Psychiatric Nursing

Contemporary Practice

EIGHTH EDITION

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Eighth Edition

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In loving memory of my parents Edward and Emma Long, who provided the opportunity to begin my nursing journey.

MAB

To Adam, for your love, support, and encouragement through every step of this journey. And to the countless students who remind me why this work matters—may this text serve you well as you serve others.

RL

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Preface

Psychiatric–mental health nurses are the forefront of health care delivery. At no other time in the history of the United States have the nursing skills of a psychiatric–mental health nurse been more essential. Mental disorders continue to be recognized as a major societal burden, contributing to high rates of morbidity and mortality, as well as lost economic productivity. One in five people will experience a mental disorder in their lifetime.

The landscape of mental health care is constantly evolving, moving from specialized psychiatric settings to primary care. Our understanding of how emotional and mental health influence overall well-being continues to deepen. While only a small number of nurses may choose a mental health practice setting, all nurses will be challenged to care for patients with psychiatric needs in their day-to-day practice. This dynamic evolution requires nursing students to have a strong background in understanding mental disorders, the knowledge of underlying principles, and the skills to implement evidence-based psychiatric–mental health care.

In the eighth edition of *Psychiatric Nursing: Contemporary Practice*, we introduce the Clinical Judgment Measurement Model, which is used throughout the text. This model challenges students to enhance their clinical judgment by identifying assessment cues, establishing priority hypotheses, and taking action. The purpose of this text is to prepare nurses to care for all people with mental health issues across all clinical settings. We address the mental health needs of underrepresented groups and those groups traditionally excluded from mainstream health care delivery. Many people with mental health needs face inequities in access and health care delivery, compounding physical and mental health needs. Factors such as ethnicity, race, and gender contribute to inequities and exclusion in accessing health care. This edition includes evidence-based discussions of these inequities and their impact on care delivery. Gender-neutral, bias-free language is used throughout the text.

A key enhancement in this edition is the increased emphasis on the holistic care of people with mental health disorders. The biopsychosocial organizing framework is expanded to include the Biopsychosocial-Spiritual Model instead of the traditional biopsychosocial approach. We emphasize spiritual assessment to support a more holistic approach to nursing care. Spiritual interventions are threaded throughout the text. In addition, we explore complementary therapies—including nutrition, dietary and herbal supplements, and essential vitamins and minerals—in a dedicated chapter and throughout the text, ensuring a well-rounded and inclusive approach to mental health care.

TEXT ORGANIZATION

The first three units of *Psychiatric Nursing: Contemporary Practice, Eighth Edition* present the conceptual underpinnings and principles of psychiatric–mental health nursing. In Unit I, students are introduced to mental health nursing care in contemporary society as an evidenced-based practice. Students are introduced to stigma and recovery in Chapter 2, which sets the stage for a more detailed discussion of recovery in Chapter 9. Chapter 3 prepares students for later discussions of cultural, spiritual, and gender-based considerations.

Unit II provides the theoretical foundations of psychiatric nursing including several nursing and recovery frameworks as well as biological and psychosocial theoretical underpinnings. Unit III is the essence of psychiatric–mental health nursing with a detailed discussion of psychiatric–mental health clinical judgment planning including explanations of evidence-based and spiritual interventions. Therapeutic communication skills, psychopharmacology, cognitive interventions, group interventions, complementary therapies, and family assessment and interventions are presented in a clear and understandable language. A new chapter, Complementary Therapies and Integrative Health, is introduced in this unit. This unit prepares the student for making clinical judgments and sound decisions in caring for patients.

Units IV and V present mental health promotion and prevention content, including comprehensive chapters on stress and mental health, crises, safety and de-escalation, and suicide prevention. Unit VI discusses the care of people with mental disorders within a recovery-oriented, evidence-based practice. For each disorder, students will find discussions on spirituality, considerations of inequities in mental health care, complementary therapies, SBAR examples for clinical decision-making, trauma-informed approaches, and clinical vignettes.

Units VII and VIII focus on the assessment and care of children and older adults with mental disorders characteristic of each age group. Unit IX includes chapters related to the mental health needs of veterans, care of

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people experiencing housing instability, and those with co-occurring mental disorders. Chapter 43 addresses the care of people with selected medical disorders that are typically found in people with mental disorders.

The text presents complex concepts in easy-to-understand language with multiple examples and explanations. Students find the text easy to comprehend, filled with meaningful information, and applicable to all areas of nursing practice.

PEDAGOGICAL FEATURES

The eighth edition of *Psychiatric Nursing: Contemporary Practice* incorporates a multitude of pedagogical features to focus and direct student learning, including the following:

By including evidence-based content from which students can draw valid inferences, students can develop clinical judgment and decision-making skills.

- **Expanded Table of Contents** allows readers to find and refer to concepts from one location.
- **Learning Objectives**, **Key Terms**, and **Key Concepts** in the chapter openers cue readers on what will be encountered and what is important to understand in each chapter.
- **Summary of Key Points** listed at the end of each chapter provides quick access to important chapter content to facilitate study and review.
- **Developing Clinical Judgment** includes competency-based statements and asks questions that require students to think critically about chapter content and the important actions to include in their nursing practice.
- **Movie, TV, or Streaming Viewing Guides** list current examples of movies that depict various mental health disorders and that are widely available. Viewing points are provided to serve as a basis for discussion in class and among students.

SPECIAL FEATURES

- **Case Studies** threaded in the disorder chapters are related to the Nursing Care Plan and Therapeutic Dialogue features, giving students the opportunity to apply content. Cases will come from the Patient Experience Videos, to help tie content from the book to the videos. For chapters without a corresponding video, a new case study has been created. Exposure to patients builds student confidence and provides a seamless transition to the practice world.
- **Wellness Challenges** threaded in disorder chapters focus on keeping patients healthy and utilize case study "patient" information to apply the content.
- **Integration with Primary Care,** also threaded in disorder chapters and utilizing case study content, addresses integration of psychiatric disorders with basic health needs blended.
- **NCLEX Notes** help students focus on important application areas to prepare for the NCLEX.
- **Emergency Care Alerts** highlight important situations in psychiatric nursing care that the nurse should recognize as emergencies.
- **Research for Best Practice** boxes highlight today's focus on evidence-based practice for best practice, presenting findings and implications of studies that are applicable to psychiatric nursing practice.
- **Mental Health Inequities** boxes present evidence-based information demonstrating the impact of social determinants, discrimination, and structural barriers that result in vulnerabilities to mental health issues, care, and access to treatment.
- **Trauma-Informed Approach** boxes illustrate the impact of trauma on mental health as well as principles of trauma informed care for nursing students to include in their mental health nursing practice.
- **Reflection of a Nurse** boxes present a scenario that was not effective followed by a reflection of the intervention. Students are provided with reflection questions relevant to the scenario.
- **Building Clinical Judgment with SBAR** boxes consist of an SBAR communication followed by brief questions for the student to provide rationale for the recommendation.
- **Therapeutic Dialogue** boxes compare and contrast therapeutic and nontherapeutic conversations to encourage students by example to develop effective communication skills.
- **Psychoeducation Checklists** identify content areas for patient and family education related to specific disorders and their treatment. These checklists support critical thinking by encouraging students to develop patient-specific teaching plans based on chapter content.
- **Clinical Judgment Vignette** boxes are twofold and present reality-based clinical portraits of patients who exhibit the symptoms described in the text, followed by short-answer clinical judgment questions for the student to identify relevant cues, analyze cues, prioritize hypotheses, and generate solutions.
- **Medication Profile** boxes present a thorough picture of commonly prescribed medications for patients with mental health problems. The profiles complement the text discussions of biologic processes known to be associated with various mental health disorders.
- **Key Diagnostic Characteristics** summaries describe diagnostic criteria, target symptoms, and target associated

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findings for select disorders, adapted from the *DSM-5* by the American Psychiatric Associations.

- **Concept Mastery Alerts** clarify common misconceptions as identified by Lippincott's Adaptive Learning Powered by PrepU.
- **Evidence-Based Nursing Practice of People with Selected Mental Health Disorders** sections provide an in-depth study of the more commonly occurring major psychiatric disorders.

TEACHING/LEARNING PACKAGE

To facilitate mastery of this text's content, a comprehensive teaching and learning package has been developed to assist faculty and students.

Instructor Resources

Tools to assist you with teaching your course are available upon adoption of this text at http://thePoint.lww.com/Boyd8e.

- **A Test Bank** lets you put together exclusive new tests from a bank containing hundreds of questions to help you in assessing your students' understanding of the material. Test questions link to chapter learning objectives.
- **PowerPoint Presentations** provide an easy way for you to integrate the textbook with your students' classroom experience, either via slide shows or handouts. Multiple choice and true/false questions are integrated into the presentations to promote class participation and allow you to use i-clicker technology.
- **An Image Bank** lets you use the photographs and illustrations from this textbook in your PowerPoint slides or as you see fit in your course.
- **Guided Lecture Notes** walk you through the chapters, objective by objective.
- **Watch & Learn Videos,** *Lippincott Theory to Practice Video Series: Psychiatric-Mental Health Nursing*, includes videos of true-to-life patients displaying mental health disorders, allowing students to gain experience and a deeper understanding of mental health patients. This edition includes five new Watch and Learn videos.
- **Movies, TV, or Streaming Viewing Guides** list current examples of movies that depict various mental health disorders and that are widely available. Viewing points are provided to serve as a basis for discussion in class and among students.
- Also available are the **AACN Competency Map, Syllabi,** and **Journal Articles**.

A FULLY INTEGRATED COURSE EXPERIENCE

We are pleased to offer an expanded suite of digital solutions and ancillaries to support instructors and students using *Psychiatric Nursing: Contemporary Practice*, Eighth Edition. To learn more about any solution, please contact your local Wolters Kluwer representative.

The same trusted solution, innovation and unmatched support that you have come to expect from *Lippincott CoursePoint+* is now enhanced with more engaging learning tools and deeper analytics to help prepare students for practice. This powerfully integrated, digital learning solution combines learning tools, case studies, virtual simulation, real-time data, and the most trusted nursing education content on the market to make curriculum-wide learning more efficient and to meet students where they're at in their learning. And now, it's easier than ever for instructors and students to use, giving them everything they need for course and curriculum success!

Lippincott CoursePoint+ includes the following:

- Engaging course content provides a variety of learning tools to engage students of all learning styles.
- A more personalized learning approach, including adaptive learning powered by PrepU, gives students the content and tools they need at the moment they need it, giving them data for more focused remediation and helping to boost their confidence.
- Varying levels of case studies, virtual simulation, and access to Lippincott Advisor help students learn the critical thinking and clinical judgment skills to help them become practice-ready nurses.
- Unparalleled reporting provides in-depth dashboards with several data points to track student progress and help identify strengths and weaknesses.
- Unmatched support includes training coaches, product trainers, and nursing education consultants to help educators and students implement CoursePoint with ease.

vSim for Nursing

vSim for Nursing, jointly developed by Laerdal Medical and Wolters Kluwer Health, offers innovative scenario-based learning modules consisting of web-based virtual simulations, course learning materials, and curriculum tools designed to develop critical thinking skills and promote clinical confidence and competence. vSim for Nursing | Mental Health includes 10 mental health scenarios authored by the National League for Nursing. Students can progress through suggested readings, pre- and postsimulation assessments, documentation assignments, and guided reflection questions, and will

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receive an individualized feedback log immediately upon completion of the simulation. Throughout the student learning experience, the product offers remediation back to trusted Lippincott resources, including Lippincott Nursing Advisor and Lippincott Nursing Procedures—two online, evidence-based, clinical information solutions used in health care facilities throughout the United States. This innovative product provides a comprehensive patient-focused solution for learning and integrating simulation into the classroom.

Contact your Wolters Kluwer sales representative or visit http://thepoint.lww.com/vsim for options to enhance your mental health nursing course with vSim for Nursing.

Lippincott DocuCare

Lippincott DocuCare combines web-based academic electronic health record (EHR) simulation software with clinical case scenarios, allowing students to learn how to use an EHR in a safe, true-to-life setting, while enabling instructors to measure their progress. Lippincott DocuCare's nonlinear solution works well in the classroom, simulation lab, and clinical practice.

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A NOTE ABOUT THE LANGUAGE USED IN THIS BOOK

Wolters Kluwer recognizes that people have a diverse range of identities, and we are committed to using inclusive and nonbiased language in our content. In line with the principles of nursing, we strive not to define people by their diagnoses, but to recognize their personhood first and foremost, using as much as possible the language diverse groups use to define themselves, and including only information that is relevant to nursing care.

We strive to better address the unique perspectives, complex challenges, and lived experiences of diverse populations traditionally underrepresented in health literature. When describing or referencing populations discussed in research studies, we will adhere to the identities presented in those studies to maintain fidelity to the evidence presented by the study investigators. We follow best practices of language set forth by the Publication Manual of the American Psychological Association, 7th edition, but acknowledge that language evolves rapidly, and we will update the language used in future editions of this book as necessary.

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Case Studies in This Book

CASES THAT UNFOLD ACROSS UNITS

CASES THAT UNFOLD WITHIN CHAPTERS

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25 Depression

Nursing Care of People With Depressive Moods and Suicidal Behavior

Barbara Jones Warren and Mary Ann Boyd

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KEYCONCEPTS

- depression
- mood
- suicidal behavior

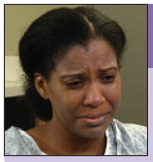
LEARNING OBJECTIVES

After studying this chapter, you will be able to:

1. Examine the roles of mood and depression in depressive disorders.
2. Relate the primary theories of major depressive disorder to clinical symptoms and the course of the disorder.
3. Evaluate the significance of trauma in the appearance of depression symptoms.
4. Examine the relationship between social determinants of health and major depressive disorder.
5. Select strategies to establish a therapeutic relationship with people with major depressive disorder.
6. Using a clinical judgment model, formulate a person-centered, recovery-oriented nursing care plan for people with major depressive disorder.
7. Identify medications that are used to treat people with major depressive disorder and evaluate their effectiveness.
8. Develop wellness strategies for people with major depressive disorder.
9. Compare and contrast mental health care provided in emergency, inpatient, community, and virtual settings.
10. Support the integration of health care and mental health care for people with major depressive disorder.
11. Compare and contrast depression and other depressive disorders.

