mood disturbances have difficulty identifying, expressing, and modulating feelings. Feelings that are particularly problematic are hopelessness, sadness, anger, guilt, and anxiety. A range of interventions is available to the nurse in meeting patient needs in this area. Box 18-11 identifies nursing interventions used to facilitate...
grief work; these are taken from the Nursing Interventions Classification (NIC) project (Bulechek et al, 2008).

Intervening to guide patients in managing their emotions requires self-understanding by the nurse. Whether the interventions will be therapeutic depends greatly on the nurse’s values regarding the various emotions, the nurse’s emotional responsiveness, and the nurse’s ability to offer genuine respect and nonjudgmental acceptance. Nurses must be able to experience feelings and express them if they expect to help patients.

**Depressed Patients.** Initially the nurse must express hope for depressed patients. Demoralization is a component of depression. They thus have a genuine need for believing that things can get better. The nurse should reinforce that depression is a self-

### Table 18-7 Antidepressant Drugs

<table>
<thead>
<tr>
<th>Generic Name (Trade Name)</th>
<th>Usual Adult Daily Dose (mg/day)*</th>
<th>Preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors (SSRIs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>20-40</td>
<td>PO, L</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>20-40</td>
<td>PO, L</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>20-60</td>
<td>PO, L</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>100-200</td>
<td>PO</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>20-50</td>
<td>PO, CR, L</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>50-200</td>
<td>PO, L</td>
</tr>
<tr>
<td><strong>Other Antidepressant Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion (Wellbutrin)</td>
<td>150-450†</td>
<td>PO, SR, XR</td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>15-45</td>
<td>PO, ODT</td>
</tr>
<tr>
<td><strong>Serotonin Antagonist and Reuptake Inhibitors (SARIs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nefazodone (Serzone)</td>
<td>300-500</td>
<td>PO</td>
</tr>
<tr>
<td>Trazodone (Desyrel)</td>
<td>150-300</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine (Effexor)</td>
<td>75-375</td>
<td>PO, XR</td>
</tr>
<tr>
<td>Desvenlafaxine (Pristiq)</td>
<td>50</td>
<td>PO</td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>20-60</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Tricyclic Antidepressant Drugs (TCAs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary (Parent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline (Elavil)</td>
<td>150-300</td>
<td>PO, IM</td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>100-250</td>
<td>PO</td>
</tr>
<tr>
<td>Doxepin (Sinequan)</td>
<td>150-300</td>
<td>PO, L</td>
</tr>
<tr>
<td>Imipramine (Tofranil)</td>
<td>150-300</td>
<td>PO</td>
</tr>
<tr>
<td>Trimipramine (Surmontil)</td>
<td>150-300</td>
<td>PO</td>
</tr>
<tr>
<td>Secondary (Metabolite)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>150-300</td>
<td>PO, L</td>
</tr>
<tr>
<td>Nortriptyline (Pamelor)</td>
<td>50-150</td>
<td>PO, L</td>
</tr>
<tr>
<td>Protriptyline (Vivactil)</td>
<td>15-60</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Tetracyclcs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxapine (Asendin)</td>
<td>150-300</td>
<td>PO</td>
</tr>
<tr>
<td>Maprotiline (Ludiomil)</td>
<td>75-200</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Monoamine Oxidase Inhibitors (MAOIs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isocarboxazid (Marplan)</td>
<td>20-60</td>
<td>PO</td>
</tr>
<tr>
<td>Phenelzine (Nardil)</td>
<td>45-90</td>
<td>PO</td>
</tr>
<tr>
<td>Selegiline (Eldepryl, Emsam)</td>
<td>20-50</td>
<td>PO, TS</td>
</tr>
<tr>
<td>Tranzylopyramine (Parnate)</td>
<td>20-60</td>
<td>PO</td>
</tr>
</tbody>
</table>

*Dosage ranges are approximate; initiate at lower dose for most patients.
†Antidepressants with a ceiling dose because of dose-related seizures.
Table 18-8  Mood-Stabilizing Drugs

