

Depressive Disorders

- Introduction
 - Depression is the oldest and one of the most frequently diagnosed psychiatric illnesses.
 - Transient symptoms are normal, healthy responses to everyday disappointments in life.
 - Pathological depression occurs when adaptation is ineffective.
 - Mood is also called *affect*.
 - Depression is an alteration in mood that is expressed by feelings of sadness, despair, and pessimism.
- Epidemiology
 - Lifetime prevalence rate: 28.2%
 - Woman > Men
 - Comorbidity
- Children and Adolescents
 - Children as young as 3 years of age have been diagnosed with MDD
 - Youth (age 12 – 17): the incidence of having at least one MDE in the past year is 11.93%
 - After recovery from an acute depressive episode, 30 to 70% of children relapse.
 - In adolescents, 20 to 50% may relapse.
- Older Adults
 - Clinical depression occurs in 7% of the general older population with significant disability for those affected.
 - Estimates of incidence in the older adult are as follows:
 - Older people living in the community range from less than 1% to about 5%
 - 13.5% in those requiring a home health care
 - 11.5% in older hospital patients
 - 10 to 15% of older adults have clinically significant depressive symptoms even in the absence of a major depressive disorder.
- Primary Risk Factors
 - History of prior episodes of depression
 - Family history of depressive disorder, especially in first-degree relatives
 - History of suicide attempts or family history of suicide
 - Member of the LGBTQ community
 - Female gender
 - Age 40 years or younger
 - Postpartum period
 - Chronic medical illness
 - Absence of social support
 - Negative, stressful life events, particularly early trauma
 - Active alcohol or substance use disorder
 - History of sexual abuse
- Theory - Biochemical
 - Serotonin: regulator of sleep, appetite, libido
 - Serotonin-circuit dysfunction = poor impulse control, low sex drive, decreased appetite, disturbed regulations of body temperature, and irritability

- Norepinephrine: ↓ levels may account for anergia, anhedonia decreased concentration, and diminished libido
- Dopamine: reward and incentive behavior process, emotional expression, and learning processes
- Cognitive Theory
 - Beck's cognitive triad:
 - Negative, self-deprecating view of self
 - Pessimistic view of the world
 - Belief that negative reinforcement will continue
- MOOD DISORDERS
 - Major Depressive Disorder
 - Persistent Depressive Disorder
 - Postpartum Depression
- Major depressive disorder
 - Characterized by depressed mood
 - Loss of interest or pleasure in usual activities
 - Symptoms present for at least 2 weeks
 - No history of manic behavior
 - Not related to substance use
 - DSM-5
 - Depressed Mood
 - Anhedonia
 - Change in weight
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue or energy loss
 - Feelings of worthlessness or guilt
 - Diminished concentration or indecisiveness
 - Recurrent thoughts of death or suicidal thoughts
- Persistent Depressive Disorder or Dysthymic Disorder
 - Depressed mood for at least 2 years, for more days than not
 - Disorder of chronicity rather than severity
 - Symptoms
 - Daytime fatigue
 - Not always able to function at work and in social situations
 - Chronic low depression/ irritable mood
 - Eating too much or too little
 - Difficulty falling sleeping and excessive sleeping (hypersomnia)
 - Decreased capacity to experience pleasure
 - Negative pessimistic thinking
 - Low self-esteem
 - “Down in the dumps”
- Postpartum Mood Disorders
 - Baby Blues
 - Postpartum Depression
 - Postpartum Psychosis
- “Baby Blues”
 - Up to 85% of women experience a mild form of depression or “baby blues”

- Is the mildest form of postpartum depression
- Symptoms peak between postpartum days 3 and 5
 - Mood swings, sadness, anxiety, crying, difficulty sleeping, loss of appetite
- Typically resolve spontaneously within 24 to 72 hours
- Treatment: Supportive care and reassurance
- Postpartum Depression
 - Occurs in 8% to 20% of all deliveries
 - Often unrecognized and undiagnosed
 - Causes
 - Link between rapid drop in estrogen and progesterone after delivery
 - Social and psychological changes associated with having a baby
 - Associated with poor nutrition
 - Folate and vitamin B12 are needed for the synthesis of serotonin and other neurotransmitters
 - Signs & Symptoms
 - Intense pervasive sadness
 - Severe labile mood swings
 - Loss of appetite or binges with weight gain
 - Sleep deprivation
 - Irritability
 - Severe anxiety and panic attacks
 - Feelings of detachment from the newborn
 - Symptoms last more than 2 weeks
- Postpartum Psychosis
 - Rare
 - Occurs in 0.1% to 0.2% of deliveries
 - Is the most severe perinatal mood disorders
 - Requires inpatient psychiatric treatment
 - Visits with the newborn must be closely supervised
 - Symptoms
 - Abnormally elevated energy levels, cognition, and mood + one or more depressive episodes
 - Manic episodes
 - Grandiosity
 - Decreased need for sleep
 - Flight of ideas
 - distractibility
 - Rapid cycling
 - Treatment
 - Inpatient psychiatric care
 - Antipsychotics, mood stabilizers, benzodiazepines
 - ECT
- Screening for Postpartum Depression
 - Screening: during pregnancy and postpartum
 - Most likely to occur 4 weeks after birth
 - Two questions to ask...
 - Over the past 2 weeks have you ever felt down, depressed, or hopeless?
 - Over the past 2 weeks have you felt little interest or pleasure in doing things?
- Tips to cope with postpartum depression

