

Depression - CE

ALERT

Don appropriate personal protective equipment (PPE) based on the patient's signs and symptoms and indications for isolation precautions.

A thorough biopsychosocial assessment that includes screening for a history of depression and current depressive symptoms should be an integral part of the admission process.

Selective serotonin reuptake inhibitors (SSRIs) can cause adverse reactions and may also paradoxically increase depressive symptoms.^{3,13}

OVERVIEW

Depression is a highly prevalent mental health disorder characterized by a chronic and persistent feeling of sadness or a loss of interest in previously enjoyable activities.³ One theory is that depression is a brain disorder that may occur because of an imbalance of neurotransmitters.⁸ Research consistently shows that depressive symptoms can be improved with treatment, including psychotherapy and antidepressant therapy.^{8,12}

Some patients may have depressive symptoms without a diagnosis of clinical depression, which occurs in several forms.

- Major depressive disorder (MDD), as defined by the American Psychiatric Association,³ can be a lifelong illness that may remit and recur. MDD may coexist with other psychiatric diagnoses, such as substance use disorder and anxiety disorders.⁸
- Depressive symptoms of bipolar or schizoaffective disorder may mimic the symptoms of MDD; however, bipolar and schizoaffective disorders are not classified as MDD.³

Common sequelae of severe depression are suicide, substance use disorders, inability to work, and worsening pain syndromes.¹¹ Depression is more than just feeling down or blue. Clinical depression can be a precursor to suicide; however, it is not an isolated cause of suicide attempts or completions.⁶ Some individuals who are depressed appear withdrawn, express lack of interest, and may be lethargic.¹⁵ Depression is an illness that does not discriminate; it affects adults of all ages as well as adolescents and children.¹⁰

Patients should be screened for depression, suicidal ideation, and risk factors on admission and periodically thereafter, and services and intervention should be provided for those determined to be at risk.⁷ Studies show that identification of depression without resources for treatment does not improve outcomes; therefore, adequate support and resources for treatment must be available.¹² If a patient is receiving treatment for depression, the treatment should be continued throughout the patient's inpatient stay. The practitioner should review the patient's diagnostic history to differentiate between MDD and bipolar disorder.

Evidence shows that corticosteroids, barbiturates, vigabatrin, flunarizine, mefloquine, efavirenz, and interferon-alpha appear to cause drug-induced depression and should be used with caution in patients with other risk factors for depression.³ In addition, SSRIs, the medication class most often used to treat depression, can cause adverse reactions and, like other medications that a patient uses, may also paradoxically increase depressive symptoms.^{3,13} The practitioner should evaluate the continuation of medication that may cause depression on a risk-versus-benefit ratio to ensure patient safety.

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EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Provide the patient and family with information about depression and its treatment.
 - Depression is not the result of personal weakness.
 - Depression may be caused by an imbalance in neurotransmitters in the brain.
 - Depression can be managed with medications and therapy.
 - Most adverse effects of depression medication are transient.
 - Depression sometimes runs in families.
 - Depression is often chronic with remissions and exacerbations.¹⁰
 - Depression may present as anhedonia (no pleasure derived from outside influences) or anergia (lack of energy to accomplish tasks).³
- Instruct and advise the patient regarding the potential adverse effects of prescribed medications and herbal medications commonly used to treat depression, such as St. John's wort.¹³
 - Advise the patient that serotonin syndrome may result from excessive serotonin intake. When too much serotonin accumulates in the body, a patient can experience: agitation or restlessness, confusion, rapid heart rate and high blood pressure, dilated pupils, twitching muscles or muscle rigidity, sweating, diarrhea or headache. The risk of serotonin syndrome increases with the ingestion of serotonergic agents either as a monotherapy or with herbal preparations, over-the-counter medications including some cough medicines, or prescribed medications.⁴
 - Agents that may cause serotonin syndrome include SSRIs, stimulants, L-tryptophan, buspirone, some analgesics such as codeine and fentanyl, monoamine oxidase inhibitors (MAOIs), antihistamines, antipsychotics, and herbal medications such as ginseng.⁴
 - Serotonin syndrome is uncommon; however, it may be life threatening.^{4,13}
- Advise the patient to avoid using herbal medications that have not been approved by the patient's mental health practitioner because herbal preparations can cause adverse effects when taken with other psychotropics.^{4,13}
- Discuss with the patient the value of regular exercise in regulating mood.
- Discuss with the patient the importance of healthy eating and balanced nutrition to enhance well-being and mood.
- Discuss healthy coping skills with the patient (e.g., avoiding alcohol and drugs).
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene and don PPE as indicated for needed isolation precautions.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Identify the patient's risk factors for depression.³
 - a. Inpatient stays for acute or chronic medical problems
 - b. Chronic disease (e.g., cardiovascular disease, Parkinson disease, kidney disease, stroke, diabetes)¹⁵