<table>
<thead>
<tr>
<th>Generic Name (Trade Name)</th>
<th>Usual Adult Dose (mg/day)*</th>
<th>Preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antimania</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lithium (Eskalith, Lithobid)</td>
<td>600-2400</td>
<td>PO, CR, SR</td>
</tr>
<tr>
<td>Lithium citrate</td>
<td>600-2400</td>
<td>L/S</td>
</tr>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valproic acid (Depakene), valproate (Depacon), divalproex (Depakote)</td>
<td>15-60 mg/kg/day</td>
<td>PO, L/S, ER, IM</td>
</tr>
<tr>
<td>Lamotrigine (Lamictal)</td>
<td>300-500</td>
<td>PO, Ch</td>
</tr>
<tr>
<td>Carbamazepine (Tegretol)</td>
<td>200-1600</td>
<td>PO, Ch</td>
</tr>
<tr>
<td>Oxcarbazepine (Trileptal)</td>
<td>600-2400</td>
<td>PO, S</td>
</tr>
<tr>
<td>Topiramate (Topamax)</td>
<td>200-400</td>
<td>PO</td>
</tr>
<tr>
<td>Tiagabine (Gabitril)</td>
<td>4-32</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Calcium Channel Blockers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verapamil (Calan)</td>
<td>240</td>
<td>PO</td>
</tr>
<tr>
<td>Nifedipine (Adalat, Procardia)</td>
<td>60-180</td>
<td>PO</td>
</tr>
<tr>
<td><strong>Atypical Antipsychotic Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>5-30</td>
<td>PO, IM, L</td>
</tr>
<tr>
<td>Risperidone (Risperdal, Risperdal Consta, M-Tabs)</td>
<td>1-8</td>
<td>PO, L, L-A, ODT</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa, Zydis)</td>
<td>5-20</td>
<td>PO, ODT, IM</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>150-750</td>
<td>PO</td>
</tr>
<tr>
<td>Ziprasidone (Geodon)</td>
<td>40-160</td>
<td>PO, IM, L</td>
</tr>
</tbody>
</table>

Ch, Chewable tablets; CR, controlled release; ER, sustained release; IM, intramuscular injection; L, oral liquid, elixir; L-A, long-acting injectable preparation; L/S, liquid/syrup; ODT, orally disintegrating tablets; PO, oral tablets or capsules; S, suspension; SR, slow release.

*The dosage range is approximate and must be individualized for each patient.

Box 18-11  NIC Interventions Related to Grief Work Facilitation

**Definition**
Assistance with the resolution of a significant loss

**Activities**
- Identify the loss.
- Assist the patient to identify the nature of the attachment to the lost object or person.
- Assist the patient to identify the initial reaction to the loss.
- Encourage expression of feelings about the loss.
- Listen to expressions of grief.
- Encourage discussion of previous loss experiences.
- Encourage the patient to verbalize memories of the loss, both past and current.
- Make empathetic statements about grief.
- Encourage identification of greatest fears concerning the loss.
- Instruct in phases of the grieving process, as appropriate.
- Support progression through personal grieving stages.
- Include significant others in discussions and decisions, as appropriate.
- Assist patient to identify personal coping strategies.
- Encourage patient to implement cultural, religious, and social customs associated with the loss.
- Communicate acceptance of discussing loss.
- Answer children’s questions associated with the loss.
- Use clear words, such as dead or died, rather than euphemisms.
- Encourage children to discuss feelings.
- Encourage expression of feelings in ways comfortable to the child, such as writing, drawing, or playing.
- Assist the child to clarify misconceptions.
- Identify sources of community support.
- Support efforts to resolve previous conflict, as appropriate.
- Reinforce progress made in the grieving process.
- Assist in identifying modifications needed in lifestyle.

From Bulechek GM, Butcher HK, Dochterman JM, editors: Nursing interventions classification (NIC), ed 5, St Louis, 2008, Mosby. NIC, Nursing interventions classification.

limiting disorder and that the future will be better. This can be expressed calmly and simply. The intent is not to cheer the patient but to offer hope that, although recovery is a slow process involving weeks or months, the patient will feel progressively better.

The nurse may acknowledge the patient’s inability to take comfort from this reassurance. For the depressed, only the depression is real; past or future happiness is an illusion (Box 18-12). By affirming belief in recovery, however, the nurse may make the patient’s existence more tolerable. This initial reassurance is a way of acknowledging the patient’s pain and despair while also conveying a sense of hope in recovery. It is not the premature reassurance of “Don’t worry, everything’s going to be just fine.” It is an open-
Manic Patients. Manic patients may have the opposite problem of patients with depression in that they are often too expressive of their feelings. These patients are often hyperverbal and need help from the nurse in pacing and modulating their expression. The nurse must be careful to not criticize or negate the feelings expressed.

Helping patients speak more slowly and follow one line of thought is an important area for nursing intervention. Manic patients need feedback on the intensity of their self-expressions, as well as the impact of their behavior on other people. Social skills modeling and reinforcement are nursing care activities that can be incorporated into the daily routine. Setting limits, giving simple directions, and keeping focused are other useful nursing interventions.

When the nurse accepts without criticism the anger, despair, or anxiety expressed by the patient, the patient sees that expressing feelings is not always destructive or a sign of weakness. Sometimes, however, patients’ expression of anger changes their cognitive set from self-blaming to blaming others. It may allow them to see themselves as more effective because it connotes power, superiority, and mastery. How this anger is expressed is important because aggressive behavior can be destructive and can further isolate them.

