

# MAJOR DEPRESSION/DYSTHYMIC DISORDER

## DSM-IV

### DEPRESSIVE DISORDERS

296.xx Major depressive disorder

296.2x Single episode

296.3x Recurrent

300.4 Dysthymic disorder

311 Depressive disorder NOS

A disturbance of mood, characterized by a full or partial depressive syndrome, or loss of interest or pleasure in usual activities and pastimes with evidence of interference in social/occupational functioning.

## ETIOLOGICAL THEORIES

### Psychodynamics

Psychoanalytical theory focuses on an early unsatisfactory parent/child relationship, with an unresolved grieving process. This results in the individual remaining fixed in the anger stage of the grieving process and turning it inward on the self. The ego remains weak, while the superego expands and becomes punitive.

Cognitive theory projects a belief that depression occurs as a result of impaired cognition, fostering a negative evaluation of self through disturbed thought processes. The individual is pessimistic and views self as inadequate and worthless and life as hopeless.

Learning theorists propose that depressive illness arises out of the individual's having experienced numerous failures (either real or perceived). A feeling of inability to succeed at any endeavor ensues. This "learned helplessness" is viewed as a predisposition to depressive illness. The behavioral model states that the cause of depression is in the person-behavior-environment interaction. Although people are seen as capable of exercising control over their behavior, they are not totally free of environmental influence.

### Biological

A family history of major affective disorders may exist in individuals with depressive disorders. Recently it has been found that the disease has a genetic marker, as shown by numerous studies that support the involvement of heredity in depressive illness.

Biochemical factors (e.g., electrolyte imbalances) appear to play a role in depressive illness. An error in metabolism results in the transposition of sodium and potassium within the neuron. Another theory implicates the biogenic amines norepinephrine, dopamine, and serotonin. The levels of these chemicals are deficient in individuals with depressive disorders. Controversy remains as to whether these biochemical changes *cause* the depression or whether they are *caused by* the illness. In recent years, a common form of major depression called *seasonal affective disorder* (SAD) has been identified. Recurring each year, starting in fall or winter and ending in spring, the symptoms are largely typical of depression, with some atypical symptoms (excessive sleep, increased appetite, and weight gain). This disorder is believed to be caused by the decreased availability of sunlight and is related to circadian cycles, which are set by each individual's internal biological clock. Circadian cycles are more precisely adjusted and coordinated by the alternation of darkness and light.

Impaired serotonergic transmission has also been investigated as a cause of depression (indolamine hypothesis). It has been shown that multiple regions of the brain in depressed clients lack metabolic responsivity, suggesting a generalized subresponsivity of the serotonergic system. Additionally, current research suggests that infection with the Borna disease virus (BDV) may be linked to some cases of major depression and other severe mood disorders.

## **Family Dynamics**

Object loss theory suggests that depressive illness occurs if the person is separated from or abandoned by a significant other during the first 6 months of life. The bonding process is thereby interrupted, and the child withdraws from people and the environment.

## **CLIENT ASSESSMENT DATA BASE**

### **Activity/Rest**

Fatigue, malaise, decreased energy level, lethargy

Sleep disturbances (e.g., insomnia) occur in 90% of cases—either anxiety insomnia (with difficulty falling asleep) or depressive insomnia (with early morning awakening, accompanied by painful ruminations); also hypersomnia (with restlessness and feeling unrefreshed, particularly in SAD)

May report feeling best early in the morning, then continually feeling worse as the day progresses (dysthymia); or the opposite may be true (especially in severe depression)

### **Ego Integrity**

Feelings of worthlessness: self-derogatory statements, expressions of guilt, or exaggeration of minor inadequacies; may assume delusional proportions with presentations of unrealistic evidence of self-worth/intense focus on self (e.g., feeling oneself responsible for major tragedies and catastrophes or persecuted for a failure)

Morbid sadness; actual loss or life stressor perceived as a loss (e.g., retirement, job loss, divorce, illness, aging); may or may not see connection between perceived losses and onset of depression

Feelings of helplessness, hopelessness, powerlessness, pessimism, irritability, excessive anger

### **Elimination**

Constipation and urinary retention may be present

### **Food/Fluid**

Decreased/increased appetite accompanied by significant change in weight (average gain of 10 pounds in SAD)

### **Hygiene**

Inattention to personal care needs, unkempt appearance

Possible body odor

Posture may be bent/slouched (defeated-looking)

### **Neurosensory**

Dejected or sad mood, with loss of interest/enjoyment in usual activities

Depressed mood for most of day, for more days than not, for at least 2 years (dysthymia), or with intermittent symptom-free periods, for at least 2 months (recurrent)

Expressed sadness, dejection, not caring about anything, not seeing any future for self; tending to sigh and be tearful

Irritability, headache

Psychotic features with prominent delusions and/or hallucinations (major depression)

**Psychomotor Retardation:** May present either a “slow motion” picture, with slowed speech and latencies (long pauses before responding), decreased amount of speech, and slowed body movements; or agitation, featuring constant, rapid, purposeless movements (severe depression)

Thinking characterized by poor concentration and decreased memory, indecision, suicidal ideation

## Safety

Thoughts of suicide/wanting to die possibly occurring frequently throughout the illness; may range in severity from indifference about the consequences of behavior (e.g., lack of cooperation with medical treatment, or dangerous driving), to wishing it were “over” or for death, to specific suicide plans and attempts

## Sexuality

Disinterest in sexual activities, and/or impotence

Women affected almost twice as often as men, primarily during the childbearing years of late 20s to early 30s and again in the postmenopausal years of late 40s to early 50s

## Social Interactions

Participation diminished, difficulty starting activities, withdrawal (e.g., housebound or remains in a single room/bed)

## Teaching/Learning

Family history of depression; high rates of alcoholism/other drug abuse

## DIAGNOSTIC STUDIES

(The several biochemical alterations in depression are not, by themselves, indicative of depression but, combined with clinical observation, may indicate best pharmacological response.)

**Thyroid-Stimulating Hormone Response to Thyrotropin-Releasing Hormone:** Decreased level suggests depression.

**Dexamethasone-Suppression Test (DST)** (an indirect marker of melancholia): Postdexamethasone cortisol levels exceeding 5 g/dl indicate abnormal/positive result and can be used to predict effectiveness of antidepressants.