KEY TERMS

• affect • anhedonia • antenatal depression • cognitive-behavioral therapy • cytokines • depressive disorders • disruptive mood dysregulation disorder • esketamine • glucocorticoids • gut–brain axis • insomnia • interpersonal therapy • interpersonal trauma • major depressive disorder • medical home model • microaggression • perinatal depression • persistent depressive disorder • postpartum depression • premenstrual dysphoric disorder • racism • resilience • self-concept • self-esteem • serotonin syndrome • social determinants of health • suicidal ideation • suicidality



Case Study: Louise

Louise, age 31, was admitted voluntarily to an inpatient mental health unit with depression with suicidal ideation. Louise and her husband, Brian, have three children ages 9, 5, and 3 years.

INTRODUCTION

Most people have bad days or times of feeling sad and overwhelmed. When depressed feelings interfere with daily activities and relationships, however, this mood can impair judgment and contribute to negative views of the world. In some instances, depression is a symptom of a depressive disorder. This chapter discusses mood and depression, depressive disorders, and the related serious issue of suicidal behavior. Major depressive disorder is highlighted.

MOOD AND DEPRESSION

Usual variations in mood occur in response to life events. Normal mood variations (e.g., sadness, euphoria, and anxiety) are time-limited and are not usually associated with significant functional impairment. Normal range of mood or affect varies considerably both within and among different cultures (Umucu et al., 2024).

KEYCONCEPT Mood is a pervasive and sustained emotion that influences one's perception of the world and how one functions.

Affect, or outward emotional expression, is related to the concept of mood. Affect provides clues to the individual's mood. For example, in depression, people often have limited facial expression. Several terms are used to describe affect, including the following:

- *Blunted:* significantly reduced intensity of emotional expression
- *Bright:* smiling, projection of a positive attitude
- *Flat:* absent or nearly absent affective expression
- *Inappropriate:* discordant affective expression accompanying the content of speech or ideation
- *Labile:* varied, rapid, and abrupt shifts in affective expression
- *Restricted or constricted:* mildly reduced in the range and intensity of emotional expression

Depression is the primary mood of depressive disorders. Depression can be overwhelming. Unless appropriately treated, depression persists over time, has a significant negative effect on quality of life (QoL), and increases the risk of suicide (Qaseem et al., 2024; Won et al., 2021).

KEYCONCEPT Depression is a common mental state characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration associated with changes in neurobiologic functioning (American Psychiatric Association [APA], 2022; World Health Organization [WHO], 2023).

DEPRESSIVE DISORDERS OVERVIEW

When a sad mood interferes with daily life, a depressive disorder may exist that will benefit from treatment. In **depressive disorders**, a sad, irritable, or empty mood is present with somatic and cognitive changes that interfere with functioning. Depressive disorders are differentiated according to duration, timing, or cause (APA, 2022). These disorders include major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, disruptive mood dysregulation disorder, and substance/medication-induced depressive disorder, and other specified depressive and unspecified depressive disorders (APA, 2022).

Depressive disorders are complex, dynamic, biopsychosocial-spiritual processes. The clinical symptoms and course of these disorders vary throughout the life span according to cultural values and beliefs. People with depressive disorders experience a lower QoL and are at greater risk for development of physical health issues than those who are not depressed. Depressive disorders are so widespread that they are generally diagnosed and treated in the primary care setting. Every nurse will have an opportunity to impact this global health concern.

Depressive disorders are characterized by severe and debilitating depressive episodes and are associated with high levels of impairment in occupational, social, and physical functioning. They cause as much disability and distress to patients as chronic medical disorders. Frequently, they are undetected and untreated. Because suicide is a significant risk, these disorders are associated with premature death, especially in those individuals who have been hospitalized for depression (GBD 2021 Diseases and Injuries Collaborators, 2024).

MAJOR DEPRESSIVE DISORDER

CLINICAL COURSE

Major depressive disorder is usually a progressively recurrent illness. With time, episodes tend to occur more frequently, become more severe, and are of a longer duration. Onset of depression may occur at any age. Even though the initial onset may occur in puberty; the most common onset occurs in people in their 20s (APA, 2022). Recurrences of depression are related to age of onset, increased intensity and severity of symptoms, and presence of psychosis, anxiety, and/or personality features. The risk for relapse is higher in people who have experienced initial symptoms at a younger age and incur other mental disorders (O'Connor et al., 2023).

DIAGNOSTIC CRITERIA

The primary diagnostic criterion for major depressive disorder is one or more moods, which is either a

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KEY DIAGNOSTIC CHARACTERISTICS 25.1

***DSM-5-TR* DIAGNOSTIC CRITERIA: Major Depressive Disorder**

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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

C. The episode is not attributable to the physiologic effects of a substance or to another medical condition.

Note: Criteria A to C represent a major depressive episode (MDE).

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness, or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of an MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. At least one MDE is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiologic effects of another medical condition.

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depressed mood or a loss of interest or pleasure in nearly all activities for at least 2 weeks. Four of seven additional symptoms must be present: disruption in sleep, appetite (or weight), concentration, or energy; psychomotor agitation or retardation; excessive guilt or feelings of worthlessness; and suicidal ideation (Key Diagnostic Characteristics 25.1).

The incidence of misdiagnosis is often greater for people who are treated by someone from a population that is culturally and ethnically different from the patient's. The clinician's explanation of symptomatology may be expressed using unfamiliar terminology, or the patient may feel uncomfortable with a clinician from a different culture (Dorsey Holliman et al., 2024).

DEPRESSIVE DISORDERS ACROSS THE LIFE SPAN

Children and Adolescents

Children with depressive disorders have symptoms similar to those seen in adults with a few exceptions. They are more likely to have anxiety symptoms, such as fear of separation, and somatic symptoms, such as stomach aches and headaches. They may have less interaction with their peers and avoid play and recreational activities that they previously enjoyed. Mood may be irritable, rather than sad, especially in adolescents. See Chapter 37 for discussion of mental health disorders in children and adolescents.

The risk of suicide, which peaks during the midadolescent years, is very real in children and adolescents. Mortality from suicide, which increases steadily through the teens, is the third leading cause of death for that age group. Findings from research indicate that experiencing chronic bullying increases the risk for depression and suicidal ideation and attempts (Kennedy & Brausch, 2024). The use of substances intensifies depressive symptomatology and the risk of suicide (Oladunjoye et al., 2023).

The COVID-19 pandemic presented psychological challenges to children and adolescents. Virtual learning during community lockdowns meant children could not engage in normal childhood socialization. College students spent weeks in isolation either at home or in a college dormitory. Learning suffered, and suicidal ideation and attempts increased during the pandemic (Danzo et al., 2024). See Chapter 16 for further discussion of suicide in children and adolescents.

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Older Adults

Depression in older adults is often undetected or inadequately treated (Brasileiro et al., 2024). The prevalence of major depressive disorder in adults aged 65 and older ranges from 6% to 9%. Significant depressive symptoms are present in approximately 15% of older adults (Sekhon et al., 2023). Depression in older adults is often associated with chronic illnesses, such as heart disease, stroke, and cancer; symptoms may have a more somatic focus. Depressive symptomatology in this group may be confused with symptoms of bipolar, dementia, or cerebrovascular accidents. Hence, differential diagnosis may be required to ascertain the root and cause of symptoms. See Chapter 39 for further discussion of mental health disorders in older adults.

COVID-19 negatively affected the psychological well-being of many older adults. Social isolation due to sheltering-in-place was associated with greater loneliness and depression. Relationships with family and friends often changed, sometimes permanently. Pandemic-related stressors included confinement and restrictions, concern about other family members, and feelings of loneliness and isolation (Ahmadi et al., 2023).

Suicide is a very serious risk for older adults, especially for those assigned male at birth. Suicide rates peak during middle age, but a second peak occurs in those aged 75 years and older (Garnett et al., 2023). During the COVID-19 pandemic, there was concern among mental health experts that many older adults felt that if they contracted the disease they would need more care than younger people and therefore might believe they would place a burden on society. This belief, combined with lack of access to mental health care caused by COVID-19 social restrictions, increased older adults' risk of suicide during the pandemic (Sadek et al., 2024). See Box 25.1 and Chapter 22.

EPIDEMIOLOGY AND RISK FACTORS

The prevalence of major depressive disorder within the U.S. population is approximately 8.3% within a 12-month time period, with a lifetime prevalence of 20.6%. Individuals between the ages of 18 and 29 years have a higher prevalence rate than do people aged 65 and older. The prevalence of adults with a major depressive disorder was highest among individuals aged 18 to 25 (18%). Episodes typically last more than 6 months. The prevalence of depression is highest among non-Hispanic White adults (21.9%), followed by non-Hispanic Black or African-American (16.2%), non-Hispanic Native Hawaiian or other Pacific Islander (14.6%), Hispanic or Latino (14.6%), and non-Hispanic Asian (7.3%) adults (Lee et al., 2023). In 2021, 14.7% of adolescents aged 12 to 17 years experienced at least one major depressive episode (MDE) with impairment (NIMH, 2023).

The prevalence of major depressive disorder among cultural and ethnic groups is unclear. Although some studies show that Non-Hispanic Black individuals have lower prevalence of major depression compared to non-Hispanic White individuals, researchers suggest that measurement scales for depression may not be culturally adapted to identify symptoms in certain racial and ethnic groups; additionally, as a result of stigma and lack of trust of the health care system, fewer Black people than White people access mental health services (Pederson, 2023).

Data from the WHO indicate that depression is the leading cause of years lost because of disability. More than 50% of people who recover from an initial episode of depression experience another episode within 5 to 10 years (WHO, 2023).

Risk factors for the development of depression include the following:

- Prior episode of depression
- Family history of depressive disorder
- Lack of social support
- Lack of coping abilities
- Presence of life and environmental stressors
- Current substance use or misuse
- Medical and/or mental illness comorbidity

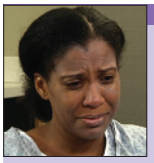
BOX 25.1

Clinical Judgment Vignette: Depression in an Older Adult

Bob, age 75, lost his wife to cancer 18 months ago. Since his wife's death, he continued to live in their family home with his dog. His dog died 2 weeks ago, and he has been despondent since then. His children found him sitting on the side of his bed with a loaded gun. He had already written a note stating he did not want to be a burden and that his children would be better off without him. His family brought him to the emergency department for evaluation.

Building Clinical Judgment

1. What is the likelihood that Bob would actually kill himself?
2. What do you think the next recovery-oriented strategy should be for Bob and his family?



Consider Louise

Louise's sister died as a result of drowning 2 months ago. She has been telling her husband that she just wants to go to sleep and not wake up. What risk factors do you recognize?

Sex Assigned at Birth

Throughout the life cycle, people assigned female at birth have a higher rate of depression than those assigned male at birth. There are a variety of explanations for

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this occurrence; people assigned female at birth are more likely to experience abuse and trauma during childhood, setting the stage for depression in later life (Canatan et al., 2024); in addition, endocrine changes associated with depression that occur across their reproductive lifestyle are well documented (Hantsoo et al., 2023).

Depression is associated with low-income living (Corcoran et al., 2021). White people assigned female at birth (8.9%) are more likely than White people assigned male at birth (7.1%) to live in poverty. Other groups have even higher rates, with 18.8% of Black, 17.0% of Latinx, 10.0% of Asian, and 21% of Native American people assigned female at birth living in poverty (Sun, 2023). People assigned female at birth living in poverty are more likely to be the sole parent, leading to food insecurity, inadequate nutrition, and unstable housing (Smith & Mazure, 2021).

Pregnancy

Perinatal depression is conceptualized as **antenatal depression** (depression during pregnancy) and **postpartum depression** (depression that occurs up to a year after delivery). Perinatal depression occurs in one of four pregnancies, and rates are higher in vulnerable populations (Al-Abri et al., 2023). Antenatal depression can lead to pre-term births, low-birth weight, gestational diabetes, substance use, ambivalence about pregnancy, and overall poor health. Infants can be exposed to elevated maternal cortisol and inflammation. Postpartum depression can lead to poor infant–parent bonding and delayed infant development including lower IQ, slower language development, and behavioral issues. It is important for perinatal depression to be recognized and treated (Stewart & Payne, 2023).

LGBTQ+ Individuals and Depressive Disorders

The prevalence of depression in LGBTQ+ individuals is higher than in non-LGBTQ+ people. Individuals who identify as LGBTQ+ face discrimination and stigmatization in school, work, and social settings. In many instances they are rejected by their own family members. These factors predispose them to depression at higher rates than their non-LGBTQ+ peers (Cai et al., 2024). It is estimated that LGBTQ+ youth (ages 13 to 24) make up 20% to 40% of the unhoused population (Mitsdarffer et al., 2023). The circumstances of the COVID-19 pandemic—such as lack of social support, social isolation leading to loneliness, and lack of access to mental health services—further exacerbated the risk for depression and suicide (Kneale & Bécaresm, 2024; Mejova & Homadova, 2023).

Ethnicity and Culture

Mental Health Inequities

Culture and ethnic identity are related to mental health disparities in mental health access and treatment (Cook et al., 2024). **Social determinants of health** (environmental conditions where people are born, live, work, learn, play, worship, and age) are recognized as contributing factors to disparities in various cultural and ethnic groups in the outcomes of depressive disorders; see Box 25.2. (For more information on social determinants of health, see Chapter 3.)

