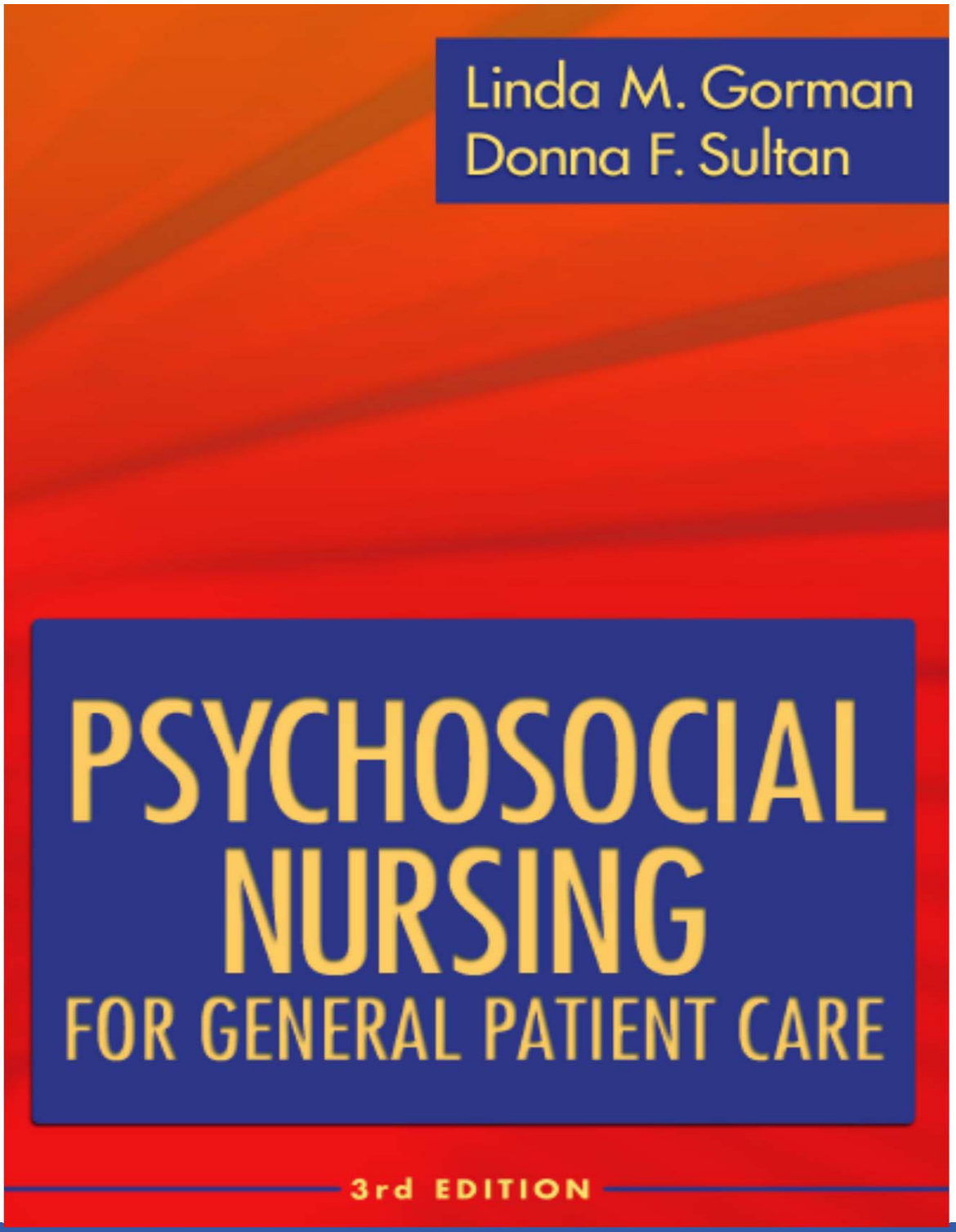

Arnel Banaga Salgado, PsyD, EdD, RN
Assistant Professor
RAK College of Nursing

8

Commonly Encountered Problems: Affect and Mood

The Depressed Patient

Learning Objectives

After the classroom discussion, the students will be able to:

