

## Nursing Care for Major Depressive Illness

Major Depressive Disorder is a common illness, with a lifetime prevalence of approximately 10%. It is a significant cause of work or school absenteeism as well as short-term or long-term disability. Persons with MDD typically feel hopeless, helpless, sad, and pessimistic about the future. In severe cases they may try to injure or kill themselves.

Research suggests that abnormalities of neurotransmitters in the brain, genetics, and stress levels can play a part in the development of Major Depressive Disorder. An overabundance of chemicals such as substance P, cortisol, and acetylcholine has been seen in some MDD patients, as well as deficiencies in serotonin, dopamine, GABA, norepinephrine, and certain peptides. These may be limited to neurons in the midbrain, hippocampus, amygdala and hypothalamus, the regions associated with perception, memory, and emotion. The relationship between these abnormalities and emotional states in MDD is still unclear, but since drugs addressing certain deficiencies (e.g., SSRIs) have been useful in treating the disorder, there is evidence that these chemicals are involved in some way (Werner & Covenas, 2014).

Genetics may underlie some of the chemical problems in the brain of a depressed person. An individual who has someone in the immediate family diagnosed with MDD is much more likely to develop MDD themselves than a person who does not have such a family member (odds ratio 2.84, Flint & Kindler, 2014). Researchers have examined a number of SNPs (single nucleotide polymorphisms) and conducted genome-wide studies, which revealed hundreds of genetic variants that could be related to depression. Flint & Kindler (2014) suggest that the high number of variants is one of the reasons for differences in symptoms and treatment response among depressed individuals. Another key finding is that major depression and generalized

anxiety disorder overlap almost 100% in their gene profiles -- this helps to reinforce the relationship between the two disorders which has been found clinically.

The effects of stressors on the development of depression have been known for some time, and are likely to be mediated through stress hormones such as cortisol which, as indicated above, is often abnormally high in persons with MDD. Psychosocial stressors include poverty, domestic violence, psychological or physical trauma, overwhelming family demands, and a high pressure job, among many others. If a person is genetically predisposed towards MDD, a significant stressor or group of stressors is still needed to change the predisposition to a reality. Thus, the three components of MDD etiology often overlap and influence each other (Monroe & Harkness, 2011).

All three contributors to MDD play a part in the three phases of the illness. In the acute phase, the symptoms are at their peak and danger of suicide is often high. The immediate goal is to achieve remission using pharmacologic (targeting abnormal neurotransmitter levels) and / or psychotherapeutic interventions (targeting stressors). Once remission is reached after 6-8 weeks, the continuation phase begins, and lasts for 16-20 weeks. The goal is to keep the person in remission and prevent relapse, so the need for medication and therapy remains. Finally, in the maintenance phase, which lasts indefinitely, continued treatment is provided as needed to prevent a recurrence or relapse. Treatments in the maintenance phase will vary according to the individual's past history of recurrence.

The DSM-5, which was released in 2013, no longer utilizes the multiaxial system of the previous manual. Instead, Axis I-III are combined in a single listing of disorders, psychosocial and contextual features replaced Axis IV, and Axis V, the Global Assessment of Functioning, has been dropped completely. With regard to MDD criteria, the bereavement exclusion was

removed and specifiers for mixed features and anxiety were added. Otherwise, the criteria are the same. The symptoms must have lasted for a 2 week period, excluding any symptoms caused by medical issues, and must cause impairment of functioning. At least five symptoms, one of which must be depressed mood or loss of pleasure, must be present for a diagnosis of MDD. Other symptoms include: significant weight loss / gain or decrease / increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; diminished ability to think or concentrate; recurrent thoughts of death or suicide.

Psychotherapy is widely used to treat MDD, but it can take many forms. One form is cognitive behavior therapy (CBT), which focuses on the patient's belief system and its effect on emotional states. Cognitive distortions can be found in the thinking patterns of most people; for example, catastrophizing is a distortion in which a person interprets a relatively minor issue as crucial to life, producing feelings of panic and hopelessness. This is colloquially known as "making a mountain out of a molehill." CBT helps the patient recognize and modify these cognitive distortions. Rational Emotive Therapy is similar to CBT, but it is applied in a somewhat different manner. Other therapy methods include dialectical behavior therapy (DBT) and problem-solving therapy (PST). Most psychotherapists use a mixture of these types.