Certain conditions, such as hypothyroidism, delirium, or dementia, can mimic depression.^{5,9}

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- c. Family history of depression
- d. Personal history of depressive episodes
- e. Insomnia
- f. Placement in an institutional living situation
- g. Substance abuse
- h. Recent loss, such as the death of a loved one, divorce, or financial loss
- i. Poverty
- j. History of postpartum depression
- k. Traumatic experiences including natural disasters
- l. Abuse (e.g., intimate partner violence)

Rationale: Identifying patients at high risk allows the health care team member to monitor them for signs of depression.

5. Ask questions that help identify signs of depression.

- a. "Have you experienced any changes in your appetite or sleep lately? If so, what is different?"
- b. "Have you experienced a lack of pleasure in things that you previously enjoyed?"
- c. "Have you been unhappy with your life recently?"

6. Obtain a patient history of depressive episodes and current treatment by asking the types of questions below.

- a. "Sometimes people who are ill may feel blue or down. You appear teary; would you like to talk?"
- b. "Have you ever been told you have depression?"
- c. "Have you been told you have manic-depressive illness or bipolar disorder?"
- d. "Are you currently being treated for depression?"
- e. "Are you receiving counseling for depression?"
- f. "Are you taking medicines for depression?"

Rationale: Patients with a history of depression are at risk for further depressive episodes.¹⁰

Obtain permission before asking questions about sensitive topics.

- 7. Assess the patient's history for events that may have triggered a depressive episode.
 - 8. Identify the patient's cultural explanations for symptoms of major depression, including cultural beliefs related to treatment and spiritual practices.
 - 9. Review the patient's home medication list for medications that may cause depression.³
 - 10. Observe the patient for signs of depression and ask the patient and family about signs and symptoms of depression. A diagnosis of major depression requires that at least five symptoms be present within a 2-week period with one of the symptoms being either a depressed mood or anhedonia.³
- a. Sadness
 - b. Tearfulness
 - c. Feeling tired
 - d. Lack of energy
 - e. Feeling hopeless

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- f. Feeling despair
- g. Lethargic behaviors
- h. Anger or agitation (these signs are more commonly seen with male patients)

Rationale: Signs can be used to identify depression and to monitor the efficacy of treatment. Observation of signs is especially helpful with patients who cannot reliably answer questions, such as those with cognitive impairment.^{9,15}

- 11. Assess the patient's support system, family, and significant others and assess the need for education, information, and referral.
- 12. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.⁷
- 13. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.

STRATEGIES

- 1. Perform hand hygiene and don appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.
- 2. Verify the correct patient using two identifiers.
- 3. Explain the strategies to the patient and ensure that he or she agrees to treatment.
- 4. Assess the patient for suicidal or homicidal ideation or thoughts of self-harm. Use an organization-approved standardized tool for suicide assessment.⁷ If homicidal or suicidal ideation is present, implement appropriate precautions based on the patient's status, including constant or enhanced visual observation or routine safety checks, per the organization's practice.

Rationale: Patients who are experiencing an exacerbation of psychiatric symptoms may be at risk for self-harm.

- 5. If risk factors for depression have been identified, provide the patient with appropriate materials.
 - a. Patient education materials on depression or mood disorders
 - b. Information on enhancing well-being (e.g., sleep hygiene to promote natural sleep)
- 6. Communicate the assessment findings to other members of the health care team.

