Depression: Major Depressive Episode

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Purpose This course explains the causes, variations, assessment, symptoms, and treatment of major depression.

Goals Upon completion of this course, the healthcare provider should be able to:

- Discuss the incidence of depression.
- Discuss biological theories of depression.
- Describe the primary neurotransmitters associated with depression.
- Discuss the psychodynamic theories of depression.
- Describe the criteria for major depressive episode, including the 2 required symptoms and at least 4 other symptoms.
- List at least 6 clinical specifiers used to describe the symptom pattern of depression.
- Describe at least 8 factors to assess.
- Discuss gender differences in depression.
- Describe 4 commonly-used depression scales.
- Describe safety measures for those with suicidal ideation.
- Discuss SSRIs, tricyclic antidepressants, atypical antidepressants, and MAO inhibitors, including use and adverse effects.
- Discuss the use of electroconvulsive therapy (ECT).
- Discuss two types of commonly-used psychological therapy.

Introduction

Virtually everyone experiences periods of depression or sadness, often related to work, social, and family responsibilities or conflicts or loss, and while the person may experience a lack of energy, agitation, or exhaustion, these feelings are usually transient. However, depression that persists and increases over time may seriously impact a person's ability to function.

Females have about twice the incidence of depression as males with 10-25% of females and 5-12% of males experiencing major depressive episodes at some point. Onset of depression is most common in the mid-20s, but this varies. About 19% of older adults (>55) experience depression, and this rate increases to 37% for older adults with comorbid conditions. Depression is also higher among single parents, the unemployed, and those in lower socioeconomic levels.

Depression is often co-morbid with other psychiatric conditions, such as post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobias, and generalized anxiety disorder. Depression also correlates with physical illnesses, especially in older adults. Disorders often associated with depression include HIV/AIDS, Parkinson's disease, cancer, stroke, diabetes, and heart disease.

What causes depression?

There are a number of different theories about the causes of depression, with most current research focusing on chemical imbalances; however, it's clear that in many cases a combination of factors are involved. In some cases, depression may be triggered by trauma or loss, but in other cases no trigger can be identified

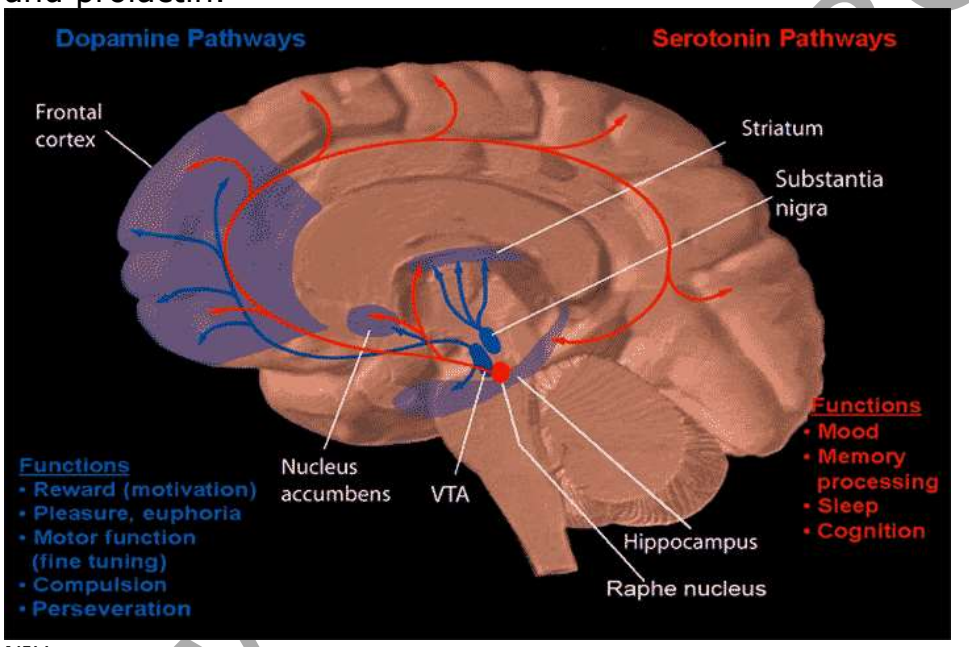
Biological theories

Family history is especially important when determining the cause of depression because those with a first-degree biological relative with depression have double the risk of developing depression as the general public. Identical twins are up to 4 times more likely to both be affected by depression than fraternal twins, suggesting that a genetic predisposition is one but not the only factor. If genetic risk is present,

that person is more likely to develop mental illness over time with aging, life stressors, and/or negative environmental interactions.

