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9. Mood Disorders (Depression and Mania)

9.1. Categories of Mood Disorders

9.2. Related Disorders

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*- Everyone occasionally feels sad, low, and tired, with the desire to stay in bed and shut out the world.
- These episodes often are accompanied by anergia (lack of energy), exhaustion, agitation, noise intolerance, and slowed thinking processes, all of which make decisions difficult.

- Work, family, and social responsibilities drive most people to proceed with their daily routines, even when nothing seems to go right and their irritable mood is obvious to all. Such “low periods” pass in a few days and energy returns.

- Fluctuations in mood are so common to the human condition that we think nothing of hearing someone say, “I’m depressed because I have too much to do.”

- Everyday use of the word depressed doesn’t actually mean that the person is clinically depressed but, rather, that the person is just having a bad day. Sadness in mood also can be a response to misfortune: death of a friend or relative, financial problems, or loss of a job may cause a person to grieve.

*- At the other end of the mood spectrum are episodes of exaggeratedly energetic behaviour.

- The person has the sure sense that he or she can take on any task or relationship.

- In an elated mood, energy for work, family, and social events is untiring. This feeling of being “on top of the world” also retreats in a few days to the average affect and activity.

- Happy events stimulate joy and enthusiasm. These mood alterations are normal and do not interfere meaningfully with the person’s life.

* **Mood Disorders**, also called **Affective Disorders**, are pervasive alterations in emotions that are manifested by depression, mania, or both.

- They interfere with a person’s life, troubling him or her with severe and long-term sadness, agitation, or elation. Accompanying self-doubt, guilt, and anger alter life activities, especially those that involve self-esteem, occupation, and relationships.

- Until the mid-1950s, no treatment was available to help people with serious depression or mania.

- These people suffered through their altered moods, thinking they were hopelessly weak to yield to these devastating symptoms.

- Family and mental health professionals tended to agree, seeing sufferers as egocentric or viewing life negatively. Although there are still no cures for mood disorders, effective treatments for both depression and mania are now available.

* **Mood Disorders** are the most common psychiatric diagnoses associated with suicide; depression is one of the most important risk factors for it.

* **Categories of Mood Disorders**

The primary mood disorders are:

1. Major Depressive Disorder

2. Bipolar Disorder (formerly called **Manic-depressive illness**).

* **A Major Depressive** episode lasts at **least 2 weeks**, during which the person experiences a **depressed mood** or **loss of pleasure** in nearly all activities.

- In addition, four of the following symptoms are present: changes in **appetite or weight, sleep, or psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation**, plans, or attempts.

- These symptoms must be present every day for 2 weeks and result in significant distress or impair social, occupational, or other important areas of functioning.

- Some people also have delusions and hallucinations; the combination is referred to as psychotic depression.

* **Bipolar Disorder** is diagnosed when a person's mood cycles between **extremes of mania and depression**.

* **Mania** is a different period during which mood is abnormally and persistently elevated, expansive, or irritable.

* **Hypomania** is a period of abnormally and persistently elevated, expansive, or irritable mood lasting **4 days** and including **three or four** of the additional symptoms described earlier.

* **Related Disorders**

Other disorders classified as mood disorders but with symptoms that are **less severe** or of **shorter duration** include the following:

- **Dysthymic disorder** is characterized by at least 2 years of depressed mood for more days than not with some additional, less severe symptoms that do not meet the criteria for a major depressive episode.

- **Cyclothymic disorder** is characterized by 2 years of numerous periods of both hypomanic symptoms that do not meet the criteria for bipolar disorder.

- **Substance-induced mood disorder** is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiologic consequence of ingested substances such as alcohol, other drugs, or toxins.

- **Mood disorder due to a general medical condition** is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiologic consequence of a medical condition such as degenerative neurologic conditions, cerebrovascular disease, metabolic or endocrine conditions, autoimmune disorders, human immunodeficiency virus (HIV) infections, or certain cancers.

* Other disorders that involve changes in mood include the following:

- **Seasonal Affective Disorder (SAD)** has two subtypes. In one, most commonly called winter depression or fall onset SAD, people experience increased sleep, appetite, and carbohydrate cravings (desires); weight gain; interpersonal conflict; irritability; and heaviness in the extremities beginning in late autumn and lessening in spring and summer. The other subtype, called spring-onset SAD, is less common, with symptoms of insomnia, weight loss, and poor appetite lasting from late spring or early summer until early fall. SAD is often treated with light therapy.

