Research on diagnosing bipolarism

Health & Medicine, Mental Health

Demographics: This patient is a 25 year-old, unmarried, white male. He is currently employed as a business manager and supervisor. He speaks English and is Presbyterian. The patient is a college student and lives alone in an apartment. He was admitted to a psychiatric hospital at the age of 15 and diagnosed as Bipolar. At the time of his Bipolar diagnosis, he was treated with unknown medication(s) and is unable to recall any follow-up treatment.

Chief Complaint (CC): “ I feel depressed.”

History of Present Illness (HPI): The male states that the onset of his CC’s began six weeks ago with feelings of depression and low energy level. Both feelings occurred consistently and every day. He was unable to identify any triggers. He voluntarily went to the clinic at the urging of his parents after confiding in them his thoughts of suicide. He states that he came to the clinic because he is “ trying to get it fixed.” He says he is good at his job and is enrolled as a college student. The patient noted difficulty falling asleep and describes a nightly routine of going to bed at 8 pm and falling asleep at 10 or 11 pm. He is unable to stay asleep, and “ wakes up at least once in the middle of the night.” While he states that he has had no changes in his appetite, he also describes having “ no energy” and a loss of interest in his hobbies. He smokes marijuana daily and claims it is relaxing. He denies other illicit drug or alcohol use.

The patient states he has been without auditory or visual hallucinations, however, he claims to have had racing thoughts in the past. With that said, the patient denies having any racing thoughts at this time. His sleep pattern was assessed and determined to be the same during periods of racing

thoughts as without. While he has experienced increased energy levels in the past, currently he denies such feelings. Prior to the last six-week period, the patient enjoyed playing tennis and working in his garden. However, recently he “ hasn’t had the energy” and verbalizes a loss of interest in these hobbies as well as spending time with friends. The patient states that his relationship with his parents and brother are “ fine.” He notes a decrease in libido but states his relationship with his girlfriend is otherwise unchanged.

The patient states having “ general thoughts of suicide” without a specific plan to hurt himself or others. He does not have access to a gun and feels safe in his home and work. He denies anxious feelings, but has had feelings of agitation. Throughout the interview, patient was seated but was fidgeting and frequently crossing and uncrossing his arms and legs. His responses were low and monotone, answering the majority of open-ended questions with one to four word responses. His face was expressionless and he made minimal eye contact, frequently looking around the room.

Theoretical Framework

Jean Watson’s theory of caring is the theoretical framework chosen to guide the care, assessment, and treatment of the patient. Watson’s theory encompasses three main concepts applicable to the patient’s depression and drug abuse. The first concept is “ carative factors,” encompassing spiritual, emotional, and human care (Watson, 2008). Carative factors provide a solid framework utilizing a supportive and protective environment, further promoting Patient 004’s physical, emotional, and spiritual health and wellbeing (Watson, 2008). A caring environment may be achieved by “

sitting down with patients, holding their hand for a few minutes, maintaining eye contact, and providing reassurance” (Lukose, 2011, p. 29).

Watson’s second concept of “ transpersonal caring relationships” is applicable during assessment (Watson, 2008). An example of a transpersonal caring relationship would include an open line of communication with the patient, for development of mutual trust. The advanced medical professional must practice the art of caring by allowing the patient time to nurture the healing relationship and develop trust with the nurse (Vandenhouten, Kubsch, Peterson, Murdock, & Lehrer, 2012).

Development of a trusting relationship allows the patient to feel comfortable expressing feelings and emotions. The medical professional, in fostering the caring relationship and developing the treatment plan, must focus on more than the “ signs and symptoms” (Vandenhouten et al., 2012, p. 327).

Watson’s third concept is “ caring occasion/caring moment” of uninterrupted time making a human-to-human connection (Watson, 2008). Examples of this concept would include providing the patient with hope, respect, and non-judgmental care. Medical professionals need to be aware that negative attitude or frame of mind can impact the level of care being provided (Vandenhouten et al., 2012). According to Butts and Rich (2011), treatment should be approached with realistic expectations of positive outcomes, with patient engagement, and promotion of a therapeutic relationship. Realistic expectations provide patient an opportunity to feel hope in a potentially hopeless situation. This promotes a supportive environment, allowing the

development of coping mechanisms to deal with his depression and drug abuse.