- Be realistic about expectations for yourself and your baby
- Limit visitors when you first go home
- Ask for help – let others know how they can help
- Sleep or rest when your baby sleeps
- Exercise; take a walk and get out of the house for a break
- Eat a balanced diet
- Keep in touch with family and friends – do not isolate
- Foster your relationship with you partner – make time for each other
- Expect good days and some bad days
- Application of the Nursing process
 - Assessment tools
 - Beck Depression Inventory
 - Hamilton Depression Scale
 - Geriatric Depression Scale
 - Zung’s Self-Rating Depression Scale
 - Patient Health Questionnaire PHQ-9
 - Edinburgh Postnatal Depression Scale (EPDS)
 - Suicidal assessment
 - Ideation related to harm of others
 - Assessment
 - Mood and affect
 - Anxiety, worthlessness, guilt, helplessness, anger, irritability
 - May not make eye contact, flat affect
 - Thought content and processes
 - Slow thinking, rumination on faults, indecisiveness, delusional thinking
 - Physical signs and symptoms
 - Anergia, psychomotor retardation, psychomotor agitation, “vegetative” signs of depression, sleep pattern changes
 - Characteristic communication styles
 - Monotone speech, more time required to respond
- Assessment Guidelines
 - Evaluate the patient’s risk of suicide or harm to others
 - Determine if the depression is primary or secondary to another disorder
 - Assess for history of depression
 - Assess support systems
 - Assess for triggering events
 - Complete a psychosocial assessment
- Nursing Diagnoses
 - Nursing diagnoses can be numerous. Individuals with depression are always evaluated for the risk of suicide.
 - Other common diagnoses include:

<ul style="list-style-type: none"> ▪ Despair ▪ Depressed mood ▪ Hopelessness ▪ Helplessness 	<ul style="list-style-type: none"> ▪ Risk for suicide ▪ Risk for self-mutilation ▪ Self-care deficit
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- Outcomes
 - No physical harm to self
 - Discusses the losses

- o No longer idealizes or obsesses about the lost entity
- o Sets realistic goals for self
- o Attempts new activities without fear of failure
- o self-control over life situation
- o Interacts appropriately with others
- o Maintains reality
- o Able to concentrate, reason, and solve problems
- Interventions
 - o Communication
 - o Health teaching and health promotion
 - o Milieu therapy
 - o First-line psychotherapy interventions
 - Cognitive Behavioral Therapy (CBT)
 - Interpersonal psychotherapy (IPT)
 - Problem-solving therapy (PST)
 - Cognitive Behavior Therapy for Insomnia (CBT-I)
 - o Mindfulness-Based Cognitive Therapy
 - o Group therapy
- Communication Guidelines:
 - o Person with depression may speak and comprehend very slowly.
 - o Extreme depression—Person may be mute.
 - o Sitting with a patient in silence is a valuable intervention.
 - o This time spent together can be meaningful to the depressed person.
 - o When a patient is mute, use the technique of making observations.
 - o “There are many new pictures on the wall” or “I see that you are wearing new shoes”
 - o Avoid saying “Things will look up” or “everyone gets down once in a while”
 - o Use simple concrete words and allow time for the client to respond
- Interventions
 - o Allow client to cry
 - o Encourage independence in the performance of ADLs.
 - o Help the client set goals.
 - o Help the client identify areas of his or her life that they can and cannot control.
 - o Convey an attitude of acceptance
 - o Close observation
 - o Encourage expression of feelings
- Physical Needs
 - o Small, high calorie, high protein foods
 - o Weigh patient weekly
 - o Encourage patient to get up and dress in the morning and stay out of bed during the day
 - o Use of relaxation in the evening
 - o Encourage self-care
 - o Encourage intake of fluids
 - o Offer foods high in fiber
 - o Encourage periods of exercise
- Resources
 - o Provide

- Suicide hotline
 - Support groups
 - Therapists/ counselors
- Evaluation
 - Self-harm
 - Suicidal ideations
 - When to seek assistance
 - Goals
 - Positive aspects about self
 - Identify areas of life where the client has control
 - Basic needs
- Psychopharmacology
- Antidepressants: Note About Safety
 - Antidepressants might *contribute* to suicidal behavior.
 - FDA provides a “black box” warning.
 - FDA recommends close observation for worsening depression or suicidal thoughts.
 - Medications that treat depression by enhancing mood
 - Five main groups:
 - Selective serotonin reuptake inhibitors (SSRIs)
 - Serotonin-norepinephrine reuptake inhibitors (SNRIs)
 - Atypical antidepressants
 - Tricyclic antidepressants (TCAs)
 - Monoamine oxidase inhibitors (MAOIs)
- Selective serotonin reuptake inhibitors (SSRIs)
 - First line drug therapy
 - Selectively block the reuptake of serotonin...
 - Cause fewer adverse effects
 - Low cardiotoxicity
 - Less dangerous when taken in an overdose
 - Cannot drink alcohol
 - Monitor for Suicidal thinking
 - Frequent Side Effects
 - Sexual dysfunction
 - CNS stimulation
 - Insomnia
 - Agitation
 - Anxiety
 - Weight loss early in therapy and then weight gain
 - Adverse Effect
 - Serotonin Syndrome
 - Rare & Life threatening
 - Can begin 2-72 hours after starting treatment
 - Symptoms
 - Mental confusion
 - delirium
 - fever
 - tachycardia
 - hypertension
 - diaphoresis

- seizures
 - death
 - Treatment:
 - discontinue medication
 - Serotonin receptor blockade
 - cyproheptadine, methysergide, propranolol
 - cooling blankets
 - Diazepam for muscle rigidity
 - anticonvulsants
 - artificial ventilation
- Abrupt Discontinuation
 - Serotonin Withdrawal Symptoms
 - nausea
 - headache
 - visual disturbances
 - Taper dose gradually
- SSRI: Examples
 - Citalopram (Celexa)
 - Escitalopram (Lexapro)
 - Fluoxetine (Prozac)
 - Paroxetine (Paxil)
 - Sertraline (Zoloft)
- Tricyclic Antidepressants
 - Increase norepinephrine and serotonin
 - Full effects may take 4 to 8 weeks
 - Dosage is always low initially and increased gradually
 - Side Effects
 - Produce anticholinergic effects
 - Orthostatic hypotension
 - Sedation
 - Examples
 - Desipramine
 - Nortriptyline
 - Doxepin
 - Amitriptyline
 - Warnings
 - Lethal in overdose: Only provide 1 week of medication at a time
 - Contraindicated:
 - Pregnancy
 - Patients who have seizure disorders or a recent MI
 - Patients taking MAOIs
 - Abrupt withdrawal
 - Alcohol
- Monoamine Oxidase Inhibitors: Second-line medication
 - Side Effects
 - Hypotension
 - Sedation
 - Insomnia
 - Changes in cardiac rhythm

