Almost everyone has days when they feel discouraged, disheartened, and a bit grouchy. Usually, these times of reduced energy and irritability last only a short time and soon vitality and enthusiasm for life returns. During these low periods, people may say they feel “depressed” or “down in the dumps,” yet rarely are they clinically depressed or grieving a significant loss.

Depressive disorders, on the other hand, are pervasive alterations in body, mood, and thoughts that significantly interfere with daily living and normal functioning, causing distress for both the person with the disorder and those around him or her. The resulting self-doubt, guilt, and anger affect the self-esteem, interpersonal relationships, and livelihood of these individuals. It is no surprise to find that suicide is associated with depressive disorders. The risk of suicide is approximately 20 times higher among individuals with major depression, and untreated depression is the number one cause for suicide (Caruso, n.d; Lyness, 2015).
TYPES OF DEPRESSIVE DISORDERS

Depressive disorders are common but serious and come in different forms. In order to help healthcare professionals recognize and treat depressive disorders more effectively, the American Psychiatric Association in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has identified the following types of depressive disorders.

**Persistent Depressive Disorder (Dysthymia)**

This disorder is a consolidation of the formerly defined chronic major depressive disorder and dysthymic disorder. It is similar to, but milder than, major depressive disorder, characterized by a chronic depressed mood that is present most of the time, identified subjectively or by observation by others, and lasts for at least 2 years in adults. In children and adolescents the mood can be irritable and must be present for at least 1 year. There is no evidence of psychotic symptoms.

This joyless disorder may begin in early childhood, adolescence, or adulthood. Although people with persistent depressive disorder experience social and occupational distress, only rarely are they hospitalized unless they threaten or attempt suicide or develop some other psychiatric disorder.

**Major Depressive Disorder (MDD)**

Major depressive disorder is not the occasional “down day” people ordinarily experience. Neither is it the chronic depression of persistent depressive disorder. It is a noticeable change in a person’s usual pattern of functioning that lasts two weeks or more. It is a terrible state of darkness, despair, and gloom, a debilitating condition in which people feel empty, hopeless, joyless, enervated, and believe that life is not worth living. When these people regain just a bit of strength, they may use that energy to die by suicide.

With major depressive disorder there is no history of manic behaviors, and the symptoms cannot be attributed to substance use or a general medical condition. It is now evident that bereavement and major depression are not always completely separate. Grief following a loss is a considerable psychological stressor and may generate a major depressive episode in some persons.

The common factor leading to depression in children is loss. This can include physical or emotional indifference by a primary caregiver, parental separation or divorce, death of a loved person or pet, a move, scholastic failure, or physical illness. A high risk factor for depression in children is the loss of a parent to death from external causes (e.g., suicide or accident) (Berg et al., 2016).

Gradually, without treatment, episodes of major depression recede and individuals return to their former cognitive, emotional, and physical state. Regrettably, however, recurrence is high, as is the rate of suicide. For a person who has had one episode of depression, risk of recurrence is 50%; for a person with two episodes, the risk is approximately 70%; and for someone with three episodes or more, the risk rises to around 90% (Tartakovsky, 2016).
Of persons experiencing major depression, 15% eventually die by suicide. In 2014 in the United States, over 42,000 persons died by suicide, and the lethality of depression can be elucidated by the fact that suicide is the tenth leading cause of death among the general population (AAS, 2015; CDC, 2015).

The positive findings are that more than 80% of people who are treated for major depressive disorder experience a reduction in symptoms (Goldberg, 2016; Halverson, 2016).

**SPECIFIERS FOR PERSISTENT DEPRESSIVE DISORDER AND MAJOR DEPRESSIVE DISORDER**

To clarify the course of diagnoses of depressive disorders, extensions known as “specifiers” may be added. These can describe the severity, onset, and special features of a disorder. The following specifiers apply to both persistent depressive disorder and major depressive disorder.

- **Anxious distress** includes feeling keyed up or tense, feeling unusually restless, having difficulty concentrating due to worrying, dreading that something awful is going to happen, and feeling the possible loss of control. To have this specified in the diagnosis, at least two of these symptoms must be present most days.

- **Mixed features** include elevated or expansive mood, inflated self-esteem or grandiosity, being more talkative or feeling pressure to keep talking, flight of ideas and racing thoughts, increased energy, increased or excessive involvement in activities that have high risk for painful consequences, and a decreased need for sleep.

- **Melancholic features** are lack of pleasure in almost anything, marked retardation or agitation, greater depression worse in the morning, excessive or inappropriate guilt, significant weight loss, and early morning awakening.

- **Atypical features** are unusual symptoms such as hypersomnia, leaden paralysis (heavy feelings in legs or arms), appetite changes, significant weight gain, or extreme sensitivity to perceived interpersonal rejection.

- **Psychotic features** include hallucinations (false perceptions) and/or delusions (false ideas or beliefs). For example, a seriously depressed man pushes his plate away and says, “I can’t eat that stuff, it’s crawling with worms.” A deeply depressed widow keeps getting up from her chair, going to the window, and anxiously looking up and down the street. When asked why she is doing this, she says, “He’s coming to see me.” When asked who is coming to see her, she responds, “My husband.” Psychotic features can be mood-congruent or mood-incongruent. Mood-congruent means symptoms are consistent with mood and circumstances (e.g., crying at a funeral). Mood-incongruent means symptoms are not consistent with mood and circumstances (e.g., laughing at a funeral).

- **Peripartum onset** applies to an episode of major depression that occurs during pregnancy or in the four weeks following delivery.
The following are specifiers that apply only to major depressive disorders:

- **Catatonia** includes odd behaviors, such as posturing, peculiar voluntary movements, waxy flexibility (limbs remain in any position they are placed in by another person), mutism, agitation, grimacing, stupor, echopraxia (involuntary mimicking of another’s movements), echolalia (involuntary mimicking of another’s speech), and extreme negativism.

- **Seasonal pattern** or **seasonal affective disorder** (SAD) are periods of increased depression in the autumn or winter and decreased depression in the spring or summer, when there is more sunlight.

**Premenstrual Dysphoric Disorder**

Persons suffering from this disorder experience a markedly depressed mood, excessive anxiety, marked irritability or anger, and mood swings. In addition there can be a decreased interest in activities, difficulty concentrating, lethargy, changes in appetite, and sleep disturbances. The symptoms begin to improve within a few days following onset of menstruation and then become minimal or absent in the week postmenses. The disorder is associated with interference with work, school, usual social activities, or relationships with others.

**Substance/Medication-Induced Depressive Disorder**

This disorder is characterized by a prominent and persistent depressed mood and/or a strikingly decreased interest or pleasure in all, or almost all, activities. The symptoms of this disorder are considered to be the direct result of the physiological effects of a substance such as a drug of abuse, a medication, or an exposure to a toxin. These substances cause clinically significant distress or impairment in social, occupational, or other areas of functioning. The depressed mood is the result of intoxication or withdrawal from substances such as alcohol, opioids, sedatives, hypnotics, anxiolytics, amphetamines, cocaine, or hallucinogens. Medications known to cause depression include antihypertensives, analgesics, anticonvulsants, cardiac medications, and many other classifications.

**Depressive Disorder Due to Another Medical Condition**

People with medical conditions are more likely to suffer depression than those who enjoy good physical health. This disorder presents with symptoms associated with a major depressive episode that are the direct physiological consequences of a medical condition. The depression causes a persistent period of depressed mood or significantly decreased interest or pleasure in all, or almost all, activities. The depression causes significant anguish or impairment in social, occupational, or other important areas of functioning. Depression has been found to accompany a host of neurological, endocrine, metabolic, respiratory, cardiovascular, cancerous, gastrointestinal, and infectious conditions.
Disruptive Mood Dysregulation Disorder (DMDD)

The American Psychiatric Association (2013) has included this new diagnostic category in the DSM-5 chapter on depressive disorders.

Children may become depressed for many reasons, and the symptoms of depression can be manifested differently in children and change with age. DMDD is characterized by severe and recurrent temper outbursts that are wholly out of proportion in intensity or duration to the circumstances. These temper outbursts can be verbal (rages) or behavioral (physical aggression toward people or property). They occur, on average, three or more times a week for one year or more.

Diagnosis of DMDD requires that the symptoms be present in at least two settings (home, school, with peers) for 12 or more months, and the symptoms must be severe in at least one of these settings. During this period the child will not have gone three or more consecutive months without symptoms. The condition can be diagnosed between ages 6 and 18, but onset must be observed before age 10.

EPIDEMIOLOGY

In the United States, it is estimated that 15.7 million adults age 18 or older had experienced at least one major episode of depression during the year 2014. At any point in time, 3% to 5% of adults experience major depression. The estimated lifetime risk is 12%, and the prevalence of major depression in adults is 17%. Although depression is twice as prevalent in young women ages 14 to 25 years, at ages older than 65 years both men and women show a decline in depression rates and prevalence becomes similar between them. Of those meeting the criteria for a diagnosis of depression, approximately one third (35%) seek treatment (Albert, 2015; Krishnan, 2016; MHA, 2016).