**EEG Sleep Profile:** This shows reduced latency of rapid eye movement (REM) sleep.

**CBC, Blood Glucose, Electrolytes, Renal/Liver Function Tests:** These identify abnormalities contributing to or resulting from depression.

**Other medical tests that may be included:**

**Platelet Monoamine Oxidase Activity (MAO):** Increased.

**Biogenic Amines (Especially Norepinephrine and Serotonin Levels):** Decreased (clients with low serotonin levels are 10 times more likely to commit suicide within a year).

**a-Acid Glycoprotein:** Inhibitor of serotonin transporter is elevated.

**Urinary 3-Methoxy-4-Hydroxyphenylglycol (MHPG):** If low, indicates decreased norepinephrine output.

**Cerebrospinal Fluid Level of 5-Hydroxytryptamine (5HIAA):** Reduced.

**Minnesota Multiphasic Personality Inventory (MMPI):** Scale 2 consistently elevated.

**Wechsler Adult Intelligence Scale-Revised (WAIS-R):** Overall performance score significantly lower than verbal score.

**Rorschach Test:** Long reaction times, chromatic color responses diminished.

**Thematic Apperception Test (TAT):** Short, stereotyped responses/simple descriptions of cards.

**Zung (or Similar) Depressive Scale (ADS):** Self-report reflecting affective, psychic, somatic characteristics of depression.

## NURSING PRIORITIES

1. Promote physical safety with special focus on suicide prevention.
2. Provide for client's basic needs, promoting highest possible level of independent functioning.

3. Provide experience/interactions that enhance self-esteem, sense of personal power.
4. Support client/family participation in follow-up care/community treatment.
5. Provide information about condition, prognosis, and treatment needs.

## **DISCHARGE GOALS**

1. Suicidal ideation/self-violent behaviors absent.
2. Physiological stability achieved with responsibility for self demonstrated.
3. Client expressing feelings appropriately with some optimism and hope for the future.
4. Client/family participating in follow-up care/community treatment.
5. Condition, prognosis, and therapeutic regimen understood.
6. Plan in place to meet needs after discharge.

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### **NURSING DIAGNOSIS**

#### **Risk Factors May Include:**

#### **[Possible Indicators:]**

#### **Desired Outcomes/Evaluation Criteria— Client Will:**

### **VIOLENCE, risk for self-directed**

Depressed mood

Feelings of worthlessness and hopelessness

Verbalization of suicidal ideation/plan or futility of trying (e.g., “What’s the use?”)

Giving possessions away/making a will

Sudden mood elevation/appearing more energized or displaying calmer, more peaceful manner

Refusal/reluctance to sign a “no harm” contract

Voluntarily comply with suicide precautions, sign “no harm” contract.

Verbalize a decrease/absence of suicidal ideas.

State 2 reasons for not harming self.

Commit no acts of self-violence.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Identify degree of risk/potential for suicide through direct questions (e.g., “Have you thought about killing yourself?”). Assess seriousness of suicidal tendency, noting behaviors such as gestures, threats, giving away possessions, previous attempts, presence of hallucinations or delusions. (Use scale of 1–10 and prioritize care according to severity of threat, availability of means.)

Reevaluate potential for suicide periodically at key times (e.g., during mood changes, at initiation of changes in medication regimen, when increasing withdrawal occurs, when discharge planning becomes active, before sending out on pass, before discharge from program).

Implement suicide precautions. For example, explain to client that you are concerned for his or her safety and that you will be helping client to stay “safe.”

Create a time-specific contract with client on what client and nurse will do to provide for client’s safety. Renew contract as appropriate. Place a copy of the “contract,” signed by client and staff, in the chart/file and give a copy to the client to keep.

### **When hospitalized:**

Provide close observation (1:1 or random checks every 10 to 15 minutes for most acute risk). Place in room close to nurse’s station; do not assign to a single room. Accompany to off-ward activities if attendance is indicated. Ask client to stay in view of staff member at all times.

Be alert to use of hazardous equipment; remove hazardous personal items (e.g., scarves, belts, razor blades, scissors).

Degree of hopelessness expressed by client is important indicator of severity of depression and suicide risk. Eight of 10 clients who state an intention to commit suicide do so. The more thought-out the plan, the higher the chances of completing it. The chances of suicide increase if there was a previous suicide attempt or if a family history of suicide and depression is present. Impulsive clients are more likely to attempt suicide without giving clues, including those with psychotic thinking who are especially at risk when hallucinations or delusions encourage self-harm. **Note:** Individuals with untreated depression have a suicide rate of 15%.

Suicide risk is the greatest during the first few weeks following admission to treatment. More than half of suicides by hospitalized clients occur out of the hospital, while they are on leave or during an unauthorized absence. The highest risk is when the client has both suicidal ideation and sufficient energy with which to act (e.g., at the point when the client begins to feel better).

Communicates caring and provides sense of protection.

Documents actions taken to prevent suicide and client response. It also promotes communication and can help client realize that others care what happens. Short-term contracts encourage client to deal with the here-and-now and provide opportunity to reassess situation.

Being alert for suicidal and escape attempts facilitates being able to prevent or interrupt harmful behavior.

Provides environmental safety; removes objects that may prompt suicidal thoughts/attempts.

Check all items brought in to or by the client as indicated. Ask family and other visitors to avoid bringing hazardous items.

Maintain special care in administration of medications.

Be alert when client is using bathroom.

Make rounds at frequent, irregular intervals (especially at night, toward early morning, at change of shift, or other predictably busy times for staff).

Routinely check environment for hazards. Provide for environmental safety (e.g., lock doors/windows when not supervised; block access to stairways, roof, and construction areas; monitor cleaning chemicals/repair supplies).

Review medical regimen, including electroconvulsive therapy (ECT), allowing client/family to ask questions and express feelings freely.

Be aware of staff attitudes toward the use of ECT, and avoid influencing client negatively.

Suicidal clients may bring harmful items back from a pass or may ask family for items, with a suicide plan in mind.

Prevents the client from saving medication up to overdose or discarding and not taking medication.

Although decreasing the client's privacy may seem awkward, it is essential that the suicidal client be within caregiver's view at all times to prevent self-harm (e.g., hanging).

