CHAPTER 9

DISTURBANCES
OF MOOD

Learning objectives

After studying this chapter, the student should be able to:

- define mood, its four adaptive functions, and the continuum of emotional responses.
- identify the characteristics that lead to the recognition of severe disturbances of mood.
- describe the concept of grief, mourning, and the delayed grief reaction.
- discuss the clinical entities of depression and mania, including their prevalence and classification in DSM-III.
- analyze stressors affecting the grief reaction and the factors that place a person at high risk.
- evaluate the various theories that have been proposed on the causation of severe disturbances of mood.
- state the value of an integrated multicausal model of severe disturbances of mood.
- identify and describe behaviors that are associated with uncomplicated grief reactions, delayed grief reactions, depression, and mania.
- formulate individualized nursing diagnoses for patients with disturbances of mood.
- assess the relationship between nursing diagnoses associated with disturbances of mood and medical diagnoses of selected psychotic and neurotic disorders.
- develop long-term and short-term individualized nursing goals for patients who are experiencing disturbances of mood.
Variations or fluctuations in mood are a dominant feature of human existence. They indicate that a person is perceiving his world about him and responding to it on some level. Extremes in mood have also been linked with extremes in the human experience, such as creativity, madness, despair, ecstasy, romanticism, personal charisma, and interpersonal destructiveness. These extremes in mood appear to have captured the interest, fascination, and curiosity of scientists, philosophers, and novelists alike, who romanticize, study, and exaggerate the possible alliance between mood, deep emotional experience, and talent.

In this text, mood refers to a prolonged emotional state that influences one's whole personality and life functioning. It pertains to one's prevailing and pervading emotion and is synonymous with the terms of affect, feeling state, and emotion. As with other aspects of the personality, emotions or moods serve an adaptive role for the individual.

The four adaptive functions of emotions have been identified as social communication, physiological arousal, subjective awareness, and psychodynamic defense. The components of affective communication, such as crying, posture, facial expression, and touch, promote early mother-child attachment and the later formation of other interpersonal bonds. Depressive mood states also initiate physiological arousal involving the central nervous system, biogenic amines, and neuroendocrine systems. Theories regarding the protective function of the resulting conservation-withdrawal response with decreased activity have been postulated. The subjective components of human emotions are believed to play important functions in goal setting and in the monitoring of current behavior, particularly in judging personal reality against internalized values and goals. Finally, the fourth adaptive function of emotions is in aiding in psychodynamic defense on both the conscious and unconscious levels.

Continuum of emotional responses

The variety of emotions one can experience, such as fear, joy, anxiety, love, anger, sadness, and surprise, are all normal accompaniments of the human condition. 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 separative process that attempts to overcome the stress of a loss. Grief work, or mourning, therefore is not a pathological process. It is an adaptive response to a real stressor. The absence of grieving in the face of a loss is suggestive of maladaptation.

If one views the expression of emotions on a continuum of health and illness, some relevant parameters become apparent (Fig. 9-1). At the adaptive, or healthy, end is emotional responsiveness. This involves being affected by, and being an active participant in, one's internal and external worlds. It implies being open to one's feelings and aware of them. If used in such a way, feelings provide us with valuable learning experiences.
experiences. They are barometers that give a person feedback about himself and his relationships with others, and they help a person function more effectively in his world. Also adaptive in the face of stress is an uncomplicated grief reaction. Such a reaction implies that the person is facing the reality of his loss and is immersed in the work of grieving.

A maladaptive response would be the suppression of emotions. This may be evident as a denial of one's feelings, a detachment from them, or an internalization of all aspects of one's affective world. Although a transient suppression of feelings may, at times, be necessary to cope, such as in an initial response to a death or tragedy, prolonged suppression of emotions, such as in delayed grief reaction, will ultimately interfere with effective functioning.

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

Nursing intervention in disturbances of mood requires an understanding of a range of emotional states. To assist in this process, the phenomenon of grief, the delayed grief reaction, depression, and mania will now be briefly described.

Grief

Grief is the subjective state that follows loss. It is one of the most powerful emotional states experienced by an individual and it affects all aspects of one's life. It forces the person to stop his normal activities and to focus on his present feelings and needs. Most commonly, it is the response to 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 experienced by everyone at some time in life. As one's interdependence on others grows, there is an increased chance that one must face loss, separation, and death, which elicits intense feelings of grief. The capacity to form warm satisfying relationships with others also makes one vulnerable to sadness, despair, and grief when those relationships are terminated.

As a natural reaction to a life experience, grief is universal. It involves stress, pain, and suffering and an impairment of the capacity to function that can last for days, weeks, or months. The understanding of grief and its manifestations has become of great practical importance. As Noyes commented:

With research linking bereavement to increased morbidity and mortality, grief has emerged as a model of psychosocial stress to be understood in terms of its impact on physical and emotional health.

The ability to experience grief is gradually formed in the course of normal development and is closely related to the acquisition of the capacity for developing meaningful object relationships. The process of growth and development is a series of goal attainments marked by emotional withdrawals from previous positions and reinvestment in new prospects that are thought to offer increased security. Progress is stimulated by physiological growth, which provides new abilities, strengths, and skills, as well as by encouragement and reinforcement from parents and significant others. Goals become more complex, and conflicts in life's choices create inner stress, turmoil, pressure, and unrest. Energies previously turned inward are projected to external objects. If the gratification obtained from the external object is relatively complete and fulfilling, the external object is valued as necessary to the self and is loved. If there is a change in the object, gratification ceases and readjustment is necessary. The person may withdraw within himself, feel isolated, and become preoccupied with his own person and feelings. This is a part of the grieving process. It is resolved only when the lost object is internalized, bonds of attachment are loosened, and new object relationships are established.

Grief responses may be either uncomplicated and adaptive or morbid and pathological. Uncomplicated grief runs a consistent course that is modified by the abruptness of the loss, one's preparation for the event, and the significance of the lost object. It is a self-limited process of realization, that is, it makes real the fact of the loss. Uncomplicated reactions can be considered to be the process of normal mourning or simple bereavement. Mourning includes all the psychological processes set in motion within the individual by the loss. The psychological symptom of increased preoccupation with all the detailed
psychiatric hospitalizations. There is also an almost universal trend, independent of country, of the greater prevalence of depression among women than among men in a fairly consistent female-to-male ratio of 2:1.

Research has also revealed the high incidence of depression among patients hospitalized for medical illnesses, as well as the fact that these depressions are largely unrecognized and hence untreated by health care personnel. Depression is found in all severities of medical illness, although its intensity and frequency were higher in patients who were more severely ill. Certain types of diseases are frequently associated with depression, especially gastrointestinal (35%), neurological (21%), and respiratory (20%). This research suggests that depression is undoubtedly a common accompaniment of any major medical illness.

At first glance, the grieving person and the depressed person may seem indistinguishable. Both are in despair. Both are unable to be interested in the world around them. Neither can believe the pain and sadness will ever cease. Both may feel life is finished or wish it were, and for both, time is meaningless.

However, there are differences between the states of mourning and depression. Drake and Price believe the difference is the quality of the individual’s attachment to the loved object. The degree and nature of the attachment determines the nature of the loss phenomenon and the extent of the depressive reaction to the loss. The disruption of a “normal” attachment results in a sense of loss and grief that is resolved in simple mourning and bereavement. In contrast, disruption of an “inordinate” attachment results in a grieving process that leads into a cycle of depression, since the person is unable to cope with life and function effectively.

Freud made the following distinction between mourning and melancholia:

The distinguishing mental features of melancholia are profoundly painful rejection, abrogation of interest in the outside world, loss of capacity to love, inhibition of all activity, and a lowering of self-regarding to a degree that finds utterances in self reproaches and culminates in a delusional expectation of punishment.... with one exception, the same traits are met with in grief. The fall in self-esteem is absent in grief.

Many theorists disagree with Freud’s position and believe the lowering of self-esteem and ambivalence toward the loved object are present in both reactions. A difference is acknowledged, however, in the level of regression experienced in both reactions as the depressed individual regresses more deeply and fully in response to the loss.

A final difference is apparent in the acknowledgment of the loss. The mourner attends to all things that are connected in any way with the person he mourns. Although his pain is heightened, it is not meaningless; rather, it is an acknowledgment of the loss, and positive feelings toward the lost object predominate. The depressed individual wishes to deny the loss and separation. Even though his affective responses express sorrow, he continues to deny his need to mourn or even that a need to mourn exists. Depression is, in a sense, abortive grieving. The specific defenses that are used to block the mourning process are repression, suppression, denial, and dissociation. There may even be the unconscious wish to be rewarded for suffering by the restoration of the lost object. Because this is impossible, the depressed person’s hopelessness takes on an added dimension. The denial of the loss in depression results in profound feelings of guilt, anger, and despair that focus on one’s own unworthiness.

**Mania**

In addition to the severely depressed disturbance of mood, one may also experience manic episodes. These episodes, like those of depression, can vary in intensity and accompanying level of anxiety from moderate manic states to severe and panic states with psychotic features. Basically, *mania* is characterized by a mood that is elevated, expansive, or irritable. The term, *hypomania*, is used to describe a clinical syndrome that is similar to, but not as severe as, that described by the term mania or manic episode.

In DSM-III, both manic episodes and depressive episodes are contained under the category of major affective disorders. Mania, however, is not given a separate category of classification as is depression. Rather, the major affective disorders are separated into two subgroups—major depression and bipolar disorders—based on whether or not manic and depressive episodes are involved longitudinally (Table 9-1). In this classification, major depression may involve either a simple episode or a recurrent depressive illness, but without manic episodes. When there
memories of the lost object is the work of mourning. Freud described it as the painful and necessary work of readjustment to the loss. As mourning is extended over time, there is a "working through" of an affect that, if released in its full strength, would overwhelm the ego.

The mourning process begins with the introjection of the lost object. When a person grieves, his feelings are directed to the mental image he possesses of the loved one. Thus the mechanism of introjection serves as a buffering mechanism. Through reality testing, the individual realizes that the love object no longer exists, and he withdraws his emotional investment from it. This is accompanied by an internal struggle because the individual does not willingly abandon a source of personal gratification. The ultimate, productive outcome is that reality wins out, but this is accomplished slowly over time. When the mourning work is completed, the ego becomes more free and uninhibited to invest in new objects.

Although the specific reactions to grief may vary, it has to be worked out. If not, the person will continue to experience emotional conflict. Hodge has explained it as follows:

The problem must be brought into the open and confronted, no matter how unpleasant it may be for the patient. The grief work must be done. There is no healthy escape from this. We might even add that the grief work will be done. Sooner or later, correctly or incorrectly, completely or incompletely, in a clear or a distorted manner, it will be done. People have a natural protective tendency to avoid the unpleasantness of the grief work, but it is necessary and the more actively it is done, the shorter will be the period of grief. If the grief work is not actively pursued, the process may be fixated or aborted or delayed, with the patient feeling that he may have escaped it. However, almost certainly a distorted form of the grief work will appear at some time in the future.

Delayed grief reaction

A maladaptive, or pathological, response to loss implies that something has prevented it from running its normal course. Two types of pathological grief reactions have been identified by Lindemann—the delayed reaction and the distorted reaction. Depression is one type of a 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 or become evident in a retarding of the process once it has begun or both. This reaction reflects the exaggerated use of the defense mechanisms of denial and suppression in an attempt to avoid the intense distress associated with grief. The delay and rejection of grief may occasionally involve many years.

The underlying 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.

Depression

The individual who does not engage in the process of mourning can experience a pathological grief reaction known as depression, or melancholia. It is an abnormal extension or overelaboration of sadness and grief. Depression is the oldest and most frequently described psychiatric illness. It has been recognized and described since as early as 1500 B.C., and it appears to be part of the human condition that is familiar to all and yet mysterious to many. The term "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 it will be viewed as a clinical entity that is severe, abnormal, maladaptive, and incapacitating in nature.

The Wall Street Journal called depression the disease of the 1970s, and some mental health workers consider it to cause more total suffering and anguish in the world than any other single medical or psychiatric illness. Depression may range from mild and moderate states to severe states with psychotic features. Psychotic depression is relatively uncommon, however, accounting for less than 10% of all depressions. It is estimated that 15% to 30% of adults experience clinical depressive episodes, most often of moderate severity, at some point in their lives, with the onset of depressive illness peaking in the 40s and 50s. However, only 25% of persons with depressive symptoms seek mental health professional attention. Furthermore, 50% to 80% of all suicides are attributed to depression, and perhaps as much as 75% of all psy-
TABLE 9-1. Classification of major affective disorders (DSM-III) relative to depressive and manic episodes

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<tr>
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<th>Major depression</th>
<th>Bipolar disorders</th>
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<td></td>
<td>Simple</td>
<td>Recurrent</td>
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<tr>
<td>Depressive episode</td>
<td>Yes</td>
<td>Yes</td>
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<td>Manic episode</td>
<td>No</td>
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has been one or more manic episodes, with or without a major depressive episode, the category of bipolar disorder is used. Bipolar disorders are subdivided according to the symptoms of the current episode as manic, depressed, or mixed.

Thus if one experiences a depressive episode with no manic episodes, it would be classified as a major depression. If one experiences a depressive episode with a history of manic episodes in the past or at present, it would be classified as a bipolar disorder.

Although a bipolar affective disorder is far less common than a major depressive illness, it has been estimated that 0.4% to 1.2% of the adult population has the disorder. The onset of bipolar illness peaks below age 30, and it appears to be equally common in women as in men.

Stressors

Stressors affecting the grief reaction

The individual is constantly experiencing losses and thus continually struggling with the tasks of integrating them. The intensity of a person's grief reaction only becomes meaningful when one understands his earlier losses and separations. A person who is reacting to a recent loss is behaving as he did in previous separations. The intensity of the present reaction therefore becomes more understandable when one realizes that the reaction is not only to the present loss but to earlier losses as well. Loss by definition is negative, a deprivation. But the ability to sustain, integrate, and recover from loss is a sign of personal maturity and growth.

Uncomplicated grief reactions can be considered to be the process of normal mourning or simple bereavement. Mourning includes a complex sequence of psychological processes and their behavioral manifestations. It is accompanied by the subjective experiences of anxiety, anger, pain, despair, and hope. The sequence is not a smooth unvarying course, however. It is filled with turmoil, regressions, and potential problems. Certain factors have been identified that influence the outcome of the mourning process:

- Childhood experiences (especially the loss of significant others)
- Losses experienced later in life
- Previous history of psychiatric illness (especially depression)
- Life crises prior to the bereavement
- Nature of the relationship with the lost person or object, including kinship, strength of attachment, security of attachment, dependency-independency bonds, and intensity of ambivalence
- Process of dying (when applicable), including age of deceased, timeliness, previous warnings, preparation for bereavement, expression of feelings, and preventability of the death
- Social support systems
- Secondary stresses
- Emergent life opportunities

These 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 and the mourner's perception of the preventability of the death—have been identified as prime predictors of the intensity and duration of the bereavement. Concurrent crises, the circumstances of the death, and a pathological relationship with the deceased are all factors that contribute to a failure to successfully resolve grief.

Loss of a loved one has been identified as a major precipitating stressor for grief reactions. Most individuals resolve this loss through simple bereavement and do not experience pathological
grief reactions or depression. A number of external and internal factors, however, can inhibit the process of mourning. An external factor may be the immersion of the mourner in practical, necessary tasks that accompany the loss but which are not directly connected to the emotional fact of the loss. These tasks may include funeral arrangements, completing the unfinished business of the deceased, or being forced to search for immediate employment and sources of support. All these tasks foster denial of the loss, which also may be encouraged by cultural norms that minimize or negate the finality of the loss. The American norm of "courage in the face of adversity" can prevent the mourner from any open display of grief.

Mourning may also be inhibited when the bereaved does not receive support from his social network or support systems. Nonsupportiveness that suppresses grieving can be evident when significant others inhibit the mourner's expression of sadness, anger, and guilt, block his review of the lost relationship, and attempt to orient him too quickly to the future. Finally, the widespread use of tranquilizers and antidepressant medications may serve to suppress normal grief and encourage the development of pathological grief reactions.

