7.5: Applying the Nursing Process to Depressive Disorders

Assessment

Assessing a client with a depressive disorder focuses on both verbal and nonverbal assessments. As the registered nurse conducts follow-up assessments, findings are compared to baseline admission assessments.

The role of the nurse in caring for clients with depression is related to primary nursing care, as well as collaboration with interprofessional team members. As a team member, the nurse may collaborate with psychiatrists, psychologists, licensed social workers, and other health care providers. The scope and practice of each team member is clearly...
defined within their professional licensure.

**Psychiatric Interview**

The registered nurse uses specific questions during the client’s admission process based on agency policy. It is also important to consider the impact of culture on a client’s perception of their illness. See suggested "Cultural Formulation Interview Questions" in the “Application of the Nursing Process in Mental Health Care” chapter.

**Mental Status Examination**

See Table 7.5a for common findings when assessing a client with a depressive disorder. (See expected findings for these components of a mental status examination in the “Assessment” section in Chapter 4.) Critical findings that require immediate notification of the provider are bolded with an asterisk.

Table 7.5a Common Findings During Mental Status Examinations for Clients With Depressive Disorders

<table>
<thead>
<tr>
<th>Mental Status Examination Component</th>
<th>Common Findings in Depressive Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Consciousness and Orientation</td>
<td><em>Disoriented/confused. The client may be very self-focused and may appear disoriented when others initiate conversation or talk about current events because they are unaware of what is occurring around them due to their depression.</em></td>
</tr>
<tr>
<td>Appearance and General Behavior</td>
<td><em>Disheveled. The client’s hair may not be combed, and they may be unwashed with poor dental care. They may be wearing dirty clothing with food stains and have body odor with little or no attention to self-care.</em></td>
</tr>
<tr>
<td></td>
<td><em>Sleep disturbances. The client may exhibit too much sleep (i.e., 14-18 hours daily) or have insomnia (i.e., less than 4 hours of sleep or in intervals of sleep).</em></td>
</tr>
<tr>
<td></td>
<td><em>Psychomotor retardation. The client may have a slow response with walking, talking, and reacting; may tend to stay put on the couch or in bed.</em></td>
</tr>
<tr>
<td></td>
<td><em>Vegetative signs. The client may exhibit weight loss, insomnia, constipation, and self-care deficits.</em></td>
</tr>
<tr>
<td></td>
<td><em>Avolition (reduced motivation or goal-directed behavior). For example, the client states, “I just don’t want to shower today.”</em></td>
</tr>
<tr>
<td></td>
<td><em>Anergia (low energy). For example, the client states, “I have no energy; I cannot get out of bed.”</em></td>
</tr>
<tr>
<td></td>
<td><em>Social isolation.</em></td>
</tr>
<tr>
<td></td>
<td><em>Aggressiveness and agitation.</em></td>
</tr>
<tr>
<td></td>
<td><em>“Verbal and nonverbal threats of harm.</em></td>
</tr>
</tbody>
</table>
| | *“Self-harming behaviors such as cutting, picking at skin, knocking head against the wall, tightening string or items on wrists, or stabbing self with anything fashioned into a weapon.*
• “Cheeking pills” (i.e., holding pills in mouth and not swallowing them). Clients may save medications for use in a later suicide attempt.

Speech

• May speak slowly in a monotone.

• May exhibit latency (i.e., a delayed response to a question or comment). However, be aware of the client’s baseline because this may be their normal if they have a history of traumatic brain injuries, dementia, or are English language learners.

Motor Activity

• Psychomotor retardation.

• Motor restlessness and anxiety.

• Inactive or not initiating self-activity or care.

Mood and Affect

• Apathy (a lack of interest in events that one previously found enjoyable). For example, the client is no longer interested in participating in pleasurable activities. This may be verbalized or observed.

• Anxious, irritable, angry, euphoric, tearful, or depressed.

• Labile mood (rapid, exaggerated changes in mood). For example, a client is crying uncontrollably but when asked about the reason for crying, they state, “I don’t know, I have no reason but can’t stop crying.”