The application of Watson's theory of caring is appropriate for assessment and treatment of the patient, as he appeared depressed, hesitant, with a flat affect, and in need of reassurance by a caring provider. Application of Watson's theory of caring will foster the development of a trusting relationship, allowing the medical professional to determine appropriate care and treatment. " It is the duty of advanced practice nurses to describe theory in simple language and transform it for nursing practice" (Lukose, 2011, p. 30). Watson's theory, broken down into its simple carative factors, may be implemented during all phases of the patient's care, which include the " mindbodyspirit" (Butts & Rich, 2011, p. 288). The patients mental health needs of treatment for depression and drug abuse would respond to the application of this theory. Application of this theory will assist in the healing of the mind while the body and spirit also heal, creating a holistic approach. Watson's theory of caring is ideal for " those who seek help from mental illness" (Butts & Rich, p. 288).

Diagnosis and Rationale

- Axis I: 296. 52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate 305. 20 Cannabis Abuse
- Axis II: 799. 9 Diagnosis Deferred
- Axis III: None
- Axis IV: Health problems in family (father with Bipolar Disorder and Diabetes Mellitus, mother diagnosed with depression and brother attention deficit hyperactivity disorder (ADHD), lives alone).

- Axis V: GAF = 48 (current)

Axis I: The patient is currently experiencing a Major Depressive Episode. By his own account, he has previously experienced at least one manic episode. Additionally, his mood episodes cannot be attributed to " Superimposed Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder Not Otherwise Specified" (American Psychiatric Association, 2000, p. 391). Therefore, the patient has satisfied the diagnostic criteria for Bipolar I Disorder.

The patient has satisfied seven of the nine criteria for experiencing a Major Depressive Episode, including "(1) depressed mood most of the day, nearly every day, (2) markedly diminished interest or pleasure in all, or almost, activities most of the day, early every day, (4) insomnia, (5) psychomotor agitation, (6) loss of energy, (8) diminished ability to concentrate and (9) recurrent thoughts of death without a specific plan" (APA, 2000, p. 356). Because the patient meets more than five of the criteria, his depression is categorized as moderate (APA, 2000).

Differential diagnoses considered include: Mood Disorder Due to a General Medical Condition, Substance-Induced Mood Disorder, Major Depressive Disorder, Dysthymic Disorder, Bipolar 2 Disorder, Cyclothymic Disorder, Schizophrenia, Schizophreniform Disorder and Delusional Disorder. The patient's laboratory results were described as good by the APN, thus ruling out Mood Disorder Due to a General Medical Condition. While Patient 004 admits to marijuana usage, he has not described symptoms of either

withdrawal or intoxication; thus, the patient is not suffering from Substance-Induced Mood Disorder (APA, 2000).

The patient has experienced at least one manic episode. Therefore, Major Depressive Disorder, Dysthymic Disorder, Bipolar 2 Disorder and Cyclothymic Disorder can be ruled out as a diagnosis. The patient has not experienced delusions, hallucinations, disorganized speech, catatonic behavior or negative symptoms and therefore any disorders related to schizophrenia can be ruled out. Finally, the patient has not experienced delusions; therefore, Delusional Disorder is ruled out (APA, 2000). The patient admits that he smokes marijuana on a daily basis. While he failed to identify any issues with work, school or the law, the possibility remains that he may experience problems in these areas as marijuana is still an illicit drug. Based on his statements, criteria A2 and A3 have been met (APA, 2000). Cannabis Dependence is not considered because he has not identified either tolerance or withdrawal symptoms. Likewise, Cannabis Withdrawal is also not applicable. Cannabis Intoxication was discredited because the patient did not identify specific maladaptive behavior as a result of cannabis usage (APA, 2000).

Axis II: No diagnosis is applicable for Axis II. Patient 004 does not meet the criteria for either personality disorder or mental retardation.

Axis III: No medical diagnosis is applicable at this time. According to the APN, the patient’s laboratory work and vital signs were “ good.”