Much current treatment is based on neurochemical theories that suggest depression is caused by underproduction or depletion of neurotransmitters, especially serotonin, norepinephrine, and dopamine. These neurotransmitters act in areas of the brain that control emotions, stress reactions, sleep, appetite, and sexuality.

Serotonin affects behavior, including mood, aggressiveness, irritability, pain perception, and activity. Serotonin also influences neuroendocrine processes. People with depression often have a deficit of serotonin as well as abnormal levels of growth hormone, cortisol, and prolactin.



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Dopamine is a stabilizing force in the brain, regulating the flow of impulses and affecting perceptions of pleasure and reward. **Norepinephrine**, which provides energy, is often decreased with depression, but in some people, it is increased, so the mechanism by which it affects mood is not clear. Norepinephrine is primarily responsible for mediating arousal and the reward system, and is released in response to stress.

Some researchers believe that **acetylcholine** may also be implicated in depression. Acetylcholine affects learning, short-term memory, arousal, and pleasure/reward systems. While medications that alter the levels of particular neurotransmitters relieve depression in many people, they don't work for everyone.

Endocrine disorders have also been associated with depression, suggesting that **neuroendocrine imbalances** may affect mood. Depression may occur with abnormalities of the thyroid gland (especially elevated TSH), adrenal glands, parathyroid glands, and pituitary gland. About 40% of people with depression have elevated levels of cortisol, especially older adults.

Developmental hormone changes at puberty or hormone disruption related to disease any also contribute to depression. Women sometimes develop a severe form of premenstrual syndrome, premenstrual dysphoric disorder (PMDD) with feeling of depression associated with hormonal changes, and women are at increased risk of depression during menopause when estrogen levels fall.

Psychodynamic theories

There are many psychodynamic theories about depression, many focusing on the individual or family. Some theories, such as Freud's, have lost favor, but there may be some valuable insight in each theory:

- **Beck:** Depression results from distortions in cognitive thinking, a negative view of the self, the world, and the future.
- **Bibring:** Depression occurs when people feel unworthy because they not able to achieve ideals they believe are important.
- **Freud**: Depression is anger turned inward because of real or perceived loss.
- **Horney**: Depression results from being reared by rejecting or unloving parents.
- **Jacobson**: Depression occurs when the ego is overpowered by the superego.
- **Meyer**: Depression is the reaction to negative life experiences.

Major depressive episode

The American Psychiatric Association (APA) lists a number of different types of depression in the *DSM: IV-TR,* generally variations of major depressive episodes. For example, about 9% of those diagnosed with depression exhibit psychotic symptoms, such as hallucination, delusions, and paranoia.

Criteria A **major depressive episode** is two or more weeks of a depressed mood, profound and constant sense of hopelessness and despair, and/or loss of interest in all or almost all activities. Criteria include ≥5 of the following, including the first 2:

- Depressed mood most of the day.
- Diminished interest in most or all activities previously found enjoyable (anhedonism).
- Significant weight gain or loss without dieting (≥5% in a month).
- Insomnia or hypersomnia.
- Agitation or psychomotor retardation.
- Persistent pessimism and feelings of worthlessness and guilt.
- Constant fatigue.
- Feelings of worthlessness.
- Reduced ability to focus on tasks.
- Recurring thoughts of death or suicide.

