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**I. HORBACHEVSKY TERNOPIL NATIONAL MEDICAL UNIVERSITY OF THE MINISTRY OF HEALTH OF UKRAINE**


**UDC: 616.89-008.454-083**

**Nargiz Melik**

**Master's Thesis**

# SPECIAL ASPECTS OF NURSING CARE FOR PATIENTS WITH DEPRESSION

**Master of Science in Nursing**

**The Scientific Supervisor of the Thesis:**
**associate prof. Olha Krekhovska-Lepiavko, MD, PhD, MSN**
**I. Horbachevsky Ternopil National Medical University**
**of the Ministry of Health of Ukraine**

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# MASTER THESIS ABSTRACT

The relevance of depression is chiefly determined by its increasing prevalence. In recent decades, depression is no longer a merely psychiatric problem. There are more and more discussions and publications on depression in patients with somatic disease. Depression is a type of affective disorder (mood disorder). However, it differs from conventional mood swings or short-term emotional responses to difficult situations in everyday life. Depression may be a serious disease, especially if it recurs and is moderate or severe. In such cases, depression leads to more suffering, reduced working capacity/academic performance and problems in patient's family life. In the most severe cases, depression may lead to suicide. Depression is not only about suicidal thoughts and actions; this condition substantially deteriorates the quality of life of the patients. Early diagnosis may improve treatment outcomes and will allow the patients to feel better and to have more strength for implementation of their plans. Involvement of nursing personnel in diagnosis, treatment and care will be a significant factor in improving the current situation. Based on global experience in treatment of patients with depression, to provide scientific rationale for the principles guiding the organization of nursing process in this disease, as well as the goals and the structure of this process. The methods of study: epidemiological, statistical and clinical methods (observation, comparison and measurement). The results of the research study deepen the knowledge of the etiological factors and pathogenesis of depression, its diagnostic criteria and principles of treatment. In course of the study, the investigator has defined the main objectives, structure and methods of nursing process in patients with depression. The study has determined the typical problems of patients with depression and evaluated their quality of life.

**TABLE OF CONTENTS**

# LIST OF ABBREVIATIONS

**CBT** = cognitive behavioral therapy

**CNS** = central nervous system

**ECT** = electroconvulsive therapy

**WHO** = World Health Organization

# INTRODUCTION

**Depression** is a mental disorder whose main features include reduced (inhibited, depressed, melancholic, anxious, fearful or indifferent) mood, reduction or loss of ability to experience pleasure (anhedonia), and loss of interest in life and usual activities [36]. Some of the following symptoms are usually also present: low self-esteem, irrational sensation of guilt, pessimism, impaired concentration, fatigue or lack of energy, sleep and appetite disorders, suicidal tendencies [2]. In some cases a person with depression may start abusing psychoactive substances [10].

Severe types of depression are characterized by the so-called "depressive triad", i.e. low mood, inhibited thinking and motor retardation [35].

In some cases, a depressed mood may be a normal temporary response to significant events in life, such as loss of a loved one [36]. Depression can be a symptom of certain medical conditions and a side effect of certain medications and treatments; however, if the cause of the depression is not apparent and a depressive disorder develops without any external stimuli, such depression is referred to as endogenous depression [44].

***Epidemiology.*** Currently, depression is the most prevalent mental disorder, affecting 3.8% of global population, including 5% of adults and 5.7% of persons over 60 years of age [24]. Approximately 280 million people suffer from depression worldwide [26]. This condition affects one in ten individuals over 40 years of age, with two thirds of these patients being females [29]. Females develop depression much more frequently than males. One of the fundamental causes of female depression is the mental stress of women, which is substantially different from that in men [30].

Depression is three times more frequent among people over 65 years of age [16]. Depression and depressive conditions affect approximately 5% of children and adolescents 10-16 years of age [31]. The total prevalence of depression (of all types) in young people is from 15% to 40% [50]. Many authors argue that the higher prevalence of affective disorders in this age group correlates with a higher suicide rate [12]. Depression occurs in 25-77% of terminally ill people [17].

***The relevance of the study.*** The relevance of depression is chiefly determined by its increasing prevalence [26]. In recent decades, depression is no longer a merely psychiatric problem. There are more and more discussions and publications on depression in patients with somatic disease [35]. Depression is a type of affective disorder (mood disorder). However, it differs from conventional mood swings or short-term emotional responses to difficult situations in everyday life [2]. Depression may be a serious disease, especially if it recurs and is moderate or severe. In such cases, depression leads to more suffering, reduced working capacity/academic performance and problems in patient's family life [44]. In the most severe cases, depression may lead to suicide [43]. More than 700,000 people worldwide commit suicide every year. Suicide ranks fourth among the leading causes of death in young people 15-29 years of age [12].

Despite the existence of known and effective treatments for mental disorders, more than 75% of people in low- and middle-income countries receive no treatment for their depression [13]. The factors that hinder access to effective treatment include lack of resources, lack of trained health workers, and social stigmatization of people with mental disorders [5]. In all countries, regardless of income level, depression is often not diagnosed in people who actually suffer from it. Too frequently, this diagnosis is made in people who actually do not have depression, but who nevertheless are prescribed antidepressants [11]. For up to 80% of people with depressive disorders, a general practitioner or a family physician is the medical professional of initial contact. A correct diagnosis is made in approximately 5% of these patients; therefore, adequate treatment is used in even fewer patients [35].

Also, as reported by the World Health Organization (WHO), depression is a leading cause of adolescent morbidity and disability. The economic and socio-medical significance of this disease is also enormous; medical costs (direct and indirect) account for approximately 5 billion euros per year [17].

Depression is one of the priority diseases within the framework of mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use (MNS) disorders. The goal of the program is to help countries scale up the services provided to individuals with mental, neurological and substance use disorders by involving

non-mental healthcare medical professionals to provide care for this patient population [24].

The systemic impact of depression in human body is multifaceted. At the initial stages, the behavioral aspect is of critical importance, when persistently low mood, pessimism and being focused on sickness are leading to hypochondriacal introspection and minimizing mental and physical challenges. There is impaired communication capacity of the individual and reduced treatment compliance [44]. It should also be kept in mind that depression has a direct adverse effect on a number of organs and systems in the body, including the autonomous nervous system and systemic and cerebral circulation [35].

The eating disorders that accompany depression affect the patient's appetite and body weight. There are possible fluctuations of body weight both upward and downward [47].

Another aspect of depressive behavior is that the patients are prone to alcohol abuse and smoking, that is, the habits that are by themselves risk factors for development and progression of somatic disease [20].

The role of nursing personnel in organization of therapeutic process and patient care for patients with depression can hardly be overemphasized, since it accommodates a broad scope of issues, without which the very implementation of a therapeutic approach to patients and, ultimately, the registration of remission states or recovery would be impossible [49]. This is not merely a mechanical implementation of medical prescriptions and recommendations, but rather a pool of creative solutions to daily challenges, which include the direct conduct of medical processes (e.g. dispensing drugs, parenteral administration of drugs, implementation of procedures), which should be carried out taking into account and with the knowledge of possible side effects and complications [37]. This ultimately involves taking responsibility for a range of therapeutic interventions. Preparing the patient for a particular procedure or event expects a lot of effort and skills on the part of the nurse; it also calls for knowing the psychology of the patient and the nature of their mental disorder [46].

Depression is not only about suicidal thoughts and actions; this condition substantially deteriorates the quality of life of the patients [12]. Early diagnosis may

improve treatment outcomes and will allow the patients to feel better and to have more strength for implementation of their plans [35]. Involvement of nursing personnel in diagnosis, treatment and care will be a significant factor in improving the current situation [49].

## The aim of the study

Based on global experience in treatment of patients with depression, to provide scientific rationale for the principles guiding the organization of nursing process in this disease, as well as the goals and the structure of this process.

## Study objectives

1. To investigate the etiological factors and the pathogenesis of depression and its diagnostic criteria. To characterize the principles of treatment and the modern techniques employed.

2. To define the goals, the structure and the methods of nursing care when working with patients with depression.

3. To identify the typical problems of patients with depression and to evaluate the quality of nursing care.

## The object of the study

Nursing process in depression.

## The subject of research

The factors that define the quality of nursing care in patients with depression.

## The methods of study:

Epidemiological, statistical and clinical methods (observation, comparison and measurement).

## The scientific and practical value of the study.

The results of the research study deepen the knowledge of the etiological factors and pathogenesis of depression, its diagnostic criteria and principles of treatment. In course of the study, the investigator has defined the main objectives, structure and methods of nursing process in patients with depression. The study has determined the typical problems of patients with depression and evaluated their quality of life.

# CHAPTER 1.
# ETIOLOGICAL FACTORS AND PATHOGENESIS OF DEPRESSION, ITS CLINICAL COURSE AND SPECIFIC ASPECTS OF DIAGNOSIS AND TREATMENT (REVIEW OF LITERATURE)

## 1.1. Etiology and pathogenesis of depression.

Depression may result from a traumatic experience; for example, from loss of a loved one, a job or a social status. In such cases, the patient's condition is assessed as a reactive (psychogenic) depression [4]. It develops as a response to an external event or situation. According to some theories, sometimes depression occurs when the brain is overburdened as a result of stress, which can be underlain by both physiological and psychosocial factors [36]. Some personality traits, such as perfectionism, may predispose to depression [47].

Traumatic childhood experiences may be a risk factor for depression in adults; for instance, child abuse may become a prerequisite for future development of depression [31]. It is believed that the unfolding of depressogenic convictions may be supported by such factors as loss of a parent in childhood; having a parent with low esteem of the child and/or themselves or a parent with excessively hard and rigid persuasions; lack of adequate social experience or social skills; having negative experiences of interacting with peers and/or siblings; the child with a physical defect [50].

In many people spending many days in a sunless weather or in those staying for prolonged periods in dark/artificially lighted premises, depression may develop due to lack of sunlight. This variant of depression is referred to as seasonal depression or seasonal affective disorder, since it is mostly observed in patients in autumn and winter. The treatment for seasonal depression includes walks in sunny weather or phototherapy [4].

Depression can develop as a side effect of certain medications (e.g. levodopa, corticosteroids, benzodiazepines); this is the so-called iatrogenic or pharmacogenic depression. Most of the time, such depression resolves on its own or subsides after discontinuation of the offending drug [42]. Antipsychotic depression (due to the use

of antipsychotics) can last from several months to 1.5 years and are often vital in nature [4]. The causes of depression often include the abuse of alcohol, sedatives or hypnotics, opiates, as well as cocaine and other psychostimulant drugs [19].

Depressions may also be somatic or, to be more precise, somatogenic, i.e. due to somatic disease (e.g., Alzheimer's disease, atherosclerosis of cerebral arteries, traumatic brain injury or influenza) [4]. In clinical practice, there are frequent cases of misdiagnosis and inadequate treatment of depression in people with medical conditions, when the actual cause of depression (that is, the medical condition or its treatment) is not taken into account [35].

