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PSİKİYATRİ HEMŞİRELİĞİ ANABİLİM DALI

INVESTIGATION OF THE PREVALENCE OF BIPOLAR DISORDERS AMONG THE RESIDENTS IN ELDERLY RESIDENTS IN AL_ DIWANIYA_ IRAQ

Master Thesis

Husham Abdulmunem YOUSIF

Çankırı 2021

INVESTIGATION OF THE PREVALENCE OF BİPOLAR DİSORDERS AMONG THE RESİDENTS İN ELDERLY RESİDENTS İN AL_ DİWANİYA_ IRAQ

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Çankırı 2021

ACCEPTANCE AND APPROVAL

Hushem Abdulmunem YOUSIF, graduate student of ÇAKÜ Health Sciences Institute with the number ….., completed his thesis titled "Investigation of the Prevalence of Bipolar Disorder among Residents of Elderly Nursing Homes in Al_ Diwaniya_ Iraq", which he prepared after fulfilling all the necessary conditions determined by the relevant regulations. presented with success.

Tez Savunma Tarihi:

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Yukarıdaki sonucu onaylarım
İmza
Prof. Dr.Özcan ÖZKAN
Enstitü Müdürü

ETHICS STATEMENT

The thesis titled “Al_ Diwaniya_ Investigation of the Prevalence of Bipolar Disorder Among Residents in Nursing Homes for the Elderly in Iraq”, which I prepared and presented as a master thesis; Written by me in accordance with scientific ethics and values. The idea/hypothesis of my thesis is entirely my own and my thesis advisor. The research in the thesis was done by me and all sentences and comments are my own.

I declare that the above mentioned facts are correct.

İmza
Tarih
Husham Abdulmunem YOUSIF

PREFACE

My father and mother, the most valuable people who have faced all the difficulties in my life with me and supported me at every stage of my life, who guided me with their close attention and suggestions at every stage of my work, did not spare any kind of help, always supported me, I will never forget the importance of every word that he used, a great understanding My esteemed teachers who showed and never hurt Assoc. Dr. Sati DIL and Dr. Haydar Emir JABIR I would like to express my endless thanks.

CONTENTS

ABBREVIATIONS

BAI **:** Hamilton Anxiety Rating Scale

DSM-IV **:** Diagnostic and Statistical Manual of Mental Disorders-IV

M.Ö. **:** B.C

M.S. **:** After B.C.

MHPG **:** 3-methoxy 4-hydroxyphenylglycol

OKB **:** Obsesif-kompulsif bozukluk

PB **:** panic disorder

PTSB **:** Posttraumatic Stress Disorder

SCID **:** Structured Clinical Interview for DSM-IV Axis I Disorders-SCID-I

SF **:** Social phobia

TSSB **:** Post traumatic stress disorder

WHO **:** World Health Organization

YAB **:** Social phobia and intense anxiety disorder

YMÖ **:** Teen Mania Scale

TABLE LISTS

ABBREVIATIONS AND SYMBOLS

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AL_ DİWANİYA_ IRAK'TA YAŞLI BAKIMEVLERİNDE KALAN SAKİNLER ARASINDA BİPOLAR BOZUKLUĞU YAYGINLIĞININ İNCELENMESİ

ÖZET

YOUSIF, Hushem Abdulmunem. "Al_ Diwaniya_ Irak'ta Yaşlı Bakımevlerinde Kalan Sakinler Arasında Bipolar Bozukluğu Yaygınlığının İncelenmesi", (Yüksek Lisans Tezi), Çankırı, 2021.

Bu çalışmanın amacı, Irak'ta huzurevinde yaşayan yaşlılarda bipolar bozukluk prevalansını ve depresyon semptomlarını ve bu prevalansla ilişkili faktörleri belirlemektir. Yaygınlık, sosyo-demografik değişkenlerle ilişkili faktörler (cinsiyet, yaş, medeni durum, sosyal güvenlik, gelir durumu, gelir kaynağı), bir kurumda kalmaya bağlı değişkenler (yaşlılık olasılığı, bir kurumda kalma nedeni ve süresi, boş zaman etkinlikleri) Değişkenler (fiziksel aktiviteyi etkileyen, sağlık durumu algısı, kronik hastalıkların varlığı ve uyuşturucu kullanımı) sıralanmaktadır. Bu araştırmanın evreni Irak'ta Kadisiye bölgesinin başkenti Diwaniye huzurevinde yaşayan yaşlılar oluşturmuştur. Çalışma örneklemi, iletişim kurabilen ve çalışmaya gönüllü olarak katılan 60 yaş ve üstü 100 erkek ve kadından oluşmaktadır.

Araştırmada veri toplama aracı olarak anket yöntemi kullanılmıştır. DSM-IV uyumlu SCID-I psikiyatrik görüşme formu kullanılarak ek anksiyete bozukluğu tanısı belirlendi. Depresyon, mani ve anksiyete değerlendirmesi için Beck Depresyon Envanteri, Young Mani Derecelendirme Ölçeği, Hamilton Anksiyete Değerlendirme Ölçeği uygulandı. Bipolar bozukluk hastalarından oluşan grup, sosyodemografik, depresyon, mani dönemleri, anksiyete düzeyleri ve anksiyete komorbidite sıklığı ve ilişkisi yönünden karşılaştırıldı.

Çalışmamızda hastaların %20'sinde en az bir anksiyete bozukluğu, %66'sinde ise birden fazla anksiyete bozukluğu tespit edilmiştir. Bu sonuçlar göstermektedir ki bipolar bozukluk-anksiyete komorbiditesi %20 olarak tespit edilmiştir. Ek anksiyete bozukluğu tanısı almayan 14 hasta (%14) bulunmaktadır. İstatistiksel analizler neticesinde gruplar arasında ölçeklerden elde edilen skorlar açısından anlamlı farklılık tespit edilmemiştir.

Anahtar Kelimeler: Anksiyete, Bipolar Bozukluk, Depresyon, Manik Depresif, Yaşlılık

INVESTIGATION OF THE PREVALENCE OF BİPOLAR DİSORDERS AMONG THE RESİDENTS İN ELDERLY RESİDENTS İN AL_ DİWANİYA_ IRAQ

ABSTRACT

YOUSIF, Hushem (Investigation Of The Prevalence Of Bipolar Disorders Among The Residents İn Elderly Residents İn Al_ Diwaniya_ Iraq), (Master's Thesis), Çankırı, 2021.

The aim of this study is to determine the prevalence of bipolar disorder and depression symptoms and factors associated with this prevalence in elderly people living in nursing homes in Iraq. Prevalence, factors associated with socio-demographic variables (gender, age, marital status, social security, income status, source of income), variables related to staying in an institution (probability of old age, reason and duration of staying in an institution, leisure activities) Variables (including physical activity health status perception, presence of chronic diseases and drug use). The universe of this research consisted of elderly people living in the Diwaniye nursing home, the capital of the Qadisiya region in Iraq. The study sample consisted of 100 men and women aged 60 and over who were able to communicate and voluntarily participated in the study.

Questionnaire method was used as data collection tool in the research. The diagnosis of additional anxiety disorder was determined by using the DSM-IV compatible SCID-I psychiatric interview form. Beck Depression Inventory, Young Mania Rating Scale and Hamilton Anxiety Rating Scale were used to evaluate depression, mania and anxiety. The group consisting of bipolar disorder patients were compared in terms of sociodemographic, depression, mania episodes, anxiety levels, and anxiety comorbidity frequency and relationship.

In our study, 20% of the patients had at least one anxiety disorder and 66% had more than one anxiety disorder. These results show that the bipolar disorder-anxiety comorbidity was found to be 20%. There were 14 patients (14%) who were not diagnosed with additional anxiety disorder. As a result of statistical analysis, no significant difference was found between the groups in terms of scores obtained from the scales.

Keywords: Anxiety, Bipolar Disorder, Depression, Manic Depressive, Aging

1.INTRODUCTION

Depressive disorders have always existed since humanity existed. Especially in today's world, such disorders have reached their peak. Depressive disorders have significant effects on people and their environment and are among the disorders that should be taken seriously and professional help should be sought in this context. There are many depressive disorders described today, one of which is bipolar disorder.

Bipolar disorder, also known as bipolar mood disorder, was formerly known as manic depression, manic episode, or manic-depressive disorder. It refers to mood disorders in which the individual suffers from depression and/or mania, hypomania and/or complex disorders (Davison and Neale, 2004).

A large proportion of people around the world experience depressive disorders. Bipolar disorder generally has a long-term and recurrent feature and has important effects on the patient and his/her environment by causing individual and social adjustment disorders. Although the lifetime prevalence of bipolar disorder has been reported as 1%, it has recently been accepted as a spectrum and there is substantial evidence that disorders in this group occur in 5% of the general population and 50% of the general population (Kaplan and Sadock, 2016).

Anxiety is generally defined as having conceptual, somatic, emotional and behavioral components, and it has serious metabolic and physical effects on living things. Emotionally, it causes feelings of fear and panic. Anxious individuals take everything in the worst possible way, which reduces morale to a minimum. Behaviorally, the patient tends to avoid the factor that causes anxiety.

It is among the most common psychiatric diseases worldwide, and it manifests itself in more than 15% of the population in each period. At the same time, its incidence is high with other psychiatric disorders (Seligman et al., 2001).
As stated above, anxiety is a disorder that can be seen together with other psychiatric

disorders (Altınay, 2005). In this context, when the literature is examined, any type of anxiety disorder, panic disorder (PD), obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), social phobia (SF), and post-traumatic stress disorder (PTSD) Comorbidities in bipolar disorder patients can be seen as bipolar disorder, also known as bipolar disorder, was previously known as manic depression, manic episode or manic depressive disorder. It refers to mood disorders in which the individual experiences depression and/or mania, hypomania, and/or complex states (Davison & Neale, 2004). A large proportion of people around the world experience depressive disorders. Bipolar disorder generally has a long-term and recurrent feature and has important effects on the patient and his/her environment by causing individual and social adjustment disorders. Although the lifetime prevalence of bipolar disorder has been reported as 1%, it has recently been accepted as a spectrum and there is significant evidence that the disorders in this group occur in 5% of the general population and 50% of the general population (Kaplan and Sadock, 2016). According to Davison and Neale (2004), bipolar disorder (bipolar disorder, previously manic-depressive) is a mental disorder characterized by two different illness periods. One of these episodes of the disease is exaggerated (mania) and the other is depressive episodes (depression). These two seemingly opposite pathological periods progress with sedation and exacerbations.

