

Depression

Introduction

- Ranges in emotion are part of the human condition...all of us as healthy people experience a range of emotions all day long. Affect should be animated, should change frequently. What we notice the most is when people are flat.
- Continuum of emotional responses
Note that there is such a thing as Chronic Sorrow...a nurse did some research on this. Grief/sorrow that lasts longer than 1 year...Dr. V says that it's normal to set aside grief or issues aside when you can't deal with them at that time...this is "suppression of emotions". As you get down to delayed grief and depression reaction...these are more maladaptive responses. Sadness and depression are a fluid kind of experience, it's not all-or-nothing.
- At least 10-15 million affected by mood disorders at any one time.
- Of the 30,000 annual suicides, approximately 16,000 associated with depressive disorders. THIS IS A MEDICAL EMERGENCY!
- Fewer than half of those with mood disorders receive help. If you are functional to some extent, you are at risk for not getting the help and treatment you need.

Epidemiology

- 1 in 4 persons will experience some type of mood disorder in their lifetime
- Major depressive disorder is most common mood disorder, with a lifetime prevalence of approximately 15%
- Major depression is two times more common among women. Dr. V thinks this is a misnomer, but she thinks its manifested differently in men (more agitated, sociopathic...this is Dr. V's opinion, no research to back this)
- Major depression is 1.5 - 2 times more common among 1st degree relatives with this disorder. GENETIC!
- Major depression as a recurring pattern: 50-60% can be expected to have a 2nd episode. Those who have a 2nd episode, have a 70% chance of having a 3rd episode. The chances of having an episode go up! This is why it is so important to get early treatment...you are more debilitating each time you have an episode. It's not always the case that someone stopped taking meds. Stress can exacerbate symptoms (voices, moods) and lead to person not taking meds...maybe the voices say "don't take that!". A person could identify early signs of when starting to deteriorate or starting to experiencing stress. Ask pt "what are your early signs of stress?" This is KEY!

Every time someone comes into the hospital, don't want pt to feel they have done something wrong...this would cause more stress. Want them to come in as early as possible, stabilize meds and get them out as quickly as possible. Lot of drug-shifting going on in the acute setting...trying to figure out what works.

- Untreated episodes of major depression last 6-24 mos. A little aside: It is VERY difficult to get someone who is bipolar to recognize they have a problem d/t the periods of mania (they feel great!). Then when they get super manic they are out of touch with reality (psychotic). With depressed people, the work is in getting them moving and motivated to understand their illness and options. Don't let the depressed person sleep all day...get them up and out in the milieu. Once they start getting out in the milieu and out of their self-absorption...can do a lot of teaching and discussion so they can do some self-analysis.
- Common age of onset of depression is 18-44. Highest age of onset is the 18-24 age group. Research says depression is rising in younger age groups...but V asks if this is reliable? It's up to the consumer to decide if the research is viable.
- Rate of depression is rising in younger age groups, or is it just that we are able to better diagnose it? Is our world more stressful now? Is there something wrong with the family? Are there toxins in the environment? Hmmm....

PREDISPOSING FACTORS

Biological Correlates (two key ones are neurotransmitter and neuroendocrine)

- Neurotransmitter hypothesis: Variety of them involved - Serotonin; Nor-epinephrine; Gamma-aminobutyric acid (GABA); Acetylcholine; Dopamine. These are all dysregulated in mood disorders...reuptake problems, problems at the synaptic cleft. This is a trial-and-error process, you just try the drug and see how it works! You may see a pt getting worse after they were better for awhile...is it a drug effect?
- Neuroendocrine hypothesis: Biological rhythms - melatonin. Dr. V doesn't think we give enough attention to this. We should all get 20 mins of sun every day to help us maintain our biological rhythm! Get outside!
- Genetic hypothesis:
 - Life time risk in relatives is 20-24%, compared to 6% in general population.
 - Identical twin has a 2-4x risk than fraternal.
- Kindling: Early episodes precipitated by psychosocial stressors/crisis in premorbid individuals. This is a newer idea. You might see someone who is functioning quite well, but at age 18 when leaving home they have their first major episode. The stress/change is not enough for them to handle. Does not just apply to depression...this theory can apply to many illnesses.