The factors potentially underlying somatogenic depression are numerous. In patients with neurological disorders, the incidence of depression is as high as 40-50%; depression is often found in patients with medical conditions that directly affect central nervous system (CNS) (e.g., depression develops in 60% of patients with Cushing's disease). Patients with hypothyroidism are remarkably prone to depression [4]. The prevalence of depression in lack of adequate thyroid function is as high as 50%, and the life-long risk of developing depressive disorders in patients with hypothyroidism is 7 times higher compared to healthy individuals [17]. Symptoms of depression often come to the fore, appearing several years before the development of an overt clinical presentation of hypothyroidism, and dominate in patient's complaints [2].

In addition, pregnancy and childbirth are major risk factors for the development of depression: up to 10% of women experience depression during pregnancy; postpartum depression is observed in 12-16% of women who have given birth [47].

However, if the psychological, iatrogenic or somatic causes of depression are absent or not apparent, such depression is referred to as endogenous, that is, "occurring from within" [44]. In approximately one third (35%) of cases, manifest depressions occur autochthonously, that is, without any external effects [18]. In terms of their structure, such depressions are endogenous from the very beginning [4].

There is currently no clear understanding of the neurobiological causes behind clinical depression (i.e. major depressive disorder). The research community offers a

number of hypotheses, none of which is currently supported by conclusive evidence [8]. Clearly, depression is a heterogeneous disorder from both clinical and etiological viewpoints. [35].

The monoamine theory links the development of depression to a deficiency of biogenic amines, namely serotonin, norepinephrine and dopamine. [22]. Some scholars conclude that this theory lacks broad understanding, since it fails to explain the efficacy limitations of antidepressants and the slow build-up of their therapeutic effect [44]. Although the serotonin hypothesis is widely accepted, there is no rigorous evidence to support this hypothesis: modern neuroscience research failed to confirm the hypothesis that depression is underlain by serotonin deficiency [47].

Scientists also view depression as an evolutionarily anchored reasoning mechanism. According to the hypothesis of analytical reflection, depression has been anchored in course of evolution as a mechanism allowing the individual to stay focused on solving complex problems [23]. The avoidance behavior in depression is, first of all, enabling the individual to circumvent the process, which humans use to cope with painful feelings (otherwise remaining when assuming an analytical approach to problem-solving and occurring as a result of consideration and use of compromises) [40]. Secondly, depression is a poorly adapted side product of propensity to an action that provides a rapid pain-soothing effect. Thirdly, depression is occurring in those social environments, where there are the available means for implementation of avoidance behavior [4].

There is also a cognitive model of depression. The partisans of cognitive psychotherapy believe that in many cases depression is attributable to and supported by dysfunctional beliefs, usually developing in childhood, and activated in an adult by a specific life event, which has served as a trigger for depression [31]. These dysfunctional beliefs predispose the patients to the characteristic reasoning biases, which underlay the so-called cognitive triad of depression: the person with depression usually has low self-esteem, low esteem of people in their immediate surroundings and low esteem of their future. Depressed patients have a consistently distorted perception of events, finding them to support the understanding of their own worthlessness, as well as the negative views of the world around them and of their

future. There may be such characteristic reasoning biases as contingency bias, “all-or-nothing” thinking, overgeneralization, selective abstraction and exaggeration [32]. In addition to the negative triad, i.e. the negative perception of themselves, their future, and the world, people with depression tend to be fixated on an idea of actual or perceived loss (thoughts about the death of loved ones, about relationship breakup, about the frustration of their hopes and about being unable to reach meaningful goals) [54]. Depressed patients are also characterized by their rigid and imperative convictions. More often than healthy people they use such imperative speech patterns as “must”, “has to”, “ought to”; Aaron Beck, the father of cognitive therapy, referred to such convictions as the “tyranny of oughtness” (for example, a depressed patient may assume they “ought to find a solution to any problem quickly and without anyone's help”, that they “ought to understand everything, know everything and foresee everything”, or that they “never ought to suffer, and ought to be always happy and serene”) [32].

According to the cognitive model, the equally important etiological components of depressive disorders include convictions, behavior and biochemical processes; these constituents reflect different levels of analysis, and none of them has a greater priority than the other [32]. Each therapeutic approach has its own point of application: the pharmacologist performs an intervention on the biochemical level, and the cognitive psychotherapist intervenes on cognitive, affective and behavioral levels. At the same time, the change in depressive convictions is linked to the changes in the predominant mood and behavior, as confirmed by certain data on the biochemistry of depression [35].

### 1.2. Diagnosis of depression: formal criteria.

The diagnosis of depression by general practitioners is challenging due to the fact that in almost half of the cases the patients are silent about the symptoms of depression [2]. Many patients are afraid of antidepressants and their side effects; some believe that keeping their emotions in check is their personal business, and not the doctor’s business; there are also concerns that the mention of depression may appear in the person’s medical record and will somehow become known to the

employer; some people are afraid of being referred to a psychiatrist [20]. This shows that in cases when depression cannot be decisively ruled out, general practitioners should use screening tools more actively, including short questionnaires. It is advisable to conduct such screening in all pregnant women. [27]. Beck's Depression Inventory [44] is often used as a tool to screen for and to assess the severity of depression.

The diagnosis of depression involves several fundamentally different objectives, namely: screening for depression, clinical assessment of depression (using questionnaires and by the physician), measurement of individual depression-associated symptoms (such as anxiety, anhedonia and suicidal activity) [35].

As of today, the diagnostic options largely defining the selection of treatment (antidepressants, psychotherapy) are more based on physicians' experience and the use of questionnaires than on objective, qualitative and measurable criteria [19]. In all patients with mood disorders, it is recommended to conduct assessments to rule out any somatic causes of depression, including assessment of thyroid function, that is, the detection of hypothyroidism or hyperthyroidism [2].

***Formal diagnostic criteria based on ICD-10.***

Depressive symptoms are divided into typical (main) symptoms and complementary symptoms. According to ICD-10, there must be two main symptoms and at least three complementary symptoms in order for the patient to be diagnosed with depression [44].

The typical (main) symptoms of depression include the following [44]:

- circumstances-independent dysphoria over a long period of time (two weeks and longer);
- anhedonia, i.e. inability to have interest in or experience pleasure from the previously enjoyable activities;
- pronounced fatigue/low energy level, when this condition is characterized by being stable over a considerable time period (for instance, over a month's time).

Additional symptoms:

- pessimism;

- sense of guilt, worthlessness, anxiety and/or fear;
- low self-esteem;
- inability to concentrate and to make decisions;
- thoughts about dying and/or suicide;
- unstable appetite; remarkable weight loss or weight gain;
- glycogeusia;
- impaired sleep pattern; insomnia or oversleeping.

According to ICD-10 diagnostic criteria, the diagnosis of depressive disorder is made if the duration of symptoms is not less than 2 weeks. However, the diagnosis can be made even for shorter periods if the symptoms are unusually severe or developing rapidly [44].

In children, depression is far less frequent than in adults. The symptoms of pediatric depression include the following [54]:

- loss of appetite;
- sleep disorders (nightmares);
- previously unknown problems with academic performance;
- character problems: being withdrawn, pouting, aggressiveness and/or vulnerability.

***Formal diagnostic criteria based on DSM-IV-TR.***

According to DSM-IV-TR diagnostic criteria, 5 or more of the below 9 symptoms should be present for 2 weeks (and these symptoms should include at least 1 of two main symptoms, i.e. depressed mood and/or loss of interests or ability to experience pleasure) [7]:

- depressed mood (in children and adolescents it may manifest as irritability/touchiness) and/or loss of interests or ability to experience pleasure;
- significant reduction of ability to experience pleasure or interest in all or almost all activities;
- weight loss and reduced appetite (increased appetite and increased body weight is possible);
- insomnia (hypersomnia is possible);
- psychomotor agitation or inhibition;

- reduced energy level and increased fatigue;
- feelings of worthlessness and low self-esteem or inadequate guilt;
- inhibited thinking or reduced mental alertness/ability to focus;
- suicidality.

### 1.3. Major types of depression.

The two distinctive types of depressive disorders are ***unipolar depression***, where the mood remains within a single low pole, and ***bipolar depression***, which is part of bipolar disorder, interspersed with manic, hypomanic and mixed affective episodes [14]. Mild depressive episodes may occur in cyclothymia [25].

One of the varieties of mixed affective episodes is ***mixed depression***, a type of depression with increased motor and speech activity within its structure. As a rule, mixed depression refers to a major depressive disorder associated with some of the maniac or hypomaniac symptoms. Mixed depression is a frequent finding in patients with depressive disorders. It is found both in bipolar disorder and in unipolar depression (although more often in bipolar disorder), and in many cases it is attributable to the use of antidepressants [35].

The following ***types of unipolar depression*** can be distinguished (according to DSM-IV) [14]:

*Major depressive disorder*, often referred to as clinical depression. *Resistant depression* is a type of major depressive disorder, where two consecutive courses of antidepressant treatment (3-4 weeks each) achieve little to none therapeutic effect.

*Minor depressive disorder*, also known as minor depression, does not meet all the criteria of clinical depression, but at least two main diagnostic symptoms are present for at least two weeks.

*Atypical depression* is a type of depressive disorder where, in addition to typical symptoms of depression, there are such specific signs as increased appetite, weight gain, increased somnolence and the so-called “emotional reactivity”.

*Postpartum depression* is a type of depressive disorder, which develops immediately after delivery.

*Recurrent brief depression* (RBD) is different from major depressive disorder mainly by its shorter duration. People with RBD experience depressive episodes approximately once a month, as isolated episodes lasting less than 2 weeks each, usually less than 2-3 days. For RBD to be diagnosed, the episodes must have been present for at least one year and, if the patient is female, must have occurred independently of the menstrual cycle. People with clinical depression may develop RBD, and vice versa.

*Dysthymia* is a mild chronic mood disorder, when the individual is complaining of an almost daily bad mood for at least two years. The symptoms are not so severe as in clinical depression, although people with dysthymia are simultaneously prone to recurrent episodes of clinical depression (this situation is sometimes referred to as "double depression").

*Mixed depression.* According to DSM, *other depressive disorders* (DD-NOS) are designated by code 311 and include the depressive disorders, which cause damage, but do not fit the officially defined diagnoses, i.e. “do not meet the criteria for any specified disorder” [14].

Another type is vital depression, which emphasizes the vital (existential) nature of this depression, with strongly pronounced sadness and anxiety, which patients experience at the physical level; for example, sadness may be felt as pain in the area of solar plexus. Vital depression develops in the cyclic fashion; it is immune to external stimuli and occurs without any apparent cause, often inexplicably for the patient themselves. Such a pattern is often pertinent, in particular, to the bipolar depression of bipolar affective disorder and to endogenous depressions on the whole. In a narrower sense, the term *“vital”* is primarily applicable to the “dreary depression”, where manifestations of sadness and despair come to the fore, as well as to depressive disorders with problems in the “vital sphere”, i.e. with impaired need for food, sleep, etc. [33]. Vital depressions are classified as a severe depressive episode without psychotic symptoms (F31.2). Despite the severity of the condition, such depressions are prognostically favorable, as they respond well to treatment with antidepressants [1]. In addition to that, the term “vital depression” is sometimes used to denote the depressive states in cyclothymia, with blurry manifestations of

melancholy, pessimism, despondency, inhibition, and where the symptoms are strongly dependent on the circadian cycle [5].