The critical symptoms of bipolar disorder are euphoric or agitated mood, episodes of mania, babbling, hyperactivity, and depression. Physiological and anatomical changes that occur with aging affect the development and outcome of diseases. With aging, there is a decrease in the biological and social motives that constitute the basic strength of the mental structure, and therefore, a decrease in the affect and depression may occur due to motivation. With aging, a decrease in perception and creative abilities, inattention, and slowing of thinking speed can be seen. As a result of the aforementioned changes, those who move away from their productive function, experience a sense of uselessness, regress in mental functions, lose interest in the environment, delay or not be able to respond to new situations, have short-term memory weakness, are touchy, egocentric, sometimes suspicious, help others to continue their daily life. Being alone and being isolated from the environment causes bipolar disorders, formerly known as manic depression. (Eser, 1991).

With aging, intellectual and perceptual problems increase gradually. Sensitive,

egocentric, and sometimes skeptical people see themselves as individuals who deviate from their productive functions, feel useless, lose their mental functions, lose interest in the environment, and are delayed or unable to respond to new situations due to changes. Being alone and isolated from this condition causes bipolar disorder, formerly known as macular depression.

The aim of this study is to determine the prevalence of bipolar disorder and depression symptoms and factors associated with this prevalence in the elderly living in nursing homes. The aim of the study is also important in this sense. People who differ physically, mentally and emotionally therefore interpret events and facts differently. Abrams et al. Fessman and Lester (2000) reported that creating a social environment in nursing homes has a positive effect on depression and loneliness. Between 10 and 15% of the elderly are neurotic or have a personality disorder. Bipolar disorder occurs in 10-20% of elderly patients, especially in women. The need for accurate and up-to-date data for the planning of health services to be given to the elderly increases the need for rehabilitation of many health problems that develop with age, advances in the diagnosis and treatment of chronic diseases and old age are noted. (Kaplan and Sadock, 2016). Studies are needed to determine the prevalence of depression and anxiety in the elderly and to make recommendations for the elderly to lead a mentally healthy life.

According to the Global Aging Monitoring Index, Iraq ranks 87th. Most elderly people with manic syndrome have bipolar mood disorder. Diagnosis can be difficult due to the scarcity of publications on the subject. Disorientation, delirium and reversible cognitive dysfunction can be seen in the manic elderly. The prevalence of bipolar disorder in the elderly over 65 years of age is 0.5%. Posttraumatic stress syndrome, psychiatric diseases, behavioral disorders, and developmental delays in children are the main mental health problems expected throughout Iraq (Medact, 2004). Environmental problems, which pose a very important threat to the health of the Iraqi people, have become much more serious with the war.

Individuals with bipolar disorder face many emotional, social and economic problems and they need support, information and cooperation in coping with these problems, in short, help and support in all processes of the disease. For these reasons, it is extremely important that individuals with bipolar disorder are the subject of

research in the Iraqi state. Therefore, in the literature review, the fact that there is no research on individuals with bipolar disorder in this area in the Iraqi state, the lack of research on the subject makes it essential to investigate this issue and reveals the importance of further research.

1. 1. Purpose of the Study

The aim of this study was to determine the prevalence of bipolar disorder and depression symptoms and the factors associated with this prevalence in the elderly living in nursing homes.

1.2. Hypotheses

Hypothesis 0: Bipolar disorder is not common among nursing home residents in Al-divaniye city, Iraq

Hypothesis 1:. Bipolar disorder is common among residents of a Nursing Home in the city of Al-diwaniya, Iraq.

H1-1: Residents living in nursing homes have high Young Mania, Hamilton Depression and Beck Depression scores.

H1-2: There is a significant difference between Young Mania, Hamilton Depression and Beck Depression scores according to the socio-demographic characteristics of the residents living in the nursing home.

H1-3 : There are significant relationships between the Young Mania, Hamilton Depression and Beck Depression scores of the residents living in the nursing home.

2. GENERAL INFORMATION

2.1 Old and senile

Human life is studied in an evolutionary way over time. The first stage of human life is considered as youth and this stage is the period until adulthood. Adolescence is the period in which bodily growth and maturation continues, the environment prepares the individual for adulthood in all aspects, characterized by continuous development and includes early childhood, childhood and adolescence. . The second period is the middle or adult age period, which is adapted to the period when the individual is biologically productive, fulfills his social life and duties, and benefits from the socialization process. The third period is old age, there is a physical decline, decrease in biological capacities, flexibility in social and life roles, and a rapid decline in the level of individual and social expectations. The transition from youth to adulthood, from adulthood to old age, refers to the process of "aging". As long as we live, that is, every day since birth, we age or age one day more than the day before. But when we talk, we don't say "I'm not a kid anymore, I'm young". It has been used and understandable given aging and dementia (Spar and La Rue 2006: 19).

It is the emergence of physiological and psychological changes in which the interaction between the genetic structure and the environment is observed at the highest level as a result of development and maturation in old age. Determining the onset of old age physiologically is difficult and psychologically almost impossible. If a person feels old and acts like an old person, he is old. This is manifested in changes such as mental indifference to the environment, withdrawal and inability to enjoy life. Aging is the sum of events regulated by a genetic program that leads the organism to death with structural and functional changes. There are different ways to define old age according to biological, social, economic and chronological criteria. These are: biological aging is considered "a broad period from adolescence to adulthood"; social aging is a stage in which society qualifies the individual as "old"; economic old age is considered in some societies as a period that begins with

"retirement"; chronological old age is the age limit "accepted as a calendar"; psychological old age, "living in memories, yearning for the past and looking to the future because of fear, anxiety, and sadness, etc." all feelings ”; social aging; it is the loss of power and capacity in social life, work and social relations (Canatan, 2008:13,14). The World Health Organization (WHO) recognized the end of the age of 64 as the first stage of the elderly population in 1989. According to the health statistics of developed countries, people over the age of 64 are quite heterogeneous in terms of age and gender. For this reason, people aged 80 and over are considered as a separate group in health statistics. According to the country's statistical yearbook, the ratio of the population aged 65 and over (elderly population) to the total population is 4.3%. According to the research, it is estimated that the population aged 65 and over will constitute 9.3% of Iraq's total population by 2025. Population estimates show that 26% of the European population will be 60 years old by 2034. From this point of view, more than two-thirds of the total population growth will occur in developing countries (Çirput, 1997).

The elderly are divided into 3 groups according to their health status and problems and the services to be provided to them. The period between the ages of 65-75 is called "young old age" and it is the period when significant functional losses are not expected. Between the ages of 75 and 85, it is the "advanced (mean) old age" period in which functional losses are seen. 85 years and older is called "very old". People at this stage, private residences and private homes need a caregiver.

In his book on geriatric psychiatry (Spar and La Rue, 2006) "Who is Elderly?" The title expansion is as follows: The biological and psychological changes that come with aging happen slowly over years or decades, so there is often no single age at which people, like older people, can be judged. The general practice of treating people over 65 as "elderly" began in Germany in the 1880s, when Otto von Bismarck chose 65 as the lower limit for some social security. In the United States, the full Social Security age has been raised to 67 for those born in 1960 and later. Although this change is mainly due to financial reasons, the increase in the age limit also indicates an increase in the productivity and viability of the elderly population.

According to a recent national survey, the age at which Americans consider people to

be old is 63; however, this view varies considerably. More than a third of respondents said 70 is the lower age limit, and the remaining quarter is under 60. Aging experts draw finer chronological boundaries within the general group of older people. A comparison can be made between young and old (typically 75 and under) or between these groups and older (typically 85 and above). While these distinctions are arbitrary, they can be useful in identifying differences in level of functioning and preventing overgeneralization of the characteristics of the elderly. It's also important to keep in mind that some people may age faster in some ways than others; for example, it is possible to be physically “older” and psychologically or socially younger (Çirput, 1997:3).

2.2 Old Age Life and Nursing Home

Old age, which is the last stage of human life, is an inevitable period. Aging is a process in which the laws of nature make us our destiny, and it is necessary to consume this process as it deserves. It is seen that the biological, psychological, economic and social characteristics of the individual are different in the old age and adulthood periods of youth. In this period, the individual is faced with biological problems such as decreased physical activity and physical deterioration due to decreasing body functions over time. In old age, changes occur in mental functions such as intelligence, memory, learning ability and speed, perception and motivation, coping and coping mechanisms and mental state." (Erinç, 2008).

Problems such as less willpower, environmental awareness, indifference or exaggerated interest in the events around, worthlessness, pessimism and loneliness can be seen depending on the past. A person who can easily socialize in adolescence and adulthood may withdraw and limit their relationships with their environment as they get older. Erikson said that the aging individual can become as mature as possible in his own cultural environment and historical period. These people, who question the meaning of life knowing that their paths crossed with a period of human history, attribute social meanings to their limited lives that increase the joy of living. For individuals who do not have this maturity, the period of not wanting to be revived is shortened. This situation creates anxiety and an intense fear of death (Kottak, 2002).

There are differences in the social status of the elderly. These differences vary according to the cultural structure of the society. Differences in social status, changing roles in old age shape and affect the elderly and their lives positively or negatively depending on the social and cultural characteristics of the social structure in which the individual lives. The historical transformation of "traditional" societies into "modern" societies in the 18th century appeared on the world stage with the industrial revolution, that is, the industrialization of the economy (Oğuzhanoğlu and Özdel, 2005: 124).

Modernization includes industrialization, urbanization, increased literacy, education, welfare, social mobilization, and a more complex and differentiated professional structure. Modernization is the product of the expansion and growth of scientific and technical knowledge, which gained momentum in the 18th century and allowed the environment to be controlled and reorganized in unprecedented ways. Modernization is a revolutionary process, a phenomenon comparable to the transition from primitive society to civilized society with the emergence of agricultural civilization 5000 years ago in the Euphrates, Tigris, Nile and Indus valleys. The attitudes, values, knowledge and culture of people in a modern society are significantly different from those in traditional society (Haviland, 2002).