- **Postpartum or "maternity" blues** are a frequent normal experience after delivery of a baby. They are characterized by labile mood and affect, crying spells, sadness, insomnia, and anxiety. Symptoms begin approximately **1 day** after delivery, usually peak in 3 to 7 days, and subside rapidly with no medical treatment.

- **Postpartum depression** meets all the criteria for a major depressive episode, with onset within 4 weeks of delivery.

- **Postpartum psychosis** is a psychotic episode developing within 3 weeks of delivery and beginning with fatigue, sadness, emotional lability, poor memory, and confusion and progressing to delusions, hallucinations, poor insight and judgment, and loss of contact with reality. This medical emergency requires immediate treatment.

* Aetiology

- Various theories for the aetiology of mood disorders exist. The most recent research focuses on **chemical biologic imbalances** as the cause. Nevertheless, **psychosocial stressors** and **interpersonal events** appear to trigger certain physiologic and chemical changes in the brain, which significantly alter the balance of neurotransmitters.
- Effective treatment addresses both the **biologic** and **psychosocial components** of mood disorders.
- Thus, nurses need a basic knowledge of both perspectives when working with clients experiencing these disorders.

1. Biologic Theories

A. Genetic Theories

- Genetic studies implicate the transmission of major depression in first-degree relatives, who are at twice the risk for developing depression compared with the general population.
- First-degree relatives of people with bipolar disorder have a 3% to 8% risk for developing bipolar disorder compared with a 1% risk in the general population.
- For all mood disorders, monozygotic (identical) twins have a concordance rate (both twins having the disorder) two to four times higher than that of dizygotic (fraternal) twins. Although heredity is a significant factor, the concordance rate for monozygotic twins is not 100%, so genetics alone do not account for all mood disorders.

B. Neurochemical Theories

- Neurochemical influences of neurotransmitters (chemical messengers) focus on **serotonin** and **norepinephrine** as the two major biogenic amines implicated in mood disorders.

* **Serotonin** has many roles in **behaviour: mood, activity, aggressiveness and irritability, cognition, pain, biorhythms, and neuroendocrine processes** (i.e., growth hormone, cortisol, and prolactin levels are abnormal in depression).

- **Deficits of serotonin**, its precursor tryptophan, or a metabolite of serotonin found in the blood or cerebrospinal fluid occur in people with depression. Positron emission tomography demonstrates reduced metabolism in the prefrontal cortex, which may promote depression.

- **Norepinephrine levels** may be deficient in depression and increased in mania. This catecholamine energizes the body to mobilize during stress and inhibits kindling.

- **Dysregulation of acetylcholine and dopamine** also is being studied in relation to mood disorders.

- Cholinergic drugs alter mood, sleep, neuroendocrine function, and the electroencephalographic pattern; therefore, acetylcholine seems to be implicated in depression and mania.

C. Neuroendocrine Influences

- Hormonal fluctuations are being studied in relation to depression. Mood disturbances have been documented in people with endocrine disorders such as those of the thyroid, adrenal, parathyroid, and pituitary glands.

2. Psychodynamic Theories

- Many psychodynamic theories about the cause of mood disorders seemed to “blame the victim” and his or her family:

- **Freud** looked at the self-depreciation of people with depression and attributed that self-criticism to anger turned inward related to either a real or perceived loss. Feeling abandoned by this loss, people became angry while both loving and hating the lost object.
- **Bibring** believed that one's ego (or self) aspired to be ideal (i.e., good and loving, superior or strong) and that to be loved and worthy, one must achieve these high standards. Depression results when, in reality, the person was not able to achieve these ideals all the time.
- **Jacobson** compared the state of depression with a situation in which the ego is a powerless, helpless child victimized by the superego, much like a powerful and aggressive mother who takes delight in torturing the child.
- **Most psychoanalytical theories** of mania view manic episodes as a "defence" against underlying depression, with the id taking over the ego and acting as an undisciplined hedonistic being (child).
- **Meyer** viewed depression as a reaction to a distressing life experience such as an event with psychic causality.
- **Horney** believed that children raised by rejecting or unloving parents were prone to feelings of insecurity and loneliness, making them susceptible to depression and helplessness.
- **Beck** saw depression as resulting from specific cognitive distortions in vulnerable people. Early experiences shaped distorted ways of thinking about one's self, the world, and the future; these distortions involve magnification of negative events, traits, and expectations and simultaneous minimization of anything positive.

