Understanding Depression: Awareness, Assessment, and Nursing Intervention

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Clinical depression often is overlooked by healthcare providers when treating patients with cancer. Oncology nurses are in a pivotal position to assess for depression, communicate any changes in emotional status to the oncology treatment team, and offer support and education to patients and families. This article discusses the symptoms of depression and the available treatment options.

Grieving about the changes that a cancer diagnosis brings is normal. The future, which may have seemed so sure before, now becomes uncertain. Oncology nurses caring for a person who reports being sad for a long period of time or who is having trouble carrying out day-to-day activities may be caring for a patient with clinical depression. In fact, as many as one in four patients with cancer have clinical depression (Brown et al., 2009; Vachon, 2006).

Clinical depression causes great distress, impairs functioning, and may inhibit the patient’s ability to follow a cancer treatment plan. Depression has been associated with decreased cancer survivorship—a 10-year follow-up study by Vachon (2006) showed that depressive symptomatology was associated with decreased survival time and enhanced disease progression.

Depression is a common response to a cancer diagnosis. However, depression often goes undetected by healthcare providers in about 50% of cases because it usually is not looked for and often is ignored or missed (Brown et al., 2009; Sharp, 2005). However, once identified and diagnosed, clinical depression can be treated.

Screening for depression and other psychiatric illnesses is a critical duty of oncology nurses. Nurses must understand that depression is an illness and the symptoms associated with this illness are not simply a normal reaction to the diagnosis of cancer. However, depression and other psychiatric illnesses still carry a stigma. Many patients may not want to admit that they are experiencing these symptoms for fear of being viewed as weak or because they have a belief that their mood or increased anxiety is something they can simply “snap out of.” In addition, some patients fear discussing their depression with their healthcare providers because of concerns that treatments may be altered, which may affect their recovery.

Assessing for clinical depression is challenging. Many of the symptoms, such as lack of energy, anxiety, or sleep disturbances, can mirror side effects from cancer treatment. According to the American Psychiatric Association (2000), signs and symptoms of major depression include change in appetite, problems with falling asleep or staying asleep, depressed mood, feelings of hopelessness or helplessness, frequent thoughts of death or suicide (not just fear of death), suicide plans or attempts, a decrease in energy, feelings of guilt, a decrease in the capacity to enjoy things that usually gives one pleasure, problems with concentration, and psychomotor agitation or retardation. If five or more of these symptoms are present almost every day for two weeks or more, or are severe enough to interfere with normal activities, then a consultation with a mental health professional is advised.

Suicidal Ideation

Suicidal thoughts are one of the most common symptoms of depression and the one with the highest risk to the patient. Nurses and other staff must communicate the following risk factors to the patient, the patient’s family, and his or her caregivers: hopelessness; helplessness; isolation; changes in affect, mood, and energy; having access to weapons; and any recent stressful events (i.e., discouraging medical news) (Espinosa et al., 2012; Sharp, 2005).

Of note, a sudden brightening of the patient’s mood should be monitored because, at times, patients who have made the decision to take their own life may feel relieved and unencumbered and feel “at peace” now that a decision and a plan of action to relieve the suffering has been solidified.

When assessing for suicidal ideation, nurses should convey a non-judgmental and empathetic style. Nurses should ask patients how they feel and then directly ask, “Have you thought about harming yourself in any way, or even taking your own life? If so, what do you plan to do?” Asking these questions will not put thoughts of suicide into a person’s
mind. Direct questioning about suicidal thoughts may, in fact, convey validation to patients that talking about these painful thoughts and feelings is okay. Other risk factors for suicide ideation are past history of suicide attempts, a family history of suicide, history of depression, and location, severity, and duration of pain. If the patient tries to hurt him or herself, or has a plan to do so, immediate intervention is necessary.

Although early detection of depression is optimal, suicide risk may actually increase as treatment is initiated. As the patient’s neurovegetative signs of depression, such as low energy and low motivation, begin to improve, his or her mood can still be depressed; therefore, the patient’s motivational ability to follow through on an existing suicide plan may increase. After a patient starts treatment, a follow-up assessment by a mental health professional should be conducted at least every one to three months, depending on the severity of the depression and the response to treatment (Sharp, 2005). In this way, the patient can be monitored, frequently assessed, and supported so that treatment for depression can be successful.