In order to understand the possibility of living with children that traditional life offers to the elderly and the need to live alone due to modern life, we should talk about the big family, which is the smallest touchstone of the societies in which they live. (Guvenc, 1973). In extended families, the decision right is usually with the eldest member of the family and other members of the family follow the decisions taken within this framework. Newly married couples in the family comply with family decisions (Kottak, 2002).

In traditional societies, the young are expected to respect the elderly. In the traditional administration of the village, the council of elders is dominant. The rules are determined by the council of elders. Nuclear family; This is the structure of parents and single children we encounter in modern life. The nuclear family is alone with various problems in industrial societies where the family has lost its basic economic feature and productive function. The need to go to work instead of staying at home and the fact that at least one or all of the adults in the family have to work

cause family members to be separated from each other for a long time. While the extended family structure consists of strong kinship ties, these situations end the kinship relations in the nuclear family structure (Huntington, 2002).

The lack of continuity of small families and the situation of the elderly are among the problems of the nuclear family. Having a respected place in the concept of extended family, which means living in accordance with their traditions, the elderly are a part of the nuclear family that is respected, valued, cared for and cannot be followed by family members. In the structure of the nuclear family, the obligation of the elderly to live alone is emphasized. This exposes the elderly to feelings of exclusion, loneliness and excess and reduces life satisfaction. Some developed countries see old age as a "crisis". The most important reason for this is defined as the burden of this age group on the economic structure of the country (Haviland, 2002).

People living in developing countries continue to hold their respected roles in society as they age; However, these people are at risk of losing their jobs due to migration, urbanization and economic instability. Especially in Western societies, the decrease in social support and relations with the elderly create a serious mental health problem. On the other hand, maintaining relationships with children and siblings is an important source of emotional satisfaction in old age (Göz, 2008: 6). Old age, which will eventually lead to the need for care, is generally associated with hopelessness (Kutsal-Seleks, 2007).

The elderly, who remind others of death and limited life span, are generally seen as weak, intolerant, stubborn and isolated from society (Oğuzhanoğlu-Özdel, 2005: 125). Limited communication, blocked feelings and thoughts between themselves and their loved ones make it difficult to reconstruct the lost, balance and psychological well-being. Thus, the energy that connects people to life and others decreases and introversion develops. Moreno said the psychological death that previously caused physical death was rarely noticed and the remedy was to find a friend and a partner for them. Partner and friend are accepted as life attachment activities that contribute to health and peace (Tufan, 2002).

Families are shrinking, women are working outside the home, and relations with

relatives and neighbors are weakening in our country, where a rapid transformation from traditional city life to modern city life is taking place. Especially in big cities, problems are encountered in meeting the needs of the elderly in terms of care, health, shelter, income protection and social protection. The evolution of the family structure with modern life sees the elderly as a burden problem. The role and status difference in the lives of the elderly in urban areas is negative. Various solutions have been tried to reduce the effects of this negative development and to eliminate some dissatisfaction in the lives of the elderly (Tufan, 2001: 287).

Nursing home, which is one of the institutional care models offered as a solution to the survival of the elderly, is a type of service that has become widespread in cities to meet the needs of the elderly in need. nursing homes; It refers to the boarding school social service organizations established to protect and care for the needy elderly in a peaceful environment and to meet their social and psychological needs. It is a boarding school offering accommodation and social life (Saka et al., 2011).

A nursing home covers a wide spectrum, from a facility that meets basic physiological needs such as food and shelter, to a facility that provides all comprehensive care and services. The first type of institutional care consists in destroying the individual's individuality and reducing it to society. The elderly staying at the facility are expected to obey the rules rather than physical and mental activities, without allowing pacifism, personal preferences and self-expression. The second type of contemporary institutional care concept is seen as a complete and inclusive living environment that provides all necessary health and social services and treatments. It provides a rich experience that develops the ability to manage and control the material, spiritual, emotional, physical and educational affairs and entertainment important to one's well-being. This situation negatively affects our elderly people, who have to live in nursing homes due to their needs in areas such as shelter, health, socio-psychological support, because a different lifestyle is offered in traditional life (Sachs et al., 2003).

Bipolar disorder is a long-term illness with periods of illness and well-being that can lead to significant psychosocial disorders and disability (Danış, 2004). It has been reported that it ranks 8th among the diseases that cause loss of function and disability

in the society.

2.3 Bipolar Disorder, Definition and History

Bipolar disorder is a condition that causes the person to feel extremely euphoric or stagnant, increased or decreased mood, mania, hypomania, depression, mixed episodes and mood swings (Akiskal, 2007).
According to Davison and Neale (2004), bipolar disorder (formerly known as manic depression) is a type of illness combined with two distinct illness episodes. One of these episodes of the disease is exaggerated (mania) and the other is depressive. These two seemingly opposite pathological periods progress with sedation and exacerbations. The critical symptoms of bipolar disorder are exuberant or agitated mood, manic episodes, babbling, hyperactivity, and depression. (Akiskal, 2007).

Mood disorders have been one of the most common diseases for about 2,500 years (Sachs and Rush, 2003). In prehistoric religious books, Greek and Latin works, patients with episodes of severe depression and euphoria were mentioned (Colom and Vieta, 2012).

Hippocrates (460-357 BC) systematically defined the concepts of mania and melancholy for the first time and defined melancholia, which he also called "black bile", as "anorexia, hopelessness, insomnia, nervousness and restlessness" (Ceylan and Oral, 2001).

Aretaeus M.S. He declared for the first time in the 1st century that mania and melancholy were two different states of the same disease, and this view formed the basis of the concept of "bipolarity" today. Farlet gave the full definition of disorder in 1854 as "cyclic madness" and Baillarger as "a double form of madness". They also stated that mania and depression were clinically and conceptually related to each other. Both researchers mentioned situations characterized by excitement, sadness and well-being at different times in their definitions (Stone, 2007).

Kraepelin (1856-1926), in addition to bringing together all kinds of mania and melancholia, presented manic-depressive disorder as a nosological and a disease and

defined the limits, underlying cyclical course and clinical features of manic-depressive psychosis and schizophrenia (Akiskal, 2007).

Leonard demonstrated in his studies that there are clinical, evolutionary and familial differences between bipolar and unipolar mood disorders, which was independently confirmed by Angst and Perris in 1966 (Colom and Vieta, 2012).

In collaboration with the North American group led by George Winokur, their work was standardized and the scientific and clinical basis for the early classification of mood disorders was established on the basis of criteria. The discovery of lithium salt (1949), along with the development of nosological concepts, is an important development in the history of bipolar disorder (Colom and Vieta 2012).

2.4 Classification and Diagnosis

Four types of disorders are mentioned under the heading of bipolar disorder in DSM-IV (DSM-IV TR, 2005);

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymic disorder
- Bipolar disorder (BTA)

According to DSM IV, bipolar disorder is defined by a specific set of symptom criteria. Type I bipolar disorder requires the presence of at least one manic or mixed episode. Typically, a patient with a manic episode will have a major depressive episode, while bipolar I disorder can be diagnosed in patients who have had a manic episode and have not had a major depressive episode in the past.

According to Stahl (2010), Bipolar I patients are in a mixed episode of full manic episode and/or complete mania in addition to simultaneous complete depression, and this period is usually followed by a full depressive episode. When mania occurs at least four times a year, it is termed rapid cycling. Bipolar I patients can also quickly switch from mania to depression or back to mania. By definition, this happens at least four times a year.

2.4.1 Bipolar-I disorder DSM-IV TR diagnostic criteria;

There is at least one manic or mixed episode. Depressive episodes are either present or appear later (however, their presence is not essential for diagnosis). Mood episodes are schizoaffective disorders and overlap with schizophrenia, schizophreniform disorders, or delusional or psychotic disorders unclassified elsewhere. Symptoms may appear clinically in social, occupational, or other areas.
This causes discomfort or significant impairment. Symptoms are not directly related to the physiological effects of a substance (eg, a substance of abuse or a drug) or a general medical illness (eg, hyperthyroidism) (Eroğlu, 2010).

The main feature of bipolar I disorder is having one or more manic or mixed episodes. Manicure department; It is characterized by high mood, euphoric or euphoric, increased self-esteem, motor arousal, and risky behavior. The patient has a pathological state of well-being, joy, pleasure, happiness and enthusiasm. Sometimes the increase in self-confidence is psychotic. Delusions and hallucinations may be mood-related or inappropriate. Due to the acceleration of psychomotor activity, rapid speech, flight of thoughts, accelerated movements, increased sexual desire and insomnia are observed. Alcoholism and drug addiction often accompany the Schedule as impulsivity and risky behaviors increase during this time. Social and occupational dysfunctions and death rate as a result of suicide are 3 times higher than the general population (Güleç and Köroğlu, 2007).

2.4.2 Manic Episode DSM-IV TR diagnostic criteria

• Abnormal and persistently increasing euphoric or restless mood for at least 1 week (regardless of whether or not hospitalization is required)
• Significant and persistent presence of at least 3 of the following symptoms during the mood disorder period (if mood is only agitated).
• Very exaggerated self-esteem or a grandiose feeling
• Decreased need for sleep
• More talkative or rushed than usual.
• Distraction (ie the ability to withdraw and be easily distracted by unimportant or irrelevant stimuli).
• Increased intentional activity (in social, occupational, school or sexual activities) or

psychomotor agitation.

• Engaging in pleasurable activities that can easily cause serious harm (eg, overspending, impulsive sex, and investing in work).

The severity or psychotic nature of the mood disorder that will cause significant impairment in work, social activities and relationships, or require hospitalization to prevent harm to oneself or others. These symptoms are substance abuse or general health. According to Yazıcı, periods in which manic and major depressive symptoms co-exist are called mixed periods. The patient experiences and exhibits severe fluctuations that fill the criteria of both periods, one after the other, in the same period. The mixed episode is basically considered as a subtype of the manic episode and comes to mind with a clear, long-term accompaniment of depressive symptoms (Yazıcı, 2007).

2.4.3 Diagnostic criteria for mixed manic episode DSM-IV TR

At least 1 week, nearly every day, meets criteria for both manic and major depressive episodes. Mood disorder causes significant impairment in occupational or social life, requiring hospitalization to avoid harming others. Symptoms should not be directly related to the physiological effects of a substance or general medical illness.