Many patients experiencing both depressive and manic emotional states have problems with expressing anger and need to learn assertive behavior and anger management techniques. These important areas of nursing intervention are explored in Chapter 30.

Relaxation techniques also may help both manic and depressed patients deal with their anxiety and tension and obtain more pleasure from life. Reducing anxiety to tolerable levels broadens one’s perceptual field and allows the nurse to intervene in the cognitive and behavioral areas. Nursing actions used to reduce anxiety are described in Chapters 15 and 29.

To successfully implement any of these nursing actions related to the patient’s affective needs, the nurse must use a variety of communication skills (Chapter 2). Particularly important are empathy skills; reflection of feeling; open-ended, feeling-oriented questions; validation; self-disclosure; and confrontation. The patient with a severe mood disturbance will challenge the nurse’s therapeutic skills and stringently test the nurse’s caring and commitment.

Cognitive Strategies

When intervening in the cognitive area, nurses have three major aims, which require that they begin with the patient’s conceptualization of the problem:

- To increase the patient’s sense of control over goals and behavior
- To increase the patient’s self-esteem
- To help the patient modify dysfunctional thinking patterns

Depressed Patients. Depressed patients often see themselves as victims of their moods and environment. They do not see their behavior and their interpretation of events as possible causes of depression. They assume a passive stance and wait for someone or something to lift their mood. One task of the nurse, therefore, is to move patients beyond their limiting preoccupation to other aspects of their world that are related to it. To do this, the nurse must progress gradually.

The first step is to help patients explore their feelings. This is followed by eliciting their view of the problem. In so doing the nurse accepts the patient’s perceptions but need not accept the patient’s conclusions. Together they define the problem to give the patient a sense of control, a feeling of hope, and a realization that change may indeed be possible.
Nursing actions should then focus on modifying the patient’s thinking. Depressed patients are dominated by negative thoughts. Often, despite a successful performance, the patient will view it negatively. Cognitive changes may be brought about in a variety of ways, as described in Chapter 29.

Often, negative thinking is an automatic process of which the patient is not even aware. The nurse can help patients identify their negative thoughts and decrease them through thought stopping or substitution. Concurrently, the patient can be encouraged to increase positive thinking by reviewing personal assets, strengths, accomplishments, and opportunities.

Next, the patient can be helped to examine the accuracy of perceptions, logic, and conclusions. Misperceptions, distortions, and irrational beliefs become evident. The patient also should be helped to move from unrealistic to realistic goals and to decrease the importance of unattainable goals.

All these actions enhance the patient’s self-understanding and increase self-esteem. More detailed interventions related to alterations in self-concept, which are inherent in disturbances of mood, are explored in Chapter 17.

Also, because the depressed patient tends to be overwhelmed by despair, it is important to limit the amount of negative evaluation in which the patient engages. One way is to involve the patient in productive tasks or activities; another way is to increase the level of socialization. These benefit the patient in two complementary ways: They limit the time spent on brooding and self-criticism, and they provide positive reinforcement.

**Manic Patients.** Cognitive therapy and other focused psychosocial interventions have been found to enhance relationship functioning and life satisfaction among patients with bipolar disorder (Miklowitz et al, 2007).

Manic patients need to gain control over their thoughts and behaviors. Here, however, the challenge is to bring together a patient’s scattered thoughts and ideas to help the patient engage in adaptive, goal-directed behavior. The communication skills of focusing, clarifying, and confrontation are useful in redirecting a patient’s self-expressions. Once this is accomplished, the nurse can begin to help the patient modify dysfunctional thinking.

Manic patients often have problems of grandiose thoughts, overestimation of self, and unrealistic pursuits. As in depression, cognitive interventions can help the patient evaluate these thought problems and identify more realistic and ego-supportive goals.

It is also important for the nurse to realize the meaning, nature, and value the manic patient places on behavior and mood change. For example, research has shown that patients with bipolar disorder receive pronounced short- and long-term positive effects from their illness. These include increases in productivity, creativity, sensitivity to surroundings, social friendliness, and sexual intensity. These effects can provide a great deal of secondary benefit from the illness and can be powerful reinforcers of maladaptive responses, thus making change more difficult. For some patients, at some times the perceived positive consequences of the illness may outweigh their perception of the negative consequences.

**Behavioral Change**

The ability to accomplish tasks and be productive depends on various factors that apply to both depressed and manic patients. First, expectations and goals should be small enough to ensure successful performance, relevant to their needs, and focused on positive activities. Box 18-13 presents a list of rewarding or potentially rewarding activities.

Next, attention should be focused on the task at hand, not what has yet to be done or was done incorrectly in the past. Finally, positive reinforcement should be based on actual performance. If such an approach is used consistently over time, the nurse can expect the patient to demonstrate increasingly productive behavior.