Psychosocial Correlates (can help you tune in to areas where you need to gather more data)

- Aggression turned inward. Pt does not know how to express emotions readily, then the stress can build up internally leading to a major depressive episode. Especially attributed to women b/c it's not attractive for women to express anger emotions.
- Object loss. For men this tends to be a job loss, and for women it is more related to loss of family structure.
- Personality disorganization...maybe a personality disorder to some extent...an underlying personal structure that does things to undermine self.
- Cognitive theory. People have faulty ideas that are not part of reality. These people will have a hard time developing sustaining relationships.
- Learned helplessness-hopelessness. "I can't do this", person feels they have no control or ability and gives up.

Complicated/Unresolved Grief (Delayed Grief)

Assessment:

- Symptoms of grief and depression overlap. Everything about grief exhibits as depression. This is why you want to find out if the person has any underlying losses in the past year. It may not just be related to loss...could have an underlying depression as well. Once grief is addressed and still showing depression, then the dx will shift. Otherwise, it is unresolved grief. Most people do get through losses within a few months and go on with their lives.
- Excessive hostility & grief: could be that the person left them and they are now angry that they have to cope alone. It is not uncommon to have some hostility/anger at some point in the resolution of the grief...should get past this. If not, then concerned!
- Prolonged feelings of emptiness & numbness. This should pass within a few months to a year.
- Inability to weep or express emotions. "I do feel profound loss, but I have to put that aside right now." They DO have to address it at some point, b/c delayed grief is going to decrease their functioning.
- Low self-esteem "I can't function without Bob." You hear stuff like this a lot with delayed grief.
- Use of present tense instead of past in relation to loss

- Persistent dreams about the loss is very common. A lot of adults who lost their parents (and were overly attached) will have persistent dreams.
- Retention of clothing of the deceased, some people even keep the body in the house for weeks.
- Inability to visit grave b/c they can't face it.
- Projection of living memories onto an object held in place of the lost person.

ASSESSMENT OF MOOD DISORDER

Major Depression (if no symptoms of mania, then you have major depression)

- Characterized by one or more recurrent episodes of depression
- May range from mild to severe...a lifetime illness of remissions and exacerbations
- Presenting symptoms unique for each person. Ask your pts what their early signs are to help them recognize when an episode is coming on. Maybe they stop making their bed, or can't sleep, or stop eating. Might start spending more time alone.
- Experiences current mood as a change (unlike self)... "I'm just not like myself anymore." This is a key finding!
- Depressed mood is the most common symptom. This is sometimes difficult for men to talk about and identify.
- Unable to enjoy life.
- Tearfulness and crying are fairly common, although some do not cry. This is individualized, so ask pt if this is one of their symptoms.
- Anxiety, experienced as a pervasive feeling of worry and fear with agitation. An anger in the voice may be present, may be jumpy. Kids likely to be angry b/c they don't understand why they are not like their peers.
- Sometimes persons will seek medical care for somatic complaints. There is almost a blame attached to this and not an understanding that the person is trying to seek out help but isn't sure how to do so...may be due to a cultural stigma of mental illness.
- Often have a concrete reason why their energy left them. "I got sick, my wife left me." "I lost my job." Pay attention to see how much they talk about this reason...may bring it up in group. There is an emotional response surrounding the concrete reason for the loss, so pay attention!
- When clients have somatic complaints, pay particular attention to mood and cognition.

Seasonal depression (SAD)

- Pretty common among older adults in LTCF, b/c they don't get outside much. Starting to administer artificial light in LTCFs to help. Also, some people live in areas where it is dark most of the time, you see higher rates of addiction and depression of people who live in these regions. Melatonin supplements can also help.

Postpartum depression

- Dr. V talked about Andrea Yeats...thinks she did not have PDD but was actually psychotic. Anyway, PPD is more common than we think. Assess the mothers on the OB unit for this! The huge change of motherhood can be a huge stressor for women.

Dysthymic Disorder

- Characterized by chronically depressed mood.
- Milder than major depression. DD is a precursor to diagnosing someone for major depression.
- Down in dumps most of day, on more days than not, and lasts for at least 2 years. Person is functional!

