

DEPRESSION

Recognition, Treatment, and Sustained Recovery

Audience: RN/APRN | **Contact hrs:** 1.75 | **Pharmacology hrs:** 0.5

Expected revision: October 5, 2028

Pharmacology hours are included in the total contact hours.

See the person behind the symptoms

A teenager stops going to rehearsal and argues whenever school is mentioned. An older adult reports pain, poor sleep, and a failing memory but denies feeling sad. A new parent says the family would be better without them. Depression may be present in any of these encounters, but the next safe action is not identical. Nursing care begins by clarifying what has changed, how the person is functioning, and whether immediate protection or medical evaluation is needed. A screening score helps organize that work; it cannot replace it. (National Institute of Mental Health [NIMH], n.d.-b; U.S. Department of Veterans Affairs & U.S. Department of Defense [VA/DoD], 2022)

Depression is a treatable health condition, not a curse, a moral failure, or a problem that someone should simply overcome through willpower. Recovery may require several treatment adjustments, and persistent symptoms are a reason to reassess the plan rather than blame the patient. Effective care attends to safety, relationships, physical illness, access to treatment, and personally meaningful function as well as mood. (NIMH, n.d.-b)

Purpose, audience, and learning outcomes

This activity develops clinical reasoning for registered nurses and advanced practice registered nurses caring for children, adolescents, adults, and older adults. It emphasizes recognition, treatment monitoring, education, and continuity. RNs assess and escalate within authorized pathways; diagnostic formulation and prescribing require the appropriate preparation, authorization, and privileges. U.S. drug labeling is identified explicitly and must not be assumed to apply in every country. The five clinical cases are fictional teaching examples.

After completing the activity, learners should be able to: (1) distinguish depressive syndromes from bipolar, medical, and developmental alternatives; (2) explain biological and psychosocial contributions without

presenting an unproven single-cause model; (3) interpret screening information and select an appropriate suicide-safety response; (4) compare evidence-supported treatments and identify medication hazards; (5) adapt assessment and education across the lifespan; and (6) plan measurement-based follow-up, relapse prevention, and a reliable handoff.

The practical question throughout this article is, “What information would change the next decision?” A symptom checklist without a timeline can miss bipolar illness. A medication list without actual use can hide withdrawal. A referral without confirmation can leave a patient untreated. Figure 1 connects developmental presentations with questions that make these gaps visible.

Name the syndrome before choosing the treatment

A major depressive episode is a sustained change from prior functioning, not simply a difficult day. The familiar diagnostic framework requires at least five symptoms during the same two-week period, including depressed mood or loss of interest or pleasure. Other domains are appetite or weight change, sleep disturbance, observable psychomotor change, low energy, worthlessness or excessive guilt, reduced concentration or indecision, and thoughts of death or suicide. Symptoms must cause clinically significant distress or impairment and require evaluation for substance, medication, and medical explanations. (NIMH, n.d.-b; VA/DoD, 2022)

The symptom count is only one part of the diagnosis. Ask about severity, duration, recurrence, functioning, psychotic symptoms, and past mood elevation. Children and adolescents may show irritability rather than a clearly described depressed mood. An inability to experience enjoyment can be more revealing than the word “sad.” In medically ill patients, fatigue and poor appetite may have several causes; the clinician should

Different presentations. The same need for careful assessment.

CHILDREN	ADOLESCENTS	ADULTS	OLDER ADULTS
			
Withdrawal from play; irritability or bodily complaints.	Loss of interest; school or peer withdrawal.	Reduced enjoyment; self-care or role difficulties.	Sleep, pain, or cognitive complaints may dominate.
Ask about change across home and school.	Include private conversation and direct safety questions.	Clarify illness, medications, and perinatal timing.	Establish baseline function; evaluate acute confusion.

Across every age: clarify duration, impairment, alternatives, and current safety.