Another type of treatment that is particularly useful for patients with MDD is mind-body connection. Meditation, yoga, music and dance therapy, guided imagery, and massage therapy are all examples of mind-body treatments. The goal is to unite the body with the mind; since a large percentage of depressed individuals experience somatic complaints, this type of intervention can be crucial. Many psychiatric hospitals integrate some of these techniques into their inpatient programs to supplement psychopharmacology and individual or group therapy.

Two types of drugs currently used for MDD include selective serotonin reuptake inhibitors (SSRIs), such as Zoloft (sertraline) or Prozac (fluoxetine), and atypical antipsychotics, such as Abilify (aripiprazole). SSRIs work by preventing reuptake of serotonin in the synapse,

thereby making it more available for use in neuron signaling. Increased suicidality is a serious potential side effect for adolescents and young adults, as well as serotonin syndrome, which produces fever, agitation, hallucinations, fast pulse, overactive reflexes, and nausea / vomiting. Other side effects of SSRIs include insomnia, dizziness, dry mouth, and decreased sex drive. Abilify is a partial agonist of dopamine and an antagonist of serotonin. Like other antipsychotics, it has the risk of causing neuroleptic malignant syndrome (producing high fever, rigid muscles, paranoia, and dysfunctioning of the autonomic nervous system) or tardive dyskinesia (uncontrollable jerking movements), both of which can be serious. Other side effects of Abilify include headache, insomnia, anxiety, and akathisia.

Overdosing on an SSRI can result in serotonin syndrome, as well as abnormal gait, hypomania, impotence, tremor, confusion, unresponsiveness, nervousness, pulmonary dysfunction, dizziness, elevated blood pressure, movement disorder, or coma. A person who overdoses with Abilify may experience vomiting, sleepiness, and tremor, as well as seizures, aspiration pneumonia, heart rhythm abnormalities, acidosis, confusion, hypo- or hypertension, aggression, coma, or respiratory arrest.

A patient who is taking an SSRI or Abilify should seek immediate assistance in case of increased suicidality, or symptoms of neuroleptic malignant syndrome, serotonin syndrome, or tardive dyskinesia. Medical care is also urgent if the person shows symptoms of overdose as outlined above.

The following nursing care plan follows NANDA nursing diagnoses and provides interventions, rationales, and outcomes for each.

Diagnosis	Intervention	Rationale	Outcomes
1. Risk of suicide	a. Nursing staff will assess patient's mental status regarding	a. This assessment will update progress and inform staff if	a. Patient will report having no suicidal thoughts within four

	<p>suicide twice per shift.</p> <p>b. Nurses will encourage the patient to express thoughts and feelings about his or her illness, outside issues, and the future.</p> <p>c. Nurses will teach the patient about four coping techniques that fit the patient's personality style.</p> <p>d. The nurse will administer antidepressant medication as prescribed.</p>	<p>patient needs greater supervision.</p> <p>b. Expressing thoughts and feelings helps the patient stop worrying and decreases hopelessness.</p> <p>c. The new coping skills will give the patient a way to help him/herself and avoid thoughts of self-harm.</p> <p>d. Antidepressant therapy will help lift the depressed mood.</p>	<p>days of admission.</p> <p>b. Patient will discuss both positive and negative feelings about the present situation and the future at least once a day within four days of admission.</p> <p>c. Patient will verbally describe the four coping techniques and give evidence of using at least two of them before discharge.</p> <p>d. Patient will take prescribed antidepressant medication within first 24 hours.</p>
2. Social isolation	<p>a. Nurses will monitor patient's participation in group activities, both physical (attendance) and verbal (speaking up).</p> <p>b. Nurses will encourage patient to socialize outside of regular group activities by providing suggestions and structure, i.e. "You might like to work the cat puzzle with Lisa.".</p> <p>c. If patient continues to isolate, nurses will encourage him/her to share feelings about</p>	<p>a. This will help nurses determine if the patient is progressing socially.</p> <p>b. This will make socializing easier for patients who fear rejection</p> <p>c. Validating the patient's feelings can help them to move past those feelings</p>	<p>a. Patient will participate, both physically and verbally, in 90% of group activities by the third day after admission.</p> <p>b. Patient will socialize with other patients outside regular groups at least once daily by the third day.</p> <p>c. Patient will verbalize thoughts and feelings about social interactions within</p>