1. **Differentiate feeling depressed from a depressive disorder.**
2. **Describe common physical symptoms seen in depressive disorders.**
3. **Describe interventions for the patient with low self-esteem.**
4. **Describe possible nurses' reactions to the depressed patient**

Useful Terminologies

1. ***Anhedonia –*** Loss of pleasure in activities or interests that were previously enjoyed.
2. ***Dysthymic disorder –*** Mild to moderate chronic depression lasting at least 2 years.
3. ***Major Depressive Disorder –*** Primary psychiatric illness manifested by characteristic symptom clusters such as depressed mood, lowered self-esteem, pessimistic thoughts, and loss of pleasure or interest in former activities.
4. ***Masked depression –*** Concealed depression in which patient is not aware of depressed mood or does not display obvious sadness. The depression is expressed through other means, such as physical complaints or diverse psychiatric symptoms such as phobias or compulsions.

Useful Terminologies

6. ***Psychomotor agitation –*** Classic symptom cluster of depression including restlessness with rapid, agitated, purposeless movements like pacing or wringing hands .
7. ***Psychomotor retardation –*** Classic symptom cluster of depression including slow movements and speech.
8. ***Seasonal affective disorder (SAD) –*** Depression associated with shortened daylight in winter and fall. It disappears during spring and summer.

Introduction

- Feeling down, discouraged, and depressed is something all people experience at different times in their lives. Periods of emotional highs and lows are normal.
- Depressive illness, also known as major depressive disorder, however, is very different from simply feeling depressed.
- Major depressive disorder is a psychiatric illness characterized by a cluster of symptoms including prolonged depressed mood, lowered self-esteem, pessimistic thoughts, and loss of pleasure or interest in former activities for at least 2 weeks. It is a painful, debilitating illness.

ETIOLOGY

No single theory of depression is accepted by all theorists and clinicians. Different theories may apply to the divergent pathways that patients travel to arrive at the various types of depression.

***Biological theories** have focused on an insufficiency of neurotransmitters, especially norepinephrine and serotonin. These insufficiencies may be the result of inherited or environmental factors. The effectiveness of antidepressants may result from enhanced levels of these neurotransmitters. The most severe depressions are predominantly biologically determined. Hormonal factors, including abnormal melatonin metabolism, are associated with seasonal affective disorder (also called major depression with seasonal pattern).*

ETIOLOGY

Genetics may be a factor in more severe depressions. Relatives of people with depression have a higher incidence of this illness than those in the general population.

Psychological theories about a predisposition to depression have focused on a personal history of deprivation, trauma, or significant loss during childhood. These patients may be more susceptible to depression because current losses revive memories of former losses. They are more likely to experience low self-esteem and powerlessness.

RELATED CLINICAL CONCERNS

Clinically significant depressive symptoms are detectable in about 12% to 36% of the medically ill population (DHHS, 1993).

1. Medical Conditions Associated with Depression

- Stroke (especially frontal lesions)
- Myocardial infarction
- Adrenal disorders
- Dementia
- Diabetes
- Cancer
- Hypothyroidism
- Brain tumors
- Parkinson's disease
- Multiple sclerosis
- Chronic pain
- End stage renal disease

RELATED CLINICAL CONCERNS

2. Drugs That Cause Depression

- *Antihypertensive agents*
  Reserpine, Beta blockers, Methyldopa, Oral contraceptives
- *Steroids*
- *Benzodiazepines*
- *Anabolic steroids*
- *Amphotericin-B*
- *Cancer chemotherapeutic agents*
  Vincristine, Vinblastine, Interferon, Procarbazine, L-asparaginase
- *Psychoactive agents*
  Alcohol, Amphetamine or cocaine withdrawal, Opioids

LIFE SPAN ISSUES

Children

- Experts do not agree on the prevalence of depression in children; however, there is consensus that it does occur, even in young children.
- Children as young as 3 years of age have been diagnosed with depression (Varcarolis, 2006).
- Depression could be the aftermath of emotional deprivation, abuse, or separation.
- Children who were abused or neglected are known to be at a higher risk for major depressive disorder in childhood and adulthood (Widom, Dumong, & Czaja, 2007).