Internal factors that inhibit mourning are often fostered by social learning that encourages the control and hiding of feelings. Crying, for example, may be seen as a sign of weakness and something to be avoided, especially in men. Two emotions are particularly repressed and suppressed in our society—grief and anger—and this may create many emotional problems for the individual. Another inhibiting factor is the belief that the quantity and quality of emotion is so unique that it cannot be effectively communicated through verbal or nonverbal channels. Both these factors lead to suppression of the mourning process and rely heavily on the intellectual concepts of behavior.

Stressors affecting depression and mania

The existence of severe disturbances of mood, such as in depressive and manic episodes, has been accounted for by numerous theories or models of causation. These models identify a variety of stressors that may affect the individual's coping response and adjustment. Some of the theories are in conflict with each other, some are not supported by research, and certainly all of them are not applicable to each person. Rather, they present the range of causative factors that may be operative in severe disturbances of mood.

GENETIC FACTORS. The first theory addresses genetic aspects of depression. There is wide agreement that both heredity and environmental factors play an important role in depressive illness. Genetic factors related to severe mood disturbances have been investigated in Scandinavia, Germany, Great Britain, and the United States. Four basic techniques of genetic investigation are used: (1) familial aggregation studies, comparing illness rates within and between generations of a particular family; (2) twin studies comparing illness rates in monozygotic and dizygotic twins; (3) general population surveys, comparing illness rates of relatives of depressed patients with those of the general population; and (4) linkage studies, using known genetic markers, such as blood type or color blindness.

Studies using only familial aggregations do not necessarily demonstrate the role of genetics, since the resulting disturbances may be the result of nutritional, infectious, or psychological factors. However, studies using genetic markers, such as blood type or color blindness, provide more compelling evidence that bipolar affective disorder is transmitted by an X-linked dominant gene. Among patients with major depression, no genetic marker has yet been found.

Other evidence from investigations supporting genetic transmission includes an increased frequency of the illness in relatives of the patient compared with the population, a greater concordance rate for the disease in monozygotic twins than in dizygotic twins, an increased frequency of psychiatric abnormalities in relatives of the affective disorder patient than in the general population, and onset of the illness at a characteristic age without any evidence of a precipitating event. One might conclude by saying that good evidence exists for the role of a genetic factor in affective disturbances. Additional studies continue to be made in this important area of psychiatric research.

OBJECT LOSS THEORY. The object loss theory of depression has been advanced by Bowlby, Robertson, Robertson, and Spitz, and it refers to the traumatic separation of the person from significant objects of attachment. Two interrelated issues are important to this theory: loss during childhood as a predisposing factor for the occurrence
of adult depressions and separation in adult life as a precipitating stress for depression.

The first issue proposes that a child has ordinarily formed a tie to a mother figure by 6 months of age, and once that tie is ruptured, the child experiences separation anxiety, grief, and the process of mourning. Furthermore, this mourning process of the early years of life frequently affects future personality development and predisposes the child to psychiatric illness. As Bowlby states:

Unfavorable personality development is often to be attributed to one or more of the less satisfactory responses to loss having been provoked during the years of infancy and childhood in such degree, over such length of time, or with such frequency, that a disposition is established to respond to all subsequent losses in a similar way.

Evidence for this model was reported by Spitz in 1942 when he described a deprivation reaction in infants separated from their mothers in the second half of the first year of life. The reaction was characterized by apprehension, crying, withdrawal, psychomotor slowing, dejection, stupor, insomnia, anorexia, and gross retardation in growth and development. This syndrome is called anaclitic depression, and it has been questioned whether it is caused by the separation or the adverse effects of institutionalization in an orphanage. A similar separation reaction was described by Robertson and Bowlby in older children. They identified three stages of response:

1. A "protest" stage in which the child appeared restless and tearful and searched for his mother.
2. A "despair" stage of apathetic withdrawal.
3. A "detachment" stage seen in some children who rejected their mothers on reunion.

From a research point of view, the connection between early object loss and adult depression can be considered to be improved. More recent work by Robertson casts doubt on the universality of the behavioral responses he described and suggests that appropriate mothering during the separation period can prevent their occurrence. Although studies indicate that, as a group, depressive patients seem to experience more parental loss from death, separation, and other causes than do normal and other diagnostic groups, that factor alone does not seem sufficient to account for all forms of depression. There is even speculation about the beneficial or immunizing effects of having successfully coped with a loss early in development.

The second issue relative to this theory views loss in adult life as a precipitating stress for 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 to be 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 loss that is often overlooked. Because of the actual and symbolic elements involved in the concept of loss, the patient's perception takes on primary importance.

In concluding this discussion of the object loss theory, it is necessary to place this model in proper perspective based on research in this area. Some studies have failed to demonstrate a relationship between separation and depression. Other studies support the relationship but suggest that depression may be the cause of alienation and object loss and not vice versa. Thus the following conclusions may be proposed:

1. Loss and separation events are prominent among the possible precipitating stressors of depression.
2. Loss and separation are not universal in all depressions.
3. Not all people who experience loss and separation will develop depressions.
4. Loss and separation are not specific to depression but may serve as precipitating events for a wide variety of psychiatric and medical illnesses.
5. Loss and separation may result from depression.

AGGRESSION-TURNED-INWARD THEORY. The anger-turned-inward theory of Freud views depression as the inward turning of the aggressive instinct, which for some reason is not directed at the appropriate object, with accompanying feelings of guilt. The process is initiated by the loss of an ambivalently loved object. The person feels both angry and loving toward the object at the same time, but he is unable to express his angry feelings because he may be suppressing them, think they are inappropriate or irrational, or have developed a pattern throughout
life of containing feelings, especially ones he views in a negative way. He then directs his angry feelings inward and turns them toward himself. Freud believed that if one went so far as to commit suicide, the self-destructive act was a strike against the hated and loved object as well as against the self.

This theory does not lend itself to empirical verification. Even though it is one of the most widely quoted theories of depression, there is little systematic evidence to substantiate it. Some researchers have identified patients suffering from depression who outwardly express their anger and hostility. Furthermore, the redirection of hostility at outside objects has not been consistently correlated with clinical improvement. In some instances it may actually have negative effects on the patient’s view of self and problem resolution. It should therefore be viewed as one possible theory of causation that is not applicable to all people experiencing disturbances of mood.

PERSONALITY ORGANIZATION THEORY. Another psychodynamic view of depression focuses on the major psychosocial variable of low self-esteem. The patient’s problem of self-concept is an underlying issue, regardless of whether this is expressed as dejection and depression, or overcompensated with an air of supreme competence as displayed in manic and hypomanic episodes. Threats to self-esteem arise for the individual from poor role performance, perceived low-level everyday functioning, and the absence of a clear self-identity.

Three forms of personality organization that could lead to depression have been identified by Arieti. One form of depression, that based on the “dominant other,” occurs because the patient has relied on an esteemed other for self-esteem. Satisfaction is experienced only through an intermediary. Clinging, passivity, manipulativeness, and avoidance of anger characterize the person with this type of depression. There is a noticeable lack of personal goals and a predominant focus on problems.

Another form results when a person realizes he may never be able to accomplish a desired, but unrealistic, goal. This is the “dominant goal” type of depression. This person is usually exclusive, arrogant, and often obsessive. He has set unrealistic goals for himself and evaluates them with an all-or-nothing standard. He spends an inordinate amount of time engaged in wishful thinking and introverted searches for meaning.

The third type of depression is manifested as a constant mode of feeling. These patients “inhibit any form of gratification because of strongly held taboos.” They experience emptiness, “hypocondriasis, pettiness in interpersonal relationships, and a harsh critical attitude toward themselves and others.”

This view of depression looks at the patients’ belief systems in relation to their experiences. Even in the absence of an apparent precipitating stressor, their depression appears to be preceded by a severe blow to their self-esteem. It emphasizes the crucial position of one’s self-concept in determining adaptation or maladaptation and the importance of the patient’s appraisal of his life situation.

COGNITIVE MODEL. The cognitive model of Beck proposes that people experience symptoms of depression because their thinking is disturbed. He proposes that depression is a cognitive problem that is dominated by the patient’s negative evaluation of himself, his world, and his future. This theory is in contrast to other theories that propose that the depressive affect is primary and the negative cognitive set is secondary. Beck suggests that in the course of his development certain experiences sensitize the individual and make him vulnerable to depression. He also acquires a tendency to make extreme, absolute judgments; loss is viewed as irrevocable and indifference as total rejection.

The depression-prone person, according to this theory, is likely to explain an adverse event as a personal shortcoming. For example, the deserted husband believes “She left me because I’m unlovable,” instead of considering the other possible alternatives, such as personality incompatibility, the wife’s own problems, or her change in feelings toward him. As he focuses on his personal deficiencies, they expand to the point where they completely dominate his self-concept. He can think of himself only in a negative way and is unable to acknowledge his other abilities, achievements, and attributes. This negative set is reinforced when he interprets ambiguous or neutral experiences as additional proof of his deficiencies. Comparisons with other people further lower his self-esteem, and thus every encounter with others becomes a negative experience. His self-criticisms increase as he views himself as deserving of blame.

Depressed patients become dominated by pessimism; they expect future adversities and ex-
experience them as though they were happening in the present or had already occurred. Their predictions tend to be overgeneralized and extreme. Since they view the future as an extension of the present, they expect their failure to continue permanently. Thus pessimism dominates their activities, wishes, and future expectations.

Beck proposes that the constellation of negative thoughts which characterize depression remains relatively dormant until a person becomes depressed. Depressed individuals 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 long-dormant negative cognitive set makes its appearance. As depression develops and increases, the negative idiosyncratic thinking increasingly replaces objective thinking.

Although the onset of the depression may appear to be sudden, Beck suggests it develops over weeks as each experience is interpreted as further evidence of failure. As a result of this "tunnel vision," the individual becomes hypersensitive to experiences of loss and defeat and oblivious to experiences of success and pleasure. He has difficulty acknowledging anger, since he thinks he is responsible for, and deserving of, insults from others and problems in living. Along with low self-esteem, he experiences feelings of apathy and indifference. He is drawn to a state of inactivity and withdraws from life. He lacks all spontaneous desire and only wishes to remain passive. Because he expects failure, he lacks the ordinary mobilization of energy to make an effort to achieve.

Suicidal wishes can be viewed as an extreme expression of the desire to escape. The patient sees his life as filled with suffering with no chance of improvement. Given this negative set, suicide seems to be a rational solution. It promises to end his misery and relieve his family of a burden, and he begins to believe that everyone would be better off if he were dead. The more he considers the alternative of suicide, the more desirable it may seem, and as his life becomes more hopeless and painful, the stronger his desires become to end his life.

Naturalistic, clinical, and experimental studies have provided substantial support for this model of depression. The nurse, using this theoretical model in her practice, will find it useful in understanding the personal world of the depressed person and organizing her observations regarding the depressed person’s idiosyncratic logic and thinking.

**Learned Helplessness Model.** The learned helplessness model evolved from Seligman’s research with dogs, from which he postulated a theory of human depression. He defines helplessness as a “belief that no one will do anything to aid you and hopelessness a belief that neither you nor anyone else can do anything.” His theory proposes that it is not trauma per se that produces depression, but the belief that one has no control over the important outcomes in one’s life and therefore the person refrains from making adaptive responses. Learned helplessness is both a behavioral state and a personality trait of a person who believes that he has lost control over the reinforcers in his environment. These negative expectations lead to hopelessness, passivity, and an inability to assert oneself.

Seligman suggests that people resistant to depression have experienced mastery in life. Their childhood experiences proved that their actions were effective in producing gratification and removing annoyances. In contrast, those susceptible to depression have had lives devoid of mastery. Their experiences proved that they were helpless to influence their sources of suffering and gratification or that they controlled too many reinforcers that did not allow for the development and use of their coping responses against failure.

Abramson, Seligman, and Teasdale proposed an attributional reformulation of the learned helplessness hypothesis. According to the attributional reformulation, the kinds of causal attributions people make for lack of control influence whether or not their helplessness will entail low self-esteem and whether or not their symptoms of helplessness will generalize across situations and time. According to the reformulation, three attributional dimensions are crucial for explaining human helplessness and depression: internal-external, stable-unstable, and global-specific.

In brief, the reformulated model postulates that attributing lack of control to internal factors leads to lowered self-esteem, whereas attributing lack of control to external factors does not. Attributing lack of control to stable factors should lead to an expectation of uncontrollability in fu-
ture situations and, consequently, helplessness deficits extended across time. Similarly, attributing lack of control to global factors should lead to an expectation of uncontrollability in other situations and, consequently, helplessness deficits extended across situations. Alternatively, attributing lack of control to unstable specific factors should lead to short-lived situation-specific helplessness deficits.

Abramson, Seligman, and Teasdale summarized the implications of the attributional reformulation for the helplessness model of depression:

1. Depression consists of four classes of deficits: motivational, cognitive, self-esteem, and affective.
2. When highly desired outcomes are believed improbable or highly aversive outcomes are believed probable, and the individual expects that no response in his repertoire will change their likelihood (helplessness), depression results.
3. The generality of depressive deficits will depend on the probability of the attribution for helplessness. The chronicity of the depression deficits will depend on the stability of the attribution for helplessness, and whether self-esteem is lowered will depend on the internality of the attribution for helplessness.
4. The intensity of the deficits depends on the strength, or certainty, of the expectation of uncontrollability and, in the case of the affective and self-esteem deficits, on the importance of the outcome.

In concluding a discussion of this model, three points are worth noting. The first is that the attributional reformulation of helplessness and depression bears a significant similarity to Beck's cognitive model of depression previously described. The second point is that this model is proposed as a sufficient, but not necessary, condition for depression, which means that other physiological and psychological factors can produce the symptoms of depression in the absence of an expectation of uncontrollability. Finally, it must be emphasized that the reformulation model is still in the process of being empirically validated.

Behavioral Model. The behavioral model studied by Lewinsohn is derived from a social learning theory framework in which the cause of depression is assumed to reside in the person-behavior-environment interaction. Social learning theory assumes that psychological functioning can best be understood in terms of continuous reciprocal interactions among personal factors, such as cognitive processes, behavioral factors, and environmental factors, all operating as interdependent determinants of one another. The relative influences exerted by these interdependent factors differ in various settings and for different behaviors.

This theory views people as being capable of exercising considerable control over their own behavior. 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 environment, but neither are they absolutely free to do whatever they choose. Rather, people and their environment are reciprocal determinants of one another.

The concept of reinforcement is crucial to this view of depression. Reinforcement is defined in terms of the quality of one's interactions with one's environment. Person-environment interactions with positive outcomes constitute positive reinforcement. Such interactions strengthen the person's behavior. The experience of little or no rewarding interaction with the environment causes the person to feel sad or blue. Thus the key assumption in this model is that a low rate of positive reinforcement is the historical antecedent of depressive behaviors.

Two particular variables are important in this regard. One is that the individual may fail to provide the appropriate responses to initiate positive reinforcement. The other is that the environment may fail to provide the reinforcement and thus worsen the patient's condition. These variables are often apparent, since depressed patients have been shown to be deficient in the social skills needed to interact effectively with others. In turn, other people find the behavior of the depressed person to be distancing, negative, or offensive and avoid him as much as possible.

Depression is likely to occur if certain positively reinforcing events are absent; particularly those which fall into the following categories:

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

These may be described as "being sexually attractive," "being with friends," "being relaxed,"
"doing my job well," and "doing things my own way." It also occurs in the presence of certain punishing events, particularly those which fall into three categories:

Mental discord
Work hassles
Receiving negative reactions from others

This model of depression emphasizes an active, rather than passive, approach to the person and relies heavily on an interactional view of personality. Within this model, social interpersonal behavior, cognitive factors, and self-regulatory mechanisms play important roles, and treatment is aimed at assisting the person to increase the quantity and quality of positively reinforcing interactions with the environment and decrease aversive interactions.