Cultural Communication of Symptoms

People from culturally and ethnically diverse populations may formulate and describe their depressive

BOX 25.2

Mental Health Inequities: Social Determinants of Health and Depression

In a large sample of 30,762 U.S. adults (49.2% of whom identified as male), 8.7% showed depressive symptoms. The majority were non-Hispanic White (44.5%) individuals, followed by non-Hispanic Black (21.4%) individuals, and then by people of other races (18.7%), and then by Mexican American individuals (15.3%). The mean age was 47.25 (SE = 0.26) years. In this sample, there was a higher prevalence of racial/ethnic and gender disparities in depression symptoms. People assigned female at birth and non-Hispanic Black individuals with unfavorable social determinants of health (SDOH) were more prone to depression symptoms compared to individuals in other groups. Adults aged 20 to 59 years had higher odds of depression when exposed to unfavorable SDOHs than older adults (i.e., those 60 years of age or older).

Individuals exhibiting depressive symptoms were more likely to be associated with various SDOHs including unemployment, poverty, food insecurity, education level below high school, lack of health insurance or having government coverage, and not being married or cohabiting with a partner. The severity of depressive symptoms was associated with an increase in the number of SDOHs. Cumulative inequality in SDOHs had a significant impact on depression symptoms. Individuals with 6 or more unfavorable SDOHs were four times more likely to experience depression compared to those with no unfavorable SDOHs.

Source: Liang, J. H., Liu, M. L., Pu, Y. Q., Huang, S., Jiang, N., Bao, W. W., Hu, L. X., Zhang, Y. S., Gui, Z. H., Pu, X. Y., Huang, S. Y., & Chen, Y. J. (2024). Cumulative inequality in social determinants of health in relation to depression symptom: An analysis of nationwide cross-sectional data from U.S. NHANES 2005–2018. *Psychiatry Research, 336*, 115894. https://doi.org/10.1016/j.psychres.2024.115894

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symptoms differently than the clinical language used for diagnosis. In some cultures, somatic symptoms, rather than sadness or guilt, may predominate. Individuals from various cultural groups may have complaints of weakness, tiredness, or imbalance. Culturally distinctive experiences should be assessed to differentiate depression from an expected cultural emotional response (Sik, 2021).

COMORBIDITY

Major depressive disorders often co-occur with other psychiatric disorders including those that are substance related. Depression often is associated with a variety of chronic medical conditions, particularly endocrine disorders, cardiovascular disease, and neurologic disorders (Basiri et al., 2023; Lee et al., 2024).

ETIOLOGY

The etiology of depression is complex and evolving. Once thought to be only psychologically based, we now know that there are multiple neurobiologic changes that underlie depression.

Biologic Theories

The following discussion summarizes current understanding of biologic theories of depression.

Genetic Factors

Family, twin, and adoption studies demonstrate that genetic influences undoubtedly play a substantial role in the etiology of mood disorders. Major depressive disorder tends to run in families and has a heritable component. Major research efforts are focused on developing a more accurate paradigm regarding the contribution of genetic factors to the development of major depressive disorder (Nguyen et al., 2023).

Neurobiologic Hypotheses

Neurobiologic theories of the etiology of depression emerged in the 1950s. These theories posit that major depression is caused by a deficiency or dysregulation in central nervous system (CNS) concentrations of the neurotransmitters norepinephrine, dopamine, serotonin, and glutamate, or in their receptor functions. These hypotheses arose in part from observations that some pharmacologic agents elevate mood; subsequent studies identified their mechanisms of action. All antidepressants currently available have their therapeutic effects on these neurotransmitters or receptors. Current research continues to focus on the role of neurotransmitters and the neurobiology of depression (Cui et al., 2024).

Neuroendocrine and Neuropeptide Hypotheses

Major depressive disorder is associated with multiple endocrine alterations, specifically of the hypothalamic–pituitary–adrenal (HPA) axis, the hypothalamic–pituitary–thyroid (HPT) axis, the hypothalamic–growth hormone axis, and the hypothalamic–pituitary–gonadal axis. High HPA activity with the release of glucocorticoids is among the most typical neurobiologic alterations in people who are depressed. **Glucocorticoids** are harmful to neurons in various brain regions. In addition, mounting evidence indicates that components of neuroendocrine axes (e.g., neuromodulatory peptides such as corticotropin-releasing factor) may themselves contribute to depressive symptoms. Evidence also suggests that the secretion of these hypothalamic and growth hormones is controlled by many of the neurotransmitters implicated in the pathophysiology of depression (Cui et al., 2024).

Cytokine Hypothesis

Psychoneuroimmunology is a recent area of research into a diverse group of proteins known as *chemical messengers* between immune cells. These messengers, called **cytokines**, signal the brain and serve as mediators between immune and nerve cells. The brain is capable of influencing immune processes, and conversely, immunologic response can result in changes in brain activity. Increased cytokine levels are associated with depression and cognitive impairment indicating that inflammatory reactions are involved in the development of some mental health disorders including depression (Cui et al., 2024).

Gut–Brain Axis

A new pathway being studied to understand major depressive disorder is the **gut–brain axis**, which communicates in complex and bidirectional ways. See Chapter 7. Research shows that individuals with major depressive disorders have altered gut microbiota. Stress disturbs the microbiota balance, leading to increased inflammation, which in turn is thought to affect depressive mood and behavior. The benefits of probiotics are currently being studied for the improvement of depressive moods (Carlessi et al., 2021; Cui et al., 2024).

Psychosocial Theories

Psychological theories that serve as a basis for nursing practice for people with a mental health disorder are explained in Chapter 6. Depression is one of the

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disorders treated from a psychological perspective. The following discussion identifies theoretical models often used in nursing care.

Psychodynamic Factors

Most psychodynamic theorists acknowledge some debt to Freud's original conceptualization of the psychodynamics of depression, which ascribes the cause to an early lack of love, care, warmth, and protection and resultant anger, guilt, helplessness, and fear regarding the loss of love. The ensuing conflict between wanting to be loved and fear of rejection engenders pathologic self-punishment (also conceptualized as aggression turned inward), self-rejection, low self-esteem, and depressive symptoms (see Chapter 6).

Behavioral Factors

Behavioral psychologists hold that depression primarily results from a severe reduction in rewarding activities or an increase in unpleasant events in one's life. The subsequent depression then leads to further restriction of activity, thereby decreasing the likelihood of experiencing pleasurable activities, which, in turn, intensifies the mood disturbance. Affected individuals often self-criticize and believe that they do not have the coping skills to deal with life's stresses. If family members believe that the individual is "sick" and lacks the necessary coping skills, they inadvertently reinforce the hopeless self-view of the person who is depressed.

Cognitive Factors

The cognitive approach maintains that irrational beliefs and negative distortions of thought about the self, the environment, and the future engender and perpetuate depressive effects (see Chapter 13). These depressive cognitions can be learned socially from family members or lack of experience in developing coping skills. These individuals think differently than nondepressed individuals and view their environment and themselves in negative ways. They blame themselves for any misfortunes that occur and see situations as being much worse than they are.

Developmental Factors

Developmental theorists posit that depression may result from the loss of a parent/caregiver through death or separation, or through lack of emotionally adequate parenting. These factors may delay or prohibit the realization of appropriate developmental milestones.

Social Theories

Social theories include family and environmental factors.

Family Factors

Family theorists ascribe maladaptive patterns in family interactions as contributing to the onset of depression, particularly in the onset and occurrence of depression in younger individuals. A family becomes dysfunctional when interactions, decisions, or behaviors interfere with the positive development of the family and its individual members. Most families have periods of dysfunction, such as during a crisis or stressful situation when coping skills are not available. Unhealthy interactions within a family system can have a negative impact on one or more family members who do not have the coping skills to deal with the situation.

Environmental Factors

Depression has long been understood as a multifactorial disorder that occurs when environmental factors (e.g., death of family member) interact with the biologic and psychological makeup of the individual. Major depression may follow adverse or traumatic life events, especially those that involve the loss of an important human relationship or role in life. Social isolation, deprivation, and financial deprivation are associated with depression (Chau et al., 2021).

Discrimination and **microaggression** (subtle, ambiguous slights, and actions that are perceived as insulting to targeted groups) are associated with depression and anxiety (Rastogi et al., 2024). **Racism** (a multifaceted system of oppression) disproportionately harms adults and children of color. Racism occurs when access to services and opportunities is based on racial group membership and is maintained through systems such as laws and policies, culture, and discrimination. Research shows that racism is a traumatic experience and can result in depression. When mothers of color experience racism and then develop depression, their children are also likely to develop depression, leading to intergenerational transmission of depression (Mekawi et al., 2023).

FAMILY RESPONSE TO DISORDER

Depression in one family member affects the whole family. Spouses/partners, children, parents/caregivers, siblings, and friends experience frustration, guilt, and anger when a family member is immobilized and cannot function. It is often hard for others to understand the depth of the mood and how disabling it can be. Financial hardship can occur when the affected family member cannot work and instead spends days in bed. The lack of understanding and difficulty of living with a person who is depressed can lead to abuse. People assigned female at birth between the ages of 18 and 45 years constitute the majority of those experiencing depression.

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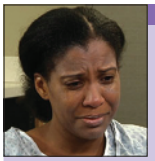
Depression can affect these individuals' ability not only to have productive lives and take care of themselves but also to take care of their children or other family members for whom they may have responsibility. Moreover, research indicates that the incidence of depression may be higher in children whose mothers experience depression (Wu, 2024).



Remember Louise?

According to her husband, Louise has neglected her self-care and that of her children since her sister's death. Brian is very understanding and supportive of Louise's need to grieve, but he is concerned that this is more than grief. Brian says that he is afraid to leave Louise alone and that the children are suffering. What recommendations would you suggest to Louise's husband? Are there indications that Louise's grief is developing into depression?

RECOVERY-ORIENTED CARE FOR PEOPLE WITH MAJOR DEPRESSIVE DISORDER

Teamwork and Collaboration: Working Toward Recovery

Although depressive disorders are the most commonly occurring mental disorders, they are usually treated within the primary care setting rather than psychiatric setting. Individuals with depression enter mental health settings when their symptoms become so severe that hospitalization is needed, usually after suicide attempts, or if they self-refer because of incapacitation. Antidepressants are indicated for depression and are discussed later in this chapter. Interdisciplinary treatment of these disorders, which is often lifelong, needs to include a wide array of health professionals in all areas. The specific goals of treatment are:

- Reduce or control symptoms and, if possible, eliminate signs and symptoms of the depressive syndrome.
- Improve occupational and psychosocial function as much as possible.
- Reduce the likelihood of relapse and recurrence through recovery-oriented strategies.

Cognitive and Interpersonal Therapies

Recent studies suggest that for mild depression, short-term cognitive and interpersonal therapies may be as effective as pharmacotherapy. In many instances, **cognitive-behavioral therapy (CBT)** is an effective strategy for preventing relapse in patients who have had only a partial response to pharmacotherapy alone (Strawn et al., 2022). CBT is implemented in individual or group therapy by a trained clinician.

Interpersonal therapy seeks to recognize, explore, and resolve the interpersonal losses, role confusion and transitions, social isolation, and deficits in social skills that may precipitate depressive states. It maintains that losses must be mourned and related affects appreciated, role confusion and transitions must be recognized and resolved, and social skills deficits must be overcome.

Combination Therapies

For patients with severe or recurrent major depressive disorder, the combination of psychotherapy (including interpersonal, cognitive-behavioral, behavior, brief dynamic, or dialectical behavioral therapies) and pharmacotherapy has been found to be superior to treatment using a single modality. Clinical practice guidelines suggest that the combination of medication and psychotherapy is particularly useful in more complex situations (e.g., depression in the context of concurrent, chronic general-medical or other psychiatric disorders, or in patients who fail to experience complete response to either treatment alone). Psychotherapy in combination with medication is also used to address collateral issues, such as medication adherence or secondary psychosocial issues (Gaddey et al., 2024). If medications and psychotherapy are not effective, other options are available: electroconvulsive therapy (ECT), light therapy, and repetitive transcranial magnetic stimulation (TMS) discussed later in the chapter.

Safety Issues

The overriding concern for people with major depressive disorder is safety because these individuals may experience self-destructive thoughts and suicidal ideation. Hence, the assessment of possible suicide risk should be routinely conducted for any person who is depressed (see Chapter 22).

EVIDENCE-BASED NURSING CARE OF PEOPLE WITH A MAJOR DEPRESSIVE DISORDER

An awareness of the risk factors for depression, a comprehensive and culturally competent mental health nursing assessment, history of illness, and past treatment are key to formulating a treatment or recovery plan and to evaluating outcomes. Interviewing a family member or close friend about the patient's day-to-day functioning and

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specific symptoms may help determine the course of the illness, current symptoms, and level of functioning. The family's level of support and understanding of the disorder should be assessed. See Clinical Judgment Nursing Care Plan 25.1, which sets forth a plan of care for Louise, the case study patient in this chapter.

RECOGNIZING CUES: RELEVANT ASSESSMENT INFORMATION

The mental health nursing assessment focuses on the physical consequences of the depression as well as the psychosocial aspects. The symptoms of depression are similar to those of some medical issues or medication side effects. Often, the psychiatric-mental health nurse is the only clinician who provides holistic care to an individual with depression. Throughout the assessment, the nurse should demonstrate cultural humility in discussing patient values and beliefs. See Chapter 3.

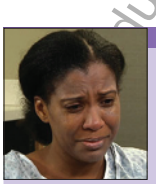
Physical Health

The nursing assessment should include a physical systems review and a thorough history of medical issues, with special attention to CNS function, endocrine function, anemia, chronic pain, autoimmune illness, diabetes mellitus, or menopause. Additional medical history includes surgeries; medical hospitalizations; head injuries; episodes of loss of consciousness; and pregnancies, childbirths, miscarriages, and abortions. A complete list of prescribed and over-the-counter (OTC) medications and herbal supplements should be compiled, including the reason a medication was prescribed, or its use discontinued. A physical examination is recommended with baseline vital signs and baseline laboratory tests, including a comprehensive blood chemistry panel, complete blood counts, liver function tests, thyroid function tests, urinalysis, and electrocardiograms (see Chapter 10).