Axis IV: The patient has problems within his primary support group and his social environment. His father, mother and brother all have psychiatric issues. The patient's father suffers from Bipolar Disorder; however he is not undergoing any treatment at this time. His father also has diabetes mellitus. The patient's mother has been diagnosed with depression, while his brother suffers from ADHD. In addition, the patient lives alone.

Axis V: Because the patient expressed suicidal ideations, a Current Global Assessment of Functioning Score was determined between 41-50. A score of 48 was deemed appropriate. Patient had minimal social impairments with work or school but expressed a lack of interest with hobbies and friends.

Nursing Diagnosis

Risk for suicide as evidenced by psychiatric illness, depressed mood and cannabis abuse (Townsend, 2011).

Ineffective coping related to inadequate coping skills as evidenced by cannabis abuse (Townsend, 2011).

Disturbed sleep pattern related to depression as evidenced by complaints of difficulty falling asleep and of interrupted sleep (Townsend, 2011).

Diagnostic Studies and Screening Tools

The symptoms this patient presents warrant a thyroid study to rule out thyroid dysfunction, as well as an adrenal function test to rule out adrenal gland dysfunction. Both of these conditions can mimic symptoms of depression and are discovered in up to 10% of patients during a depression work up (Sadock & Sadock, 2007). The patient reports regular use of

cannabis; a serum and urine toxicology screen should be ordered to evaluate for further drug use.

Screening tools are an important part of any assessment as they can act as a standardized guide for the provider to evaluate, diagnose and evaluate treatment. These tools assist in communicating with other providers as well. A common depression-screening tool is the Hamilton Rating Scale for Depression (HAM-D), which allows the provider to rate the patient on a scale from 0-76 based on their answers (Sadock & Sadock, 2007).

In terms of screening for suicidal ideations, the study done by Desseilles et al., (2012), supports using the HAM-D as a suicide screening tool, finding it to be as reliable as Beck's scale for suicidal ideations. A screening tool for drug abuse is the Drug Abuse Screening Test (DAST)-10 or 12. These two objective rating scales aid in identifying someone at risk for these potentially harmful disorders and enable the provider to monitor the patient for improving or worsening symptoms during treatment (DAST-10, 2008).

Collaborative Management and Plan of Care

Physical Examination:

In order to differentiate a psychiatric illness from a medical disease, the medical professional would need to conduct a comprehensive physical examination. The comprehensive medical exam includes the history of present illness, past medical and surgical history, review of relevant diagnostic studies, review of medications, social and family history, review of all body systems, and an evaluation of comorbidities. It is important for the medical professional to rule out any underlying medical condition or

medication use that can mimic symptoms of depression (Sadock & Sadock, 2007). The provider would investigate current marijuana use and determine if other substance related disorders exist, as patients with depression often use stimulants to improve their symptoms (Sadock & Sadock, 2007).

Psychiatric Evaluation

The psychiatric evaluation of the patient consists of a two-part exam that will review his psychiatric history and examine his mental status. The medical professional will assess the history of the present illness and any past psychiatric or medical history. The mnemonics of " SIGECAPS" (sleep disorders, interest deficit, guilt, energy deficit, concentration deficit, appetite disorder, psychomotor agitation, and suicidal ideation) and " DIGFAST" (distractibility, indiscretion, grandiosity, flight of ideas, activity increase, sleep deficit, and talkativeness) can aid in determining if the chief complaint is associated with any mood disorders such as bipolar disorder or depression (Sadock & Sadock, 2007). The medical professional will then conduct a mental status examination, which evaluates the patient through observations. Specifically, attention will be paid to the patient's appearance, overt behavior, attitude, speech, mood and affect, thinking, perceptions, sensorium, cognition, insight, and level of judgment (Sadock & Sadock, 2007).