LIFE SPAN ISSUES

Adolescents

- National Institute of Mental Health (NIMH) (2007b) estimates that 5% of adolescents suffer from major depressive disorder.
- Adolescents often do not express feelings of depression verbally because they may fear exhibiting feelings of vulnerability and dependency.

LIFE SPAN ISSUES

Adults

- Aggressive behavior in adults often reflects lifelong learned patterns.
- For instance, persons who abuse their spouses have often witnessed abuse in their parents' relationship or been abused themselves as children.

LIFE SPAN ISSUES

Postpartum

- Debate continues as to whether the cause of postpartum depression is solely hormonal represents an intermingling of psychological and physiological stressors.
- Although postpartum “blues” (a few days of labile mood after the birth of a baby) are extremely common, more severe reactions are relatively rare.
- Postpartum depression can include psychotic symptoms including delusions that often concern the newborn infant.

LIFE SPAN ISSUES

Older Adults

- Depression is the most common emotional disorder of later life.
- Elderly people are at higher risk because they experience multiple losses and more medical illnesses than the rest of the population.
- However, in geriatric patients, depression is more likely to be masked rather than exhibited by typical depression symptoms such as sadness, so it is often not diagnosed.
- Using the Geriatric Depression Scale is a useful way to capture this diagnosis.

ASSESSMENT

1. Behavior and Appearance
2. Mood and Emotions
3. Thoughts, Beliefs, and Perceptions
4. Relationships and Interactions
5. Physical Responses
6. Pertinent History

COLLABORATIVE MANAGEMENT

1. *Pharmacological*

- The advent of so many new antidepressants has provided many more opportunities for successful treatment.
- The American Psychiatric Association Practice Guidelines for Major Depressive Disorders (Karasu, Gelengerg, Merriam, & Wang, 2000; Fochtman & Gelenberg, 2005) recommend antidepressants be prescribed for moderate to severe depression and can be used with mild depressive symptoms if the patient wishes. Components of first line treatment today are the Selective Serotonin Reuptake Inhibitors (SSRIs) and newer atypical antidepressants.

COLLABORATIVE MANAGEMENT

2. Psychotherapy

- Psychotherapy and other psychosocial treatments continue to be an important component of depression treatment.
- A combination of psychotherapy and pharmacotherapy is more effective than pharmacotherapy alone. Combination therapy is particularly helpful in improving treatment adherence (Fochtmann & Gelenberg, 2005). One short-term psychotherapy approach is cognitive therapy.
- This method is brief, structured, directive treatment designed to alter the negative thoughts so common in depression. Group therapy can also be helpful to enhance the patient's socialization.

COLLABORATIVE MANAGEMENT

3. Electroconvulsive Therapy

- Electroconvulsive therapy (ECT) is a first-line treatment option only for patients with more severe or psychotic forms of depression. It may also be used for those who have failed to respond to other therapies or those with medical conditions that preclude the use of antidepressants.

NURSING MANAGEMENT

SELF-CARE DEFICIT evidenced by decreased ability to manage own hygiene, grooming, feeding, and daily activities related to loss of energy, inhibition of motivation, anxiety, and/or dependency.

Patient Outcomes

- Increased participation in self-care, daily activities
- Improved grooming and hygiene

NURSING MANAGEMENT

Interventions

- Determine patient's level of self-care before onset of depressive symptoms to set realistic goals.
- Assess whether the patient is expressing certain psychological needs such as dependency or rebellion by not performing self-care. Observe whether patient acts more independently when unaware of being watched.
- Encourage as much independence as possible. Take the time to allow patient to do things for himself or herself. Assign care to staff member who may have more time or is especially patient. Make sure all staff members reinforce patient's participation. Encourage patient's participation in decisions about timing, sequence, and approaches to self-care.

NURSING MANAGEMENT

- Create a positive attitude that patient can learn and progress with practice. Avoid taking over for the patient if he or she has trouble.
- If patient is not eating, encourage small meals that are high in protein and nutrition dense.
- Break down tasks into small steps so patient can experience some success. For instance, have the patient focus on washing his or her face rather than completing the whole bath. Recognize that patient's thinking processes are slowed.
- Create an environment to ease patient's participation, such as having proper utensils available at mealtime or having the walker available in room if patient is ambulating to bathroom.
- Provide reassurance and encouragement. Avoid minimizing patient's problems or infantilizing him or her.