Prevents staff surveillance from becoming predictable. To be aware of client's location is important, especially when staff is busy and least available/observant.

Minimizing opportunities for self-harm is an ongoing issue requiring constant attention and consideration of the unusual.

Antidepressant drugs may take 3 or more weeks to lift mood. In the meantime, other forms of therapy may be required to provide protection for the suicidal client. ECT is generally a second line of treatment, used if depression has not responded to pharmacological treatment and/or client continues to display suicidal ideation, sleeplessness, refusal to eat and drink. Client may fear ECT, and nurse needs to empathize with client's fears while supporting ECT as being a positive treatment alternative.

When nurses/others have negative or ambivalent feelings toward this treatment, these feelings can be communicated to the client, causing confusion/reluctance to accept appropriate therapy.

## Collaborative

Administer medications as indicated, e.g.: SSRIs: fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), sertraline (Zoloft); tricyclics, e.g., amitriptyline (Elavil), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil); heterocyclics, e.g., amoxapine (Asendin), bupropion (Wellbutrin), maprotiline (Ludiomil), trazodone (Desyrel); monoamine oxidase inhibitors (MAOIs), e.g., phenelzine (Nardil), isocarboxazid (Marplan), tranylcypromine (Parnate).

Evaluate cardiac status, obtain ECG as appropriate.

Prepare for/assist with ECT as indicated.

Selective serotonic reuptake inhibitors and cyclic antidepressants are generally considered the safest and easiest to manage of the antidepressants and so are started first. If response is not noted in 4 to 6 weeks, an MAOI may be the drug of choice. These drugs act by blocking enzyme degradation of neurotransmitters (norepinephrine, serotonin).

**Note:** Medications inhibiting reuptake of serotonin, or heterocyclic drugs (e.g., Wellbutrin), are usually preferred for treating depression in bipolar disorders, whereas tricyclics and MAOIs may increase possibility of switch to manic behavior. (Tricyclics use a “shotgun approach,” whereas newer generations of drugs usually target a specific neurotransmitter. TCAs also can cause toxicity before therapeutic levels are achieved, and MAOIs can cause fatal central serotonin syndrome if administered within 2 weeks of SSRI therapy).

TCAs can increase cardiac conduction disturbances and cause dangerous interaction with antidysrhythmic medications.

ECT becomes essential and in some cases life saving when depression does not respond to other treatments and suicide is a major risk. (Of clients with major depression, 80% to 90% show marked improvement after ECT.)

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### NURSING DIAGNOSIS

#### May Be Related to:

#### Possibly Evidenced by:

### GRIEVING, dysfunctional

Multiple life changes, actual/perceived loss including loss of physiopsychosocial well-being (poor nutrition, little or no exercise)

Thwarted grieving response to a loss, lack of resolution of previous grieving response

Absence of anticipatory grieving

Perception of areas in life as unfulfilled or as losses; denial of loss; expression of unresolved issues, guilt

Crying/labile affect

Interference with life functioning, alterations in concentration/pursuit of tasks, changes in eating habits, sleep/dream patterns, activity level, libido

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Demonstrate progress in dealing with stages of grief at own pace.

Participate in work/self-care activities at level of ability.

Verbalize a sense of progress toward resolution of the grief and hope for the future.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Assess losses that have occurred in the client's life. Discuss meaning these have had for the client.

Denial of the impact/importance of a loss may be contributing to severity of depression.

Determine cultural factors and ways individual has dealt with previous loss(es).

Cultural beliefs affect how people express and accept grieving processes.

Encourage verbalization of and assist in identification of feelings and relationship between feelings and event/stressor, when the event is known.

Verbalization of feelings in a nonthreatening environment can help client begin to deal with unrecognized/unresolved issues that may be contributing to depression. Helps client realize response (feeling) is connected to the stressor or precipitating event.

Discuss ways to identify and cope with underlying feelings (e.g., hurt, rejection, anger). Set limits regarding destructive behavior.

Begins to increase the client's repertoire of coping strategies. Learning that choices are available for behaving differently can often decrease the feeling of being stuck. "Storytelling" of how others have handled situations may be helpful, not only in providing potential solutions but also in giving the idea that the problem is manageable.

Identify normal stages of grief and acknowledge reality of associated feelings, e.g., guilt, anger, powerlessness.

Helps client understand normalcy of feelings and may alleviate some of the guilt generated by these feelings.

Assist client to identify need to address problem differently. Describe all aspects of the problem through the use of therapeutic communication skills.

Contracting for change begins with agreeing on "the problem." It helps the client to consider all aspects of the problem, to define clearly what the client is dealing with.

Help client recognize early symptoms of depression and plan ways to alleviate them. Help client formulate steps to take for outside support if symptoms continue.

Involves the client actively, reducing sense of powerlessness. Rehearsal promotes generalization of recently learned coping strategies to new situations and may help to minimize recurrence of depressive feelings.

Reinforce the positive aspects of being able to reach out for help.

Encourages the client to learn how to manage/take care of self. It is important that the client has support available should help be needed and that the client experience needing to reach out as positive, reflecting sense of empowerment and own self-worth.

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**NURSING DIAGNOSIS****ANXIETY [moderate to severe]/THOUGHT PROCESSES, altered****May Be Related to:**

Psychological conflicts; unconscious conflict about essential values/goals of life

Unmet needs

Threat to self-concept

Sleep deprivation

Interpersonal transmission/contagion

**Possibly Evidenced by:**

Reports of nervousness or fearfulness, feelings of inadequacy

Agitation, angry or tearful outbursts, rambling and disorganized speech

Restlessness, hand-rubbing or -wringing, tremulousness

Poor memory and concentration, decreased ability to grasp ideas, inability to follow, impaired ability to make decisions, circumstantiality (unable to get to the point)

Numerous, repetitious physical complaints without organic cause

Ideas of reference, hallucinations/delusions

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Verbalize awareness of feelings of anxiety, changes in thinking/behavior.

Identify ways to deal effectively with decision-making.

Converse appropriately with staff or in groups.

Attend to and complete tasks (ADLs, occupational therapy projects, etc.) of increasing length and difficulty.

Report anxiety is reduced to manageable level.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Evaluate/reevaluate level of anxiety.

Approaches differ, depending on level of anxiety. (Refer to CP: Generalized Anxiety Disorder.)