Among the pediatric population in the United States, the prevalence of depression is:

- 0.5% for 3- to 5-year-olds
- 1.4% for 6- to 11-year-olds
- 3.5% for 12- to 17-year-olds

The portion of the adolescent population that has experienced depression at some point in their lives (lifetime prevalence) is 11%, and the ratio of female to male adolescents with major depression is estimated to be 2 to 1. The lifetime prevalence rates for adolescent females is 18% and for males 8%. However, in prepubertal children depression is far more common in boys than girls, with an estimated prevalence of 60% (Bonin, 2016).

Major depression is the leading cause of disability among Americans ages 15 to 44 (APA, 2016a).
Being in a low socioeconomic group has been shown to increase the prevalence of depression, perhaps due to perceived low social status, cultural factors, financial problems, stressful environments, social isolation, and greater daily stress (Martin, 2016).

Racial and ethnic studies show lifetime prevalence of major depression for whites is 18%, Caribbean blacks is 13%, and African Americans is 10%. Depression is more chronic with greater functional impairment in blacks compared with whites (Krishnan, 2016).

ETIOLOGY

Depression is believed to be a group of diverse disorders that are similar in the manner in which genetic and environmental influences come together to create behavior. They are thought of as the final common pathway of these various disease processes. Multiple interacting factors make up this common pathway and include:

- **Internalizing factors**
  - Genetics
  - Tendency toward negative emotional states
  - Low self-esteem
  - Early-onset anxiety disorder
  - Past history of major depression

- **Externalizing factors**
  - Genetics
  - Substance misuse
  - Conduct disorder

- **Adversity**
  - Trauma during childhood or adulthood
  - Stressful life events in the past year
  - Parental loss
  - Negative parental experience
  - History of divorce
  - Marital problems
  - Low social support
  - Low level of education
  (Krishnan, 2016)

The etiology of depressive disorders is unclear, and no single theory or hypothesis has been put forth that demonstrates a precise explanation for the disorders. Studies continue to produce evidence supporting multiple causes, including the combined effects of genetics, biologic
imbalances, psychosocial stressors, and interpersonal events that appear to trigger physiologic and chemical changes in the brain.

**Biological Theories**

**GENETICS**

It is known that genetics plays a part in the development of depression; however, a definitive mode of genetic transmission has yet to be confirmed. Various studies have been conducted involving twins, families, and adopted offspring showing evidence that a link exists. Twin studies indicate heritability is probably 40% to 50%.

Each person inherits a unique genetic combination from both parents, and certain combinations can predispose an individual to the development of depressive disorders. A study reported in 2016 has identified 15 genetic loci that are associated with risk of developing major depression in people of European descent, but researchers say they account for only a fraction of the risk for depression (Halverson, 2016; Hyde et al., 2016; Levinson & Nichols, 2016).

**NEUROBIOLOGICAL INFLUENCES**

*Monoaminergic System Abnormalities*

Depression has been linked to problems or imbalances in the brain involving the neurotransmitters serotonin, norepinephrine, and dopamine. There is indirect evidence only, as it is extremely difficult to actually measure the level of transmitters in the brain. Knowledge of this influence is the result of the actions of antidepressant medications on these particular neurotransmitters and their receptors. It is true, however, that brain chemicals are part of the cause, but it has been found to be a much more complex process.

**Serotonin** has many roles in behavior, including mood, cognition, pain, aggressiveness, biorhythms, and neuroendocrine processes. Current research shows that a decrease in the production of serotonin can lead to depression in some people and can result in a mood that produces suicidal feelings.

The catecholamine hypothesis suggests that a deficiency of norepinephrine in certain areas of the brain is the cause for the development of depressed moods. Recent studies indicate that in some people low levels of serotonin trigger a decrease in norepinephrine levels that then results in depression.

**Dopamine** has also been linked to depression. This neurotransmitter is important in controlling the motivation to seek out rewards and the ability to experience a sense of pleasure. Low levels of dopamine may be the reason why people with depression do not enjoy the same activities they did before they became depressed.
Research is currently underway involving other neurotransmitters, such as acetylcholine, glutamate, and gamma-aminobutyric acid (GABA), and their possible roles in the development of depressive disorders (Nemade, 2016).

**HPA Axis Dysregulation**

Studies have shown that early life stressors increase an individual’s risk for developing depression. Abnormalities in the hypothalamic-pituitary-adrenal (HPA) axis increases adrenocortical secretion of hormones, primarily cortisol. Patients with depression have been found to have increased concentrations of cortisol, an exaggerated cortisol response to adrenocorticotropic hormone, and an enlargement of both the pituitary and adrenal glands. HPA dysfunction has also been linked with higher rates of relapse and chronic depression (Juruena, 2014; Thase et al., 2014).

**PHYSIOLOGIC INFLUENCES AND SECONDARY DEPRESSION**

Depression occurring as the result of a medical condition is referred to as secondary depression. There are many such conditions, which can include the following:

- Neurologic disorders: epilepsies, Parkinson’s disease, multiple sclerosis, Alzheimer’s disease, cerebrovascular disease, traumatic brain injury
- Infectious disorders: neurosyphilis, HIV/AIDS
- Cardiac diseases: ischemic heart disease, heart failure, cardiomyopathy
- Endocrine and metabolic disorders: hypothyroidism, diabetes mellitus, vitamin deficiencies (D and B₁₂), parathyroid disorders
- Inflammatory disorders: collagen-vascular diseases, irritable bowel syndrome, chronic liver disorders
- Neoplastic disorders: central nervous system tumors, paraneoplastic syndromes
- Medications: glucocorticoids, interferons
  (Lyness, 2016; Krishnan, 2016)

**Psychological Theories of Depression**

Psychological theories attempt to explain why people think, feel, and behave the way they do. They involve personality factors, past history, early experiences, and interpersonal relationships.

**PSYCHODYNAMIC THEORIES**

Psychodynamic theories attempt to explain a person’s personality by emphasizing unconscious psychological processes and suggest that childhood experiences are crucial in the shaping of the
adult personality. One such theory states that depression arises from self-hatred resulting from **anger turned inward**. Such anger is thought to be the result of a child’s need to please the parent and the child’s continued failure to do so.

Another psychodynamic theory proposes that depression is the result of **object loss**. Such “objects” are representations of a person’s relationships with others. Depression results from problems in trying to maintain emotional contact with those desired objects. A person may feel dependent upon relationships and grieve over the threatened or actual loss of them. Other persons might feel they have failed to meet their own or others’ standards and as a result experience intense fear of losing approval, recognition, and love from the desired object.

These theories have had a major impact on how researchers currently approach the question of the cause of depression; however, they are difficult to validate scientifically and are limited by the emphasis on the unconscious and early childhood (McLeod, 2015; Nair, 2016).

**EXAMPLES OF PSYCHODYNAMIC THEORIES**

- K. Abraham (1911), Aggression Turned Inward
- S. Freud (1917), Structure of the Personality
- J. Bowlby (1980), Object Loss and Attachment Theory

**COGNITIVE THEORIES**

Cognitive theories conclude that **behavior is learned**, and they focus on mental processes. These theories are based on the belief that depression is caused by the way people think about themselves and how they process personal information. Cognitive theories propose that depression is the result of having a **negative view** of the self, a negative view of the world, and a negative view of the future. Depressed people are said to think more pessimistically about stressful events, that whatever they do will be ineffective, and that they do not have any control over their environment. They have “learned” helplessness.

A critical evaluation of these theories is that helplessness and negative thinking may be the result of rather than the cause of depression (McLeod, 2015; Nair, 2016).

**EXAMPLES OF COGNITIVE THEORIES**

- M. Seligman (1975), Learned Helplessness
- Beck (1967), Cognitive Triad
BEHAVIORAL THEORIES

Behavioral theories stress the significance of environment in the shaping of an individual’s behavior. The focus is on observable behavior and the conditions by which a person learns such behavior. Depression is the result of a combination of stressors in a person’s environment and a lack of personal skills to interact effectively, which then brings about a lack of positive reinforcement.

Such theories help to explain depression as a direct response to an external event (reactive depression) but do not address the issue of endogenous depression, which occurs without a preceding negative event. These theories also do not address how thoughts influence mood (McLeod, 2015).
INTERPERSONAL THEORIES

The interpersonal theory is based on the belief that people have a basic need for social connection, and depressed persons tend to interact with others in a manner that brings about rejection. This, in turn, increases their risk for future depression (Hames et al., 2013; Stewart, 2013).

SCREENING AND ASSESSING FOR DEPRESSION

The most common psychiatric disorder among the general population and the most common mental health problem in primary care patients is depression. However, even though it is so prevalent, few patients are willing to talk about their symptoms with clinicians.

It is important that patients be directly asked about their mood, as they often fail to provide such information. Reasons for this may include the fear of being stigmatized with a mental health label, the belief that primary care clinicians do not provide care for mental health issues, and that depression is not an illness but rather a personal weakness.

When depression is untreated, there is a decrease in the quality of life, an increased risk of suicide, and poor physiological outcomes when chronic medical conditions coexist with depression. It is therefore of great benefit to screen for depression in primary care.

The U.S. Preventive Services Task Force recommends screening in the general adult population, including pregnant and postpartum women. Screening is also recommended in adolescents 12 to 18 years of age, but current evidence is insufficient to recommend screening in children 11 years or younger. Screening should be implemented with adequate systems in place in order to ensure proper diagnosis, treatment, and appropriate follow-up (USPSTF, 2016a, 2016b).