- When depressed, at least two of the following symptoms are present...
 - Poor appetite or overeating; Insomnia or hypersomnia; Low energy or fatigue; Low self-esteem; Poor concentration or difficulty making decisions; Sometimes have double depression (also have MDD...periods of mood-swings and non functionality)

Risk for Suicide

Not characterized as a disorder, but you are at higher risk if you have:

- Depressive disorders; Schizophrenia; Substance use disorder; Personality disorder; Panic disorder; Organic mental disorder

Epidemiology of Suicide

- 8th leading cause of death in U.S.A. 3rd among 15-24 year olds. Highest rate of suicide is among white men > 85 yrs (men more likely to do so when spouse dies or can no longer be functional)
- Firearms most common method (men tend to use more volatile methods than women. Women tend to use overdoses, car exhaust in the garage).
- High rates among: Native Americans and Alaskan Natives...addiction rates are highest among these groups also!

THEORETICAL PERSPECTIVES

- Psychobiological:
 - Loss of love (people get profoundly depressed...maybe they even killed the person...ouch!) The homicidal, suicidal shift can go either way...hard for them to see the difference between the two.
 - Narcissistic injury. Person has perceived notion they have been profoundly hurt in some way
 - Overwhelming moods (see in rapid cycler bipolars)
 - Identify with a suicide victim
 - Group suicides (ex: Plano Tx)...suicide pacts on the internet
- Biochemical-Genetic Theories
 - Runs in families – ex: Hemingways (interaction of alcohol and depression). May even think it is part of the family tradition...can get ingrained socioculturally into family members.
 - Lower levels of 5-HT/serotonin Higher 5-HT-2 in brain and platelets (may lead to biological markers)

Assessment

- Look for clues, both verbal and non verbal. Dr. V gave example of the pt who came up to nurses station while she was getting meds and reminiscing about his life. She'd never heard him do that before, but she was multi-tasking so didn't think too much of it at the time. Intuitively, she thought something wasn't right, so she later went and checked on him...the door was partially shut and he came walking out of the bathroom with a wrapped up wire in his hand...he gave it to her and said "I was thinking of killing myself." Usually the mood is more elevated b/c they have more energy to commit suicide...so notice ANY mood/behavior changes in your depressed patients.
- State of despair & loneliness
- Any change from usual behavior (You feel uneasy but often cannot pinpoint what it is) -Behavioral; Somatic &/or Emotional

Dissection of Suicide Plan

- Helps to determine degree of suicide risk
- Evaluate specificity of details (if they have a plan to hang themselves, do they have a rope?)
- Lethality of proposed method (how many Xanax do they actually have?)
- Availability of means (do they have the gun in their possession?)

High Risk Factors

- Social isolation (no support system)
- Severe life events (lots of losses, stress or change)
- Suicide by imitation (15-24 yr. olds)
- Low self-esteem in vulnerable adolescents (ex: discounting their own contributions/opinions, talking about not measuring up to peers)

Assessment Tools: SAD PERSONS Scale (pg. 478)

Sex Age Depression Previous attempt Ethanol use Rational thinking loss Social support lacking Organized Plan
No spouse Sickness

Health Care Worker Self-assessment

- Anxiety, irritation, avoidance, denial are all common.

Client Assessment

- Risk and protective factors; Personal and family history
- Other health problems, demographics
- Determine level of risk and assess for major change to peaceful mood
- If outpatient, then supports must be in place...also a contract!

Risk Factors

- | | |
|---|-------------------------------------|
| • Suicide ideation with intent | * Lethal plan |
| • Co-occurring disorders | * Hx childhood abuse/family suicide |
| • Recent isolation; Recent major stress | * Hopelessness |
| • Panic attacks | * Shame/humiliation |
| • Impulsivity; Aggressiveness | * Loss of cognitive function |
| • Access to firearms | * Substance abuse |

Protective Factors

Sense of responsibility (fam; spouse); Pregnancy; Religious beliefs; Satisfaction with life; Positive social support; Effective coping skills; Effective problem-solving skills; Intact reality testing