The following symptoms are characteristics of depression and should be assessed:

- *Appetite and weight changes*: In major depression, changes from baseline include a decrease or increase in appetite with or without significant weight loss or gain (i.e., a change of more than 5% of body weight in 1 month). Weight loss occurs when the individual is not dieting. Older adults with moderate-to-severe depression need to be assessed for dehydration as well as weight changes.
- *Sleep disturbance*: The most common sleep disturbance associated with major depression is **insomnia**, which is broken into three categories: initial insomnia (difficulty falling asleep), middle insomnia (waking up during the night and having difficulty returning to sleep), and terminal insomnia (waking too early and being unable to return to sleep). Less frequently, the sleep disturbance is hypersomnia (i.e., prolonged sleep episodes at night or increased daytime sleep). The individual with either insomnia or hypersomnia complains of not feeling rested on awakening.
- *Tiredness, decreased energy, and fatigue*: Fatigue associated with depression is a subjective experience of feeling tired regardless of how much sleep or physical activity an individual has had. Even the smallest tasks require substantial effort.

NCLEXNOTE In determining the severity of depressive symptoms, nursing assessment should explore physical changes in appetite, sleep patterns, and energy level. Remember these three major assessment categories. A question on the exam may state several patient symptoms and expect the student to recognize that the patient being described is depressed.



Consider This:
Recall that Louise has not been eating because she is not hungry; she has lost 15 lb over the last 6 weeks. She is also not sleeping well. She wakes up during the middle of the night and cannot go back to sleep. What symptoms of depression is Louise experiencing?

Physical Functioning

Changes in physical functioning (mobility and activities of daily living) may be an indication of the severity of the mood disturbance. The nurse should assess any changes and the rate of change in physical functioning over time. Other areas to assess include the presence of excessive sleepiness or falling asleep, sleep apnea, and sudden lapses into sleeping throughout the day.

History of Trauma

Assessing the history of trauma is important in everyone with depression because depressive states are linked to trauma. Childhood trauma is associated with depression in youths and adults. Multiple traumas and interpersonal and sexual trauma in childhood are associated with worsening depression. **Interpersonal trauma** (child maltreatment, physical and sexual assault, witnessing of violence) in childhood is associated with suicidality (Goodman et al., 2024).

Encouraging people who identify as LGBTQ+ to self-identify gender status will allow the nurse to gather trauma history cues. LGBTQ+ people have high rates of lifetime trauma exposure that is linked to depression and

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CLINICAL JUDGMENT NURSING CARE PLAN 25.1

The Individual With Depressive Disorder

Louise is a 31-year-old female assigned at birth with a diagnosis of major depressive disorder with suicidal ideation. She feels hopeless, helpless, and worthless. She is grieving the loss of her sister and also feels that she has failed her. She believes her family would be better off without her. She has lost interest and pleasure in everything that she used to enjoy. She lacks energy to get out of bed or do basic self-care. Her thoughts are negative and distorted. Her facial expression is sad and restricted. She has difficulty smiling or seeing humor in a situation.

Setting: Intensive Care Psychiatric Unit in a General Hospital

Baseline Assessment: Louise is oriented to time, place, and person. She is dressed in a sweatshirt and sweatpants. Her appearance is disheveled, she has a slight body odor, and her hair is not combed. Her physical care plan reveals a recent 15 lb weight loss, insomnia, and loss of appetite. Her vital signs and laboratory values are within normal limits. She denies having a suicidal plan but says she wants to go to sleep and not wake up. Her husband said he is very worried about her because "she is physically there but not available to any of us."

Associated Psychiatric Diagnosis	Medications
Major depressive disorder	Initiated escitalopram (Lexapro) 20 mg/day

Priority Hypothesis Safety and Suicide Prevention

Important Characteristics	Associated Considerations
Feelings of hopelessness Expresses desire to die Lethal means available	Recently lost sister Believes she is a burden to family

Planning Recovery and Wellness Outcomes

Initial

1. Remain free from self-harm.
2. Identify factors that led to suicidal intent and methods for managing suicidal impulses if they return.
3. Accept treatment of depression by trying the SSRI antidepressants and psychotherapy.

Discharge

1. Agrees to continue with outpatient therapy.
2. Agrees to take antidepressant.
3. Agrees that family can remove gun(s) from home.

Taking Action: Nursing Interventions

Interventions	Rationale	Ongoing Assessment
Initiate a nurse–patient relationship by demonstrating an acceptance of Louise as a worthwhile human being through the use of nonjudgmental statements and behavior.	A sense of worthlessness often underlies suicidal ideation. The positive therapeutic relationship can support hopefulness.	Assess the stages of the relationship and determine whether a therapeutic relationship is actually being formed. Identify indicators of trust.
Initiate suicide precautions per hospital policy.	Safety of the individual is a priority with people who have suicidal ideation.	Determine intent to harm self—plan and means.
Discuss with family members removal of lethal weapons from home.	Suicidal behavior is often impulsive. Removing means of suicide may prevent people from acting on impulsive thoughts.	Follow-up with the patient and family member about removing lethal weapons.

Evaluation

Outcomes	Revised Outcomes	Interventions
Has not harmed herself.	Identify strategies to resist suicide attempts in the future.	Discuss antecedents that led to the suicide attempt. Discuss initiation of an antidepressant.

Clinical Judgment Nursing Care Plan 25.1 Continued

Priority Hypothesis Hopelessness	
Important Characteristics	**Associated Considerations**
Decreased affect Decreased appetite Insomnia Lack of initiative States she has no reason to live	Loss of sister

Planning Recovery and Wellness Outcomes	
Initial	**Discharge**
Accept support through the nurse–patient relationship. Identify hopelessness as a pervasive feeling.	Express feelings of being hopeful for the future.

Taking Action: Nursing Interventions		
Interventions	**Rationale**	**Ongoing Assessment**
Establish a trusting therapeutic relationship.	Therapeutic relationships are effective in instilling hope.	Observe verbal and nonverbal cues that increase communications.
Enhance Louise's sense of hope by being attentive, validating your interpretation of what is being said or experienced, and helping him verbalize what she is expressing nonverbally.	By showing respect for the patient as a human being who is worth listening to, the nurse can support and help build the patient's sense of self.	Determine whether the patient confirms interpretation of situation and if she can verbalize what she is expressing nonverbally.
Assist to reframe and redefine negative statements ("not a burden but missing your sister").	Reframing an event positively rather than negatively can help the patient view the situation in an alternative way.	Assess whether Louise is feeling more hopeful.
Participate in a recovery group focusing on hope.	Group support can be very effective in discussing hope and identifying strategies to establish hopefulness.	Determine if the patient is attending group sessions and participating in discussions.

Evaluation		
Outcomes	**Revised Outcomes**	**Interventions**
Able to discuss future events in a positive manner.	Discuss specific plans for future events.	Continue with cognitive approaches when discussing future events.
Attending recovery group regularly.	None.	

SSRI, selective serotonin reuptake inhibitor.

other mental disorders. Many can associate their trauma directly to their gender identity. The trauma and depression of individuals in this population are also linked to suicidality (Hammer et al., 2024). See Box 25.3.

Medication

In addition to a physical assessment, an assessment of current medications should be completed. The frequency and dosage of prescribed medications, OTC medications, and use of herbal or culturally related medication treatments should be explored. When treating a patient with depression, the nurse must always assess the possible lethality of the medication the patient is taking. For example, if a patient has sleeping medications at home, the individual should be further questioned about the number of pills in the bottle.

A patient's use of herbal substances should be determined because of the potential for drug–drug interactions. For example, patients taking antidepressants that affect serotonin regulation could also be taking St. John's wort (*Hypericum perforatum*) to fight depression. The combined drug and herb could interact to cause serotonin syndrome (altered mental status, autonomic dysfunction, and neuromuscular abnormalities). SAMe (*S*-adenosyl-L-methionine) is another herbal preparation that patients may be taking. Patients need to be advised of possible adverse side effects of SAMe taken with any prescribed antidepressant because the exact action of this herb remains unclear. (See Chapters 11 and 12.)

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BOX 25.3

Trauma-Informed Approaches: Childhood Trauma and Psychological Distress for LGBTQ+ Individuals

Background

People who identify as LGBTQ+ experience discrimination, prejudice, microaggressions, and internalized stigma. They are at risk of experiencing a mental disorder, self-injury, and suicidal thoughts. They experience high rates of trauma exposure and posttraumatic stress disorder.

Interventions

- Recognize the impact of identity-based trauma on cognition, emotion, development, behavior, and perception.
- Provide physical and emotional safety.
- Communicate safety procedures.
- Create a predictable environment.
- Demonstrate respect and empathy in interactions in a nonjudgmental approach.

Source: Hammer, L. A., Fergerson, A. K., & Bonfils, K. A. (2024). Recommendations for the assessment of sexual and gender minority status in serious mental illness research and clinical care. *Psychological Services, 21*(3), 417–425. https://doi.org/10.1037/ser0000852

Substance Use

A significant proportion (25%) of people with a major depressive disorder also have a substance use disorder (Rao et al., 2023). Patients should be assessed for their use of alcohol, marijuana, and other mood-altering medications. Alcohol use disorder increases the risk of a depressive disorder more than fourfold (Hassan & Le Foll, 2021). Self-medicating with substances as a coping strategy for dysphoria and stress is well documented (Seager et al., 2024). Not only can substance use lead to dependency, but self-medicating can heighten inflammation and lead to dysregulation of the brain circuitry (Nusslock et al., 2024). These co-occurring disorders have an adverse impact on both mood and substance use outcomes.

Psychosocial Cues

The psychosocial assessment for people who have major depressive disorder includes the mental status (mood and affect, thought processes and content, cognition, memory, and attention), coping skills, developmental history, psychiatric family history, patterns of relationships, quality of support system, education, work history, and impact of physical or sexual abuse on interpersonal function. See Chapter 10. The nurse should identify the individual's strengths, as well as problem areas, by asking the patient to describe their thoughts, feelings, and behaviors before the current depressive episode. Including a family member or close friend in the assessment process can be helpful. The following discussion identifies key assessment areas for people who are depressed.

Mental Status and Appearance

Mood and Affect

The individual with major depressive disorder has a sustained period of feeling depressed, sad, or hopeless and may experience **anhedonia** (loss of interest or pleasure). The patient may report "not caring any more" or not feeling any enjoyment in activities that were previously considered pleasurable. In some individuals, this may include a decrease in or loss of libido (i.e., sexual interest or desire) and sexual function. In others, irritability and anger are signs of depression, especially in those who deny being depressed. Individuals often describe themselves as depressed, sad, hopeless, discouraged, or "down in the dumps." If individuals complain of feeling "blah," having no feelings, constantly tired, or feeling anxious, a depressed mood can sometimes be inferred from their facial expression and demeanor (APA, 2022).

Numerous assessment scales are available for assessing depression. Easily administered self-report questionnaires can be valuable detection tools. These questionnaires cannot be the sole basis for making a diagnosis of MDE, but they are sensitive to depressive symptoms. The following are five commonly used self-report scales:

- General Health Questionnaire (GHQ)
- Center for Epidemiological Studies Depression Scale (CES-D)
- Beck Depression Inventory (BDI)
- Zung Self-Rating Depression Scale (SDS)
- PRIME-MD

Clinician-completed rating scales may be more sensitive to improvement in the course of treatment, can assess symptoms in relationship to the depressive diagnostic criteria, and may have a slightly greater specificity than do self-report questionnaires in detecting depression. These include the following:

- Hamilton Rating Scale for Depression (HAM-D)
- Montgomery–Asberg Depression Rating Scale (MADRS)
- National Institute of Mental Health Diagnostic Interview Schedule (DIS)

Thought Content

Depressed individuals often have an unrealistic negative evaluation of their worth or have guilty preoccupations

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or ruminations about minor past failings. Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects. They may also have an exaggerated sense of responsibility for untoward events. As a result, they feel hopeless, helpless, worthless, and powerless. The possibility of disorganized thought processes (e.g., tangential or circumstantial thinking) and perceptual disturbances (e.g., hallucinations, delusions) should also be included in the assessment.

Cognition and Memory

Many individuals with depression report an impaired ability to think, concentrate, or make decisions. They may appear easily distracted or complain of memory difficulties. In older adults with major depression, memory difficulties may be the chief complaint and may be mistaken for early signs of dementia (pseudodementia) (APA, 2022). When the depression is fully treated, the memory issue often improves or fully resolves.

Behavioral Responses

Changes in patterns of relating (especially social withdrawal) and changes in level of occupational functioning are commonly reported. These changes may represent a significant deterioration from baseline behavior. Increased use of "sick days" may occur.

Self-Concept

A negative **self-concept** (beliefs about self) with low **self-esteem** (self-value) is associated with several health issues such as obesity, cardiovascular events, and depression (Segal & Gunturu, 2024; Yavari et al., 2023). Assessing self-esteem helps in establishing goals and direction for treatment.

Stress and Coping Patterns

The individual should be assessed for coping patterns and **resilience** (the ability to adapt successfully to stress, trauma, or chronic adversity). How does the individual cope with the everyday stresses of life? How does the individual cope with the depression and how does the depression impact the individual's ability to cope with daily stressors? The nurse helps the patient identify positive coping patterns such as meditating, talking to a loved one, and negative coping patterns such as overeating and using alcohol or nonprescribed drugs.

Suicidal Behavior

Patients with major depressive disorder are at increased risk for suicide. The development of suicide behavior is a complex phenomenon because symptoms are often hidden or veiled by somatic symptoms.