A number of clinical specifiers are used to describe the symptom pattern of depression. These include:

- Single or recurrent episode.
- Mild, moderate, severe: Descriptor depends on severity of symptoms.
- Psychotic features: Hallucinations, delusions.
- Catatonic features: Psychomotor disturbance, negativism, mutism, echolalia, or echopraxia.
- Melancholic features: Symptoms exaggerated and severe.
- Dysthymic (Chronic): Current episode has persisted ≥2 years.
- With seasonal pattern: Seasonal episodes (usually fall or winter) outnumber seasonal episodes.
- Postpartum onset: ≤4 weeks postpartum.
- Complicated bereavement: Excessive grieving for extended periods of time.
- Bipolar disorder: Cyclic periods of depression and mania may alternate.

Without treatment, a major depressive episode usually abates within 6 to 24 months. Depression may be cyclical to some degree as 50-60% of those with depression have a second episode, and 70% of those who have a second episode have recurrence.

Assessment	
Appearance	People may appear sad with head down, slouched into chair. People may avoid eye contact. Some

	may be disheveled or unkempt.
Responses	Some people may have difficulty answering questions or exhibit **latency of response** (requiring up to 30 seconds to respond).
Anxiety	Some people may exhibit **psychomotor agitation**, signs of anxiety, such as wringing hands, pacing, or the inability to sit still.
Affect	May be blunted or flat.
Mood	People may describe themselves in negative terms, such as stating that they are failures. They may also lose pleasure in normal activities and exhibit anger at themselves or others.
Cognitive processes	Thought processes are often very slow, and people may have difficulty concentrating and memory impairment. Some may **ruminate,** or go over the same thoughts over and over like an endless loop in their minds. People often believe they are hopeless and have constant pessimistic thoughts. They may have **suicidal ideation.**
Orientation	Some people, especially those with psychotic manifestations and hallucinations or delusions, become disoriented to person, time, and place, while others remain oriented.
Judgment	People exhibit impaired judgment related to difficulty concentrating, impaired problem-solving ability, negative thought processes, and apathy. People may or may not have insight into their behavior or symptoms.
Self-esteem	Most people exhibit decreased self esteem and think of themselves as worthless or losers. They may feel guilty about their ability to perform and come to believe that family and friends would be better off without them, increasing risk of suicidal ideation.
Responsibilities	People are often unable to carry out their roles or responsibilities in the home, academic, or work environment, putting severe strain on relationships.
Physiological changes	Lack of appetite and weight loss are common although some people may react to depression by overeating. Some people neglect an adequate fluid intake and become dehydrated, which can contribute to constipation. Sleep disturbance is also common with some

	people experiencing insomnia and others excessive sleeping. People usually feel exhausted, regardless of the amount of sleep they receive. Impairment in sexual function is common, and men may experience impotence.

Gender differences

Males: Males are more likely to have low energy associated with depression as well as irritability and anger, sometimes directed at others. They may act aggressively toward others and engage in risky behavior, including substance abuse, and are 4 times more likely to commit suicide than females. Sleep problems are common.

Females: Females are more likely to become depressed at an earlier age and experience longer periods of depression and more recurrence. Females are more likely to exhibit seasonal depression and atypical symptoms, such as craving carbohydrates, weight gain, feeling of heaviness, and increasingly impaired mood in the evenings. Females with depression are also more likely to have anxiety, eating disorders, and dependent personalities. Females with a history of depression are 5 times more likely to develop depression during menopause than those with no history of depression.

Depression rating scales

While the interview and physical assessment are often the first steps in diagnosing depression, depression rating scales are also used to assess evidence of depression or severity. Some scales are self-rating (completed by the person) while others are completed by healthcare professionals, based on observations.

Geriatric Depression Scale

The Geriatric Depression Scale is a self-assessment tool to identify depression in older adults although the questions may be applicable to those of other ages. The tool is simple can be used with those with normal cognition or those with mild to moderate impairment. People answer "yes" or "no" to 15 questions. A score of >5 "yes" answers is indicative of depression:

Geriatric Depression Scale
1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel your life is empty?