Planning

- Determine priority for care (is it the suicidal ideation? maybe they need to find ways to build a social support system, or determine their prodromal symptoms)
- Manage other health problems
- Activate resources
- Continue ongoing assessment
- Evaluate experience of loss and grief

Intervention

- Involve a variety of services and providers...need to tell pt they can talk to anyone on the unit.
- Match client needs to services
- Treat person as an individual
- **Primary Intervention:** Provide support, education, information
- **Secondary Intervention:** Treatment of acute crisis (does not have to be inpatient, can be outpatient, could include going to support group); Work with client ambivalence (client may be indecisive and this can be frustrating for the nurse. Assess their level of understanding and concern for this, intervention may be to have fewer options.)
- **Tertiary Intervention:** Work with family/friends of person who has committed suicide; Interventions with person who has attempted suicide- minimizing trauma is important (don't let them get hurt)

Hospitalized Suicidal Patient

- Suicide precautions: arms length, one-to-one (step down to staff line-of-site, step down accompanied by staff off unit) restraints if absolutely necessary, records/assessments every 15 mins. Make contract with patient! It gives them power and responsibility (increases internal LOC)

Outside the Hospital

- Garner support of family/SO/friends
- Social support: at least 3 contacts they can talk to if they feel depressed
- Appropriate treatment maintained: medication, ECT, other
- Key supports should be given primary providers contact info.
- Appts in place for ongoing evaluation
- Family, SO, and friends should be alerted to signs and symptoms and change from morose to carefree or from sad to happy or "worry free"
- Record-keeping important for rationale as to why to hospitalize, or rationale not to hospitalize.
- Limited supply of medications (2-3 days worth at a time). SSRIs not much of a problem, but benzos/alcohol/sedatives could be used to overdose.
- Provide list with #'s of support people and crisis lines for family and patient
- Latest research suggests replacing contract with pt. not to kill self, with contract in which pt. agrees to notify staff if feels suicidal, a sense of hopelessness or despair.

Therapeutic Techniques for All Settings

- Establishment of interpersonal relationship...the sense of hope that we impart to pts has a huge impact on pt's own sense of hope. Don't be glib, but carry a sense of hope to the pt "Let's work on this together", "I think that we can perhaps establish some ways that you can work better for yourself out there in the community."
- Encouragement of realistic problem solving
- Reaffirm hope

Crisis Management for Suicidal Persons

- Remain calm. If person tells you they are contemplating suicide, call police!
- Deal directly with topic of suicide "Do you have thoughts of killing yourself?" Be confident and up front with it!
- Encourage problem solving and positive actions
- Encourage person to get assistance
- UCLA – Suicide Prevention. Important to let client know these things: crisis is temporary, unbearable pain can be survived, help is available, you are not alone. Client may have tunnel vision and feel totally alone.

Crisis Management for Suicidal Persons in the Community

- Relieve isolation
- Remove all weapons
- Encourage alternative expression of anger
- Avoid final decision for suicide during crisis
- Reestablish social ties
- Relieve extreme anxiety & sleep loss

Survivors of Completed Suicide

- Intervention initiated within 24-72 hours after suicide
- Often must grieve without the usual informal social supports
- Stigmatized and cut off
- Confused feelings of pain, anger and guilt
- Few seek counseling
- May experience symptoms of PTS reactions
- Initiate post traumatic loss debriefing can help to precipitate an adaptive grief process
- Stages of debriefing: Introductory, Fact (talk openly about every detail, go to grave, make it real so no hidden pieces), Life review, Feeling (express the feelings fully), Reaction, Learning, Closure

Diagnoses Examples

- **NANDA:** Dysfunctional grieving, Powerlessness, Spiritual distress, Hopelessness
- **DSM IV:** Dysthymic disorder, Major depressive disorder
- **Outcome identification:** The patient will be emotionally responsive and return to a pre-illness level of functioning

- Planning Implementation: Counseling, Therapeutic use of self
- **Critical pathway:** Facilitating expression of feelings, Facilitating self-esteem, Cognitive restructuring, Group interventions, Family interventions, Milieu therapy, Promoting physical activity, Self-care activities
- Somatic interventions: ECT: electroconvulsive therapy; Phototherapy for melatonin issues; Psychopharmacology

Electroconvulsive Therapy (ECT)

- Can achieve higher than 90% remission rate in 1-2 weeks
- Useful for people who don't respond to antidepressants (20-30%)
- Long-term results are mixed; however, there is some indication that it is an effective treatment for selected clients

How Does ECT Work?