Figure 1. Depression may be expressed through changes in participation, behavior, bodily experience, or mood. Developmental context shapes recognition; no single presentation is diagnostic. Original educational illustration. Sources: American College of Obstetricians and Gynecologists, n.d.; National Institute of Mental Health, n.d.-b; Walter et al., 2023.

integrate their timing with cognitive, emotional, and behavioral changes rather than automatically include or discard every physical symptom. (VA/DoD, 2022; Walter et al., 2023)

Major depressive disorder refers to the appropriate depressive episode history without a manic or hypomanic episode that establishes bipolar illness. A previous episode of unusually increased energy, markedly reduced need for sleep, pressured speech, impulsive spending, or grandiosity changes the differential. Ask whether others noticed a distinct change and what consequences followed. “I felt better” is not enough to identify hypomania, but sustained activation must not be relabeled as ordinary recovery without assessment. (Lam et al., 2024; VA/DoD, 2022)

Persistent depressive disorder describes a chronic depressive pattern lasting at least two years in adults or one year in children and adolescents, with additional diagnostic requirements. “Chronic” does not mean harmless: someone may have adapted their expectations around longstanding symptoms and still have

substantial impairment. Conversely, several weeks of low mood does not establish this diagnosis. Document a longitudinal history, including symptom-free intervals and any superimposed major episodes. (NIMH, n.d.-b; Walter et al., 2023)

Premenstrual dysphoric disorder is characterized by a recurring relationship between symptoms and the menstrual cycle, not merely depression in someone who menstruates. Prospective daily ratings across at least two symptomatic cycles help distinguish it from worsening of a pre-existing disorder. Disruptive mood dysregulation disorder involves chronic, severe irritability and recurrent outbursts in childhood; it is not a synonym for adolescent depression or an episode of mania. Developmental history and specialist assessment prevent overly broad labels. (American College of Obstetricians and Gynecologists [ACOG], 2023a; NIMH, n.d.-c; Nevatte et al., 2013)

Depressive symptoms may also be associated with a substance, a medication, or another medical condition. A temporal link is informative but does not by itself

prove causation. Alcohol, sedating substances, medication changes, endocrine disease, neurologic illness, and sleep disorders deserve consideration when the history suggests them. Grief, adjustment-related distress, trauma, anxiety, and neurocognitive disorders may coexist with depression. Bereavement does not exclude a major depressive episode, and a major depressive diagnosis should not erase an understandable response to loss. (Lam et al., 2024; VA/DoD, 2022)

CASE 1 | An incomplete mood history

Andre, 32, presents with six weeks of anhedonia, guilt, and poor concentration. Before an antidepressant is started, the nurse asks about periods of unusually high energy. Andre describes five days the previous year when he slept three hours nightly without fatigue, spoke rapidly, started several costly projects, and seemed “unlike himself” to his partner. He had not mentioned this because he considered it a productive week.

The appropriate next step is diagnostic clarification, including the episode timeline, impairment, substance exposure, family history, and collateral information with permission. This account raises concern for hypomania; it does not permit a nurse to assign a final bipolar diagnosis from a brief vignette. The prescriber should reassess the treatment plan rather than assume recurrent unipolar depression and proceed automatically with antidepressant monotherapy. Current safety and functioning still require assessment. (Lam et al., 2024; VA/DoD, 2022)

Diagnostic systems serve related but different purposes. DSM terminology and ICD coding should be applied using the current system required locally, rather than mixing older categories into one severity ladder. Bipolar disorders and cyclothymia are not simply more severe positions on a continuum of unipolar depression. A provisional description of symptoms and uncertainty is safer than an unsupported definitive label. (VA/DoD, 2022; World Health Organization [WHO], 2024)

Biology without a single-cause story

Depression arises through interacting biological, psychological, and social processes. Neurotransmitter signaling, stress regulation, reward processing, sleep, immune activity, and learning are relevant, but there is

no routine blood test or scan that establishes major depressive disorder. An antidepressant acting on serotonin does not prove that an individual’s illness was caused by a measurable serotonin deficiency. This distinction permits an honest explanation of treatment without undermining its potential benefit. (Lam et al., 2024; Miller & Raison, 2016)

Serotonin, norepinephrine, dopamine, glutamate, and gamma-aminobutyric acid participate in distributed circuits rather than isolated “mood centers.” Changes in motivation, threat processing, attention, and emotional regulation can influence one another. Neuroplasticity describes the capacity of these networks to adapt; it is not a promise that one treatment restores a visibly damaged brain. Group-level imaging differences cannot be used to tell a patient that their hippocampus has shrunk or to select a treatment without an established clinical indication. (Beurel et al., 2020; Miller & Raison, 2016)