Bipolar II disorder is distinguished from bipolar I disorder by the presence of hypomania without a manic episode. The main feature of this disorder is the presence of at least one major depressive episode and at least one hypomanic episode, but not a manic or mixed episode. A hypomanic episode differs from mania in that it lasts for a short time (4 days instead of at least 1 week) and causes less severe changes (significant change in social or occupational functioning, psychiatric hospitalization, or psychotic features) (Colom and Vieta 2012).

2.4.4 Diagnostic criteria for bipolar-II disorder DSM-IV TR

Presence of at least one manic-depressive episode or previous episode. Presence of at least one hypomanic episode or previous episode. Not having a manic or mixed episode. Symptoms cause clinically significant or unchanging distress in social, occupational, or other areas (Colom and Vieta 2012).

2.5 Epidemiology

Bipolar disorder does not differ between populations and is seen on average in 2-3%. Its lifetime prevalence varies between 0.45-5.5% and its 12-month prevalence varies between 0.37-1.3% (Akkaya et al., 2012). According to the rare prepubertal bipolar disorder, the mean age of onset is 18 in men and 20 in women. Although the most common age of onset is in the mid-20s, the first symptoms most often appear between the ages of 15 and 19, followed by a second onset between the ages of 20 and 24. However, there is usually a gap of 5 to 10 years between the onset of the first symptoms and the first hospitalization (Güleç and Köroğlu, 2007). BPB begins in the 1920s, BPB I and BPB II have a similar age of onset, but BPB II would start a little later. The first symptoms appear before the age of 21 in 20 to 30% of patients, and after the age of 50 in 10%. Early onset (before the age of 18) is observed in approximately one third of the cases (Eroğlu, 2010). 5-10% of people with depression typically experience their first manic episode in their early 30s 5-10 years later and are diagnosed with bipolar disorder (BPB Meeting, 2008). It is known that 30-40% of people diagnosed with BPD in adulthood experience their first attack during adolescence. According to Lewinson et al., the prevalence of BPD type I in adults is between 1.2% and 1.6%, and the prevalence of BPD type II in adults is 4% (Lewinson, 2013).

Although the lifetime prevalence of BPD in women and men is similar, gender has been reported to have an effect on the phenomenology and course of the disease. Studies show that the average age of onset of mania is 24.4 in men and 24.8 in women (Eroğlu, 2010).

Although BPD type I is seen equally in men and women, BPD type II is more common in women. Although type I BPD begins with a manic episode in men and a major depressive episode in women, the evidence is inconclusive. Manic episodes are more common in men, depressive episodes are more common in women (Sadock, Sadock, & Ruiz, 2009).

2.6 Etiology

Mood disorders occur as a result of the interaction of genetic, biological and

psychosocial factors. If the patients are examined carefully, psychosocial factors can be seen in the emergence of both depression and mania periods, especially at the beginning of the disease. However, over time and as the disease progresses, mood episodes can occur spontaneously without obvious psychosocial factors. Biological factors are thought to play a more important role in mania and recurrent depression. At the same time, it should not be forgotten that the painful life events encountered in early childhood cannot only be mental processes, but can leave permanent traces in the brain (Öztürk, 2008).

2.6.1 Genetic causes

The role of genetic factors in the emergence of bipolar disorder is greater than that of unipolar mood disorder. In a study in which all studies based on family interviews conducted in the last 40-45 years were re-evaluated, the risk of having the same disease in the families of those with bipolar disorder was found to be 8.7% (Smoller & Finn, 2003), which is 8-10% compared to the prevalence of the disease in the general population. times more. In all twin studies conducted in bipolar disorder, the rate of comorbidity in identical twins was found to be higher than in fraternal twins (Average 80% vs 25%) (Blackwood, Visscher, & Muir, 2001).

In adoption studies, the rate of disease in biological parents was found to be higher than in adoptive parents. If one of the parents has BPD-I, the rate of occurrence of mood disorders in their children is 50-75% (Akiskal & Pinto, 1999).

Investigations on some chromosomes in bipolar disorder continue, and in one of these studies, a link was shown with locations on the X chromosome in Israeli families (Baron, Risch, and Hamburger, 1987) and on the 11th chromosome in an Amish family (Egeland, Gerhard, & Pauls, 1987), but these results previously shown links were lost in studies that were not repeated in other families and repeated by expanding families (Baron et al., 1987).

2.6.2 Biochemical causes

It has been suggested that neurotransmitters primarily noradrenaline and serotonin activity levels are impaired in patients with bipolar disorder. The importance of adrenaline and noradrenaline in the emergence of emotions such as fear, anger,

anxiety has been known since ancient times. In some studies, the levels of 3-methoxy 4-hydroxyphenylglycol (MHPG), the main disruptor of the noradrenergic function of the nervous system, were significantly decreased or increased in urine and CSF in patients. Severe depression and increase or decrease in noradrenergic activity were applied. The fact that drugs that lower norepinephrine levels, such as methyldopa, propanolol, and reserpine, can cause depression and an amphetamine that causes an increase in norepinephrine at the synaptic junction supports this hypothesis. It has been suggested that noradrenaline increases in mania, and lithium used for treatment decreases noradrenaline release and increases its reuptake in these patients. Noradrenergic neurons in the cerulous locus in the brainstem send their projections to the cerebral cortex, limbic system, basal ganglia, hypothalamus, and thalamus. It is thought that noradrenergic neurons extending to the hippocampus play a role in the regulation of sensitivity to stress and the emergence of learned helplessness with the continuous stimulation of the locus cerulous (Andreasen and Black, 2006).

Serotonergic neurons in the brain send their projections from the posterior raphe nuclei in the brainstem to the cortex, hypothalamus, thalamus, basal ganglia, septum pellicidum, and hippocampus. Serotonin, together with sleep-wake, desire to eat, adrenaline and dopamine, play an active role in purposeful motor functions and in the restriction of aggressive behaviors. Recently, neurotransmitters and intracellular transmission processes have been investigated in terms of cell plasticity, especially in relation to BPB. Strong evidence has been obtained from different studies regarding the role of changes in nerve cell plasticity and cellular endurance in mood disorders, and these can be summarized as follows (Öztürk, 2008).
Strain causes atrophy in hippocampal cells, which in long-term cell death is observed. Strain prevents hippocampal neurogenesis.

Structural neuroimaging studies of patients with collapse have shown reduced brain volume. Antidepressants increase hippocampal neurogenesis. Antidepressants can prevent strain-induced hippocampal atrophy. Lithium and valproate inhibit GSK-3b (glycogen synthase kinase), which plays a central role in many neurotransmitters and transmission processes in BPB, and increase the level of B20 catenin. Lithium has a cell protective (neuroprotective) effect against different effects. Valproate activates the ERK-MAP (mitogen activated protein)-kinase pathway and supports neurite

outgrowth. Lithium increases the level of N-acetylaspartate, which is a nerve cell life sign, in the brain. Lithium increases the amount of gray matter in the brain.

2.6.3 Neuroendocrine factors

The neuroendocrine system has become an important field of study in the etiology of mental disorders due to the stimulation of emotion in hyperthyroidism, depression frequently seen in hypothyroidism, premenstrual hypersensitivity, and important mental disorders that occur in the postpartum period. At the same time, the lack of expected cortisol suppression when dexamethasone is given in mental depression, the detection of blunted TSH response when TRH is applied, the decrease in the growth hormone response to insulin, and the lack of expected responses in the tests performed by stimulating different endocrine systems have led to an increased interest in this subject. The most common irregularity in the etiology of BPD is in the thyroid, adrenal and growth hormone axis. However, today it is accepted that the disorder in hormonal systems may reflect a dysfunction in the brain (Arora and Daughton, 2007).

2.7. Clinical Features in Bipolar Disorder

The manic phase of bipolar disorder, which is part of the DSM IV mood disorder, is lively, highly active, and extremely safe. She refuses to go to the doctor because she feels well. He is angry with the doctor and those who took him to the doctor. His speech is loud, fast and intense. Speech progresses very quickly and jumps from branch to branch due to excessive thought formation. Emotions are dominated by enthusiasm, extreme joy, and especially anger, and this is called a "high mood". The patient's happiness also affects those around him. But this is not the typical case where joy alone reigns. Mood swings are quite common. Consciousness is clear, orientation and memory are strong. Although attention, perception and memory increase at first, it gradually becomes difficult to focus his attention. Hallucinations can be seen in psychotic mania. The thinking process, that is, associations, accelerated in the patient. He is constantly talking, moving from one subject to another. It cannot dwell on a particular subject. Ideas quickly follow each other (Benazzi, 2007).

The content of the thought often reflects the driving force of the ego. The patient's sense of self-confidence has increased and he believes that he has superior qualities than everyone else. Such grandiose thoughts gradually turn into illusions of grandeur. While 50% of patients in the manic episode showed psychotic symptoms, these symptoms were consistent with mood in about 67% of patients with psychotic symptoms, while the rest had delusions incompatible with mood. Delusions incompatible with manic mood are usually of paranoid type (Sayıl, 2000).

People with depression often have prominent facial features, slumped shoulders, and a sad expression on their face. Speech is weak and slow. The mood is often described as hopelessness, depression, and helplessness. No disorientation (Dell 'Osso, 1993). Most patients complain of forgetting. They say their ability to focus their thoughts or make decisions is weakened. Psychomotor changes include latency or restlessness. Loss of energy, fatigue and exhaustion are common. About 65% of patients have suicidal thoughts and about 15% try to kill themselves. Delusions consistent with mood can often be seen. (Öztürk, 2008; Sayıl, 2000). In a mixed episode, symptoms of mania and depression coexist. Symptoms often include restlessness, insomnia, loss of appetite, psychotic features, suicidal thoughts.

2.8. Comorbidity Status in Bipolar Disorder

Comorbidity is the condition of having two different diseases in a patient. (Mcelroy et al., 2001). The lifetime psychiatric comorbidity rate in type I bipolar patients ranges from 50 to 70%. This difference in rate may be due to the different populations studied. In a study of 288 patients, 65% of patients met DSM criteria for at least one comorbidity, 42% had 2 or more, and 24% had 3 or more axis 1 comorbidities. IV (Krishnan, 2005). Axis 1 comorbidity was associated with early onset of affective symptoms, rapid cycling, and increased cycling severity. Comorbidity has also been associated with poor prognosis, increased risk of suicide, onset of depression, and poor response to lithium (Mcelroy et al., 2001).