KEYCONCEPT Suicidal behavior is the occurrence of persistent thought patterns and actions that indicate an individual is thinking about, planning, or enacting suicide.

Suicidal ideation includes thoughts that range from a belief that others would be better off if the individual were dead, or thoughts of death (passive suicidal ideation), to actual specific plans for suicide (active suicidal ideation). See Chapter 22. The frequency, intensity, and lethality of these thoughts can vary and can help to determine the seriousness of intent. The more specific the plan and the more accessible the means, the more serious becomes the intent. The risk for suicide needs to be initially assessed in patients when diagnosed with depressive disorders as well as reassessed throughout the course of treatment.

Suicidal ideation is not an ordinary reaction to stress. People who express any suicidal ideation need immediate mental health assessment regarding the depth of their thoughts and intentions. Risk factors for suicidal ideation include lack of availability and inadequacy of social supports; family violence, including physical or sexual abuse; past history of suicidal ideation or behavior; presence of psychosis or substance use or misuse; and decreased ability to control suicidal impulses. See Chapter 22.

Differences exist regarding suicidal behavior.

- Sex Assigned at Birth: People assigned male at birth often use firearms, whereas those assigned female at birth often use pills or other poisonous substances to attempt suicide.
- Age: Children often use suffocation to attempt suicide.
- Ethnicity: Data on suicide completion rates are reported highest in people of Native American, Alaskan Native, and non-Hispanic White descent. These rates are lowest for people of Hispanic, non-Hispanic Black, and Asian and Pacific Islander descent (Stone et al., 2023).
- Veterans: Ongoing research regarding suicide in veterans indicates that they have a higher risk than people in the general population (VA Suicide Prevention, 2023). Psychological stress and previously diagnosed psychiatric disorders are major risk factors for veterans.

NCLEXNOTE With patients who are depressed, the possibility of suicide should always be a priority for the nurse. Assessment and documentation of suicide risk should always be included in patient care.

Social Network

Assessment and documentation of patients' social network, social systems, and functional status always need to be a component of patient care. It is important to determine how the patient defines their social network. A network of connections on social media will not provide the needed support that family and friends can provide.

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An astute nurse will determine the number of friends and family members that make up the patient's social network. Fewer members in the social network increases the risk for depression. Emotional support from the social network is critical in supporting a patient with depression (Li et al., 2023).

Quality of Life

A poor QoL often occurs with an individual who is depressed. They no longer seek out friends and families and experience extreme loneliness. They often forget or neglect to carry out routine activities of daily living such as bathing, eating, and cleaning. As the lack of social contacts continues, loneliness increases, and QoL continues to decrease (Fadipe et al., 2023).

Spiritual Assessment

The spiritual assessment is especially important for people experiencing depression and suicidal ideation. Assessing the individual's spiritual or religious beliefs helps the nurse view the patient from a holistic perspective and provides the patient the opportunity to explain their perspective on the meaning of life and their views on medical or psychiatric treatment. For example, a religious belief may prevent a patient from taking certain medications. By discussing the patient's religious/spiritual beliefs, the nurse can understand how the patient copes with being sick (Henry & Gilley, 2024).

Strength Assessment

Throughout the assessment, the nurse should be observing for strengths such as positive physical health status, coping skills, and social support. A positive self-concept is protective for the development of severe depression. The following questions may be used to determine an individual's strength:

- When you have been depressed before, how did you cope with the feelings?
- What do you do to relax?
- Do you reach out to anyone when you are feeling down?
- When you are not depressed, what makes you feel good?

ANALYZING CUES AND DEVELOPING HYPOTHESES

Several symptoms and effects of depression could potentially require nursing care. In collaboration with the patient, the nurse can discuss hypotheses and establish priorities of care. Suicidal thoughts and behaviors are always the first priority and should be considered. If a patient does not have suicidal thoughts, the nurse can focus on the physical impact of the depression such as lack of sleep, loss of appetite, and lack of energy to carry out daily routines. Feelings of hopelessness and low self-esteem are usually present and need attention. Many people who are depressed have difficulty making decisions. As the priorities are established, the results of the strength assessment should be discussed and included in the determining approaches to care. These strengths will help the individual recover from the depressed state.

PLANNING RECOVERY AND WELLNESS OUTCOMES: GENERATING SOLUTIONS

Nursing intervention selection is a collaborative process between the patient and the nurse. As goals and interventions are agreed on by both the nurse and the patient, the individual's strengths (e.g., motivation to get better, resources, family support) should be emphasized in making treatment choices.

THERAPEUTIC RELATIONSHIP

One of the most effective tools for caring for any person with a mental disorder is the therapeutic relationship. For an individual who is depressed, there are a number of effective approaches:

- Establishment and maintenance of a supportive relationship based on the incorporation of culturally competent interventions and strategies
- Support in times of crisis
- Vigilance regarding danger to self and others
- Education about the illness and treatment goals
- Encouragement and feedback concerning progress
- Guidance regarding the patient's interactions with the personal and work environment
- Realistic goal setting and monitoring
- Support of individual strengths in treatment choices

Interacting with individuals who are depressed is challenging because they tend to be withdrawn and have difficulty expressing feelings and engaging in interpersonal interactions. The therapeutic relationship can be strengthened through the use of cognitive interventions as well as the nurse's ability to win the patient's trust through the use of culturally competent strategies in the context of empathy (Box 25.4).

Nurses should avoid approaching patients with depression with an overly cheerful attitude. This "cheerleading" blocks communication and can be quite irritating to

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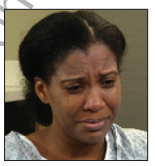
BOX 25.4

Therapeutic Dialogue: Approaching the Patient Who Is Depressed

Louise is severely depressed and has not left her hospital room since admission to the mental health unit. She has missed breakfast and is not interested in taking a shower or getting dressed.



INEFFECTIVE APPROACH

Nurse: Hello, Louise. My name is Sally. How are you feeling today?

Louise: I didn't sleep last night and need to rest. Please go away.

Nurse: Sorry, but it is time to get up. You've already missed breakfast. You have to take a quick shower now to get to group on time.

Louise: I have no interest in taking a shower or going to group.

Nurse: Why are you here if you don't want to be treated?

Louise: Go away. I don't want you in this room.

EFFECTIVE APPROACH

Nurse: Good morning. My name is Sally. I am your nurse today.

Louise: I didn't sleep last night and need to rest. Please go away.

Nurse: You didn't sleep well last night?

Louise: No, I can't remember when I was able to sleep through the night.

Nurse: Oh, I see. Is that why you missed breakfast?

Louise: I'm just not hungry. I have no energy.

Nurse: Lack of appetite and lack of energy are very common when people are depressed.

Louise: Really?

Nurse: Yes, so let's take one step at time. I'd like to help you get up.

Louise: Ok, I might be able to sit up.

Nurse: (Helps her sit up). Now, let's walk to the bathroom.

Louise: (Walks to the bathroom). Now what?

Nurse: Let's work on your AM care.

CRITICAL THINKING CHALLENGE

1. What ineffective techniques did the nurse use in the first scenario and how did they impair communication?
2. What effective techniques did the nurse use in the second scenario, and how did they facilitate communication?

patients who are depressed. Instead, a calm, supportive empathic approach keeps communication open.

NCLEXNOTE Establishing the patient–nurse relationship with an individual who is depressed requires an empathic, quiet approach that is grounded in the nurse's understanding of the cultural needs of the patient.

TAKING ACTION: NURSING INTERVENTIONS

Priorities of Care

Safety is a priority for anyone with a depressive disorder. The nurse should frequently ask the patient if they have any suicidal thoughts or intentions. The nurse should continue to monitor mood and behavior for any changes that indicate a change in suicidal ideation. (See Box 25.5.) Another priority is helping the patient engage in the therapeutic process and plan of care.

Physical Care

Because weeks or months of disturbed sleep patterns and nutritional imbalance only worsen depression, one of the first nursing interventions is helping the individual re-establish normal sleep patterns and healthy nutrition. Supporting self-care management by encouraging patients to practice positive sleep hygiene and eat well-balanced meals regularly helps the patient move toward remission or recovery.

Activity and exercise are important for improving depressed mood state (Noetel et al., 2024). Many people find that regular exercise is hard to maintain, and people who are depressed may find it impossible. When teaching about exercise, it is important to start with the current level of patient activity and increase it slowly. For example, if the patient is spending most of the time in bed, encouraging the patient to get dressed every day and walk for 5 or 10 minutes may be all that the patient can tolerate.

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BOX 25.5

Building Clinical Judgment With SBAR: Nurse Communication With Provider Regarding Suicide Precautions

SBAR

S: Situation

Harper is a 45-year-old patient admitted to a mental health unit at 10:00 pm for depression. There is no order for suicide precautions.

B: Background

This is the second admission for Harper, who had a recent breakup from a long-time partner. Harper has a history of depression, substance use, childhood abuse, loss of social support, and discrimination.

A: Assessment

- Suicide screen is positive for ideation (thoughts of killing self) and plan (loaded gun at home).
- Has a history of previous suicide attempts.

R: Recommendation

- Notify supervisor that Harper is a suicide risk, and implement one-to-one observation protocol.
- Harper needs to remain on observation until suicide is no longer considered a risk.

BUILDING CLINICAL JUDGMENT

1. Why did the nurse screen the patient for suicide?
2. Should the nurse have contacted the provider before placing Harper on one-to-one observation?

Gradually, patients should be encouraged to establish a regular exercise program and to slowly increase their food intake. These activities are consistent with wellness goals.

Wellness Challenges

Depression robs the individual of energy to carry out simple activities. Previous wellness activities from physical activities, nutrition and stress management often disappear during depression. The side effects of the antidepressants may actually interfere with normal wellness activities. The nurse should work with the individual to re-establish these activities. The individual may not feel like doing anything, but through the nurse–patient relationship, the nurse should seek commitment to gradually incorporate wellness activities. See Table 25.1.

Medication Interventions

Antidepressant medications have proven effective in all forms of major depression. To date, controlled trials have shown no single antidepressant drug to have greater efficacy in the treatment of major depressive disorder. See Chapter 11 for a list of antidepressant medications, usual dosage range, half-life, and therapeutic blood levels.

An antidepressant is selected based primarily on an individual patient's target symptoms; genetic factors; responses related to cultural, racial, and ethnic influences; and a pharmacologic agent's side-effect profile. Other factors that may influence choice include prior medication response, drug interactions and contraindications, concurrent medical and psychiatric disorders, patient age, and cost of medication. Selecting medications on the basis of pharmacogenetic properties improves symptom remission (Vest et al., 2023).

TABLE 25.1 WELLNESS CHALLENGES AND COPING STRATEGIES FOR THE INDIVIDUAL WITH DEPRESSION

Challenge	Coping Strategies
To cope effectively with lack of energy and sadness	Start with the easiest—take a walk after dinner; talk to a friend
To manage stress	Say "no" to being a perfectionist; consider a massage; meditation
To decrease feelings of worthlessness	Keep a list of accomplishments, help others; keep busy
To understanding the stigma of depression	Educate yourself and others about depression; join a support group
To recognize the need for physical activity, healthy foods, and sleep	Track physical activity, diet, and sleep in a journal
To develop a sense of connection, belonging, and a support system	Contact at least one friend, attend religious service
To expand a sense of purpose and meaning in life	Pray, meditate, help others, volunteer

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BOX 25.6

Medication Profile: Escitalopram Oxalate

DRUG CLASS: Antidepressant

RECEPTOR AFFINITY: A highly SSRI with low affinity for 5-HT1–7 or α- and β-adrenergic, dopamine $D_{1–5}$, histamine $H_{1–3}$, muscarinic $M_{1–5}$, and benzodiazepine receptors or for Na^+, K^+, Cl^-, and Ca^{++} ion channels that have been associated with various anticholinergic, sedative, and cardiovascular side effects.

INDICATIONS: Treatment of major depressive disorder, generalized anxiety disorder

ROUTES AND DOSAGES: Available as 5-, 10-, and 20-mg oral tablets

Adults: Initially 10 mg once a day. May increase to 20 mg after a minimum of 1 week. Trials have not shown greater benefit at the 20-mg dose.

Geriatric: 10-mg dose is recommended. Adjust dosage related to the drug's longer half-life and the slower liver metabolism of older adult patients.

Renal Impairment: No dosage adjustment is necessary for mild-to-moderate renal impairment.

Children: Safety and efficacy have not been established in this population.

HALF-LIFE (PEAK EFFECT): 27 to 32 hours (4 to 7 hours)

SELECTED ADVERSE REACTIONS: Most common adverse events include insomnia, ejaculation disorder, diarrhea, nausea, fatigue, increased sweating, dry mouth, somnolence, dizziness, and constipation. Most serious adverse events include ejaculation disorder in men; fetal abnormalities and decreased fetal weight in pregnant patients; and serotonin syndrome if coadministered with MAOIs, St. John's wort, or SSRIs, including citalopram (Celexa), of which escitalopram (Lexapro) is the active isomer.

BOXED WARNING: Suicidality in children, adolescents, and young adults

WARNING: There is potential for interaction with MAOIs. Lexapro should not be used in combination with an MAOI or within 14 days of discontinuing an MAOI.

SPECIFIC PATIENT AND FAMILY EDUCATION

- Do not take in combination with citalopram (Celexa) or other SSRIs or MAOIs. A 2-week washout period between escitalopram and SSRIs or MAOIs is recommended to avoid serotonin syndrome.
- Families and caregivers should be advised of the need for close observation and communication with the prescriber.
- Notify your prescriber if pregnancy is possible or being planned. Do not breastfeed while taking this medication.
- Use caution driving or operating machinery until you are certain that escitalopram does not alter your physical abilities or mental alertness.
- Notify your prescriber of any OTC medications, herbal supplements, and home remedies being used in combination with escitalopram.
- Ingestion of alcohol in combination with escitalopram is not recommended, although escitalopram does not seem to potentiate mental and motor impairments associated with alcohol.