• Dysphoria (a state of unease or dissatisfaction). For example, the client states, “I don’t like it here.”

• Sadness.

• Crying episodes.

• Flat or blunted affect.

• Constricted/restricted affect. For example, a client usually laughs at jokes and giggles at funny comments but now does neither.

• Incongruency (a lack of alignment between response and actions). For example, a client responds that they are fine, yet their body language is curled in a fetal position with no eye contact, and they are mumbling.

• Mood is inappropriate for the current situation.

• *Hopelessness. For example, a client may feel there is no longer any hope for them getting better or for life improving.

• *Worthlessness. For example, a client may have feelings of guilt regarding themselves and their depression. They may feel like a burden to others and are unable to recognize their own value.

• *Helplessness. For example, a client does not feel in control of life events.

*Note: Hopelessness, worthlessness, and helplessness are related to an increased risk of self-injury behavior and suicide and must be reported to provider. Do not leave clients
alone if statements such as these are being made.

- Poverty of content (responds without saying anything substantive or says much more than is necessary to convey a message). For example, if a client is asked, “How did you sleep last night?,” the client answers with a long response about different brands of bedsheets without answering the question.
- Decreased attention span.
- Obsessions/preoccupations/ruminations. For example, a client may dwell on negative aspects of self-concept or faults and failures because they are unable to focus on anything else and thus repeat these thoughts often.
- *Suicidal ideation.
- *Homicidal ideation.
- *Violence ideation.

*Note: Suicidal, homicidal, and violence ideations are characteristics of depression with recurring thoughts of death. These types of comments indicate increased risk for self-injury, suicide, or injury to others and must be reported to provider. Do not leave clients alone if statements such as these are being made.

- Unaware of the current situation.
- Unable to relate to current trends or settings.
- Lack of perception.
- Low awareness outside of self.
- Irritability.

- The inability to make decisions, think clearly, or solve problems is common in clients with depression.

Psychosocial Assessment

As previously discussed in the “Application of the Nursing Process in Mental Health Care” chapter, psychosocial assessment obtains additional subjective data that detects risks and identifies treatment opportunities and resources. Agencies have specific forms used for psychosocial assessment that typically consist of these components:

- Cultural assessment
- Reason for seeking health care (i.e., "chief complaint")
- Thoughts of self-harm or suicide (both current and historical)

https://med.libretexts.org/Bookshelves/Nursing/Nursing%3A_Mental_Health_and_Community_Concepts_(OpenRN)/07%3A__
• Current and past medical history
• Current medications
• History of previously diagnosed mental health disorders
• Previous hospitalizations
• Educational background
• Occupational background
• Family dynamics
• History of exposure to psychological trauma, violence, and domestic abuse
• Substance use (tobacco, alcohol, recreational drugs, misused prescription drugs)
• Family history of mental illness
• Coping mechanisms
• Functional ability/Activities of daily living
• Spiritual assessment

Screening Tools

Screening tools assess characteristics of specific mental health disorders. The screening tools listed below are examples of screenings, assessments, and question/answer prompts designed to address depressive disorders. These screening tools may be used on admission and at different times throughout the hospital or treatment stay. The findings may be used to compare and contrast client progress within the hospital stay, from a previous admission, or periodically on an outpatient basis. The registered nurse often conducts these tools as a collaborative member of the health care team.

Links to Common Screening Tools for Depressive Disorders

• **Columbia-Suicide Severity Rating Scale (C-SSRS) PDF**: A rating scale for suicidal ideation and behaviors that rates the degree of risk or intent of harm. It can be a self-assessment or administered by the health care professional.

• **Patient Health Questionnaire-9 (PHQ-9)**: A quick screening tool with nine criteria for assessing a client’s risk of depression.

• **Beck Depression Inventory (BDI)**: A 21-item self-assessment questionnaire that determines the severity of depression from none to severe.

• **Hamilton Depression Scale (HDRS) PDF**: A 17-item questionnaire used to rate the severity of one’s depression.

• **Geriatric Depression Scale (GDS) PDF**: A self-report of depressive symptoms for older adults; the new version is 15 questions.