1. Major Depressive Disorder

- Major depressive disorder typically involves 2 or more weeks of a sad mood or lack of interest in life activities with at least four other symptoms of depression such as anhedonia and changes in weight, sleep, energy, concentration, decision making, self-esteem, and goals.
- Major depression is twice as common in women and has a 1.5 to 3 times greater incidence in first-degree relatives than in the general population.
- Incidence of depression decreases with age in women and increases with age in men.
- Single and divorced people have the highest incidence. Depression in pre-pubertal boys and girls occurs at an equal rate.

Onset and Clinical Course

- An untreated episode of depression can last 6 to 24 months before remitting. Fifty to sixty percent of people who have one episode of depression will have another. After a second episode of depression, there is a 70% chance of recurrence. Depressive symptoms can vary from mild to severe. The degree of depression is comparable with the person's sense of helplessness and hopelessness. Some people with severe depression (9%) have psychotic features.

DSM Diagnostic Criteria of Major Depressive Disorder:

Symptoms of Major Depressive Disorder

- Depressed mood
- Anhedonism (decreased attention to and enjoyment from previously pleasurable activities)
- Unintentional weight change of 5% or more in a month
- Change in sleep pattern
- Agitation or psychomotor retardation
- Tiredness

- Worthlessness or guilt inappropriate to the situation (possibly delusional)
- Difficulty thinking, focusing, or making decisions
- Hopelessness, helplessness, and/or suicidal ideation

Treatment and Prognosis

Psychopharmacology

Major categories of antidepressants include cyclic antidepressants, monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), and atypical antidepressants. The choice of which antidepressant to use is based on the client's symptoms, age, and physical health needs; drugs that have or have not worked in the past or that have worked for a blood relative with depression; and other medications that the client is taking.

1. Selective Serotonin Reuptake Inhibitors (SSRIs), the newest category of antidepressants (Table 1), are effective for most clients. Their action is specific to serotonin reuptake inhibition; these drugs produce few sedating, anticholinergic, and cardiovascular side effects, which make them safer for use in older adults. Because of their low side effects and relative safety, people using SSRIs are more apt to be compliant with the treatment regimen than clients using more troublesome medications. Insomnia decreases in 3 to 4 days, appetite returns to a more normal state in 5 to 7 days, and energy returns in 4 to 7 days. In 7 to 10 days, mood, concentration, and interest in life improve.

Fluoxetine (Prozac) produces a slightly higher rate of mild agitation and weight loss but less somnolence. It has a half-life of more than 7 days, which differs from the 25-hour half-life of other SSRIs.

Table 1: Selective Serotonin Reuptake Inhibitor (SSRI) Antidepressants

Generic (Trade) Name	Side Effects	Nursing Implications
Fluoxetine (Prozac)	Headache, nervousness, anxiety, sedation, tremor, sexual dysfunction, anorexia, constipation, nausea, diarrhea, and weight loss	Administer in AM (if nervous) or PM (if drowsy). Monitor for hyponatremia (lack of Sodium). Encourage adequate fluids. Report sexual difficulties to physician.
Sertraline (Zoloft)	Dizziness, sedation, headache, insomnia, tremor, sexual dysfunction, diarrhoea, dry mouth and throat, nausea, vomiting, and sweating	Administer in PM if client is drowsy. Encourage use of sugar-free beverages or hard candy. Drink adequate fluids. Monitor hyponatremia; report sexual difficulties to physician.
Paroxetine (Paxil)	Dizziness, sedation, headache, insomnia, weakness, fatigue, constipation, dry mouth and throat, nausea, vomiting, diarrhea, and sweating	Administer with food. Administer in PM if client is drowsy. Encourage use of sugar-free hard candy or beverages. Encourage adequate fluids.
Citalopram (Celexa)	Drowsiness, sedation, insomnia, nausea, vomiting, weight gain, constipation, and diarrhea	Monitor for hyponatremia. Administer with food. Administer dose at 6 PM or later. Promote balanced nutrition and exercise.
Escitalopram (Lexapro)	Drowsiness, dizziness, weight gain, sexual dysfunction, restlessness, dry mouth, headache, nausea, and diarrhea	Check orthostatic blood pressure. Assist client to rise slowly from sitting position. Encourage use of sugar-free beverages or hard candy. Administer with food.