Screening can easily be done at the time of a routine health visit using short screening tools that can be self-administered by patients in the waiting area prior to being seen, or administered by a clinician.

SELF-ADMINISTERED DEPRESSION SCREENING TOOLS

- **Patient Health Questionnaire (PHQ-9 and PHQ-2).** The PHQ-9 is a multipurpose tool for screening, diagnosing, monitoring, and measuring the severity of depression as well as the presence and duration of suicide ideation. The PHQ-2 consists of the first two items of the PHQ-9, which inquire about the degree to which an individual has experienced depressed mood and anhedonia (lack of pleasure) over the past two weeks.

- **World Health Organization Well-Being Index (WHO-5),** a short, five-item questionnaire, is among the most widely used screening tools.

- **Beck Depression Inventory (BDI)** assess depression in individuals ages 13 to 80 years, consists of 21 items and takes five minutes for patient or clinician to administer.
• **Edinburgh Postpartum Depression Scale** (EPDS), as well as the PHQ-9, have been validated in practices serving pregnant or postpartum women.

• **Geriatric Depression Scale** (GDS) is a 30-item “yes” or “no” self-report assessment used to identify depression in the older adult.

Sources: APA, 2016b; Bienenfeld, 2016; Topp et al., 2015; Manea et al., 2016.

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**CASE**

**HARVEY**

Harvey McBeal, a 55 year-old-man, comes to the clinic for his semi-annual routine checkup for evaluation of treatment for hypertension. He checks in with the receptionist, who requests he complete a WHO-5 questionnaire. She tells him the form is used to screen for signs and symptoms of depression, and he should respond according to how he has been feeling over the last two weeks.

The form Harvey fills out asks him to respond to five statements using a scale that runs from 0 to 5, with 0 meaning at no time, 1 meaning some of the time, 2 meaning less than half the time, 3 meaning more than half the time, 4 meaning most of the time, and 5 meaning all of the time.

1. “I have felt cheerful and in good spirits.” Harvey checks the box number 1.
2. “I have felt calm and relaxed.” Harvey again checks the box number 1.
3. “I have felt active and vigorous.” Harvey checks the box number 2.
4. “I woke up feeling fresh and rested.” Harvey selects the box number 2.
5. “My daily life has been filled with things that interest me.” Harvey selects box number 2 again.

Harvey returns the form to the receptionist, who gives the form to the nurse. The instructions for scoring indicate the total score can range from 0 to 25, with 0 representing the worst possible and 25 representing the best possible quality of life. A score below 13 or a 0-to-1 response to any of the five items signals poor well-being and is an indication for further evaluation for depression. Harvey receives a score of 8 and has responded with a “1” to two of the statements.

(continues)

**Comprehensive Assessment**

Diagnosis of depressive disorders depends upon a comprehensive clinical history and examination that includes:

• History of present illness
• Family history
• Social history
• Mental status exam
• Physical examination
• Laboratory and neuroimaging studies
• Suicide/homicide assessment

HISTORY OF PRESENT ILLNESS

The history of the present illness requires interviewing the patient and may also include interviewing family members and significant others as well as other clinicians. This interview may be considered the most important diagnostic tool and should include the following:

• Presence of depressive symptoms
• Chronology of the current symptoms
• Prior history of depressive episodes, including their course and treatment
• Impact on occupational and personal functioning
• Alleviating or aggravating factors
• Comorbidities, both psychiatric and medical
• History of mania or hypomania (to rule out bipolar disorder)

The interview may be structured or semi-structured, and a formal rating scale may be utilized to establish a baseline for comparison should the patient be diagnosed with depression and require treatment and follow-up (Lyness, 2016).

SYMPTOMS OF DEPRESSION

• Persistent feelings of sadness, emptiness, hopelessness, pessimism
• Feelings of guilt, worthlessness, helplessness
• Loss of interest or pleasure in most or all normal activities
• Anxiety, agitation, restlessness
• Angry outbursts, frustration, even over small matters
• Difficulty sleeping, early-morning awakening, or oversleeping
• Decreased energy, fatigue, tiredness, slowed speech or body movements
• Changes in appetite and/or weight
• Difficulty concentrating, remembering, making decisions
• Thoughts of death or suicide; suicide attempts
• Persistent physical symptoms such as back pain or headaches

Sources: NIMH, 2016a; Mayo Clinic, 2016a.

DEPRESSION RATING SCALES FOR ASSESSMENT AND MONITORING

Rating scales are available for assessing the severity of depression in patients both during comprehensive assessment and in determining effectiveness of treatment interventions.

• **Patient Health Questionnaire-9 (PHQ-9)** is standard among scales for monitoring symptoms of depression. This scale corresponds to the nine DSM-5 criteria for unipolar major depression.

• **Clinically Useful Depression Outcome Scale (CUDOS)** contains 18 items assessing all of the DSM-5 criteria for unipolar major depression as well as psychosocial impairment and quality of life.

• **Quick Inventory of Depression Symptomatology-Self Report 16 (QIDS-SR16)** contains 16 items and covers the symptoms of DSM-5 unipolar major depression, including wishes for death and suicidal ideation.

Source: Zimmerman, 2016.

FAMILY HISTORY

A family history of depressive disorders is a strong predictor and the strongest risk factor for depression. The patient should be asked about a family history of depression, suicide, psychosis (delusions, hallucinations), and bipolar disorder (Lyness, 2016). Information about treatment for depression in family members can be useful later when determining treatment options (Brannon, 2016).

SOCIAL HISTORY

When assessing for depression, patients should be asked about any recent changes in their interpersonal, occupational, and/or financial situations; what their current stressors are; and who are the significant people in their lives. The functioning of family and quality of social and family relationships should be examined.

Social history should also include recreational activities, housing issues, as well as substance use. Sexual history, level of education, and cultural or racial issues that may potentially be pertinent should also be addressed (Lyness, 2016).
**CASE**

**HARVEY (continued)**

Harvey is sitting on a chair in the examination room when his primary care clinician enters, greets him, and asks how he’s been doing. Harvey tells him he has been taking his medications, monitoring his blood pressure, and seems to be doing okay. He denies any concerns.

The clinician looks at the nurses’ notes, which indicates that his vital signs are good but his WHO-5 screening questionnaire resulted in a score suggesting symptoms of depression. Harvey is asked how his mood has been and if there has been anything happening in his life that might make him feel depressed.

Harvey tells the clinician that over the past year his mother died, his father had a stroke and is in a nursing home, and he has been recently divorced from his wife of 33 years.

Harvey reports he’s had “a bit of insomnia,” has lost his appetite and dropped a few pounds, is tired all the time, and just can’t seem to get interested in anything lately. He says he has felt this way for the past few months and has never been depressed like this in the past. He says it’s getting harder and harder to concentrate at work and admits that sometimes “it doesn’t seem important to go on with life.”

He denies any family history of mental illness or suicide. He used to bowl twice a week but has given that up (“I just don’t have the energy”). Over the past few weeks he reports he is drinking one or two extra glasses of wine or beer every evening to “sleep better.” He is a college graduate and lives with his son and daughter-in-law since his divorce.

*(continues)*

**MENTAL STATUS EXAMINATION**

A mental status examination is part of the normal practice of psychiatrists and neurologists, but it is important for all clinicians to be aware of the elements involved in this examination process.

- **Appearance** includes all the physical aspects of the patient, such as gender, how the patient looks compared with stated age, ethnicity, and any distinguishing features. The patient is observed for basic grooming and hygiene and for appropriateness of attire for the weather and circumstances.

- **Level of alertness and orientation** includes the ability to remain focused. Is the patient alert, sleepy, uninterested, or easily distracted? Is the patient oriented to person, place, and time?

- **Motor activity** includes observation of body posture and general body movement, facial expressions, gait, and level of psychomotor activity. Slowing of physical and emotional reactions, for example, may be present in patients with depression.
- **Speech and language** addresses tone, volume, fluency, coherency, and quantity. Expressive and receptive language assessment includes the ability to express oneself and ability to comprehend questions.

- **Behavior** is how the patient interacts with the examiner and includes cooperativeness, pleasantness, and appropriateness. Is the patient relaxed, withdrawn, irritable, resistant, shy, or defensive?

- **Mood and affect.** Mood assessment involves asking for the patient’s subjective report of his or her emotional state and determining if it is appropriate for his or her current situation. Affect is the clinician’s objective interpretation of the patient’s display of feelings or emotions during the interview. Did the patient make eye contact? Is the patient excitable, flat (unchanging), appropriate?

- **Thought process and cognition** assessment determines the patient’s ability to concentrate; the flow of thoughts; whether thoughts are relevant, logical, and organized; as well as memory.

- **Thought content,** or what the patient is thinking, includes the presence or absence of delusions (fixed false beliefs), obsessional thoughts, and suicidal or homicidal ideation.

- **Perceptual disturbances** such as hallucinations should be addressed, including their content and the sensory system involved.

- **Insight** determines how aware the patient is and the understanding of the mental health problem being experienced.

