

University of Baghdad/ College of Nursing  
Psychiatric Mental Health Nursing Department  
Master Programme/ Specialty  
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**Application of the Nursing Process: Bipolar Disorder**

**Assessment**

**History**

The nurse can collect assessment data from the client and family or significant others, previous chart information, and others involved in the support or care. It may take several short periods to complete the assessment because clients who are severely depressed feel exhausted and overwhelmed. It can take time for them to process the question asked and to formulate a response. It is important that the nurse does not try to rush clients because doing so leads to frustration and incomplete assessment data.

To assess the client's perception of the problem, the nurse asks about behavioural changes: when they started, what was happening when they began, their duration, and what the client has tried to do about them. Assessing the history is important to determine any previous episodes of depression, treatment, and client's response to treatment. The nurse also asks about family history of mood disorders, suicide, or attempted suicide.

**General Appearance and Motor Behaviour**

Many people with depression look sad; sometimes they just look ill. The posture often is slouched with head down, and they make minimal eye contact. They have **psychomotor retardation** (slow body movements, slow cognitive processing, and slow verbal interaction). Responses to questions may be minimal, with only one or two words. **Latency of response** is seen when clients take up to 30 seconds to respond to a question. They may answer some questions with "I don't know" because they are simply too fatigued and overwhelmed to think of an answer or respond in any detail. Clients also may exhibit signs of agitation or anxiety such as wringing their hands and having difficulty sitting still. These clients are said to have **psychomotor agitation** (increased body movements and thoughts), which includes pacing, accelerated thinking, and argumentativeness.

**Mood and Affect**

Clients with depression may describe themselves as hopeless, helpless, down, or anxious. They also may say they are a burden on others or are a failure at life, or they may make other similar statements. They are easily frustrated, are angry with themselves, and can be angry with others. They experience **anhedonia**, losing any sense of pleasure from activities they formerly enjoyed. Clients may be apathetic, that is, not caring about self, activities, or much of anything. Their affect is sad or depressed or may be flat with no emotional expressions. Typically, depressed clients sit alone, staring into space or lost in thought. When addressed, they interact minimally with a few words or a gesture. They are overwhelmed by noise and people who might make demands on them, so they withdraw from the stimulation of interaction with others.

**Thought Process and Content**

Clients with depression experience slowed thinking processes: their thinking seems to occur in slow motion. With severe depression, they may not respond verbally to questions. Clients tend to be negative and pessimistic in their thinking, that is, they believe that they will always feel this bad, things will never get any better, and nothing will help. Clients make self-belittling remarks, criticizing themselves harshly and focusing only on failures or negative attributes.

They tend to **ruminate**, which is repeatedly going over the same thoughts. Those who experience psychotic symptoms have delusions; they often believe they are responsible for all the tragedies and miseries in the world.

Often clients with depression have thoughts of dying or committing suicide. It is important to assess suicidal ideation by asking about it directly. The nurse may ask, “Are you thinking about suicide?” or “What suicidal thoughts are you having?” Most clients readily admit to suicidal thinking. Suicide is discussed more fully later in this chapter.

### **Sensorium and Intellectual Processes**

Some clients with depression are oriented to person, time, and place; others experience difficulty with orientation, especially if they experience psychotic symptoms or are withdrawn from their environment. Assessing general knowledge is difficult because of their limited ability to respond to questions. Memory impairment is common. Clients have extreme difficulty concentrating or paying attention. If psychotic, clients may hear degrading and belittling voices or they may even have command hallucinations that order them to commit suicide.

### **Judgment and Insight**

Clients with depression experience impaired judgment because they cannot use their cognitive abilities to solve problems or to make decisions. They often cannot make decisions or choices because of their extreme apathy or their negative belief that it “doesn’t matter anyway.”

Insight may be intact, especially if clients have been depressed previously. Others have very limited insight and are totally unaware of their behaviour, feelings, or even their illness.

### **Self-Concept**

Sense of self-esteem is greatly reduced; clients often use phrases such as “good for nothing” or “just worthless” to describe themselves. They feel guilty about not being able to function and often personalize events or take responsibility for incidents over which they have no control. They believe that others would be better off without them, a belief which leads to suicidal thoughts

### **Roles and Relationships**

Clients with depression have difficulty fulfilling roles and responsibilities. The more severe the depression is the greater the difficulty. They have problems going to work or school; when there, they seem unable to carry out their responsibilities. The same is true with family responsibilities. Clients are less able to cook, clean, or care for children. In addition to the inability to fulfil roles, clients become even more convinced of their “worthlessness” for being unable to meet life responsibilities.

Depression can cause great strain in relationships. Family members who have limited knowledge about depression may believe clients should “just get on with it.” Clients often avoid family and social relationships because they feel overwhelmed, experience no pleasure from interactions, and feel unworthy. As clients withdraw from relationships, the strain increases.

### **Physiologic and Self-Care Considerations**

Clients with depression often experience pronounced weight loss because of lack of appetite or disinterest in eating. Sleep disturbances are common: either clients cannot sleep, or they feel exhausted and unrefreshed no matter how much time they spend in bed. They lose interest in sexual activities, and men often experience impotence. Some clients neglect personal hygiene because they lack the interest or energy. Constipation commonly results from decreased food and fluid intake as well as from inactivity. If fluid intake is severely limited, clients also may be dehydrated.

## **Data Analysis**

The nurse analyses assessment data to determine priorities and to establish a plan of care. Nursing diagnoses commonly established for the client with depression include the following:

- Risk for Suicide
- Imbalanced Nutrition: Less Than Body Requirements
- Anxiety
- Ineffective Coping
- Hopelessness
- Ineffective Role Performance
- Self-Care Deficit
- Chronic Low Self-Esteem
- Disturbed Sleep Pattern
- Impaired Social Interaction

## **Outcome Identification**

Outcomes for clients with depression relate to how the depression is manifested-for instance, whether or not the person is slow or agitated, sleeps too much or too little, or eats too much or too little. Examples of outcomes for a client with the psychomotor retardation form of depression include the following:

- The client will not injure himself or herself.
- The client will independently carry out activities of daily living (showering, changing clothing, grooming).
- The client will establish a balance of rest, sleep, and activity.
- The client will establish a balance of adequate nutrition, hydration, and elimination.
- The client will evaluate self-attributes realistically.
- The client will socialize with staff, peers, and family/ friends.
- The client will return to occupation or school activities.
- The client will comply with antidepressant regimen.
- The client will verbalize symptoms of a recurrence.

## **Intervention**

Providing for Safety

Meeting Physiologic Needs

Providing Therapeutic Communication

Promoting Appropriate Behaviours

Managing Medications

Providing Client and Family Teaching

Client Family Education

Client and family education for Mania

Providing Client and Family Teaching

## **Evaluation**

Evaluation of the treatment of bipolar disorder includes but is not limited to the following:

- Safety issues
- Comparison of mood and affect between start of treatment and present
- Adherence to treatment regimen of medication and psychotherapy
- Changes in client's perception of quality of life
- Achievement of specific goals of treatment including new coping methods

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