• **Edinburgh Postnatal Depression Scale (EPDS)**: A self-report of ten statements by mothers to screen for postpartum depression.
Laboratory Testing

For patients with depressive symptoms in the absence of general medical symptoms or findings on examination, the utility of screening laboratory tests has not been demonstrated. Commonly performed screening laboratory tests for new onset or severe depression include complete blood count, serum chemistry panels, urinalysis, thyroid stimulating hormone, rapid plasma reagin (RPR) for syphilis, human chorionic gonadotropin (HCG) for pregnancy, and toxicology screening for drugs of abuse. [3]

Routine laboratory monitoring is performed for some clients based on the medications they are taking, such as the following:

- Kidney Function (Creatinine, BUN)
  - May be impaired from medications the client is taking
- Liver Function (AST, ALT, Bilirubin)
  - May be impaired from antidepressants
- Therapeutic Medication Blood Levels
  - Some medications require that drug levels be monitored to assess for toxicity and therapeutic ranges

Read more about laboratory monitoring required for specific medications in the "Treatments for Depression" section of this chapter.

Life Span Considerations

Life span considerations influence how the client is assessed, as well as the selection of appropriate nursing interventions. Depressive disorders can be found across the life span from the very young to the very old. Read more about specific disorders in the "Childhood and Adolescence Disorders" chapter or the "Vulnerable Populations" chapter. It is important to individualize all interventions to the age and developmental level of the client. Review developmental stages in the "Application of the Nursing Process in Mental Health Care" chapter.

Depression Associated With Dementia

Individuals with dementia are susceptible to depression. Dementia refers to a group of symptoms that lead to a progressive, irreversible decline in mental function severe enough to disrupt daily life caused by a group of conditions including Alzheimer's disease, vascular dementia, frontal-temporal dementia, and Lewy body disease. Alzheimer's disease is one of the most common forms of dementia. Alzheimer's disease causes impaired memory and the ability to learn, reason, make judgments, communicate, and carry out daily activities. An early symptom of Alzheimer's disease can be subtle memory loss and personality changes that differ from normal age-related memory problems. They seem to tire or become upset or anxious more easily. They do not cope well with change. For example, they can follow familiar routes, but traveling to a new place confuses them, and they can easily become lost. In the early stages of the illness, people with Alzheimer's disease are particularly susceptible to depression. [4]

While changes in the brain that cause dementia are permanent and worsen over time, thinking and memory problems
can be aggravated by untreated depression. Nurses should report new symptoms of depression in clients who have been diagnosed with dementia.

Read more about dementia at the Alzheimer’s Association’s webpage.

Reflective Questions

1. How does the nurse differentiate between depression, delirium, dementia, and psychosis
2. What are some common underlying medical conditions that could potentially mimic the symptoms of depression or mania in those who are elderly?
3. What other symptoms might a client who is a child/adolescent display that would indicate the need to assess for disorders other than depression?

Cultural Considerations

Review cultural considerations of care in the "Application of the Nursing Process in Mental Health Care" chapter.

Reflective Questions:

1. Reflect on how a client’s cultural values, beliefs, or preferences impact presenting symptoms, the nursing care plan, or treatment modalities. Consider the following components:
   - Religious/Spiritual beliefs
   - Language/Communication
   - Nutritional preferences
   - Fasting
   - Potential drug-food interactions
   - Rituals/Customs/Practices
   - Gender dysphoria

Diagnoses

Mental health disorders are diagnosed by mental health providers using the DSM-5, similar to how medical conditions are diagnosed by trained medical professionals. Nurses create individualized nursing care plans based on the client’s response to mental health disorders. See common nursing diagnoses related to mental health disorders in the “Diagnosis” section of the “Application of the Nursing Process in Mental Health Care” chapter.

Risk for suicide is always evaluated for clients with depressive disorders because suicidal ideation is a symptom of depression. Other common nursing diagnoses and sample expected outcomes for clients with depressive disorders are discussed in the following section in Table 7.5b.
Outcome Identification

SMART outcomes are identified in relation to the established nursing diagnoses for each client. SMART is an acronym for Specific, Measurable, Attainable/Actionable, Relevant, and Timely.