	interacting with others.	and progress.	four days of admission.
3. Anxiety	<p>a. The nurse will administer anxiety medication as prescribed by the psychiatrist.</p> <p>b. Nurse will encourage patient to verbalize thoughts and feelings about anxiety -- describing worrisome situations, fears, and feelings of helplessness.</p> <p>c. The nurse will discuss with the patient 3 techniques for dealing with anxiety, such as relaxation, meditation, taking action, asking for help, and positive self-talk.</p>	<p>a. Anxiety medication will provide physiological help for anxious feelings.</p> <p>b. Identifying fears is the first step to coping with them.</p> <p>c. Knowing these techniques will give the patient alternatives when he or she feels anxious and thus help to prevent relapse.</p>	<p>a. Patient will take anxiety medication as prescribed during the first 24 hours.</p> <p>b. Patient will identify at least 3 sources of hopeless/helpless feelings and the thoughts surrounding them, within 3 days of admission.</p> <p>c. Patient will give evidence, prior to discharge, of using at least two techniques to cope with anxiety.</p>

Prioritized Discharge patient teaching would include reducing risk of self-harm as first priority. Components include a crisis plan, list of people to call for help, ways to limit risk at home by removing dangerous items, ways family members can help, and follow-up treatment. Second, relapse prevention would include knowledge of relapse risk factors, requesting feedback from family members when they see risk factors, action to take when risk factors are seen, and when to seek medical help. Third, medications would be discussed -- importance of staying on meds, potential side effects, and danger signs which would indicate medical help is required. Fourth, patient should list circumstances that can bring on emotional difficulty, such as death of loved one, physical or emotional trauma, physical illness, excess stress, and frustrated plans;

patient and nurse will discuss ways to handle each of these situations so that they do not lead to relapse.

Caring for clients with MDD will give me more insight into this common disorder, and help to remove any lingering stigma I feel about mental illness. It will also help me understand the importance of emotions in recovery from any illness, whether mental or physical, and to recognize subtle signs of depression in other clients.

To care for clients with MDD, I need to practice validating feelings rather than judging them, and increase my understanding of when to simply validate and when to gently encourage changes in thoughts or actions. For example, in my experience many depressed people do not want to hear advice on how to get rid of their depressed feelings, because they believe they are being judged as "wrong." Since it is important for me, as a nurse, to challenge the patient's thinking errors and teach new coping skills, I should learn how to do this while minimizing the risk of the patient feeling worse about themselves. Sometimes all it takes is validation -- "I can understand why you would feel that way," or "I might feel that way too." Once the patient is reassured that he or she is not "wrong" for having feelings, it will be easier to introduce new concepts.

Validation first is a technique I might encourage families to use as well. Oftentimes, family members want to "fix" the depressed person because he or she makes them feel uncomfortable or guilty. I would explain to family that, although their desire is understandable, sometimes it is better just to acknowledge the feelings instead of trying to change them. I would also want to listen to their feelings and thoughts -- when I care for a patient with MDD, I'm not caring for the patient alone, but their family as well.

This is one of the principles of collaborative care for depression. Other elements include

the partnership between primary care providers, psychiatrists, therapists, and in/outpatient psychiatric hospitals, electronic record-keeping so that each provider knows what the others are doing, and routine follow-up visits to assess medication adherence, moods, and behavior patterns (Katon et al., 2010).

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## References

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