Occupational and recreational activities can be helpful. Another source of accomplishment is movement and physical exercise (Trivedi et al, 2006). Jogging, walking, swimming, bicycling, and aerobics are popular forms of exercise that may be incorporated in a regular program of activity. They are beneficial because they improve the patient’s physical condition, release emotions and tensions, and can have an antidepressant effect.

Successful behavior is a powerful reinforcer or antidepressant. However, this idea seldom occurs to depressed patients, who use their despondent mood as a rationalization for inactivity. They instead believe that once their mood lifts, they will be productive.

**Box 18-13 List of Potentially Rewarding Activities for Depressed or Manic Patients**

- Plan something you will enjoy.
- Go on an outing (e.g., a walk, a shopping trip downtown, or a picnic).
- Go out for entertainment.
- Go on a trip.
- Go to meetings, lectures, or classes.
- Attend a social gathering.
- Play a sport or game.
- Spend time on a hobby or project.
- Entertain yourself at home (e.g., reading, listening to music, or watching television).
- Do something just for yourself (e.g., buying something, cooking something, or dressing comfortably).
- Spend time just relaxing (e.g., thinking, sitting, napping, or daydreaming).
- Care for yourself or making yourself attractive.
- Persist at a difficult task.
- Complete a routine task or unpleasant task.
- Do a job well.
- Cooperate with someone else on a common task.
- Do something special for someone else, being generous, going out of your way.
- Seek out people (e.g., calling, stopping by, making a date or appointment, or going to a meeting).
- Initiate conversation (e.g., at a store, party, or class).
- Discuss an interesting or amusing topic.
- Express yourself openly, clearly, or frankly (expressing opinion, criticism, or anger).
- Play with children or animals.
- Compliment or praise someone.
- Physically show affection or love.
- Receive praise, compliments, or attention.
Discuss generalization of new skills to other aspects of the patient's life and functioning.

Table 18-9 Patient Education Plan Enhancing Social Skills

<table>
<thead>
<tr>
<th>Content</th>
<th>Instructional Activities</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe behaviors interfering with social interaction.</td>
<td>Instruct the patient on corrective behaviors.</td>
<td>Patient identifies problematic and more facilitative behaviors.</td>
</tr>
<tr>
<td>Discuss positive social skills that could be used by the patient.</td>
<td>Model effective interpersonal skills for the patient.</td>
<td>Patient describes specific skills that could be acquired.</td>
</tr>
<tr>
<td>Analyze the way in which the patient could incorporate these specific skills.</td>
<td>Use role play and guided practice to allow patient to test these new behaviors.</td>
<td>Patient shows beginning skill in assumed social behaviors.</td>
</tr>
<tr>
<td>Encourage patient to test new skills in other situations.</td>
<td>Give the patient homework assignments to do in one's natural environment.</td>
<td>Patient discusses ability to complete the assigned tasks.</td>
</tr>
<tr>
<td>Discuss generalization of new skills to other aspects of the patient's life and functioning.</td>
<td>Give feedback, encouragement, and praise for newly acquired social skills and their generalization.</td>
<td>Patient is able to integrate the new social behaviors in social interactions with others.</td>
</tr>
</tbody>
</table>

again. Such an idea is consistent with a negative cognitive set and a sense of helplessness. However, inactivity prevents satisfaction and social recognition. Thus it reinforces a depressive state. Likewise, overactivity or uncompleted activity lowers the self-evaluation of manic patients.

Therefore nursing interventions should focus on activating the patient in a realistic, goal-directed way. Directed activities, strategies, or homework assignments mutually determined by the nurse and patient can reveal alternative coping responses. This work should be sensitive to the patient's culture, values, and treatment goals (Warren and Lutz, 2007).

Many depressed patients benefit from nursing actions that encourage them to redirect their self-preoccupation to interests in the outside world. The timing of these interventions is crucial. Patients should not be forced into activities initially. Also, they will not benefit from coming into contact with too many people too soon. Rather, the nurse should encourage activities gradually and suggest more involvement on the basis of patients' energy.

For severely depressed, hospitalized patients, a structured daily program of activities can be beneficial. Because these patients lack motivation and direction, they are slow to initiate actions. The nurse should take into consideration the patient's tolerance to stress and probability of succeeding. The particular task should be neither too difficult nor too time consuming. Success tends to increase expectations of success, and failure tends to increase hopelessness.

Elated patients usually need little encouragement to become involved with others. Because of their short attention span and restless energy, however, they cannot deal with complicated projects. They need tasks that are simple and can be completed quickly. They need room to move about and furnishings that do not over-stimulate them.