### 1.4. The clinical course of depression.

At first, there are subtle signals in the form of sleep disturbances, irritability, and refusal to carry out normal activities. If these symptoms deteriorate within two weeks, then this usually suggests the onset or relapse of the disease, although the full manifestation will appear in two months, or even later. Isolated single episodes may occur [47]. If untreated, depression may lead to suicide attempts, alienation from other people, failure to perform the majority of vital functions and family breakup [38]. Depression may be caused and accompanied by other mental disorders, including neurosis [35].

The average duration of the disease is from 6 to 8 months, but in a part of patients depression assumes a chronic course. Chronic depression means a depression with a duration of more than two years [54].

Resistant depression is a depression where two consecutive courses of adequate and prolonged monotherapy with drugs of different pharmacological classes achieve none to insufficient clinical effect [39]. Resistance to the first antidepressant is found in 40 to 60% of patients, and in approximately a third of patients according to other data [48]. There are different methods of overcoming this resistance, both pharmacological and non-pharmacological [13].

### 1.5. Treatment of depression: key areas.

Not all patients will need hospital admission; in many cases, the treatment is conducted on an outpatient basis. The main areas of therapy for depression include pharmacotherapy, psychotherapy and social therapy [19]. The most important criterion of successful antidepressant therapy is the correct clinical diagnosis; the approach to the treatment of depression should be informed by its cause. In

somatogenic depressions, the underlying somatic condition should be treated; second-line therapies include symptomatic psychopharmacological treatments and psychotherapy [13]. In endogenous depressions, psychopharmacotherapy is the main method, and psychotherapy is used as an additional method; in psychogenic (neurotic and reactive) depressions, psychotherapy is no less important than psychopharmacotherapy [19].

Even when somatic disease is not a direct cause of depressive disorder, the presence of some somatic disease (for example, subclinical hypothyroidism, Cushing's disease, coronary artery disease and cancer) in depressive patients may aggravate the course of depression and lead to emergence of resistance to treatment [11]. In such cases, the treatment of somatic disease is required in addition to psychopharmacological drugs, which allows overcoming resistance to treatment [20].

### 1.6. Pharmacotherapy of depressive disorders.

The antidepressants with predominantly stimulating effect are used for the treatment of patients whose depression is associated with inhibition, apathy and gloom. Fluoxetine, venlafaxine, milnacipran, bupropion, clomipramine, imipramine are indicated for the treatment of profound melancholic or apathetic depression [10]. Antidepressants with a predominantly sedative effect are indicated for the treatment of patients with anxious depression, unconscious anxiety and sullen irritability [19]. In pronounced anxious depression (especially with suicidal thoughts and intentions) the indicated treatments include paroxetine, sertraline, mirtazapine and amitriptyline [38].

In cases of mild to moderate depression, herbal medications can be used, such as hypericin (St. John's wort), which is tolerated better than traditional antidepressants. Nevertheless, just as in case with traditional antidepressants and other medications, the patients taking such herbal supplements should take into account potentially dangerous interactions with traditional antidepressants and with other drugs [10].

A special group of depressions includes the varieties where anxiety and inhibition are simultaneously present. Antidepressants of balanced effect are indicated in these conditions [11].

When an antidepressant drug is selected incorrectly, without consideration for whether a stimulating or sedative component prevails in its action, administration of the drug may lead to deterioration of the patient's condition: when a stimulating antidepressant is used, this exacerbates anxiety and increases suicidality; when a sedative antidepressant is used, this leads to psychomotor inhibition and reduced mental alertness [10].

Antidepressants do not work immediately; more often than not, the antidepressant effect takes 2-3 weeks to unfold (unlike sedative or stimulant effects, which begin much faster). In some cases, the antidepressant effect develops only after 6-8 weeks of using the drug, and sometimes even after 10-16 weeks. The drug and its dosage are determined individually for each patient [5].

After management of depressive symptoms, the administration of the drug continues for a minimum of 4-6 months (and sometimes for several years), which is due to the high probability of recurrence during this period. In addition to that, in some cases, when an antidepressant is discontinued abruptly, a withdrawal syndrome is possible [11].

Antidepressants are chemically complex and work in different ways. Administration of these drugs weakens the sensation of fear, but most often does not affect physical response times. Fluoxetine, a popular antidepressant, prevents the loss of serotonin; new generation drugs stimulate the levels of two and even three neurotransmitters [44]. All drugs used for the treatment of depression have certain adverse effects, and their use without a doctor's prescription is not recommended. Modern antidepressants lead to remission only in 40-60 % of cases [19].

In the absence of a sufficient antidepressive response (despite adequate selection of therapy), the healthcare provider will need to evaluate the duration of treatment and the appropriateness of dosing, reconsider the diagnosis and rule out somatic or mental comorbidities [35]. In doubtful cases, therapeutic drug monitoring should be performed to determine the adequate levels of the drug in the blood. It may

be necessary to evaluate the factors (i.e. clinical and social) that hinder a therapeutic response. There is data concerning the efficacy of such strategies as changing the drug or increasing the dose, especially in case of a partial response to treatment [27].

When single agent therapy is ineffective, as well as in severe and recalcitrant depressions, combinations of several concomitant antidepressants are used (in cases of unipolar depression). In recalcitrant depression, potentiation may be an effective strategy (i.e., adding a different substance, which, by itself, is not used as a specific drug for the treatment of depression, but which may enhance the response to the antidepressant taken) [47]. There is a large number of drugs, which may be used for potentiation. However, the vast majority of them lacks adequate level of evidence for their use [10]. The best evidence base has been obtained for lithium salts, some anti-epileptic drugs and atypical antipsychotics (the latter include aripiprazole, olanzapine, quetiapine, risperidone), which, in addition to triiodothyronine, melatonin, testosterone, clonazepam, scopolamine and buspirone are the first-line potentiating drugs [12]. Nevertheless, the drugs with low evidence level/strength of recommendations may also be used in treatment-resistant depression in case first-line potentiating agents lack efficacy [19].

In all affective disorders, lithium therapy significantly reduces suicide rate [12]. This is not only due to the treatment of the disease, but also because lithium reduces aggressiveness and, possibly, impulsiveness. In addition to that, lithium therapy reduces suicide rate compared to treatment with other drugs; all-cause mortality is also reduced [39].

Inversion of affect is possible with antidepressant therapy (i.e. the development of mania or hypomania). The risk for inversion of affect is especially high in bipolar depression; in unipolar depression, the change of phases (usually the development of hypomania) is a rare occurrence [6]. In addition to that, antidepressants may cause mixed states in bipolar depression (coexistence of mania and depression); in some cases, they may predispose to severe recalcitrant depressive states [48]. Overall, antidepressants may adversely affect the course of disease in patients with bipolar depression (i.e., cause therapeutic resistance, increased depression, mixed depression and agitation, chronic dysphoria, and increase the risk of suicide) [38].

In order to prevent the inversion of affect in bipolar depression, antidepressants may be used in combination with mood stabilizing agents. However, mood stabilizing agents are the “gold standard” in treatment of bipolar depression. Therefore, if signs of depression appear in a patient with bipolar disorder, first of all, it is recommended to optimize mood stabilizing dosage rather than use antidepressants [5, 6]. The results of efficacy studies of antidepressants in bipolar depression are controversial: in addition to positive results, evidence is accumulating that antidepressants lack sufficient efficacy in this disorder or even that they are not superior to placebo [11].

In most cases of treatment of depression caused by hypothyroidism or hyperthyroidism (thyrotoxicosis), it is sufficient to use adequate therapy to normalize hormonal balance, which leads to disappearance of depressive symptoms [44]. Antidepressant therapy for hypothyroidism is usually ineffective; in addition to that, patients with thyroid dysfunction are at a higher risk for undesirable effects of psychotropic drugs [19]. Tricyclic antidepressants may lead to rapid cycling in patients with hypothyroidism; the use of tricyclic antidepressants in thyrotoxicosis increases the risk for anticholinergic and adrenergic side effects and cardiotoxicity [2].

The use of lithium in thyrotoxicosis may lead to short-term symptomatic improvement with subsequently increased symptoms of hyperthyroidism and the development of ophthalmopathy [12]. Impaired thyroid function also increases the risk for adverse effects of antipsychotic drugs, including the risk for arrhythmias and dystonic reactions (in hyperthyroidism), thyroid coma and severe arrhythmia (in hypothyroidism) [35].

Facts to be told to the patient at the start of pharmacotherapy include the following [10, 19]:

- The onset of action of the antidepressant will be seen after at least 2 weeks (in some cases, in 4 weeks). This is important to mention, since many patients stop treatment after a week believing the drug "doesn't work".
- The drug must be taken daily.
- Improvement may be accompanied by periods of deterioration. The patient should know about it in order to avoid disappointment.

- The treatment shall be continued until the disappearance of all symptoms, at the very least for 4 months after improvement of patient's health status; however, the physician may prolong the course of treatment. If the individual discontinues the drug(s) abruptly, they may experience withdrawal symptoms, such as anxiety, diarrhea, vivid dreams and nightmares. In order to avoid it, the dose shall be reduced gradually.

It is important to regularly remind the patient and their family that pharmacotherapy is a complement to lifestyle modification, relaxation technique, as well as to psychotherapy or to other non-pharmacological methods [13]. Every time an antidepressant or an anxiolytic is prescribed, the physicians and the nurses should carefully review the list of adverse effects, and patients and their family should be informed about the potential adverse effects of the drug(s) [48].

### 1.7. Psychotherapy of depression.

Not only psychotropic drugs, but also non-pharmacological treatments can be used as modalities of first choice in mild to moderate depression [19]. For example, psychotherapy can be used as the main method, without the use of psychotropic drugs [3]. Psychotherapy and pharmacotherapy can be used in combination [13]. In severe depression, either pharmacotherapy or a combination of pharmacotherapy and psychotherapy is generally thought to be indicated. However, there is also evidence that cognitive psychotherapy is not inferior to antidepressants, even in severe depression [19, 45].

According to studies, a combination of antidepressants and psychotherapy represents the most comprehensive and effective approach to the treatment of acute depressive episodes. It is also very significant in treatment of recalcitrant depressions with a trend towards chronic course and frequent relapses [13]. A number of studies have shown that the efficacy of combination therapy in depressive disorders was greater than using each of these methods alone [19].

Patients with mild to moderate depression may benefit from psychotherapy; this includes patients with psychosocial or interpersonal problems and/or with

intrapersonal conflict. On the whole, in mild to moderate depression, psychotherapy may be even more effective compared to classic drug treatment or at least not inferior to pharmacotherapy [13].

It is emphasized in the literature that patients with depression who receive drug therapy are usually looking for the cause of their problems in chemical imbalance only and explain the improvement of their condition by the action of drugs. As a result, the patient is no longer inclined to use or develop their own coping mechanisms for depression [22]. Meanwhile, psychotherapeutic experience has an educational value for the patient. As a result, the patient is able to develop effective ways to cope with depression and to learn the effective ways to control depression in the future; the patient is also learning to recognize the signs of approaching depression and to prevent its recurrences [11].