Cyclic Antidepressants: Tricyclics, introduced for the treatment of depression in the mid-1950s, are the oldest antidepressants. They relieve symptoms of hopelessness, helplessness, anhedonia, inappropriate guilt, suicidal ideation, and daily mood variations (irritable in the morning and better in the evening). Other indications include panic disorder, obsessive-compulsive disorder, and eating disorders. Each drug has a different degree of efficacy in blocking the activity of norepinephrine and serotonin or increasing the sensitivity of postsynaptic receptor sites. Tricyclic and heterocyclic antidepressants have a delay period of 10 to 14 days before reaching a serum level that begins to alter

symptoms; they take 6 weeks to reach full effect. Because they have a long serum half-life, there is a lag period of 1 to 4 weeks before steady plasma levels are reached and the client's symptoms begin to decrease. They cost less primarily because they have been around longer and generic forms are available.

Tricyclic antidepressants are contraindicated in severe impairment of liver function and in myocardial infarction (acute recovery phase). They cannot be given concurrently with MAOIs. Because of their anticholinergic side effects, tricyclic antidepressants must be used cautiously in clients who have glaucoma, benign prostatic hypertrophy, urinary retention or obstruction, diabetes mellitus, hyperthyroidism, cardiovascular disease, renal impairment, or respiratory disorders (Table 2).

Over dosage of tricyclic antidepressants occurs over several days and results in confusion, agitation, hallucinations, hyperpyrexia, and increased reflexes. Seizures, coma, and cardiovascular toxicity can occur with ensuing tachycardia, decreased output, depressed contractility, and atrioventricular block. Because many older adults have concomitant health problems, cyclic antidepressants are used less often in the geriatric population than newer types of antidepressants that have fewer side effects and less drug interactions.

Tetracyclic Antidepressants: Amoxapine (Asendin) may cause extrapyramidal symptoms, tardive dyskinesia, and neuroleptic malignant syndrome. It can create tolerance in 1 to 3 months. It increases appetite and causes weight gain and cravings for sweets.

Maprotiline (Ludiomil) carries a risk for seizures (especially in heavy drinkers), severe constipation and urinary retention, stomatitis, and other side effects; this leads to poor compliance. The drug is started and withdrawn gradually. Central nervous system depressants can increase the effects of this drug.

Table 2: Tricyclic Antidepressant Medications

Generic (Trade Name)	Side Effects	Nursing Implications
Amitriptyline (Elavil)	Dizziness, orthostatic hypotension, tachycardia, sedation, headache, tremor, blurred vision, constipation, dry mouth and throat, weight gain, urinary hesitancy, and sweating	Assist client to rise slowly from sitting position. Administer at bedtime. Encourage use of sugar-free beverages and hard candy. Ensure adequate fluids and balanced nutrition. Encourage exercise. Monitor cardiac function.
Amoxapine (Asendin)	Dizziness, orthostatic hypotension, sedation, insomnia, constipation, dry mouth and throat, and rashes	Assist client to rise slowly from sitting position. Administer at bedtime if client is sedated. Ensure adequate fluids. Encourage use of sugar-free beverages and hard candy. Report rashes to physician.
Doxepin (Sinequan)	Dizziness, orthostatic hypotension, tachycardia, sedation, blurred vision, constipation, dry mouth and throat, weight gain, and sweating	Assist client to rise slowly from sitting position. Administer at bedtime if client is sedated. Ensure adequate fluids and balanced nutrition. Encourage use of sugar-free beverages and hard candy. Encourage exercise.
Imipramine (Tofranil)	Dizziness, orthostatic hypotension, weakness, fatigue, blurred vision, constipation, dry mouth and throat, and weight gain	Assist client to rise slowly from sitting or supine position. Ensure adequate fluids and balanced nutrition. Encourage use of sugar-free beverages and hard candy. Encourage exercise.
Desipramine (Norpramine)	Cardiac dysrhythmias, dizziness, orthostatic hypotension, excitement, insomnia, sexual dysfunction, dry mouth and throat, and rashes	Monitor cardiac function. Assist client to rise slowly from sitting position. Administer in AM if client is having insomnia. Encourage sugar-free beverages and hard candy. Report rashes or sexual difficulties to physician.
Nortriptyline (Pamelor)	Cardiac dysrhythmias, tachycardia, confusion, excitement, tremor, constipation, and dry mouth and throat	Monitor cardiac function. Administer in AM if stimulated. Ensure adequate fluids. Encourage use of sugar-free beverages and hard candy. Report confusion to physician.