4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

Hamilton Rating Scale for Depression

HAM-D is completed by the interviewer based on observation and assessment. This scale is intended for those already diagnosed with depression in order to measure the severity of illness. There are 17 items used to evaluate depression and 4 additional measures for informational purposes on the standard scale. A modified scale is often used. The modified scale usually has 13 questions with 4 additional measures.

Two different scoring scales are used:

- **0-2:** 0 = absent, 1 = trivial or mild, and 2 = present.
- **0-4:** 0 = absent, 1 = trivial, 2 = mild, 3 = moderate, and 4 = severe.

Hamilton Rating Scale for Depression (simplified version)	
1. Depressed mood	Score 0-4
2. Guilt	Score 0-4
3. Suicide	Score 0-4
4. Insomnia, initial	Score 0-2
5. Insomnia, middle	Score 0-2
6. Insomnia, delayed	Score 0-2
7. Work and interest	Score 0-4
8. Retardation	Score 0-4
9. Agitation	Score 0-4
10. Anxiety (psychic)	Score 0-4
11. Anxiety (somatic)	Score 0-4
12. Somatic gastrointestinal	Score 0-2
13. Somatic general	Score 0-2

14. Genital	Score 0-2
15. Hypochondriasis	Score 0-2
16. Insight	Score 0-4
17. Loss of weight	Score 0-2
TOTAL	**TOTAL SCORE**
Diurnal variation	Score 0-2
Depersonalization	Score 0-4
Paranoid symptoms	Score 0-4
Obsessional symptoms	Score 0-4

Children's Depression Rating Scale-Revised (CDRS-R) is based on the adult HAM-D and evaluates a child for depressive disorders and monitors treatment response. CDRS-R includes 17 items, 14 of which are assessed during an interview, and 3 of which are assessed by the clinician's interpretation of the patient's nonverbal cues. The CDRS-R is designed specifically for patients aged 6 through 12 but may also be used during an interview with the patient's parents, caregivers, and teachers. The items included in the interview include the following: schoolwork; capacity to have fun; social withdrawal; sleep; appetite or eating patterns; excessive fatigue; physical complaints; irritability; guilt; self-esteem; depressed feelings; morbid ideation; suicidal ideation; weeping; depressed affect; tempo of speech; and hypoactivity.

Beck Depression Inventory BDI is a self-assessment tool that is widely used. The tool consists of 21 items to measure the degree of depression. DBI is intended for those 17 to 80 years old. The items rank in four possible answer choices, based on an increasing severity of symptoms. The test is scored with the answers ranging in value from 0 to 3. The total score is the utilized to determine the degree of depression. The usual rages include:

- 0-9 no signs of depression.
- 10-18 mild depression.
- 19-29 moderate depression.
- 30-63 severe depression.

A modified Beck Depression Inventory is also frequently used. Typically, modified versions include about 12-13 items. **[See APPENDIX A]**

Treatment approaches

Treatment focuses on outcomes identification and the best methods to achieve these outcomes. Common outcomes include:

- Client will avoid self-injury, suicide.
- Client will be independent in ADLs.
- Client will achieve balance in activities, rest, and sleep.
- Client will have adequate nutrition and fluids.
- Client will exhibit ability to socialize with staff, friends, peers, and family.
- Client will return to home, occupation, or academic activities.
- Client will follow treatment outline.
- Client will recognize and report signs of recurrence.
- Client will have realistic self-assessment.

Treatment approaches may include measures to ensure safety, psychodynamic and/or behavioral therapy, and medications.

Suicide prevention

Question: Because of the risk of suicide in people with depression, the healthcare provider should always be direct in asking people if they have thought about harming themselves in some way. It's especially important to ask people if they have a specific plan because those who have both a plan and means (such as pills or a gun) to carry out suicide are at much higher risk than those with no plan or means.

Provide safe environment: All potentially dangerous items (razors, scissors, knives, pills, ties, belts) should be removed, so that people do not have access to them. People should be supervised during meals and medication administration (as some people may hoard pills to use in a suicide attempt). In some cases, room searches may be indicated.