- ** Judgment** is the patient’s ability to identify the consequences of actions. This may be difficult to assess, but a history of compliance with medications can serve as a measurement.  
  (Goldberg, 2015)

### CASE

**HARVEY (continued)**

Because Harvey has a positive WHO-5, during his clinic visit, his clinician makes the following inquiries and observations, incorporating the components of the mental status examination. His notes read as follows:

Harvey is a tall, thin, white male, who appears his stated age. He is slightly disheveled in appearance and dressed appropriately for the cold weather and a clinic visit. He is alert and oriented times three. He shows slowing of psychomotor activity and sits slouched in his chair with his hands quietly dangling between his knees. His speech is normal in tone and volume. He is fluent and coherent. He answers questions appropriately.
He reports his mood has been “down” or “sad” over the past two weeks. His affect is blunted. He makes good eye contact. He is able to concentrate, and his thoughts are logical and organized. He denies rumination, delusions, and homicidal ideation but does acknowledge having had thoughts of death shortly after his wife left him. He denies hallucinations.

Harvey understands he may be experiencing “a bit of depression.” He has been medication compliant under our care for blood pressure medications and self-monitoring for the past three years.

PHYSICAL EXAMINATION

A screening physical examination has been shown to be important for new onset depression. Hidden medical illness may produce depressive symptoms that can occur before any other signs or symptoms of the underlying medical illness are apparent (see “Physiologic Influences and Secondary Depression” above for medical conditions) (Lyness, 2016).

LABORATORY AND NEUROIMAGING STUDIES

It is recommended that focused laboratory tests be done for new-onset depression, severe depression, or treatment-resistant depression. Common laboratory tests performed for screening include:

- Complete blood count
- Comprehensive metabolic panel (hyperparathyroidism, Cushing’s syndrome and Addison’s disease, liver dysfunction, kidney disease)
- Urinalysis (kidney disease)
- Thyroid stimulating hormone and free T4
- Human chorionic gonadotropin hormone (pregnant women)
- Urine toxicology screen for drugs of abuse
- Sedimentation rate (ESR) and C-reactive protein (malignancy, infection, connective tissue diseases)

Other laboratory studies may be indicated, guided by the medical history, review of systems, and physical examination.

Neuroimaging studies are done when there is likelihood that depression is the result of structural brain disease. Neuroimaging is also recommended for older depressed patients, especially for those with new-onset depression (Lyness, 2016; NIMH, 2016b).
SUICIDE/HOMICIDE ASSESSMENT

It is important that all depressed patients be asked specifically about suicidal ideation and behavior. If there is any positive or vague response, clinicians then:

- Ask about the specific nature of the ideation, intent, whether the patient has a suicide plan, what are the means and actions available to the patient, and the lethality of those means.

- Assess for risk factors for suicide. These include prior history of suicide attempts, comorbid psychiatric and general medical illnesses, and family history of suicidal behavior.

- Determine the presence of psychotic symptoms such as delusions or command auditory hallucination.

- Assess for severe anxiety and substance-related disorders.

- Develop a safety plan for further evaluation and treatment depending on the level of risk. This may involve continued primary care follow-up alone, or referral to outpatient psychiatric or emergency room psychiatric evaluation.

- Ask the patient about homicidal ideation and behavior, and evaluate the risk of violence directed toward others.

Evaluation in an emergency department and/or hospitalization should be considered for patients at immediate risk of suicide (Lyness, 2016; Simon & Ciechanowski, 2015a).

CASE

HARVEY (continued)

During the interview with Harvey, his clinician noted that Harvey had “thoughts of death” shortly after his wife left him. He reminds Harvey of his statement and asks, “Have you had thoughts of harming yourself?”

Harvey: “Yes, off and on.”

Clinician: “Tell me about these thoughts.”

Harvey: “Well, I sometimes think it would be easier to just not be here anymore.”

Clinician: “Tell me how you would go about ‘just not being here anymore.’”

Harvey: “Oh, I have an old automatic I could probably use.”
Clinician: “How long have you had these thoughts, Harvey?”

Harvey: “Actually, I’ve been having them for some time, but I think about it more often lately.”

Clinician: “Do you intend to follow through with these thoughts?”

Harvey: “I don’t really think so.”

Clinician: “Have you ever tried to harm yourself in the past?”

Harvey: “No, never.”

Clinician: “Has anyone in your family attempted or completed suicide?”

Harvey: “No, no one.”

Clinician: “Have you ever tried to harm anyone else in the past?”

Harvey: “No.”

Clinician: “Have you had thoughts about harming others lately?”

Harvey: “Oh, my goodness, no!”

The clinician then asks Harvey if he would be willing to be referred to the clinic’s psychiatric nurse practitioner, as he is concerned about his depressive symptoms and suicidal thoughts. He tells Harvey he does not think he is an imminent risk for suicide but wants him to be seen as soon as possible.

Harvey agrees to this, and in Harvey’s presence his clinician calls the nurse and sets up an appointment for him. Before Harvey leaves his clinic visit, his clinician asks him to agree to have his gun removed from his home by his family. Harvey agrees to do this.

At Harvey's six-month follow-up visit with his clinician, Harvey reports that he has been diagnosed with a major depression and is now taking an antidepressant as well as attending a grief/bereavement support group. He states that his daughter-in-law has secured the handgun in a location known only to her. He states his mood is much better, and he's feeling more positive about the future.
DIAGNOSING DEPRESSION

Once all other conditions that may cause depression have been ruled out, the clinician then uses DSM-5 criteria to determine the appropriate diagnosis of depression.

Medical Diagnoses

The American Psychiatric Association (2013) identifies the criteria upon which a depressive disorder can be diagnosed. The following are three examples of such criteria.

<table>
<thead>
<tr>
<th>MAJOR DEPRESSIVE DISORDER (MDD) DIAGNOSTIC CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Five or more of the following symptoms reported subjectively or observed by others have been present over a two-week period and represent a change from previous functioning; at least one of the symptoms is either a depressed mood or loss of interest or pleasure:</td>
</tr>
<tr>
<td>• Depressed mood most of the day and nearly every day</td>
</tr>
<tr>
<td>• Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day</td>
</tr>
<tr>
<td>• Changes in appetite nearly every day; in children, failure to make expected weight gain</td>
</tr>
<tr>
<td>• Psychomotor agitation or retardation nearly every day</td>
</tr>
<tr>
<td>• Significant weight loss or gain (more than 5% of body weight in 1 month)</td>
</tr>
<tr>
<td>• Insomnia or hypersomnia nearly every day</td>
</tr>
<tr>
<td>• Chronic fatigue or low energy nearly every day</td>
</tr>
<tr>
<td>• Feelings of worthlessness/guilt nearly every day</td>
</tr>
<tr>
<td>• Difficulty thinking, concentrating, or making decisions nearly every day</td>
</tr>
<tr>
<td>• Recurrent thoughts of death or suicide, plans, or attempt</td>
</tr>
<tr>
<td>2. Symptoms cause significant distress in social, occupational, or other important areas of functioning.</td>
</tr>
<tr>
<td>3. Symptoms cannot be attributed to the physiological effects of a substance or other medical condition.</td>
</tr>
<tr>
<td>4. The occurrence of MDD is not better explained by another psychiatric psychotic disorder.</td>
</tr>
<tr>
<td>5. Specifiers/special features:</td>
</tr>
<tr>
<td>• With anxious distress</td>
</tr>
</tbody>
</table>
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

**PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA) DIAGNOSTIC CRITERIA**

1. Depressed mood for most of the day, for more days than not for at least two years, reported subjectively or through observation by others

2. Presence, while depressed, of two or more of the following:
   - Poor appetite or overeating
   - Insomnia or hypersomnia
   - Low energy or fatigue
   - Low self-esteem
   - Poor concentration or difficulty making decisions
   - Feelings of hopelessness

3. During the two-year period (one year for children or adolescents), the person has never been without the above symptoms for more than two months at a time.

4. Criteria for a major depressive disorder may be continuously present for two years.

5. There has never been a manic episode or hypomanic episode, and criteria have never been met for cyclothymic disorder.

6. Symptoms cannot be attributed to the physiological effects of a substance or another medical condition.

7. Symptoms cause major impairment in social, occupational, or other areas of functioning.

8. Specifiers include:
   - With anxious distress
• With mixed features
• With melancholic features
• With atypical features
• With mood-congruent psychotic features
• With mood-incongruent psychotic features
• With peripartum onset
• With pure dysthymic syndrome
• With persistent major depressive episode
• With intermittent major depressive episodes, with current episode
• With intermittent major depressive episodes, without current episode
• In partial remission
• In full remission
• Early onset (before 21 years)
• Late onset (21 years or older)
• Mild
• Moderate
• Severe


PREMENSTRUAL DYSPHORIC DISORDER DIAGNOSTIC CRITERIA

1. For a majority of menstrual cycles, five or more symptoms must be present in the final week before the onset of menstruation, then start to improve within a few days after the onset, and become minimal or absent in the week after menstruation ends.

