Keywords Depression/Mental health/Assessment/Comorbidities

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In this article...

- The symptoms and possible causes of depression, including comorbidities
- How depression is diagnosed and categorised, and issues with the process
- Treatments for depression and how relapses can be prevented

Symptoms and causes of depression, and its diagnosis and management

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Key points

People often have similar symptoms of depression, but each person's experience is unique

Common symptoms include feelings of hopelessness, loss of interest in things previously enjoyed, reduced motivation and reduced energy

There is no single cause of depression; there may be genetic, biological, environmental and psychological factors

Treatment options vary and a stepped-care approach is recommended

Depression is recurrent, so treatment needs to focus on maintaining wellness and preventing relapse

Authors Mary Munro is lecturer, mental health nursing, Robert Gordon University Aberdeen and community mental health nurse (substance misuse), Royal Cornhill Hospital Aberdeen; Rosa Milne is community mental health nurse (adult services), Royal Cornhill Hospital Aberdeen.

Abstract Depression is a common condition. It presents differently in each person, but common symptoms include feelings of hopelessness, loss of interest in things previously enjoyed, and reduced motivation and energy. Diagnostic tools are available but, as they do not capture all the factors that affect depression, full clinical assessments are needed. Misdiagnosis is common. Causes of depression may vary but may relate to situational, genetic, biological, environmental or psychological factors. It often occurs alongside other mental health conditions or long-term physical conditions. Treatment options vary, depending on the severity of the episode, and a stepped-care approach is recommended. Depression can be recurrent, so treatment should focus on avoiding relapse.

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Depression is a major public health issue in the UK and worldwide (Norman and Ryrie, 2018). It is estimated to affect 264 million people globally (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018), and defined by the World Health Organization (2020) as a leading cause of disability worldwide and a major contributor to the overall burden of disease. WHO (2020) defines depression as low mood and loss of enjoyment in things that were previously enjoyed.

The human experience involves periods of low mood or difficulty, but for most people these feelings pass. The difference between a low mood and depression is when an individual's feelings consistently interfere with their daily life over a minimum period of two weeks (Norman and Ryrie, 2018). An episode of depression can vary in duration from weeks to years, but normally lasts for a minimum of several weeks (Mind, 2017).

Signs and symptoms

For any diagnosis of depression, and ideally before treatment options are explored, the severity of an individual's depression should be ascertained; this is indicated by their symptoms. Symptoms may vary between individuals but, generally, they will encompass feelings of sadness and hopelessness (Lotfaliany et al, 2019). Norman and Ryrie (2018) have said the signs and symptoms of depression can be split into two categories: how an individual feels and how these feelings affect their behaviour.

Common feelings associated with depression include:

- Low mood;
- Sadness;
- Hopelessness;
- Worthlessness;
- Low self-esteem;
- Irritability;
- Anger.

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Box 1. **Common signs and symptoms of depression**

- Feelings of hopelessness
- Loss of interest in things previously enjoyed
- Reduced motivation
- Reduced concentration
- Reduced self-esteem
- Reduced or increased appetite
- Reduced libido
- Disturbed sleep
- Feelings of helplessness
- Reduced energy
- Unexplained aches and pains
- Anger or irritability
- Changes in cognition
- Guilt or worthlessness
- Ideas or acts of self-harm
- Suicidal thoughts

The detrimental effect these feelings have on how an individual behaves in their daily life means that behavioural symptoms often include a lack of motivation in personal care, work and relationships. Most people present with a variety of signs and symptoms; the most common are listed in Box 1 (Norman and Ryrie, 2018).

Diagnosis

Categorisation

Two main classification system manuals are used to diagnose depression:

- WHO's (2016) *The International Classification of Diseases, 10th Revision* (ICD-10);
- the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).

Both manuals categorise depression into three main categories – mild, moderate and severe – depending on the number of symptoms (Table 1), their duration and frequency.

Mild depression. The DSM-5 defines mild depression as:

- Depressed mood;
- increased fatiguability;
- Loss of interest and enjoyment;
- At least two other symptoms from those listed in Box 1.

Symptoms must be evident but not presenting to an intense degree. There may be some difficulty continuing with ordinary work and social activities, but they will not stop completely.

Moderate depression. Christensen et al (2019) define moderate depression as:

- A low mood;
- Loss of interest;
- At least three other symptoms from those listed in Box 1.