BIOCHEMICAL MODEL. Another major area of research on depression involves a biochemical model, which explores chemical changes in the body that take place during depressed states. Whether these chemical changes cause depression or are a result of the depression is not yet clearly understood. However, significant abnormalities can be demonstrated in the functioning of many body systems during a depressive illness. These include electrolyte disturbances, especially of sodium and potassium; neurophysiological alterations based on findings from electrophysiological studies using electroencephalography and evoked potential methods; 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 serve as central nervous system and peripheral neurotransmitters, including norepinephrine, serotonin, dopamine, and acetylcholine.

The possibility of hormonal causes of depression was generated by the increased prevalence of depression among women as compared to men. Thus interest was stimulated in the relation of depression to female sex hormones. However, despite evidence suggesting that depression may be linked to the menstrual cycle, research has not succeeded in relating depression to any specific hormone, and the situation remains unresolved.

Disturbances in both classes of biogenic amines, the catecholamines (dopamine and noradrenaline) and the indolamines (serotonin and tryptamine), have also been hypothesized to cause affective disorders. The catecholamine hypothesis states that depression is associated with a deficiency of catecholamines, particularly norepinephrine, in the central nervous system, and mania is associated with an excess of catecholamine. A consensus appears to be developing on the possible role of lowered serotonin levels in both depression and mania and elevation of catecholamines in the switch process from depression to mania.

The research in support of this hypothesis has been extensive and of high quality. The discovery of neuropharmacological abnormalities is not surprising, nor does it preclude psychological causes as well. Furthermore, a biochemical model based on one amine is undoubtedly an oversimplification. According to Akiskal and McKinney, "biochemical statements that propose a causal relationship between a chemical event in the brain and a set of observable behaviors or subjective experiences present serious philosophical problems," since neurevology has dismissed the possibility of such a direct one-to-one relationship.

Although the research in this model of depression is conflicting at times, there is sufficient evidence to suggest that a variety of precipitating stressors can induce changes in biogenic amines, and the neuropharmacological mechanisms that have been investigated might form final common pathways for both psychological and biological causes. Some depressions might be due primarily to neuropharmacological dysfunctions, resulting in reduced norepinephrine; others might be due to events whose psychological effect would presumably have parallel neurophysiological phenomena resulting in reduced release of norepinephrine. In other cases both effects might apply, the life event tipping the balance more easily into depression because activity of the norepinephrine-producing system was already reduced.

LIFE STRESSORS. Disturbances of mood are a specific response to stress. Although this statement is undoubtedly true, its simplicity tends to mask the full implications of it. For example, there are two major types of stress that a person may experience. The first is the stress of major life events that are evident to others. The second type of stress may not be obvious at all to others, but it is the minor stress or irritations of daily life. These are the small disappointments, frustrations, criticisms, and arguments that, when accumulated over time, and in the ab-
sence of compensating positive events produce a major and chronic negative impact. McLean notes:

Nondepressed persons also report high rates for these kinds of stressors, but the critical difference is that, on the average, nondepressed persons experience compensating numbers of positive events and outcomes within the same time period that effectively offset the negative impact of the routine stressors. It is the ratio between negative and positive events and outcomes that is decisive for mood determination.45,106

It is appropriate, therefore, to examine in more detail some of the sources of life stressors that may produce disturbances of mood. Four such sources include major life events, roles, coping resources, and physiological changes.

Major life events. Holmes and Rahe29 did the pioneering work in this area with the development of the Social Readjustment Rating Scale described in Chapter 4. Subsequently, others have used this approach for measurement of stress concentrations experienced by people who have become depressed shortly thereafter.

Research conducted by Paykel et al.31 on life events and depression reveals that, on the average, depressed patients reported the occurrence of nearly three times as many important life events during the 6 months before the onset of their clinical depressive episode as did normal subjects. The events included loss of self-esteem, interpersonal discord, socially undesirable occurrences, and major disruptions of life patterns. The authors found that those events perceived as undesirable were most often the precipitants of depression. He further categorized the events into “exit” events, which involved separation and interpersonal losses, and “entrance” events, which involved the introduction of a new person into the social sphere of the subject. Analysis of the data showed that exit events more frequently than entrance events were followed by worsening of psychiatric symptoms, physical health changes, impairment of social role performance, and depressive illnesses in particular. The concept of exit events in his study overlaps with the psychiatric concept of loss.

Most psychiatric clinicians are convinced that a relationship does exist between stressful life events and depression. Some believe that life events play the primary or major role in depression; others are more conservative, limiting the role of life events to that of contributing to the onset and timing of the acute episode. Any definitive conclusions, however, should be made with caution. The fact is that all people experience stressful life events, but not all people become depressed. This suggests that specific events can contribute only partially to the onset or the development of depression. Wender26 noted that, when the incidence of a single event to account for the disease is low, as with affective disorders, the power of a single event to account for the disease is relatively limited. Thus, in an analysis of loss in relation to depression, exits from the social field occurred in 25% of depressives and 5% of controls. Exits preceded depression in only a small, although substantial, number of depressive cases. Furthermore, less than 20% of the population experiencing exits became clinically depressed. This evidence suggests that other factors must also be significant in the development of disturbances of mood.

Roles. The relationship between role strain and depression has gained popularity with the emergence of the women’s movement in American society. Women have higher rates of depression, and various theories have been proposed linking depression with various aspects of women’s lives. For example, Beck11 examined learned helplessness and prejudice as possible explanations for depression in women. Very few research studies, however, have explored the relationship between role strain and depression. The most notable work in this area has been done by Iffeld who developed nine scales to measure current social stressors defined as “those circumstances or conditions of daily social roles which are generally considered to be problematic or undesirable.”32 These scales measure ongoing stressful experiences instead of single “events” that occurred in the past. They include stressors from the social role areas of neighborhood, job, financial affairs, homemaking, parenting, marriage, singlehood, unemployment, and retirement. The survey population was divided into five subgroups to compare the relative potency of different social stressors and the differential effects of any one stressor across each population. He found that current social stressors are significantly related to depressive symptoms for each of the five groups. Table 9-2 presents a summary of the five subgroups and a ranking of the stressors for each group in order of magnitude of stress from the greatest to the least.33 These findings indicate that current marital/singlehood stressors have the highest correlation for all groups except single employed women. Parenting, job, and financial stressors
were intermediate in association. The parenting scale, however, was constructed only for parents who had a child 6 years or older. Therefore they did not assess the role strain associated with parenting children under 6 years of age. Also, homemaking was not assessed for men, only women.

It is possible to analyze each social role stressor in more detail. It becomes obvious in doing so that much of the literature focuses on women. This is a reflection of the predominance of depression among women as compared to men and the increasing interest in women's changing roles in contemporary society. Role strain associated with marriage emerges as a major stressor related to depression for both men and women. Jacob et al. studied role expectation and role performance in distressed and nondistressed couples and found that nondistressed couples reported (1) greater satisfaction, pleasure, and fidelity in sexual relationships with spouses, (2) more shared activities and positive emotional interchanges, and (3) greater wife influence in various areas of family decision making. Gove studied the rates of mental illness among married men and women. He found higher rates of mental illness for married women, whereas single, divorced, and widowed women have lower rates than men. From this, he concludes that being married has a protective effect for males but a detrimental effect for females.

Another explanation for differences in rates of mental illness, particularly depression, between men and women may be the role strain inherent in parenting. LeMasters and Dyer found an "extreme crisis reaction" to the birth of the first child in many young mothers, particularly those with extensive professional training or work experience. Cohen found more pregnancy-related emotional problems in multiparas than in primiparas, commenting that it looked as though these mothers had realized that pregnancy and parenting were sources of conflict and dissatisfaction.

An interesting finding in this regard reported by Ilfeld is the relatively low position of parenting as a social role stressor for employed married men and unemployed married women as compared to its primary ranking along with marriage as a social role stressor for employed married women (Table 9-2). This finding is interesting, especially since it includes only those individuals with children over 6 years of age. It suggests an interaction and possible role strain between parenting and employment for women.

Additional research also shows that married career women have, or need, supportive husbands. The nature of this support, however, is not clearly described in the literature. Much of the literature on two-career families directly documents the additive nature of the mother's role, that is, the assumption of a career role in addition to her domestic role. Ilfeld did not even include homemaking as a social role for men. Division of household labor did emerge as an important aspect of Rosenfield's study. She examined the relationship between depressive symptoms and traditional and nontraditional sex-role relationships in the family in terms of division of labor. In nontraditional relationships, males were found to have higher levels of depressive symptoms than females. She suggests that this gives further support to a sex-role basis.

<table>
<thead>
<tr>
<th>Stressors (in degree of magnitude)</th>
<th>Employed married fathers</th>
<th>Employed married mothers</th>
<th>Unemployed married mothers</th>
<th>Employed single men</th>
<th>Employed single women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Marriage</td>
<td>equal</td>
<td>Marriage</td>
<td>Singlehood</td>
<td>Financial</td>
</tr>
<tr>
<td>Job</td>
<td>Parental</td>
<td>equal</td>
<td>Homemaking</td>
<td>Financial</td>
<td>Singlehood</td>
</tr>
<tr>
<td>Financial</td>
<td>Financial</td>
<td></td>
<td>Parental</td>
<td>Neighborhood</td>
<td></td>
</tr>
<tr>
<td>Parental</td>
<td>Neighborhood</td>
<td></td>
<td>Financial</td>
<td>Job</td>
<td></td>
</tr>
<tr>
<td>Neighborhood</td>
<td>Homemaking</td>
<td></td>
<td>Neighborhood</td>
<td></td>
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</tbody>
</table>

for sex differences in depressive symptoms.

Clearly, the relationship between role strain and depression merits further exploration. Research in this area, however, must take into account the complexity of factors involved in causal or interactive relationships. Stuart has identified these as follows:

1. **Predisposing factors.** Important variables include sex, marital status, income, age, education, type of occupation, social position, level of social integration, past experiences (particularly history of disturbances of mood), and a sense of mastery over one's own fate or locus of control.

2. **Role strain as a precipitating stress.** Measurements should provide for identification of roles; type of role strain experienced (role conflict, ambiguity, discontinuity, or overload); magnitude, intensity, and unpredictability of strain; degree of control over roles; duration of role strain (short term vs. habitual pattern or personality characteristic); and interaction among roles.

3. **Affective significance of role strain.** The meaning or significance of the role strain experienced should be placed within the context of the need-value system of the individual.

4. **Coping-defensive patterns available.** Focus should be placed on the individual's social support systems that might act as buffers, including family members and a community of significant others who express shared values. The marital relationship merits particular emphasis through examining the supportiveness of the spouse, ways in which this support is expressed, power relationships within the marriage, and levels of marital satisfaction and intimacy.

5. **Illness outcome.** In addition to depressive symptoms, one might assess the length and intensity of disability, areas of impaired functioning, and long-term consequences of the depression (i.e., role strain that induces depression might serve to legitimize future role failure).

6. **Adaptive outcome.** Research in this area would assess specific coping strategies used by individuals to handle role strain, including division and delegation of responsibilities, changing expectations, clarifying goals, and use of social resources. Research of this nature would have direct implications for planning and implementing preventive and therapeutic interventions in the future.

**Coping resources.** Life stress may also take the form of inadequate coping resources. Personal resources available to individuals include their socioeconomic status (income, occupation, social position, and education), families (nuclear and extended), interpersonal networks, and the secondary organizations provided by the broader social environment. The far-ranging effects of poverty, discrimination, inadequate housing, and social isolation cannot be ignored or taken lightly. The results of three studies are relevant in this regard.

In the first study, Myers, Lindenthal, and Pepper reported that the level of social integration is associated with the relationship between life events and psychiatric symptoms and changes in that relationship over 2 years. In particular, those who report few life events but significant symptoms are less well integrated than those who report few symptoms but many events. Three particular deficiencies in social networks or support systems serve to increase the individual's vulnerability to stress—social isolation, social marginality, and status inconsistency.

The second study, which takes into consideration these issues, was reported by Brown and Harris. Using data collected from a community survey in London, they examined the relationship between psychosocial stress and subsequent affective disorders among women. They found that working-class married women with young children at home had the highest rates of depression. They were five times more likely to become depressed than middle-class women given equal levels of stress. Four factors were found to be significant in this regard: loss of a mother in childhood, three or more children under age 14 living at home, absence of an intimate and confiding relationship with a husband or boyfriend, and lack of full- or part-time employment outside the home. The first three factors were more frequent among working-class women. Confidants other than a spouse or boyfriend did not have a protective effect. Rather, an important factor in preventing depression in the presence of stress was the amount of emotional support the husband or boyfriend gave the woman and the general levels of satisfaction and intimacy inherent in the relationship. Employment outside the home was seen to provide a protective effect by alleviating boredom, increasing self-esteem, improving financial affairs, and increasing social contacts. This is the type of research needed to answer etiological questions regarding life stress and illness.

A final and most important study was conducted by Warheit on the relationship between...
life-event losses, coping resources, and depressive symptoms. The major findings of the research can be summarized as follows:

1. Persons having high life-event loss scores had higher depression scores than those with low to moderate loss scores.

2. The presence of a spouse was significantly correlated with lower depression scores for all groups. The presence of relatives nearby was not significant. The availability of friends was significantly correlated with lower depression scores for the high-loss group.

3. Low socioeconomic status (SES) was significantly correlated with higher depression scores. It was also found that 64.8% of those in the low SES group were in the high-loss group, compared with 31.1% of those in the high SES group. The data suggest that low SES places persons in double jeopardy; they have fewer resources with which to cope and experience more losses.

4. A series of regression equations showed that losses, absence of resources, and preexisting depressive symptoms were powerful predictors of depression scores. Of these variables, the most powerful predictor was preexisting depressive symptoms, followed by absence of resources (including personal, familial, social, cultural, and socioeconomic status). Life-event loss scores had the lowest predictive value.

The author concludes that these data illustrate the complex nature of the interrelationships between life events, coping resources, and depressive symptoms.

The findings suggest that while life-event losses and the absence of personal and social resources are related to high depression scale scores, other factors are statistically (and probably theoretically) more important sources of explanation of depressive symptomatology. The findings also suggest that for some persons, at least, depressive symptomatology is a trait condition that may predispose them to life events which in turn exacerbate their preexistent levels of psychiatric distress. The data also indicate that life-event losses are mitigated somewhat by the availability of personal, familial, interpersonal, and other resources; this finding has implications for early therapeutic intervention designed to assist those experiencing significant life-event losses.62,607

Physiological changes. Disturbances in mood may also occur as a response to physiological changes produced by drugs or a wide variety of physical illnesses. Drug-induced depressions have been noted to occur following treatment with various antihypertensive drugs and the abuse of addictive substances, such as amphetamines and barbiturates.

Depression may also occur secondary to a wide variety of medical illnesses, for example, viral infections, nutritional deficiencies, endocrine disorders, anemias, and central nervous system disorders, such as multiple sclerosis, tumors, and cerebral vascular disease. The depressions of the elderly are particularly complex because the differential diagnosis often involves organic brain damage and clinical depression. The diagnostic differentiation is complicated by the fact that persons with early signs of senile brain changes, vascular disease, or other neurological diseases associated with age may be more at risk for depression than is the general population. In the United States there has been a tendency to overdiagnose arteriosclerosis and senility in persons over 65, without recognizing that depression may manifest itself by a slowing of psychomotor activity, a reduction of intellectual functioning, a decrease in concentrating ability, and a loss of interest in sex, hobbies, and activities, changes that may be taken as signs of brain damage.66

Mania has also been found to occur secondary to drugs, infections, neoplasms, epilepsy, and metabolic disturbances. The evidence that mania can result from a variety of 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 unitary model of causation, whether the proposed factor of causation be biochemical, psychological, genetic, or structural.