In the Watershed Epidemiological Study (ACE), 46% of patients suffered from drug or alcohol addiction, 41% from drug addiction, 2% from panic disorder, and 21% from obsessive-compulsive disorder (Krishnan, 2005).

2.9. Generalized anxiety disorder (GAD)

The main distinguishing feature of Generalized Anxiety Disorder (GAD), a chronic disorder, is extreme anxiety, fear, and nervous anticipation associated with certain events and activities, experienced almost daily. Some symptoms such as restlessness, excitement, fatigue, inability to concentrate, muscle tension and sleep disorders contribute to this situation that the individual cannot control (Dilbaz, 2005).

GAD is a mental disorder that is often overlooked and therefore underrecognized. It is not just about being anxious, it is about feeling anxious all the time (Arkonaç, 1999). It is a type of anxiety disorder in which excessive distress, anxiety and anxiety are felt about many events or activities due to the anxiety and worry experienced, the person has difficulty in controlling his anxiety and the functionality of the person is greatly impaired (Sanderson & Barlow, 1990).

The main symptom of this type of anxiety disorder is anxiety. While anxiety is a symptom seen in other anxiety and depressive disorders, it is a defining feature of GAD. Anxiety is felt more intensely, for a long time, and out of control than in healthy people (Algulander & Bandelow, 2003). At the same time, most GAD patients reported that they experienced more extreme anxiety than other anxiety disorders, even with minor problems (Işık & Işık, 2006).

As in DSM-IV TR, the main feature of the disorder is uncontrollable delusional anxiety and anticipation, which is qualitatively different from waiting anxiety in other anxiety disorders (Sürmeli, 1997). GAD patients are generally those who are disturbed by small things, are constantly afraid and expect the worst to happen (Köroğlu, 2004). This disorder is a restrictive and chronic disorder (Ormel et al., 1994; Wittchen et al., 2000.).

Anxiety is a feeling of worry and fear that threatens life or is perceived as a threat, such as internal distress, anxiety and anxiety (Işık & Taner, 2006). Although it is a fear-like feeling, the person is seen as bad news or disaster, is defined as distressed and anxious, and the intensity of this perception can vary in intensity. Severe patients report that they will do everything to alleviate this problem (Zeytin, 2012).

Behavioral and physical responses also contribute to situations such as fear and anxiety that occur in the individual with anxiety disorder. The person reacts to events disproportionately with anxiety. Lack of self-confidence, seeing himself as an inadequate person, and the emergence of such negative thoughts increase his reactions to events more disproportionately (Öztürk, 2008).

Anxiety affects many systems that work in harmony with each other. As a result, the body becomes unable to perform the necessary processes (Ay, 2011). The experience of anxiety has two parts: fear or worry. Depending on the anxiety, effects on the motor activities and organs of the person can be seen. It also has effects on thinking, perception and learning. Disturbances in attention, forgetfulness and ability to associate events may occur (Esel, 2003).

Anxiety prepares the person for changes in their environment and often accompanies a psychiatric disorder. Anxiety is a condition that exists in every person to some degree. As part of the organism's biological protection system, it is necessary to provide an escape or struggle against the event (Altındağ et al., 2006; Keller, 2006). However, if there is no danger, if it lasts for a long time, pathological anxiety is mentioned. In addition to psychosomatic reactions such as headache, tinnitus, palpitations and fatigue, symptoms such as restlessness, tension and distress may also be seen (Gürbüz, 2010).

People diagnosed with an anxiety disorder experience general restlessness, tense posture, irritability, and restlessness. Patients have an excited tremor in their voices. There is no obvious disorder in the content of the thought and there is a lot of anxiety in the thought (Bal, 2010).

Studies have revealed the relationship between anxiety and bipolar disorder. Anxiety disorders according to DSM IV-TR; panic disorder, generalized anxiety disorder, obsessive compulsive disorder, specific phobia, social phobia, acute stress disorder, post-traumatic stress disorder, anxiety disorder due to a general medical condition. (Ozturk, 2008).

2.10. Anxiety and Bipolar Disorder

When we ask one of the basic questions of a psychiatry exam at any level, the answers will usually be as follows: Bipolar disorders are the group with the most comorbidities among all diseases in psychiatry; The frequency of coexistence with any psychiatric or other physical illness reaches 65-70%. In studies conducted both in our country and abroad, the rate of anxiety disorders in bipolar disorder is around 40%. It has been reported that anxiety disorders are more common among bipolar patients, women, young people, and those with low education levels and unemployed. Is it really that easy to answer this question, which we have thus answered in a rather dry and general medical concept? While man's indefinite fear is called anxiety, it can be assumed that this is the equivalent of the real feeling of fear in animals. Anxiety originates from the depths of our consciousness according to some theories, from our innate temperament traits according to some, and from our feeling of existence according to some. Humans are the only living things in the world that think about their own existence and develop theories. (Freeman et al. 2002).

Although some of us call this a gift from God, and some of us call it the highest level that the instinct to control the living environment, which exists in every living thing, has reached through evolution, the destination is the fact that anxiety is an inevitable part of human existence under all circumstances. In today's societies, what people perceive as a threat is constantly changing shape, and as Fromm describes when explaining psychopathology, starting from the fact that all problems begin with the separation of people from the soil (or the world), anxiety gradually becomes the result of social life, not natural events. As a matter of fact, in the latest version of the American psychiatric classification system DSM, which is the most famous of the systems in which psychiatric disorders are limited, it can be seen how much reference is made to the social dimension in the whole category of anxiety disorders. When the categorical point of view of classification systems is added to this, it will be inevitable to see that anxiety, which constitutes an integral part of our existence, exists in various dimensions in almost every mental state (Bowen et al., 1995).

Although the word anxiety, which we use in daily life, corresponds to anxiety in a

foreign language, some local sources preferred anxiety disorder to anxiety disorder while describing an anxiety disorder describing a disease state. The patients themselves sometimes express these complaints as distress, sometimes as distress, sometimes as anxiety, sometimes as anxiety. Keeping the fact that this situation can sometimes be experienced as an illness and result in help-seeking behavior, we should not forget that anxiety is almost always present in our daily life and actually forms a part of our existence (Freeman et al. 2002).

In the following years, the number of studies on the relationship between bipolar disorder and anxiety disorders has increased and the important results obtained from these studies are as follows: The relationship between these two disease groups is quite common. In addition, the recognition of this relationship makes a great contribution to the correct diagnosis of patients and the determination of appropriate treatment approaches (ECA, 2002). It has been stated that if this relationship is not detected, the symptoms of the disease can be interpreted as a personality pathology, it will be difficult to recognize mixed attacks and it will cause unresponsiveness to treatment (Kessler et al., 1997).

A Hungarian study found that bipolar disorder was associated with a general risk of anxiety disorder and panic disorder and a specific phobia (Freeman et al., 2002).
Although the association between unipolar depression and anxiety disorder has often emerged, some studies show that comorbid anxiety disorders are higher in bipolar disorder than in unipolar depression. In the ACE study, panic disorder comorbidity was 21% for bipolar disorder, 10% for unipolar depression, and 0.8% for the general population. In other words, the risk of anxiety disorder comorbidity in bipolar disorder is 1.8 times higher than in unipolar depression. In the National Comorbidity Study, the comorbidity of panic disorder in the general population was 33% versus 3.5% (OK, 2007).

It has been suggested that panic disorder comorbidity is higher in rapidly progressive bipolar disorder. In the study of Mcelroy et al., it was observed that 20% of the patients were additionally diagnosed with panic disorder. Based on the strong comorbidity of mixed episodes and rapid cycling bipolar disorder, it has been suggested that active panic attacks may be associated with depressive symptoms

(McElroy, 2001).

Numerous studies have revealed that BPD-Anxiety disorder comorbidity is quite common and anxiety comorbidity negatively affects disease severity and prognosis in BPD patients. Despite this general consensus, it is difficult to say that there is a consensus on the prevalence of comorbidity, its relationship to clinical variables, and explanation patterns at this stage. Studies stating that PD is frequently found in BPD and emphasizing the genetic aspect of their relationship suggest that PD-BPD cases should be considered as a subgroup of BPD. Currently, there is no widely accepted model to explain the relationship between anxiety disorders and BPD. As we mentioned earlier, current proposed models fall short of fully explaining the conditions of all BPD patients and the coexistence of these two disorders (Perugi et al., 1997).

It is hoped that studies involving family and genetic analyzes will illuminate the molecular basis of this relationship in the future and give us more information about the nature of diseases. Another limitation of the studies conducted so far is that they evaluated the effects of all comorbid anxiety disorders on the BPD process together. While some researchers from studies conducted so far state that PD should be considered under the title of a genetic subgroup associated with BPD, others point to the course of the presence of GAD and SF among anxiety disorders and the outcome of BPD (Bowen et al., 1995).

2.11. The Role of the Psychiatric Nurse in the Care of Bipolar Disorder Patients

The care given to patients by psychiatric nurses during treatment and care in bipolar disorder includes maintaining the patient's health level, controlling the patient's anxiety, depression and disease symptoms, and preparing the necessary knowledge and skills to carry out their own care. Psychiatric nurses for bipolar disorder perform activities aimed at eliminating or reducing related risk factors for primary prevention, increasing resistance to the disease and preventing the spread of the disease; Planning, implementation and evaluation of practices including early diagnosis of depression or suicidal ideation and prevention of chronic depression and suicides in secondary prevention activities, and social support and skills practices involving individuals with the disease and their families in tertiary prevention, and actions involving reintegration of patients into society. have responsibilities and roles.

(Saarman, Daugherty and Riegel 2000; Silver, Iced, Çakır, 2016).

3. MATERIALS AND METHODS

The research was carried out in a descriptive relational type to determine the prevalence of bipolar disorder and depression symptoms and factors associated with this prevalence in elderly people living in nursing homes in Iraq.

3.1 Universe and Sample

The population of this research consisted of the elderly living in the Divaniye nursing home, the capital of the Kadisiye region. Sample selection was not made in the study, and it was aimed to reach all men and women aged 60 and over who stayed in nursing homes, communicated and volunteered to participate in the study. The study was planned to be conducted by interviewing 120 patients staying in the institution. However, 20 patients were excluded from the study due to the presence of delirium, dementia and organic mental disorders over the age of 86 and the study was completed with 100 patients.