**Critical Thinking** What physiological changes occur as a result of exercise? Relate these to what is currently known about the biology of depression.

### Social Skills

Social factors play a major role in the causation, maintenance, and resolution of affective disorders. Socialization moderates depression by providing an experience incompatible with depressive withdrawal. It also provides increased self-esteem and a sense of self-efficacy through the social reinforcers of approval, acceptance, recognition, and support (Cutler, 2005).

A major problem is that patients with maladaptive emotional responses are less accomplished in social interaction. In addition, others may avoid them because of their self-absorption, pessimism, or elation. One nursing action that can be used to counteract this problem is to help patients improve their social skills.

**A Patient Education Plan for enhancing social skills is presented in Table 18-9. It applies to patients with either depression or mania.**

Involvement with others often is a result of shared activities. The nurse can work with the patient to identify recreational, career, cultural, religious, and personal interests and how to pursue these interests through community groups, organizations, and clubs. Women's groups, single-parent groups, jogging clubs, church groups, and neighborhood associations are all opportunities. Although this may appear to be a simple nursing intervention, it often challenges the nurse's creativity and knowledge of resources.

### Family and Group Treatment

In addition to a one-to-one relationship, patients with maladaptive emotional responses can benefit from family and group work. Social support is a critical aspect in both the prevention of and recovery from mood disorders.

Behaviors associated with depression and mania may be inadvertently supported by other family members. The patient's problems in human relationships are examined in light of family patterns, and all members are expected to take responsibility for their share of the continuing pattern.

Family and friends may reinforce and support the patient's maladaptive behavior. Much attention and secondary gain are usually received from others, who respond by being helpful, nurturing, or annoyed. When the patient acts in a more adaptive way, however, attention given is minimal. Therefore one goal of family therapy is to have the family reinforce adaptive behavior and ignore maladaptive mood responses.

Another goal is to reduce family burden. For example, when caregivers of patients with bipolar illness experience a high burden,
Box 18-14 Outline of Topics for Patient-Family Psychoeducational Sessions on Depression

I. Defining depression
   A. Definitions and descriptions of depression and mania
   B. How depression differs from “the blues” we all experience (duration, impact on mood, functioning, self-esteem, responsiveness to the environment)
   C. Possible causes: the Stuart Stress Adaptation Model

II. Depression and the interpersonal environment
   A. What depression looks like: interpersonal difficulties
      1. Oversensitivity and self-preoccupation
      2. Unresponsiveness (to reassurance, support, feedback, sympathy)
      3. Behaviors that appear willful
      4. Apparent lack of caring for others, unrealistic expectations
      5. Apparent increased need to control relationships
      6. Inability to function in normal roles, tasks
   B. Negative interactional sequences
      1. Family attempts to coax, reassure, protect (potential for overinvolvement)
      2. Patient is unresponsive, family escalates attempts to help or withdraws
      3. Patient feels alienated, family becomes withdrawn, angry, or both
      4. Family feels guilty and returns to overprotective stance
      5. Patient feels unworthy, hopeless, infantilized
      6. Families burn out over time but remain caught in guilt/anger dilemma
      7. Alienation or overprotection

III. Treatments
   A. Psychotropic medication


patient outcome and medication adherence are adversely affected (Perlick et al, 2004).

Group therapy also can provide multiple benefits. For example, a format for group treatment of patients with depression or mania can have as its overall aim that of increasing self-worth and self-esteem through identification with the group and awareness of personal strengths. Specifically, group members can do the following:

• Learn more about their own behavior and relationships with others based on feedback from the group.
• Increase social support through group relatedness.
• Gain a heightened sense of identity, self-understanding, and control over their own lives.
• Realize that other people have problems similar to their own, which helps reduce their sense of loneliness and isolation, thereby also decreasing feelings of hopelessness, helplessness, and powerlessness.
• Learn new ways to cope with stress from others in the group.
• More realistically modify their perceptions and expectations of self and others.
• Allow for the expression of feelings of hopelessness and frustration within the supportive context of the group.

Mental Health Education

A final but important aspect of nursing care related to maladaptive emotional responses is mental health education of the public about the nature, extent, and treatments available for mood disorders (Box 18-14). Despite the prevalence of treatments, most people with depressive illnesses do not seek treatment because they do not know that they have a treatable disease or because they perceive stigma surrounding psychiatric illnesses. Outreach targeted to ethnic and racial minority communities is a particular need.

Early diagnosis is especially important. For example, earlier age of onset of depression has been associated with more impaired social and occupational functioning, poorer quality of life, greater medical and psychiatric comorbidity, a more negative view of life and the self, more lifetime depressive episodes, greater symptom severity, and more suicide ideation and attempts (Zisook et al, 2007).