Recognize and deal with own feelings in response to client's anxiety.

Anxiety is highly communicable. If the nurse becomes anxious (or impatient, irritable, etc.), this will be communicated and feed client's anxiety.

Listen nonjudgmentally to client's expressions; convey empathy; acknowledge or label feelings for client.

Helps client identify basis for anxious feelings, communicates acceptance, and assists in reducing current level of anxiety.

Use short, concrete communication. Assume calm, "in-control-of-things" manner. Let client know about safety and supportive attentions of the staff/facility.

Decrease environmental stimulation; remove to quiet area away from other clients. Suggest activity that may be relaxing (e.g., warm bath, back rub). Involve in a quiet activity when calmer.

Maintain a calm attitude and use physical touch, if acceptable to client.

Defer problem-solving, assessment of precipitating factors until anxiety is reduced to a more manageable level.

Analyze incident with client and staff to identify precipitating factors, early signs of building anxiety, previously helpful interventions.

Stay with client as indicated.

Decrease decision-making for client by offering a choice between only 2 options (e.g., whether to have cereal or eggs, rather than a full menu).

Choose for the client when necessary, based on knowledge of the client's interest and activity level, telling client how the choice was decided.

Discourage use of caffeine.

Assist client to learn relaxation/imagery exercises. Use tapes of relaxation exercises and calm music. Prompt client to use these techniques when becoming anxious.

Engage in role-playing and encourage practice of stress relief techniques when client is not feeling anxious.

Encourage creative activities and development of greater leisure skills.

Attention, concentration, and problem-solving are compromised by anxiety. Benign attention/monitoring by staff may be interpreted in a paranoid manner by the client.

Reduces anxiety-provoking stimuli and distractions. Helps client refocus away from anxiety.

May prove helpful if anxiety stems from delusions/hallucinations; touch can restore client to reality. Caution is required with suspicious clients who may interpret touch as aggression.

Ability to problem-solve is compromised, and such requests may increase anxiety.

Develops an individualized plan that will help decrease anxiety; establishes/reestablishes previous coping skill. Client needs to learn how to manage own anxiety by recognizing the signs and then acting to lower the anxiety.

Promotes sense of safety and provides opportunity to focus on present and use techniques to alleviate anxious feelings.

Decreasing options lessens the amount of information to process and enhances decision-making. As ability to think through incoming information increases, more options can be added.

Judicious choosing for the client may decrease sense of inadequacy when client feels overwhelmed and may provide role-modeling of decision-making process.

Can produce anxiety-like symptoms, compounding clinical picture and client's perception of situation.

Develops skills for coping with anxiety responses.

Enables client to use skill more effectively (automatically) as needed and helps individual handle problems/pressures as they occur.

Helps expand positive energy and attention. Enhances self-worth.

Encourage participation in regular exercise program, sporting activities, occupational/recreational therapy including brisk walks, jogging, punching bag, volleyball.

Involve in group settings, encouraging and reinforcing appropriate participation. Redirect into activities, e.g., interaction with others, as indicated.

Deal with physical complaints in matter-of-fact style. Investigate appropriately if new; redirect if not new or validated. Do not ask how client is or feels. Help client recognize physical symptoms as anxiety signals when appropriate. Note history of mitral valve prolapse (MVP).

### **Collaborative**

Provide phototherapy as indicated.

Participation in individually prescribed activities and large motor exercises provides safe, effective methods for discharging pent-up tensions, learning to trust self, and enhancing self-esteem. Exercise releases endorphins, enhancing sense of well-being. **Note:** Exercise therapy does not need to be aerobic or intensive to achieve desired effect.

Increases opportunities for/reinforcement of desired, productive interaction style. Sharing with others decreases sense of being the only one. Client may learn new coping styles from stress of participation as well as from peers who have experienced similar stressors.

Detection of physical problems and prevention of discounting client's discomfort are important. Reduces reinforcement for focusing on self and symptoms while providing opportunity and reinforcement for other-directed, more appropriate interaction style. **Note:** Focus on physical complaints occurs in depressed persons in about 25% of cases. Palpitations resulting from MVP may increase anxiety to panic state and require medical evaluation/treatment.

Light therapy using white fluorescent lights (2500 to 10,000 lx) at a distance of 3 feet from the client for several hours a day has been found to improve mood within 2 to 4 days in presence of SAD. Treatment has few disadvantages, although relapse is common if therapy is discontinued. For this reason, light therapy may be combined with medication.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

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### **PHYSICAL MOBILITY, impaired/SELF CARE deficit (specify)**

Disinterest or unconcern; lack of energy/inertia; psychomotor retardation

Impaired self-concept; depression; severe anxiety

Impaired ability to make decisions, such as whether to get out of bed, what to wear/eat; disheveled appearance

Reports of "I can't/don't want to" or "Wait until later" to perform self-care activities

Requests for help in the absence of physical incapacity

Inactivity

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Verbalize understanding of own situation and individual treatment regimen.

Demonstrate resumption of activities, increased concern/attention to grooming and hygiene, and behaviors to begin to direct own life.

Initiate/perform self-care and other activities independently.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Speak directly to client; respect individuality and personal space as appropriate.

Promotes sense of worthwhileness of the person.

Provide structured opportunities for client to make choices of care, (e.g., what to wear today, what activity to participate in).

Begins to establish own ability to make decisions and accept/deal with consequences.

Be aware of the amount of time client actually spends in bed/chair, especially clients who appear in a poor nutritional state.

Immobility places client at increased risk for skin lesions/decubitus, circulatory stasis, constipation, and infection.

Examine skin over bony prominences for redness (include heels) after client has been in bed/chair awhile.

Identifies compromised tissues receiving decreased circulation (because of prolonged pressure) and requiring prompt intervention.

Encourage/provide skin care with attention to cleanliness; gentle massage and lotion every 2–3 hours. Recommend change position every 2 hours, including bed to chair or to stroll “once around the day room.” Progress to regular exercise program.

Until etiological factors are remedied (immobility and nutritional status) these actions help prevent skin breakdown by alleviating pressure and promoting circulation. Also stimulates peristalsis, enhancing elimination.

Set progressive activity goals with client.

Reduces risks of complication related to sedentary lifestyle/immobility. Activity can also release natural endorphins, which help elevate mood.