Among the patients who were diagnosed with Bipolar Disorder according to DSM-IV criteria, 100 patients who met the sampling criteria were included in the study. I conducted all the interviews as a researcher. Before inclusion in the study, patients were informed about the study and their consent was obtained.

3.2. Place and Time of Research

The research was applied through face-to-face interviews with elderly individuals staying in Divaniye nursing home, the capital of the Qadisiya region in Iraq, between April 2020 and May 2021.

Promotion of nursing homes: These are centers or social housing that generally provide full care for the elderly or persons over 60 years of age. The old people stay there and pass their old age with a number of other old people. They also receive food, drink, clothing, begging and medical treatment or health care while they stay there.

Nursing home activities: 1-Housing insurance: The elderly benefit from their own room or a room that they share with other elderly people, and they have a special

bed, wardrobe and all the needs to sleep in addition to their living needs and personal needs. 2-Health care: Most of the elderly complain of health problems that may be normal such as inability to move easily, joint pain, or some of them are exposed to serious diseases that require intensive care such as paralysis and others. 3-Recreation services: The elderly have trouble adjusting to the idea of living in nursing homes, so some nursing homes work hard to provide them with a comfortable environment, taking them to parks or open spaces or doing some lively activities such as ceremonies to reward them from time to time or avoid seeing them. by accepting visitors who like it and renewing their sense of being intertwined with people and social life, they always feel like they are between their home and loved ones. 4-Cultural activities: In addition to the provision of newspapers, magazines, some books and other media such as television and radio, it includes organizing seminars appropriate to their interests and ages. 5-Sports activities: In addition to mental games such as chess, sports, which is one of the things that should be done to improve general health such as walking and light exercises, plays an important role in eliminating the boredom felt by the elderly.

The researcher has been serving in the health unit of the Nursing Home for 7 years. The number of employees there is 20.

Research Inclusion Criteria

1. Patients are well enough to complete the interview

2. Absence of delirium, dementia and organic mental disorders

3. To be between 60-85 years old

4. Being literate

5. Volunteering to participate in research

6. Absence of education and language problems that prevent the interview

3.2. Application of Research

The elderly living in Divaniye nursing home, the capital of the Iraqi city of Qadisiya, were included in the study. Patients who were diagnosed with bipolar disorder

according to DSM-IV diagnostic criteria and met the study criteria and volunteered were included. Patients were enrolled individually. The patients included in the study filled the socio-demographic data form developed by the researcher. Comorbidity of anxiety disorders was determined using the DSM-IV compatible SCID-I psychiatric interview form. (Appendix 4) Beck Depression Scale (Appendix 7), Young Mania Rating Scale (Appendix 5), Hamilton Anxiety Rating Scale (Appendix 6) were applied to evaluate depression, mania and anxiety. The patient group with bipolar disorder was compared in terms of socio-demographic characteristics, depression, manic episodes, anxiety levels and frequency, and the anxiety-comorbid relationship. The obtained data were evaluated statistically.

3.3 Data collection tools

Sociodemographic data form: This form was prepared by the researcher considering the literature information. In the form filled by the researcher during face-to-face interviews with the participants, socio-demographic information such as age, marital status, gender, education, monthly income, city of residence, number of hospitalizations in previous years and number of seizures are included. (Appendix 2)

Clinical version of SCID-I: It was created by the American Psychiatric Association in 1997 by revising the test adapted to DSM III-R diagnostic criteria according to DSM IV diagnostic criteria. Developed by First, Spitzer, Gibbon, and Williams, the clinical version of SCID-I, consisting of six modules, examines a total of 38 DSM-IV Axis I disorders with diagnostic criteria and 10 Axis I disorders without diagnostic criteria. The presence of diagnostic criteria is determined by exceeding the threshold of severity. Its reliability is high in severe psychiatric disorders. It is used as a standard interview to confirm the diagnosis in clinical studies (Aydemir and Köroğlu, 2012)

Young's mania scale: Young RC et al. It is ready to measure the severity and change of the manic state it is developing and consists of 11 items in total. Seven of these items are in the five-point likert type and the other four are in the nine-point likert type. These four items were prepared by increasing weights in order to better distinguish patients who are difficult to communicate.

The total scale score is obtained by summing the patient's scores for each item. Turkish adaptation and reliability study was performed (Aydemir & Köroğlu, 2012). (ADDITIONAL…)

Hamilton Anxiety Rating Scale (HAM-A): Developed by Hamilton, it determines the level of anxiety and symptom distribution and measures the change in intensity. It contains a total of 14 questions that challenge mental and physical symptoms. It provides five Likert-type measurements. The total score is obtained by summing the scores obtained for each item. The score of each item varies between 0 and 4, and the total score of the scale varies between 0 and 56. Turkish adaptation and reliability study was carried out (Aydemir & Köroğlu, 2012).

Beck Depression Scale: The scale developed by Beck et al. aims to measure the severity of depression, monitor changes and define the disease. It consists of 21 items and each item is given a number between 0 and 3. People should check the statement describing how they felt last week. The result is obtained by adding elements. A Turkish adaptation and reliability study was conducted (Öner, 2012).

3.4. Ethical Principles of Research

After obtaining the necessary written permissions from the institutions for the implementation of the research (Appendix 1), the residents staying in the nursing home were informed about the study and their verbal consent was obtained. The Worker was applied by providing appropriate social distance within the scope of the Work Covid-19 measures. Data collection tools were applied to nursing home residents who met the inclusion criteria and agreed to participate in the study.

3.5. Evaluation of Data

SPSS 22.0 software package (Statistical Package for Social Sciences) was used in the analysis of the data obtained from the study. Percentage, mean and standard deviation values are given as explanatory statistics. An independent variable t-test (independent samples t-test) was used to compare paired parametric groups and a Mann-Whitney U test was used to compare non-parametric groups. The Kruskal

Wallis test was used to compare the nonparametric groups with more than two variables. The results obtained were graded at the 95% significance level ($p < 0.05$).

4. FINDINGS

The findings obtained from the study are given in charts below.

Table 4.1. Distribution of elderly individuals according to their Sociodemographic Characteristics

	N	**Percent(%)**
Woman	50	50,0
Man	50	50,0
60-85	100	100.0
Married	40	40,0
Single	42	42,0
Widow	18	18,0
Literate	14	14,0
Primary education	7	7,0
Secondary education	50	50,0
University	25	25,0
Master	4	4,0
Bad	8	8,0
Middle	42	42,0
Good	50	50,0
Metropolis	80	80,0
City	18	18,0
District	2	2,0

A total of 100 patients were included in our study, and 50 (50%) of them were women and 50 (50%) were men. The distribution of the patients included in the study according to age groups was examined and the results seen in the Table above were obtained. Accordingly, 100% of the patients are in the 60-85 age range. Of the patients included in the study, 40 (40%) were married, 42 (42%) were single, and 18 (18%) were widowed. The distribution of the patients included in the study according to their educational status is shown in the Table above. According to this, while 14 (14%) of the patients were literate, 4 (4%) graduate, 7 (7%) primary education, 50 (50%) secondary education and 25 (25%) patients.) is a university graduate.

The earning rates of the patients used in our study were considered as bad below 850 TL (153758.86 Iraqi dinars), moderate between 850-3000 TL (153758.86-542678.33 Iraqi dinars), and good over 3000 TL (542678.33 Iraqi dinars). While only 8 (8%) of the patients included in the study had a low income, 42 (42%) had a medium income

level and the remaining 50 (50%) had a good income level. The distribution of the patients who participated in the study we have done, according to the place of residence before they came to the nursing home, is as above. Accordingly, while 80 (80%) of the patients reside in the metropolitan city, 18 (18%) reside in the city and 2 (2%) reside in the district.

Table 4.2. Distribution of Elderly Individuals according to their previous hospitalization status

	N	Percent (%)
Yes	68	68,0
No	32	32,0
Average	100	100,0

Whether or not the patients included in the study were hospitalized before are shown in the Table above. Of the patients included in the study, 68 (68%) stated that they had been hospitalized before, while 32 (32%) stated that they had not been hospitalized before.

Table 4.3. Distribution of patients according to the number of seizures they have had before

	N	**Percent (%)**
0	50	50,0
1	30	30,0
2	13	13,0
3	5	5,0
4	1	1,0
7	1	1,0
Average	100	100,0

The number of seizures was determined by the discourse of the patients. The distribution of the patients according to the number of seizures is as above. When Table 4.3 is examined, 50 (50%) of the 100 patients included in the study did not have seizures before, 30 (30%) 2 times, 13 (13%) once, 5 (5%) 3 times, It was observed that 1 (1%) had seizures 4 times and 1 patient (1%) had 7 seizures.

Table 4.4 Distribution of the scores of the Elderly Individuals from the Young Mania, Hamilton Anxiety and Beck Depression Scales

Scales	**Sub-Dimensions**	**Average ± SS**	**Hydrangea**	**Minimum**	**Maximum**

Young Mania	**H_{1-1}**	12,44	2	0	4
	H_{1-2}	9,10	2	0	4
Hamilton Anxiety	**H_{1-1}**	12,5	2	0	4
	H_{1-2}	11,5	2	0	4
Beck Depression	**H_{1-1}**	11,69	2	0	4
	H_{1-2}	11,14	2	0	4

When Table 4.4 is examined, it was seen that the H1-1 sub-dimension was not statistically significant when the distribution of the scores of the Elderly Individuals from the Young Mania, Hamilton Anxiety and Beck Depression Scales were examined according to the sub-dimensions ($p>0.05$).

Table 4.2. Distribution of the scores obtained from the Young Mania, Hamilton Anxiety and Beck Depression scales by the Gender of the Elderly Individuals

	Gender	**Average**	**SS (±)**	**t**	**p**
Young Mania	Woman	8,80	8,47	-1.195	.238
	Man	11,68	8,56		
Hamilton Anxiety	Woman	13,96	9,02	.354	.725
	Man	13,12	7,72		
Beck Depression	Woman	11,64	9,85	.203	.840
	Man	11,08	9,65		

When Table 4.5 is examined, it is seen that women scored lower than men in the Young Mania Scale, but this difference was not statistically significant ($p>0.05$). Again, as a result of the t-test, it is seen that men and women obtained almost the same scores from the Hamilton Anxiety Scale and the Beck Depression Scale. In this context, no significant difference was found between the two genders in terms of the specified scale score ($p>0.05$).