Make a contract: Making a short-term oral or written contract with people who are suicidal may help them avoid a suicide attempt and provide an opportunity for them to express their feelings as well as placing some responsibility on them for their own safety.

Secure promise: The healthcare provider should ask people to make a promise that they won't act on suicidal ideation without first talking about it with a staff person or support person. Because people are often ambivalent about suicide, this may prevent rash actions.

Observe: People who are suicidal must be maintained under close observation and should not be placed in private rooms. Rooms should be close to the nursing desk for easy observation. People may require

one-on-one observation, constant visual observation, or every 15 minutes checks. Some people must be observed even in the bathroom. Making rounds at irregular intervals helps to make staff observations less predictable for people who may be tempted to harm themselves when they believe they won't be observed.

Explore feelings: People must be encouraged to express their feelings, including anger (within appropriate limits). People may explore their anger to determine the source and methods of coping with the anger.

Identify resources: Help people make concrete plans for seeking assistance and identify resources in the community that may provide support.

Orient: While being careful not to belittle people, healthcare providers should point out sensory misperceptions, keeping people grounded in reality.

Medications Antidepressants are commonly used to treat depression with **SSRI**s the most popular because they have fewer side effects and are often more effective than older tricyclic antidepressants. However, all medications have side effects, and SSRIs have been associated with increased suicidal ideation, weight gain or loss, and sexual dysfunction, so careful monitoring is essential. Many side effects, such as insomnia and depressed appetite decrease within the first week, and symptoms may start to abate with 7-10 days. Older adults may tolerate SSRIs better than other depressants.

Selective serotonin reuptake inhibitors (SSRIs)		
Medication	**Adverse Effects**	**Considerations**
Citalopram (Celexa®)	Drowsiness, sedation, insomnia, slight weight loss, dry mouth, nausea, constipation, diarrhea, increased perspiration, tremor, ejaculatory disorder, impotence, decreased libido, and suicidal ideation (≤ age 24).	Give after 6 pm with food. Monitor for hyponatremia. Avoid NSAIDs, ASA, linezolid, lithium, or St. John's Wort. **Indications:** Acute depression (treatment for 6-8 weeks)
Escitalopram (Lexapro®)	Drowsiness, dizziness, orthostatic hypotension,	Give with food. Check orthostatic BP

	weight loss/gain, sexual dysfunction, restlessness, somnolence, dry mouth, headache, nausea, diarrhea, and suicidal ideation (≤age 24).	and instruct patient to rise slowly from sitting. Encourage
Fluoxetine (Prozac®)	Headache, nervousness, anxiety, somnolence, insomnia tremor, sexual dysfunction, anorexia, constipation, nausea, diarrhea, weight gain, and suicidal ideation (all ages).	Give in AM with nervousness or PM with drowsiness. Monitor for hyponatremia.
Paroxetine (Paxil®)	Headache, dizziness, sedation, insomnia, nausea, vomiting, weight gain, constipation, diarrhea, dry mouth, sweating, ejaculatory disorders, and decreased libido (especially in males).	Give with food, in PM if causes drowsiness. Not approved for pediatrics. Side effects often more pronounced than with other SSRIs.
Sertraline (Zoloft®)	Headaches, nausea, diarrhea, somnolence, insomnia, tremor, dizziness, dry mouth, nausea, vomiting, weight loss, decreased libido, ejaculatory failure, and suicidal ideation (all ages),	Give in PM if causes drowsiness. Monitor for hyponatremia.
Vilazodone hydrochloride (Viibryd®)	Nausea, vomiting, insomnia, suicidal ideation in those ≤24, serotonin syndrome, neuroleptic malignant syndrome, increased risk of bleeding.	Give with food. Give in AM with insomnia.

Tricyclic antidepressants are associated with many side effects and are less well tolerated by many, especially older adults. Tricyclics are contraindicated with many medical conditions, such as liver disease, BPH, diabetes, cardiovascular disease, renal impairment, and respiratory disease. Overdosage may cause severe adverse effects. Response to therapy is slower than with SSRIs, typically taking up to 6 weeks to reduce symptoms.