Monitor intake and output. Note color/concentration of urine. Observe for complications of reduced fluid intake (e.g., dry mucous membranes and lips, poor skin turgor, constipation), and treat accordingly.

Direct indicators of individual needs/presence of problems. Poor hydration directly affects tissues (increasing risk of damage/breakdown in face of decreased mobility) and elimination.

Offer fluids frequently/leave small amounts of fluid within easy reach. Encourage intake of at least 1500–2000 ml/day.

Improves overall intake in depressed person to whom everything seems too difficult. Client may drink because it is available. Small amounts prevent guilt over things being “wasted” if all is not consumed. Prevents options for negative self-reinforcement (e.g., “nothing available,” “can’t drink that much”).

Note dietary intake/deficits. Increase roughage; provide fruit juices, stimulant beverages (hot or caffeine-containing, if tolerated).

Perform/assist with needed self-care activities for client, as necessary. Note frequency of elimination pattern.

Provide/obtain needed equipment, client's own supplies, clothing.

Choose one self-care activity and plan with client how to implement in a simple, concrete fashion.

Provide low-key reinforcement for improved functioning in this area.

Give low-key reminder regarding need to perform a self-care activity.

### **Collaborative**

Refer to occupational/recreational therapy involving motor activities (e.g., walking, working with clay, aerobic exercise, crafts, activities of daily living).

Encourage beautician/barber appointments, if services accessible.

Administer stool softener/bulk preparation.

Provide glycerine suppository or laxative product according to protocol, if no bowel movement occurs.

Promotes general well-being, helps increase energy level, and promotes improved pattern of elimination. Fiber improves stool consistency and bowel function. Caffeine has a cholinergic effect, and some juices, such as prune, contain a by-product that stimulates intestinal mobility.

Ensures that needed activities are accomplished if client is unable/unwilling to perform alone. Promotes prompt intervention as indicated, reducing risk of complications (e.g., constipation).

Availability may prompt performance; having one's own things enhances self-esteem, autonomy.

Assists client toward self-care in a slow and achievable manner. Depressed clients feel overwhelmed, and it is important that success is experienced 1 task at a time.

Enhances self-esteem; low-key style avoids provoking discounting, self-derogation.

Gentle prodding can be helpful to the client; however, reminders may be perceived as criticism and can feed into self-derogatory thinking.

These activities help to discharge anger and aggression and relieve guilt, as well as build self-confidence and prepare client for return to previous occupation/leisure-time activities.

Can enhance self-image, stimulate participation in self-care activities.

May be used to supplement dietary inadequacies/soften stool until normal stool is established.

Prevents impaction and helps to restore regular pattern.

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### **NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by:**

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### **NUTRITION: altered, less/more than body requirements**

Inappropriate nutritional intake to meet metabolic needs

Lack of interest in eating/food or choosing nutritional foods; aversion to eating

Dysfunctional eating pattern (e.g., eating in response to internal cues other than hunger)

Recent weight loss, poor muscle tone, decreased subcutaneous fat/muscle mass; pale conjunctiva and mucous membranes; or weight gain

Sedentary activity level

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Demonstrate progressive weight gain/loss toward goal.

Be free of signs of malnutrition with normalization of laboratory values.

Identify actions/lifestyle changes to regain and/or to maintain appropriate weight.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Monitor/record amount and type of food eaten, calculate total calorie intake. Note how client perceives food and the act of eating.

Provides baseline data and documents change/progress toward goal.

Explain to client that malnutrition itself decreases energy levels and ability to think cohesively (e.g., decreased protein and vitamin B affect and may deepen depression).

May provide incentive to eat, increasing cooperation with regimen and intake of nutritious foods.

Determine calorie requirements based on physical factors and activity. Increase calorie intake as activity level increases.

Caloric requirements need to be adapted to provide sufficient energy to meet expenditures/maintain appropriate weight.

Monitor body weight, depending on the seriousness of the problem and the client's response to being weighed.

Provides information about therapeutic needs/effectiveness. **Note:** Increased appetite is one of the earliest responses to antidepressant use.

Avoid getting into a "power struggle" about these issues.

Focuses attention on food and weight, overemphasizing them (possibly providing secondary gain) rather than underlying dynamics.

Provide small meals and interval feedings, emphasizing nutritious choices (e.g., high protein/carbohydrates, increased fiber).

A full meal may look like an insurmountable challenge, especially for client who is depressed.

Identify and obtain foods client thinks would be interesting/appealing. Use family/friends as resources as indicated.

May enhance desire to eat and promote increased/balanced intake. Family can provide information about client's likes and dislikes, other helpful ideas to increase food intake.

Feed client, if indicated by physical condition and refusal/inability to eat.

Assisting client to eat can help to meet nutritional needs.

**Collaborative**

Consult with dietitian as necessary.

Helpful in determining individual needs, alternate dietary therapy, reinforcing proper eating habits.

Monitor laboratory studies (e.g., serum albumin, prealbumin, glucose, electrolytes, nitrogen balance).

Detects deficiencies/imbbalances, identifies therapeutic needs/effectiveness.

Provide tube feeding, as indicated.

May be necessary when client refuses or is unable to eat and client safety/condition requires.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Client Will:****SLEEP PATTERN disturbance**

Biochemical alterations (decreased serotonin)

Unresolved fears and anxieties

Difficulty in falling/remaining asleep, early morning awakening/awakening later than desired

Reports of not feeling rested

Hypersomnia, using sleep as an escape

Identify interventions to promote/enhance sleep.

Report falling asleep within 30 minutes of retiring and sleeping 4–6 hours before awakening.

Verbalize having had a satisfactory night's sleep/feeling well rested.

Refrain from using sleep as a means of escaping real feelings and fears.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Identify nature of sleep disturbance and variation from usual pattern (e.g., insomnia [difficulty falling asleep or may awaken early and be unable to return to sleep] or hypersomnia).

Assess what client does when awake and plan with client to change pattern as indicated.

Establish a realistic goal with client.  
sleep.

Identify previous bedtime rituals that may have been interrupted by illness/hospitalization, and reestablish when possible.

Decrease afternoon and evening caffeine intake (coffee, tea, chocolate, colas).

Restrict evening fluids and have client void before retiring.