Table 4.3. Distribution of the scores obtained from the Young Mania, Hamilton Anxiety and Beck Depression Scales by Age of Elderly Individuals

		N	Average	SS (±)	χ^2	P
Young Mania	60-65	32	11,68	6,42	6.020	.049
	66-75	46	7,73	9,04		
	76-85	22	13,36	9,40		
Hamilton Anxiety	60-65	32	15,00	8,90	.680	.712
	66-75	46	12,95	7,74		
	76-85	22	12,63	9,13		
Beck Depression	60-65	32	12,06	9,06	.285	.867

	66-75	46	11,56	10,59	
	76-85	22	9,90	9,14	

In the study, Kruskal Wallis, one of the non-parametric tests, was applied to determine whether there was a difference between the scores obtained from the scales according to the age of the patients. When the chart was examined, only a statistically significant difference was found between the groups in the Young Mania scale ($p < 0.05$). From the Young Mania scale, patients aged 60-65 had the lowest score, while patients aged 76-85 had the highest score.

Table 4.4. Distribution of scores obtained from Young Mania, Hamilton Anxiety and Beck Depression Scales by Marital Status of Elderly Individuals

		N	**Avr.**	**SS (±)**	χ^2	**P**
Young Mania	marrid	40	12,00	10,54	.917	.632
	single	42	10,00	7,72		
	widow	18	6,88	3,82		
Hamilton Anxiety	marrid	40	12,25	8,65	1.278	.528
	single	42	15,09	8,59		
	widow	18	12,77	7,13		
Beck Depression	marrid	40	8,95	7,60	1.378	.502
	single	42	12,23	10,37		
	widow	18	14,66	11,66		

Since the participants in the study did not have a homogeneous distribution according to their marital status, the non-parametric Kruskal Wallis test was applied to compare the scores obtained from the scales, and the results shown in the Table above were obtained. When Table 4.7 is examined, it is seen that widows have the lowest mean and married people have the highest mean in the Young Mania scale, and there was no statistically significant difference between the groups ($p>0.05$). When the average scores obtained from the Hamilton Anxiety Scale are examined, it is seen that the married and widows have a higher average than the single ones, but this difference is not statistically significant ($p>0.05$). Married patients had a lower mean score from the Beck Depression Scale compared to single and widowed patients.

However, as a result of the statistical analysis, it was determined that the mean scores obtained from the Beck Depression Inventory did not differ according to marital status (p>0.05).

Table 4.5. Distribution of the scores obtained from the Young Mania, Hamilton Anxiety and Beck Depression Scales by the Educational Level of the Elderly Individuals

		N	Average	SS (±)	χ^2	P
Young Mania	Literate	14	9,00	12,72	1.580	.812
	Primary	7	8,00	-		
	Secondary	50	11,69	9,11		
	University	25	10,21	8,57		
	Master	4	3,50	4,94		
Hamilton Anxiety	Literate	14	17,00	21,21	4.079	.395
	Primary	7	4,00	-		
	Secondary	50	14,15	8.61		
	University	25	13,03	7,69		
	Master	4	19,00	5,65		
Beck Depression	Literate	14	10,50	12,02	7.421	.115
	Primary	7	32,00	-		
	Secondary	50	15,00	11,21		
	University	25	8,78	7,74		
	Master	4	19,50	10,60		

As a result of the Kruskal Wallis test, which we conducted to determine whether the scores obtained from the scales differ according to the education level, the results seen in the above Table were obtained. Accordingly, it is seen that those with a master's degree from the Young Mania scale have the lowest average, and those with secondary education have the highest average, but there is no statistically significant difference between the groups (p>0.05). While the patient with a primary education degree from the Hamilton Anxiety Scale has the lowest mean score, the patients with a master's degree have the highest mean score. There was no statistically significant difference between the groups (p>0.05). Although the mean score obtained from the Beck Depression Scale of the patient who was a primary school graduate was higher than the others, no significant difference was found between the groups in terms of the scores obtained from the related scale (p>0.05).

Table 4.6. Distribution of the scores obtained from the Young Mania, Hamilton Anxiety and Beck Depression Scales by the Income Level of the Elderly Individuals

		N	**Average**	**SS (±)**	**χ^2**	**P**
Young Mania	Bad	8	6,50	3,69	.763	.683
	Middle	42	10,42	7,33		
	Good	50	10,68	10,01		
Hamilton Anxiety	Bad	8	18,00	13,88	1.974	.373
	Middle	42	14,19	6,90		
	Good	50	12,28	8,50		
Beck Depression	Bad	8	22,50	9,71	5.716	.057
	Middle	42	11,47	9,17		
	Good	50	9,48	9,16		

The above results were obtained as a result of the Kruskal Wallis test, which was conducted to determine whether the average scores obtained from the scales differed according to the income status of the patients. According to this, in the Young Mania scale, those with low income had the lowest average and those with good income had the highest average, but there was no statistically significant difference between the groups ($p>0.05$). While those with low income status obtained the highest mean score from the Hamilton Anxiety scale, it was determined that the patients with good income status had the lowest average, and no statistically significant difference was found between the groups ($p>0.05$). From the Beck Depression Scale, it was determined that those with good income had the lowest average, and those with poor income had the highest average. As a result of the statistical analysis, the scores obtained from the Beck Depression Scale were found to be significant between the groups in terms of scores ($p = 0.057$).

Table 4.7. Distribution of the scores of the elderly individuals on the Young Mania, Hamilton Anxiety and Beck Depression scales by Place of Residence

		N	Average	SS (±)	χ^2	P
Young Mania	Metropolis	80	10,10	8,86	1.354	.50
	City	12	10,00	7,59		
	District	2	18,00	.		
Hamilton Anxiety	Metropolis	80	13,62	8,25	3.346	.18
	City	12	11,11	6,58		

	District	2	32,00	.		
Beck Depression	Metropolis	80	10,92	9,79	.815	
	City	12	12,44	9,67		.66
	District	2	19,00	.		

The above results were obtained as a result of the Kruskal Wallis test, which was performed to determine whether the mean scores obtained by the patients from the scales differ according to the place of residence. When Table 4.10 is examined, it is seen that the patients living in the city have the lowest average and those living in the district have the highest average from the Young Mania scale, but there is no statistically significant difference between the groups (p>0.05). While those residing in the district had the highest average score from the Hamilton Anxiety Scale, it was determined that the patients living in the city had the lowest average, and no statistically significant difference was found between the groups (p>0.05). It was found that those living in metropolitan cities had the lowest average and those living in villages had the highest average from the Beck Depression Scale. As a result of the statistical analysis, no significant difference was found between the groups in terms of the scores obtained from the Beck Depression Scale (p>0.05).

Table 4.8. Distribution of scores obtained from Young Mania, Hamilton Anxiety and Beck Depression scales according to previous hospitalizations of elderly individuals

	Hospitalization	**N**	**Average**	**SS (±)**	**U**	**p**
Young Mania	Yes	68	11,4167	8,96143	184.50	.143
	No	32	7,2143	6,78435		
Hamilton Anxiety	Yes	68	12,9722	8,28936	219.00	.475
	No	32	15,0000	8,54850		
Beck Depression	Yes	68	10,5000	9,08845	209.50	.358
	No	32	13,5714	11,03640		

Mann-Whitney U test, which is one of the non-parametric tests, was used to determine whether there was a difference between the average scores obtained from the scales according to whether the patients were hospitalized before or not, and the results shown in the Table above were obtained. When the table is examined, it is seen that the patients hospitalized before the Young Mania scale had a higher mean than the others, but this difference was not statistically significant (p>0.05). As a result of the statistical analysis, it was determined that those hospitalized before the Hamilton Anxiety Scale had a lower mean than the others and there was no

statistically significant difference between the two groups (p>0.05). It was determined that those who stated that they had been hospitalized before using the Beck Depression Scale had a lower mean than the others and there was no significant difference between the groups (p>0.05).

Table 4.9. Distribution of Elderly Individuals by Comorbid Anxiety Disorder

		N	Avr.	SS (±)	χ^2	P
Young Mania	No additional anxiety disorder	14	6,50	7,89		
	At least 1 anxiety disorder	20	9,70	11,22	3.576	.167
	Multiple anxiety disorders	66	11,34	7,75		
Hamilton Anxiety	No additional anxiety disorder	14	16,37	10,83		
	At least 1 anxiety disorder	20	11,10	7,06	.874	.646
	Multiple anxiety disorders	66	13,59	8,03		
Beck Depression	No additional anxiety disorder	14	12,62	8,84		
	At least 1 anxiety disorder	20	10,00	9,06	.306	.858
	Multiple anxiety disorders	66	11,46	10,23		

As a result of the Kruskal Wallis test performed to determine whether there is a difference between the scores obtained from the scales according to the additional diagnosis of anxiety disorder, the results seen in the above Table were obtained. Accordingly, it was observed that patients without additional anxiety disorder on the Young Mania scale had a lower mean score than the others, but the difference between the groups was not significant (p>0.05). As a result of the statistical analysis, it was determined that the patients without additional anxiety disorder from the Hamilton Anxiety Scale had a higher mean score than the others, and no significant difference was found between the groups (p>0.05). Patients without additional anxiety disorder had a higher mean score from the Beck Depression scale than the other scales. However, as a result of the analysis, no significant difference was found between the groups in terms of the scores obtained from the Beck Depression Scale (p>0.05).