2. One or more of the following must be present:
   • Significantly depressed mood
   • Irritability, anger, or increased interpersonal conflicts
   • Mood swings
   • Excessive anxiety

3. Additionally, one or more of the following must be present to reach a total of five when combined with criteria #2 above:
   • Decreased interest in usual activities
• Difficulty concentrating
• Lethargy or significant lack of energy
• Changes in appetite, overeating, or having food cravings
• Insomnia or hypersomnia
• Feeling overwhelmed, out of control
• Physical symptoms including breast tenderness or swelling, joint or muscle pain, a bloating sensation, weight gain

4. Symptoms are associated with significant interference with school, work, social activities, or relationships.

5. Symptoms are not part of the physiological effects of a substance, another psychiatric disorder, or medical condition.


CASE

AREVY

Avery is a 19-year-old female college student who has been referred to the campus healthcare center to meet with a nurse practitioner for psychiatric evaluation following positive screening for depression. Avery tells the nurse she has been very depressed off and on and has been having increasing problems in her relationships with classmates.

During her evaluation, Avery reports that she has always had mood swings that were related to her menstrual cycle but that “things have been getting out-of-hand lately.” She reports being severely depressed during the week before menstruation begins, and she gets extremely irritable and angry over “little things.” She reports that when her period starts, she begins to feel better, and she always used to feel back to normal after her period ended. Now, however, the symptoms seem to continue, although milder, until the week before her period begins again.

She reports she is currently failing some of her classes, has problems concentrating, and feels very overwhelmed with everything she cannot seem to accomplish. She denies any drug or other substance use and denies any history of mental or physical disorder. A recent physical exam was within normal limits. She is not taking any medications. Avery denies any suicidal or homicidal ideation or intent.

Following a comprehensive assessment, the nurse practitioner determines that Avery meets the DSM-5 criteria for the diagnosis of premenstrual dysphoric disorder.

A plan of care is discussed with Avery that includes a nutritional supplement, an antidepressant medication, and lifestyle modifications. The nurse suggests Avery begin to take a calcium
supplement for two weeks prior to the start of her menstrual periods, which will assist in reducing any physical symptoms and is known to improve mood. Because her symptoms are moderate to severe, Avery is given a prescription for Celexa (citalopram), an SSRI antidepressant, along with a patient medication information sheet.

In addition, the nurse provides Avery with a list of lifestyle modifications that are known to be of benefit for treatment of premenstrual dysphoric disorder. The list includes:

1. Begin a program of regular aerobic exercise.
2. Do not skip meals and maintain a regular routine for mealtimes.
3. Eat a diet that includes complex carbohydrates and avoid refined sugars.
4. Get 6 to 8 hours of sleep each night.
5. Reduce caffeine, alcohol, red meat, and salty food consumption.
6. Practice relaxation techniques.
7. Quit smoking.

The nurse also provides Avery with a list of community resources for group relaxation sessions.

At the conclusion of the visit, the nurse recommends a follow-up appointment in two weeks and provides a referral for therapy.

At her two-week follow-up visit, Avery states she is tolerating the medication well and has attended two relaxation therapy sessions. She has been attempting to follow the lifestyle modifications and has experienced less irritability but has not yet recognized any improvement in her mood. She was reminded that the antidepressant takes sometimes 2 to 8 weeks or more to begin to take effect. She should continue as she has been doing and is scheduled to return again in two weeks.

**Caregiver/Nursing Diagnoses**

Caregiver/nursing diagnoses address functional issues that affect the care of depressed individuals. The table below gives some typical nursing/caregiver diagnoses, goals, and interventions for depressed individuals.

<table>
<thead>
<tr>
<th>ADDRESSING FUNCTIONAL ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td>Risk of suicide</td>
</tr>
<tr>
<td>Complicated grieving</td>
</tr>
<tr>
<td>Disturbed sleep patterns</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Nutritional imbalance</td>
</tr>
<tr>
<td>Self-care deficit</td>
</tr>
<tr>
<td>Chronic low self-esteem</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Social isolation/impaired social interaction</td>
</tr>
<tr>
<td>Anergia, anhedonia, hopelessness</td>
</tr>
<tr>
<td>Powerlessness</td>
</tr>
<tr>
<td>Ineffective role performance</td>
</tr>
<tr>
<td>Spiritual distress</td>
</tr>
</tbody>
</table>

**CASE**

**EDNA**

Edna Fox is a 72-year-old widow admitted to the psychiatric unit for evaluation and treatment of depression. Her husband died six months ago, and Mrs. Fox has become more and more depressed and neglectful of herself and her home. A family member became concerned when visiting from out of state and took her to see her family doctor, who requested admission for evaluation and treatment of major depressive disorder.

Following her nursing assessment, Sheila, the unit RN, reviews Mrs. Fox’s symptoms and develops a nursing care plan for her. One of the nursing diagnoses she includes is “self-care...
deficit as evidenced by an inability to bathe, groom, or dress herself independently.” Sheila understands that being clean and well groomed can temporarily increase the patient’s self-esteem and that slowed thinking and difficulty concentrating makes organizing simple tasks difficult. She chooses the following interventions.

1. Assist with self-care needs to avoid energy expenditure and frustration.
2. Ensure that bathing, hygiene, and grooming supplies and utensils are readily available.
4. Use consistent routines and allow adequate time for self-care tasks.

Sheila determines the expected outcome will be that Mrs. Fox will safely perform self-care activities to her maximum ability.

TREATMENT INTERVENTIONS

The goal of treatment intervention initially is relief of symptomatology and the restoration of baseline functioning. It is recommended that treatment consist of a combination of pharmacotherapy and psychotherapy. Studies have shown this combination treatment to be more effective than either one alone. Pharmacotherapy can treat the symptoms of depression but does not necessarily address its causes. However, psychotherapy alone is often suggested for relatively mild depressive symptoms (Simon & Ciechanowski, 2015b).

Antidepressant Medications

How antidepressant medications work is not known for certain, but it is theorized that they increase the activity of certain mood-enhancing chemicals in the brain called neurotransmitters (e.g., serotonin, dopamine, norepinephrine).

FIRST-GENERATION ANTIDEPRESSANTS

Antidepressants were discovered in the 1950s when researchers found that a medication for tuberculosis had a mood-improving effect. This led to the development of two classes of first-generation antidepressants: tri- and tetracyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs).

**Cyclic Antidepressants**

TCAs increase levels of norepinephrine and serotonin and block the action of acetylcholine. It is believed this factor accounts for their ability to elevate mood. In addition to treating depression, these drugs are used to treat such conditions as panic disorder, obsessive-compulsive disorder, and eating disorders.
Unfortunately, there are many drawbacks to TCAs. They take two to six weeks to begin taking effect, they produce anticholinergic side effects (dry mouth, weight gain, sweating, blurred vision, sexual dysfunction), and an overdose can be lethal. Furthermore, TCAs must be used cautiously with people with glaucoma, liver impairment, diabetes mellitus, cardiovascular disease, renal impairment, and respiratory disorders.

Common TCAs are:

**Tricyclic antidepressants**

- Amitriptyline
- Amoxapine
- Clomipramine (Anafranil)
- Desipramine (Norpramin)
- Doxepin (Seilnor, Zonalon)
- Impramine (Surmontil, Tofranil)
- Nortriptyline (Pamelor)
- Trimipramine (Surmontil)

**Tetracyclic antidepressants**

- Maprotiline

<table>
<thead>
<tr>
<th>TCA SIDE EFFECTS AND CAREGIVER RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Side Effect</strong></td>
</tr>
<tr>
<td>Blurred vision</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Urinary retention</td>
</tr>
<tr>
<td>Orthostatic hypotension</td>
</tr>
<tr>
<td>Reduced seizure threshold</td>
</tr>
<tr>
<td>Tachycardia or arrhythmias</td>
</tr>
</tbody>
</table>
Photosensitivity | Encourage the use of sunblock, sunglasses, and protective clothing.
--- | ---
Weight gain | Assist with a low calorie diet; encourage increased activity.


**Monoamine Oxidase Inhibitors (MAOIs)**

The enzyme monoamine oxidase is responsible for inactivating such amines as serotonin, norepinephrine, dopamine, and tyramine—all neurotransmitters that raise the mood of individuals. Thus, when a person ingests an MAO inhibitor, mood-elevating neurotransmitters are not broken down and they are available for synaptic release.

Beside elevating mood, an increase in tyramine can also create problems; it can increase blood pressure and cause a hypertensive crisis and cerebrovascular accidents. For this reason, those taking MAOIs must reduce their intake of foods and drugs that contain high levels of tyramine. These include fermented or smoked products such as bacon, ham, bologna, aged cheeses, red wines, and chicken or beef liver. Individuals who are seriously depressed may not be able to adhere to these dietary limitations.

Furthermore, there is a two- to four-week lag period before MAOIs reach therapeutic levels. Before clients can start a different antidepressant drug, they must wait at least five weeks for the body to eliminate residual MAOIs.