- Muscle cramps
 - Constipation
 - Toxic Side Effects: Hypertensive Crisis
 - Hypertensive Crisis
 - Severe headache
 - Stiff, sore neck
 - Flushing; cold, clammy skin
 - Tachycardia
 - Nausea and vomiting
 - Examples
 - Isocarboxazid (Marplan)
 - Phelzine (Nardil)
 - Tranylcypromine (Parnate)
- Selective Serotonin Norepinephrine Reuptake inhibitors (SNRI)
 - Blocks the reuptake of serotonin and norepinephrine
 - Examples:
 - Venlafaxine (Effexor)
 - Duloxetine (Cymbalta)
 - Side Effects
 - Headache, insomnia, anxiety
 - Nausea, anorexia, weight loss
 - Hypertension & Tachycardia
 - Dizziness, blurred vision
 - Sexual dysfunction: ↓ libido
 - Adverse Effects
 - Withdrawal Symptoms
 - Headache, nausea, visual disturbances, anxiety, dizziness, tremors
 - Interactions
 - Taking venlafaxine and NSAIDs/ anticoagulants, increase risk for bleeding
 - SNRI & St. John's Wort can cause serotonin syndrome
- Atypical Antidepressants
 - Less sexual dysfunction side effects than other antidepressants
 - Examples:
 - Mirtazapine (Remeron)
 - Bupropion (Wellbutrin)
 - Trazodone
 - Vilazodone
 - Side Effects
 - Headache, dry mouth
 - GI distress, constipation, N/V, anorexia, weight loss
 - Tachycardia, HTN
 - Restlessness, insomnia
- Other therapies
 - Electroconvulsive Therapy (ECT)
 - Chest pain, stroke, coma, death
 - Treatment
 - Nifedipine (Procardia) SL
 - VS Q 15 minutes

- Approximately 15% of depressed people do not respond to antidepressant medications and continue to experience depression. Of this 15%, approximately 90% find relief from depression through ECT.
- Major depression, bipolar, schizophrenia, and other disorders
- Safe and effective
- Over 100,000 patients annually receive ECT in the U.S.
- Usual course is 2-3 treatments/ week for a total of 6-12 treatments
- Procedure
 - Informed consent must be signed
 - General anesthetic and muscle-paralyzing agent are used
 - Electrodes are placed on each side of the head and an electrical stimulus is delivered, inducing a seizure
 - Monitor vital signs
- Post-Procedure Complications
 - Cognitive adverse effects
 - Memory impairment- temporary
 - Headache
 - Muscle soreness
 - Nausea
- Light Therapy
 - First line treatment for Seasonal Affective Disorder
 - Used in adjunct with medications for MDD
 - Treatment: 30-60 minutes/ day
- Herbal Therapy
 - St. John's Wort
 - May be helpful mild depression
 - Not for MDD, women who are pregnant, or children
 - May reduce effectiveness of oral contraceptives
 - Can cause photosensitization dermatitis

Bipolar Disorder

- Prevalence
 - Bipolar disorder affects approximately 5.7 million American adults.
 - First manic episode occurs: Teens, 20's or 30's
 - Chronic and recurrent
 - Frequently underdiagnosed
 - Strong genetic link
 - Bipolar disorder is characterized by mood swings from profound depression to extreme euphoria (mania), with intervening periods of normalcy.
 - Delusions or hallucinations may or may not be part of clinical picture.
 - A somewhat milder form of mania is called *hypomania*.
- Prevalence and Comorbidity
 - Lifetime prevalence of bipolar disorders: ~4.4%
 - Average age of onset: 18 years
 - Male to female ratio
 - Bipolar I: 1:1
 - Bipolar II: 1:2
 - Comorbidity
 - Other mental disorders

- Medical: cardiovascular diseases, metabolic diseases, endocrine disorders; type 2 diabetes; obesity
 - Theory
- o Risk factors
 - The cause of BSDs involves a complex interaction of poorly understood environmental, genetic and neurochemical factors.
- o Biological findings
 - Genetic factors
 - Neurobiological factors
 - Neuroendocrine factors
 - Neuroanatomical factors
- o Types
 - Bipolar I Disorder
 - Most significant
 - At least one episode of mania alternating with major depression.
 - Marked impairment in social and occupational functioning
 - Bipolar II Disorder
 - Severe and prolonged periods of depression that alternate with brief periods of hypomania
 - Has never met criteria for full manic episode
 - Cyclothymic disorder
 - Mood swings between hypomania and persistent depressive episodes for at least 2 years
- o DSM-5 Diagnostic Criteria for Mania
 - Elevated, expansive, or irritable mood, lasting for at least 1 week
 - And, three or more of the following:
 - Inflated self-esteem
 - Decreased need for sleep
 - More talkative, pressured speech
 - Flight of ideas
 - Distractibility
 - Increase in goal-directed activity
 - Increased involvement in pleasurable activities
- o Delirious Mania
 - Rare
 - Severe clouding of consciousness and intensified symptoms of mania
 - Labile mood
 - Panic anxiety
 - Disorientation/ confusion
 - Agitated, purposeless movements
- o Diagnostic Criteria for Hypomania
 - A distinct period of abnormally and persistently elevated, expansive, or irritable mood and persistently increased activity or energy, lasting 4 consecutive days and present most of the days, nearly every day.
 - During this time, 3 or more of these symptoms must be present:
 - Inflated self-esteem or grandiosity
 - Decreased need for sleep
 - More talkative
 - Flight of ideas
 - Easily distractible