Nursing care also must address the specific needs of patients and families for education concerning mood disorders. A psychoprophylactic model can be used with families, who are a valuable resource in helping patients deal with their illness. The overall goal of such a program is to improve patient and family functioning.
# Table 18-10 Nursing Treatment Plan Summary Maladaptive Emotional Responses

**Nursing Diagnosis:** Hopelessness  
**Expected Outcome:** The patient will be emotionally responsive and return to preillness level of functioning.

<table>
<thead>
<tr>
<th>Short-Term Goal</th>
<th>Intervention</th>
<th>Rationale</th>
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| The patient's environment will be safe and protective. | Continually evaluate the patient's potential for suicide.  
Hospitalize the patient when there is a suicidal risk.  
Help the patient move to a new environment when appropriate (new job, peer group, family setting). | All patients with severe mood disturbances are at risk for suicide; environmental changes can protect the patient, decrease the immediate stress, and mobilize additional resources. Both depressed and manic patients resist becoming involved in a therapeutic alliance; acceptance, persistence, and limit setting are necessary. |
| The patient will establish a therapeutic relationship with the nurse. | Use a warm, accepting, empathetic approach.  
Be aware of and in control of your own feelings and reactions (anger, frustration, sympathy).  
*With the depressed patient:*  
Establish rapport through shared time and supportive companionship.  
Give the patient time to respond.  
Personalize care as a way of indicating the patient's value as a human.  
*With the manic patient:*  
Give simple, truthful responses.  
Be alert to possible manipulation.  
Set constructive limits on negative behavior.  
Use a consistent approach by all health-team members.  
Maintain open communication and sharing of perceptions among team members. | Physiological changes occur in disturbances of mood; physical care and somatic therapies are required to overcome problems in this area. Patients with severe mood disturbances have difficulty identifying, expressing, and modulating feelings. |
| The patient will be physiologically stable and able to meet self-care needs. | Help the patient meet self-care needs, particularly in the areas of nutrition, sleep, and personal hygiene.  
Encourage the patient's independence whenever possible.  
Administer prescribed medications and somatic treatments. | Physiological changes occur in disturbances of mood; physical care and somatic therapies are required to overcome problems in this area. |
| The patient will be able to recognize and express emotions related to daily events. | Review the patient's conceptualization of the problem, but do not necessarily accept conclusions.  
Identify the patient's negative thoughts and help to decrease them.  
Help increase positive thinking.  
Examine the accuracy of perceptions, logic, and conclusions.  
Identify misperceptions, distortions, and irrational beliefs.  
Help the patient move from unrealistic to realistic goals.  
Decrease the importance of unattainable goals.  
Limit the amount of negative personal evaluations the patient engages in. | This will help increase sense of control over goals and behaviors, enhance self-esteem, and modify negative expectations. |
| The patient will implement two new behavioral coping strategies. | Assign appropriate action-oriented therapeutic tasks.  
Encourage activities gradually, escalating them as the patient's energy is mobilized.  
Provide a tangible, structured program when appropriate.  
Set goals that are realistic, relevant to the patient's needs and interests, and focused on positive activities.  
Focus on present activities, not past or future activities.  
Positively reinforce successful performance.  
Incorporate physical exercise in the patient's care plan. | Successful behavioral performance counteracts feelings of helplessness and hopelessness. |
| The patient will describe rewarding social interactions. | Assess the patient's social skills, supports, and interests.  
Review existing and potential social resources.  
Instruct and model effective social skills.  
Use role playing and rehearsal of social interactions.  
Give feedback and positive reinforcement of effective interpersonal skills.  
Intervene with families to have them reinforce the patient's adaptive emotional responses.  
Support or engage in family and group therapy when appropriate. | Socialization is an experience incompatible with withdrawal and increases self-esteem through the social reinforcers of approval, acceptance, recognition, and support. |
The effectiveness of nursing care is determined by changes in the patient’s maladaptive emotional responses and the effect they have on functioning. Problems related to self-concept and interpersonal relationships merge and overlap. Because all people experience life stress and related losses, the nurse can ask a fundamental question related to evaluation: “Did I assess the patient for problems in this area?”

Supervision and peer support groups can be helpful to the nurse working with patients with mood disorders. Of particular significance are the many special aspects of transference and countertransference that may occur. The patient’s heightened attachment and dependency behaviors and lowered defensiveness can lead to intense transference reactions that should be worked through. Themes of loss and fear of loss, control of emotions and lack of control, and ambivalence predominate. Termination of the nurse-patient relationship may be difficult because the patient experiences it as another loss that requires mourning and integration.

Countertransference can be related to the nurse’s own bereavements; attitudes about anger, guilt, sadness, and despair; the ability to confront these emotions openly and objectively; and most importantly, conflicts about death and loss. Difficulties with any of these issues can be evident in avoidance behavior, preoccupation with fantasies, blocking of feelings, or shortening of sessions.