Symptoms are present to a marked degree, and there is difficulty continuing with daily activities.

Severe depression. DSM-5 categorises severe depression as:

- Five or more symptoms during a two-week period;
- A change from previous functioning;
- Low mood for most of the day, nearly every day, as indicated by either:
  - Subjective report by the individual that they feel sad, empty or hopeless;
  - Objective observation made by others that the individual appears tearful or irritable, or is expressing suicidal thoughts (National Institute for Health and Care Excellence, 2009).

Diagnostic tools

Health professionals can use a variety of tools to help with accurate and robust diagnosis of depression (Nabbe et al, 2018). However, NICE (2009) identified that a range of biological, psychological and social factors can have a significant impact on depression and are not wholly captured by diagnostic systems. It is, therefore, vital to consider the individual's personal history and family history of depression during a diagnostic assessment (NICE, 2009).

The Whooley questions for depression screening (Box 2) form a commonly used depression diagnostic tool. However, findings have suggested the tool alone cannot determine whether a person has depression; if they answer yes to one or both questions, a full clinical assessment is needed (Bosanquet et al, 2015). The assessment can be carried out by a GP or, if the patient presents in secondary care, an assessing nurse or doctor who is competent to perform a mental health assessment. The assessment must evaluate the person's mental state and accompanying functional, interpersonal and social difficulties (NICE, 2009).

Nurses work at the forefront of patient interaction and care. It is, therefore, essential that they understand depression, along with its signs, symptoms and clinical, social and economic impacts to be able to provide effective person-centred care. Nurses from all fields can learn to recognise depression and ensure further assessment and interventions are offered.

Misdiagnosis

Misdiagnosis of depression is common (Bostwick, 2012) because several illnesses have similar symptoms; for example, hyperthyroidism symptoms include low mood, reduced attention span and fatigue.

Depression is underdiagnosed in older adults (Rodda et al, 2011) and can be misdiagnosed as dementia due to the similarity in some symptoms, such as increased social isolation and mood changes. An assessment tool such as the General Practitioner Assessment Of Cognition (gpcog.com.au) may be required to differentiate between symptoms of depression and dementia.

Possible causes

Depression is a complex condition, and its causes are not fully understood. Genetics,

Table 1. **Overview of the categories of depression**

	Depression category		
	Mild	Moderate	Severe
Feature	Two or three common depressive symptoms (Box 1)	Four or more common depressive symptoms (Box 1)	Several common depressive symptoms (Box 1), which are marked and distressing
Presentation	• The individual may display some distress due to these symptoms, but can continue with daily activities with little impact	• The individual is likely to have great difficulty continuing with daily activities	• The individual has marked feelings of worthlessness, hopelessness or guilt; difficulty or inability to continue with daily activities • Suicidal thoughts and plans

Box 2. **Whooley questions for depression screening**

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things

'Yes' to one or both questions = positive test (requires further evaluation)
'No' to both questions = negative test (individual does not have depression)

Source: Whooley et al (1997)

biology, environment and psychological factors may play a role, and it can affect people of any age, race and socioeconomic status. Why people experience depression varies, so it is important to treat each person individually and understand their symptoms and behaviours by getting to know them – don't look at the diagnosis of depression alone, as the cause will be personal to individual (Norman and Ryrie, 2018).

Epidemiology

In the *Adult Psychiatric Morbidity Survey* undertaken in England in 2014, 3.3% of respondents reported that they were experiencing depression (McManus et al, 2016), while in Scotland 20% of the adult population experienced one or more symptom of depression in 2014/15 (Mental Health Foundation, 2016).

Although the exact reasons why depression manifests are unclear, there are some theories to help our understanding. Almost all community epidemiological studies find that gender, age and marital status are associated with depression. Kessler and Bromet (2013) have suggested that adult women are at almost double the risk of severe depression compared with men and a study by Van de Velde et al (2010) identified that women represented statistically higher rates of severe depression in 15 of the 18 countries they studied. Kessler and Bromet (2013) suggested people who are separated or divorced have significantly higher rates of severe depression, compared with those who are married.

Some studies suggest that genetics can influence the risk of developing depression – for example, Elwood et al (2019) have found that some genes may play a key role in developing recurrent depression. However, it must be noted that there is no one gene linked to depression.