MAOI, monoamine oxidase inhibitor; OTC, over-the-counter; SSRI, selective serotonin reuptake inhibitor.

The newer antidepressants, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and the norepinephrine-dopamine reuptake inhibitor (NDRI) are used most often because these drugs selectively target the neurotransmitters and receptors thought to be associated with depression and minimize side effects. See Boxes 25.6 and 25.7. Individualizing dosages is usually done by fine-tuning medication dosage based on patient feedback. See Box 25.8. The tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) are being used less often than the other agents. Given their dietary restrictions, MAOIs usually are reserved for patients whose depression fails to respond to other antidepressants or patients who cannot tolerate typical antidepressants. See Chapter 11.

Ketamine, a noncompetitive *N*-methyl-D-aspartate receptor (NMDAR) antagonist, has recently been approved by the FDA to treat severe depression or treatment resistant depression. The use of ketamine, a clinical anesthetic, is significant because of its rapid antidepressant effects (Kim et al., 2024). Patients feel the effects immediately and do not have to wait for weeks for the antidepressant relief. Currently, **esketamine** nasal spray is the only ketamine formulation that is approved by the FDA for the treatment of depression. The side effects include sedation, loss of consciousness, dissociation, and respiratory depression.

NCLEXNOTE Patients may be reluctant to take prescribed antidepressant medications or may self-treat depression based on their cultural beliefs and values (Leung, 2023). A plan for culturally competent nursing care and teaching needs to address the importance of adherence to a medication regimen and emphasize any potential drug–drug interactions.

Administering Medications

Antidepressants are available in oral form and should be taken as prescribed. See Box 25.8. Even after complete remission of symptoms, medication should be continued for at least 6 months to 1 year after the patient achieves. If the patient experiences a recurrence after tapering the first course of treatment, the regimen should be reinstituted for at least another year, and if the illness reoccurs, medication should be continued indefinitely (DeBattista & Schatzberg, 2024).

Esketamine is administered twice per week initially and then once weekly or every 2 weeks after the induction. Nurses should receive instruction on the operation of the nasal device prior to administration. Some

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BOX 25.7

Medication Profile: Mirtazapine

DRUG CLASS: Antidepressant

RECEPTOR AFFINITY: Believed to enhance central noradrenergic and serotonergic activity antagonizing central presynaptic α_2-adrenergic receptors. Mechanism of action is unknown

INDICATIONS: Treatment of depression

ROUTES AND DOSAGE: Available as 15- and 30-mg tablets

Adults: Initially, 15 mg/day as a single dose preferably in the evening before sleeping. Maximum dosage is 45 mg/day.

Geriatric: Use with caution; reduced dosage may be needed.

Children: Safety and efficacy have not been established.

HALF-LIFE (PEAK EFFECT): 20 to 40 hours (2 hours)

SELECTED ADVERSE REACTIONS: Somnolence, increased appetite, dizziness, weight gain, elevated cholesterol or triglyceride and transaminase levels, malaise, abdominal pain, hypertension, vasodilation, vomiting, anorexia, thirst, myasthenia, arthralgia, hypoesthesia, apathy, depression, vertigo, twitching, agitation, anxiety, amnesia, increased cough, sinusitis, pruritus, rash, urinary tract infection, mania (rare), agranulocytosis (rare)

BOXED WARNING: Suicidality in children, adolescents, and young adults

WARNING: Contraindicated in patients with known hypersensitivity. Use with caution in older adults, patients who are breastfeeding, and patients with impaired hepatic function. Avoid concomitant use with alcohol or diazepam, which can cause additive impairment of cognitive and motor skills.

SPECIFIC PATIENT AND FAMILY EDUCATION

- Take the dose once a day in the evening before sleep.
- Families and caregivers should be advised of the need for dose observation and communication with the prescriber.
- Avoid driving and performing other tasks requiring alertness.
- Notify your prescriber before taking any OTC or other prescription drugs.
- Avoid alcohol and other CNS depressants.
- Notify your prescriber if pregnancy is possible or planned.
- Monitor temperature and report any fever, lethargy, weakness, sore throat, malaise, or other "flu-like" symptoms.
- Maintain medical follow-up, including any appointments for blood counts and liver studies.

CNS, central nervous system; OTC, over-the-counter.

state statutes require nurse to complete an instructional program and have supervised clinical practice prior to administration. Blood pressure should be taken prior to administration and the provider should be notified for baseline blood pressure >140 mm Hg systolic or >90 mm Hg diastolic. Patients should be monitored for at least 2 hours after administration. Blood pressure should be reassessed at approximately 40 minutes after administration. Patients should be monitored for signs of misuse (Janssen Pharmaceutical Companies, 2024).

BOX 25.8

Guidelines for Administering and Monitoring Antidepressant Medications

Nurses should do the following in administering and monitoring antidepressant medications:

- Observe the patient for cheeking or saving medications for a later suicide attempt.
- Monitor vital signs (such as orthostatic vital signs and temperature): Obtain baseline data before the initiation of medications.
- Monitor periodically results of liver and thyroid function tests, blood chemistry, and complete blood count as appropriate and compare with baseline values.
- Monitor the patient symptoms for therapeutic response and report inadequate response to the prescriber.
- Monitor the patient for side effects and report to the prescriber serious side effects or those that are chronic and problematic for the patient. (Table 25.3 indicates pharmacologic and nonpharmacologic interventions for common side effects.)
- Monitor drug levels as appropriate. (Therapeutic drug levels for antidepressants are listed in Chapter 11.)
- Monitor dietary intake as appropriate, especially with regard to MAOI antidepressants.
- Inquire about patient use of other medications, alcohol, "street" drugs, OTC medications, and herbal supplements that might alter the desired effects of prescribed antidepressants.

MAOI, monoamine oxidase inhibitor; OTC, over-the-counter.

Monitoring Medications

Patients should be carefully observed for therapeutic effects and side effects of the antidepressants. In the depths of depression, saving medication for a later suicide attempt is quite common. If there are minimal therapeutic effects, the nurse can suspect the patient is saving medications and ask the patient about this possibility. If the patient has been saving medications, the nurse should retrieve the medications and closely observe the patient for suicide attempts.

During antidepressant treatment, the nurse should monitor and document vital signs, plasma drug levels (as appropriate), liver and thyroid function tests, complete blood counts, and blood chemistry to make sure that patients are receiving a therapeutic dosage and are adherent to the prescribed regimen. Results of these tests also can help the nurse evaluate for toxicity (see Chapter 11 for therapeutic blood levels).

Baseline orthostatic vital signs should be obtained before initiation of any medication, and in the case of medications known to have an impact on vital signs (such as TCAs, MAOIs, or SNRIs), vital signs should be monitored on a regular basis. If these medications are administered to children or older adults, the dosage

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should be lowered to accommodate the physiologic state of the individual.

Managing Side Effects

Many people stop taking the prescribed antidepressants because of the side effects. (See Table 25.2.) Ideally, side effects are minimal and can be alleviated by nonpharmacologic interventions. For example, if a patient is having difficulty falling asleep, avoiding caffeinated products may help (Table 25.3). SSRIs tend to be safer and have fewer side effects than the older medications. The most common reason individuals stop taking their SSRIs is gastrointestinal side effects including diarrhea, cramping, and heartburn. The most common side effects associated with TCAs are the antihistaminic side effects (e.g., sedation and weight gain) and anticholinergic side effects (potentiation of CNS drugs, blurred vision, dry mouth, constipation, urinary retention, sinus tachycardia, and decreased memory).

For the MAOIs, the most common side effects are headache, drowsiness, dry mouth and throat, constipation, blurred vision, and orthostatic hypotension. Additional adverse effects of MAOIs include insomnia, nausea, agitation, dizziness, asthenia, weight loss, and postural hypotension. Although priapism was not reported during clinical trials, the MAOIs are structurally similar to trazodone, which has been associated with priapism (prolonged painful erection). For those taking MAOIs, close attention to dietary restrictions should be given. See Chapter 11 for tyramine-restricted diets.

EMERGENCY CARE ALERT If coadministered with food or other substances containing tyramine (e.g., aged cheese, beer, red wine), MAOIs can trigger a hypertensive crisis that may be life threatening. Symptoms include a sudden, severe pounding, or explosive headache in the back of the head or temples, racing pulse, flushing, stiff neck, chest pain, nausea and vomiting, and profuse sweating.

Management of Complications

Suicidality

Suicidality is highlighted as a boxed warning on all antidepressants for an increased risk of suicide in children, adolescents, and young adults with major depressive or other psychiatric disorders. After the age of 24 years, the suicidality risk does not increase when taking an antidepressant, and after age 65, the risk of suicide decreases when taking an antidepressant. The SSRIs are the least lethal of the antidepressants, but fatalities due to suicide have been reported (DeBattista & Schatzberg, 2024).

EMERGENCY CARE ALERT If possible, TCAs should not be prescribed for patients at risk for suicide. Lethal doses of TCAs are only three to five times the therapeutic dose, and more than 1 g of a TCA is often toxic and may be fatal. Death may result from cardiac arrhythmia, hypotension, or uncontrollable seizures.

Serum TCA levels should be evaluated when overdose is suspected. In acute overdose, almost all symptoms develop within 12 hours. Anticholinergic effects are prominent and include dry mucous membranes, warm and dry skin, blurred vision, decreased bowel motility, and urinary retention. CNS suppression (ranging from drowsiness to coma) or an agitated delirium may occur. Basic overdose treatment includes induction of emesis, gastric lavage, and cardiorespiratory supportive care.

MAOIs are more lethal in overdose than are the newer antidepressants and thus should be prescribed with caution if the patient's suicide potential is elevated (see Chapter 11). An MAOI generally is given in divided doses to minimize side effects.

Serotonin Syndrome

Serotonin syndrome is a potentially serious side effect caused by drug-induced excess of intrasynaptic serotonin, 5-hydroxytryptamine (5-HT). See Box 25.9. First reported in the 1950s, it was relatively rare until the introduction of SSRIs. Serotonin syndrome is most often reported in patients taking two or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, the SSRIs, and the TCAs (Simon et al., 2024).

Although serotonin syndrome can cause death, it is mild in most patients, who usually recover with supportive care alone. Unlike neuroleptic malignant syndrome, which develops within 3 to 9 days after the introduction of neuroleptic medications (see Chapter 24), serotonin syndrome tends to develop within hours or days after starting or increasing the dose of serotonergic medication. Symptoms include altered mental status, autonomic dysfunction, and neuromuscular abnormalities. At least three of the following findings must be present for a diagnosis: Mental status changes, agitation, myoclonus, hyperreflexia, fever, shivering, diaphoresis, ataxia, and diarrhea. In patients who also have peripheral vascular disease or atherosclerosis, severe vasospasm, and hypertension may occur in the presence of elevated serotonin levels. In addition, in a patient who is a slow metabolizer of SSRIs, higher-than-normal levels of these antidepressants may circulate in the blood. Medications that are not usually considered serotonergic, such as ciprofloxacin and fluconazole have been associated with the syndrome (Simon et al., 2024).

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TABLE 25.2 ANTIDEPRESSANTS AND COMMON SIDE EFFECTS IN TREATING DEPRESSION

Medications	Common Side Effects
Selective Serotonin Reuptake Inhibitors (SSRIs)	
Fluoxetine Sertraline Paroxetine Fluvoxamine Citalopram Escitalopram	Gastrointestinal distress Sedation Anticholinergic effects Weight gain or loss in some people Sexual dysfunction Dizziness Diaphoresis
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	
Desvenlafaxine Duloxetine Levomilnacipran Milnacipran Venlafaxine	Gastrointestinal distress Anticholinergic effects Insomnia or sedation Decreased appetite Sexual dysfunction Unusual dreams Dizziness Jitteriness Hypertension Irritability Photosensitivity
Norepinephrine-Dopamine Reuptake Inhibitor (NDRI)	
Bupropion	Anticholinergic effects Headache Agitation Gastrointestinal distress Insomnia Anorexia Anxiety Weight loss Diarrhea and flatulence
Alpha$_2$ Antagonist	
Mirtazapine	Sedation Anticholinergic effects Appetite increase Weight gain Hypercholesterolemia Weakness and lack of energy Dizziness Hypertriglyceridemia
Other Antidepressants	
Trazadone	Sedation Anticholinergic effects Headache Dizziness Nausea/vomiting
Vilazodone	Diarrhea Nausea Dizziness Dry mouth Insomnia Unusual dreams
Vortioxetine	Nausea Diarrhea Dizziness Dry mouth Constipation Vomiting
Tricyclic Antidepressants	
Amitriptyline Amoxapine Clomipramine Imipramine Desipramine Doxepin Nortriptyline Protriptyline	Drowsiness Anticholinergic effects Orthostatic hypotension Palpitations Tachycardia Impaired coordination Increased appetite Diaphoresis Weakness Disorientation Sexual side effects (impotence, changes in libido)
Tetracyclic Antidepressants	
Maprotiline	Blurred vision Dizziness Lightheadedness Sedation Dry mouth Libido changes Impotence Weight changes
Monoamine Oxidase Inhibitors	
Isocarboxazid	Dizziness Headache Nausea Dry mouth Constipation Drowsiness Sleep disturbance Orthostatic hypotension
Phenelzine	Orthostatic hypotension Edema Dizziness Headache Drowsiness Sleep disturbance
Tranylcypromine	Orthostatic hypotension Dizziness Headache Drowsiness Sleep disturbance Restlessness Central nervous system stimulation
Selegiline	Application site reaction Headache Insomnia Diarrhea Dry mouth Orthostatic hypotension Dyspepsia

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TABLE 25.3 INTERVENTIONS TO RELIEVE SIDE EFFECTS OF ANTIDEPRESSANTS

Side Effect	Pharmacologic Intervention	Nonpharmacologic Intervention
Dry mouth, caries, inflammation of the mouth	Bethanechol 10–30 mg tid Pilocarpine drops	Sugarless gum Sugarless lozenges 6–8 cups of water per day Toothpaste for dry mouth
Nausea, vomiting	Change medication	Take medication with food Soda crackers, toast, tea
Weight gain	Change medication	Nutritionally balanced diet Daily exercise
Urinary hesitation	Bethanechol 10–30 mg tid	6–8 cups of water per day
Constipation	Stool softener	Bulk laxative Daily exercise 6–8 cups of water per day Diet rich in fresh fruits, vegetables, and whole grains
Diarrhea	OTC antidiarrheal	Maintain fluid intake
Orthostatic hypotension		Increase hydration Sit or stand up slowly
Drowsiness	Shift dosing time Lower medication dose Change medication	One caffeinated beverage at strategic time Do not drive when drowsy No alcohol or other recreational drugs Plan for rest time
Fatigue	Lower medication dose Change medication	Daily exercise
Blurred vision	Bethanechol 10–30 mg tid Pilocarpine eye drops	Temporary use of magnifying lenses until body adjusts to medication
Flushing, sweating	Terazosin 1 mg once daily Lower medication dose Change medication	Frequent bathing Lightweight clothing
Tremor	β-Blockers Lower medication dose	Reassure the patient that tremor may decrease as the patient adjusts to medication. Notify the caregiver if tremor interferes with daily functioning.