Atypical Antidepressants: Atypical antidepressants are used when the client has an inadequate response to or side effects from SSRIs. Atypical antidepressants include venlafaxine (Effexor), duloxetine (Cymbalta), bupropion (Wellbutrin), nefazodone (Serzone), and mirtazapine (Remeron) (Table 3).

Venlafaxine blocks the reuptake of serotonin, norepinephrine, and dopamine (weakly). Duloxetine selectively blocks both serotonin and norepinephrine. Bupropion modestly inhibits the reuptake of norepinephrine, weakly inhibits the reuptake of dopamine, and has no effects on serotonin. Bupropion is marketed as Zyban for smoking cessation.

Nefazodone inhibits the reuptake of serotonin and norepinephrine and has few side effects. Its half-life is 4 hours, and it can be used in clients with liver and kidney disease. It increases the action of certain benzodiazepines (alprazolam, estazolam, and triazolam) and the H₂ blocker terfenadine. Remeron also inhibits the reuptake of serotonin and norepinephrine, and it has few sexual side effects; however, its use comes with a higher incidence of weight gain, sedation, and anticholinergic side effects.

Table 3: Atypical Antidepressants

Generic (Trade) Name	Side Effects	Nursing Implications
Venlafaxine (Effexor)	Increased blood pressure and pulse, nausea, vomiting, headache, dizziness, drowsiness, dry mouth, and sweating; can alter many lab tests, e.g., AST, ALT, alkaline phosphatase, creatinine, glucose, and electrolytes	Administer with food. Ensure adequate fluids. Give in PM. Encourage use of sugar-free beverages or hard candy.
Duloxetine (Cymbalta)	Increased blood pressure and pulse, nausea, vomiting, drowsiness or insomnia, headache, dry mouth, constipation, lowered seizure threshold, and sexual dysfunction	Administer with food. Ensure adequate fluids. Encourage use of sugar-free beverages or hard candy. Give with food.
Bupropion (Wellbutrin)	Nausea, vomiting, lowered seizure threshold, agitation, restlessness, insomnia, may alter taste, blurred vision, weight gain, and headache	Administer dose in AM. Ensure balanced nutrition and exercise.
Nefazodone (Serzone)	Headache; dizziness; drowsiness; alters results of AST, ALT, LDH, cholesterol, glucose, and hematocrit	Administer before meal (food inhibits absorption). Monitor liver and kidney functions
Mirtazapine (Remeron)	Sedation, dizziness, dry mouth and throat, weight gain, sexual dysfunction, and constipation	Administer in PM. Encourage use of sugar-free beverages and hard candy. Ensure adequate fluids and balanced nutrition. Report sexual difficulties to physician.

Monoamine Oxidase Inhibitors: MAOIs are used infrequently because of potentially fatal side effects and interactions with numerous drugs, both prescription and over-the-counter preparations (Table 4). The most serious side effect is hypertensive crisis, a life-threatening condition that can result when a client taking MAOIs ingests tyramine-containing foods and fluids or other medications. Symptoms are occipital headache, hypertension, nausea, vomiting, chills, sweating, restlessness, nuchal rigidity, dilated pupils, fever, and motor agitation. These can lead to hyperpyrexia, cerebral hemorrhage, and death. The MAOI-tyramine interaction produces symptoms within 20 to 60 minutes after ingestion. For hypertensive crisis, transient antihypertensive agents, such as phentolamine mesylate, are given to dilate blood vessels and decrease vascular resistance.

There is a 2- to 4-week delay period before MAOIs reach therapeutic levels. Because of the delay period, adequate washout periods of 5 to 6 weeks are recommended between the times that the MAOI is discontinued and another class of antidepressant is started.

Table 4: Monoamine Oxidase Inhibitor (MAOI) Antidepressants

Generic (Trade) Name	Side Effects	Nursing Implications
Isocarboxazid (Marplan)	Drowsiness, dry mouth, overactivity, insomnia, nausea, anorexia, constipation, urinary retention, and orthostatic hypotension	Assist client to rise slowly from sitting position. Administer in AM.
Phenelzine (Nardil)		Administer with food. Ensure adequate fluids.
Tranlycypromine (Parnate)		Perform essential teaching on importance of low-tyramine diet.

Other Medical Treatments and Psychotherapy

Electroconvulsive Therapy: Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select groups, such as:

- Clients who do not respond to antidepressants or
- Those who experience intolerable side effects at therapeutic doses (particularly true for older adults).
- In addition, pregnant women can safely have ECT with no harm to the fetus.

* Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication.

- ECT involves application of electrodes to the head of the client to deliver an electrical impulse to the brain; this causes a seizure. It is believed that the shock stimulates brain chemistry to correct the chemical imbalance of depression. Historically, clients did not receive any anesthetic or other medication before ECT, and they had full-blown grand mal seizures that often resulted in injuries ranging from biting the tongue to breaking bones. ECT fell into disfavor for a period and was seen as “barbaric.” Today, although ECT is administered in a safe and humane way with almost no injuries, there are still critics of the treatment.

- Clients usually receive a series of 6 to 15 treatments scheduled thrice a week. Generally, a minimum of six treatments are needed to see sustained improvement in depressive symptoms. Maximum benefit is achieved in 12 to 15 treatments. Preparation of a client for ECT is similar to preparation for any outpatient minor surgical procedure: The client receives nothing by mouth (or, is NPO) after midnight, removes any fingernail polish, and voids just before the procedure. An intravenous line is started for the administration of medication.

- Initially, the client receives a short-acting anesthetic so he or she is not awake during the procedure. Next, he or she receives a muscle relaxant/paralytic, usually succinylcholine, which relaxes all muscles to reduce greatly the outward signs of the seizure (e.g., clonic tonic muscle contractions). Electrodes are placed on the client’s head: one on either side (bilateral) or both on one side (unilateral). The electrical stimulation is delivered, which causes seizure activity in the brain that is monitored by an electroencephalogram, or EEG. The client receives oxygen and is assisted to breathe with an Ambubag.

- He or she generally begins to waken after a few minutes. Vital signs are monitored, and the client is assessed for the return of a gag reflex.

- After ECT treatment, the client may be mildly confused or briefly disoriented. He or she is very tired and often has a headache. The symptoms are just like those of anyone who has had a grand mal seizure. In addition, the client will have some short-term memory impairment. After a treatment, the client may eat as soon as he or she is hungry and usually sleeps for a period. Headaches are treated symptomatically.

- Unilateral ECT results in less memory loss for the client, but more treatments may be needed to see sustained improvement. Bilateral ECT results in more rapid improvement but with increased short-term memory loss.
- The literature continues to be divided about the effectiveness of ECT. Some studies report that ECT is as effective as medication for depression, whereas other studies report only short-term improvement.
- Likewise, some studies report that memory loss side effects of ECT are short lived, whereas others report they are serious and long term.
- ECT is also used for relapse prevention in depression. Clients may continue to receive treatments, such as one per month, to maintain their mood improvement. Often, clients are given antidepressant therapy after ECT to prevent relapse. Studies have found maintenance ECT to be effective in relapse prevention.

Psychotherapy: A combination of psychotherapy and medications is considered the most effective treatment for depressive disorders. There is no one specific type of therapy that is better for the treatment of depression. The goals of combined therapy are symptom remission, psychosocial restoration, and prevention of relapse or recurrence, reduced secondary consequences such as marital discord or occupational difficulties, and increasing treatment compliance.

- **Interpersonal therapy** focuses on difficulties in relationships, such as grief reactions, role disputes, and role transitions. Interpersonal therapy helps the person to find ways to accomplish this developmental task.
- **Behavior therapy** seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions. It also may focus on improving social skills.
- **Cognitive therapy** focuses on how the person thinks about the self, others, and the future and interprets his or her experiences. This model focuses on the person's distorted thinking, which, in turn, influences feelings, behavior, and functional abilities.

Investigational Treatments: Other treatments for depression are being tested. These include transcranial magnetic stimulation (TMS), magnetic seizure therapy, deep brain stimulation, and vagal nerve stimulation. TMS is the closest to approval for clinical use. These novel brain-stimulation techniques seem to be safe, but their efficacy in relieving depression needs to be established.

Nursing Interventions for Depression

- Provide for the safety of the client and others.
- Institute suicide precautions if indicated.
- Begin a therapeutic relationship by spending non-demanding time with the client.
- Promote completion of activities of daily living by assisting the client only as necessary.
- Establish adequate nutrition and hydration.
- Promote sleep and rest.
- Engage the client in activities.
- Encourage the client to verbalize and describe emotions.
- Work with the client to manage medications and side effects.

Assist. Professor
Dr. Maan Hameed Ibrahim
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