**MAOIs** include:

- Isocarboxazid (Marplan)
- Phenelzine (Nardil)
- Tranylcypromine (Parnate)
- Selegiline (Eldepryl, Zelapar)
- Selegiline transdermal system (Ensam)

**MAOI SIDE EFFECTS AND CAREGIVING RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Caregiver Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertensive crisis</td>
<td>Can occur if foods containing tyramine are ingested. Observe for occipital headache, palpitations, chest pain, nausea or vomiting, nuchal rigidity, fever, sweating, significantly increased blood pressure, and coma; monitor vital signs; administer prescribed antihypertensives; use external cooling measures if fever is present.</td>
</tr>
<tr>
<td>Skin reactions in those using transdermal system (Emsam)</td>
<td>Topical corticosteroids can be used for treatment; if problematic, report to physician.</td>
</tr>
</tbody>
</table>
SECOND-GENERATION ANTIDEPRESSANTS

In the 1980s newer drugs were introduced and classified as second-generation antidepressants. These drugs have fewer side effects than the first generation antidepressants and reduce the risk of harm in overdose or in combination with certain medications or food.

Selective serotonin reuptake inhibitors (SSRIs) are recommended as first-line therapy for all types of depression except those with psychotic and melancholic features (see “Diagnostic Criteria” tables above). SSRIs are effective for most clients, and since they have low cardiotoxicity, they are safer for older adults. In addition, these drugs have a low suicide-lethality risk and low incidence of anticholinergic side effects (dry mouth, blurred vision, sweating, sexual dysfunction, urinary retention). As a result, clients are more likely to comply with treatment regimes of these drugs.

Selective serotonin reuptake inhibitors (SSRIs) include:

- Citalopram (Celexa, Escitalopram)
- Fluoxetine (Olanzapine, Prozac, Sarafem, Symbyax)
- Fluvoxamine (Luvox)
- Paroxetine (Brisdelle, Paxil, Pexeva)
- Sertraline (Zoloft)
- Vilazodone (Viibryd)

<table>
<thead>
<tr>
<th>SSRI SIDE EFFECTS AND CAREGIVER RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Side Effect</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Insomnia and/or agitation</td>
</tr>
<tr>
<td>Headache</td>
</tr>
<tr>
<td>Weight changes</td>
</tr>
<tr>
<td>Sexual dysfunction</td>
</tr>
<tr>
<td>Serotonin syndrome</td>
</tr>
</tbody>
</table>


THIRD-GENERATION ANTIDEPRESSANTS

During the 1990s on into the 2000s, a third generation of antidepressants was introduced. This is a group of drugs with variable action not confined to serotonin reuptake inhibition. There are no studies providing evidence that they perform better than the second-generation drugs, however they
are equivalent in safety to the SSRIs and maintained improvements in safety over the first-generation drugs. Among these, the atypical antidepressants are frequently used in patients who have inadequate responses or intolerance to the side effects of other antidepressants (Mayo Clinic, 2016b).

Third-generation antidepressants include:

**Serotonin-norepinephrine reuptake inhibitors (SNRIs)**
- Desvenlafaxine (Khedezla, Pristiq)
- Levomilnacipran (Fetzima)
- Milnacipran (Savella)
- Venlafaxine (Effexor)

**Selective serotonin-norepinephrine reuptake inhibitors (SSNRIs)**
- Duloxetine (Cymbalta)

**Atypical antidepressants**
- Buproprion (Wellbutin, Zyban)
- Mirtazapine (Remeron)
- Nefazodone
- Vortioxetine (Trintellix)

### THIRD-GENERATION ANTIDEPRESSANT SIDE EFFECTS

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Caregiver Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>Provide sugar-free hard candies to suck on or sugarless gum to chew. Instruct in the use of alcohol-free mouth wash; avoidance of carbonated drinks, caffeine, tobacco, and alcohol; moistening food with broths, soups, sauces; and oral care twice a day.</td>
</tr>
<tr>
<td>Constipation</td>
<td>Administer a mild herbal stimulant laxative such as Senokot as needed. Encourage exercise to increase motility. Correct dietary deficiencies. Increase fluid intake.</td>
</tr>
<tr>
<td>Nausea</td>
<td>Provide clear liquids, dry toast, or crackers.</td>
</tr>
<tr>
<td>Dizziness and/or lightheadedness</td>
<td>Initiate fall prevention and safety precautions.</td>
</tr>
</tbody>
</table>

Source: Mayo Clinic, 2016b; Gulanick & Myers, 2014.
CONSIDERATIONS IN DRUG CHOICES

All neurotransmitters affect mood, but they do not affect every person in the same way or to the same extent. For this reason, it may be necessary to try different antidepressants or combinations of drugs to find the most effective treatment.

In addition to client responsiveness, drugs have different costs, safety features, and maintenance considerations. These factors affect how faithfully a client follows the prescribed plan of care. Selecting a drug is based on the following factors:

- Safety: risk of suicide, medical factors, history of prior drug responses
- Effectiveness: neurotransmitter specificity
- Side effects: weight gain, dry mouth, blurred vision, sexual dysfunction
- Specific depressive symptoms
- Comorbid illnesses
- Concurrent medications and potential drug-drug interaction
- Ease of administration: daily oral dose versus monthly intramuscular injections
- Patient preference or expectations
- Patient response to antidepressants during prior depressive episodes
- Family history of response to antidepressants
- Cost of medication: out-of-pocket versus insurance-paid

(Simon & Ciechanowski, 2015b)

CASE

JENNIFER

Jennifer, a 42-year-old accountant, had recently been diagnosed with persistent depressive disorder with anxious distress and was started on citalopram (Celexa) five weeks ago. Today she came in to her psychiatrist's office because of a “personal problem.” Marjorie, the office nurse, obtained a history of her present complaint. Jennifer said that lately she has lost all interest in sex, and when she and her husband do have intercourse, she finds no enjoyment in it and no longer has orgasms. She said her sexual desires have always been strong before but wonders if the Celexa is causing the problem, which has now become intolerable and is making her depression and anxiety even worse.

Following her visit with the psychiatrist, Jennifer met with Marjorie again to discuss the new medication being prescribed and to address any other concerns she may have. Jennifer was given a prescription for Viibryd (vilazodone). She said the doctor explained that this drug is technically an SSRI but that it has a second action. She said she understood what serotonin was
and how the Celexa worked, but she was not able to recall what she had been told about this new drug.

Marjorie drew a picture for Jennifer to help her understand. The picture showed a presynaptic nerve ending, the synapse, and the postsynaptic nerve ending. She described how the SSRI she had been taking prevented the reabsorption of serotonin back into the presynaptic nerve end, and that the new medication pretends to be serotonin and activates the receptors of the postsynaptic nerve ending. She told Jennifer that this second action helps reduce side effects such as loss of sexual interest, but as yet it is not known exactly how or why.

At the end of the visit, Marjorie provided Jennifer with written directions for stopping Celexa and starting the new medication.

**Electroconvulsive Therapy (ECT)**

Electroconvulsive therapy involves applying electrodes to the head and delivering a small electric impulse to the brain and is used mainly to treat severe depression. The mechanism of action is unknown but has been effective for individuals who cannot take or do not respond to antidepressant drugs as well as for those who are at high risk for suicide. ECT is often chosen only after a trial of therapy with medications has proved ineffective. Although it is effective, safe (even for a pregnant woman and fetus), and practiced widely around the world, it remains controversial based on misinformation and misperceptions of how it is performed and its after-effects (Kellner, 2016).

ECT was first used in the 1930s as a treatment for patients with a wide range of severe mental disturbances and was also used to control difficult patients. Many of the general public and psychiatrists opposed its use because it seemed brutal and uncivilized. Often patients who received ECT described it as frightening.

Historically, clients did not receive sedation or anesthesia before ECT. They were placed on a bed or table, electrodes were attached to their heads, and they were held down by attendants as the electric current produced a grand mal seizure. After a long, deep sleep, they gradually awoke confused, disoriented, often with significant memory loss and broken bones.

Currently, ECT is administered in a hospital either during a hospital stay or on an outpatient basis to anesthetized clients who have received muscle relaxants. Carefully calculated current, monitored by an electroencephalogram, is passed through one or both sides of the brain, resulting in a carefully controlled seizure that lasts 20 to 90 seconds. Clients awaken in 5 to 10 minutes and may have short-term amnesia.

There is no standard number of treatments for an acute ECT course and no way to predict how many treatments will be needed. Most patients remit with 6 to 12 treatments, some require only three, while others may require 20 or more (Kellner, 2016).
Common side effects may include:

- Aspiration pneumonia
- Fracture in those with severe osteoporosis
- Dental and tongue injuries
- Headache
- Nausea
- Rarely death, mostly related to cardiopulmonary events

Common cognitive effects occur in approximately 50% to 80% of patients, however they are generally short lived. These include:

- Acute confusion
- Anterograde amnesia (decreased ability to retain new information)
- Retrograde amnesia (loss of memory for events or information learned prior to ECT) (Kellner, 2016)

**Repetitive Transcranial Magnetic Stimulation (TMS)**

Repetitive transcranial magnetic stimulation is a relatively new treatment for patients who have not responded to more conventional treatments for depression. Repetitive TMS treats depression by stimulating nerve cells in the brain using very short pulses of magnetic energy similar to the electrical activity observed with ECT. Waves are passed through a coil placed on the scalp to areas of the brain involved in mood regulation. Exactly how it works is unknown, but its use appears to alleviate depressive symptoms and improve mood.

Repetitive TMS does not require hospitalization, requires no anesthesia, is less expensive than ECT, and is relatively free of serious side effects. Common side effects include headache; scalp discomfort at application site; spasms, tingling, or twitching of facial muscles; and lightheadedness. More serious side effects include seizures, mania in persons with bipolar disorder, and hearing loss from inadequate ear protection during the procedure.