Studies have shown that lifestyle choices such as a lack of exercise, being underweight or overweight and having fewer social relationships can increase the risk of developing depressive symptoms (Esiwe et al, 2015). The use of legal and illegal drugs may also be a way of coping for some individuals, and has been linked to a greater risk of developing depression as well as other mental health conditions (Esiwe et al, 2015).

Ongoing research suggests that people who have experienced adverse childhood events, trauma or abuse have increased symptoms of depression compared with the general population (Bond, 2019). Depression has also been found to be more prevalent in people with a lower socioeconomic status and a lower subjective social status (Hoebel et al, 2017). There is also evidence suggesting an association between social deprivation and depression: Fiske et al (2009) found that people in areas of great deprivation are four times more likely than the general population to experience depressive symptoms.

Comorbidity with physical conditions

A number of studies have highlighted the link between depression and long-term physical health conditions, including:

- Arthritis;
- Asthma;
- Cancer;
- Cardiovascular disease;
- Diabetes;
- Stroke;
- Respiratory illnesses;
- Musculoskeletal disorders;
- Neurological disorders (Kang et al, 2015; Fiske et al, 2009; NICE, 2009).

The life expectancy of people who are diagnosed with severe depression is 10 years lower than that of the general population; one reason for this is the higher suicide rate in this group, but it is also because depression elevates the risk of the onset, persistence and severity of a wide range of physical disorders (Norman and Ryrie, 2018). Long-term physical conditions can also cause or exacerbate depressive symptoms (NICE, 2009). This comorbidity has been attributed to:

- Both conditions causing a poor quality of life;
- The physical condition progressing, causing increased depressive symptoms;
- An increased mortality risk;
- Increased economic issues caused by ill health;
- Greater levels of disability;
- An increased deterioration in functioning than when depression or a physical condition is present alone (Kang et al, 2015).

These findings emphasise the importance of careful psychological assessment and treatment of people with a long-term physical condition, even in the critical stages of a disease. Nurses in all fields should consider the mental health of people in their care.

Comorbidity with mental health conditions

Depression can exist comorbidly with other mental health conditions, including substance use disorders (Blanco et al, 2013). Kellner et al (2012) said this was partly because people with a substance use disorder commonly face stigmatisation, marginalisation and financial insecurity, which can cause depressive symptoms. People with a substance use disorder who have a diagnosis of depression are at a higher risk of death by overdose than other substance users (Pabayo et al, 2013). Kellner et al (2012) identified that 50% of people with a substance use disorder reported symptoms of severe depression but were not receiving any treatment for it.

Another common comorbidity of depression is anxiety disorder (Hranov, 2007). Having both anxiety and depression has been found to increase the severity and number of symptoms of each condition, resulting in greater impairment (Hofmeijer-Sevink et al, 2012). Some of the symptoms of anxiety and depression also overlap, for example overthinking, avoidance and sleep disturbance (WHO, 2020). The high rate of comorbidity of anxiety and depression suggests we should consider the occurrence of one disorder as a pre-disposing factor for developing the other (Cameron, 2007).

Treatment and support

Treating depression

NICE (2009) recommended a stepped-care approach to treat depression, using a framework that lists the most-effective interventions (Table 2). In stepped care, the least-intrusive, most-effective intervention is provided first; if a person does not benefit from it, or declines it, they should be offered an appropriate intervention from the next step.

Cognitive behavioural therapy, behavioural activation methods, self-help

Table 2. **Stepped-care approach to treating depression**

Step	Focus of the intervention	Nature of the intervention
1	All known and suspected presentations of depression	Assessment; support; psychoeducation; active monitoring and referral for further assessment and interventions
2	Persistent sub-threshold depressive symptoms; mild-to-moderate depression	Low-intensity psychosocial interventions; psychological interventions; medication; referral for further assessment and interventions
3	Persistent sub-threshold depressive symptoms or mild-to-moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication; high-intensity psychological interventions; combined treatments; collaborative care and referral for further assessment and interventions
4	Severe and complex depression; risk to life; severe self-neglect	Medication; high-intensity psychological interventions; electro-convulsive therapy; crisis service; combined treatments; multiprofessional and inpatient care

Source: Adapted from NICE (2009)

approaches, interpersonal therapy and counselling have all proved effective psychological interventions for depression (Ekers and Webster, 2012). Both technology-assisted and face-to-face therapy have been found to be effective (Zhang et al, 2019).

Electroconvulsive therapy can be used for severe depression; despite controversy about the treatment, due to misconceptions or unfamiliarity, it is acknowledged as one of the most-effective treatments for severe mood disorders (Kellner et al, 2012).