The most widely spread methods for psychotherapy of depression include cognitive-behavioral, interpersonal, existential, psychodynamic and client-centered therapies [3, 53]. The lesser known methods include reminiscence therapy, social problem therapy, and role therapy. Group cognitive therapy can be used in the treatment of depression, which is a cost-effective alternative to individual cognitive therapy [45].

Behavioral psychotherapy in depression helps the patient plan pleasant activities and avoid tedious and painful activities [3]. The objective is set to increase the patient’s level of activity, to train their composure and to acquire social competence. The patient is provided with assistance in dealing with daily activities and in destroying depression-maintaining behavioral patterns [13]. Cognitive psychotherapy helps identify the cognitive deviations of depressive nature, as well as the painful and pessimistic thoughts that impede potentially useful activity [45]. It reduces the severity of negative self-perceptions and negative understanding of the world around the patient and of the future, and adjusts reasoning, which allows preventing future recurrences of depression. The efficacy of psychotherapy is especially high when cognitive approach is combined with behavioral therapy methods [53].

Unlike cognitive therapy, the efficacy of another widely spread psychotherapeutic treatment modality, that is, psychoanalysis, is only marginally superior to placebo (both placebo and psychoanalysis are within the efficacy envelope between 30% and 37-38%) [10].

Interpersonal psychotherapy views clinical depression as a combination of disease symptoms, social activity and the personality of the patient; it is focused on the connection between mood and social situations/life circumstances and teaches patients social skills; the patient is being trained in various current-time social roles, which previously caused difficulties [3]. Interpersonal therapy is focused on patients' disappointments in their personal expectations, as well as on conflicts with the surrounding people. Behavior and emotions are considered within the framework of interpersonal relationships. This method of psychotherapy is especially effective in dysthymia [13].

Family therapy is a method of psychotherapy aimed at changing the interactions between family members, at improving of family functioning (as a whole or as subsystems) and/or improving the functioning of individual family members. The goal of family therapy of depression is to help family members dissociate from destructive communication patterns and to improve the symptoms of depression as a result [13].

Studies demonstrate equal efficacy of cognitive and interpersonal psychotherapy compared to pharmacotherapy [13, 45]. According to a number of studies, cognitive therapy is superior to pharmacotherapy in terms of efficacy in depression, but these inferences are not always supported [45]. Cognitive behavioral therapy and interpersonal therapy are capable of ensuring prevention of recurrence outside the acute period as a maintenance therapy [53]. When cognitive therapy is used, patients with depression are less likely to have recurrent depression than when antidepressants are used; there is a resistance to depletion of tryptophan, a precursor of serotonin [45]. While antidepressants allow preventing relapses of depression only when taken preventively on a constant basis, cognitive behavioral therapy allows preventing the relapses long term, even when the duration of the therapy is short [53].

A substantial problem in pharmacotherapy of depression is the presence of residual symptoms in many patients in case of successful therapeutic interventions: the majority of patients have persisting symptoms of depression even if antidepressants do work [5]. Cognitive psychotherapy contributes to reduction in residual symptoms after successful pharmacotherapy of depression [45]. The reduction in residual symptoms in patients with remission is also supported by cognitive training (i.e. training in modification of attention shift). Cognitive training reduces the risk for development of depressive episodes in the future [53]. Psychotherapy also provides the patients with an opportunity to adjust to real life if affective disorders, reasoning disorders and impaired fundamental premises are recalcitrant despite treatment [13].

There is a general consensus about the value of psychotherapy when working with suicidal patients [39]. Since the psychological core of the patient with suicidal thoughts and intentions involves the sensation of hopelessness or an extensive negative anticipation, psychotherapy is more effective than pharmacotherapy in course of treatment of such patients [38].

Psychotherapy is recommended as first line therapy in outpatients with depression along with antidepressants; other indications to psychotherapy include mild to moderate depressions, especially when the patient declines treatment with antidepressants, has poor tolerance of these drugs or when the depression has apparent external causes (this includes reactive depressions, psychogenic depressions, situational depressions, consequences of traumatic experiences, psychogenic responses to severe somatic disease), unfavorable family and social circumstances, manifest social maladjustment, problems with interpersonal relationships, the presence of comorbid personality disorders or comorbid anxiety disorders, panic disorder and social phobia [13, 19, 21].

Based on efficacy studies of depression treatment, NICE (National Institute for Health and Care Excellence) issued the following recommendations in 2004 [19, 45, 48]:

- in mild depression, cognitive behavioral therapy (CBT) is to be considered the method of choice;

- in moderate depression, pharmacotherapy with antidepressants or CBT (at the patient's choice) is to be considered the method of choice;
- in pronounced depression, a combination of antidepressants and CBT shall be used;
- in drug-resistant depression, along with the possible replacements of psychopharmacological drugs, an option of adding CBT to pharmacotherapy is suggested;
- in chronic and recurrent depression, a combination of antidepressant therapy and CBT should be used;
- in a setting of depression in children and adolescents, the primary strategy is to use CBT or interpersonal and/or short-term family psychotherapy; only when psychotherapeutic methods fail or are unavailable, pharmacotherapy with antidepressants shall be considered.

### 1.8. Physical exercise

Physical exercise therapy has also demonstrated certain efficacy in the treatment of depression; this modality can be used in mild to moderate depression both instead of psychotropic drugs and complementary to them [9]. There are data on the efficacy of physical activity as a modality to potentiate drug therapy for recalcitrant depression. Physical exercise is no more effective than antidepressants or psychotherapy in reducing symptoms of depression, although this conclusion is based on a small number of studies [28]. Evidence whether exercise improves the quality of life in patients with depression is inconclusive [10].

The effectiveness of exercise in the treatment of depression can be explained by three existing hypotheses [9]:

1. Strengthening social communication, reducing problems in interpersonal relationships.
2. The effect of increased physical activity on the neurotransmission of certain mediators (an increase in the concentration of β-endorphins, a decrease in cortisol levels and an increase in the production of serotonin).

3. Increase in body temperature leading to increased intensity of metabolism.

It is only reasonable to encourage a patient with depression to physical exercise if they are ready to exercise and feel positive about it. Meanwhile, patients with severe depression do not usually feel inclined to such activities, and no amount of encouragement and persuasion will be effective; the willingness to engage in physical exercise may appear in the patient already on their way to recovery [9]. Physical exercise is useful in patients with remission; it may prevent the occurrence of new depressive episodes (in some patients, physical exercise may prevent relapses only when combined with other methods) [28]. In order to achieve a sufficient therapeutic effect, exercise should be regular, i.e. 2-3 times a week. Family or friends should provide support to the patient, for example, engage in physical activity together with them [9].

### 1.8. Other methods of treatment.

In cases of prolonged and recalcitrant depression, electroconvulsive therapy (ECT) is used. The essence of this method is causing controlled seizures by running electric current through the brain for 1-2 seconds. As a result of chemical changes in the brain, mood-enhancing substances are released [10]. This procedure is performed under anesthesia. In order to avoid injuries, the patient should be given muscle relaxants. Usually 6-10 sessions are prescribed per course. Adverse consequences of ECT include memory loss and disorientation, usually reversible. According to studies conducted in the 2000s, the memory impairment and cognitive dysfunction resulting from the use of ECT, may become irreversible in some cases. [19]. According to existing estimates, ECT is more effective than antidepressants [20].

Light therapy is an effective treatment method for all types of depression. It is used in seasonal affective disorder (SAD) as monotherapy, and in non-seasonal depressions it is preferable to use this method of treatment not as monotherapy, but rather as a potentiating modality, in combination with traditional treatment methods. The duration of treatment is 30 minutes to 1 hour, preferably in the morning, after

waking up [35]. Apart from artificial lighting (i.e. using a special-purpose light chamber), it may be effective to go outdoors in natural sunlight, when the weather is good. In SAD, the treatment should span across the entire darker season, while in non-seasonal depressions light therapy should be used until remission is reached and continued for 8-12 weeks daily [42].

One of the non-pharmacological treatments for some types of depression (especially those with elements of apathy) includes sleep deprivation [42]. Total sleep deprivation (the patient goes without sleep all night and the next day) is effective in 60-70% of depressed patients; late night sleep deprivation (the patient is woken up between 1 and 2 am and stays awake for the rest of the day) is also an effective method of treatment and is better tolerated. Nonetheless, most patients experience frequent relapses after sleep deprivation; in a significant number of patients, symptoms of depression return after normal sleep pattern is reestablished [10]. This is why wakefulness therapy alone is often not enough; sleep deprivation is used in some countries as a standard treatment for depression combined with antidepressants, lithium and bright light therapy [12]. The incidence of mania in bipolar depression no higher than that resulting from the use of antidepressants, and there is no increase in the risk of suicide [39].

Therapeutic narcosis has weak strength of recommendations in the treatment of depression; efferent methods (plasmapheresis, extracorporeal pharmacotherapy, ultraviolet radiation, laser therapy), hyperbaric oxygenation and craniocerebral hypothermia all have low evidence level [10]. Other potential methods include hemodialysis, low frequency alternating magnetic field therapy, microwave resonance therapy and lateral therapy [19]. Very low strength of recommendations is typical for clinical studies of such depression treatments, as manual acupuncture, aromatherapy, herbal therapy, homeopathy, hypnosis, massage, dance therapy, qigong, yoga-type exercise, comprehensive diets, fasting; treatment with inositol, magnesium, omega-3 fatty acids, probiotics, tryptophan, vitamins B and D, and zinc supplements [20]. These are supplementary methods, which can be used in combination with rational pharmacotherapy, but not as a replacement for the latter [10]. It has been proven that people with depression often have lower stores of

omega-3 in the body than depression-free people; the more scarce this depot, the more severe the symptoms. The amount of omega-3 in the daily diet affects the tendency to develop depression [20]. As suggested by the studies, in some cases, the antidepressant effect is attainable by daily administration of certain amounts of a mixture of two types of fish oils, i.e. eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) in combination with vitamin E, vitamin C and selenium [19]. Treatments for depression may include music therapy, art therapy, work therapy, color therapy, zootherapy, balneotherapy and magnetic field exposure of the brain (magnet therapy). These are the complementary methods, which cannot be used as monotherapy for depression [10].

Another potential treatment is autogenic training, a self-administered stress reduction technique performed individually or in a group [3]. This type of treatment is not suitable in acute depression, since the patient is incapable of attaining the required level of concentration and is unable to relax. The patient may benefit from autogenic training when his/her condition has already improved; autogenic training may help relieve some symptoms of depression (such as insomnia and headache due to muscle spasms) and may help relieve anxiety [19]. There are suggestions about the possible effectiveness of controlled dosage hypoxia, meditation and neurosurgical methods [10].

There is a need for development of educational programs for patients and their relatives, as well as a need for development of stands and leaflets containing information about the methods of treatment and psychological support in depression [19]. All these will gradually help the patient abandon a pessimistic outlook, provide him/her with more strength and patience and will support the worried family of the patient [13].