INTEGRATIVE MODEL. There is continuing debate throughout psychiatry over the nature of depression—that is, whether depression is a single illness with different signs and symptoms or whether there are several different diseases. This discussion of the various models or theories of causation of severe mood disturbances also suggests the controversies in psychiatric research and practice. Each of these theories contributes to an understanding of mood disturbances. It is obvious that many of them overlap and interrelate. It is also clear from recent research that there are multiple causes for mood disturbances involving an interactive effect among predisposing and precipitating factors that are biological and psychosocial in ori-
TABLE 9-3. Summary of models of causation of severe mood disturbances

<table>
<thead>
<tr>
<th>Model</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic</td>
<td>Transmission through heredity and family history</td>
</tr>
<tr>
<td>Object loss</td>
<td>Separation from loved one and disruption of attachment bond</td>
</tr>
<tr>
<td>Aggression turned inward</td>
<td>Turning of angry feelings inward against oneself</td>
</tr>
<tr>
<td>Personality organization</td>
<td>Negative self-concept and low self-esteem influence one's belief system and appraisal of stressors</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Hopelessness experienced because of negative cognitive set</td>
</tr>
<tr>
<td>Learned helplessness</td>
<td>Belief that one's responses are ineffectual, and reinforcers in the environment cannot be controlled</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Loss of positive reinforcement in life</td>
</tr>
<tr>
<td>Biochemical</td>
<td>Impaired monoaminergic neurotransmission</td>
</tr>
<tr>
<td>Life stressors</td>
<td>Response to life stress from four possible sources: major life events, roles, coping resources, and physiological changes</td>
</tr>
<tr>
<td>Integrated</td>
<td>Interaction of chemical, experiential, and behavioral variables acting on the diencephalon</td>
</tr>
</tbody>
</table>

gin. Thus a unitary theory is not possible, but perhaps a unified theory is. Table 9-3 summarizes these major theories on causation.

Akiskal and McKinney have presented a unified model of depression that attempts to integrate the various conceptual models which now exist. They view depression as the feedback interaction of three sets of variables at the chemical, experiential, and behavioral levels, with the diencephalon serving as the field of action. They propose that impairment in one of the variables affects the other two. Thus any one of the three variables can contribute to a depression and produce changes in the other two areas. For example, a chemical imbalance can result in distorted perceptions, or a major life change can cause a chemical imbalance. In their model, depressive illness is the culmination of various processes that converge in those areas of the diencephalon which modulate arousal, mood, motivation, and psychomotor functions. The specific form the illness will take depends on the interaction of the following factors:

1. Genetic vulnerability—important particularly in recurrent and manic-depressive illnesses.

2. Developmental events—early object loss that may sensitize the individual to future stress, create negative cognitive sets, and originate experiences resulting in learned helplessness.

3. Physiological stressors—stimuli such as viral infections and childbirth that induce physiochemical changes.

4. Psychosocial stressors—stressful life events that overwhelm the coping mechanisms of the individual.

This integrative multicausal model presents a useful frame of reference for the nurse because it is holistic in nature and encourages the assessment of behavior in developing appropriate nursing interventions. It also presents a variety of causative factors and stresses the interrelationship of them in explaining present behavior. Obviously predisposing factors are important, and the way in which they interact with the precipitating event is crucial in determining whether a severe mood disturbance will result. Such an integrated model is most valuable for the nurse to utilize when completing a patient assessment and implementing nursing care.

Data collection

Behaviors associated with uncomplicated grief reactions

The successful resolution of uncomplicated grief reactions follows, to some degree, a sequence of phases or steps by which the nurse can determine if healing is occurring. Knowledge of behaviors associated with the normal process of mourning allows the nurse to provide supportive interventions, as well as identify maladaptive responses, if they should occur. Various theorists have identified stages of grief and mourning, including Bowlby, Kübler-Ross, and Engel, and there are many similarities among these stages.

A cross-cultural study of grief and mourning in 78 cultures indicated that the mourning pro-
cess and the accompanying state of grief represent a universal human response. The specific form of emotional expression varies from culture to culture, but an emotionless reaction to the loss of a loved person is rare. Bowlby's phases present a comprehensive review of the process of mourning and they can be applied to losses of any type. These phases of mourning are (1) the urge to recover the lost object, (2) disorganization, and (3) reorganization. Each phase will be briefly described with the emotional component of mourning that accompanies it.

Phase 1 is characterized by disequilibrium. Initially the survivor experiences feelings of shock and disbelief. This reaction is followed by a numbed sensation in which the survivor does not acknowledge the reality of the death and hopes to recover his loss. Two of the major affective components of this phase are weeping and anger. Tears are evoked by loss, and crying fulfills an important function in the work of mourning. Crying involves both an acknowledgment of the loss and a regression to a more childlike state. Tears among the survivors are generally accepted, and they elicit certain kinds of support and help from the group, although this varies greatly from culture to culture.

Anger is the other major component of this stage. It may erupt toward nurses or other health care personnel whom the survivor associates with the death. The mourner may also turn this anger on himself, particularly if he feels the death was his responsibility in any way. Guilt is a related emotion as the survivor berates himself for failing to do right by the lost one. The greater the survivor's ambivalence toward the deceased, the greater will be his sense of guilt.

Phase 2 is characterized by disorganization. When the survivor realizes the loss is permanent, despair sets in and his behavior becomes increasingly disorganized and restless. He experiences a loss of self-esteem, and profound feelings of loneliness, fear, and helplessness overwhelm him. This phase is a painful and alarming one for the individual, and he might use the mechanism of denial to protect himself. Symptoms of somatic stress might appear. Lindemann identified the most common ones: (1) the tendency to sighing respirations, (2) the complaint of lack of strength and exhaustion, and (3) the occurrence of digestive difficulties, such as loss of appetite and feeling of emptiness in the stomach. There may be the reactiva-
that 2.9% of 3245 admissions to psychiatric hospitals took place within 6 months of the death of a close relative. The frequency of admission after the death of a spouse was six times greater than would be expected by chance alone. Although the bereaved patients proved to have a variety of psychiatric illnesses, the most common diagnosis was depression. Although the evidence relating object loss to somatic symptom formation does not prove a cause-and-effect relationship, it strongly suggests that grief related to object loss may contribute to a number of diverse somatic reactions.

Behaviors associated with delayed grief reactions

The designation of grief as pathological indicates that something has prevented it from running its normal course. The defenses that were used successfully in the uncomplicated grief reaction become exaggerated or maladaptive in the pathological reaction. The result may be a delayed grief reaction or a distorted reaction, such as depression or mania. Delayed grief reactions may be indicated by excessive hostility and grief, prolonged feelings of emptiness and numbness, an inability to weep or express emotions, low self-esteem, use of the present tense instead of the past when speaking of the loss, persistent dreams about the loss, retention of the clothing of the deceased, an inability to visit the grave of the deceased, and the projection of living memories into an object that is held in place of the lost one. Clinical example 9-1 illustrates some of the behaviors associated with a delayed grief reaction.

CLINICAL EXAMPLE 9-1

Mrs. G was a 38-year-old married woman who had no history of previous 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. At present she was living alone with her husband.

Her family history revealed that she had three children—two boys and a girl. Her oldest son, age 20, was attending college out of state, and her daughter, 19 years of age, was living with a girl friend in an apartment in the same city. Her youngest son was killed in an automobile accident 2 years ago when he was 15 years old. She described him as her "baby" and expressed much guilt for contributing to her son's death. She scolded herself for allowing him to drive to the shore 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, Mrs. 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.

In this example Mrs. G was experiencing a delayed grief reaction that was precipitated by the emotionally invested event of her deceased son's would-be graduation. She had failed to progress through the process of mourning at the time of her son's death and was beginning to engage in the "grief work" at the present time. The behaviors she displayed were consistent with the state of depression she was experiencing.

Because feelings of sadness, disappointment, and frustration are normal accompaniments of human life, the boundary between normal and abnormal mood is often difficult to define. Basically, behaviors associated with severe mood disturbances or affective disorders reflect an increase in the intensity or the duration of otherwise normal emotions. They may range from behaviors associated with moderate anxiety (and indicative of neurotic health problems) to those associated with panic levels of anxiety (and indicative of psychotic health problems). In severe forms, disturbances of mood can be recognized as being maladaptive because of their intensity, pervasiveness, persistence, and interference with effective daily functioning. This may be reflected in impaired body functioning; the inability to perform expected social roles, such as at work, in the family, or at school; suicidal thoughts; and interference with reality testing, such as delusions, hallucinations, or confusion.

Behaviors associated with depression

The behaviors associated with depression are varied. Sadness and slowness may predominate, or there may be states of agitation. The key element to a behavioral assessment is change—the individual changes his usual behavioral patterns and responses. Research indicates that the individual working through the normal mourning process responds to his loss with a set of psychological symptoms that are often indistin-
guishable from depression but are accepted by him and by his environment as normal. In contrast, patients with depression experience their condition as a “change” unlike their usual self, which often leads them to seek help.20

A number of behaviors are associated with states of depression. These may be divided into affective, physiological, cognitive, and behavioral manifestations (Table 9-4). Obviously, some of these behaviors are contradictory and incompatible. The lists are intended to describe the spectrum of possible behaviors, acknowledging that not all individuals experience all of them.

The most common and central behavior is that of the depressive mood. This is not necessarily described by the patient as “depression” but as feeling sad, blue, down in the dumps, unhappy, or unable to enjoy life. Crying commonly occurs. On the other hand, some depressed persons 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 perverseness. 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 of change whereby certain times of the day, such as morning or evening, are consistently worse or better.

In the literature there is a lack of agreement on which behaviors typically reflect depression and which are most significant for assessment, treatment, and prognosis. Neither are the identified behaviors exclusive to depression; they may also appear in other kinds of health problems. Levitt and Lubin21 reviewed the literature and listed the symptoms of depression cited in at least 2 of 13 selected sources published between 1961 and 1969. They also reviewed the symptoms of depression appearing in at least 2 of 16 depression measurement instruments. Of the 24 self-rating measures of depression, the following four are most commonly used: the Minnesota Multiphasic Personality Inventory (MMPI) depression scale, the Beck Depression Inventory, the Zung Self-Rating Depression Scale, and the Depression Adjective Checklist. Beck22 provided further data by reviewing the proportions of depressed patients manifesting various symptoms. Table 9-5 selectively summarizes the findings of Levitt and Lubin and Beck. Using patient reporting as the criterion reference (Beck’s data on severely depressed patients), the cardinal symptoms of a depressive syndrome, as defined by their presence in at least 75% of cases, include feelings of inadequacy and helplessness, loss of motivation, psychomotor retardation, indecisiveness, crying spells, loss of interest and enjoyment, fatigability, sleep disturbance, pessimism, dejected mood, and self-devaluation.
TABLE 9.5. Symptoms of depression and their prevalence

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Sources using symptom(^a) (%)</th>
<th>Measurement instruments monitoring symptom(^b) (%)</th>
<th>Severely depressed patients showing symptom(^c) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-devaluation</td>
<td>54</td>
<td>100</td>
<td>81</td>
</tr>
<tr>
<td>Dejected mood</td>
<td>92</td>
<td>87</td>
<td>88</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>100</td>
<td>81</td>
<td>74</td>
</tr>
<tr>
<td>Pessimism, feelings of hopelessness</td>
<td>77</td>
<td>81</td>
<td>87</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>77</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>77</td>
<td>75</td>
<td>87</td>
</tr>
<tr>
<td>Loss of libido</td>
<td>84</td>
<td>44</td>
<td>61</td>
</tr>
<tr>
<td>Fatigability</td>
<td>46</td>
<td>81</td>
<td>75</td>
</tr>
<tr>
<td>Loss of interest, enjoyment</td>
<td>46</td>
<td>62</td>
<td>92</td>
</tr>
<tr>
<td>Guilt feelings</td>
<td>70</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>38</td>
<td>69</td>
<td>64</td>
</tr>
<tr>
<td>Crying spells</td>
<td>38</td>
<td>44</td>
<td>83</td>
</tr>
<tr>
<td>Indecisiveness</td>
<td>30</td>
<td>50</td>
<td>76</td>
</tr>
<tr>
<td>Constipation</td>
<td>30</td>
<td>44</td>
<td>52</td>
</tr>
<tr>
<td>Psychomotor retardation</td>
<td>30</td>
<td>81</td>
<td>87</td>
</tr>
<tr>
<td>Loss of motivation</td>
<td>46</td>
<td>62</td>
<td>86</td>
</tr>
<tr>
<td>Diurnal mood variation</td>
<td>40</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td>Feelings of inadequacy, helplessness</td>
<td>30</td>
<td>20</td>
<td>90</td>
</tr>
</tbody>
</table>

Finally, the potential for suicide should always be assessed in severe mood disturbances. Suicide and other self-destructive behaviors are discussed in detail in Chapter 10. The intensity of the feelings of anger, guilt, and worthlessness may precipitate suicidal thoughts, feelings, or gestures, as illustrated in Clinical example 9-2.

CLINICAL EXAMPLE 9-2

Mr. W was a 60-year-old man who lived alone. His son and daughter were married and lived in the same state. His wife died 2 years ago, and since that time his children had often asked him to move in with either of them. He had consistently refused to do this, believing that both he and his children needed privacy in their lives. Six months ago he was diagnosed as having advanced prostatic cancer with metastasis. After the diagnosis was made and because of increasing disability, he left his job and began to receive disability compensation. He visited his children and their families on the average of twice a month and kept his regularly scheduled visits with the medical clinic. The nurses and physicians at the clinic noted he was “depressed and withdrawn” but viewed this 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 grounds keeper 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.

This example dramatically emphasizes three important points. First, the experience of a medical illness frequently involves a loss of some type for the individual—loss of function, body part, or
appearance. Therefore all patients should be assessed for the presence of depression. Second, all people experiencing states of depression and despair have the potential for suicide. Third, nurses can intervene in a variety of ways to support the grieving and mourning process whether it is of an uncomplicated or pathological nature. Nursing actions can be preventive, curative, or rehabilitative, based on the nursing assessment and diagnosis.

Behaviors associated with mania

Mania and hypomania occur more rarely than depressive states. Some believe that mania is a mirror image of depression and that even though the behaviors are dissimilar, the dynamics are related. According to this view manic behavior is a defense against depression as the individual attempts to deny his feelings of worthlessness and helplessness. His elation and hyperactivity are an appeal for love and a protection from depression.

The essential feature of mania is a distinct period of intense psychophysiological activation. Some of the behaviors associated with it are given in Table 9-6. In this state the predominant mood is either elevated or irritable accompanied by one or more of the following symptoms: hyperactivity, the undertaking of too many activities, lack of judgment of the consequences of actions, pressure of speech, flight of ideas, distractibility, inflated self-esteem, and hyposexuality.

If the mood is elevated or euphoric, it is often infectious in nature. Patients report feeling happy, unconcerned, carefree, and devoid of problems. Although such experiences would seem enviable, these affects are exhibited without any concern for reality or the feelings of others. Mood is often expansive, and some patients have extraordinary delusional notions about their power and importance. They characteristically involve themselves in various seemingly senseless and risky enterprises.

Alternately, the mood may be irritable, especially when the patient’s plans are thwarted. In such a case they can be contentious and readily provoked by seemingly harmless remarks. Self-esteem is inflated during a manic episode, and, as the activity level increases, the feelings about the self become increasingly disturbed. Delusional grandiose symptoms are in evidence, 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 there is a denial of realistic danger. The patient’s boundless energy, cunning, planning, schem-

<table>
<thead>
<tr>
<th>TABLE 9-6. Behaviors associated with mania</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affective</strong></td>
</tr>
<tr>
<td>Elation or euphoria</td>
</tr>
<tr>
<td>Expansive</td>
</tr>
<tr>
<td>Humorous</td>
</tr>
<tr>
<td>Inflated self-esteem</td>
</tr>
<tr>
<td>Intolerable of criticism</td>
</tr>
<tr>
<td>Lack of shame or guilt</td>
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</tbody>
</table>
ing, and inability to forecast resulting consequences frequently lead to irresponsible enterprises and excessive spending, as well as to misdeeds of a sexual, aggressive, or possessive nature. In contrast to the depressed state, patients in the manic state have heightened libidinal drives, with abounding energy and a heightened sexual appetite. Characteristic physical changes can be related to the basic affect: inadequate nutrition, partly because manic patients have no time to eat, and serious loss of weight in conjunction with their insomnia and overactivity. In severe cases, there may be dehydration, which requires prompt attention.