Read more about outcome identification in the “Application of the Nursing Process in Mental Health Care” chapter.

Table 7.5b. Common Expected Outcomes for Nursing Diagnoses Related to Depressive Disorders

<table>
<thead>
<tr>
<th>Nursing Diagnosis</th>
<th>Sample Expected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk for Suicide</td>
<td>*Note: Clients with depression are at higher risk of suicide when experiencing sudden euphoric recovery from major depression.</td>
</tr>
<tr>
<td>Ineffective Coping/Readiness for Enhanced Coping</td>
<td>The client will identify effective coping strategies within 24 hours of admission.</td>
</tr>
<tr>
<td>Self-Neglect</td>
<td>The client will increase participation in baseline personal care each day during their stay.</td>
</tr>
<tr>
<td>Fatigue/Sleep Deprivation</td>
<td>The client will, within one week, report feeling rested upon awakening.</td>
</tr>
<tr>
<td>Imbalanced Nutrition: Less than Body Requirements</td>
<td>The client will eat 50% or more on their meal tray at each meal.</td>
</tr>
<tr>
<td>Constipation</td>
<td>The client will have a soft, formed stool at least every three days during their inpatient stay.</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>The client will communicate with others during their inpatient stay by participating in daily group offerings within the milieu.</td>
</tr>
<tr>
<td>Chronic Low Self-Esteem</td>
<td>The client will verbalize at least three personal strengths within three days of admission.</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>The client will describe plans for a positive future by discharge.</td>
</tr>
<tr>
<td>Spiritual Distress</td>
<td>The client will identify a meaning and purpose in life within two weeks.</td>
</tr>
<tr>
<td>Readiness for Enhanced Knowledge</td>
<td>The client will verbalize three common side effects of their medications by the end of the shift.</td>
</tr>
</tbody>
</table>
Planning Interventions

Interventions are planned based on the client’s nursing diagnoses, expected outcomes, and current status. Clients with depressive disorders are monitored closely for risk of suicide, and interventions are planned according to their level of risk. See interventions for clients at risk of suicide in the “Application of the Nursing Process in Mental Health Care” chapter.

Implementation

As discussed earlier in this chapter, a combination of pharmacological treatments and psychotherapies are often an effective approach to treating depressive disorders. There are three phases in treatment and recovery from major depression:

• The active phase (6 to 12 weeks) is directed at reduction of depressive symptoms and restoration of psychosocial and work function. Hospitalization may be required, and medication and other biological treatments may be initiated.
• The continuation phase (4 to 9 months) is directed at prevention of relapse through pharmacotherapy, education, and depression-specific psychotherapy. This phase focuses on maintaining the client as a functional and contributing member of the community after recovery from the acute phase.
• The maintenance phase (1 year or more) is directed at preventing future episodes of depression. Medication may be phased out or continued.

Nurses target interventions based on the client’s current phase of treatment and recovery.

Interventions can be categorized based on the American Psychiatric Nurses Association (APNA) standard for Implementation that includes the Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy; and Therapeutic Relationship and Counseling. Read more about these subcategories in the “Application of the Nursing Process in Mental Health Care” chapter. See examples of interventions for each of these categories for clients with depressive disorders in Table 7.5c.

<table>
<thead>
<tr>
<th>Subcategory of the APNA Standard of Implementation</th>
<th>The nurse will …</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of Care</td>
<td>Communicate client trends, such as risk for suicide or cheeking of medications, with interprofessional team members.</td>
<td>All team members providing care must be aware of the client’s suicide risk to maintain a safe environment.</td>
</tr>
<tr>
<td>Health Teaching and Health Promotion</td>
<td>Promote health by teaching about adaptive coping strategies such as journaling and daily exercise.</td>
<td>Nurses encourage resilience with adaptive coping strategies.</td>
</tr>
<tr>
<td>Pharmacological,</td>
<td>Deliver patient education about antidepressants and</td>
<td>Client understanding of their</td>
</tr>
</tbody>
</table>

https://med.libretexts.org/Bookshelves/Nursing/Nursing\%3A_Mental_Health_and_Community_Concepts_(OpenRN)/07\%3A...
Biological, and Integrative Therapies

Expected time frames for improvement.