# CHAPTER 2.
# THE SPECIFICS OF ORGANIZATION OF NURSING PROCESS WHEN WORKING WITH PATIENTS WITH DEPRESSION

## 2.1. Definition and the objectives of the nursing process, the structure of the nursing process.

The main objective of nursing is to help the patients and their families to determine and unfold their physical, mental and social potential with allowances made for potentially unfavorable living conditions and working conditions [37]. Nursing is aimed at the human person, at maintaining his/her comfort, at restoring harmony and at ensuring the quality of life in a state of illness [46].

The fundamental concept of the modern model of nursing is **nursing process**, a methodology of scientifically substantiated and practically implemented nursing functions related to patient care [52]. The concept of "nursing process" includes the following elements [52]:

1. The structure organizing nursing practice;
2. Critical thinking;
3. The art of patient care;
4. The scientific method of professional solution to nursing problems;
5. Systematic approach to definition of situation and problems, for the purposes of fulfilling the plan of care acceptable for both parties;
6. Formalized process of nursing decision-making and nursing actions.

The main objectives of nursing process in depression include the following [37]:

1. Strengthening and preserving the health of the patient, the family and the society, and prevention of disease;
2. Ensuring maximal possible mental and physical comfort for the patient;
3. Restoring and maintaining the independence of the patient in meeting the principal bodily needs.

Nursing process has the following additional functions*:*

- Determines the specific care needs of the patient;

- Helps prioritize existing care needs and expected outcomes of care, and predicts the outcomes of care;
- Determines the nursing action plan and the strategy aimed at meeting the needs of the patient;
- To evaluate the efficacy of nursing interventions and the professional capacity of nursing personnel;
- To safeguard the quality of care by making it measurable and controllable.

The attitude of the nurse towards patients should always be benevolent, no rude remarks are acceptable; it is important to take into account the individual psychological characteristics and to be able to listen and understand the concerns of the patient [51]. Prior to procedures, the nurse should use patient-appropriate lay language to explain the significance and the essence of, and the need for the procedures for successful treatment and attempt to relieve the psychoemotional tension [41].

***The structure of the nursing process*** [37]:

1. Nursing assessment.
2. Establishing impaired needs of the patient (nursing diagnosis).
3. Planning of nursing care.
4. Implementation of the nursing care plan.
5. Efficiency evaluation and correction.

## 2.2. Nursing assessment.

Currently, the nurse may become an important support to the physician in early diagnosis of depressive disorders in the patients. This requires the knowledge of symptoms, the nurse's interest in the diagnostic process, and the conviction that early treatment will significantly improve the quality of life of the patient and their family [15]. Being in constant communication with the patient and their family, targeted interviews with the patient, the use of special scoring scales and tests, active observation of the patient's appearance and behavior are the steps of nursing diagnosis in depression [20].

When having a conversation with the patient, the nurse will find out the patient's understanding of their health status (feelings, emotions, and the perception of their condition and life situation). Of some value is also the information obtained from friends, relatives and from other healthcare professionals [34]. The nurse shall notice and document verbal and nonverbal cues suggesting the patient's status, such as posture, facial expressions, gestures, manner of speaking, movements, ability to communicate, appropriateness of reaction to the question asked and voice characteristics; the nurse shall also document the patient's orientation to time and place [49].

The diagnosis of masked depressions may be assisted by careful questioning about the following [20]:

- Whether the patient is able to enjoy life as before;
- Whether the patient seeks to avoid the society he/she previously found pleasant and entertaining;
- Whether the patient is excessively bothered by performing household- and work-related duties;
- Whether the patient is disturbed by a sense of hopelessness.

When observing the patient, the nurse may notice the following signs of depression [49]:

- dysphoria irrespective of circumstances, which persists over a long period of time;
- inability of the patient to have interest in or experience pleasure from the previously enjoyable activities (anhedonia);
- significant fatigue, low energy level;
- pessimism of the patient;
- low self-esteem;
- sense of guilt, worthlessness, anxiety and/or fear;
- inability to concentrate and to make decisions;

When working with the patient, it is necessary to control his/her mood, pay attention to what the patient does during the day/monitor the quality of night sleep, since depression is characterized by the presence of insomnia or oversleeping [37].

The nurse should also document the presence of suicidality, which is manifested as the presence of thoughts about death and/or suicide [38]. The nurse should ask questions about appetite and note weight reduction or weight gain over the last period of time [41].

Particular attention is paid to the following issues [49]:

- whether the patient can control their feelings and desires;
- whether the patient is adjusted to the conditions of life;
- whether the patient is capable of self-care (personal hygiene);
- whether the patient is able to consciously relate to the functions of their body;
- how the patient behaves in relation to other people, whether the patient can maintain contact them;
- how the patient complies with social norms;
- whether the patient has intact professional skills;
- how the patient reacts to conventional and unusual situations;
- how the patient perceives themselves;
- whether the patient respects personal safety.

Unfortunately, a pessimistic view of life and disease is developing during the depressive period, and patients (especially males) do not always seek help [49]. It is extremely important that a patient with depression be encouraged to receive treatment. This is what modern nurses are capable of doing. During all periods of observation and treatment of patients with depression, the nursing personnel should know the signs of depression and a correct approach to such patients [20].

### 2.3. Establishing impaired needs of the patient (nursing diagnosis).

Every problem of the patient is analyzed by the nurse and stated as a brief conclusion (nursing diagnosis). Examples of definitions [49]:

- Depressed mood with a sense of despair and hopelessness;
- Decreased and inadequate physical activity;
- Negative psychoemotional experiences (nervous shivering, crying, fear, apathy, stupor);

- Self-care motivation deficit, limited self-care capacity (going to the toilet, washing and bathing, dressing and eating);
- Limited capacity of establishing and maintaining contacts with other people;
- Severe physical weakness and helplessness of the patient;
- Sleep disorder, insomnia-related;
- Risk for suicide;
- Risk of loneliness and social isolation.

### 2.4. Planning of nursing interventions.

Nursing interventions in patients with depression should be adequately planned. Depending on the urgency of implementation, the interventions are distinguished into urgent and non-urgent. [37]. The interventions can be independent (decided upon and implemented exclusively by the nurse) and interdependent (decided upon and implemented in collaboration with the psychiatrist, psychologist and social worker). Nursing interventions should be customized for each patient. These interventions must apply to physical and emotional, spiritual and social problems of the patient [49].

The nurse assesses the potential problems of an inpatient (which may appear after their discharge from the hospital) or risk factors in an outpatient [46]. The timing of evaluation of nursing interventions depends on their urgency. The interventions that require longer time to take effect (for example, the interventions aimed at restoring family relationships) may be evaluated on a weekly basis [37].

### 2.5. Implementation of nursing interventions.

The following are the typical ***nursing interventions*** used in patients with depression [49]:

1. To evaluate the nature of statements by and experiences/actions of the patient with reflection in the patient's diary (patient's nursing record), and guide the patient to critical self-evaluation of their judgments and behavior.

2. To define the stress factors enhancing the patient's feelings and deteriorating their mood, and provide the patient with a calm environment. Document suicidality and threats of suicide.

3. Assess and enhance the patient's self-esteem. Conduct conversations with the patient regarding positive behavior practices and more active engagement in physical activity.

4. Only where needed, assist the patient with self-care and personal hygiene (going to the toilet, washing and bathing, dressing), and encourage autonomy in self-care.

5. Manage the patient’s behavior, use psychological correction. Establish trust-based relations with the patient. Help the patient express their experiences and encourage their attempts to communicate with other people. Help increase the patient’s capacity of establishing and maintaining contacts with other people. Reduce the risk of loneliness and social isolation.

6. Execute and monitor the execution of physician’s orders, record their efficacy, adverse effects of medications and notify the physician when necessary. Educating the patients and their family/significant others about the adverse events of medications the patient is receiving and explaining the dangers of self-medication.

7. Encouraging the patient to participate in group activities (communication with other people, work therapy, group therapy, etc.).

8. Working actively with the family of the patient. Teaching the patient’s significant others to identify the first signs of deterioration and to seek medical/psychiatric aid immediately. Informing the significant others about the prognosis of the patient's disease.

9. Thoroughly document and keep all the information obtained during interaction with the patient in the patient’s diary (patient’s nursing record).

### 2.6. Evaluation of nursing interventions.

Evaluation of nursing interventions is performed on an ongoing basis. In order to determine treatment efficacy or adverse effects of drugs: daily; when providing assistance with self-care or when encouraging the patient to activity: weekly. As

required, after evaluation of nursing interventions, the plan will need to be reviewed and adjusted. If the final result leads to failure, then interventions must be analyzed to identify potential errors and to modify the plan [37]. When the projected goals have not been reached, this evaluation allows identifying any impeding factors. Successful implementation of the plan of care depends on the nursing personnel, on their professional training and competence, on the environment and on the willingness of the patient and his/her family to cooperate [46].

### 2.7. Supporting compliance with therapeutic and protective regimen. Ensuring the safety of the patient and of the people around him/her.

The personnel providing care will need to maintain full self-control and composure. The nursing staff will need to perform a critical assessment of the situation and decide on the kind of aid that needs to be provided. The nurse should talk to the patient in a calm and confident manner. A dismissive, perplexing, accusatory, intimidating or judgmental tone of conversation may aggravate the patient's condition [49]. The nurses and any other healthcare personnel should refrain from discussing the patient's condition in his/her presence, since the words and actions of other people may provoke anxiety and resentment. The patient needs to be gently and kindly reassured, and to be explained that nothing threatens them, that they seem to be upset; the nurse should also attempt to divert the patient's thoughts to a different direction. A calm conversation improves the patient’s condition [20].

If the patient feels a need to share his/her thoughts and he/she takes the initiative to address the healthcare team, the team member should listen patiently and encourage the patient. Extraneous conversations in the presence of patients are unacceptable, since these patients may interpret what they hear along morbid mechanisms [49].

It is very important to create a calm environment around the patient and to curb any manifestations of fear and panic on the part of the personnel. It is important to establish a routine, which makes the patient’s life more organized. A clearly defined daily routine helps the individual attain maximal independence within the current disease-associated limitations [49]. At the same time, it is necessary to maintain the

previously established order of the patient's life for as long as possible. The daily routine of the patient should include their usual activities; this will help them maintain a sense of confidence and security. It is important to help the patient retain their dignity. Creating comfortable conditions in the patient's room is another area of activity of nursing staff [49].

When providing professional services, the nurse should behave in such a way as to let the patient feel that they are being taken care of. It is necessary to avoid loud conversations, avoid slamming doors, rattling dishes, etc. At the same time, nurses should avoid limiting the patient's autonomy and helping with activities the patient is capable of performing independently; such "excessive care" may become burdensome for the patient [49].