Provide light bedtime nourishment, such as milk, if client likes it and it is not otherwise contraindicated.

Encourage relaxation exercises to soft music prior to sleep.

Patterns provide clues to help client and nurse to work together to solve the problem.

Clients often awaken and ruminate about themselves in a hopeless/helpless manner. Having client set aside a period during the day to ruminate may extinguish this behavior at night.

Some individuals have unrealistic ideas of a “normal” night's

Restoring familiar, successful rituals may allow the client to reestablish usual pattern.

Avoids stimulants, which may affect ability to fall/stay asleep.

Reduces need to rise at night to void.

Milk (with L-tryptophan) is thought to be helpful in promoting sleep. Snack may prevent awakening during night because of hunger.

Aids in release of tension and promotes falling asleep.

Reduce environmental stimuli (e.g., lights, noises, loudspeakers, etc.). Encourage use of white noise as appropriate.

Provide night lights, environmental control (room adequately warm or cool); appropriate nightwear/bedding, including special blanket/pillow, which can be brought from home.

Schedule treatments, procedures, assessments, and medications during the daytime.

Increase daytime activity, including stimulating diversionary activities in daily schedule. Set limits on time spent in room, discourage returning to bed during the day.

Explore fears and feelings that sleep is helping to suppress.

### **Collaborative**

Provide hypnotic or sedative only if other methods fail.

Recommend use of/administer antidepressants or other medication with sedative side effects at bedtime when possible.

Decreases distracting stimuli that may interfere with sleep.

May prevent confusion upon awakening. Ensures personal comfort, promotes sleep, sense of security.

Prevents unnecessary interruption during sleep.

Increased activity without overexertion promotes sleep. **Note:** If client must nap, morning napping disrupts sleep pattern less than afternoon naps.

Identifies these factors so they can be dealt with to enable client to progress with therapy.

Products may suppress REM sleep, resulting in not feeling rested upon awakening.

Decreases daytime drowsiness and aids sleeping at night.

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## **NURSING DIAGNOSIS**

### **May Be Related to:**

### **Possibly Evidenced by:**

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## **SOCIAL ISOLATION/SOCIAL INTERACTION, impaired**

Alterations in mental status/thought process (depressed mood)

Inadequate personal resources; decreased energy/inertia

Difficulty engaging in satisfying personal relationships

Feelings of worthlessness/low self-concept; inadequacy in or absence of significant purpose in life

Knowledge/skill deficit about social interactions

Verbalization/demonstration of awareness that interpersonal or social interactions do not have desired, satisfactory, or reinforcing outcomes

Changes in patterns or interacting/communication (e.g., slowed speech, latencies, decreased amount of speech, muteness)

Decreased involvement with others; expressed feelings of difference from others; dysfunctional interaction with peers, family, and/or others

Refusing invitations/suggestions of social involvement; remaining in home/room/bed

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Attend/then participate in a specific number of activities per day/week.

Participate in 1:1 interaction for specified number of minutes.

Complete errands, initiate socialization activities a specific number of times per week.

Reinstate 2 previously enjoyed activities involving others or develop new ones.

Verbalize increased satisfaction with outcomes of social interactions.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Be consistent and on time in planned meetings with client.

Client will experience lateness as further evidence of decreased self-worth. In building trust, client needs to know that the nurse will follow through on previously agreed meetings/commitments.

Greet routinely, beginning with client's name and personal comment (e.g., appearance, clothing); share pertinent information from shift report, observations, etc. without concern for response by client.

Reinforces individuality, gets attention. Provides a "no-demand" acceptance, opportunity to interact if client chooses. Matter-of-fact manner prevents demand for client to provide a response when depressed feelings interfere.

Use touch, unless contraindicated.

Touch is a basic form of communication and can help client in interactions, demonstrate caring, and reinforce sense of self-worth.

Start conversation and "give" client a topic (e.g., unit or world event, OT project, etc.).

Initiating activity is often very difficult for client and having an assignment helps get the activity started.

Keep input fairly short and concrete. Ask only one question (about one thing) at a time. Avoid asking "yes-no" and "why" questions.

Requires less effort for client to attend to and retain. Promotes focus and requires that client put thinking into response. "Why" questions are often perceived as threatening/demanding of an answer.

Take adequate time; wait patiently for responses. Observe and give feedback regarding the feeling tone conveyed and interaction style observed.

Indicates interest, enhances self-esteem. Recognition of these feelings demonstrates empathy, sensitivity. Promotes understanding of how client is perceived by others, when discomfort and feelings of inadequacy have been experienced and provides opportunity for insight/change.

Emphasize attendance at routine unit activities as well as nondemanding activities (e.g., movies). Initially emphasize attendance rather than participation or enjoyment to be gained.

Starting with achievable goals gives client the ability to succeed and enhance self-esteem. Attendance precedes participation.

Contract with client (e.g., for nonsuicidal client, 1 hour of attendance at an activity is rewarded by 1 hour in room without being “pestered”).

Gradually increase activity schedule. Involve with one other person or in quiet activity in day area.

Avoid taking client’s difficulty in responding or negative/hostile responses personally.

Encourage visits by friends, relatives, other social contacts identified/located by family member.

Determine what the client’s interests/activities were, and ask client to share those. Let client teach others about past skills by asking questions, indicating desire to learn about client’s contributions to job and family. Obtain hobby equipment from home, if indicated.

Involve family and friends to escort/transport on outings and functional (shopping, business, obtaining belongings at home) or social activities (a brief meal, religious service, etc.).

Assist individual to assess own satisfaction with outcome(s) of interpersonal interactions. Avoid asking client if activities are “enjoyable” or “fun.”

Request feedback on outings and activities from both client and others involved (therapists, companions).

Use social skills training model to help client identify alternative strategies; role-play/rehearse new (more effective) behavior; obtain feedback and reinforcement; try new behavior in a “real situation.”

Use group situations for maximum impact/reinforcement (e.g., group therapy, OT, RT, etc.).

Give positive reinforcement regarding attendance/performance (e.g., increased involvement in groups, demonstration of more effective social skills).

Assist client in identifying the natural reinforcers that occur with more effective interactions.

Involving client in decision-making increases sense of control over situation and may promote cooperation.

Enhances changes of cooperation, diminishes threat, promotes progression of interaction.