NURSING MANAGEMENT

SELF-ESTEEM DISTURBANCE evidenced by statements of low self-esteem, misinterpreting positive or pleasurable experiences, expressions of shame and guilt related to feelings, thoughts of worthlessness, failures, and negative reinforcement.

Patient Outcomes

- Identifies positive aspects of self
- Modifies unrealistic expectations for self
- Demonstrates reduced symptoms of depression

NURSING MANAGEMENT

Interventions

- Provide emotional nurturing through empathetic listening and supportive encouragement. Treating the patient as a valued individual will enhance his or her self-esteem.
- Avoid blanket reassurances like “things will get better soon.” These tend to alienate the patient, who may feel that you don’t understand his or her pain.
- Encourage patient to share feelings, especially negative ones. If this is too difficult, consider alternative means of expression such as writing about feelings or drawing pictures.
- Point out any specific improvement, no matter how small. Depressed people often do not see improvement because they are so focused on the negative.

NURSING MANAGEMENT

- Encourage patient to speak up if he or she disagrees or feels his or her rights are being violated. Reinforce assertive response.
- Recognize and point out manifestations of self-destructive or self-undermining thinking or behavior:
  1. Requiring self to be perfect or setting unattainable goals
  2. Assuming responsibility for and feeling guilt about failures and events that are outside the patient's control
  3. Basing entire feeling of self-worth on one achievement or attribute, a single relationship, or obtaining approval from others
  4. Projecting own feelings of self-hate onto family, staff, or friends, such as "All the nurses hate me." "My family blames me for my illness."
  5. Expressing self-hate directly through suicidal thoughts and behavior

NURSING MANAGEMENT

POWERLESSNESS evidenced by lack of initiative, non-achievement of realistic goals, passivity; nonparticipation in decision making related to decreased motivation, decreased energy, hopelessness, perfectionistic expectations or sadness.

Patient Outcomes

- Identifies factors that he or she can control
- Participates in decisions about his or her care

NURSING MANAGEMENT

Interventions

- Encourage the patient to describe feelings or the experience of powerlessness. Let the patient know that you are interested and that you understand his or her pain. For instance, you may state, “You believe there is no hope for you to ever feel better.”
- Once the patient indicates that he or she feels understood, suggest alternative viewpoints. Work with patient to identify times in life when he or she felt better or felt more in control.
- Work with the patient to identify realistic goals to work toward. Encourage having patience and accepting current limitations. Break down goals into small steps and recognize progress as each is achieved.

NURSING MANAGEMENT

Interventions

- Allow the patient to maintain reasonable control over some of the daily routine if able.
- Have the patient list specific situations in which he or she felt powerless. Correct distorted assumptions, discuss alternative ways to handle situations, and identify helpful resources.
- Direct the patient to other topics if he or she obsesses on unrealistic goals or things that cannot be changed.

NURSING MANAGEMENT

ALTERNATE NURSING DIAGNOSES

1. *Anxiety*
2. *Coping, Ineffective*
3. *Grieving, Dysfunctional*
4. *Hopelessness*
5. *Injury, Risk for*
6. *Nutrition, Altered*
7. *Sleep Pattern, Disturbed*
8. *Social Interaction, Impaired*
9. *Thought Processes, Disturbed*

NURSING MANAGEMENT

ALTERNATE NURSING DIAGNOSES

1. Anxiety
2. Coping, Ineffective
3. Self-Esteem, Disturbed
4. Thought Processes, Disturbed

WHEN TO CALL FOR HELP

- Extreme self-care deficit to point of not being able to care for basic needs
- Suicidal thoughts, threats, or attempts
- Hallucinations or delusions
- Severe side effects from antidepressants, including severe urinary retention, dramatic fluctuations in blood pressure, cardiac complications, seizures

WHO TO CALL FOR HELP

- Psychiatric Team
- Social Worker
- Attending Physician

End of Chapter