The hypothalamic–pituitary–adrenal axis links stress signaling to adrenal glucocorticoid release. The hypothalamus releases corticotropin-releasing hormone; the pituitary releases adrenocorticotrophic hormone; the adrenal cortex releases cortisol. Feedback normally helps regulate this response. Altered stress regulation is observed in some depressed populations, but it is neither universal nor specific enough to function as a routine diagnostic test. Cortisol is not an antidepressant target that should be manipulated outside an appropriate clinical indication. (Beurel et al., 2020; Miller & Raison, 2016)

Inflammation provides another useful, but incomplete, model. Peripheral immune signals can communicate with the brain through neural and vascular pathways. Microglia participate in immune surveillance and responses to injury. Inflammatory signaling may influence reward circuits, neuroplasticity, stress responses, and tryptophan metabolism through indoleamine 2,3-dioxygenase and the kynurenine pathway. These interacting mechanisms may be important for some patients; they do not establish that all depression is an inflammatory disease. Figure 2 shows the distinction between plausible pathways and individual clinical tests. (Beurel et al., 2020; Miller & Raison, 2016)

C-reactive protein and cytokines are nonspecific. A raised result can reflect infection, obesity, inflammatory disease, or other processes and does not identify a

Table 1. Diagnostic distinctions that change the next decision

Presentation	Distinction to establish	Practice implication
Major depressive episode	Sustained symptom cluster, duration, distress or impairment; exclude relevant alternatives.	Assess safety, history, function, and previous mood elevation; do not diagnose from a score alone.
Persistent depressive pattern	At least 2 years in adults or 1 year in youth, with additional diagnostic criteria.	Build a longitudinal history and identify superimposed episodes.
Premenstrual symptoms	Cyclic symptoms versus premenstrual worsening of another disorder.	Use prospective daily ratings across at least 2 symptomatic cycles.
Childhood irritability and outbursts	Chronic dysregulation, a depressive episode, developmental concerns, or episodic mania.	Use developmental and multi-informant assessment; avoid treating these as interchangeable labels.
Past elevated energy with little need for sleep	Possible mania or hypomania, not simply absence of sadness.	Clarify bipolar illness before routine antidepressant monotherapy.
New symptoms with illness or exposure	Medication/substance effect, medical disease, delirium, or coexisting depression.	Evaluate the timing and relevant physical findings; urgent medical changes follow their own pathway.

Sources: American College of Obstetricians and Gynecologists, 2023a; National Institute of Mental Health, n.d.-c; Nevatte et al., 2013; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2022; Walter et al., 2023.

depression subtype with a proven universal treatment. Likewise, research using translocator-protein positron emission tomography does not justify routine scanning for “microglial depression.” Anti-inflammatory medicines, gut-microbiome products, and supplements must not replace established treatment on the basis of a proposed mechanism alone. Clinical usefulness requires evidence that testing or treatment improves patient outcomes. (Lam et al., 2024; Miller & Raison, 2016)

Genetic vulnerability is probabilistic and distributed across many variants. Family history is useful, but it does not determine an individual’s future. Large-sample research did not support several historical candidate-gene and candidate-gene-by-environment claims, including simplified stories built around the serotonin transporter. Commercial genetic information should therefore not be presented as a diagnostic confirmation or a guarantee of which antidepressant will work. Pharmacokinetic information and claims about treatment response are different questions. (Border et al., 2019; Lam et al., 2024)

Sleep and depression can reinforce each other. Insomnia may precede an episode, persist after mood improves, or signal a coexisting sleep disorder. Ask about actual

sleep opportunity, shift work, snoring, daytime sleepiness, substance use, and a reduced need for sleep without fatigue. The last pattern raises a different concern from wanting sleep but being unable to obtain it. Treating a verified sleep problem is clinically useful without assuming that it explains every depressive symptom. (Lam et al., 2024; VA/DoD, 2022)

Understand the setting in which symptoms persist

Psychological formulations explain potentially changeable patterns, not personal defects. Repeated avoidance may reduce distress briefly while shrinking opportunities for rewarding activity. Negative expectations may discourage action before it starts. Interpersonal conflict, loneliness, loss, and repeated experiences of threat can then reinforce hopelessness. The same symptom pattern may arise through different combinations of these processes, which is one reason treatment should be individualized. (Lam et al., 2024)