Nursing care will be more appropriate and effective if the nurse is aware of these issues and sensitive to personal feelings and conflicts regarding loss. Supervision and peer support groups can be of great help in this area.

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**Competent Caring: A Clinical Exemplar of a Psychiatric Nurse**

Sure, you read about therapeutic interactions in your nursing textbooks, but every person is not the same, so the only way you learn is by doing, by experiencing. Rarely in school do we have the time to become overly involved with our patients. We are taught on our psychiatric rotation not to let the boundaries between self and others become blurred. Yet the dynamics of a therapeutic relationship are not real until we come face to face with the situation.

It happened to me, subtly, soon after I started working in a private psychiatric hospital. I was working as a staff nurse on the intensive care unit. I was assigned to the next admission. From the intake sheet, I could see it was another depressed, suicidal patient. But when Ms. R and her husband walked onto the unit, I was immediately drawn to her with an empathic feeling. She was tiny, frail looking; her face was thin and drawn. Her long, dark hair partially hid her face. She ignored introductions and stared at the floor. My initial challenge was to establish trust to open channels of communication, assess her suicide potential, and provide a secure environment.

Her potential for self-harm was quite high. She was put on strict suicidal precautions.

Initially, as I worked with Ms. R it required observations of her appearance, gestures, and interests, as well as nonverbal communication. I often had to make inferences, and I shared these with her. I felt like she was testing the waters of trust. She would often wrap herself up in her pink blanket and rock back and forth during our interactions. I found myself wondering what she was thinking.

One day during our time together I asked her about how it felt to be depressed. For her it was the beginning of self-disclosure. She was able to acknowledge her fear and pain and unmet needs. She talked about what it was like growing up in New York City, living in rat-infested row houses. Her father worked at a bakery, and sometimes their only food was the bread he brought home. She had two brothers and two sisters. Eventually she told me her uncle and grandfather lived with them, too. As she learned to trust me, she disclosed sexual abuse from her uncle and grandfather. At times the details became so vivid she trembled as she cried. It is hard to express, but there was a sense that we were making contact.

We talked about her present life, her frugality, her 6-year-old daughter, and the nightmares. She often remarked that her husband and daughter would be better off without her. She believed she could not have a “normal life.” Ms. R was very bright and talented. She had many hobbies. We started concentrating on these things. I knew her self-esteem was low, and this was the start of some good work. But being her primary nurse and assigned to her one-to-one daily made me realize I was becoming enmeshed in the situation. I went to my nurse manager for supervision. We discussed several options. I questioned whether I was helping her. I think sometimes nurses want to feel like omnipotent rescuers. I was not sure whether I was fostering independence or dependence. It was important to acknowledge my feelings to someone else openly, to discuss them, and then to move on.

Even though I felt a bond, I had to help Ms. R find strength on her own. We discussed her upcoming discharge date; we talked about priorities and decisions she had made. We talked about good choices, bad choices, and no choices. She had suffered many setbacks, but she was making plans.

I remember staying late the day of her discharge to say good-bye. Ms. R sent me cards at the hospital, dropped gifts off at the admissions office for me, and once tried to reach me at home. It was difficult to not acknowledge these things; I wanted so much to talk to her, but I knew the boundaries of a therapeutic relationship, and I knew she would be fine. I did talk to her outpatient therapist, and he told me she had completed a course in sign language (during her stay she befriended a deaf elderly woman), and she also was attending clown school, something she had always wanted to do—to make people laugh and feel good.

In psychiatric nursing it is important to remember that the art is to offer what you can without dictating the results while recognizing that you are not the only one to contribute to a person’s health and happiness. I learned this important lesson from Ms. R.
Chapter Focus Points