- Increased goal-directed activity
 - Excessive involvement in pleasurable activities
 - Diagnostic Criteria for Major Depression
 - Five or more of the following must be present during the same 2 week period:
 - Depressed mood
 - Change in weight
 - Insomnia/ hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue
 - Feelings of worthlessness
 - Diminished ability to concentrate
 - Recurrent thoughts of death
 - Thought content and Thought Process
 - Thought content may include delusions or hallucinations
 - 50% of patients during the manic phase have psychotic symptoms
 - Delusions of Grandeur/ Paranoid Delusions
 - Hallucinations
 - Pressured Speech
 - Flight of ideas
 - Clang associations
 - Grandiosity
- Nursing Diagnosis/ Intervention
 - Risk for Injury related to
 - Extreme hyperactivity, increased agitation, and lack of control over purposeless and potentially injurious movements
 - Prevention of exhaustion and death from cardiac collapse
 - The patient's activity level is dangerous to his or her health
 - Risk for violence: self-directed or other-directed related to
 - Manic excitement
 - Delusional thinking
 - Hallucinations
 - Impulsivity
 - Imbalanced nutrition less than body requirements
 - Weight loss
 - Disturbed thought processes
 - delusions of grandeur and persecution
 - inaccurate interpretation of the environment
 - Disturbed sensory perception
 - auditory and visual hallucinations
- Outcomes
 - Well hydrated within 24 hours
 - Prevent cardiac complications
 - 6-8 hours of sleep a night
 - Provide a quiet milieu
 - Demonstrate self-control with aid of staff or medication
 - Make no attempt at self-harm with aid of staff or medication
 - Is no longer exhibiting signs of physical agitation
 - Eats a well-balanced diet with snacks to prevent weight loss and maintain nutritional status
 - Verbalizes an accurate interpretation of the environment

- Verbalizes that hallucinatory activity has ceased and demonstrates no outward behavior indicating hallucinations
 - Accepts responsibility for own behaviors
 - Does not manipulate others for gratification of own needs
 - Interacts appropriately with others
- Outcomes: Long Term
 - Focus on relapse prevention
 - Limit the severity and duration of future episodes
 - Coping skills
 - Support groups
 - Medication compliance
- Milieu Management
 - Safety
 - Consistency among staff
 - Reduce environmental stimuli
 - Solitary/ noncompetitive activities
- Interventions
 - Remove all dangerous objects from the environment.
 - If restraint is deemed necessary, ensure that sufficient staff are available to assist.
 - Set limits on manipulative behaviors.
 - Do not argue, bargain, or try to reason with the client.
 - Provide positive reinforcement.
- Communication
 - Use firm and calm approach
 - Use short and concise explanations or statements
 - Remain neutral; avoid power struggles and value judgments
 - Be consistent in approach and expectations
 - Have frequent staff meetings
 - With other staff, decide on limits, tell patient in simple, concrete terms with consequences
 - Firmly redirect energy into more appropriate and constructive channels
 - Use distraction techniques as a tool to de-escalate
- Interventions
 - Provide client with high-protein, high-calorie foods.
 - Maintain an accurate record of intake, output, and calorie count.
 - Monitor sleep patterns.
 - Clear, concise directions and comments
 - Do not Reinforce hallucinations or delusions
 - Redirect patients into more “healthy” activity such as a brisk walk, housekeeping chores.
 - When a patient’s activity begins to escalate, the staff need to employ additional interventions
 - De-escalation, sedating medication, seclusion
- Evaluation
 - Has the client avoided personal injury?
 - Has violence to client or others been prevented?
 - Has agitation subsided?
 - Have nutritional status and weight been stabilized?
 - Have delusions and hallucinations ceased?

- Treatment modalities
 - Therapy
 - Individual psychotherapy
 - Group therapy
 - Family therapy
 - Cognitive Behavioral therapy
 - Accept diagnosis
 - Monitor mood
 - Problem-solving skills
 - Social skills
 - Routine
- Psychopharmacology
 - For mania
 - Lithium carbonate
 - Anticonvulsants
 - Antipsychotics
 - For depressive phase
 - Use antidepressants with care (may trigger mania).
- Lithium
 - Blood Levels
 - Therapeutic blood level: 0.6 to 1.0 mEq/L
 - Toxic blood level: 1.5 to 2.5 mEq/L
 - A typical lithium dose is 300mg 3-4 times a day
 - The window between therapeutic levels and toxic levels is very small, plasma levels should be monitored routinely
 - 2-3 days until therapeutic range has been reached
 - Maintenance: 1-3 months
 - Expected Side Effects: < 0.4-1.0 mEq/L
 - Fine hand tremor
 - Polyuria
 - Mild thirst
 - Mild nausea and general discomfort
 - Weight gain
 - Signs of Early Toxicity: <1.5 mEq/L
 - N/V/D
 - Thirst
 - Polyuria
 - Slurred speech
 - Muscle weakness
 - Coarse hand tremors
 - Mental confusion
 - Incoordination
 - *Interventions*
 - Medication should be withheld, blood lithium levels measured, and dosage reevaluated.
 - Dehydration, if present, should be addressed
 - Severe Toxicity: >2.0 mEq/L
 - Ataxia
 - Serious EEG changes
 - Blurred vision
 - Clonic movements
 - Large output of dilute urine
 - Seizures
 - Severe hypotension
 - Coma - death
 - *Interventions*
 - Gastric lavage