Client will try to reinforce feeling of “worthlessness” by trying to create negative responses from others. Working with depressed client requires much patience and ability to recognize small goals as improvement.

Helps reestablish neglected, previously rewarding relationships.

Revitalizes memories from a time when client felt better, promoting client’s individuality and sense of offering self to others. Encourages resumption of previously enjoyed activities, reduces sense of isolation, and increases sense of purpose.

Events such as these require little of client but increase social involvement and yield social reinforcement. Decreases sense of isolation from outside world.

Helps client plan what is to be expected from interacting and how client can behave to realize those expectations. Involves the client in problem identification and helps to evaluate whether goals are realistic. **Note:** Cheerfulness may be interpreted as false.

The goal is to increase involvement, and because client will likely report a less successful event than a more objective observer, input is important from both. The client can also hear others’ perception of an event, which can serve to validate/add to the client’s perception.

Client may need to learn social skills and practice new behaviors. Improved social skills are more likely to have results that satisfy/reinforce interactions.

Group situations provide more opportunity for interactions, feedback, reinforcement.

Client is unable to discount reinforcement and is thus reinforced for participation. Positive reinforcement increases the reward for trying the new tactics, encourages repetition of desired behaviors.

These reinforcers will increase the client’s confidence and strengthen the behavior.

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**NURSING DIAGNOSIS****SEXUAL dysfunction/SEXUALITY PATTERNS, altered****May Be Related to:**

Decreased energy and concern, apathy; loss of sexual desire

Decreased self-esteem; values conflict

Misinformation/misconceptions about sexual functioning/behavior

Impaired relationship with SO; psychosocial abuse (e.g., harmful relationships)

**Possibly Evidenced by:**

Reported difficulties, limitations, or changes in sexual behaviors/activities (e.g., inability to achieve desired satisfaction, women may express a loss of interest; men may experience impotence and loss of libido)

Actual/perceived limitation imposed by condition/therapy

Alteration in relationship with partner

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Verbalize understanding of effect of depression on sexual functioning.

Identify stressors that contribute to dysfunction and make changes as able.

Resume sexual functioning at level desired/as agreed on by client and partner.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Review client's sexual history and degree of satisfaction prior to depression.

Establishes a baseline and elicits client's feelings about previous sexual satisfaction. **Note:** May need to discuss this when client is well into recovery, as feelings of self-worth are intertwined with feelings about sexual satisfaction.

Assist client to define expectations for sexual satisfaction and decide what can be done to attain these.

Planning can help the client identify more clearly what own desires are and whether they are reasonable/attainable.

Provide sex education as necessary. Include significant other/partner as appropriate.

Often sexual problems are partly ignorance and misconceptions about sexual facts, and knowledge can assist with problem resolution. **Note:** Client may need support to terminate abusive relationships/initiate involvement with others.

Review medication regimen; observe for side effects of drugs prescribed.

Discuss appropriateness of delaying scheduled antidepressant dose until after coitus.

### **Collaborative**

Evaluate need for dose reduction, drug substitution, or combination therapy.

Refer for further counseling/sex therapy as indicated.

Many medications can affect libido, cause delayed or inability to achieve orgasm, impaired erectile capacity, delayed ejaculation, or impotence, putting a strain on a relationship and interfering with treatment. Evaluation of drug and individual response is important to ascertain whether drug is responsible for the problem.

Increases likelihood that client will continue therapeutic regimen if it does not interfere with sexual performance.

May help reduce unwanted side effects of medication.

May need additional or more in-depth assistance if problems are severe/unresolved as depression lifts.

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### **NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by:**

**Desired Outcomes/Evaluation Criteria—**

**Family Will:**

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### **FAMILY PROCESSES, altered**

Situational crisis of illness of family member

Developmental crisis (e.g., loss of family member/relationship)

Expressions of confusion; statements of difficulty coping with situation

Family system not meeting needs of its members; difficulty accepting or receiving help appropriately

Ineffective family decision-making process; failure to send and receive clear message.

Express feelings freely and appropriately.

**Demonstrate individual involvement in problem-solving** processes directed at appropriate solutions for the situation/crisis.

Encourage and allow member who is ill to handle situation in own way, progressing toward independence.

Identify/use community resources appropriately.

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## ACTIONS/INTERVENTIONS

## RATIONALE

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### Independent

Assess degree of family dysfunction and current coping methods of individual members.

Identifies problems of individual family members, provides direction for intervention. Areas most affected are communication, marital adjustment and satisfaction, expressed emotion and problem-solving. **Note:** These families tend to have a greater degree of functional impairment than families dealing with other major mental illnesses.

Identify family developmental stage (e.g., newly married couple/divorced, children leaving home); components of family and client's role in the family constellation.

Developmental stage may be a factor in current situation and client's depression. Disruption of client's role may contribute to family disorganization/strain on other family members who have to step in and assume duties client usually takes care of.

Identify patterns of communication within the family. Are feelings freely expressed? Is blame or fault assigned? What is the process of decision-making in the family and who makes the decisions? What is the interaction between family members?

Dysfunctional communication (such as high levels of tension, negative expressions, self-preoccupation, diminished nonverbal patterns of support) contributes to feelings of inadequacy, rejection, and inability to cope on the part of the members of the family.

Acknowledge difficulties observed while giving permission to express feelings and discussing more effective methods of communication.

Reassures family that feelings are acceptable and can be dealt with appropriately.

Note the extent of feelings of powerlessness and lack of pleasure in daily life. Discuss effect on family members.

Client often displays hopelessness and anhedonia, which are very stressful and can be disruptive to family functioning. Promotes understanding that these feelings are part of the illness and enables family members to deal with own frustrations appropriately.

Provide information as necessary in verbal, written, and/or tape format as appropriate.

Provides opportunity for family members to review and incorporate new knowledge to assist in resolution of current situation.

Establish/discuss goals and expectations of family members/clients following discharge from care. Let individuals know the importance of "taking it slow" and not pressuring each other to change.

Realistic expectations of abilities of client to assume place in the family are crucial to continued recuperation. Family needs to understand that members need to continue to work on new style of communication and changing ways of dealing with conflict issues.

## Collaborative

Involve in group, family and psychotherapy, as indicated.