Laboratory/Imaging Studies

Before a diagnosis of bipolar it can be confirmed, all other differential medical diagnoses must be ruled out. Laboratory studies need to be ordered such as a complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid studies, drug screen, and adrenal function tests. Disorders of

endocrine systems such as the thyroid and adrenal glands can produce symptoms of depressive disorders. Imaging studies such as a CT or MRI can be used to detect brain abnormalities such as hyperintensities in subcortical regions in patients with bipolar disorder. However, these are not necessary to confirm diagnosis in this case and they do not affect treatment (Sadock & Sadock, 2007).

Medication Management

The first-line treatment for acute bipolar depression is a combination of an antidepressant and a mood stabilizer. According to Sadock and Sadock (2007), the combination of Zyprexa and Prozac is an effective treatment for acute bipolar depression. If given over an eight-week period, mania or hypomania can be avoided. Patient 004 will be started on Prozac 20mg p. o. daily. If the patient's depression symptoms do not improve, the dose of Prozac can be increased after several weeks by 10-20mg increments until a maximum of 40mg is reached. Dosages larger than 20mg per day need to be divided into two daily doses, one in the morning and one around lunchtime.

The patient will also be started on Zyprexa 10mg p. o. daily. If the patient continues to experience bipolar manic symptoms, Zyprexa can be increased every 24 hours by 5mg per day until a maximum of 20mg per day is reached (Deglin & Vallerand, 2009). A fixed combination of Prozac and Zyprexa will be used for eight weeks. If the patient's depression does not improve with Prozac or other standard antidepressants, Lamotrigine may be considered. Lamotrigine has excellent antidepressant properties but is not as useful with reducing manic symptoms (Sadock & Sadock, 2007).

Lithium is the gold standard for maintenance treatment of bipolar disorder. The typical maintenance dose for lithium is 300-400 mg p. o. three times a day. Lithium doses are based on maintaining serum levels of 0. 8-1. 2 mEq/L (Deglin & Vallerand, 2009). Initially, serum levels would be checked every week until they are consistently therapeutic. Then serum levels are checked only once every few months. A EKG will be needed as well and once yearly. If necessary, combination treatment with Carbamazepine and Valproic Acid can be used to decrease adverse effects of lithium. The provider would consistently need to monitor the patient for suicide, substance use, lithium toxicity, and other adverse effects (Sadock & Sadock, 2007).

Patient Education

It is necessary for the patient to be educated on the importance of taking his medication as prescribed and to not abruptly stop taking any of the medications. Side effects of the prescribed medications should be reviewed. Prozac may cause insomnia, agitation, sedation, GI distress, and sexual dysfunction (Sadock & Sadock, 2007). Zyprexa may cause agitation, dizziness, headache, restlessness, sedation, constipation, dry mouth, and weight loss or weight gain (Deglin & Vallerand, 2009). He should be educated on Lithium’s narrow therapeutic range and that regular lab draws will be required. Patient 004 should notify the provider for signs and symptoms of lithium toxicity such as nausea, vomiting, diarrhea, tremors, drowsiness, ataxia, altered mental state, seizures and signs of diabetes insipidus (Carroll, 2014). The patient also needs to be aware that marijuana could exacerbate his Bipolar illness and increase his risk for suicide. It is

important that he not abuse alcohol or other substances (Sadock & Sadock, 2007).

Therapy

Pharmacotherapy along with psychotherapy is currently suggested to help treat mood disorders. The medical professional will review and discuss with the patient the determined diagnosis, explanation of examination results, treatment modalities, and together choose a psychotherapy that is more agreeable to him. Cognitive Therapy has been proven to be effective for major depressive disorder (Sadock & Sadock, 2007).

A Cognitive Therapy goal for the patient is to focus and “ identify negative cognitions, developing alternative and positive ways of thinking” (Sadock & Sadock, 2007 p. 553). His emotions and behaviors are influenced by his perception of events, and therefore therapy can assist him in establishing healthy behaviors, and help him express himself during his depressed moods. According to research conducted by Thimm & Antonsen (2014), cognitive behavior group therapy showed a decrease in BDI-II score from 28. 5 to 18. 5. During follow up, 57% of patients showed a significant improvement in depression and 40% recovered from depression. A long-term therapy goal can be to include his family in therapy. His friends and family can help him overcome his depression by encouraging him to continue with treatment (Sadock & Sadock, 2007).