Attachment-informed thinking draws attention to the experience of safety, reliability, closeness, and help-seeking in important relationships. A history of adversity may affect trust in care, but it should not be

Interacting pathways, not a single chemical deficit

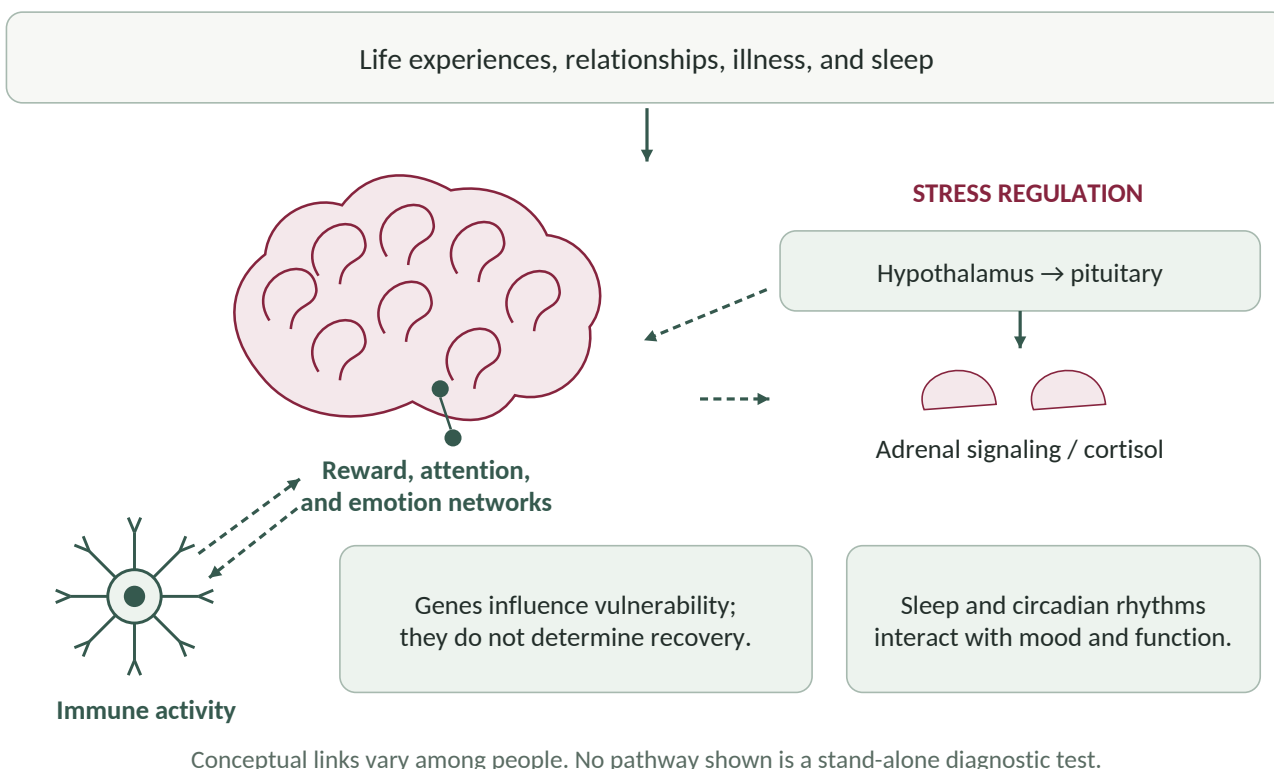


Figure 2. Conceptual relationships among stress signaling, immune activity, neural circuits, sleep, and environment. The pathways are not present to the same degree in every person and do not constitute a diagnostic test. Original schematic; not an anatomic study. Sources: Beurel et al., 2020; Border et al., 2019; Miller & Raison, 2016.

treated as proof that a particular parent caused the illness. Protective relationships can also change over time. Invite the patient to identify people who are helpful now, and avoid insisting on family participation when a relationship is unsafe. Trauma-informed care emphasizes choice, collaboration, and predictable explanations rather than forced disclosure. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2026)

Older formulations such as anaclitic and introjective depression describe themes of abandonment, dependency, self-criticism, or perceived failure. They are not substitutes for a contemporary depressive-disorder diagnosis. Their practical value, when used carefully, is to suggest questions: Does a missed appointment feel like rejection? Is accepting help experienced as failure? A formulation is useful when it improves understanding and treatment engagement, not when it assigns a fixed personality explanation to every symptom.