Repetitive TMS treatments last about 30 to 40 minutes. The number of treatments necessary has not been established, but it is recommended by some that a trial of repetitive TMS should last a minimum of three to four weeks before determining its benefit (Holtzheimer, 2015a).

Although ECT is more effective than repetitive TMS, patients may prefer TMS because it is better tolerated and does not require general anesthesia or the induction of seizures.

**Light Therapy**

The use of artificial light that mimics natural outdoor light is used for treating major depressive disorder, recurrent, with seasonal pattern, commonly referred to as seasonal affective
disorder (SAD). This disorder is thought to be related to melatonin, which is produced by the pineal gland and plays a role in regulating biological rhythms for sleep and activation. Melatonin is produced nocturnally and stops in daylight. During months of longer darkness, there is an increase in melatonin production that seems to trigger symptoms of depression in susceptible persons. This is a form of treatment that is comparable to the use of antidepressant medications but with fewer adverse effects.

Persons receiving light therapy sit with eyes open in front of a box containing white fluorescent lights with a screen that blocks ultraviolet rays. Treatment lasts for 10 to 15 minutes initially and progresses to 30 to 45 minutes. Light therapy is effective in approximately 60% of patients. It has been found to be most beneficial if administered early in the morning. Some patients experience improvement within a few days, and others may take several weeks before feeling better. Side effects seem to be dosage related and include headache, eyestrain, nausea, irritability or agitation, photophobia, insomnia, and rarely, hypomania, mania or hyperactivity (Mayo Clinic, 2016c; Avery, 2016).

**Vagus Nerve Stimulation (VNS)**

VNS is used for treatment of resistant major depression. It involves a surgical procedure done most often under general anesthesia to attach an electrode around one vagus nerve (mostly the left) in the carotid sheath. The electrode is connected to a pulse generator implanted subcutaneously in the chest wall. The device is turned on after a postsurgical recovery period of approximately two weeks. Stimulation is intermittent (30-second period every five minutes), inducing changes in brain metabolism in areas of the brain associated with depression, and involves activation of brainstem regions associated with dopamine activity.

There is no rigorous data to indicate the effectiveness of vagus nerve stimulation for treatment-resistant major depression, but the benefit may possibly accrue over time. Risks include:

- Bleeding, infection, anesthesia complications
- Voice alteration/hoarseness
- Cough
- Dyspnea
- Neck pain
- Paresthesia
- Vomiting
- Laryngismus
- Dyspepsia
- Headache
- Hypomania or mania
  (Holtzheimer, 2015b)
Other Invasive/Surgical Neuromodulation Therapies

Several procedures for the treatment of depression under investigation and available in the United States only through a research protocol include:

- Focal electrical administered seizure therapy (FEAST), which attempts to induce seizures more efficiently than ECT
- Transcranial low voltage pulsed electromagnetic fields (T-PEMF)
- Transcranial direct current stimulation (tDCS)
- Trigeminal nerve stimulation
- Low-field magnetic stimulation (LFMS)
- Deep brain stimulation (DBS)
- Direct cortical stimulation (DCS)
  (Holtzheimer, 2015b)

Psychotherapeutic Interventions

Psychotherapy is commonly referred to as talk therapy or counseling. Psychotherapy uses short-term approaches that have been found to be effective for the treatment of psychiatric disorders including depression. It is effective as a primary treatment for major depression.

The role of psychotherapy is to help patients develop coping strategies to deal with everyday stressors. It is the therapist’s responsibility to provide a safe environment and a caring therapeutic milieu. Psychotherapeutic approaches are employed by healthcare practitioners who specialize in psychotherapy. These professionals may be advanced-practice nurses, marriage and family therapists, social workers, psychologists, and psychiatrists.

There are various types of psychotherapy that can be given in a variety of formats and approaches, and the choice of the most appropriate method is based partly on the patient’s specific problem or diagnosis.

TYPES OF THERAPY

- **Individual therapy** involves only the patient and the therapist in private sessions.

- **Group therapy** involves two or more patients and the therapist participating in therapy at the same time. They can share their experiences and hear that others feel the same way and have had similar experiences.

- **Marital/couples therapy** helps spouses and partners deal with troublesome issues in their lives and learn new behaviors.
• **Family therapy** relies on awareness that the family is a major part of the team that helps persons with mental illness improve. It is helpful for family members to understand what the depressed person is experiencing, how they can help, and how they can cope.

**THERAPEUTIC APPROACHES**

• **Psychodynamic therapy** is based on the assumption that the past repeats itself in the present in ways that are painful for the patient. The patient is having difficulties due to unresolved, mostly unconscious conflicts, desires, thoughts, feelings, and patterns of relating to others that stem from childhood. The goal of psychodynamic therapy is to gain understanding and learn to cope better with these feelings by talking about experiences. This approach takes generally three to four months but can last for years (Gabbard & DeJean, 2016).

• **Interpersonal therapy** is a time-limited (usually three to four months), structured treatment that focuses on current relationships and the connection between recent adverse life events and depression. It has been shown to be effective in the treatment of adolescent patients; however, for older patients the results are mixed. This approach works well for persons depressed due to bereavement, relationship conflicts, major life events, and social isolation (Swartz, 2016).

• **Cognitive behavior therapy** (CBT) is designed to help identify and change patients’ inaccurate perceptions both of themselves and the world around them. It includes education, relaxation exercises, coping skills training, stress management, or assertiveness training. CBT can be done individually or in groups and focuses on the immediate present. It is interested in what and how, more than why, persons think the way they do. This approach requires the patient and therapist to actively work together to challenge irrational beliefs and requires homework by the patient. Therapy is problem-focused and goal-directed, helping to establish new ways of thinking about wrong or right assumptions. This approach has been shown to be as effective as antidepressant medications for some with depression and superior in preventing relapse. Cognitive behavior therapy is time-limited, lasting 14 to 16 weeks (Lord et al., 2016).

• **Mindfulness cognitive therapy** is a group program used to delay or prevent recurrence of major depression, and it may also reduce depressive symptoms. This therapy combines the clinical application of mindfulness meditation (the purposeful, nonjudgmental attention to the present moment) with elements of cognitive behavior therapy. Mindfulness cognitive therapy emphasizes accepting, but not attaching or reacting to, dysfunctional thoughts. This differs from cognitive behavior therapy, in which the emphasis is on changing dysfunctional thoughts by gathering evidence to dispute their truth. Mindfulness cognitive therapy is based on the theory that maladaptive thoughts and behaviors are the cause of psychopathology. This therapy generally consists of a group of 8 to 15 patients attending eight weekly sessions, each lasting two hours (Segal, 2016).

• **Supportive psychotherapy or counseling** is used to assist patients to cope with illness, deal with a crisis, or treat depression by improving self-esteem, psychological
functioning, and adaptive skills, focusing on current, difficult relationships and maladaptive patterns of behavior and emotional responses. This form of therapy is used as both primary and adjunctive treatment with pharmacotherapy (Lord & Levy, 2016).

**Occupational Therapy Interventions**

Occupational therapists who specialize in depression mainly work in hospital settings, but some work in other settings, including home, school, and the community. They may offer interventions to assist in structuring a patient’s day; replacing bad habits with good ones; and balancing leisure, work, and relationships. Occupational therapists can help patients to review work roles, social skills, and management of daily routines, and to overcome a sense of isolation. They can help patients to feel motivated and gain confidence to accomplish the things most important to them (Opp, 2016).

However, there is a lack of evidence-based interventions that help patients to a more satisfying everyday life. A recent trial in Sweden evaluated an intervention known as the Tree Theme Method (TTM) that can complement cognitive behavior therapy and pharmacologic treatment. This is an intervention in which patients paint pictures of trees that represent certain periods of their lives. The patient then uses the paintings as a starting point for telling his or her life story, focusing on the activities and routines that are part of everyday life.

TTM is based on what is known about art therapy, life storytelling, and the value of meaningful activities in maintaining well-being. The goals of the intervention are to increase patients’ abilities to cope with everyday life and to help develop strategies for becoming active. It involves five sessions and is carried out over a period of six to nine weeks.

Patients involved in this study reported that TTM was a turning point when they gained new perspectives on self-care, productivity, leisure, and their relationships with others. Evaluation of this method showed consistently positive outcomes for the patient group. In a three-year follow-up it was found that TTM demonstrated a sustainable positive outcome, particularly in regard to increased ability to perform everyday activities both at home and at work (Gunnarsson et al., 2015).

**DEPRESSION AND SUICIDE**

A high risk of suicide is one of the costs of depression. More than 90% of those who die by suicide have a diagnosable illness such as clinical depression (ADAA, 2016). The American Association of Suicidology (2016) points out that suicide is the tenth leading cause of death in the United States and the second leading cause of death for ages 15 to 24 years. These are the numbers for completed suicide, but many more attempt suicide than succeed, and many, many others contemplate suicide without carrying it out.

The nursing diagnosis for a person who is suicidal may address many areas, but the highest priority is “risk for suicide.” Feelings of hopelessness, anger, poor impulse control, frustration,
abandonment, and rejection are common among people who are suicidal, and suicide is often related to a loss.

