Module 3 - Caring for a person experiencing depression

Explanations for depression

Neurobiology: Neurotransmitter disturbances in the levels of serotonin, norepinephrine and dopamine have an important role

Genetics: Neurological, cognitive or social vulnerability

Learning theory: repeated sense of failure and an external locus of control can contribute to depression and low mood

Cognitive theory: negative schemes / core beliefs can contribute to a view of self as unworthy

Sociocultural / gender factors: discrimination of minority groups can contribute to depression or increase the vulnerability to depression.

Affective disorders are a set of psychiatric disorders, also called mood disorders e.g. depressive, bi-polar disorder. Other disorders are anxiety disorders and substance use disorders

One off depressive episode, nurses express that it's entirely treatable,

Peri/postnatal depression – effects men and women alike

Depression as a result of medical condition

Adjustment disorder – people adjusting to major change or trauma

Criteria for Major Depressive Episode: DSM-V

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    - Note: Do not include symptoms that are clearly attributable to another medical condition, or mood-incongruent delusions or hallucinations
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
    3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
    4. Insomnia or hypersomnia nearly every day.
    5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
    6. Fatigue or loss of energy nearly every day.
    7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
    8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
    9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.
    - Note: Criteria A–C represent a major depressive episode.
    - Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.
    - Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Module 4 - Caring for a person experiencing suicidal thoughts and behaviours

Prevalence In 2015:

Australia's 13th leading cause of death was suicide.

Suicide accounted for just over 33% of youth deaths (15 - 24yrs)

Death resulting from intentional self-harm is three times higher in males (19.3 deaths per 100,000) than females (6.1 deaths per 100,000).

Suicide death rate for all males in 2015, was observed to be 12.4%. Previously males aged 85+ had a higher incidence of suicide. Current data indicate that men aged between 40 & 54 had more than 30 deaths per 100,000.

Males between 15-19 years of age have the lowest incidence (approx.12 per 100,000 males). However, suicide accounted for 29.6% of deaths for this age group.

For females, the highest age-specific suicide death rate in 2015 was observed in the 45-49 year age group, with 10.4 deaths per 100,000.

Outside of the 0-14 year age group, the lowest age-specific death rate for female deaths was in the 65-69 year age group (4.5 deaths per 100,000).

Self-harm is a familiar presentation to Emergency Departments. It refers to intentional physical damage to one's own body; non-fatal act, where the motivation or intent is not to die.

Difference between suicide and self-harm is the intent underlying the behaviour. People who attempt suicide want to kill themselves, while those who self-harm may or may not. Self-harm can coexist with suicidality.

Self-harm is not necessarily a subset of suicide but people who self-harm may become suicidal and there can be a clear link to increasing suicidal behaviour.

Self harm is more common in younger adults and more common in women than in men. It is usually associated with psychological distress.

People who are suicidal may feel overwhelmed by life events; deciding the only option for finding relief is in ending their life.

Intense feelings of fear, loss, anger, or despair can result in individual to commit suicide

Theories on suicide - Interpersonal factors, Behavioural theory

Interpersonal factors: Suicide may result when people experience social isolation and become alienated from community, family and friends. Another factor is rapid social change. People who have difficulty adapting to demands of new roles are more likely to view suicide as a solution to their problems. Loss is closely related to suicidal thoughts and behaviours.

Behavioural theory: Suicide is a learned problem-solving behaviour. There is internal reinforcement that the behaviour itself, serves to decrease anxiety.

At risk mental state:

- Major mental illness / disorder
- Preoccupation with despair, hopelessness & feelings of worthlessness
- Severe anger, hostility & poor impulse control
- Continual / specific thoughts of suicide (intent, plan, access to means, planning of time, notifying others) or thoughts, plans & symptoms that indicate a risk of suicide
- Command hallucinations or delusion about dying
- Recent interpersonal crisis or major life event – divorce, separation, rejection, humiliation and / or loss.
- Significant past history of risk:
    - Following admission to a MH facility, particularly during the first week
    - Following discharge from a MH setting, predominantly the first month
    - Previous suicide attempt with high lethality
    - Previous history of deliberate self-harm behaviour

Module 5 - E - Caring for a person experiencing anxiety

Anxiety is the most common mental health condition in Australia. On average, 1 in 4 people – 1 in 3 women and 1 in 5 men – will experience anxiety.

In a 12-month period, over two million Australians experience anxiety

Every year in Australia, approximately 14 per cent of the population (1 in 7) experiences an anxiety disorder and 2.7 per cent experiences GAD. Nearly 6 per cent of the population will experience GAD in their lifetime.

Research suggests that 10 per cent of the Australian population experiences social phobia during their lifetime, with 4.7 per cent experiencing social phobia in a 12-month period. More women than men appear to develop the disorder.Close to 3 per cent of people in Australia experience OCD in their lifetime and approximately 2 per cent in a 12 month period.

Around 12 per cent of Australians will experience PTSD in their lifetime. Serious accidents are one of the leading causes of PTSD in Australia.

Up to 40 per cent of the population will experience a panic attack at some time in their life.

Approximately 5 per cent of people in Australia will experience panic disorder in their lifetime, with 2.6 per cent experiencing panic disorder over a 12-month period.

Anxiety can vary in severity from mild uneasiness through to a terrifying panic attack disorder

Anxiety can cause impulsivity, severe Anxiety can lead to suicide

Anxiety Disorder differs from normal anxiety as it is more severe, long lasting, and interferes with a person's work or relationships

People suffering with Anxiety Disorders generally have 2 ways thinking; overestimation of danger or underestimation of persons perception of how they will cope within situation

Anxiety can be protective factor

Types of Anxiety Disorders

- Generalized anxiety disorder (GAD)
- Panic Disorder and Agoraphobia
- Phobic disorders: Social phobia and Specific Phobias
- Post-traumatic stress disorder (PTSD)
- Obsessive-compulsive disorder (OCD)
- Acute Stress Disorder (ASD)
- A person can also experience anxiety alongside other conditions i.e. People with low mood may be an increased risk of anxiety, People with ongoing physical health concerns may present with anxiety, Those who have a changing self – identity may experience anxiety

Theoretical Explanations of Anxiety Disorders

- Behavioural Theory - Anxiety can be learned, neutral cues evoke feelings associated with pain (intergenerational anxiety, child learns how to behave in situation) | Anxiety can motivate a person to avoidance behaviours (overestimation of danger, person doesn't learn to deal with triggers)
- Stress Theory - Based on endocrinology responses | Alarm reactions are a physiological response to stress
- Existential Theory - Fact of life

Theoretical Explanations of Anxiety Disorders

- Biological Theories - Genetics, brain chemistry, neuro-chemical, substances or physiological abnormality
- Psychoanalytical Theory - Anxiety occurs when the individual represses unacceptable thoughts and emotions and they re-emerge in the form of anxiety. Freud believed that individuals mobilise defence mechanisms to control anxiety

Environmental Dimension - Factors which precipitate or exacerbate the physiological experiences of anxiety include:

- Caffeine consumption
- Opium & hallucinogenic drugs
- Medications
- Loss of sleep
- Premenstrual oedema
- Poor nutrition
- Threats to body integrity (Surgery or Injury)