In addition to mood disturbance, speech is often disturbed. As the mania gets more intense, formal and logical speech is displaced, and speech becomes loud, rapid, and difficult to interpret. As the activated state increases, speech becomes full of plays on words and irrelevancies that can increase to loosened associations and flight of ideas. Some of these behaviors are evident in Clinical example 9-3.

**Clinical Example 9-3**

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 ago 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 ten cylinders instead of four.” 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 “mod” wardrobe. His friend brought him in because his behavior was becoming more erotic and his physical condition was failing.

The nurse who admitted Mr. B asked about his social relationships. He revealed that his girlfriend of 7 years had left him 6 months ago for another man. He said that initially she 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 out there just waiting for him.”

Associated behaviors found in mania include lability of mood with rapid shifts to brief depression. Such behavior accounts for those patients who have loosened associations and alternately laugh and cry. In addition, hallucinations of any type, ideas of reference, and frank delusions may be present with predominant feel-

ings of guilt and thoughts of suicide. Manic episodes have a high tendency toward recurrence, only about 25% of manic patients have only one episode, and almost all individuals with manic episodes also have depressive episodes. However, there is variation in the duration and severity of the manic episode and in the intervals between relapses and recurrences.

All of these clinical examples illustrate the interrelatedness of disturbances of mood with the problem of self-esteem and disrupted interpersonal relationships. Because of the intensity of the reaction, multiple aspects of the individual's life are affected. This may also include his physical health, as reflected in the lists of physiological behaviors. Another effect on physical functioning is the possible onset of psychosomatic illness. Hypertensive crises, irritable bowel syndromes, coronary occlusions, rheumatoid arthritis, migraine headaches, and various dermatological conditions can occur in conjunction with severe mood disturbances.

**Nursing Diagnosis**

The diagnosis of disturbances of mood depends on an understanding of many interrelated concepts, including anxiety, self-concept, and hostility. One task of the nurse in formulating a diagnosis is to decide if the patient is experiencing primarily a state of anxiety or depression. It is often difficult to distinguish between them because they may coexist in one patient and present similar behaviors. Crany and Crany suggest some comparative observations that may be helpful to the nurse. They note that the depressed patient is often slowed down in speech and movements, whereas the anxious patient often responds normally or more actively. The depressed patient is reluctant to discuss his problems or symptoms, while the anxious patient is more likely to discuss his symptoms and related topics. The depressed patient has decreased his outside interests, whereas the anxious patient usually retains interest in some things. The depressed patient has difficulty enjoying things, but the anxious patient can enjoy some activities. The depressed patient usually feels worse in the morning or after sleep, whereas the anxious patient usually feels worse in the evening and better after sleep or rest; and the depressed patient usually has a decreased appe-
FIG. 9-2
Model of health-illness phenomena with continuum of emotional responses.
tite and enjoyment of food, while the anxious patient usually eats intermittently and generally enjoys at least some foods.

An appropriate nursing diagnosis should include the patient’s maladaptive coping response and related stressor. Fig. 9-2 presents the model of health-illness phenomena with the continuum of emotional responses. The maladaptive responses are a result of feelings of anxiety, hostility, self-devaluation, and guilt. This model suggests that nursing care will be centered around increasing self-esteem and encouraging the appropriate expression of emotions.

The model also identifies some medical diagnoses that are appropriate to disturbances of mood or affective disorders. The psychiatric classification of affective disorders has reflected, to a large extent, the controversies surrounding the nature, cause, and treatment of these disorders. Although these traditional labels are no longer used in the revised DSM-III, nurses should be familiar with them because they may continue to have some research and clinical value.

One traditional distinction has been to separate patients into psychotic vs. neurotic affective states. Unfortunately these terms have acquired multiple meanings and have lost their precision in defining clinical or research practice. Another traditional distinction has been between endogenous vs. reactive, or exogenous, types of depression. Endogenous depressions were believed to have resulted from early personality development and intrinsic biological processes, whereas exogenous, or reactive, types were believed to have occurred in response to external environmental stress, such as recent loss or disappointment. Research, however, has failed to verify the existence of these traditional distinctions. Thus the psychotic-neurotic distinction and the endogenous-reactive dichotomy are better regarded as continuums along which patients may be placed. Most patients are intermediate on the continuum and few are at the extremes. Neither classification is used in DSM-III.

Another classification system developed by Robins and Guze avoids the controversial endogenous-reactive and psychotic-neurotic dichotomies. They propose a distinction between primary and secondary affective disorders based on two criteria, chronology and the presence of associated illnesses. “Primary” affective disorders are the disorders in patients who have been well or whose only previous episodes of psychi-

atriic disease were mania or depression. “Secondary” affective disorders include feelings of sadness, inadequacy, and hopelessness that occur with another preexisting psychiatric disorder, such as anxiety reactions. It also includes symptoms secondary to medical illnesses.

A final distinction is the bipolar-unipolar one. It proposes the separation of depressed patients with a history of manic episodes (the bipolar group) from those patients who have had only recurrent episodes of depression (the unipolar group). Among the newer approaches, the bipolar-unipolar distinction has achieved considerable rapid acceptance. DSM-III accepts the evidence pointing to the importance of the distinction between unipolar and bipolar forms of affective disorder.

DSM-III distinguishes three categories of “primary” affective disorders or disturbances of mood not due to any other physical or mental disorder:

1. Major affective disorders
2. Other specific affective disorders
3. Atypical affective disorders

Major affective disorders include the subcategories of bipolar disorder and major depression. These are distinguished by whether or not there has ever been a manic episode. When there has been one or more manic episodes, with or without a history of depression, the category of bipolar disorder is used. Bipolar disorder is subclassified as mixed, manic, or depressed. Major depression is subclassified as single episode or recurrent and with or without psychotic features and the presence of melancholia.

Other specific affective disorders include cyclothymic disorder and dysthymic disorder. In cyclothymic disorder there are symptoms characteristic of both the manic and depressive states but not of sufficient severity and duration to meet the criteria for a major affective disorder. In dysthymic disorder the symptoms are not of sufficient severity and duration to meet the criteria for a major affective disorder, and there have been no manic periods. Atypical affective disorders are a residual category for individuals who do not meet the criteria for the other two major categories.

Based on this discussion of dynamics, criteria, and diagnostic categorization, it is now possible to present some nursing diagnoses related to disturbances in mood. In Table 9-7, selected nursing diagnoses are related to appropriate medical
### TABLE 9-7. Comparative examples of nursing diagnoses and medical diagnoses associated with disturbances in mood

<table>
<thead>
<tr>
<th>Nursing diagnoses</th>
<th>Medical diagnoses (as described in DSM-III)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple bereavement related to death</td>
<td>No mental disorder—UNCOMPPLICATED BEREAVEMENT</td>
</tr>
<tr>
<td>of mother</td>
<td></td>
</tr>
<tr>
<td>Depression related to hyperthyroidism</td>
<td>Diagnostic criteria for ORGANIC AFFECTIVE SYNDROME</td>
</tr>
<tr>
<td></td>
<td>A. The predominant disturbance is a disturbance in mood, with at least two of the associated symptoms listed in criterion B for manic or major depressive episode</td>
</tr>
<tr>
<td></td>
<td>B. No clouding of consciousness, as in delirium; no significant loss of intellectual abilities, as in dementia; no predominant delusions or hallucinations, as in organic delusional syndrome or organic hallucinosis</td>
</tr>
<tr>
<td></td>
<td>C. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance</td>
</tr>
<tr>
<td>Manic state related to discovery of spouse’s extramarital affair</td>
<td>Diagnostic criteria for BIPOLAR DISORDER, MANIC</td>
</tr>
<tr>
<td></td>
<td>Currently (or most recently) in a manic episode (if there has been a previous manic episode, the current episode need not meet the full criteria for a manic episode)</td>
</tr>
<tr>
<td></td>
<td>Diagnostic criteria for a MANIC EPISODE</td>
</tr>
<tr>
<td></td>
<td>A. One or more distinct periods with a predominantly elevated, expansive, or irritable mood; the elevated or irritable mood must be a prominent part of the illness and relatively persistent, although it may alternate or intermingle with depressive mood</td>
</tr>
<tr>
<td></td>
<td>B. Duration of at least 1 week (or any duration if hospitalization is necessary), during which, for most of the time, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:</td>
</tr>
<tr>
<td></td>
<td>1. Increase in activity (either socially, at work, or sexually) or physical restlessness</td>
</tr>
<tr>
<td></td>
<td>2. More talkative than usual or pressure to keep talking</td>
</tr>
<tr>
<td></td>
<td>3. Flight of ideas or subjective experience that thoughts are racing</td>
</tr>
<tr>
<td></td>
<td>4. Inflated self-esteem (grandiosity, which may be delusional)</td>
</tr>
<tr>
<td></td>
<td>5. Decreased need for sleep</td>
</tr>
<tr>
<td></td>
<td>6. Distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli</td>
</tr>
<tr>
<td></td>
<td>7. Excessive involvement in activities that have a high potential for painful consequences which is not recognized, e.g., buying sprees, sexual indiscretions, foolish business investments, reckless driving</td>
</tr>
<tr>
<td></td>
<td>C. Neither of the following dominate the clinical picture when an affective syndrome (i.e., criteria A and B above) is not present, that is, before it developed or after it has remitted:</td>
</tr>
<tr>
<td></td>
<td>1. Preoccupation with a mood-incongruent delusion or hallucination (see definition below)</td>
</tr>
<tr>
<td></td>
<td>2. Bizarre behavior</td>
</tr>
<tr>
<td></td>
<td>D. Not superimposed on either schizophrenia, schizophreniform disorder, or a paranoid disorder</td>
</tr>
<tr>
<td></td>
<td>E. Not due to any organic mental disorder, such as substance intoxication</td>
</tr>
</tbody>
</table>

TABLE 9-7. Comparative examples of nursing diagnoses and medical diagnoses associated with disturbances in mood—cont’d

<table>
<thead>
<tr>
<th>Nursing diagnoses</th>
<th>Medical diagnoses (as described in DSM-III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum depression related to new</td>
<td>Diagnostic criteria for ADJUSTMENT DISORDER</td>
</tr>
<tr>
<td>rule as parent</td>
<td>A. A maladaptive reaction to an identifiable psychosocial stressor, that occurs within 3 months of the onset of the stressor</td>
</tr>
<tr>
<td></td>
<td>B. The maladaptive nature of the reaction is indicated by either of the following:</td>
</tr>
<tr>
<td></td>
<td>1. Impairment in social or occupational functioning</td>
</tr>
<tr>
<td></td>
<td>2. Symptoms that are in excess of a normal and expectable reaction to the stressor</td>
</tr>
<tr>
<td></td>
<td>C. The disturbance is not merely one instance of a pattern of overreaction to stress or an exacerbation of one of the mental disorders previously described</td>
</tr>
<tr>
<td></td>
<td>D. It is assumed that the disturbance will eventually remit after the stressor ceases or, if the stressor persists, when a new level of adaptation is achieved</td>
</tr>
<tr>
<td></td>
<td>E. The disturbance does not meet the criteria for any of the specific disorders listed previously or for uncomplicated bereavement</td>
</tr>
<tr>
<td>Attempted suicide related to loss of</td>
<td>Diagnostic criteria for MAJOR DEPRESSIVE EPISODE</td>
</tr>
<tr>
<td>child in utero</td>
<td>A. One or more major depressive episodes</td>
</tr>
<tr>
<td></td>
<td>B. Has never had a manic episode or hypomanic episode</td>
</tr>
<tr>
<td></td>
<td>Diagnostic criteria for MAJOR DEPRESSIVE EPISODE</td>
</tr>
<tr>
<td></td>
<td>A. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes; the dysphoric mood is characterized by symptoms such as the following: depressed, sad, blue, hopeless, low, down in the dumps, irritable; the mood disturbance must be prominent and relatively persistent, but not necessarily the most dominant symptom, and does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as are seen in states of acute psychotic turmoil; (for children under 6, dysphoric mood may have to be inferred from a persistently sad facial expression)</td>
</tr>
<tr>
<td></td>
<td>B. At least four of the following symptoms have each been present nearly every day for a period of at least 2 weeks (in children under 6, at least three of the first four)</td>
</tr>
<tr>
<td></td>
<td>1. Poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain (in children under 6, consider failure to make expected weight gains)</td>
</tr>
<tr>
<td></td>
<td>2. Insomnia or hypersomnia</td>
</tr>
<tr>
<td></td>
<td>3. Psychomotor agitation or retardation (but not merely subjective feelings of restlessness or being slowed down) (in children under 6, hypoactivity)</td>
</tr>
<tr>
<td></td>
<td>4. Loss of interest or pleasure in usual activities, or decrease in sexual drive not limited to a period when delusional or hallucinating (in children under 6, signs of apathy)</td>
</tr>
<tr>
<td></td>
<td>5. Loss of energy; fatigue</td>
</tr>
<tr>
<td></td>
<td>6. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt (either may be delusional)</td>
</tr>
<tr>
<td></td>
<td>7. Complaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness not associated with marked loosening of associations or incoherence</td>
</tr>
<tr>
<td></td>
<td>8. Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt</td>
</tr>
</tbody>
</table>

Continued.
Part one  ■  Principles of psychiatric nursing

TABLE 9-7. Comparative examples of nursing diagnoses and medical diagnoses associated with disturbances in mood—cont’d

<table>
<thead>
<tr>
<th>Nursing diagnoses</th>
<th>Medical diagnoses (as described in DSM-III)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted suicide related to loss of child in utero—cont’d</td>
<td>C. Neither of the following dominate the clinical picture when an affective syndrome (i.e., criteria A and B above) is not present, that is, before it developed or after it has remitted:</td>
</tr>
<tr>
<td></td>
<td>1. Preoccupation with a mood-incongruent delusion or hallucination (see definition below)</td>
</tr>
<tr>
<td></td>
<td>2. Bizarre behavior</td>
</tr>
<tr>
<td></td>
<td>D. Not superimposed on either schizophrenia, schizophreniform disorder, or a paranoid disorder</td>
</tr>
<tr>
<td></td>
<td>E. Not due to any organic mental disorder or uncomplicated bereavement</td>
</tr>
<tr>
<td>Depression related to son’s departure from home to college</td>
<td>No mental disorder—PHASE OF LIFE PROBLEM</td>
</tr>
<tr>
<td>Development of ulcerative colitis related to suppression of grief</td>
<td>Diagnostic criteria for PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION</td>
</tr>
<tr>
<td></td>
<td>A. Psychologically meaningful environmental stimuli are temporally related to the initiation or exacerbation of a physical condition (recorded on axis III)</td>
</tr>
<tr>
<td></td>
<td>B. The physical condition has either demonstrable organic pathology (e.g., rheumatoid arthritis) or a known pathophysiological process (e.g., migraine headache, vomiting)</td>
</tr>
<tr>
<td></td>
<td>C. The condition is not due to a somatoform disorder</td>
</tr>
<tr>
<td>Process of normal mourning related to mastectomy</td>
<td>No related psychiatric diagnosis</td>
</tr>
</tbody>
</table>

diagnoses from DSM-III. Although these are not intended to be all inclusive, they do reflect the complementary, yet distinctive, nature of the nursing and medical diagnosis.

Planning and implementation of nursing interventions

Goal setting

The general goal of the nurse working with a patient who is experiencing an uncomplicated grief reaction is to support the patient in the subjective experience of his grief work or to help the person mourn. This means helping the person know what has been lost, that his pain is worthy of his own respect, and that real hope lies in acknowledging rather than denying his loss. He needs to extricate himself from his bondage to the lost object and find new patterns of rewarding interaction. In this way he copes with the loss, integrates it into his past, and grows from the experience. The content of the mutual long-term goals will therefore refer to the patient’s completing the process of grieving, mourning, or bereavement. This may take 6 months to a year or possibly longer, since the duration of the grieving process varies considerably among different cultural groups. Short-term goals are necessary to identify specific realistic steps the patient can take as he works through the mourning process. They should reflect progression through Bowlby’s phases: (1) the urge to recover the lost object, (2) disorganization, and (3) reorganization. Possible short-term goals may include the following:
The patient will:

1. Express feelings of sorrow caused by the loss of her husband within 10 days.
2. Describe her ambivalence (love and anger) toward her husband by the end of 1 month.
3. Review her relationship with her husband, including shared pleasures, regrets, etc.