- Hemodialysis
- o Client/Family Education
 - Take the medication regularly.
 - Do not skimp on dietary sodium.
 - Drink six to eight glasses of water each day.
 - Notify physician if vomiting or diarrhea occur.
 - Have serum lithium level checked every 1 to 2 months, or as advised by physician.
 - Do not take with diuretics
- Anticonvulsant Drugs
 - Valproates: Divalproex (Depakote)
 - Carbamazepine (Tegretol)
 - Lamotrigine (Lamictal)
 - Do not discontinue abruptly.
 - Monitor for:
 - skin rash
 - unusual bleeding/ bruising
 - sore throat
 - Fever/ malaise
 - dark urine
 - yellow skin or eyes
 - No alcohol or over-the-counter medications
- o Valproates: Divalproex (Depakote)
 - SE: nausea, vomiting, indigestion, hepatotoxicity, pancreatitis, thrombocytopenia, weight gain
 - Teaching:
 - Monitor liver functions
 - Monitor amylase
 - Monitor platelets
- o Carbamazepine
 - SE: double vision, vertigo, headache
 - more severe: aplastic anemia & agranulocytosis
 - Teaching:
 - Gradually increase dose
 - Administer at bedtime
 - CNS effects should subside in a few weeks
 - Avoid grapefruit juice
 - Monitor CBC periodically
- o Lamotrigine
 - SE: double vision, dizziness, headache, nausea, vomiting, skin rash (Stevens-Johnson Syndrome)
 - Teaching:
 - Hold medication- rash
- o Newer anticonvulsant drugs
 - Topiramate (Topamax)
 - Helpful for mania and does not cause weight gain
 - SE: weight loss, fatigue, dizziness, paresthesia
 - Oxcarbazepine (Trileptal)
 - Similar to Carbamazepine
 - Better tolerated, less side effects
- Antianxiety Drugs

- Clonazepam (Klonopin) and Lorazepam (Ativan)
 - Useful in the acute treatment of mania
 - Effective with psychomotor agitation
- Atypical Antipsychotics
 - Help with insomnia, anxiety, and agitation
 - Risperidone (Risperdal)
 - Ziprasidone (Geodon)
 - Aripiprazole (Abilify)
 - Olanzapine (Zyprexa)
 - Do not discontinue drug abruptly
 - Even if symptoms subside
 - Causes photosensitivity
 - Rise slowly from a sitting or lying position.
 - Avoid alcohol and over-the-counter medications.
 - SE: metabolic syndrome

Eating Disorders

- Anorexia Nervosa (AN)
 - Intense irrational beliefs about weight
 - Self-starvation
- Bulimia Disorder (BD)
 - Binging & induced vomiting
- Binge-eating disorder (BED)
 - Binge eating causes significant distress
 - Obesity
- Prevalence
 - Anorexia Nervosa (AN)
 - Lifetime prevalence: 0.6%; 3 times higher in females as compared to males
 - Bulimia Nervosa (BN)
 - Overall prevalence in the past year: 0.3%; 5 times higher in females as compared to males
 - Bulimia Nervosa is more common than AN and has a better prognosis.
 - Lifetime prevalence: 1.0%
 - Binge Eating Disorders (BED)
 - Overall prevalence in the past year: 1.2%; twice as many females as males
 - Of those with the disorder 18.5% had severe impairment
 - Lifetime prevalence is 2.8%
- Eating disorders affect up to 30 million Americans
- 1 in 5 women
- Bullying in schools
- Of 10-year-old children, 81% are afraid of being “fat”
- ↑ to 60% of girls (6-12yrs) are concerned about their weight
- 10-15% of those with AN & BN are male
- 61% of adult Americans are either overweight or obese

- Theory
 - Genetic Models
 - A large-scale, international whole-genome analysis found evidence that AN is associated with genetic anomalies on chromosome 12.
 - Female relatives of people with AN are more likely to develop AN and BN.
 - Psychological and Psychosocial Models
 - Cultural pressure, parental attitudes, stress, trauma
 - Dysfunctional family
 - Peer pressure
- Comorbidity
 - co-morbid psychiatric illnesses
 - Anxiety disorder
 - Major depressive disorder or dysthymia (50 - 75%)
 - Sexual abuse history (20 - 50%)
 - Obsessive–compulsive disorder
 - Substance use disorders
 - Bipolar disorder
 - Eating disorders are also associated with a high risk for suicide and self-harm.
- Cultural Considerations
 - Eating disorders are more common in industrialized societies where there is an abundance of food and being thin is considered attractive.
 - Female athletes involved in running, gymnastics, or ballet and male body builders or wrestlers are at increased risk.
- Possible Signs and Symptoms of AN
 - Terror of gaining weight
 - Preoccupation with thoughts of food
 - View of self as fat even when emaciated
 - Peculiar handling of food:
 - Cutting food into small bits
 - Pushing pieces of food around plate
 - Possible development of rigorous exercise regimen
 - Possible self-induced vomiting; use of laxatives and diuretics
 - Cognitive distortions: individual judges own self-worth by weight
 - Physical symptoms
- Possible Signs and Symptoms of BN
 - Binge eating behaviors
 - Compensatory behavior after bingeing
 - History of anorexia nervosa
 - Depressive signs and symptoms
 - Problems with:
 - Interpersonal relationships
 - Self-concept
 - Impulsive behaviors; reports feeling “out of control” at times
 - Increased levels of anxiety and compulsivity
 - Possible co-morbid substance use disorder
 - Russell’s Sign
- Binge Eating Disorder (BED)