Open all medications in front of the client.

Medications and potential side effects can increase medication compliance.

Opening all medications in front of the client may decrease paranoia.

Milieu Therapy

Perform and document intentional rounding every 15 to 60 minutes on varied schedule.

Visually rounding on every client in the milieu creates a strong safety plan for all clients and staff.

Therapeutic Relationship and Counseling

Provide 1:1 therapeutic communication to encourage the client to develop adaptive coping strategies, use stress management techniques, develop supportive relationships, and seek spiritual supports.

Providing effective therapeutic techniques for clients with depression can promote hope and positive self-esteem.

Nursing interventions are also planned that target common physiological signs of depression and associated self-care deficits. See common interventions for these conditions in Table 7.5d.

Table 7.5d Nursing Interventions Targeting Physiological Signs of Depression and Self-Care Deficit

<table>
<thead>
<tr>
<th>Problem/Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td></td>
</tr>
<tr>
<td>• Offer small, high-calorie, and high-protein snacks and fluids frequently.</td>
<td>Poor nutrition increases the risk for physical illness. Small, frequent snacks are more easily tolerated than large portions of food if the client has a loss of appetite. Fluids prevent dehydration and minimize constipation.</td>
</tr>
<tr>
<td>• When possible, encourage family or friends to join the client during meals.</td>
<td>Eating is a social event. Eating with loved ones reinforces the idea that someone cares about them and can serve as an incentive to eat.</td>
</tr>
<tr>
<td>• Encourage the client to participate in selecting food and drinks.</td>
<td>The client is more likely to eat foods they prefer.</td>
</tr>
<tr>
<td>• Refer the client to a dietician if necessary.</td>
<td>A dietician can help create an individualized diet plan.</td>
</tr>
<tr>
<td>• Weight the client weekly and monitor trends.</td>
<td>Monitoring the patient’s status provides data for evaluating effectiveness.</td>
</tr>
<tr>
<td>• Observe the client’s eating patterns.</td>
<td>Disturbances in one’s sleep cycle can intensify feelings of depression.</td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
</tr>
</tbody>
</table>
• Provide periods of rest after activities.
• Encourage the client to get up and dress and stay out of bed during the day.
• Encourage relaxation measures in the evening, such as a warm bath, warm milk, or soothing music.
• Avoid caffeinated beverages.

Minimizing sleep during the day and establishing routines increase the likelihood of restful sleep at night.

Relaxation techniques induce sleep.

Decreasing caffeine intake increases the possibility of sleep.

Elimination (Constipation)

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor frequency of bowel movements.</td>
<td>Many depressed patients are constipated, so frequency of bowel movements should be monitored.</td>
</tr>
<tr>
<td>Encourage fluids and foods high in fiber.</td>
<td>Fluids, fiber, and exercise stimulate peristalsis and soften stools.</td>
</tr>
<tr>
<td>Provide periods of exercise.</td>
<td>Bowel management programs may be needed to avoid constipation or fecal impaction.</td>
</tr>
<tr>
<td>Evaluate the need for a bowel management program with stool softeners and laxatives.</td>
<td></td>
</tr>
</tbody>
</table>

Self-Care Deficits

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the use of a toothbrush, washcloth, soap, and makeup or shaving supplies.</td>
<td>Being clean and well-groomed can improve self-esteem.</td>
</tr>
<tr>
<td>When appropriate, give step-by-step reminders, such as “Wash the right side of your face and now your left.”</td>
<td>Slowed thinking and difficulty concentrating make organizing simple tasks difficult.</td>
</tr>
</tbody>
</table>

Communication Tips

Some clients with depression are so withdrawn they are unwilling or unable to speak. Sitting with them in silence may feel like a waste of time, but nurses should be aware that providing therapeutic presence can be meaningful in supporting the client with depression. Helpful communication techniques for severely withdrawn clients and their rationale are described in the following box.