A person who is suicidal may present with overt or covert clues, has a plan, and is in a high-risk category on assessment (elderly, teenager, isolated, depressed, has had a recent loss). If suicidal intent is low, the person may be treated in outpatient settings. Arrangements must be made so that the person is not left alone and that the environment is free of dangerous items such as firearms. If there is no family or friends, then the person should be hospitalized. When such patients are hospitalized, they are put on suicide precautions or one-to-one observation (Andrew, 2016).

Even in a psychiatric unit, the condition of depressed patients is dynamic, changing from hour to hour. As antidepressant medications begin to take effect, patient outlook and behavior change. On admission, they may be too depressed to carry out a plan of suicide. However, as energy returns, they may gain enough energy to carry out their plan. For that reason, suicide precautions and caregiver vigilance should increase rather than decrease with time.

**SUICIDE PRECAUTIONS**

**Patient**

- Suicide precautions for a patient assessed as actively suicidal include one-on-one monitoring at all times, including during toileting and during the night.
- Suicide observations include a 15-minute visual check when the patient is not assessed to be actively suicidal.
- For each of the above, behavior, mood, and verbatim statements are recorded in the chart every 15 minutes.

**Environment**

- Provide plastic utensils for eating.
- Do not assign to a private room.
- Hang-proof the bathrooms; install break-away shower rods and recessed shower nozzles.
- Keep electrical cords to a minimal length.
- Install unbreakable glass in windows and keep windows locked.
- Lock all utility rooms, kitchens, stairwells, and offices.
- Take all potentially harmful gifts from visitors before allowing them to see the patient.
Go through belongings with the patient and remove all potentially harmful objects.
Ensure that visitors do not leave potentially harmful objects in the patient’s room.
Search patients for harmful objects on return from pass.

INTERPERSONAL SUPPORT AND THERAPEUTIC COMMUNICATIONS

Therapeutic communication involves specific responses that encourage the expression of thoughts and feelings by the patient and convey the clinician’s acceptance and respect. The goals of therapeutic communication are to establish rapport, identify the most important concerns of the patient, assess the patient’s perceptions of problems, facilitate the patient’s expression of emotions, teach the patient necessary skills, and implement interventions to address these issues.

The characteristics of effective therapeutic communication include:

- **Rapport** is a mutual understanding or connection in which the clinician and patient each understands the other, and is based upon acceptance, common interest, a sense of trust, and a nonjudgmental attitude.
- **Trustworthiness** is demonstrated by being sincere, dependable, reliable, and by keeping confidentiality.
- **Genuineness** is the ability to be open and honest, listen and communicate without distorting messages, and be clear and concrete in communication.
- **Positive regard** implies respect. It is the ability to view another person as being worthy of caring about and as someone who has strengths and achievement potential. Respect is shown indirectly by actions such as attending (being fully present) and suspending value judgments.
- **Empathy** is the ability to see things from another person’s perspective and to communicate this understanding to the other person. It denotes understanding and acceptance of the patient and his or her situation and tells the patient that the caregiver understands.

In order to give supportive care to depressed individuals, caregivers:

- **Establish a connection with clients.** Introduce yourself. Reach out in kindness. No matter how depressed a person may be, they will know you are there and you care. They may be silent, agitated, or freely respond. Self-disclosure may establish trust and connection with others.
• **Demonstrate care.** You may not be able to “do anything” and feel quite useless or even frustrated, yet by simply “being there” you convey a message of genuine interest and concern.

• **Affirm by behavior** that the depressed individual is valuable and autonomous and that there is hope—the very opposite of feelings of worthlessness, helplessness, and hopelessness. These messages can be offered in simple ways, such as giving patients choices, affirming their value, and mentioning future events. If patients begin to communicate, allow them to lead the conversation (Patil, 2014).

**Family and Individual Education**

Whether depressed persons are hospitalized in a psychiatric unit or served by caregivers outside the hospital, they and their families need to learn about the illness of depression and the medications they are taking. Some important goals in educating patients and family include:

- Teach about the illness of depression.
- Discuss the various treatment options for depression, their benefits and effectiveness.
- Teach signs and symptoms that may signal a relapse.
- Provide instruction on the management of co-existing medical conditions.
- Provide resources for support groups in the community.
- Discuss the importance of follow-up appointments.
- Encourage participation in support groups.
- Teach the action, side effects, and special instructions regarding medications.
- Discuss methods to manage side effects of medication.
  (Crowley & Martin, 2016)

**CONCLUSION**

Depression is the leading cause of disability in the United States, often associated with medical and other mental disorders. It is caused by internal and external factors, along with adversity. Because depressive disorders are so prevalent among the general population, it is essential that all healthcare providers learn how to screen for them and to take the necessary steps to help those with evidence of depression receive further evaluation and treatment.

All healthcare providers must learn how to establish a rapport that allows patients to communicate their concerns and feelings and to provide support for them as they move through the diagnostic and treatment phases of their illness.
RESOURCES

Beck Depression Inventory II

Depression (National Institutes of Mental Health)
http://nimh.nih.gov/health/publications/depression/

Edinburgh Postnatal Depression Scale

Geriatric Depression Scale (Short Form)
http://geriatric-toolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF

Patient Health Questionnaire (PHQ-9)

WHO-5 questionnaires
https://www.psykiatri-regionh.dk/who-5/Pages/default.aspx

REFERENCES


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1. A characteristic feature of major depressive disorder is a:
   a. Chronic depressed mood often associated with psychotic features.
   b. Noticeable change in a person’s pattern of functioning.
   c. Range of feelings such as irritability, anger, and mood swings.
   d. Strong association to an underlying medical condition.

2. Which is a depressive disorder in children characterized by severe and recurrent temper outbursts?
   a. Catatonia
   b. Persistent depressive disorder (dysthymia)
   c. Disruptive mood dysregulation disorder (DMDD)
   d. Depressive disorder with psychotic features

3. What percentage of Americans meeting the criteria for a diagnosis of depression seeks treatment?
   a. 35%
   b. 50%
   c. 65%
   d. 80%

4. Which is a correct statement about the etiology of depression?
   a. Early life stressors increase the risk for developing depression.
   b. There is direct evidence that decreased serotonin levels causes depression.
   c. A definite mode of genetic transmission has been confirmed.
   d. Medications do not cause secondary depression.

5. Lack of positive reinforcement is a characteristic of which theory of depression?
   a. Behavioral
   b. Interpersonal
   c. Cognitive
   d. Psychodynamic
6. The most important diagnostic tool for depression is the:
   a. Patient Health Questionnaire (PHQ-9).
   b. Interview.
   c. Beck Depression Inventory.
   d. Clinically Useful Depression Outcome Scale (CUDOS).

7. A mental status examination includes:
   a. History of past mental illnesses.
   b. Recent changes in occupational situation.
   c. Thought process and cognition.
   d. Quick Inventory of Depressive Symptomatology-Self Report 16.

8. Making the appropriate medical diagnosis of a specific depressive disorder involves:
   a. Completing a mental status examination.
   b. Use of depression rating scales.
   c. Use of DSM-5 criteria.
   d. Laboratory and neuroimaging studies.

9. First-generation antidepressants include which class of drugs?
   a. Selective serotonin reuptake inhibitors (SSRIs)
   b. Atypical antidepressants
   c. Serotonin-norepinephrine reuptake inhibitors (SNRIs)
   d. Monoamine oxidase inhibitors (MAOIs)

10. Which is a true statement about tricyclic antidepressants?
    a. They are one of the newest types of antidepressant drugs available today.
    b. They inhibit the reuptake of norepinephrine and serotonin and block acetylcholine.
    c. They are frequently used for patients with glaucoma and diabetes.
    d. They do not cause anticholergenic side effects such as dry mouth and weight gain.

11. When a patient takes a monoamine oxidase inhibitor for depression, he or she must reduce the intake of foods that contain high levels of:
    a. Serotonin.
    b. Tyramine.
    c. Dopamine.
    d. Norepinephrine.
12. Which is a true statement about electroconvulsive therapy (ECT)?
   a. It is often chosen only after a medication trial proves ineffective.
   b. It involves short pulses of magnetic energy to the brain.
   c. It increases melatonin production.
   d. It can cause bleeding, infection, and anesthesia complications.

13. Which psychotherapeutic approach is characterized by its focus on current relationships and the connection between recent adverse events and depression?
   a. Interpersonal therapy
   b. Cognitive behavior therapy
   c. Psychodynamic therapy
   d. Supportive therapy or counseling

14. Which is an occupational therapy intervention that involves painting and a patient’s life story?
   a. Mindfulness cognitive therapy
   b. Interpersonal storytelling
   c. Tree Theme Method (TTM)
   d. Psychodynamic analysis

15. After a patient’s treatment for depression begins to be effective and their energy begins to return, it is important for caregivers to increase their vigilance for:
   a. The side effects of antidepressant medications.
   b. Behaviors indicative of increased suicide risk.
   c. Signs of grieving for a previous loss.
   d. The need to increase the medication dosage.

16. Therapeutic communication includes:
   a. Being judgmental about unacceptable behaviors.
   b. Making assumptions about feelings.
   c. Stating a personal opinion.
   d. Establishing rapport.