- Variant of compulsive overeating
- Similar pattern to BN but without compensatory mechanisms such as self-induced vomiting
- Usually co-occurring with psychiatric disorders such as bipolar disorder, depressive disorder, anxiety disorder, and, to a lesser extent, substance use disorders
- In approximately 50% of a sample of obese binge eaters, no attempt to restrict dietary intake occurred before bingeing, unlike with BN
- Body Mass Index
 - Anorexia nervosa is characterized by a BMI of 17 or lower, or less than 15 in extreme cases.
 - A BMI range for normal weight is 20 to 24.9.
 - *Overweight* is defined as a BMI of 25.0 to 29.9.
 - Obesity is defined as a BMI of 30 or greater.
- Nursing Diagnoses
 - Imbalanced nutrition: Less than body requirements
 - Refusal to eat
 - Deficient fluid volume (risk for or actual) related to
 - decreased fluid intake
 - self-induced vomiting
 - laxative and/or diuretic abuse
 - Imbalanced nutrition: More than body requirements
 - compulsive overeating
 - Disturbed body image/low self-esteem
 - dysfunctional family system, or
 - feelings of dissatisfaction with body appearance
 - Anxiety (moderate to severe)
 - helplessness
 - lack of control over life events
- Outcomes: Anorexia & Bulimia
 - The Client
 - Has achieved and maintained at least 85-90% of ideal body weight
 - Normalize eating patterns by eating 75% of three meals per day plus two snacks.
 - Has vital signs, blood pressure, and labs within normal limits
 - Refrain from self harm
 - Verbalizes events that precipitate anxiety and demonstrates techniques for its reduction
 - Verbalizes ways in which he or she may gain more control of the environment
 - Less preoccupation with own appearance
- Outcomes: Binge Eating Disorder
 - The Client
 - Has established a healthy pattern of eating
 - Verbalizes plans for future maintenance of weight control
- Interventions
 - Hospitalization may be necessary in cases of:
 - Malnutrition
 - Dehydration
 - Severe electrolyte imbalance
 - Cardiac arrhythmia or severe bradycardia
 - Hypothermia
 - Hypotension
 - Suicidal ideation

- Medical Intervention
 - Stabilization
 - IV lines, feeding tubes
 - Labs: Electrolytes
 - Refeeding and weight restoration
 - Normalize eating patterns, as evidenced by eating 75% of three meals per day plus two snacks.
 - Achieve 85% to 90% of ideal body weight.
 - Monitor for refeeding syndrome
 - Close monitoring
 - After stabilization
 - Psychotherapy is treatment of choice
- Interventions
 - Determine appropriate calories to provide adequate nutrition and weight gain.
 - Do not focus on food and eating specifically.
 - Keep a strict record of intake and output.
 - Establish trusting relationship.
 - Avoid arguing or bargaining with the client.
 - Refer client to a support or therapy group.
 - Encourage diary of food intake.
 - Provide instruction about medications.
 - Promote feelings of control.
 - Help client realize perfection is unrealistic.
- Communication Guidelines
 - Milieu Therapy:
 - Highly structured unit, precise mealtimes, adherence to selected menu
 - Observe patients during and after mealtime
 - Interdisciplinary team approach
 - Avoid authoritarianism and assumption of a parental role
 - Realize the patient's main fear is gaining weight which is our #1 outcome
 - Frequent acknowledgement of the difficulty of the situation helps with resistance
- Treatment Modalities
 - Individual therapy
 - Helpful when underlying psychological problems are contributing to the maladaptive behaviors
 - Family therapy
 - Involves educating the family about the disorder
 - Assesses the family's impact on maintaining the disorder
- Health Teaching and Promotion
 - Importance of meal planning
 - Use of relaxation techniques
 - Maintenance of a healthy diet and exercise
 - Coping skills
 - Knowledge of the physical and emotional effects of bingeing and purging
 - Knowledge of the effects of cognitive distortions
 - Outpatient program

- Treatment Modalities
 - Psychopharmacology
 - Medications that have been tried with some success include:
 - For anorexia nervosa
 - Fluoxetine (Prozac)
 - Clomipramine (Anafranil)
 - Cyproheptadine (Pariactin)
 - Chlorpromazine (Thorazine)
 - Olanzapine (Zyprexa)
 - For bulimia nervosa
 - Fluoxetine (Prozac)
 - Imipramine (Tofranil)
 - Desipramine (Norpramine)
 - Amitriptyline (Elavil)
 - Nortriptyline (Aventyl)
 - Phenelzine (Nardil)
 - For BED with obesity
 - Topiramate (Topamax)
 - Fluoxetine (Prozac)
 - Lisdexamfetamine (Vyvanse)
- Conclusion
 - The most effective treatments involve an interdisciplinary team approach that enlists the expertise of various health care professionals, including primary care providers, medical specialists, advanced practice psychiatric nurses, psychologists, psychiatrists, and nutritionists.
 - Pharmacological interventions include use of SSRs, which increase the risk of suicide in an already vulnerable population

Schizophrenia

- Introduction
 - Schizophrenia requires treatment that is comprehensive and presented in a multidisciplinary effort.
 - Of all mental illnesses, schizophrenia probably causes more:
 - Lengthy hospitalizations
 - Chaos in family life
 - Exorbitant costs to people and governments
 - Fears
- Nature of the Disorder
 - Schizophrenia causes disturbances in
 - Thought processes
 - Perception
 - Affect
 - With schizophrenia, there is a severe deterioration of social and occupational functioning.
 - In the United States, the lifetime prevalence of schizophrenia is about 1%.
 - Premorbid behavior of the patient with schizophrenia can be viewed in four phases.
- Prevalence
 - Lifetime prevalence of schizophrenia: 1% worldwide