Newer treatments are being developed for treatment-resistant depression, such as esketamine given by infusion (Bozymski et al, 2019). Most first-line antidepressants take 4-6 weeks to achieve full effect; the response time for esketamine is as short as 2-24 hours post-administration in clinical trials (Bozymski et al, 2019). Although esketamine could be a promising option for treatment-resistant depression, its disadvantages include its cost, the time commitment required to attend an infusion clinic and its unpleasant side-effects. According to the *British National Formulary* these include arrythmias, dizziness, hypersalivation, nausea, vomiting, respiratory issues, sleep disorders and vision problems.

Treatment and support for depression can come from many health professionals in primary or secondary care, depending on the severity of symptoms. Mental health nurses, GPs, occupational therapists, psychologists and psychiatrists can all provide evidence-based interventions. Core interventions for nurses working with people with depression include:

- Psychological approaches;
- Psycho-education (the process of providing education and information to people seeking or receiving mental health services and their families);
- Medications management;
- Monitoring.

Providing support

NICE's (2009) guidance stated that when working with people who have depression, 'best practice' means:

- Having a non-judgemental attitude;
- Promoting hope and recovery;
- Being respectful of privacy and dignity;
- Supporting families or carers.

NICE (2009) also recognised that depression may be accompanied by discrimination and stigma.

Stigma is a significant issue in mental health: it lowers people's self-esteem, makes symptoms more severe and limits help-seeking behaviours (Sastre et al, 2019). Nurses should be aware of the potential for self-stigmatisation in people with depression. Forming an effective therapeutic alliance has been shown to improve clinical outcomes in people with depression (Arnow et al, 2013) and reduce negative self-perception (Porr et al, 2012).

Community and third-sector support is also often available. This can include:

- Peer support groups;
- Social groups;
- Opportunities for exercise;
- Help to change to a healthy diet.

These have been shown to improve symptoms (Rosenbaum et al, 2014; Cruwys et al, 2013; Sanchez-Villegas and Martínez-González, 2013; Pfeiffer et al, 2011).

A key part of recovering from a mental health condition is patient choice; people with depression may benefit from a multifaceted, holistic approach to treatment (Loos et al, 2017).

Avoiding relapse

Depression is common and often chronic and recurrent (Uher and Pavlova, 2016). Its symptoms and outcomes are marked by persistent suffering, poor overall health and negative effects on several areas of life, including psychosocial, academic and work life (de Zwart et al, 2018). One study found that fewer than a third of patients recovered and remained well in the 18 months after an episode of depression (Mulder, 2015). This suggests treatment needs to focus on maintaining wellness and preventing relapse.

To help prevent relapse, it is helpful to use the recovery model, a holistic, person-centred approach to mental health care that is becoming the standard model. It is based on two simple premises:

- It is possible to recover from a mental health condition;
- The most-effective recovery is patient directed.

A significant part of sustained recovery from depression is being able to avoid or cope with relapse risk factors (Jumnoodoo et al, 2017). Recovery can mean a person staying in control of their life and living in a way that is meaningful to them, rather than returning to the level of functioning they experienced before depression (Jacob, 2015). Although depression is a chronic condition that can recur throughout someone's life (Uher and Pavlova, 2016), this does not have to mean a state of consistent suffering and powerlessness but, instead, a journey that includes setbacks and successes (Scottish Recovery Network, NHS Education for Scotland, 2007).

Modern-day living and its pressures have been linked to a rise in depressive symptoms and prevalence of depressive disorders (Hidaka, 2012; Walsh, 2011). Although psycho-education, medication and psychological approaches have been shown to be effective at treating depression (NICE, 2009), people can take several lifestyle approaches to maintain good mental health. These include:

- Making connections with other people;
- Getting regular exercise;
- Eating well;
- Taking breaks when required;
- Drinking alcohol within recommended limits (MHF, 2016).

Nurses are well-placed to advise patients on these.

Conclusion

This article has provided a general overview of depression, its treatment, outcomes and significance when providing nursing care and assessment. As nurses in all settings and specialties work at the forefront of patient interaction and care, a knowledge of depression, its signs and symptoms, and its potential implications for patients is essential to provide person-centred care. Nurses from all fields can learn to recognise depression in their patients and ensure further assessment and interventions can be offered. **NT**

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