- Mood is a prolonged emotional state that influences the person’s whole personality and life functioning.
- The four adaptive functions of emotions are social communication, physiological arousal, subjective awareness, and psychodynamic defense.
- The continuum of emotional responses ranges from the most adaptive state of emotional responsiveness to the more maladaptive states of delayed grief reaction, depression, and mania.
- Grief is the subjective state that follows loss. As a natural reaction to a life experience, grief is universal; however, the way it is expressed is culturally determined. The two types of pathological grief reactions are the delayed reaction and the distorted reaction.
- Depression may range from mild and moderate states to severe states with or without psychotic features. Psychotic depression accounts for less than 10% of all depressions.
- The lifetime risk for major depression is 7% to 12% for men and 20% to 30% for women.
- Most untreated episodes of major depression last 6 to 24 months.
- More than 50% of those who have had an episode of depression will eventually have another, and 25% of patients will have chronic, recurrent depression.
- Depression is a common accompaniment of many major medical illnesses. One of every five patients seeing a primary care practitioner has significant symptoms of depression. However, only one third of all people with depression seek help, are accurately diagnosed, and obtain appropriate treatment. The U.S. Preventive Services Task Force recommends screening adults for depression in primary care settings that have systems in place to ensure accurate diagnosis, effective treatment, and responsive follow-up.
- Mania is characterized by an elevated, expansive, or irritable mood. Hypomania is a clinical syndrome similar to but not as severe as mania.
- A depressive episode with no manic episodes would be classified as a depressive disorder. A depressive episode with previous or current manic episodes would be classified as a bipolar disorder or manic depressive illness because the patient experiences both mania and depression.
- The key element of a behavioral assessment is change; depressed people change their usual patterns and responses. The most common and central behavior is that of the depressive mood. Some patients may initially deny their anxious or depressed moods but identify a variety of somatic complaints.
- Postpartum blues are brief episodes, lasting 1 to 4 days, of labile mood and tearfulness that occur in about 50% to 80% of women within 1 to 5 days of delivery. Postpartum depression may occur from 2 weeks to 12 months after delivery but usually occurs within 6 months. The incidence of postpartum psychosis is low, and the symptoms typically begin 2 to 3 days after delivery. The period of risk for postpartum psychosis is within the first month after delivery.
- Seasonal affective disorder (SAD) is depression that comes with shortened hours of daylight in winter and fall and disappears during spring and summer.
- The potential for suicide always should be assessed in severe mood disturbances. About 15% of severely depressed patients commit suicide, and between 25% and 50% of patients with bipolar disorder attempt suicide at least once.
- The essential feature of mania is a distinct period of intense psychophysiological activation. Other behaviors found in mania include lability of mood with rapid shifts to brief depression. About 75% of manic patients have more than one episode, and almost all those with manic episodes also have depressive episodes.
- Current evidence suggests a significant genetic role in the cause of recurrent depression and bipolar disorder. Other predisposing factors affecting emotional responses include the aggression turned inward theory, object loss theory, personality organization theory, cognitive model, learned helplessness-hopelessness model, and behavioral model.
- Mood disorders occur because integrated biological control systems are disrupted, as evidenced by dysregulation in neurotransmitter systems, particularly serotonin, and by the fact that the brain mechanisms that control hormonal balance and biological rhythms are implicated in mood disorders.
- Precipitating stressors include loss of attachment, life events, role strain, and physiological changes. Mood states are affected by a wide variety of medications and physical illnesses. Most chronic debilitating illnesses, whether physical or psychiatric, are accompanied by depression.
- Uncomplicated grief reactions can be normal mourning or simple bereavement. A delayed grief reaction uses the defense mechanisms of denial and suppression in an attempt to avoid intense distress. Specific defenses used to block mourning are repression, suppression, denial, and dissociation.
- Primary NANDA-I nursing diagnoses related to maladaptive emotional responses are complicated grieving, hopelessness, powerlessness, spiritual distress, risk for suicide, and risk for self-directed violence.
- Primary DSM-IV-TR diagnoses include bipolar I and II disorders, cyclothymic disorder, major depressive disorder, and dysthmic disorder. Cyclothymia is a disorder resembling bipolar disorder but with less severe symptoms, characterized by repeated periods of nonpsychotic depression and hypomania for at least 2 years. Dysthymia is a milder form of depression lasting 2 or more years.
- The expected outcome of nursing care is that the patient will be emotionally responsive and return to a preillness level of functioning.
- In planning care the nurse’s priorities are the reduction and ultimate removal of the patient’s maladaptive emotional responses, restoration of the patient’s occupational and psychosocial functioning, improvement in the patient’s quality of life, and minimization of the likelihood of relapse and recurrence.
- Treatment consists of three phases: acute, continuation, and maintenance. The goal of acute treatment is to eliminate the symptoms. The goal of continuation treatment is to prevent relapse, which is the return of symptoms, and to promote recovery. The goal of maintenance treatment is to prevent recurrence, or a new episode of illness.
- Early diagnosis and treatment are associated with more positive outcomes.
- Nursing interventions must reflect the complex, multicausal nature of the model and address all maladaptive aspects of a person’s life.
- In caring for patients with a severe mood disorder, highest priority should be given to the potential for suicide. They are at particular risk when they appear to be coming out of their depression because they may then have the energy and opportunity to kill themselves. Acute manic states are also life threatening.
- Nursing interventions address environmental issues, nurse-patient relationships, physiological treatments, expressing feelings, cognitive strategies, behavioral change, social skills, and mental health education.
- Supervision and peer support groups can be helpful to the nurse working with patients with mood disorders. Of particular significance are the many special aspects of transference and countertransference that may occur.
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