- Early age of onset
 - More evidence of structural brain abnormalities
 - More prominent negative and disabling symptoms
 - Poorer prognosis
- Later age of onset (25 to 35 years)
 - More likely to be female
 - Have less evidence of structural brain abnormalities
 - Better long-term outcomes
- Comorbidity
 - Substance use disorders
 - Other psychiatric disorders
 - Anxiety disorders
 - Obsessive-compulsive disorder
 - Panic attacks
 - Acquired immune deficiency syndrome (AIDS)
 - Cardiovascular disease
 - Respiratory disease
 - Influenza and pneumonia
 - Metabolic syndrome
 - Human immunodeficiency virus (HIV)
- Predisposing Factors
 - Biochemical influences:
 - One theory suggests that schizophrenia may be caused by an excess of dopamine activity in the brain.
 - Abnormalities in other neurotransmitters have also been suggested.
 - Increased C4 activity:
 - Prolonged synaptic pruning leads to symptoms of schizophrenia
 - Synaptic pruning normally happens in adolescents
 - Physiological influences
 - Factors that have been implicated include:
 - Viral infection
 - Anatomical abnormalities
 - Head injury in adulthood
 - Genetic Influences
 - Strong genetic component
 - How it is inherited is uncertain
 - Genetic markers for schizophrenia
 - New research in identifying regions on chromosomes that are related to the development of schizophrenia
- Course of Illness
 - Prodromal phase
 - Precedes the acute phase of schizophrenia
 - Deterioration in role functioning and social withdrawal
 - Substantial functional impairment
 - Sleep disturbance, anxiety, irritability
 - Depressed mood, poor concentration, fatigue
 - May appear 1 month – 1 year before the first psychotic break
 - Acute Phase
 - In the active phase of the disorder, psychotic symptoms are prominent.
 - Positive symptoms
 - Negative symptoms
 - Cognitive symptoms
 - Mood symptoms
 - Stabilization Phase

- Positive symptoms decrease in severity
 - Maintenance Phase
 - Symptoms are in remission
 - May be milder persistent symptoms (residual symptoms)
- Nursing Process: Assessment
 - The major symptoms of Schizophrenia can be grouped into 2 categories:
 - Positive Symptoms
 - Negative Symptoms
 - Positive Symptoms
 - Disturbances in Content of Thought
 - Delusions: False personal beliefs
 - Persecutory
 - Grandiose
 - Somatic
 - Paranoid
 - Form of thought
 - Concrete thinking:
 - Literal interpretations of the environment
 - Echolalia
 - Repeating words that are heard
 - Loose association:
 - Shift of ideas from one unrelated topic to another
 - Neologisms:
 - Made-up words
 - Clang associations:
 - Choice of words is governed by sound
 - Word salad
 - Group of words put together randomly
 - Circumstantiality
 - Delay in reaching the point of a communication because of unnecessary and tedious details
 - Tangentiality
 - Inability to get to the point of communication
 - Mutism
 - Inability or refusal to speak
 - Perseveration:
 - Persistent repetition of the same word or idea in response to different questions
 - Magical thinking:
 - Ideas that one's thoughts or behaviors have control over specific situations
 - Sensory Perception: interpretation of stimuli through the senses
 - Hallucinations: False sensory perceptions not associated with real external stimuli
 - Auditory
 - Visual
 - Tactile
 - Gustatory
 - Olfactory
 - Illusions: Misperceptions of real external stimuli
 - Echopraxia: Repeating movements that are observed
 - Cues
 - Important for the nurse to know if the patient is hallucinating

- Turning or tilting of the head
 - Frequent blinking of the eyes and grimacing
 - May verbally respond to “unseen others”
- Negative Symptoms: absence of normal behaviors
 - Affect: The feeling state or emotional tone
 - Inappropriate affect: Emotions are incongruent with the circumstances
 - Bland: Weak emotional tone
 - Flat: Appears to be void of emotional tone
 - Apathy: Disinterest in the environment
 - Avolition: Impairment in the ability to initiate goal-directed activity
 - Emotional ambivalence: Coexistence of opposite emotions toward same object, person, or situation
 - Deterioration in appearance: Impaired personal grooming and self-care activities
 - Impaired interpersonal functioning and relationship to the external world
 - Impaired social interaction
 - Clinging and intruding on the personal space of others, exhibiting behaviors that are not culturally and socially acceptable
 - Social isolation
 - A focus inward on the self to the exclusion of the external environment
 - Lack of Insight
 - Anergia: deficiency of energy
 - Anhedonia: Inability to experience pleasure
 - Associated Features
 - Waxy flexibility
 - Passive yielding of all movable parts of the body to any effort made at placing them in certain positions
 - Posturing
 - voluntary assumption of inappropriate or bizarre postures
 - Pacing and rocking
 - Pacing back and forth and rocking the body
 - Regression:
 - Retreat to an earlier level of development
 - Eye movement abnormalities
- Diagnoses
 - Disturbed Sensory Perception (auditory and visual)
 - panic anxiety
 - extreme loneliness
 - withdrawal into self
 - Disturbed Thought Processes
 - inability to trust
 - panic anxiety
 - Social Isolation
 - inability to trust
 - panic anxiety
 - delusional thinking
 - Risk for Violence
 - Extreme suspiciousness
 - Panic anxiety
 - Rage reactions
 - Command hallucinations

- Impaired Verbal Communication
 - Panic anxiety
 - Regression
 - Withdrawal
 - Disordered unrealistic thinking
 - Self-Care Deficit
 - Withdrawal
 - Panic anxiety
 - Inability to trust
 - Nursing Process: Diagnosis
 - Interrupted Family Processes
 - Ineffective health maintenance
 - Impaired home maintenance
 - Outcomes
 - The client
 - Recognizes distortions of reality
 - Has not harmed self or others
 - Perceives self realistically
 - Demonstrates ability to perceive the environment correctly
 - Maintains anxiety at a manageable level
 - Demonstrates ability to trust others
 - Uses appropriate verbal communication
 - Performs self-care activities independently
 - Planning
 - Phase I (Acute)
 - Brief hospitalization is frequently indicated if patient:
 - Is considered a danger to self or others
 - Refuses to eat or drink
 - Is too disorganized to provide self-care
 - Aftercare needs and appropriate referrals
 - Discharge planning
 - Phase II (Stabilization) and Phase III (Maintenance)
 - Identifying the social, interpersonal, coping, and vocational skills needed
 - Teaching relapse prevention strategies is highlighted
 - Determining how and where these needs can best be met within the community
 - Interventions
 - Disturbed Sensory Perception: Auditory/Visual
 - Observe the client for signs of hallucinations.
 - Help client understand connections between anxiety and hallucinations.
 - Distract the client from hallucinations/ delusions
 - Disturbed Thought Processes
 - Do not argue or deny the belief.
 - Reinforce and focus on reality.
 - Risk for Violence
 - Observe client's behavior.
 - Maintain calm attitude.
 - Have sufficient staff on hand.
 - Interventions for Paranoia
 - Place yourself beside patient, not face-to-face
 - Can be seen as confrontational