In a home care setting, good overhead lighting should be provided in the room, as well as well-lighted stairs and nightlights in the bedroom and in the bathroom. Stairs, windows and balconies shall be protected to prevent the patient from falling out. Fall prevention handrails shall be installed on the stairs. Temperature conditions in the room should be controlled (not too cold or too hot, with no drafts); the patient should be assisted to select and put on the clothes that meet temperature conditions. The healthcare team shall monitor the quality of food products and make sure the patient does not consume any spoiled or low-quality foods [49]. Safety handles and rails should be installed in the bath or in the shower. Skid-safe rug should be placed on the bottom of the bath or the shower. To prevent falls, all floors in the home must be skidproof. Rugs and mats should be removed (to prevent the danger of falls). All door locks must open from the outside. The furniture should be robust and steady; the chairs and the bed should be of sufficient height [37].

## 2.8. Providing support to people with negative psychoemotional experiences (uncontrolled nervous shivering, fear, crying, emotional breakdown, apathy).

The help that a nurse may provide to a patient with negative psychoemotional experiences primarily includes creating favorable conditions for “deescalation” of nervous tension. The nurse will need to remain calm, smile and laugh with the patient (but not at him). Good humor relieves stress and resolves any conflict situations and worries [10]. The nurse may not draw the attention of the patient to his/her failures. Anger, bitterness or resentment of the patient should be perceived by the nurse with an understanding of what causes these manifestations. Otherwise, a conflict is possible, which may deteriorate the situation and aggravate the problem [49].

Patients with anxious depression are often restless, pace back and forth, and groan (agitated depression). They must be watched closely, since they may often seek to commit suicide, and may even ask to help them die [38]. In such cases, the patient may need to be restrained. Immediately report any changes in the mental state of the patient to the doctor on duty [49].

*Helping the patient with uncontrollable nervous shivering***.** Grab the patient by the shoulders and shake them carefully but firmly for 10-15 seconds. It is very important to keep talking to the patient, because otherwise they may perceive such actions as aggression. The nurse should not try to calm the patient verbally, he/she should not tell them to “pull themselves together”, or try to hug or hold them. After the episode is over, it is preferable to give the patient the opportunity to rest or put them to bed [44].

*Help in patients with fear***.** Panic fear in depression may induce the patient to attempt to flee, cause stupor or, conversely, agitation, and aggressive behavior. At the same time, the patient has poor self-control; in addition, the patient is not aware of what he is doing and what is happening around them. In a conversation with a patient, it is important to listen to them carefully, emphasizing genuine concern, understanding and empathy. In this situation, the nurse may calmly grab the patient by the hand to reassure them, and ask the patient to breathe evenly and deeply. A light massage of the most tense muscles in the body may be performed [49].

*Helping the crying patient***.** Never leave the crying patient alone. It might be helpful to establish age-, culture- and gender-appropriate physical contact (i.e. take the patient by the hand, put hand on the patient's shoulder/back, pat them on the head, etc.). The nurse should not attempt to offer verbal consolation, ask unnecessary questions and try to advise the patient. The most important thing is to let the patient know the nurse is there for them, and give them an opportunity to cry and ventilate their feelings [20].

*Helping a patient with hysteria***.** It is preferable to stay with the patient one-on-one (provided that the patient is not a physical threat to personnel), ask any extraneous people ("spectators") to leave the room and create a calm environment. The nurse may suddenly perform an action to surprise the patient (i.e. clap his/her hands). The nurse should address such a patient in a calm and confident tone, using command-like short phrases. Under no circumstances the patient's unreasonable wishes or demands can be granted. The patient will most likely feel exhausted after the bout of hysteria, so it might be a good idea to put them to bed [44].

*Helping a patient with apathy***.** Apathy is a sensation of tiredness, when the subject wants neither to move nor talk; when forced/compelled to, movements and words come with a substantial effort. In the patient's mind, there is emptiness, indifference, and lack of strength even to express feelings. In this situation, the nurse may need to ask the patient a few simple questions: "What is your name ?"; "How are you feeling?", and listen carefully to them and try to start the conversation. The family members/significant others may help by involving the patient in any joint activity (i.e. take a walk, go out for a cup of tea or coffee, listen to music, watch a movie, etc.) [20].

**2.9. Help in self care motivation deficits and in limited self-care capacity (going to the toilet, washing and bathing, dressing and eating).**

The nurse is the principal advocate and mentor of the depressed patient with limited self-care capacity. Particular attention is paid to the patient's ability to control urination and bowel movements, wash, use the shower, dress themselves and take food. The nurse is teaching the patient self-care skills, while respecting the patient's privacy and dignity [37].

When washing the patient, the nurse should attempt to respect the patient's previous routine, and agree with the patient on a suitable bathing day. It is best to create a stable habit; for example, Sunday is a bathing day. The caregiver will need to prepare the bathroom; place the patient's favorite towel, their favorite shower gel or bath fragrance. The caregiver should try to make washing/bathing a pleasant experience, which helps the patient relax. The nurse or other caregiver may need to tell the patient how pleasant a washing/bathing routine can be, and that the patient will not only feel better and more fresh, but will also be more pleasant for other people around them. Shower is a good alternative to taking a bath. If the patient refuses to take a bath or a shower, the caregiver may want to wait for a while: the patient's mind may change. If the patient is embarrassed when assisted to take a bath or a shower, some parts of their body may remain covered [37]. If the patient refuses to wash themselves independently, the caregiver may help them, while maintaining a friendly conversation during this routine. When brushing the patient's teeth or combing their hair, the nurse may show the patient how to do it properly. By trying to imitate the caregiver, the patient may regain the lost skill [46].

Organization of proper diet of the patient is another important precondition for the management of depression. The nurse may need to educate the patient's family concerning the need for a varied diet rich in proteins, vitamins and other nutrients, concerning the aesthetics of dishes and the favorable accompaniment of meals [37].

There are cases when a patient with depression refuses to eat entirely. Therefore, the caregiver will need to make sure the patient consumes nutritious foods in sufficient amounts, and at the same time eats not more than one serving at a time. The nurse will need to make sure the patient's daily fluid consumption is 1.5-2 liters

on the average. If the patient eats independently, it is much better than feeding them [37]. Such a patient will need the following [46]: regularity of meal times; the caregiver will need to allocate a sufficient and realistic amount of meal time; the patient may need to be reminded of the necessity to eat the foods intended for a particular mealtime (i.e. breakfast, lunch); a good idea is to provide the patient with finger foods; in some cases, the patient may need to be reminded to eat slowly.

In the practice of a nurse, there may be cases when a patient refuses to eat. In such a situation, the nurse will need to find out the specific reason why the patient is refusing food. The nurse will need to patiently persuade the patient to start eating on their own. When possible, probably overcoming a small non-physical resistance, the caregiver may try to feed the patient. A helpful strategy may be to choose a staff member or a relative whom the patient trusts with feeding. Whenever the patient displays negativism, put the food aside and leave the patient alone for a while. As recommended by the physician, the patient's food cravings may be increased by giving them 4-16 units of insulin in a fasted condition. If all of the above measures fail to lead to a positive result, the patient will need to be fed artificially through an orogastric/nasogastric tube [49].

### 2.10. Help in limited capacity to establish and maintain interpersonal contacts. Maintaining a positive dialogue.

The nurse needs to be serious, polite, communicable and address the patient respectfully, using formal name. Conditions will need to be created to ensure a positive, friendly and productive dialogue, and to show love and warmth [15]. At the same time, the healthcare professional should not be overly affectionate and ingratiating, as this may annoy the patient. It is important to know the current mental condition of the patient. Before beginning to talk, the caregiver/nurse will need to make sure the patient is listening. It is necessary not to rush the patient and to give them ample time so that he they may speak out whatever they may find necessary [34]. The nurse should speak clearly and slowly, face to face with the patient. keep his/her head at the patient's eye level; the nurse will need to find out which gestures and phrases are necessary to effectively maintain communication with the patient

[41]. No extraneous conversations shall be tolerated in the presence of patient, even if the patient seems completely withdrawn. In the presence of third parties, healthcare team members should not discuss the disease and/or express their judgment concerning the prognosis; it is unacceptable to be laughing at sick people or to talk with the patients with an ironic, jocular air [51]. The healthcare team members should avoid negative criticism, arguments and conflicts [34].

It is common knowledge that being engaged in work is a good remedy for depression. Using all of the possible ways for personal fulfillment in the family and in the professional sphere, in order to increase the patient's self-esteem is possible with involvement of the nurse. It is possible to switch the patient's attention to socially significant goals (i.e. transfer of life experience to loved ones, communication with children/grandchildren; painting, needlework, writing poetry, etc.) [51].

Patients with depression suffer from loneliness and social isolation. Considering this, the nurse introduces the patient to roommates, and places the patients in the room taking into account age, sociocultural and communication factors, as well as the disease specifics, and exhibits the interest in what the patient tells about themselves [41]. The patient is accepted as they are; verbalization of their mood is encouraged. The nurse helps the patient maintain their contact with reality using sensory stimuli, updating the patient on the news and reminding the patient about the important dates. By entering into psychological contact with the patient's family, the nurse teaches them how to perform care, and discusses with them any questions that might arise [51].

### 2.11. Help in patients with disturbances of night sleep. Helping the patient with limited physical activity stay fit.

To ensure a healthy and comfortable night sleep, all necessary sanitary-hygienic and psychological conditions must be created. The patient may stay awake at night, which is a tiresome problem for those taking care of the patient. Such a patient should not be allowed to sleep at daytime and should be "loaded" with various physical activities [37].

For a time, sports activities and physical exercise may help preserve the existing physical and mental capacities of the patient. The type and the volume of physical challenge shall be agreed with the physiotherapy/exercise therapy specialist [28]. Thus, if a person liked swimming, going to the gym or working in the garden before their illness started, they may enjoy using the skills they have retained. As the mental illness progresses, the patient's abilities and interests may change. Therefore, the care professional should observe the patient attentively and make adjustments to the type and content of his/her activities [49].

### 2.12. Help in suicidal patients.

The healthcare personnel must ensure a continuous and uninterrupted patient monitoring in order to safeguard the patient from suicide. The mental health team may never leave such a patient unmonitored either day or night; they may not let them cover themselves completely, with their head under the blanket; such patients need to be escorted even to the bathroom. The patient’s bed should be frequently and carefully inspected in order to find out whether dangerous items or medicines are hidden there. The patient should be taking medications only in the presence of a social worker or a nurse, to prevent the patient from hiding and accumulating the drugs with an intent to commit suicide; the patient’s clothes should also be inspected for dangerous items [38].

If there is a noticeable improvement in the patient's condition, this should never be regarded as a pretext to relax vigilance; on the contrary, all suicide prevention protocols should remain fully in force. Being in a state of partial improvement and having more energy may even increase the patient’s risk for self-injury. Sad patients do not pay attention to themselves; this is why they need special care, i.e. helping them with dressing, washing, and making their bed. It is necessary to make sure that they do eat, and to this end, they sometimes need to be persuaded for a long time, patiently and kindly. Often the caregiver has to persuade them to go out for a walk. Sad patients are silent and self-absorbed. They have a difficult time maintaining a conversation. This is why they should not be disturbed by excessive conversations [39].