Tricyclic antidepressants		
Medication	**Adverse Effects**	**Considerations**
Amitriptyline (Elavil®)	Orthostatic hypotension, dizziness, dry mouth, tachycardia, sedation, blurred vision, weight gain, constipation, dysuria, excessive sweating.	Monitor cardiac status. Instruct patient to rise slowly from sitting.
Amoxapine (Asendin®)	Orthostatic hypotension, sedation, dizziness, dry mouth, rash, insomnia, extrapyramidal symptoms, tardive dyskinesia, neuroleptic malignant syndrome.	Instruct patient to rise slowly from sitting. Administer at bedtime with sedation.
Desipramine (Norpramin®)	Cardiac dysrhythmias, orthostatic hypotension, dizziness, dry mouth, rash, sexual dysfunction, insomnia.	Instruct patient to rise slowly from sitting. Administer in AM with insomnia.
Doxepin (Sinequan®)	Orthostatic hypotension, dizziness, dry mouth, sedation, weakness, fatigue, weight gain, blurred vision.	Instruct patient to rise slowly from sitting. Administer at bedtime with sedation.
Imipramine (Tofranil®)	Orthostatic hypotension, dizziness, dry mouth, weakness, fatigue, weight gain.	Instruct patient to rise slowly from sitting.
Nortriptyline (Pamelor®)	Cardiac dysrhythmias, tachycardia, dry mouth, constipation, confusion, excitement, tremor.	Monitor cardiac status. Administer in AM with stimulation. Observe for confusion.

Atypical antidepressants or antipsychotics are used if people do not have an adequate response to SSRIs or excessive side effects. Atypical antidepressants may be given in addition to SSRIs to potentiate their action. People with seizure disorders must be monitored carefully as drugs may lower threshold for seizures.

Atypical antidepressants/antipsychotic		
Medication	**Adverse Effects**	**Considerations**
Aripiprazole (Abilify®)	Increased rate of death with dementia, increased risk of stroke.	Atypical antipsychotic is used as an "add on" drug with SSRI.

	Suicidal ideation, tremors, hyperglycemia, faintness, high fever, tachycardia, muscle rigidity, sweating, hypertension, nausea, vomiting, constipation, headache.	
Bupropion (Wellbutrin)	Nausea, vomiting, agitation, restlessness, insomnia, altered taste, blurred vision, headache, weight gain.	Give in AM.
Duloxetine (Cymbalta®)	Hypertension, tachycardia, nausea, vomiting, impaired sleep, dry mouth, headache, constipation, sexual dysfunction.	Give with food.
Mirtazapine (Remeron®)	Dizziness, sedation, dry mouth, constipation, weight gain, and sexual dysfunction.	Give in PM.
Nefazodone (Serzone®)	Headache, dizziness, drowsiness, alterations in multiple lab tests.	Give before meal. Monitor hepatic and renal function.
Venlafaxine (Effexor®)	Hypertension, tachycardia, nausea, vomiting, headache, dry mouth, increased perspiration, dizziness, drowsiness, alterations in multiple lab tests.	Give with food in PM.

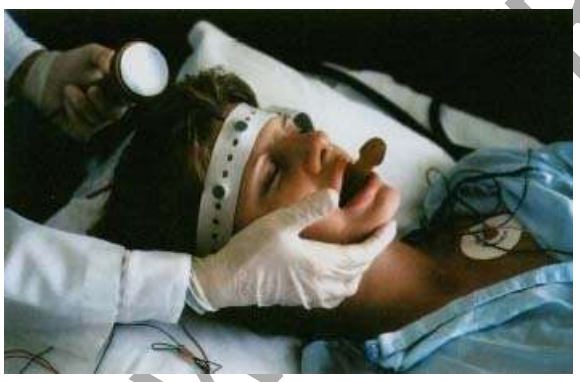
Monoamine oxidase inhibitors (MAOIs) are rarely used because of potentially fatal side effects. Additionally, they interact with many drugs and tyramine-containing foods and may result in life-threatening hypertensive crisis. MAOIs cannot be taken with amphetamines, ephedrine, fenfluramine, isoproterenol, meperidine, phenylephrine, phenylpropanolamine, pseudoephedrine, SSRIs, tricyclic antidepressants, or tyramine.