Provide information about resources available as needed (e.g., social services, homemaker assistance, counseling [e.g., marital, spiritual], visiting nurse services).

Opportunity to hear others discuss shared problems and ways of handling can encourage family members to look at new ways of interacting. **Note:** Children living in this setting have as high as a 45% risk of developing affective disorders and may require focused therapy.

Assistance may be needed for family members to assimilate new skills and begin to make necessary lifestyle changes to promote wellness. There is a high rate of relapse for individuals dealing with major depression, and divorce rates are 9 times higher in the presence of greater expressed emotion than the national average.

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### NURSING DIAGNOSIS

#### May Be Related to:

#### Possibly Evidenced by:

#### Desired Outcomes/Evaluation Criteria— Client Will:

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### KNOWLEDGE deficit [LEARNING NEED] regarding diagnosis, prognosis, treatment and self care needs

Lack of information about pathophysiology and treatment of depression

Misconceptions about mental illness

Inaccurate statements about own situation and potential for recovery

Lack of follow-through with treatment regimen

Inappropriate behavior, apathy

Exhibit increased interest, participating in learning process.

Verbalize understanding of condition, prognosis, and therapeutic regimen.

Assume responsibility for following through on treatment options.

Identify/use resources appropriately.

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### ACTIONS/INTERVENTIONS

#### Independent

Determine level of knowledge, mental/emotional readiness for learning.

Provide information about depression/treatment as indicated. Give written as well as verbal information.

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### RATIONALE

May be first experience with illness/mental health system. Previous experience may or may not have provided accurate information. May be too depressed to access information accurately.

Provides opportunity for client to learn about own situation and enhances recall.

Provide information about drug therapy and potential side effects, e.g., anticholinergic effects, sedation, orthostatic hypotension of antidepressants; possibility of hypertensive crisis if individual consumes foods containing tyramine while taking MAOIs; dysrhythmias; photosensitivity; reduction of seizure threshold.

Encourage frequent fluids, lip salve, ice chips, as indicated.

Suggest medication dosage be taken at bedtime, when appropriate.

Discuss importance of monitoring blood pressure as indicated. Suggest client rise slowly from sitting/lying position.

Review diet restrictions (e.g., tyramine-free diet [avoid aged cheeses, fermented foods, wine/beer, liver, sour cream/yogurt, soy sauce, yeast products], limitation of caffeine).

Discuss importance of healthy diet and regular exercise.

Emphasize necessity to avoid driving or operating dangerous machinery during initiation/changes in medication regimen.

Encourage client to stop smoking, avoid alcohol intake.

Instruct client to contact provider before taking other prescription or OTC medications and to notify other healthcare providers of drug regimen.

Discuss use of identification bracelet/card.

Reinforce importance of not stopping drugs abruptly.

Refer to resources/agencies (e.g., social services, homemaker/baby-sitting, support groups).

Client needs to know what to expect from drug trial. Knowledge can increase cooperation with drug regimen. Particularly, clients need to be aware that improvement may not occur for 4–6 weeks after drug therapy is begun, and that side effects will generally improve/disappear within 2 weeks.

Provides relief of dry mouth caused by anticholinergic effect of drug therapy.

Sedative effect may be helpful in promoting and maintaining sleep.

Most common side effect of antidepressants is orthostatic hypotension, which can result in dizziness, injury following sudden position change.

Necessary to avoid interaction (hypertensive crisis) when MAOIs are used, and for 2 weeks following discontinuation of drug.

Important for general well-being. Additionally, bone mineral density of depressed clients may be significantly lower, requiring focused interventions.

Side effects of drowsiness or dizziness are usually self-limiting but require adjustment in activities until resolved.

Smoking increases metabolism of tricyclic medications, necessitating adjustment in dosage to achieve therapeutic effect. Alcohol potentiates CNS effects of antidepressants.

Many medications contain substances that, in combination with antidepressants, could precipitate a life-threatening crisis.

Provides information, if needed, in emergency situation to prevent sudden termination of medication, which could be detrimental.

Sudden cessation of drugs can result in untoward effects (e.g., may aggravate condition, deepening | depression, and cause withdrawal with nausea/vomiting and diarrhea).

May be helpful to client for long-range planning for regaining/maintaining wellness.

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**NURSING DIAGNOSIS****Risk Factors May Include:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:**

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**INJURY, risk for [effects of ECT therapy]**

Electroconvulsive effects on the cardiovascular, respiratory, musculoskeletal, and nervous systems

Pharmacological effects of anesthesia

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

Maintain physiological stability, free of injury/complications.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Review medical testing (e.g., CBC, ECG, chest x-ray, urinalysis, and x-rays of lateral aspects of the spine) before procedure.

A complete medical workup can identify preexisting problems and the potential for problems, which should be reported to personnel involved with procedure.

Discuss what will be done (e.g., anesthesia, muscle relaxants, oxygenation, drugs used, who will be with the client, and how the client is likely to feel after ECT).

Knowledge can reduce anxiety and decrease fear response and is necessary for informed consent to procedure. Client will feel more secure knowing nurse will be there upon awakening. Awareness that confusion/memory loss are temporary helps alleviate associated fears.

Verify informed consent/signed permission form has been obtained.

Indicates that client agrees to procedure and received appropriate information.

Have client empty bladder, remove jewelry/hair decorations, eyeglasses/contacts, and dentures before treatment.

Reduces risk of injury/aspiration.

Orient client upon awakening after the treatment, and support client while immediate confusion clears.

Short-term memory may be affected, and client awakens confused. May be frightened by amnesia. Confusion increases with each treatment, knowledge that after-effects disappear will be reassuring.

Monitor vital signs every 15 minutes until stable.

Premedication, muscle relaxants, and anesthesia may produce dysrhythmias and respiratory depression, which need immediate intervention.

Have emergency equipment, suction, Ambu bag, etc. available.

Prompt treatment of respiratory depression/airway obstruction can prevent/correct life-threatening complications.

**Collaborative**

Restrict oral intake as indicated.

Provide supplemental oxygen as necessary.

Administer preprocedural medications as indicated (e.g., atropine sulfate).

Reduces risk of vomiting/aspiration.

Provides for optimum oxygenation during period of reduced ventilation.

Decreases secretions to prevent aspiration and increases heart rate to offset response to vagal stimulation caused by ECT.