Table 4.10: Distribution of Elderly Individuals according to SCID-I results

	N	**Percent**
No comorbid anxiety disorder	14	14.0
Social Phobia	6	6.0
Specific phobia	2	2.0
PTSB	2	2.0

Specific phobia/GAD	2	2.0
PB/Specific phobia	2	2.0
PB/GAD	2	2.0
Agoraphobia/GAD without a history of PD	2	2.0
PTSD/Social phobia	2	2.0
PTSD/Specific phobia	2	2.0
OCD/Specific phobia	2	2.0
OCD/Social phobia/GAD.	2	2.0
PD/Specific phobia/Social phobia	2	2.0
PB/OCD/GAD	2	2.0
PD/Specific phobia/GAD	2	2.0
PTSD/Social phobia/Specific phobia	4	4.0
PTSD/Social phobia/GAD	2	2.0
OCD/Social phobia/Specific phobia/GAD	2	2.0
PD/Social phobia/Specific Phobia/GAD with Agoraphobia	2	2.0
PTSD/Social phobia/Specific phobia/GAD	2	2.0
panic disorder with agoraphobia	4	4.0
OCD/Social phobia	4	4.0
PB story. Being. Agoraphobia	4	4.0
PB/Social phobia with agoraphobia	4	4.0
PD/Social phobia/GAD	4	4.0
Social phobia/Specific phobia/GAD	4	4.0
GAD	1	1.0
OCD/GAD	6	5.0
Social phobia/GAD	11	11.0
Average	100	100.0

The SCID-I results of the patients included in the study are shown in the Table above. Accordingly, 4 (4%) patients had panic disorder with agoraphobia, 2 (2%) obsessive-compulsive disorder (OCD) and specific phobia, 2 (2%) OCD, social phobia and intense anxiety disorder (GAD).), 4 (4%) had OCD and social phobia, 5 (5%) had OCD and GAD, 2 (2%) had OCD, social phobia, specific phobia and GAD, 2 (2%) had specific phobia, specific phobia and GAD in 2 (2%), panic disorder (PD) and specific phobia in 2, PD, specific phobia and social phobia in 2 (2%), PD in 2 (2%), OCD and GAD, 4 (4%) PD, social phobia and GAD, 2 (2%) panic disorder and GAD, 4 (4%) agoraphobia without PD history, 2 (2%) PD , specific phobia and GAD, posttraumatic stress disorder (PTSD) in 2, PTSD and social phobia in 2 (2%), PTSD, social phobia and specific phobia in 2 (2%), 2 (2%) PTSD, social phobia and GAD, 2 (2%) PTSD and specific phobia, 2 (2%) social phobia, specific phobia and

GAD, 4 (4%) social phobia and GAD, 12 (12% had social phobia, 6 (6%) had GAD detection, 4 (4%) had agoraphobia with PD and social phobia, PD with agoraphobia in 2, social phobia, specific phobia and GAD in 2, agoraphobia and GAD without a history of PD in 2 (2%), PTSD, social phobia, specific phobia and GAD were detected in 2 (2%) has been done.

Table 4.11. Distribution of Elderly Individuals by Number of Anxiety Disorders

	N	**Percent**
No anxiety disorder-	14	14
1 Anxiety disorder	20	20
2 Anxiety disorder together	40	40
3 Anxiety disorder together	20	20
4 Anxiety disorder together	6	6
Average	100	100

Considering the findings in the Table above, 14 (14%) of the patients did not have any additional anxiety disorder. Twenty patients (20%) had at least one anxiety disorder, and 66 (66%) had more than one anxiety disorder.

Table 4.15. Correlation analysis between scale sub-dimensions of Elderly Individuals

		1	**2**	**3**
1-Young Mania	Pearson Correlation	1		
2-Hamilton Anxiety	Pearson Correlation	,844**	1	
3-Beck depression	Pearson Correlation	,857**	,864	1

- P<0.05
- **p<o.o1

Correlation analysis was applied to determine the relationships between the scores of the Young Mania Rating Scale, Hamilton Anxiety Scale, and Beck Depression Scale applied in the study. According to the applied scales, a positive significant relationship was found between the scales.

5. DISCUSSION

In recent years, clinical and pharmacological studies have shown that bipolar disorder and anxiety disorders are strongly related. Although studies on the relationship between bipolar disorder and anxiety disorders have increased in recent years, they are unfortunately insufficient especially in our country. According to OK, the lifetime prevalence of anxiety disorder comorbidity in patients diagnosed with bipolar disorder ranges from 24% to 39%. Most of these patients have more than one comorbid anxiety disorder. In patients with anxiety and bipolar disorder, there is a significant increase in the general level of psychopathology, decreased response to treatment, a negative effect on the disease process, and an increased risk of suicide (Tamam, 2007).

Coryell et al. (2003) compared 148 bipolar patients they had followed for 6 years with normal controls and found that they were unable to advance their education and career significantly, and were far more unemployed until last year.

Although normal witnesses matched age, the marriage rate was half the rate, and the divorce and separation rates were twice as high among married people. In our study, no significant difference was found between the groups as a result of the statistical analysis applied to determine whether the scores obtained from the scales differ according to the educational status and income status of bipolar disorder patients with comorbid anxiety disorder. Simon et al. (2004), in their study on 475 patients with bipolar disorder, reported that the education level of patients with comorbid anxiety disorder was low.

In our study, it was found that 20 (20%) of the elderly individuals had at least 1 anxiety disorder and 66 (66%) had more than one anxiety disorder (Table 4.13 and table 4.14).

Increasing clinical and epipemiological studies in recent years have reported that bipolar disorder and anxiety disorders are associated with a high rate. Although studies on the relationship between bipolar disorder and anxiety disorders have increased in recent years, they are quite insufficient, especially in our country. According to OK, the lifetime prevalence of comorbid anxiety disorder in patients diagnosed with bipolar disorder varies between 24% and 39%. Most of these patients have more than one anxiety disorder co-diagnosis. It has been observed that there is a significant increase in the general psychopathology level, a decrease in the treatment response, the disease process is adversely affected, and the risk of suicide increases

in bipolar disorder patients diagnosed with anxiety disorders (Tamam, 2007).

As stated above, 20% of the patients included in our study had at least one anxiety disorder, thus a comorbidity of 20% was found, while 33 (66%) of the patients had more than one additional anxiety disorder. As a result of the statistical analysis, no significant difference was found between the groups that were not diagnosed with additional anxiety, had at least one additional diagnosis of anxiety, and were diagnosed with more than one additional anxiety, in terms of the scores obtained from the scales.

Boylan et al. (2004), in their study on 138 patients with bipolar disorder, reported that 77 patients had a present or lifetime anxiety disorder diagnosis, 33 patients had one anxiety disorder, 22 patients had two anxiety disorders, and 22 patients had three or more anxiety disorders. In the same study, they found that co-diagnosis of anxiety disorder generally negatively affected the bipolar disorder process, but there was no relationship between the increase in the number of comorbidities and the severity and outcome of the illness. However, the researchers said the focus should be on the types of anxiety disorders rather than the number of comorbidities.

According to research by Toprak and Yavuz, 32.9% of patients with bipolar disorder were diagnosed with anxiety disorder during the evaluation period. The most common associated anxiety disorders are panic disorder and PTSD (6.3%), social anxiety disorder (14%), generalized anxiety disorder (9.6%) and OCD (22%), (Toprak and Yavuz, 2011). In conclusion, such patients should be included in the treatment process by detecting the presence of comorbid anxiety disorder during examination and treatment. However, in practice, it is observed by clinicians that this is deficient. The aim of the thesis is to draw attention to the elimination of this deficiency.

A significant relationship was found in the correlation analysis between the total scores of the scales used in the study. Accordingly, the higher the anxiety and depression levels in the elderly, the higher the mania levels. The H1-3 hypothesis in the study was accepted. Accordingly, there are significant relationships between the Young Mania, Hamilton Depression and Beck Depression scores of the residents living in the nursing home.

Within the scope of preventive mental health practices of psychiatric nurses, the findings of this research are illuminating for the plans and practices to be made within the scope of the responsibilities of protecting the health of the elderly people staying in nursing homes, directing them to early diagnosis and treatment, and rehabilitation.

CONCLUSION and RECOMMENDATIONS

The study was carried out with 100 elderly individuals in order to determine the prevalence of bipolar disorder and depression symptoms and factors associated with this prevalence in the elderly living in nursing homes in Iraq.

According to the results;

*100% of the elderly individuals included in the study are in the 60-85 age range. *Forty (40%) of the individuals were married, 42 (42%) were single, and 18 (18%) were widowed.

*When examining the distribution of the individuals included in the study according to their educational status, 14 (14%) of the patients were literate, 4 (4%) were postgraduate, 7 (7%) were primary school, 50 (50%) were secondary school. and 25 (25%) were university graduates.

* Even though the elderly individuals participating in the study currently live in nursing homes, looking at the distribution according to the place of residence before they came to the nursing home, 80 (80%) reside in the metropolitan city, 18 (18%) in the city and 2 (2%) in the district. residency has been reached.

* The SCID-I results of the patients included in the study were panic disorder with agoraphobia in 4 (4%) patients, obsessive-compulsive disorder (OCD) and specific phobia in 2 (2%) patients, and OCD in 2 (2%) patients. social phobia and intense anxiety disorder (GAD), 4 (4%) OCD and social phobia, 5 (5%) OCD and GAD, 2 (2%) OCD, social phobia, specific phobia and GAD, Specific phobia in 2 (2%), specific phobia and GAD in 2 (2%), panic disorder (PD) and specific phobia in 2, PD, specific phobia and social phobia in 2 (2%), 2 PD, OCD and GAD in 4 (2%), PD, social phobia and GAD in 4 (4%), panic disorder and GAD in 2 (2%), agoraphobia without a history of PD in 4 (4%), PD, specific phobia and GAD in 2 (2%), posttraumatic stress disorder (PTSD) in 2, PTSD and social phobia in 2 (2%), PTSD, Social phobia and specific phobia in 2 (2%) PTSD, social phobia and GAD in 2 (2%), PTSD and specific phobia in 2 (2%), social phobia, specific phobia and GAD in 2 (2%) and social phobia in 4 (4%) phobia and GAD, 12 (12%) social phobia, 6

(6%) GAD detection, 4 PD and social phobia with agoraphobia in 2 (4%), PD, social phobia, specific phobia and GAD with agoraphobia in 2, agoraphobia and GAD without a history of PD in 2 (2%) 2) PTSD, social phobia, specific phobia and GAD were detected.

According to the results obtained from the research;

Although it is mild, the anxiety level of male participants was higher than female participants. Depending on this situation, it was thought that it would be beneficial to determine the situations that cause the male participants to experience anxiety and to organize the necessary psychological, physical and social activities and activities in this regard.

In the study, the frequency of anxiety levels of the primary school graduates was higher. In this regard, it was thought that it would be beneficial to provide the necessary financial and moral support to the primary school graduates.

Based on the research findings, it is recommended to plan intervention studies for elderly individuals with additional anxiety disorders for future studies.

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