- Avoid direct eye contact
 - Seen as threatening or confrontational
- Offer food or drink in a closed container: soda, carton of yogurt, unpeeled fruit
 - Paranoid patients may think their food is poisoned, offer food that hasn't been “tampered” with
- If anxiety escalates, use least restrictive interventions
 - One-to-one therapy, prn medications, last resort seclusion
- Associative Looseness
 - Do not pretend that you understand when you are confused
 - Tell the patient that you are having difficulty understanding
 - Verbalize the implied
 - Place the difficulty in understanding on yourself, not the patient
 - Look for recurring topics and themes
 - Emphasize what is going on in the patient’s immediate environment (here and now) and involve the patient in simple reality-based activities
 - Tell the patient what you do understand, and reinforce clear communication and accurate expression of needs, feelings, and thoughts
- Additional Interventions
 - Accept their feelings
 - If acting odd and hallucinating is suspected, the patient should be asked about it
 - Pharmacologic treatment
 - Set limits
 - Help patients identify stressors that precipitate hallucinations or delusions
- Milieu Management
 - Be calm
 - Keep promises & be consistent
 - Be reliable & honest
 - Orient the person to time, person, and place if indicated
 - Do not touch patients without warning them
 - Avoid whispering or laughing when patients are unable to hear all of the conversation
 - Reinforce positive behaviors
 - Avoid competitive activities
- Client/Family Education
 - Management of the illness
 - Connection of exacerbation of symptoms to times of stress
 - Appropriate medication management
 - Side effects of medications
 - Importance of not stopping medications
 - When to contact health-care provider
 - Relaxation techniques
 - Social skills training
 - Daily living skills training
- Psychosocial Therapies
 - Family needs to be included in:
 - Psychologic strategies aimed at reducing psychotic symptoms
 - Teaching patient and family about illness
 - Recognizing effect of stress
 - Psychosocial activities
 - Identifying support sources
 - Medication groups for patients and family

- Pharmacologic Therapy: Antipsychotic Medications
 - Alleviate symptoms of schizophrenia but cannot cure underlying psychotic processes.
 - Antipsychotic drugs are effective in:
 - Acute exacerbations of schizophrenia
 - Preventing or mitigating a relapse
- Conventional Antipsychotic Medications: First Generation
 - Target positive symptoms
 - Side Effects: Extrapyramidal Side Effects (EPSs)
 - Acute Dystonia: severe spasms of tongue, neck, face, or back (tongue and jaw first), drooling
 - Parkinsonism- bradykinesia, rigidity, shuffling gait, drooling, tremors
 - Tardive dyskinesia (TD)- movement disturbance: lip smacking, sucking, puckering, tongue protrusion, worm-like movements in the tongue, and chewing.
 - Akathisia: internal & external restlessness (pacing or fidgeting)
 - Can also cause Agranulocytosis
 - Neuroleptic Malignant Syndrome
 - Symptoms: sudden high grade fever, BP fluctuations, tachycardia, muscle rigidity, diaphoresis, change in LOC, coma, drooling
 - Nursing considerations:
 - Stop medication immediately
 - Monitor VS
 - Apply cooling blanket
 - Administer antipyretics
 - Increase fluid intake
 - Administer diazepam for anxiety
 - Administer dantrolene to induce muscle relaxation
 - Trifluoperazine, Loxapine, Chlorpromazine
 - Treatment of Extrapyramidal Symptoms
 - Side effects often appear early in therapy and can be minimized with treatment.
 - Treatment usually consists of:
 - Lowering the dose
 - Parkinsonism:
 - Benztropine (Cogentin)
 - Acute Dystonia Reactions:
 - Diphenhydramine IM
- Conventional (First-Generation) Antipsychotics
 - High Potency:
 - Trifluoperazine
 - Thiothixene (Navane)
 - Fluphenazine (Prolixin)
 - Haloperidol (Haldol)
 - Pimozide (Orap)
 - Medium Potency:
 - Loxapine (Loxitane)
 - Molidone (Moban)
 - Perphenazine (Trilafon)
 - Low Potency:
 - Chlorpromazine (thorazine)
 - Thioridazine (Mellaril)

- Atypical Antipsychotic Medications: Second Generation
 - Target positive and negative symptoms
 - Atypical agents have fewer side effects.
 - Produce minimal to no EPS symptoms
 - Higher risk for metabolic syndrome
 - Weight gain, Diabetes, Dyslipidemia
 - Long lasting injectables
 - Paliperidone (1-2 months)
 - Zyprexa Relprevv (2-4 weeks)
 - Invega Sustenna (1-2 months)
 - Invega Trinza (3-4 months)
 - Risperdal Consta (4-6 weeks)
- Atypical (Second-Generation) Antipsychotics
 - No EPS:
 - Clozapine (Clozaril)
 - Low EPS:
 - Olanzapine (Zyprexa)
 - Quetiapine (Seroquel)
 - Ziprasidone (Geodon)
 - Aripiprazole (Abilify)
 - Mild EPS:
 - Paliperidone (Invega)
 - High EPS:
 - Risperidone (Risperdal)
 - Lurasidone (Latuda)
- Adjuncts to Antipsychotic Drug Therapy
 - Antidepressants are administered for severe depression.
 - Lithium and other mood stabilizers reduce aggressive behavior.
 - Benzodiazepines for acute psychosis
 - Clonazepam decreases anxiety & agitation