Monoamine oxidase inhibitors (MAOIs)		
Medication	**Adverse Effects**	**Considerations**
Isocarboxazid (Marplan®), **Phenelzine**	Orthostatic hypotension, dry mouth, drowsiness, agitation, insomnia, loss of appetite,	Administer in AM with food. Instruct in low-

(Nardil®), **Tranylcypromine** (Parnate®)	constipation, dysuria. **Life-threatening hypertensive crisis** may occur if taken with tyramine-containing foods, such as chocolate, beer, ale, wine, cheese, yogurt, bananas, nuts, legumes, figs, prune, raisins, soy sauce, MSG, vanilla, yeast, pineapple, picked and salted fish.	tyramine diet. Instruct patient to rise slowly from sitting.

Electroconvulsive therapy

People who are not responsive to medications or cannot tolerate them may benefit from electroconvulsive therapy (ECT), also referred to as electroshock therapy. Seizures are induced while the person is anesthetized. Electrodes are applied to the head and an electrical impulse generated. People usually receive a series of 6 to 15 treatments (usually 3 times weeks). Six treatments are the minimum usually required for therapeutic effect.



ECT may safely be used during pregnancy and is effective in older adults who may not tolerate drugs well. Unilateral ECT causes short-term memory loss and more treatments than bilateral ECT, which results in faster improvement but increased short-term memory loss. ECT may be used once monthly to prevent relapse in some cases.

Psychological therapy

A number of different psychological therapies are used to treat depression, most focusing on behavioral change. Traditional psychoanalytic therapy has not been shown to be effective as therapy and is rarely now employed as a primary therapy for depression.

Cognitive behavioral therapy: CBT is one of the most common and effective therapies used for depression. CBT focuses on the way in which thoughts affect behavior and feelings, including distorted

thinking processes, and encourages people to use rational thought to alter perceptions and behavior. This approach to counselling is usually involves about 12-20 sessions. People are typically assigned "homework" to practice new approaches to thinking and to develop new coping strategies. Together, the client and therapist identify goals and methods to achieve these goals. People are helped to realize that while they cannot control all problems, they can learn to deal with them more effectively. Each session focuses on a particular goal and coping techniques to deal with it. People are helped to unlearn old behaviors and ways of reactions and to questions behaviors as part of learning new behaviors.

Interpersonal therapy: Interpersonal therapy is especially effective if depression is situational. It is a short-term therapy, usually involving six 20-minute therapy sessions. Interpersonal therapy is usually focused on one type of problem, such as dealing with grief or loss of job, and may explore a number of interpersonal issues:

- Conflicts: family, friends, co-workers, peers.
- Changing roles: Retirement, death of spouse, divorce, loss of job, empty nest.
- Mourning and grief after death or profound loss.
- Deficiencies in interpersonal skills.

The therapist guides people to develop specific goals, showing empathy and respect but making concrete observations. The therapist confronts clients when their behavior does not match the appropriate behavior. The therapist encourages clients to stay focused on the problem and to discuss specific concrete feelings and responses rather than discussing feelings in the abstract to help them to gain awareness of their inner processes.

Conclusion

People with depression benefit most from a combination of medications and other therapy. A number of investigations therapies are under study, including transcranial magnetic stimulation and deep brain stimulation, for those who do not benefit from other treatment. Because people often feel overwhelmed by feelings of depression, the healthcare provider must provide a supportive environment and encourage people to talk about these feelings. People who have difficulty performing tasks may do better if tasks are broken into smaller steps. Suicidal ideation must be monitored throughout therapy, as medication may increase the energy needed to attempt suicide while not abating the depression. Both the clients and their families need education about depression so that they can recognize signs of

recurrence and have a better understanding that depression is an illness rather than a personal failing.