Pain

Nurses should be aware that pain from cancer is among the most significant contributors to emotional distress. Helplessness, hopelessness, and irritability engendered by unrelieved pain foster fears of being unable to cope, particularly at the end of life. Anxiety reactions, fears of a loss of control, phobias, and panic attacks can ensue. Therefore, patients with cancer and severe, unrelieved pain are more likely to consider and to commit suicide than other populations of patients with pain (Blair, Larsen, & Belonick, 2012; Lancee et al., 1994; Massie & Holland, 1990; Tang & Crane, 2006).

Specifically, the presence of back pain or all-over body pain, or a longer duration of pain, is associated with increased suicide ideation and thoughts of self-harm as well as comorbid depression (Fishbain, 1999; Tang & Crane, 2006). Because pain causes anguish and contributes to feelings of suicide, hopelessness, and depression, treating the patient’s pain is critical. And, by treating and managing the patient’s painful symptoms, the nurse also conveys empathic validation of the patient’s subjective experience of suffering.

Talking with the patient about coping mechanisms that worked well in the past and strengths that can support them in the present and future can be most helpful. Nurses should provide expressions of hope to patients in a positive, low-key manner. For example, the nurse might say, “I know you feel you cannot go on with the pain you are having and the tough treatments you are going through, but we are hoping to buy some time so we can work together to make life, once again, worth living. You’ve found solace in attending religious services in the past; I’m hoping you will find that helpful once again.”

Treatments

Many effective treatment options exist for depression. In addition to, or in combination with, individual psychotherapy with an experienced psychiatric healthcare provider, antidepressant medications and anxiolytic agents can help with mood and sleep issues. Couples and family therapy are available as well and can offer support and education to the patient’s loved ones so that they, in turn, can support the patient. In addition, group therapy (either supportive or supportive and expressive types) can be helpful. Although most types of psychiatric care are now provided in the outpatient setting, for more serious types of problems such as suicidal ideation, homicidal thoughts, or psychosis, inpatient treatment is available.

Transcranial magnetic stimulation (TMS) therapy was approved by the U.S. Food and Drug Administration in 2009 and is considered a cutting-edge treatment for depression. TMS therapy uses a highly focused pulsed magnetic field to stimulate nerve cells in the area of the brain thought to control mood. TMS is a procedure that can be performed in an ambulatory setting under the supervision of a psychiatrist. During the procedure, the patient remains awake and alert. The typical treatment course consists of five treatments per week in a four to six week period for 20 to 30 treatments (George, 2010; Hampton, 2005).

Another long-standing and effective treatment for depression is electroconvulsive therapy (ECT). ECT is a psychiatric treatment in which seizures are electrically induced for therapeutic effect in anesthetized patients. ECT’s mode of action is unknown. To date, ECT is most often recommended for use as a treatment for severe depression that has not responded to other treatment. In some cases, a psychiatrist may decide to begin ECT when the patient’s thoughts of suicide are of such an imminent nature that the patient cannot safely wait for antidepressant medication to take effect. Despite its effectiveness and safe track record in the treatment of depression, much stigma and public controversy remain about ECT—largely from the media’s depiction of ECT over the years and the public’s lack of education and understanding of how safely and humanely this treatment is now performed (Sharp, 2005).

Whatever the setting, a multidisciplinary treatment team approach is recommended when working with a patient with clinical depression. This team typically consists of nurses, physicians, social workers, occupational or recreational therapists, and nutritionists. Nurses can then gather the appropriate specialists together to further assess the severity of depression, prescribe proper medication, evaluate thinking patterns, and even recommend a diet and exercise regimen. For additional resources and information about clinical depression and treatment options, see Figure 1.

FIGURE 1. Resources About Clinical Depression

• American Psychiatric Association
  www.psych.org
• Electroconvulsive Therapy
  www.ect.org
• Institute of Living
  www.instituteofliving.org
• International Foundation for Research and Education on Depression
  www.ifred.org
• Mayo Clinic
  www.mayoclinic.com
• National Alliance of Mental Illness
  www.nami.org
• National Institute of Mental Health
  www.nimh.nih.gov/health
• Transcranial Magnetic Stimulation
  www.neurostartms.com
Conclusion

Nurses in all specialties should be educated about depression and other psychiatric illnesses so they can provide holistic and safe care to their patients. The oncology nurse is in a pivotal position to assess for clinical depression, communicate any changes in emotional status to the treatment team, and offer support and education to patients and their families.

References


Do You Have an Interesting Topic to Share?

Safety provides readers with information on safety issues affecting patients with cancer and those caring for them. Length should be no more than 1,000–1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Camille A. Servodidio, RN, MPH, CRN, OCN®, CCRP, at cservod@harthosp.org.