Guidelines for Communication With Severely Withdrawn Individuals: 

• Use simple, concrete words and allow the client time to respond.
• **Rationale:** Slowed thinking and difficulty concentrating impair comprehension and require time to formulate a response.

• Listen for covert messages and ask about suicide plans.
  • **Rationale:** People often experience relief and decreased feelings of isolation when they share thoughts of suicide.

• Avoid platitudes such as “Everyone feels down once in a while.”
  • **Rationale:** Platitudes minimize the individual’s feelings and can increase feelings of guilt or worthlessness because they cannot “snap out of it.”

• When a client is silent, use the technique of making observations, such as “There are new pictures on the wall,” or “You are wearing new shoes.”
  • **Rationale:** When an individual is not ready to talk, direct questions can raise their anxiety levels. Pointing out objects in the environment draws the person into reality.

There are several guidelines for counseling individuals with depression, helping them identify current coping skills, and exploring new adaptive coping strategies:

• Encourage stress management techniques such as exercise, good sleep, and healthy food choices.
• Promote the formation of supportive relationships such as peer support and support groups to reduce social isolation and enable the individual to work on personal goals and relationship needs.
• Provide information about spiritual support as the individual defines it, such as chaplain or pastoral visits or spending time in nature; many people find strength and comfort in spiritual and/or religious activities.
• Help the client reconstruct a healthier and more hopeful attitude about the future (without providing false reassurance).

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### Collaborative Mental Health Treatments

Nurses assist in implementing collaborative interventions based on the client’s treatment plan. Review collaborative mental health treatments and common medications used to treat depression in the “Treatments for Depression” section of this chapter.

### Patient Education Regarding Antidepressant Medications

Nurses educate clients about their medications, including the manner in which they work, common side effects, and issues to report to their provider. Clients taking antidepressants should also be educated regarding the following considerations:

• When taking antidepressants, it is important to follow the instructions on how much to take. Some people start to feel better a few days after starting the medication, but it can take four to eight weeks to feel the most benefit. Antidepressants work well and are safe for most people, but it is still important to talk with your mental health care provider if you have side effects such as sexual dysfunction, weight gain, dizziness, nausea, palpitations, drowsiness, insomnia, or anxiety. Side effects may go away as your body adjusts to the medication, but in some cases, switching to a different medication may be required.

• Don’t stop taking an antidepressant without first talking to your mental health care provider. Stopping your medicine...
suddenly can cause symptoms or worsen depression.

- Antidepressants cannot solve all of your problems. Antidepressants work best when combined with psychotherapy and healthy coping strategies. If you notice that your mood is getting worse or if you have thoughts about hurting yourself, it is important to call your provider right away.

- Some people who are depressed may think about hurting themselves or committing suicide (taking their own life). If you are having thoughts about committing suicide, please seek immediate help by calling your provider, 911, or 1–800–273–TALK to reach a 24–hour crisis center that provides free, confidential help to people in crisis.

- Some antidepressants may cause risks to the baby during pregnancy. Talk with your provider if you are pregnant or might be pregnant or if you are planning to become pregnant.

- For individuals who are very depressed or suicidal, it is important to provide close monitoring when the individual first starts taking an antidepressant medication. Often an individual may have increased energy to make a suicidal attempt when they first begin a medication, whereas previously they may have had suicidal thoughts but lacked the energy to make an attempt.

Supporting Family Members

It is important to support the family members and significant others who are living with an individual with a depressive disorder. Read tips on living with someone with depression in Figure 7.9.\[15\]

**Figure 7.9 Supporting Family Members and Significant Others**

Evaluation

Evaluation of the client’s progress towards meeting expected outcomes occurs continuously throughout the treatment phase. Evaluation includes comparing results from screening tools, reviewing laboratory results, and monitoring the effectiveness of prescribed medications, treatments, and nursing interventions. Based on the evaluation findings, the nursing care plan may be modified, or new interventions or outcomes may be added.