When the patient is experiencing a maladaptive disturbance of mood, the long-term goals may be directed toward reinitiating a delayed grief reaction or exploring areas of conflict underlying a depressive or manic state. When nursing intervention is planned, psychotherapeutic, sociotherapeutic, and somatotherapeutic factors should be considered collectively and conjointly.

The long-term goals of nursing care for the patient with a severe mood disturbance have the following aims:

1. To allow for the recognition and continuous expression of feelings, including denial, hopelessness, anger, guilt, blame, helplessness, regret, hope, and relief within a supportive therapeutic atmosphere.
2. To allow for the gradual analysis of the stressors the individual is experiencing while strengthening his self-esteem.
3. To increase the patient’s sense of identity, control, awareness of choices, and responsibility for behavior.
4. To encourage the establishment of healthy interpersonal ties with others.
5. To promote the understanding of the nature of one’s maladaptive emotional responses and acquire more adaptive coping responses to life stressors.

Specific short-term goals should be generated from the behaviors displayed by the patient, present areas of difficulty, and relevant stressors. Goal setting should involve a holistic view of the patient and his world. It is probable that goals will need to be developed regarding the patient’s self-concept, physical status, behavioral performance, expression of emotions, and interpersonal relationships. All these areas can directly relate to the disturbance of mood displayed by the patient. The participation of the patient in setting these goals can be a significant first step in regaining mastery over his own life.

Intervening in uncomplicated grief reactions

The overall goal of the nurse is to assist the patient who has experienced a loss to work through the process of grieving or mourning and to prevent maladaptive emotional responses. The grieving process is resolved when the lost object is internalized, bonds of attachment are loosened, and new object relationships are established. Grief reactions most commonly occur as a response to separation. They may also occur, however, following the loss of something tangible or intangible that is highly regarded. Thus loss of a body part or function, job, opportunity, relationship, family possessions through an accident, or status and regard among one’s peers can all precipitate grief reactions.

Nurses frequently care for patients who have experienced losses related to the body and its parts and functions. Such losses include body parts (amputation and mastectomy), internal organs, sensory loss (vision and hearing), sexual function (impotence and menopause), and aging (mental functioning and physical strength). More than 40,000 limb amputations are performed annually in the United States. Breast amputation is a major approach to the treatment of mammary cancer, a disease that accounts for 25% of all malignancies in women. Such partial loss of the body is an increasingly common experience, and it often results, at least temporarily, in a disturbance in body image (Chapter 8). The precise nature of the patient’s reaction to a loss of body part and is unconsciously comparable to the loss of a significant person. Consequently, a process of mourning is initiated and grief is the normal emotional response.

In a larger sense, loss and separation are the recurrent themes of human life, and all change can be regarded as loss—the loss of the past in the movement to something new. This new area can be anticipated or feared, valued or dreaded. It can also be a normal developmental change, such as entering school or getting married. Even if society regards the event as a positive one, the significance of it for the individual may be quite different. Thus both the nature of the change or loss, as well as the significance of it, needs to be appropriately assessed by the nurse. The principles underlying therapeutic nursing interventions in complicated grief reactions are the same, however, regardless of the exact nature of the loss.

Interventions in this area can be initiated through anticipatory guidance even before the loss occurs. This involves talking about the impending loss with the individual and his family,
if appropriate. Past losses may be reviewed and analyzed to clarify the meaning of the present loss. Since losses are present in all aspects of life and in all settings, any nurse may implement these interventions. For example, the industrial nurse may discuss the impending retirement of an employee; an office nurse may discuss the implications of a scheduled hysterectomy for a young woman; or a public health nurse may focus on a mother’s feelings about her youngest child starting school. Many opportunities for interventions in this area are overlooked by nurses and yet their preventive potential is immeasurable.

Engel identifies a number of preventive actions the nurse can implement in working with a dying patient and his family. He suggests that news of death or impending death should be communicated to a family group, rather than an individual alone, in a private setting. The nurse should be prepared for the possibility of staying with and comforting the bereaved at least until a friend or clergyman arrives. The survivor’s need to see the dying or dead patient should be met whenever possible because this is helpful in facing the reality of death.

When the nurse is confronted with an angry hostile reaction from the survivor, two considerations should be kept in mind. First, the person could be justified, but, if not, he may be trying to deal with his own anger and guilt toward the dying person. In this case the reaction is not directed toward the nurse as a person, but it serves as an important coping mechanism in the initial stage of mourning. Another defense that may be displayed by the survivor after hearing the news is disbelief and distraught behavior. The nurse should find a place for the survivors to cry and express their feelings, since this is an important need of the bereaved. The nurse should also be considerate of the cultural, religious, and social customs of the mourners, regardless of how different they may be from her own. Finally, Engel stresses the importance of the need for the patient to grieve for himself. This point is emphasized by Kübler-Ross in her work with dying patients.

The principal task of the nurse is to support the process of normal mourning, and her effectiveness will be increased if she is able to identify those individuals who are likely to experience difficulty in this task. The factors used in the nursing assessment will be helpful in this regard. Childhood experiences and later losses provide information about early separations that predispose the individual to renewed conflicts and unresolved feelings which may surface in the present loss or disruption. Previous history of psychiatric illness alerts the nurse to recurrent depressive episodes or decreased coping abilities. Information about life crises prior to the bereavement reveals the amount of stress previously experienced and the quantity of adaptive resources available at present. The nature of the relationship with the lost person or object is a critical factor. A close interpersonal relationship, a strong attachment, a high degree of dependency, and great ambivalence are all factors that will make the mourning process more complex and painful. As Bugen states, “Individuals who believe that they now have no life of their own or who cling to symbolic vestiges of the deceased will perceive their world only through grief-colored glasses.”

When the separation occurs through death, the process of dying is also crucial. A sudden death poses greater problems for the bereaved, as do a denial of emotions in the early mourning phase, the death of a child or young adult, and a belief that the death was preventable. Bugen asserts that the belief that the death was preventable is the “single most influential factor contributing to the prolongation of the human grief response.” The bereaved’s support systems, secondary stresses, and future opportunities are relevant factors in planning interventions and promoting future growth.

Before the nurse becomes actively involved with the bereaved, she must have an understanding of her own feelings and reactions to loss. Time should be spent recalling previous losses in her own life, examining related feelings, and resolving areas of conflicts. If she is uncomfortable or ambivalent about death or has delayed the grief work involved in a personal loss, she will be unable to be therapeutic with the bereaved she hopes to help. Hope is an essential quality for the nurse to possess. Her hope and commitment in the future can be transmitted to the bereaved. Hope also involves sharing and a sense of partnership. These are demonstrated in the nurse-patient relationship as the nurse shares the grief work of the bereaved. Finally, nurses working with patients in the process of mourning need support systems of their own. Nursing peers, supervisors, and other professionals can provide formal or informal opportunities for ventilation and rejuvenation. This is essential because assisting the bereaved in the
process of mourning can be psychologically draining and interpersonally painful at times.

The core nursing interventions are directed toward helping the patient go through the “grief work” by helping him experience the feelings and emotions connected with the loss and eventually find new patterns of rewarding interaction. He needs to accept the reality of the loss and realize that grieving is appropriate and sharing it makes it less painful. In establishing a contract, the nurse can explain that she would like to help the bereaved talk over any feelings and difficulties he might have related to the loss. Many people find it is easier to talk to an impartial “outsider” about painful memories, ambivalent feelings, and problems that threaten self-esteem. With the nurse the bereaved does not have to fear alienation from the family. In addition, it is important for the nurse, in establishing the contract, to convey her belief in the person’s recovery and future coping ability.

Initially the person may be in a dazed or numbed condition. If so, he will need help in making even simple decisions. He will also need time to organize his ideas and take in what has happened. After the initial reaction has subsided, it will be possible to explore the loss, related memories, and affect of the bereaved. A useful beginning point is a discussion of the circumstances and nature of the loss. This often mobilizes the expression of significant and related feelings and reveals those which are absent or inappropriately expressed, such as sadness or anger. Many bereaved people are surprised and frightened by the intensity of their emotions. They may ask, “Is this normal?” or “Am I going mad?” Distractions, difficulty remembering, and a sense of unreality may cause worry and concern. Reassurance that they are not going mad and that such feelings are normal is helpful, particularly if the nurse does not seem frightened or alarmed by them. Nurses can show by their willingness to reveal their own feelings that they are not ashamed of them or rendered useless by them.

Guilt, anger, and sadness are all important emotions to be explored. Crying is an effective emotional release that can communicate strong feelings and drain off immobilizing energy or tension. At times, the values of the nurse or society may negate crying as an emotional outlet because it is viewed as a sign of weakness or causes discomfort in others. Nurses need to guard against these prejudices and encourage crying as an acceptable emotional release. In these instances silence and companionship are often the most therapeutic responses. The appropriateness of sadness and the common occurrence of anger and guilt need to be communicated to allow the free expression of these emotions. Asking how the person feels about a certain event, suggesting the way the person may have felt (“that must have made you feel angry”), or describing how another person would feel in the situation (“that would make me feel isolated and forgotten”) may help the bereaved person explore his emotions. In the beginning the bereaved may test out the nurse for the clichés of reassurance used by others. The person may be exploring whether the nurse can confront the loss. If the nurse does not respond in a stereotyped and superficial way, the bereaved may begin to express “bad” memories as well as “good.”

Initially, defenses need to be supported, but with time they should be analyzed and released. Denial needs to be changed to developing awareness. Reaction formation may lead to idealization of the lost one and may have to be dealt with by releasing the negative emotions involved. In projective identification the anger and guilt are acknowledged in another but not as part of oneself, and the concern is with the other. With this defense the nurse needs to promote more direct expression of feeling. The goal is to place the loss in perspective and loosen the bonds of attachment.

A number of resistances may appear. Early resistance shows as attempts to concentrate on the practical or financial problems rather than the emotional. The bereaved may ask help in getting a job or collecting the insurance. The nurse can offer appropriate assistance or referral in these areas while also encouraging the expression of grief and promoting the mourning. The nurse must not join with the bereaved in avoiding the grief. Another resistance occurs when the person shuts out the nurse through such statements as “No one really knows what I’m going through” or “You’re so young, how can you possibly understand what it’s like?” Other resistances occur when the person focuses on the nurse’s losses as a way of escaping his own or when he claims that his grief is resolved, although the nurse realizes it is a premature resolution.

It may be necessary for the nurse to work directly or indirectly to promote an appropriate social network support, that is, support that will
TABLE 9-8. Summary of nursing interventions in uncomplicated grief reactions
Goal—Assist the patient who has experienced a loss to work through the process of grieving
or mourning and prevent maladaptive emotional responses

<table>
<thead>
<tr>
<th>Principle</th>
<th>Rationale</th>
<th>Nursing actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grieving can be facilitated by anticipating losses and their consequences</td>
<td>Anticipatory guidance by the nurse can be an effective intervention in primary prevention</td>
<td>Discuss impending losses and their significance with the patient and family</td>
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<tr>
<td></td>
<td></td>
<td>Review past losses</td>
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<tr>
<td>Support the patient and family at the time of the loss</td>
<td>Therapeutic interventions at the time of the loss can prevent future maladaptive responses</td>
<td>Be prepared to stay with and comfort the bereaved until others arrive</td>
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<td>Use the family group or significant others as a coping resource to provide initial support for those experiencing the loss</td>
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<td></td>
<td>Provide the bereaved a place to express their feelings</td>
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<td></td>
<td>Unconditionally accept the emotional responses of those grieving</td>
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<td></td>
<td></td>
<td>Incorporate the cultural, religious, and social customs of those grieving in one’s nursing care</td>
</tr>
<tr>
<td>Identify those persons at high risk for maladaptive responses</td>
<td>Nursing interventions will be more effective if adapted to a person’s unique needs</td>
<td>Individuals at high risk for maladaptive responses should be identified by assessing factors that significantly influence the outcome of the mourning process</td>
</tr>
<tr>
<td>Awareness and control of nurse’s own feelings</td>
<td>Self-awareness is a prerequisite for the “therapeutic use of self” in working with those experiencing loss</td>
<td>Understand one’s own feelings and reactions to loss</td>
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<td>Recall previous losses and resolve areas of conflict</td>
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<td>Communicate hope in the future and commitment to the work of grieving in the nurse-patient relationship</td>
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<tr>
<td></td>
<td></td>
<td>Utilize one’s own personal and professional support systems for ventilation and rejuvenation</td>
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promote the expression of grief. The nurse may modify the bereaved’s support system or may mobilize various significant others, such as the clergy. The nurse may hold a conjoint interview with the family to open up channels of communication and break the conspiracy of silence that frequently blocks grief.

The use of daytime sedatives and tranquilizers should be avoided. They may help the person maintain a calm appearance and avoid crying, but they artificially extend the period of denial and suppress the normal process of mourning. With the suppression of these emotions the balance of normal ambivalence may be tipped to its extreme, producing depression instead of mourning with its greater degree of maladaptation. They can also encourage the development of patterns of drug dependence, sedation, and inhibition of grief in response to stress.

As the grief process is resolved, the person will be seen investing himself in new situations and relationships. The loss is placed in perspective, the attachment bonds are released, and energy is directed back out into the world. New patterns of rewarding interaction should be encouraged and reinforced.

It is important that in terminating the nurse-patient relationship, sufficient time is allowed for dealing with the loss termination imposes. The person may wish to continue the relationship as a substitute for the previous loss. Awareness of these issues will allow the nurse to con-
TABLE 9-8. Summary of nursing interventions in uncomplicated grief reactions—cont’d

<table>
<thead>
<tr>
<th>Principle</th>
<th>Rationale</th>
<th>Nursing actions</th>
</tr>
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<tbody>
<tr>
<td>Help the patient go through the “grief work”</td>
<td>This will help him accept the reality of the loss and realize that grieving is an appropriate and healthy response</td>
<td>Convey belief in the person’s recovery and future coping ability</td>
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<td></td>
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<td>Initially assist the patient in immediate decision making if necessary</td>
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<td></td>
<td></td>
<td>Explore the circumstances and nature of the loss</td>
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<td></td>
<td>Facilitate the patient’s expression of feelings, including guilt, anger, and sadness</td>
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<td></td>
<td>Offer acceptance and assurance of the appropriateness and commonality of the patient’s positive and negative emotions</td>
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<td></td>
<td>Initially support the patient’s ego defense mechanisms; with time, encourage his analysis and release of them by placing the loss in perspective and loosening bonds of attachment</td>
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<td></td>
<td>Work through any resistances that may occur in the nurse-patient relationship</td>
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<tr>
<td></td>
<td></td>
<td>New patterns of rewarding interactions should be encouraged and reinforced</td>
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<td></td>
<td></td>
<td>Deal with the loss imposed by the termination of the nurse-patient relationship</td>
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<table>
<thead>
<tr>
<th>Principle</th>
<th>Rationale</th>
<th>Nursing actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote social network support as a coping resource</td>
<td>The positive role social support plays in dealing with loss has been well established in both research and clinical practice</td>
<td>Mobilize a social support system for the patient that is appropriate to his needs (i.e., family, clergy, and community agency)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitate the formation and growth of organizations that act as support groups to others</td>
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front them and encourage the independence of the bereaved.

Other therapeutic nursing interventions look to society in general. The nurse can work to encourage others in her community to accept the open expression of grief and the display of emotions. If these are accepted and supported, one type of stress can be avoided. In addition to changing attitudes, the nurse can facilitate the growth of organizations for the bereaved. The effectiveness of widow-to-widow groups, colostomy associations, and single-parent groups has been well established. Support groups play a significant role in preventing maladaptive emotional responses and are an appropriate area for nursing intervention. These interventions related to uncomplicated grief reactions are summarized in Table 9-8.