- It's believed that ECT works by using an electrical shock to cause a seizure. This seizure releases selective neurotransmitters (especially GABA in the occipital cortex) in the brain. The release of these chemicals improves communication between brain cells.
- The neuroendocrine hypothesis, (from human studies), argues that the affective disorders result from a deficiency of a mood-modifying peptide (antidepressin) from the hypothalamus.
- Convulsive therapy stimulates the production and release of antidepressin.

Indications for ECT

- Need for rapid effective response in a suicidal and homicidal client
- Client is extremely agitated, stuporous or has marked psychomotor retardation
- Risks of other treatments greater
- History of poor drug response &/or positive response to ECT
- Client's request
- For clients with major depression and bipolar disorder with delusions (guilt, somatic or infidelity)
- Also helpful in manic clients resistant to lithium and antipsychotic meds, and in rapid cyclers.
- Known to be effective in catatonia, schizoaffective, pregnant psychotic clients, & some clients with Parkinson's

Course of ECT Treatment

- 6-12 treatments, 2-3 times a week
- Special care to clients with a history of MI, CVA, Cerebrovascular lesions
- Informed consent for voluntary. For involuntary: kin- or court-ordered.
- General anesthesia and muscle-paralyzing agents prevent grand mal seizure
- Bilateral side effects include: confusion, disorientation and short-term memory loss, most everyone gets HA.
- Post treatment may require frequent orientation
- Clients often complain of memory deficits for the first few weeks, but the memory usually returns
- Headache common for 8-24 hours after treatment

- Not a permanent cure for depression – supplemented with TCAs or lithium decreases the relapse rate
- Maintenance ECT: Once a week to once a month; May also help decrease relapse rates in those who tend to relapse. Some pt may get a “tune up” once a year.

Psychopharmacology Antidepressants

- **Tricyclics (TCAs):** Enhance neurotransmission of selected neurotransmitters. Block their reuptake at presynaptic neuron; Inhibit their metabolism & subsequent deactivation; Enhance the activity of receptors.
- TCA Client Teaching
 - 7-28 days for mood elevation
 - Reinforce frequently
 - Drowsiness, dizziness and hypotension usually subside after a few weeks
 - Be careful driving, operating heavy machinery
 - Alcohol can block effects
 - Full dose at bedtime to avoid side effects
 - If forgets bedtime dose or 1 a day dose, take within 3 hrs or wait until next day
 - Do not stop meds abruptly: nausea, altered heartbeat, nightmares, and cold sweats in 2-4 days
- **SSRI's:** Inhibit reuptake of serotonin; Permit serotonin to act for an extended period at synaptic site. They have fewer side effects (such as anticholinergic); Examples: Prozac, Lexapro, Paxil, Zoloft
- **MAOI's: Monoamine Oxidase Inhibitors:** Prevent inactivation of certain brain amines, such as norepinephrine, serotonin, dopamine, and tyramine. Therefore, an increase of these amines available for synaptic release in the brain. Increase of tyramine poses a problem...Can lead to high blood pressure, hypertensive crisis, and later, to CVA, so must reduce intake. Avoid foods and drugs that contain it (i.e., avocados, figs, bananas, fermented foods, almost all cheeses, beer and chianti)
- **Novel Antidepressants-** Bupropion (Wellbutrin or Zyban): Active serotonin (5 HT₂) receptor antagonist; Binds to the serotonin transmitter (inhibits serotonin reuptake)

IN CLOSING, your pts with MDD and DD need...

- Health teaching re: Prodromal symptoms
- Case management includes managing needs in community
- Health promotion and health maintenance to de-stress and have healthier lifestyle
- Differentiation of: Symptoms of grief vs. depression; Interventions - grief vs. depression
- Evaluation

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