References

- Beck, AT, & Alford, BA. (2009). *Depression: Causes and Treatments.* Philadelphia: University of Pennsylvania Press.
- Depression. (2010, September 23). *NIMH.* Retrieved April 14, 2021, from http://www.nimh.nih.gov/health/publications/depression/index.shtml
- Dryden-Edwards, R & Lee, D. (2021). *MedicineNet.* Retrieved April 14, 2021, from http://www.medicinenet.com/depression/article.htm
- Mayo Clinic staff. (2010, February 11). Depression (major depression). *Mayo Clinic.* Retrieved April 14, 2021, from http://www.mayoclinic.com/health/depression/DS00175/METHOD=print
- Townsend, MC. (2008), *Nursing Diagnoses in Psychiatric Nursing.* Philadelphia: FA Davis Co.
- Viibryd medication guide. (2021, January). *Trovis Pharmaceuticals.* Retrieved April 14, 2021, from http://www.frx.com/pi/viibryd_pi.pdf#MedicationGuide
- Videbeck, SL. (2021). *Psychiatric-Mental Health Nursing,* 5th ed. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

APPENDIX A

Modified Beck Depression Inventory

1. (Sadness)
   a. I do not feel sad.
   b. I feel sad or unhappy.
   c. I am unhappy or sad all of the time and can't snap out of it.
   d. I am so unhappy or sad that I can't stand it.
2. (Outlook)
   a. I am not particularly pessimistic or discouraged about the future.
   b. I feel discouraged about the future.
   c. I feel I have nothing to look forward to.
   d. I feel that the future is hopeless and that things can't improve.
3. (Failure)
   a. I do not feel like a failure.
   b. I feel I have failed more than the average person.

c. As I look back on my life, all I can see is a lot of failures.
d. I feel I am a complete failure as a person (parent, husband, wife).

4. (Satisfaction)
   a. I am not particularly dissatisfied.
   b. I don't enjoy things the way I used to.
   c. I don't get satisfaction out of anything any more.
   d. I am dissatisfied with everything.
5. (Guilt)
   a. I don't feel particularly guilty.
   b. I feel bad or unworthy a good part of the time.
   c. I feel quite guilty.
   d. I feel as though I am very bad or worthless.
6. (Disappointment)
   a. I don't feel disappointed in myself.
   b. I am disappointed in myself.
   c. I am disgusted with myself.
   d. I hate myself.
7. (Suicidal ideation)
   a. I don't have any thoughts about harming myself.
   b. I feel I would be better off dead.
   c. I have definite plans about committing suicide.
   d. I would kill myself if I could.
8. (Interest)
   a. I have not lost interest in other people.
   b. I am less interested in other people than I used to be.
   c. I have all of my interest in other people and have little feeling for them.
   d. I have lost all of my interest in other people and don't care about them at all.
9. (Decisions)
   a. I make decisions about as well as ever.
   b. I try to put off making decisions.
   c. I have great difficulty in making decisions.
   d. I can't make decisions anymore.
10. (Appearance)
   a. I don't feel I look any worse than I used to.
   b. I am worried that I am looking old or unattractive.
   c. I feel that there are permanent changes in my appearance and they make me look unattractive.
   d. I feel that I am ugly or repulsive looking.
11. (Ability)
   a. I can work about as well as before.
   b. It takes extra effort to get started at doing something.

c. I have to push myself very hard to do anything.
d. I can't do any work at all.

12. (Tiredness)
    a. I don't get more tired than usual.
    b. I get tired more easily than I used to.
    c. I get tired from doing anything.
    d. I get too tired to do anything.
13. (Appetite)
    a. My appetite is no worse than usual.
    b. My appetite is not as good as it used to be.
    c. My appetite is much worse now.
    d. I have no appetite at all any more.

Scoring: a = 0, b = 1, c = 2, d = 3
Total/Results:

- **0-10 = not depressed**
- **12-18 = depressed.**
- **20+ = very depressed.**