Intervening in depression and mania

Maladaptive emotional responses may emerge at unpredicted moments, can vary in intensity from mild to severe, and can be transitory, recurrent, or more stable trait conditions. Episodes of depression and mania can occur in any setting and can arise in conjunction with existing medical problems. So too, the treatment of mood disturbances can take place in various settings—at home, at an outpatient department, or in a hospital. The choice of where the patient can be best treated depends on the severity of the illness,
available support systems, and resources of the treatment center. In timing one's intervention the nurse should remember that help given when maladaptive patterns of thought and behavior are developing is likely to be more acceptable and effective than help given a long time after these maladaptive patterns have been established. Thus early diagnosis and treatment are associated with more positive outcomes.

The nursing interventions that will be described relative to severe mood disturbances are based on a unified, multicausal, and interactive model of affective disorders. Such a model dismisses the notion of either one cause or one cure modality for the range of maladaptive emotional responses. Rather, it proposes that affective problems have many determinations and many dimensions that affect all aspects of a person's life. Thus a single approach to nursing care would be inadequate. Nursing interventions must instead reflect the complex 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. The ultimate aim of these nursing interventions is to teach the patient adaptive coping responses and increase the satisfaction and pleasure he receives from his world.

These nursing actions can be implemented in any setting. They are described on the basis of patients' needs in the following areas:

1. Environmental
2. Nurse-patient relationship
3. Affective
4. Cognitive
5. Behavioral
6. Social
7. Physiological

The specific interventions that will now be described are derived from an integration of the models of the causation of severe mood disturbances presented earlier in this chapter.

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, high priority should be given to the potential for suicide. Hospitalization is definitely indicated when there is a suicidal risk.

In the presence of a history of rapidly progressing symptoms and the absence or rupture of the usual support systems in the environment, hospitalization is strongly indicated. Nursing care in this case means protection and assuring the patient he will not be allowed to harm himself. Specific interventions related to the suicidal patient are described in Chapter 10.

The depressed patient must always be assessed for possible suicide. The patient is at particular risk for suicide when he appears to be coming out of his depression because he may then have the energy and opportunity to kill himself. 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 environmental measures must be instituted to prevent a fatal outcome.

Another kind of environmental intervention involves changing the physical or social setting by assisting the patient to move to a new environment. Sometimes a change in the patient's general pattern of living is indicated, such as a leave of absence from work, a change of jobs, a new peer group, or leaving one's family setting. Environmental changes such as these serve to decrease the immediate stress and mobilize additional support systems.

NURSE-PATIENT RELATIONSHIP. Both depressed and manic patients present unique challenges to the nurse who wishes to engage them in a therapeutic alliance. Depressed patients resist involvement through the defenses of withdrawal and nonresponsiveness. Because of their negative view of life they tend to remain isolated, verbalize little, feel they are unworthy of help, and form dependent attachments to others.

In working with depressed patients, the nurse's approach should be a quiet, warm, and accepting one. She should demonstrate the qualities of 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 or resentful of his helplessness or fear rejection by him. The nurse needs patience and a belief in the potential of each person to grow and change. If this is calmly communicated to the patient, both verbally and nonverbally, in time he may begin to respond to the nurse's perceptions.

The nurse should avoid assuming an overaggressive or light-hearted approach with the depressed individual. 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 between the nurse and patient and block the formation of a potential relationship. Neither should the nurse sympathize with the patient. Subjective overidentification by the nurse can cause her to experience similar feelings of hopelessness and helplessness and seriously limit her ability to be therapeutic.

Rapport is best established with the depressed patient through shared time, even if the patient talks little, and supportive companionship. The very presence of the nurse indicates that she believes the patient is a valuable person. The nurse should adjust to the depressed patient's pace by speaking more slowly and allowing him sufficient time to respond. She should address him by name, talk to him, and listen to him. By studying the life and interests of the patient, the nurse might select topics that can serve as points of entry and lay the foundation for more meaningful discussions.

In contrast, elated patients may be very talkative and need simple explanations and concise truthful answers to questions. Although the manic patient might appear to be very willing to talk, he resists involvement through the defenses of manipulation, testing limits, and superficiality. His 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 unit and resist engagement in the work of therapy. They may dominate group meetings or therapy sessions by their excessive talking and manipulate the nursing and medical staff or patient group. By identifying a vulnerable area of another person or a group's area of conflict, manic patients are able to exploit and manipulate others. This provokes defensive and angry responses in others. Nurses are particularly susceptible to these feelings, since they often have the most contact with patients and the responsibility for coordinating and maintaining the psychiatric unit. When anger is generated, there is a breakdown of coordinated therapeutic care. Thus the maneuvers of manic patients serve as diversionary tactics. By alienating themselves they 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 coor-
progressively better and will not remain at his current level of depression. Related to this, the nurse may acknowledge the patient's inability to take comfort from this reassurance. For him, only the depression is real; past or future happiness is an illusion. However, by affirming her belief, she may make his existence more tolerable.

This initial reassurance is a way of acknowledging the patient's pain and despair, while also conveying to him the nurse's sense of hope in his recovery. It is not the premature reassurance of "Don't worry—everything's going to be just fine." It is an openness to his feelings and acknowledgment of them. This is a very important first step. It also tells him that his present state is not permanent but is changeable. For the depressed patient who lacks a perspective of time, it directs his thoughts beyond the present time and into the future with genuine hopes for tomorrow.

Nursing actions in this area should convey that expressing feelings is normal and necessary. Blocking or repressing emotions is partially responsible for his present pain. She can help him to realize that his overwhelming feelings of dejection and worthlessness are defenses that serve to prevent him from dealing with his problems. Encouraging a patient to express his unpleasant or painful emotions through verbalizing them can reduce their intensity and make the person feel more alive and masterful. Thus the nursing actions should be directed toward first helping the patient experience his feelings and then express them. These actions are prerequisite to implementing interventions in the cognitive, behavioral, or social areas.

When the nurse accepts without criticism the anger, despair, or anxiety expressed by the patient, he sees that expressing feelings is not destructive or a sign of weakness. Sometimes, however, the expression of anger by the patient changes his cognitive set from self-blaming to other blaming. It may allow him to see himself as more effective because it connotes power, superiority, and mastery. How this anger is expressed is important because aggressive behavior can be destructive and serve to further isolate him interpersonally. Many patients experiencing both depressive and manic emotional states have problems with the expression of anger and need to learn effective assertive behavior. This important area of nursing intervention is explored in more depth in Chapter 12.

Relaxation techniques may also be useful in helping both manic and depressed patients deal with their anxiety and tension and obtain more pleasure from life. Reducing anxiety to tolerable levels broadens the individual's perceptual field and allows the nurse to introduce interventions in the cognitive and behavioral areas. Nursing actions to reduce anxiety are described in Chapter 7.

To successfully implement any of these nursing actions related to the patient's affective needs, she must utilize the variety of facilitative communication skills and responsive and action dimensions in the therapeutic nurse-patient relationship. These are described in Chapter 3. Particularly important among these are empathy skills, reflection of feeling, open-ended feeling-oriented questions, validation, self-disclosure, and confrontation. Feelings are the essence of empathy and, as such, make empathy an essential therapeutic quality. The various other communication skills must also be used to focus on feelings rather than facts. The patient with a severe mood disturbance will challenge the nurse's therapeutic skills and stringently test the level of her caring and commitment.

COGNITIVE INTERVENTIONS. When intervening in the cognitive area, the nurse has three major aims, which require that the nurse begin with the patient's conceptualization or definition of his problem:

1. To increase the patient's sense of control over his goals and behavior
2. To increase the patient's self-esteem
3. To assist the patient in modifying his negative expectations

Depressed patients usually see themselves as victims of their moods and environment. They do not view their behavior and their interpretation of events as possible causes of depression. They assume a passive stance and wait for someone or something to come along that will lift their mood. One task of the nurse, therefore, is to move the patient beyond his limiting preoccupation with his mood to a recognition of other aspects of his world that are related to it. To do this, the nurse will progress gradually with the patient. The first step is to help him explore his feelings. This is followed by eliciting his view of the problem. In so doing the nurse accepts the patient's perceptions but need not accept his conclusions. Together they need to define the problem so as to give the patient a sense of control, a feeling of hope, and a realization that change may indeed be possible.

Nursing actions may then be focused on
modifying the patient’s thinking. Depressed patients are noticeably dominated by negative thoughts. The effect of this is that often, despite a successful performance, the patient will view it negatively because of his pessimistic world view. Cognitive changes may be brought about in a number of ways. Frequently, negative thinking is an automatic process of which the patient is not even aware. The nurse can therefore assist him in identifying his negative thoughts and decreasing them through thought interruption or substitution. Concurrently, the patient can be encouraged to increase his positive thinking by reviewing his personal assets, strengths, accomplishments, and opportunities. Next the patient can be assisted in examining the accuracy of his perceptions, logic, and conclusions. In so doing, misperceptions, distortions, and irrational beliefs become evident. The patient should be helped to move from unrealistic to realistic goals and attempt to decrease the importance of unattainable goals. All of these actions serve to enhance the patient’s self-understanding and increase his level of self-esteem. More detailed interventions in this area are explored in Chapter 8, which addresses alterations in self-concept—a problem inherent in disturbances of mood.

Also, because the depressed patient tends to be overwhelmed by his despair, it is important to limit the amount of negative personal evaluations he engages in. One way this can be accomplished is by involving the patient in productive tasks or activities; another way is to increase his level of socialization. These benefit the patient in two complementary ways: they limit the time he can spend on brooding and self-criticism, and they provide positive reinforcement in themselves.

A final consideration in this area is that the nurse needs to realize the meaning, nature, and value the patient places on his behavior and mood change. Most research has been focused on the psychopathologic nature of affective disorders. One study that explored the positive aspects of them found that patients with bipolar illnesses receive pronounced short- and long-term positive effects from their manic-depressive illness. The patients reported short- and long-term increases in productivity, creativity, sensitivity, social outgoingness, and sexual intensity. It is important for the nurse to understand these attributions because they suggest that disturbances of mood can produce powerful reinforcers of a maladaptive response and thus make change more difficult. It would appear that for some patients, the positive consequences of an illness may outweigh their perception of negative outcomes.

**Behavioral Interventions.** Successful behavior is a powerful antidepressant. This idea, however, seldom occurs to depressed patients who use their despondent mood as a rationalization for inactivity. They believe, instead, that once their mood lifts, they will be able to be productive once again. Such an idea is consistent with a negative cognitive set and a sense of helplessness over one’s life. But inactivity prevents the patient from obtaining satisfaction and receiving social recognition. So, in actuality, it serves to reinforce one’s depressive state.

Nursing interventions in this area therefore focus on activating the patient in a realistic, goal-directed way to move the patient in the direction of adaptive coping responses. The assignment of therapeutic tasks can be viewed as directed activities, strategies, or homework assignments mutually determined by the nurse and patient based on their long-term treatment goals. They are action-oriented and behavior focused and allow the patient to explore alternative coping responses. Some of the benefits derived from assigning therapeutic tasks as identified by Berg include the following:

1. The client continues to be involved with the therapist even when not in therapy, thus strengthening the therapeutic relationship.
2. The responsibility for change is the client’s.
3. The implication is that the client can change, which instills hope.
4. If successfully completed, therapeutic tasks tend to enhance the client’s self-esteem.
5. They help restructure a system.
6. They teach problem-solving skills by providing the client an opportunity for experiential learning.
7. They test the flexibility of a person or system and reveal areas of resistance to change.
8. They encourage the generalization of therapeutic gains beyond the therapy session.

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. The patient should not be forced into activities initially. Neither will he benefit from coming into contact with too many people too soon. Rather, the nurse should encourage activities gradually and suggest escalating involvement on the basis of the mobilization of his energy.
Part one ■ Principles of psychiatric nursing

For severely depressed hospitalized patients a structured daily program of activities can be beneficial. Because these patients lack motivation and direction, they are reticent to initiate actions. In this case the nurse should provide a tangible structure for activities, taking into consideration the patient's tolerance to stress and probability of succeeding. The particular task should not be too difficult nor too time consuming. Success tends to increase the patient's expectations and the possibility of future success. Failure tends to increase his feelings of worthlessness and hopelessness.

The elated patient usually needs little encouragement to become involved with others. Because of his short attention span and restless energy, however, he cannot deal with complicated projects. He needs tasks that are simple and that can be completed quickly. In his environment he needs room to move about and furnishings that do not overstimulate him.

The patient's ability to accomplish tasks and be productive will depend on a number of factors. First, expectations and goals for him should be small enough to ensure successful performance, relevant to his needs, and focused on positive activities. Following is a positive activities list* that contains categories of rewarding or potentially rewarding activities†.

1. Planning something you will enjoy
2. Going on an outing (e.g., a walk, a shopping trip downtown, a picnic)
3. Going out for entertainment
4. Going on a trip
5. Going to meetings, lectures, classes
6. Attending a social gathering
7. Playing a sport or game
8. Spending time on a hobby or project
9. Entertaining yourself at home (e.g., reading, listening to music, watching TV)
10. Doing something just for yourself (e.g., buying something, cooking something, dressing comfortably)
11. Spending time just relaxing (e.g., thinking, sitting, napping, daydreaming)
12. Caring for yourself, making yourself attractive
13. Persisting at a difficult task
14. Completing a routine task or unpleasant task
15. Doing a job well
16. Cooperating with someone else on a common task
17. Doing something special for someone else, being generous, going out of your way
18. Seeking out people (e.g., calling, stopping by, making a date or appointment, going to a meeting)
19. Initiating conversation (e.g., at a store, party, or class)
20. Discussing an interesting or amusing topic
21. Expressing yourself openly, clearly, or frankly (e.g., opinion, criticism, anger)
22. Playing with children or animals
23. Complimenting or praising someone
24. Physically showing affection or love
25. Receiving praise, compliments, attention

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 preformance. If such an approach is used consistently over time, the nurse can expect the patient to demonstrate increasing amounts of productive behavior.

When considering possible activities for the patient, occupational and recreational ones are usually easily identified by the nurse. These can be most valuable and are well represented in the positive activities list. Another source of accomplishment is in the area of movement and physical exercise. Brown has made the following observations about the relationship between mood and movement:

- Physical fitness is often associated with a feeling of well-being and reduced depression and anxiety.
- Fitness appears to be associated with physical and psychological benefits regardless of the subject's age.
- The biological benefits of exercise may be associated in part with changes produced among brain amines, salt metabolism, muscle neuronal activity, and striatal functions.
- A comprehensive history of the depressed patient's motor activity is useful in prescribing an exercise regimen of maximum benefit.

Jogging, walking, swimming, bicycling, and aerobics are popular forms of exercise that may be incorporated in a regular program of physical activity for the patient. They are beneficial because they improve the patient's physical condition and provide a release of emotions and tensions.

SOCIAL INTERVENTIONS. Evidence from diverse sources indicates that social factors play a major role in the causation, maintenance, and

resolution of affective disorders, particularly depression. Socialization serves to moderate the experience of depression by providing an experience that is incompatible with depressive withdrawal and by providing a source of increased self-esteem through the social reinforcers of approval, acceptance, recognition, and support.

A major problem in the social area is that patients with maladaptive emotional responses have fewer interpersonal skills and are less accomplished in social interaction. In addition, they may be avoided by others because of their self-absorption, pessimism, or elation. One nursing action to counteract this problem is to help the patient improve his interpersonal style and increase his social skills. This can be accomplished in a sequential learning process that includes the following:

1. Assessing the patient's social skills, supports, and interests
2. Reviewing existing and potential social resources available to the patient
3. Instruction and modeling of effective social skills
4. Role playing and rehearsal of troublesome social situations and interactions
5. Feedback and positive reinforcement of effective interpersonal skills
6. Encouraging the initiation of socialization in an expanded social arena

This final accomplishment often proves to be difficult for depressed patients who report they are unable to meet new people and engage in an active social life. Thus increasing a patient's social activities is another area of nursing intervention. 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 best pursue these interests through community groups, organizations, and clubs. Women's groups, single parents groups, jogging clubs, church groups, and neighborhood associations are all possible opportunities for expanding one's social network. Although this may appear to be a relatively simple nursing intervention, it is often one that taxes the nurse's knowledge of resources and creativity.