OTC, over-the-counter; tid, three times a day.

BOX 25.9

Serotonin Syndrome

CAUSE: Excessive intrasynaptic serotonin

HOW IT HAPPENS: Combining medications that increase CNS serotonin levels, such as SSRIs + MAOIs; SSRIs + St. John's wort; or SSRIs + diet pills; dextromethorphan or alcohol, especially red wine; or SSRI + street drugs, such as LSD, MMDA, or ecstasy

SYMPTOMS: Mental status changes, agitation, ataxia, myoclonus, hyperreflexia, fever, shivering, diaphoresis, diarrhea

TREATMENT

- Assess all medications, supplements, foods, and recreational drugs ingested to determine the offending substances.
- Discontinue any substances that may be causative factors. If symptoms are mild, treat supportively on an outpatient basis with propranolol and lorazepam and follow-up with the prescriber.
- If symptoms are moderate to severe, hospitalization may be needed with monitoring of vital signs and treatment with intravenous fluids, antipyretics, and cooling blankets.

FURTHER USE: Assess on a case-by-case basis and minimize risk factors for further medication therapy.

CNS, central nervous system; LSD, lysergic acid diethylamide; MAOI, monoamine oxidase inhibitor; MMDA, 3-methoxy-4,5-methylenedioxyamphetamine; SSRI, selective serotonin reuptake inhibitor.

EMERGENCY CARE ALERT The most important emergency interventions are stopping use of the offending drug, notifying the prescriber, and providing necessary supportive care (e.g., intravenous fluids, antipyretics, cooling blanket). Severe symptoms have been successfully treated with antiserotonergic agents, such as cyproheptadine (Simon et al., 2024).

Monitoring for Drug Interactions

Several potential drug interactions are associated with antidepressants. Alcohol consumption should be avoided when taking any antidepressant because SSRIs are metabolized in the liver, and other substances (such as alcohol) that are also metabolized in the liver by the same enzyme can cause an increase in drug levels, leading to toxicity and serotonin syndrome. For example, if migraine medications known as "triptans" are given with the SSRIs, serotonin syndrome can occur. Bupropion cannot be given at the same time as an MAOI. Grapefruit should not be consumed while taking trazodone. It is beyond the scope of this text to review drug–drug interactions in detail. Nurses should check with pharmacy resources for any drug–drug interactions when administering medications.

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Teaching Points

If depression goes untreated or is inadequately treated, episodes can become more frequent, more severe, longer in duration, and can lead to suicide. Patient education involves explaining this pattern and the importance of continuing medication use after the acute phase of treatment to decrease the risk for future episodes. Patient concerns regarding long-term antidepressant therapy need to be assessed and addressed. All teaching points need to be developed and delivered using a culturally competent approach to enhance patient adherence.

Patients should also be advised not to take herbal substances such as St. John's wort or SAMe if they are also taking prescribed antidepressants. St. John's wort also should not be taken if the patient is taking nasal decongestants, hay fever and asthma medications containing monoamines, amino acid supplements containing phenylalanine, or tyrosine. The combination may cause hypertension.

Other Somatic Therapies

Electroconvulsive Therapy

Although its therapeutic mechanism of action is not completely understood, ECT is an effective treatment for patients with severe depression. It is generally reserved for patients whose disorder is refractory or intolerant to initial drug treatments such as older adults or for those who are so severely ill that rapid treatment is required (e.g., patients with malnutrition, catatonia, or suicidality). Older age is associated with a favorable response to ECT, but the effectiveness and safety in this group has not been shown (Sarma et al., 2024).

ECT is contraindicated for patients with increased intracranial pressure. Other high-risk patients include those with recent myocardial infarction, recent cerebrovascular accident, retinal detachment, or pheochromocytoma (a tumor in the cells of the adrenal gland) and those at risk for complications of anesthesia.

The role of the nurse in the care of the patient undergoing ECT is to provide educational and emotional support for the patient and family, assess baseline or pretreatment levels of function, prepare the patient for the ECT process, monitor and evaluate the patient's response to ECT, provide assessment data with the ECT team, and modify treatment as needed. The actual procedure, possible therapeutic mechanisms of action, potential adverse effects, contraindications, and nursing interventions are described in detail in Chapter 11.

Light Therapy (Phototherapy)

Light therapy is described in Chapter 11. Given current research, light therapy is an option for well-documented mild-to-moderate seasonal, nonpsychotic, winter depressive episodes in patients with recurrent major depressive disorders, including children and adolescents. Evidence also indicates that light therapy can modestly improve symptoms in nonseasonal depression, especially when administered during the first week of treatment in the morning for those experiencing sleep deprivation (Chen et al., 2024).

Repetitive Transcranial Magnetic Stimulation

Repetitive transcranial magnetic stimulation (rTMS) is FDA approved for the treatment of patients with mild treatment-resistant depression. In rTMS, a magnetic coil placed on the scalp at the site of the left motor cortex releases small electrical pulses that stimulate the site of the left dorsolateral prefrontal cortex in the superficial cortex. This rapidly changing magnetic field stimulates the brain sufficiently to depolarize neurons and exert effects across synapses. These pulses (similar in type and strength as a magnetic resonance imaging machine) easily pass through the hair, skin, and skull, requiring much less electricity than ECT. The patient is awake, reclining in an rTMS chair during the procedure, and can resume normal activities immediately after the procedure. Because anesthesia is not required, no risks are associated with sedation. Treatment of depression typically consists of 20 to 30 sessions, lasting 37 minutes each over 4 to 6 weeks. Depending on the level of practice and training, the nurse's role in the use of the rTMS varies from patient education, pre- and postprocedure care to performing the procedure (Oberman & Benussi, 2024).

Psychosocial Interventions

Therapeutic Interactions

Individuals experiencing depression often withdraw from daily activities, such as engaging in family activities, attending work, and participating in community functions. During hospitalization, patients often withdraw to their rooms and refuse to participate in unit activity. Nurses help the patient balance the need for privacy with the need to return to normal social functioning. Explain to patients that attending social activities, even though they do not feel like it, will promote the recovery process and help them achieve their goals. Even though patients who are depressed should not be approached in an overly enthusiastic, cheerful manner, they should be encouraged to set realistic goals to reconnect with their families and communities. Nurses should help the patient identify personal strengths and encourage them to use their strengths to reduce their depressive feelings.

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Enhancing Cognitive Functioning

Cognitive interventions such as thought stopping and positive self-talk can dispel irrational beliefs and distorted attitudes and in turn reduce depressive symptoms during the acute phase of major depression. Nurses should consider using cognitive approaches when caring for people who are depressed. The use of cognitive interventions in the acute phase of treatment combined with medication is now considered first-line treatment for mildly to moderately depressed outpatients. See Chapter 13.

NCLEXNOTE A cognitive therapy approach is recommended for helping people restructure the negative thinking processes related to an individual's concept of self, others, and the future. This approach should be included in most nursing care plans for patients with depression.

Using Behavioral Interventions

Behavioral interventions are effective in the acute treatment of patients with mildly to moderately severe depression, especially when combined with pharmacotherapy. Therapeutic techniques include activity scheduling, social skills training, and problem solving. Behavioral therapy techniques are described in Chapter 6.

Complementary Therapies

Alternative or complementary therapies are often used in the treatment of depression. Acupuncture, yoga or tai chi, meditation, guided imagery, and massage therapy are a few therapies that may be helpful to palliate depression. Music or art therapy is also used often in conjunction with medication or psychotherapy (Zhao et al., 2023).

Spiritual Intervention

Spiritual well-being can reduce depression and anxiety. There are several interventions that lead to improved spiritual well-being. For example, reminiscence therapy has been shown to relieve anxiety and depression in stoke patients and their spouse caregivers (Zhang et al., 2024a). Other interventions that support spiritual well-being include spiritual counseling, prayer, worship, and religious rituals. Interventions associated with specific religious practices should be conducted by a religious or spiritual expert specific to that belief system.

Psychoeducation

Teaching About Symptoms

Patients with depression and their significant others often incorrectly believe that their illness is their own fault and that they should be able to "pull themselves up by their bootstraps and snap out of it." People from some cultural groups believe that the symptoms of depression may be a result of someone placing a hex on the affected person because the individual has done something evil. It is vital to be culturally competent to be effective in teaching patients and their families about the treatment modalities for depression.

Patients need to know the full range of suitable treatment options before consenting to participate in treatment. Information empowers patients to ask questions, weigh risks and benefits, and make the best treatment choices. The nurse can provide opportunities for patients to question, discuss, and explore their feelings about past, current, and planned use of medications and other treatments. Developing strategies to enhance adherence and to raise awareness of early signs of relapse can be important aids to increasing treatment efficacy and promoting recovery (Box 25.10).

Wellness Strategies

The patient needs to be able to incorporate wellness strategies to support recovery and resilience processes. The nurse needs to assess what the patient may be doing now for their wellness and support current wellness strategies, as well as provide new strategies. Sleep hygiene, healthy nutritional choices, leisure activities, relaxation, exercise, and positive interactions should be encouraged. For example, the nurse suggests walking 5 to 10 minutes 1 or 2 days a week and gradually increasing to 20 minutes a day three to four times per week. Nurses should encourage multiple strategies to help patients understand how to improve their resilience and recovery in conjunction with everyday functioning. The nurse should support any positive health approaches that the patient is incorporating into their daily life.

BOX 25.10

Psychoeducation Checklist: Major Depressive Disorder

When caring for the patient with a major depressive disorder, be sure to include the following topic areas in the teaching plan:

- Psychopharmacologic agents, including drug action, dosing frequency, and possible side effects
- Risk factors for recurrence; signs of recurrence
- Adherence to therapy and treatment program
- Recovery strategies
- Nutrition
- Sleep measures
- Self-care management
- Goal setting and problem solving
- Social interaction skills
- Follow-up appointments
- Community support services

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Providing Family Education

The family needs education and support during and after the treatment of family members. Because major depressive disorder is a recurring disorder, the family needs information about specific antecedents to a family member's depression and what therapeutic steps to take. For example, one patient may routinely become depressed during the fall of each year, with one of the first symptoms being excessive sleepiness. For another patient, a major loss, such as a child going to college or the death of a pet, may precipitate a depressive episode. Families of older adults need to be aware of the possibility of depression and related symptoms, which often occur after the deaths of friends and relatives. Families of children who are depressed often misinterpret depression as behavioral issues.

Promoting Safety

For patients who are admitted to the psychiatric hospital because of a suicide attempt, suicidality should continually be evaluated, and the patient should be protected from self-harm (see Chapter 22). During the depths of depression, patients may not have the energy to complete a suicide. As patients begin to feel better and have increased energy, they therefore may be at a greater risk for suicide. If a patient who was previously depressed appears to have become energized overnight, they may have decided to die by suicide and thus may be relieved that the decision is finally made. The nurse may misinterpret the mood improvement as a positive move toward recovery; however, this patient may be very intent on suicide. These individuals should be carefully monitored to maintain their safety.

Convening Support Groups

Individuals who are depressed can receive emotional support in groups and learn how others deal with similar issues. As group members serve as role models for new group members, they also benefit as their self-esteem increases, which strengthens their ability to address their own issues (see Chapter 14). Group interventions are often used to help an individual cope with depression associated with bereavement or chronic medical illness. Group interventions are also commonly used to educate patients and families about their disorder and medications.

Nurses are exceptionally well positioned to engage patients and their families in the active process of improving daily functioning, increasing knowledge and skill acquisition, and increasing independent living. Consumer-oriented support groups can help to enhance the self-esteem and the support network of participating patients and their families. Advice, encouragement, and the sense of group camaraderie may make an important contribution to recovery. Organizations providing support and information include the Depression and Bipolar Support Network (DBSA), National Alliance on Mental Illness (NAMI), and the Mental Health Association and Recovery, Inc. (a self-help group).

Implementing Milieu Therapy

While hospitalized, milieu therapy (see Chapter 10) helps patients who are depressed maintain socialization skills and continue to interact with others. When depressed, people are often unaware of the environment and withdraw into themselves. On a psychiatric unit, patients who are depressed should be encouraged to attend and participate in unit activities. These individuals have decreased energy levels and thus may be moving more slowly than others; however, their efforts should be praised.

Family Interventions

Patients who perceive high family stress are at risk for greater future severity of illness, higher use of health services, and higher health care expense. Marital and family issues are common among patients with mood disorders; comprehensive treatment requires that these issues be assessed and addressed. They may be a consequence of the major depression but may also predispose people to develop depressive symptoms or inhibit recovery and resilience processes. Family and friends of people who attempt or die by suicide should be provided counseling and supportive services because they may experience feelings of grief, guilt, anger, depression, and confusion.