Rationale: If depression screening is positive, the patient needs further evaluation by a qualified professional (e.g., physician, social worker, advanced practice nurse, psychologist). All members of the health care team who are directly caring for the patient should contribute to the ongoing assessment of the patient's mental and physical status.¹²

- 7. Instruct the patient to report any adverse effects from medication. Notify the practitioner.

Rationale: The practitioner may adjust the dose to minimize the adverse effects or prescribe an alternative medication that the patient may tolerate better.

- 8. Consult social services for additional community resources to address depression.

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9. Contact the spiritual care department for a chaplain to visit the patient, if the patient agrees, especially if the patient is in spiritual distress.
10. Ensure that a patient who is currently receiving treatment for depression receives continuing treatment while an inpatient.
11. Prepare the patient for discharge by providing information about community resources (e.g., support groups) and crisis numbers to call in case of emergency.
12. Remove PPE and perform hand hygiene.
13. Document the strategies in the patient's record.

REASSESSMENT

1. Reassess clinical signs that may indicate worsening depression.³
 - a. Insomnia
 - b. Change in appetite
 - c. Weight loss without apparent medical cause
 - d. Expression of sadness or thoughts of self-harm
 - e. Persistent signs of sadness (e.g., flat affect, crying, excessive worry)
 - f. Persistent somatic complaints without apparent physical cause¹⁵
2. Monitor the effectiveness of medications used to treat depression by evaluating the patient for an improved mood.
3. Observe the patient for medication adverse effects.
4. Carefully assess a patient receiving therapy with an SSRI for suicidal behaviors during the early phase of treatment.¹³
5. Reassess mood at least once, per the organization's practice, or after a significant event (e.g., patient receives bad news or experiences a loss).
6. Assess, treat, and reassess pain.

EXPECTED OUTCOMES

- Patient at risk for depression is identified and treated promptly.
- Culturally appropriate treatment and interventions are implemented.
- Patient who is currently in treatment for depression has continuing treatment while in an acute care setting.
- Antidepressant medications and therapeutic treatment are provided.
- Patient is provided with information pertaining to community resources on discharge.
- Patient remains safe.
- Patient expresses hope for the future by expressing attachment to plans or individuals.⁹

UNEXPECTED OUTCOMES

- Patient who has clinical depression is not recognized as depressed.
- Depressed patient is not referred for further evaluation and treatment.
- Patient attempts suicide or self-injury.

DOCUMENTATION

- Assessments conducted, including screening test and results
- Signs and symptoms of depression
- Patient's response to medication, including any adverse reactions
- Suicide precautions when indicated
- Level of patient and family support provided
- Education

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- Effectiveness of strategies implemented
- Unexpected outcomes and related interventions

ADOLESCENT CONSIDERATIONS

- Observe adolescents who are receiving antidepressant medications for signs of suicidal ideation and suicidal behaviors. Adolescents are more susceptible to the paradoxical response that increases suicidality.¹⁰
- Substance abuse is associated with depression in adolescents.¹⁴

OLDER ADULT CONSIDERATIONS

- Depression is not a normal part of aging.
- A patient with dementia may also have depression and vice versa.⁹
- Certain medications used for depression (e.g., antipsychotics, tertiary tricyclic antidepressants, SSRIs) are more likely to cause adverse reactions or toxicity in older adults and should be avoided.²
- The risk of serotonin syndrome in older adults is high because of polypharmacy.

SPECIAL CONSIDERATIONS

- Women should be screened for depression and risk factors at least once during the perinatal period, and services should be provided for those at risk.¹
- Depression is less commonly recognized in men.¹⁵
- Depression in men may present as agitation or anger.¹⁰
- Men are more likely to die by suicide than women.¹⁰
- Depression in children and adolescents may present as somatic complaints and sleep disruptions.¹⁰

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*In these skills, a "classic" reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

Elsevier Skills Levels of Evidence

- Level I - Systematic review of all relevant randomized controlled trials
- Level II - At least one well-designed randomized controlled trial
- Level III - Well-designed controlled trials without randomization
- Level IV - Well-designed case-controlled or cohort studies
- Level V - Descriptive or qualitative studies
- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

Supplies

- Gloves and PPE, as indicated

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