In addition to a one-to-one relationship, patients with maladaptive emotional responses can also benefit from family and group therapy. In the context of family therapy the behaviors of depression can be interpreted as signs of dependency, which is contributed to and supported by other family members. The patient's sense of powerlessness in human relationships is examined in light of family patterns, and all family members are expected to take responsibility for their share of the continuing pattern.

The notion that friends and partners often reinforce and support the patient's depression has been well documented. When a person gets depressed, he usually receives a lot of attention and secondary gain from others who respond by being helpful, nurturing, or annoyed. But when the patient acts in a nondepressed way, there is little attention paid to him. Therefore one goal of family therapy is to help the family reinforce adaptive nondepressed behavior and ignore his maladaptive depressive responses.

There is also a need for family interventions with manic patients. In one study that followed the families of patients with bipolar manic-depressive illness, the authors noted the following:

The recurring psychopathology of manic-depressive patients has significant effects on the psychosocial adaptation of their spouse and children. Not only is the genetic predisposition handed down over generations, but the environment may have long-term detrimental effects on the children's personality.

The "waving capacity for interpersonal relatedness" on the part of the patient and other family members is a clear indication for nursing interventions at the family level of care.

Group therapy can also provide multiple benefits. Knowledge that others have ambivalence and the sharing of guilt concerning this, as well as the realistic sympathy and support of the group members, enable the depressed patient to lessen his guilt, give up his maladaptive behavior patterns, and develop more satisfying relationships with others in the group. Van Sreven and Dull developed a format for group treatment of women with major depressive illness. The overall aim is to increase self-worth and self-esteem through identification with the group and awareness of personal strengths. The depressed women in Van Sreven and Dull's group identified several general goals:

1. Learning more about their individual behavior and relationships with others based on feedback from members and group process.
2. Increasing social support through group relatedness.
3. Gaining a heightened sense of identity, self-understanding, and control over their own lives.
4. Realizing that other people have problems similar to their own, which helps to reduce their sense of loneliness and isolation, thereby also decreasing feelings of hopelessness, helplessness, and powerlessness.

5. Learning new ways to cope with stress from others in the group.

6. More realistically modifying their perceptions and expectations of self and others.

7. Allowing for the expression of feelings of hopelessness and frustration within the supportive context of the group.

An essential part of any therapeutic intervention is the evaluation of its effectiveness. The authors also present a format for evaluation that can be used to measure change in the specific patients in group treatment. Research in comparing and evaluating various therapeutic modalities used by nurses continues to be a high priority in the future.

**Physiological Interventions.** Interventions in this area include both physical care and somatic therapies. They begin with a thorough physical examination and health history to determine present health status, past and present health problems, and the presence of current treatments or medications that may be affecting the patient’s mood state.

In depression, physical well-being may be forgotten or the patient may not be capable of caring for himself. The more severe the depression, the more important is the physical care.

The anorexic patient may need to have his diet monitored. Staying with the patient when he is eating, arranging for preferred foods, and encouraging frequent small meals may be helpful. Recording his intake and output and weighing him daily will help in evaluating this need.

Sleep disturbances are common. 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.

The patient’s appearance may be neglected and all his movements slowed. If it is necessary to assist the hospitalized patient with bathing or dressing, it should be done matter of factly with the explanation that he is being helped because he is unable to do it for himself at the present time. Cleanliness and interest in appearance can be noticed and praised. It is important for the nurse to allow the patient to help himself whenever possible. Often the nurse might rush the patient or do a task herself to save time, but these do not facilitate the patient’s recovery and should be avoided.

The manic patient primarily needs protection from himself. He may be too busy to eat or take care of himself. Eating problems can be handled in the same way as with the depressed patient. Sleep is scarce; so rest periods should be provided along with supportive interventions, such as baths, soft music, and whirlpools. The manic patient may also need help in selecting appropriate clothes and carrying out hygiene activities. Setting limits and firm decisive actions are effective approaches to the physical care of the patient with a severe mood disturbance.

Antidepressant medications are frequently administered to elevate the mood of the depressed patient. At this time no single drug has been found to be effective for all kinds of depressions. Of the two types of antidepressants—tricyclics and monoamine oxidase (MAO) inhibitors—the former are used more commonly. Tricyclic drugs appear to be the most effective class of antidepressants. They pose a smaller risk of side effects than the MAO inhibitors and appear to be useful against relapses of depression. Lithium carbonate is considered by many to be the drug of choice in the treatment of mania. Some believe that it not only produces a remission of symptoms but also actually prevents a recurrence of the manic state. The overall success rate of drugs for the treatment of depression is 70% to 90%. Electroconvulsive therapy (ECT) is also used with depressed patients, particularly those with recurrent depressions and those who are resistant to drug therapy. ECT is regarded by many as a specific therapy for those severe depressions characterized by somatic delusions and delusional guilt, accompanied by a lack of interest in the world, suicidal ideation, and weight loss. A more detailed discussion of antidepressant medication and electroconvulsive therapy is presented in Chapter 15.

A recent development in this area is a laboratory test for somatically treatable depression—the dexamethasone suppression test (DST). The test is easy, relatively inexpensive, and of minimal risk to the patient. The DST is most useful in identifying patients who do not display the typical behaviors of depression but who are likely to respond to somatic treatments, such as antidepressant therapy or ECT. It may also be useful in monitoring recovery from depression and assist in the decision about when to stop maintenance antidepressant therapy safely.

Sleep deprivation therapy may also be effec-
TABLE 9-9. Summary of nursing interventions in depression and mania

**Goal—Teach the patient adaptive emotional responses and increase the satisfaction and pleasure he receives from his world**

<table>
<thead>
<tr>
<th>Principle</th>
<th>Rationale</th>
<th>Nursing action</th>
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<tbody>
<tr>
<td>Modify the patient’s environment if it is dangerous, impoverished, aversive, or lacking in personal resources</td>
<td>All patients with severe mood disturbances are at high risk for suicide; environmental changes can protect the patient, decrease the immediate stress, and mobilize additional resources</td>
<td>Continually evaluate the patient’s potential for suicide Hospitalize the patient when there is a suicidal risk Assist the patient to move to a new environment when appropriate (i.e., new job, peer group, family setting)</td>
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<tr>
<td>Establish and maintain a therapeutic nurse-patient relationship</td>
<td>Both depressed and manic patients resist becoming involved in a therapeutic alliance; acceptance, persistence, and limit setting are necessary</td>
<td>Utilize a warm, accepting, empathic approach Be aware of and in control of one’s own feelings and reactions (i.e., anger, frustration, sympathy) With the depressed patient: 1. Establish rapport through shared time and supportive companionship 2. Allow the patient time to respond 3. Personalize his care as a way of indicating his value as a human being With the manic patient: 1. Give simple truthful responses 2. Be alert to possible manipulation 3. Set constructive limits on negative behavior 4. Use a consistent approach by all health team members 5. Maintain open communication and sharing of perceptions among team members 6. Reinforce the patient’s self-control and positive aspects of his behavior</td>
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<tr>
<td>Assist in the patient’s recognition and expression of emotions</td>
<td>Patients with severe mood disturbances have difficulty identifying and expressing feelings</td>
<td>Demonstrate emotional responsiveness and acceptance Utilize facilitative communication skills and the responsive and action dimensions described in Chapter 3 Respond empathically with a focus on feelings rather than facts Acknowledge the patient’s pain and convey a sense of hope in his recovery Help the patient experience his feelings and then express them Assist the patient in the appropriate expression of anger Reduce the patient’s anxiety to mild-moderate levels</td>
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<td>Aid the patient in modifying his negative cognitive set</td>
<td>This will help to increase his sense of control over his goals and behaviors, enhance his self-esteem, and modify his negative expectations</td>
<td>Review with the patient his conceptualization of the problem but do not necessarily accept his conclusions Identify the patient’s negative thoughts and help him to decrease them through thought interruption or substitution Help him increase his positive thinking Examine the accuracy of his perceptions, logic, and conclusions</td>
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*Continued.*
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<tr>
<th>Principle</th>
<th>Rationale</th>
<th>Nursing action</th>
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<tr>
<td>Aid the patient in modifying his negative cognitive set—cont’d</td>
<td>Identify misperceptions, distortions, and irrational beliefs</td>
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<td>Help him move from unrealistic to realistic goals</td>
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<td>Decrease the importance of unattainable goals</td>
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<td></td>
<td>Limit the amount of negative personal evaluations he engages in</td>
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<td>Realize the meaning, nature, and value the patient places on his behavior and mood change</td>
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<td>Activate the patient in a realistic goal-directed way</td>
<td>Successful behavioral performance counteracts feelings of helplessness and hopelessness</td>
<td>Assign appropriate action-oriented therapeutic tasks</td>
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<td>Encourage activities gradually, escalating them as the patient’s energy is mobilized</td>
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<td>Provide a tangible structured program when appropriate</td>
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<td>Set goals that are realistic, relevant to the patient’s needs and interests, and focused on positive activities</td>
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<td>Focus on present activities, not past or future activities</td>
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<td>Positively reinforce successful performance</td>
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<td>Attain mutuality whenever possible</td>
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<td>Incorporate physical exercise in the patient’s plan of care</td>
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<td>Enhance the patient’s establishment of interpersonal relationships</td>
<td>Socialization is an experience that is incompatible with withdrawal and increases self-esteem through the social reinforcers of approval, acceptance, recognition, and support</td>
<td>Assess the patient’s social skills, supports, and interests</td>
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<td>Review existing and potential social resources</td>
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<td>Give feedback and positive reinforcement of effective interpersonal skills</td>
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<td>Encourage increasing socialization in an expanded social arena</td>
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<td>Intervene with families to have them reinforce adaptive emotional responses of the patient</td>
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<td>Support or engage in family and group therapy when appropriate</td>
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<td>Promote the patient’s physical health and wellbeing</td>
<td>Physiological changes occur in disturbances of mood; physical care and somatic therapies are required to overcome problems in this area</td>
<td>Complete a nursing assessment of the patient’s physiological health status</td>
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<td>Assist the patient to meet his self-care needs, particularly in the areas of nutrition, sleep, and personal hygiene</td>
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<td>Encourage the patient’s independence whenever possible</td>
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<td></td>
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<td>Administer prescribed medications and treatments</td>
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tive in the treatment of depression. Research indicates that depriving some depressed patients of a night’s sleep will bring about an improvement in their clinical condition. The means by which sleep deprivation works is not known, and the duration of the improvement varies greatly. Further developments in somatic therapies will have direct implications for nursing care.

All of the previously described nursing interventions in depression and mania are summarized in Table 9-9. It appropriately reflects the holistic nature of the nursing care given to patients with disturbances of mood.

**Evaluation**

The effectiveness of nursing care is determined by changes in the patient’s maladaptive emotional responses and the effect they have on his present functioning. Problems related to self-concept and interpersonal relationships merge and overlap. Since all individuals experience life stress and related losses, one of the fundamental questions the nurse can ask related to evaluation is “Did I assess my patient for problems in this area?”

Of particular significance with this problem are the many special aspects of transference and countertransference that may occur. The patient’s heightened attachment and dependency behaviors and his 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, since the patient experiences it as another loss that requires mourning and integration.

Countertransference issues can be related to the nurse’s own bereavements, her attitudes about anger, guilt, sadness, and despair, her ability to confront these emotions openly and objectively, and, most important, her own conflicts about death and loss. Difficulties related to any of these issues can be evident in avoidance behavior, preoccupation with fantasies, blocking of feelings, or shortening of sessions. The nurse can expect to review and perhaps rework her feelings about personal bereavement. Her nursing care will be more appropriate and effective if she is aware of these issues and sensitive to her own feelings and conflicts regarding loss. Supervision and peer support groups can be of great help to her in this area.

**Suggested cross-references**

Therapeutic relationship skills and self-awareness of the nurse are discussed in Chapter 3. The model of health-illness phenomena, including precipitating life stressors and the phases of the nursing process are described in Chapter 4. Strengthening coping resources through health education, environmental change, and supporting social systems is presented in Chapters 5 and 6. Interventions related to self-concept and cognitive therapy are discussed in Chapter 8. Interventions with the suicidal patient are discussed in Chapter 10. Disruptions in interpersonal relationships are discussed in Chapter 11. Problems with anger and limit setting are discussed in Chapter 12. Somatic therapy is discussed in Chapter 15. Group therapy is discussed in Chapter 24. Family therapy is discussed in Chapter 25. Care of the dying and their family is discussed in Chapter 32.

**SUMMARY**

1. Mood refers to a prolonged emotional state that influences one’s whole personality and life functioning. It pertains to one’s prevailing and pervading emotion and is synonymous with the terms affect, feeling state, and emotion. Four adaptive functions of mood and a continuum of emotional responses were described. Severe mood disturbances can be recognized by their intensity, prevasiveness, persistence, and interference with usual social and physiological functioning.

   a. Grief is an individual’s subjective response to the loss of a person, object, or concept that is highly valued. Uncomplicated grief is a healthy, adaptive, reparative response that is closely related to the acquisition of the capacity for developing meaningful object relationships. An uncomplicated grief reaction is the process of normal mourning. Mourning is resolved only when the lost object is internalized, bonds of attachment are loosened, and new object relationships are
established. The work of mourning may take 6 months to a year. If grief is not worked through, delayed grief reactions and depression can occur.
b. Depression was distinguished from grief by the attachment to the loved object, degree of regression, acknowledgment of the loss, and intensity of emotions over time.
c. Mania is characterized by a mood that is elevated, expansive, or irritable. Hypomania is similar to mania but less severe. The prevalence of depression and mania was described, as well as their classification in DSM-III.

2. Stressors affecting the grief reaction and factors that place a person at high risk for maladaptive responses were identified. Ten models of causation of severe mood disturbances were discussed. These included the genetic, object loss, aggression turned inward, personality organization, cognitive, learned helplessness, behavioral, biochemical, life stressors, and integrated models. An integrated multicausal model is the most valuable for the nurse to use when implementing nursing care.

3. The phases associated with the process of mourning as described by Bowlby were presented. These are the urge to recover the lost object, disorganization, and reorganization. They can be applied to losses of any kind. Behaviors associated with delayed reactions, depression, and mania were identified. The key element of a behavioral assessment is change in the person's usual patterns and responses.

4. Maladaptive emotional responses were related to feelings of anxiety, hostility, self-devaluation, and guilt. The psychiatric classification of affective disorders was discussed. Selected nursing diagnoses were related to appropriate medical diagnoses from DSM-III.

5. The general goal of the nurse when working with a patient who has experienced loss is to support the patient in the subjective experience of his grief work. He needs to extricate himself from his bondage to the lost object and find new patterns of rewarding interaction. When the patient is experiencing a maladaptive disturbance of mood, the long-term goals may be directed toward reinitiating a delayed grief reaction or exploring areas of conflict underlying a depressive or manic state. Psychotherapeutic, sociotherapeutic, and somatotherapeutic factors should be considered collectively and conjointly. More specific short-term goals should be identified with the patient based on his behavior, present area of difficulty, and relevant stressors.

6. Interventions in uncomplicated grief reactions were described as anticipatory guidance, supporting the process of normal mourning, and social system intervention. Interventions in depression and mania were presented in the environment, nurse-patient relationship, affective, cognitive, behavioral, social, and physiological areas. Intervening in as many areas as possible should have the maximum effect in modifying maladaptive responses and alleviating severe mood disturbances.

7. When evaluating the nursing care, the nurse should pay particular importance to problems with transference and countertransference. Supervision and peer support groups can be helpful to the nurse in working with patients experiencing grief reactions.