Research suggests that marital and family therapy may reduce depressive symptoms and the risk for relapse in patients with marital and family issues (Salinger et al., 2021). The depressed spouse's depression has a significant impact on the marital adjustment of the nondepressed spouse. It is recommended that treatment approaches be designed to help couples be supportive of each other, to adapt, and to cope with the depressive symptoms within the framework of their ongoing marital relations.

Counseling and supportive services should be provided to family and friends of people who attempt or die by suicide because family and friends may experience feelings of grief, guilt, anger, and confusion.

Many family nursing interventions may be used by the psychiatric nurse in providing targeted family-centered care. These include:

- Monitoring patient and family for indicators of stress
- Teaching stress management techniques

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- Counseling family members on coping skills for their own use
- Providing necessary knowledge of options and support services
- Facilitating family routines and rituals
- Assisting the family to resolve feelings of guilt
- Assisting the family with conflict resolution
- Identifying family strengths and resources with family members
- Facilitating communication among family members

Developing Recovery-Oriented Rehabilitation Strategies

Nurses should incorporate recovery and resilience concepts into inpatient settings as these strategies help to improve the QoL, help the transition to outpatient care, and decrease hospital readmission rates (Aggestrup et al., 2024). The guiding principles for recovery include a strength-based, self-directed approach so patients can feel a sense of hope, gain an understanding of their disorder, decrease the effects of trauma, and increase their ability to become more resilient in dealing with their everyday life situations.

Evaluation of Patient Outcomes

The major goals of treatment are to help the patient to be as independent as possible and to achieve stability, remission, and recovery from major depression. These goals are often a lifelong struggle. To monitor outcomes of treatment, ongoing evaluation of the individual's symptoms, functioning, and QoL should be carefully documented in the patient's record.

Continuum of Care

Mild-to-moderate depression is often first recognized in primary care settings. Primary care nurses should be able to recognize depression in these patients and make appropriate interventions or referrals.

Emergency Care

Those with more severe depressive symptoms or thoughts of suicide will be directly admitted to inpatient and outpatient mental health settings or emergency departments.

Inpatient-Focused Care

Although most patients with major depression are treated in outpatient settings, brief hospitalization may be required if the patient is suicidal, a danger to others, or experiencing psychosis. Nurses working on inpatient units provide a wide range of direct services, including administering and monitoring medications and target symptoms; conducting psychoeducational groups; and more generally, structuring and maintaining a therapeutic environment.

Community Care

The continuum of care beyond primary care and hospital settings may include partial hospitalization or day treatment programs; individual, family, or group psychotherapy; and home visits. Nurses providing home care have an excellent opportunity to detect undiagnosed depressive disorders and make appropriate referrals.

Virtual Mental Health Care

Virtual mental health care or telehealth is an important resource that has emerged as an efficacious option for assessing and treating depression and depressive disorders (Kelber et al., 2024). The use of video and audio formats can closely mimic in-person interactions and psychotherapy sessions. Although more research is needed regarding patient satisfaction and treatment effectiveness, studies support the use of telehealth for individuals who are depressed and have a chronic disease, are homebound, need a physically safe environment, or have transportation issues (Wu et al., 2024). Internet-based CBT for depression can be a cost-effective intervention and is showing efficacy in treating major depression (Newby et al., 2024).

Telehealth is becoming an important tool in suicide prevention. National hotline numbers, texting sites, and suicide alert systems imbedded in telehealth psychotherapy programs have the potential to reduce communication barriers for individuals with suicidal ideation or intention (Shoib et al., 2024).

Integration with Primary Care

Comprehensive services require a coordinated ongoing interaction among patients, families, and health care providers. This includes using the complementary skills of both psychiatric and medical care colleagues for forming overall goals, plans, and decisions and for providing continuity of care as needed. Collaborative care between the primary care provider and mental health specialist is also key to achieving remission of symptoms and physical well-being, restoring baseline occupational and psychosocial functioning, and reducing the likelihood of relapse or recurrence.

Depression is often treated in the primary care setting with readily available antidepressants. Ideally, mental health services are integrated into primary health care settings. See Box 25.11. Many individuals need more than

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BOX 25.11

Research for Evidence-Based Practice: Mental Health Integration in a Nurse Home Visiting Program

Beeber, L. S., Gasbarro, M., Knudtson, M., Ledford, A., Sprinkle, S., Leeman, J., McMichael, G., Zeanah, P., & Mosqueda, A. (2024). A mental health innovation for nurse home visiting program shows effectiveness in reducing depressive symptoms and anxiety. Prevention Science, *25(1), 126–136. https://doi.org/10.1007/s11121-023-01574-6*

THE QUESTION: Is a mental health intervention within a nurse-delivered home visiting program for first-time mothers effective in increasing mental health screenings and referral to mental health services?

METHODS: The Mental Health Innovation (MHI) program prepares nurses to assess, refer, manage crises, and intervene using evidence-based approaches including mindful cognitive-behavioral approaches, social support mobilization, advance directives, activity amplification. Two versions of the MHI were evaluated. The *standard* intervention provided online learning modules, team meeting education modules, and clinical resources to Nurse Family Partnership (NFP) agencies nationwide. The *enhanced* intervention provided the standard intervention with periodic consultations with experts in mental health care to a subset of NFP teams.

A pre/postlaunch comparison of 356 teams randomized to standard versus enhanced intervention was analyzed for an increase in screenings and enrollment in NFP services. Six teams (42 nurses and 6 supervisors) were randomized to the enhanced intervention.

FINDINGS: There was a significant increase in enrollment of patients with a mental health diagnosis or positive screen for depression from pre- to postlaunch MHI. The enhanced group served more patients with a mental health diagnosis or positive depression screen.

IMPLICATION FOR NURSING: This study supports the use of mental health screenings in a nurse home visiting program for first-time mothers who are experiencing a mental disorder or screen positively for depression.

medication, but do not access mental health services for a variety of reasons such as stigma, fear of being labeled as mentally ill, and lack of resources. There are also several medical issues associated with depression such as hypothyroidism (Zhou et al., 2024). Pain is a common issue for individuals who are depressed (Tesic et al., 2023). It is important to communicate with the primary care provider to coordinate care.

The **medical home model** is becoming widely accepted in the United States. If a patient is cared for within a medical home model, all of their health and mental health needs are coordinated by one health provider. Meaningful long-term relationships can be developed. The advantage of a medical home is the recognition and coordination of all health care needs. This model is helpful when many of comorbid disorders requiring multiple providers. This model reduces expensive care and enhances continuity of care (Fakeye et al., 2023).

OTHER DEPRESSIVE DISORDERS

Other depressive disorders with similar symptoms are treated similarly to the major depressive disorders. Nursing care should be individualized and based on their patients' mental health needs and strengths.

PERSISTENT DEPRESSIVE DISORDER

In **persistent depressive disorder** (*dysthymia*), major depressive disorder symptoms last for at least 2 years for an adult and 1 year for children and adolescents. These individuals are depressed for most of each day. A major depressive disorder may precede the persistent depressive disorder or co-occur with it (Patel et al., 2024).

PREMENSTRUAL DYSPHORIC DISORDER

Premenstrual dysphoric disorder is diagnosed when there are clinically significant somatic and psychological manifestation (mood swings, feelings of sadness, or sensitivity to rejection) that occur consistently during the luteal phase of the menstrual cycle and negatively impact functioning and lifestyle. The mood begins to improve a few days after menses begins. Stress, history of interpersonal trauma, seasonal changes are associated with this disorder (Mishra et al., 2023).

DISRUPTIVE MOOD DYSREGULATION DISORDER

Disruptive mood dysregulation disorder is characterized by severe irritability and outbursts of temper. The onset of disruptive mood dysregulation disorder begins before the age of 10, when children have verbal rages and/or are physically aggressive toward others or property. These outbursts are outside of the normal temper tantrums children display. They are more severe than what would be expected developmentally and occur frequently (i.e., two or three times a week). This behavior disrupts family functioning as well as the child's ability to succeed in school and social activities. This disorder can co-occur with attention-deficit/hyperactivity disorder. See Chapter 37.

Disruptive mood dysregulation disorder is similar to pediatric bipolar disorder, but the *DSM-5-TR* differentiates it from bipolar disorder. Children with this disorder have similar deficits in recognition of emotion through facial expression, decision-making, and control as those

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with bipolar disorder. More research is needed in understanding this disorder (Zhang et al., 2024b).

SUMMARY OF KEY POINTS

- Moods influence perception of life events and functioning. Depressive disorders are characterized by persistent or recurring disturbances in mood that cause significant psychological distress and functional impairment (typified by feelings of sadness, hopelessness, loss of interest, and fatigue).
- Risk factors include a family history of depressive disorders, prior depressive episodes; lack of social support; stressful life events; substance use; and medical issues, particularly chronic or terminal illnesses.
- Pregnant patients and people who are subjects of discrimination, such as people of color and people who identify as LGBTQ+, are at high risk for depression and being unhoused.
- Treatment of major depressive disorder primarily includes antidepressant medication, psychotherapy, or a combination of both. ECT, light therapy, and rTMS are also used.
- Nurses must be knowledgeable regarding culturally competent related to the use of antidepressant medications, pharmacologic therapeutic effects and associated side effects, toxicity, dosage ranges, and contraindications. Nurses must also be familiar with ECT protocols and associated interventions. Patient education and the provision of emotional support during the course of treatment are also nursing responsibilities.
- Many symptoms of depression (e.g., weight and appetite changes, sleep disturbance, decreased energy, fatigue) are similar to those of medical illnesses. Assessment includes a thorough medical history and physical examination to detect or rule out medical or psychiatric comorbidity.
- Suicide assessment and prevention are priorities in caring for people with depression.
- Mental health nursing assessment includes assessing physical health and functioning; mood; speech patterns; thought processes and content; suicidal or homicidal thoughts; cognition and memory; spirituality and social factors, such as patterns of relationships, quality of support systems, and changes in occupational functioning. Several self-report scales are helpful in evaluating depressive symptoms.
- Establishing and maintaining a therapeutic culturally competent nurse–patient relationship is key to successful outcomes. Nursing interventions based on cultural humility that foster the therapeutic relationship include being available in times of crisis, providing understanding and education to patients and their families regarding goals of treatment, providing encouragement and feedback concerning the patient's progress, providing guidance in the patient's interpersonal interactions with others and work environment, spiritual interventions, and helping to set and monitor realistic goals.
- Psychosocial interventions for depressive disorders include self-care management, cognitive therapy, behavior therapy, interpersonal therapy, patient and family education regarding the nature of the disorder and treatment goals, marital and family interventions, and group interventions that include medication maintenance support groups and other consumer-oriented support groups.

DEVELOPING CLINICAL JUDGMENT

1. Describe how you would do a suicide assessment on a patient who comes into a primary care office and is distraught, expressing concerns about their ability to cope with the current situation.
2. Describe how you would approach a patient who does not want to talk with you.
3. Describe how you would approach a patient who is expressing concern that the diagnosis of depressive disorder will negatively affect personal social and work relationships.
4. If a patient is depressed and does not seem inclined to talk about their depression, what measures would you take to initiate a therapeutic relationship?
5. Compare the primary side effects of the SSRIs, TCAs, and MAOIs.
6. Think about all the above situations and relate them to people from a specific cultural or ethnic underrepresented group (e.g., people of African, Latinx, or Asian descent; individuals who practice Judaism or who are Jehovah's Witnesses; individuals across the life span, from children to older adult populations).

MOVIES, TV, OR STREAMING PROGRAMS

***The Holdovers:* 2023.** In the 1970s, five students at a prestigious New England boys' boarding school are unable to leave school for their Christmas break. One of the boys, Angus Tully (Dominic Sessa), is unable to leave school because his mother unexpectedly canceled their family vacation at the last minute in order to be with her new husband. Angus is often in trouble and is not well liked by his peers. Faculty member Paul Hunham (Paul Giamatti) is forced to stay and supervise the boys with the cafeteria manager, Mary Lamb, whose son was recently killed in Vietnam. (Da'Vine Joy Randolph won the 2024

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Best Supporting Actress Oscar for her portrayal of Mary Lamb.) Professor Hunham is a cranky, depressed, stern middle-aged teacher of the classics who is determined to maintain a strict schedule for the boys. When one of the students' fathers arrives to take the boys on a skiing trip, all of the boys are able to go except Angus, who is unable to reach his mother for permission to go on the trip. The story unfolds as the three distraught people left at the school try to make the best of the situation.

Paul, Mary, and Angus have symptoms of depression from trauma. Paul's career has been derailed, and he is fearful of losing his teaching position. Mary is grieving the death of her only son. Angus is dealing with being abandoned by his father and rejected by his mother.

Viewing Points:

1. Identify the traumas that Paul, Mary, and Angus experienced.
2. How does each character exhibit and cope with their depression?
3. How could these three diverse people manage to experience a meaningful holiday? Give an example.
4. Identify the medication that Angus was prescribed. Would that medication be the best treatment for his depression today?

Unfolding Patient Stories: Li Na Chen • Part 2

Recall from Chapter 3 **Li Na Chen**, who was hospitalized with a diagnosis of recurrent major depressive disorder after a suicide attempt by overdose. Her treatment plan includes transitioning to a partial hospitalization program before fully transitioning home. Her husband is concerned about their two children, ages 12 and 14, and his ability to collaborate with Li Na in the management of her treatment when she is home. How can the nurse further assess the husband's concerns? How may Li Na's depression and attempted suicide affect her husband and children? The nurse includes the pharmacologic plans for Li Na's care in discharge planning. What nonpharmacologic interventions need to be considered in discharge planning for Li Na as well as for her husband and children?

Care for Li Na and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimMentalHealth). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

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