Remove piercing and cutting objects. Patients should not have long pencils, penknives or hairpins in their possession. Shaving patients is done by a hairdresser; it is better to use a safety razor for this purpose. Knives and forks are not issued to patients during mealtime. Food is prepared in advance in such a way that it can be eaten using only a spoon [49].

When dispensing medicines, the healthcare worker may not leave the patient until he/she is certain that the patient has swallowed the pill. Some patients may throw the pill away later because they don't want to receive treatment (for a number of reasons, such as fear or negativism). Other patients may accumulate the pills with the intent of taking a large single dose to poison themselves. If there is a ground for such suspicion, the nurse shall inspect the personal belongings and the bed of the patient (which, however, should be done intermittently with many patients). In order to avoid insulting the patient's dignity and autonomy, the inspection of personal items should be performed when the patient is out for a walk or when the patient is taking a bath/shower. At no time, the patient may have access to any dangerous electrical appliance (e.g. iron, bread slicer, hair dryer, toaster) [49].

In the kitchen, shut off the gas valve when the patient is alone in the home. Use protection of stoves and ovens (for fire prevention). Install alternative appliances for the patient's safety (e.g. a microwave oven for cooking). Check the door locks; install patient-proof window locks. Make sure that lighters and matches are not accessible to the patient. Patients who are smokers should be carefully monitored. These patients should not have matches or lighters with them on their person (fire hazard) [37].

It is also important to carefully monitor suicidal patients when they are outdoors; sometimes they may look for and pick pieces of glass, metal or nails during their walks in the hospital garden. The premises of the hospital garden should be carefully inspected and cleaned. During work therapy, it is important to watch the patients lest they hide needles, hooks, scissors or other sharp objects on their person. During their visits, the relatives should not be allowed to pass any objects and items into the hands of the patients [49].

In all periods of observation, the nursing personnel should know the signs of depression in order to prevent suicide in patients with an otherwise potentially

favorable outcome of the disease. Such signs include sleep disorders, increased isolation and increased apathy. The most probable signs of suicide include the presence of mental disorders, depression and alcohol abuse. Suicidal tendencies are urgent conditions. Any remarks by the patients concerning their unwillingness to live or wanting to die should be treated seriously and with the greatest caution. A patient with suicidal ideation needs an emergency consultation by a psychiatrist; at the same time, this patient should be under incessant vigilance of healthcare team and/or family (as applicable). During the conversation, it is important to create confidence in the patient that they can receive substantial help from a doctor; it is necessary to encourage the patient himself to try to find an alternative way out of their situation, which would be more positive than suicide [38].

## CHAPTER 3.
## THE RESULTS OF THE STUDY AND THEIR ANALYSIS

We have set a task to detect the principal impaired needs and the typical problems in patients with depression, to develop the technique of nursing care for such patients and to evaluate its quality.

**The object of the study** included 100 patients with depression aged 18 to 92 years under treatment in a psychiatric ward. During their first days of in-patient treatment, the patients were scarcely available for contact; they were suspicious, tense, immersed in their feelings, and gave one-word, formal responses to questions. Some of them expressed the ideas of self-humiliation and self-condemnation.

**The results of the study**.

**Distribution of patients by gender was as follows:** there were 32 males (32%) and 68 females (68%) among the study subjects (Fig. 1):

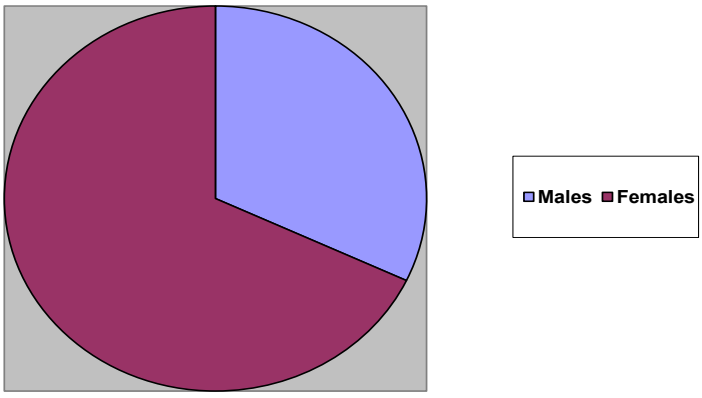


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**Fig. 1. The distribution of the patients by gender.**

**3.2. The distribution of patients by age groups** was as follows: 18-20 years: 3 pts. (3%); 21-30 years: 8 pts. (8%); 31-40 years: 11 pts. (11%); 41-50 years: 22 pts. (22%); 51-60 years: 20 pts. (20%); 61-70 years: 21 pts. (21%); 71-80 years: 9 pts. (9%); 81-90 years: 3 pts. (3%); 91-92 years: 3 pts. (3%) (Fig. 2.).

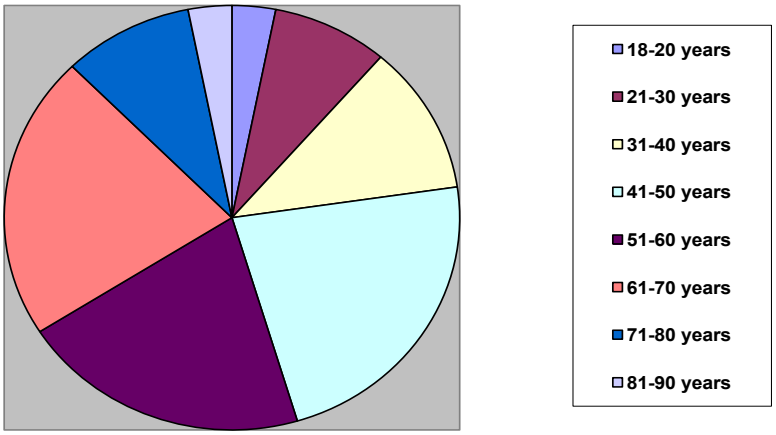


**Fig. 2. Distribution of patients by age groups.**

**Family status:** 30 patients (30%) have never been married; 23 subjects (23%) were married; 15 subjects (15%) were widows/widowers; 32 subjects (32%) were divorced (Fig. 3.):

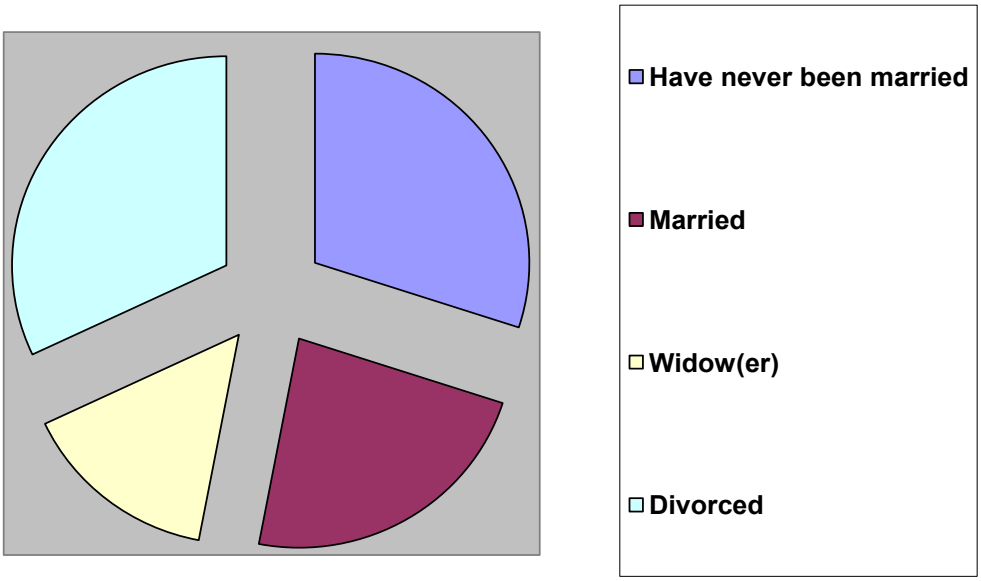


**Fig. 3. The family status of the patients.**

**The principal impaired needs in patients with depression.** The nursing diagnosis was made in course of nursing care based on conversations and observations; the findings were documented in the chart of patient's basic needs (defined according to Maslow and Henderson).

| No. | The principal impaired needs in patients with depression (as defined according to Maslow and Henderson) | % of patients where a given need is impaired |
|---|---|---|
| 1. | Normal breathing | 0% |
| 2. | Receiving enough food and fluid | 67% |
| 3. | Elimination of human waste | 11% |
| 4. | Movement and maintaining required posture | 6% |
| 5. | Sleep and rest | 91% |
| 6. | The ability to dress/undress independently; the ability to choose clothing | 18% |
| 7. | Maintaining body temperature within normal limits by proper choice of clothes and modification of the patient's environment | 7% |
| 8. | Maintaining personal hygiene; taking care of appearance | 62% |
| 9. | Ensuring personal safety and not being a source of danger to other people | 66% |
| 10. | Maintaining communication with other people by expressing emotions and opinions | 85% |
| 11. | Performing religious rites in accordance with one's faith | 25 % |
| 12. | Engaging in one's favorite work | 87% |
| 13. | Recreation; participating in entertainment and games | 78% |
| 14. | Satisfying one's curiosity and the need for normal personal development | 71% |

The principal impaired need was impaired sleep pattern and impaired rest, which was found in 91% of the cases. Eighty-seven respondents could not engage in their favorite work; 85 respondents reported inability to maintain communication with other people and to express their emotions and opinions. Seventy-eight patients could not normally recreate or participate in entertainment and games. Sixty-seven patients reported not being able to receive enough food and fluid; 71 patients reported inability to satisfy their curiosity and the need for normal personal development. Sixty-six patients were not able to ensure their safety; 62% of patients could not

observe personal hygiene and take care of their appearance as a result of mental illness.

**Determination of the severity of depression in the patients according to Beck's Depression Inventory.** This inventory was proposed in 1961 by Aaron Temkin Beck et al. It was developed based on clinical observations of the authors, which allowed detecting a limited set of the most relevant and significant symptoms of depression and the complaints most frequently reported by the patients. After matching this list of parameters against the clinical narratives of depression contained in the corresponding literature, a questionnaire was developed, which included 21 categories of symptoms and complaints. Each category consists of 4-5 statements, which correspond to specific manifestations/symptoms of depression. These statements were ranged in proportion to the specific contribution of a symptom; in each category, it was calculated in the following manner: each item on the scale was scored from 0 to 3 according to the severity of the symptom (i.e., the more severe the symptom, the higher the score). The total score was from 0 to 63 and decreased as the patient’s condition improved.

The results of the test were interpreted in the following manner (Fig. 4): 0-13 (variations that are considered normal) in 0 pts. (0%); 14-19 (mild depression) in 12 pts. (12%); 20-28 (moderate depression) in 61 pts. (61%); 29-63 (severe depression) in 27 pts. (27%).

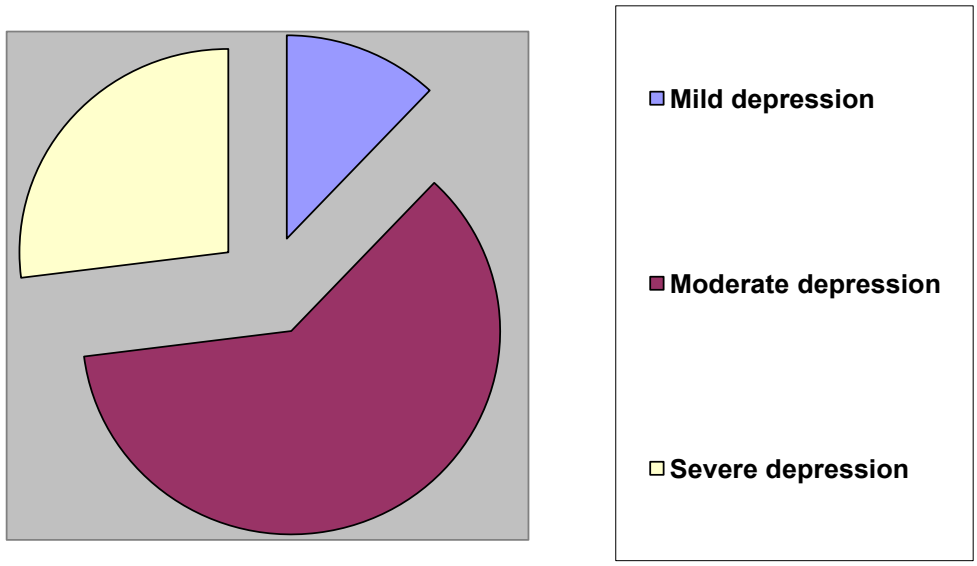


**Fig. 4. Determination of the severity of depression in the patients according to Beck's Depression Inventory**

**Wording of nursing diagnoses.** After problems have been identified and priorities have been set, the following **nursing diagnoses** were made:

- Depressed mood with a sense of despair and hopelessness;
- Decreased and inadequate physical activity;
- Negative psychoemotional experiences (nervous shivering, crying, fear, apathy, stupor);
- Self-care motivation deficit, limited self-care capacity (going to the toilet, washing and bathing, dressing and eating);
- Limited capacity of establishing and maintaining contacts with other people;
- Severe physical weakness and helplessness of the patient;
- Sleep disorder, insomnia-related;
- Risk for suicide;
- Risk of loneliness and social isolation.

During the stage of planning, the specialists jointly developed the plan of care. It should be borne in mind that the nurse may consult other nurses or physicians in

order to confirm the data obtained during assessment and to select the best nursing strategy.

A list of intended nursing interventions was made:

1. To evaluate the nature of statements by and experiences/actions of the patient with reflection in the patient's diary (patient's nursing record), and guide the patient to critical self-evaluation of their judgments and behavior.

2. To define the stress factors enhancing the patient's feelings and deteriorating their mood, and provide the patient with a calm environment. Document suicidality and threats of suicide.

3. Assess and enhance the patient's self-esteem. Conduct conversations with the patient regarding positive behavior practices and more active engagement in physical activity.

4. Only where needed, assist the patient with self-care and personal hygiene (going to the toilet, washing and bathing, dressing), and encourage autonomy in self-care.

5. Manage the patient's behavior, use psychological correction. Establish trust-based relations with the patient. Help the patient express their experiences and encourage their attempts to communicate with other people. Help increase the patient's capacity of establishing and maintaining contacts with other people. Reduce the risk of loneliness and social isolation.

6. Execute and monitor the execution of physician's orders, record their efficacy, adverse effects of medications and notify the physician when necessary. Educating the patients and their family/significant others about the adverse events of medications the patient is receiving and explaining the dangers of self-medication.

7. Encouraging the patient to participate in group activities (communication with other people, work therapy, group therapy, etc.).

8. Working actively with the family of the patient. Teaching the patient's significant others to identify the first signs of deterioration and to seek medical/psychiatric aid immediately. Informing the significant others about the prognosis of the patient's disease.

9. Thoroughly document and keep all the information obtained during interaction with the patient in the patient's diary (patient's nursing record).

Nursing interventions were performed according to the plan.

**The outcomes and the efficacy of nursing interventions.**

During hospital stay and observation (during one month), the majority of patients reported improved mental status:

- Mood improved: in 79 pts. (79%);
- Physical activity improved: in 68 pts. (68%);
- Negative psychoemotional experiences (nervous shivering, crying, fear, apathy, stupor) resolved or reduced: in 59 pts. (59%);
- Self-care capacity improved: in 55 pts. (55%);
- Sleep improved: 79 pts. (79%);
- Appetite returned to normal: 51 pts. (51%);
- Social activity improved: 78 pts. (78%).

The above findings suggest a high level of professionalism of nursing staff, their proper attitude to treatment and the high quality of their work.

Thus, nursing care is playing a major role in the treatment of patients with depression. The quality of relationships between the nurse and the patient, as well as their mutual rapport, may often become a decisive factor for the outcome of the disease.

## CONCLUSIONS

1. The study has investigated the etiological factors and the pathogenesis of depression, as well as its diagnostic criteria, therapeutic principles and modern treatments. Thus, depression develops as a response to an external event or situation; quite often, occurs when the brain is overburdened as a result of stress, which can be underlain by both physiological and psychosocial factors. Depression can develop as a side effect of certain medications (iatrogenic or pharmacogenic depression). The causes of depression often include the abuse of alcohol, sedatives or hypnotics, opiates, as well as cocaine and other psychostimulant drugs. Depressions may somatic (somatogenic), due to somatic disease (Alzheimer's disease, atherosclerosis of cerebral arteries, traumatic brain injury or influenza). Pregnancy and labor are substantial risk factors of depression. Depression is a clinically and etiologically heterogeneous disorder. The research community offers a number of hypotheses for the pathogenesis of depression, such as monoamine theory, cognitive model of depression, etc.According to DSM-IV-TR diagnostic criteria, 5 or more of the below 9 symptoms should be present for 2 weeks (and these symptoms should include at least 1 of two main symptoms: depressed mood and/or loss of interests or ability to experience pleasure): depressed mood (in children and adolescents it may manifest as irritability/touchiness); significant reduction of ability to experience pleasure or interest in all or almost all activities; weight loss and reduced appetite (increased appetite and increased body weight is possible); insomnia (hypersomnia is possible); psychomotor agitation or inhibition; reduced energy level and increased fatigue; feelings of worthlessness and low self-esteem or inadequate guilt; inhibited thinking or reduced mental alertness/ability to focus; suicidality. The main areas of therapy for depression include pharmacotherapy, psychotherapy, social therapy and physical exercise. The most important criterion of successful antidepressant therapy is the correct clinical diagnosis. In somatogenic depressions, the underlying somatic condition should be treated; second-line therapies include symptomatic psychopharmacological treatments and psychotherapy. In endogenous depressions, psychopharmacotherapy is the main method, and psychotherapy is used as an

additional method; in psychogenic (neurotic and reactive) depressions, psychotherapy is no less important than psychopharmacotherapy.

2. We have defined the objective, the structure and the methods of nursing care in depression. The main objectives of nursing process in depression include the following: strengthening and preserving the health of the patient, the family and the society, and prevention of disease; ensuring maximal possible mental and physical comfort for the patient; restoring and maintaining the independence of the patient in meeting the principal bodily needs. The structure of the nursing process includes the following components: nursing assessment, establishing impaired needs of the patient (nursing diagnosis), planning of nursing care, implementation of the nursing care plan, efficiency evaluation and correction. The nurse is helping the patient to be compliant with therapeutic and protective regimen, ensures the safety of the patient and of the people around him/her, and provides support in negative psychoemotional experiences (such as uncontrolled nervous shivering, fear, crying, emotional breakdown, apathy). It is important to provide the patient with help in self care motivation deficits and in limited self-care capacity (going to the toilet, washing and bathing, dressing and eating); with help in limited capacity to establish and maintain interpersonal contacts; with help in disturbances of night sleep, as well as helping the patient with limited physical activity stay fit.

3. This work has defined typical problems and impaired needs in patients with depression and evaluated the quality of nursing care. Thus, the principal impaired need was impaired sleep pattern and impaired rest, which was found in 91% of the cases. Eighty-seven respondents could not engage in their favorite work; 85 respondents reported inability to maintain communication with other people and to express their emotions and opinions. Seventy-eight patients could not normally recreate or participate in entertainment and games. Sixty-seven patients reported not being able to receive enough food and fluid; 71 patients reported inability to satisfy their curiosity and the need for normal personal development. Sixty-six patients were not able to ensure their safety; 62% of patients could not observe personal hygiene and take care of their appearance as a result of mental illness.The following nursing diagnoses have been made in the patients: depressed mood with a sense of despair

and hopelessness; decreased and inadequate physical activity; negative psychoemotional experiences (nervous shivering, crying, fear, apathy, stupor); self-care motivation deficit, limited self-care capacity (going to the toilet, washing and bathing, dressing and eating); limited capacity of establishing and maintaining contacts with other people; severe physical weakness and helplessness of the patient; sleep disorder, insomnia-related; risk for suicide; risk of loneliness and social isolation. The list of planned nursing interventions was compiled, which included the following: to evaluate the nature of statements by and experiences/actions of the patient with reflection in the patient's diary (patient's nursing record), and guide the patient to critical self-evaluation of their judgments and behavior; to define the stress factors enhancing the patient's feelings and deteriorating their mood, and provide the patient with a calm environment, document suicidality and threats of suicide; assess and enhance the patient's self-esteem, conduct conversations with the patient regarding positive behavior practices and more active engagement in physical activity; only where needed, assist the patient with self-care and personal hygiene (going to the toilet, washing and bathing, dressing), and encourage autonomy in self-care; manage the patient's behavior, use psychological correction, help the patient express their experiences, encourage their attempts to communicate with other people, help increase the patient's capacity of establishing and maintaining contacts with other people, reduce the risk of loneliness and social isolation; execute and monitor the execution of physician's orders, record their efficacy, adverse effects of medications and notify the physician when necessary, educating the patients and their family/significant others about the adverse events of medications the patient is receiving and explaining the dangers of self-medication; encouraging the patient to participate in group activities (communication with other people, work therapy, group therapy, etc.); teaching the patient's significant others to identify the first signs of deterioration and to seek medical/psychiatric aid immediately, informing the significant others about the prognosis of the patient's disease; thoroughly document and keep all the information obtained during interaction with the patient in the patient's diary (patient's nursing record). Nursing interventions were performed according to the plan. During hospital stay and observation (during one month), the

majority of patients reported improved mental status: mood improved in 79 pts. (79%); improved physical activity in 68 pts. (68%); negative psychoemotional experiences (nervous shivering, crying, fear, apathy, stupor) resolved or reduced in 59 pts. (59%); self-care capacity improved in 55 pts. (55%); sleep improved in 79 pts. (79%); appetite returned to normal in 51 pts. (51%); and social activity improved in 78 pts. (78%). The above findings suggest a high level of professionalism of nursing staff, their proper attitude to treatment and the high quality of their work. Thus, nursing care is playing a major role in the treatment of patients with depression. The quality of relationships between the nurse and the patient, as well as their mutual rapport, may often become a decisive factor for the outcome of the disease.

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