Ask about housing, food, caregiving responsibilities, discrimination, employment, violence, transportation, and the costs of care. These are not peripheral concerns when they determine whether someone can sleep, obtain medication, attend therapy, or remain safe. A referral to a resource should specify what problem it addresses and how access will be checked. Describing a patient as “nonadherent” without examining these constraints may obscure the actual obstacle. (SAMHSA, 2026; VA/DoD, 2022)

Use the patient’s own language and a qualified interpreter when needed. Some people describe distress through bodily discomfort, spiritual concerns, anger, or withdrawal rather than a psychiatric label. Respect that explanation while assessing risk and impairment. A useful response is, “I hear how this has affected you. Let us also look at sleep, energy, enjoyment, concentration, and safety.” Validation and diagnostic curiosity can occur together; neither requires agreement with an unverified causal explanation.

Assessment beyond a screening score

Population screening, diagnostic assessment, severity measurement, and suicide assessment are different tasks. The U.S. Preventive Services Task Force recommends depression screening for adults, including pregnant and postpartum people and older adults, and for adolescents aged 12–18 years. Screening must connect to diagnostic evaluation and effective care. Insufficient evidence for population screening in younger children is not a recommendation to ignore a symptomatic child. The same distinction applies to an insufficient-evidence statement about universal suicide-risk screening. (U.S. Preventive Services Task Force [USPSTF], 2022; USPSTF, 2023)

A positive screen invites a conversation; it does not automatically establish major depression or determine a prescription. Clarify the onset, duration, previous episodes, stressors, substance exposure, medical illness, and functional change. Ask what the person has stopped doing, what takes much more effort, and whether others have noticed a change. A person can meet obligations while experiencing severe internal distress, so preserved employment or school attendance does not end the assessment. (VA/DoD, 2022; USPSTF, 2023)

The Patient Health Questionnaire-9 measures nine symptom domains over the preceding two weeks, with a total score from 0 to 27. Common severity bands begin at 5, 10, 15, and 20. These bands support communication and monitoring, not a stand-alone diagnosis. Review the individual responses and impairment alongside the total. A low overall score with a concerning self-harm response still needs a direct safety assessment; a score without that response does not exclude suicide risk when the interview is concerning. (Kroenke et al., 2001; NIMH, n.d.-a)

Use the same validated measure over time when feasible, but do not treat a numerical change as the whole outcome. Ask about adverse effects, sleep, relationships, self-care, and return to valued roles. Clinician-rated scales such as the Hamilton or Montgomery–Åsberg measures can be useful in specialist care; their scores and thresholds are not interchangeable with the PHQ-9. Record which measure was used and when. Measurement-based care means that the results inform the plan, not merely that a questionnaire was completed. (Lam et al., 2024; VA/DoD, 2022)

In children and adolescents, gather information from the young person and caregivers, and from school when appropriate and authorized. Different accounts may reflect genuinely different settings rather than dishonesty. Include private conversation with the adolescent, explain the limits of confidentiality before asking sensitive questions, and explore bullying, substance use, trauma, developmental conditions, and family stress. The PHQ-A, Mood and Feelings Questionnaire, and Children’s Depression Inventory are examples of age-oriented instruments; use the version, interpretation, and permissions appropriate to the population and setting. (Walter et al., 2023)

In older adults, a Geriatric Depression Scale may support assessment, but sensory loss, language, and cognition affect how a questionnaire works. Establish the baseline and time course of any cognitive change. Acute fluctuating attention or confusion needs medical evaluation for delirium and other causes. Depression and a neurocognitive disorder may coexist, and improvement in mood does not automatically settle the cognitive diagnosis. A collateral history can reveal missed meals, medication mistakes, or withdrawal that a brief office interaction misses. (NIMH, n.d.-b; VA/DoD, 2022)

Physical assessment and testing should follow the history and examination. Medication reconciliation, vital signs, neurologic findings, endocrine symptoms, nutritional concerns, pain, and sleep disorders may identify a relevant contributor. Tests such as a blood count, thyroid studies, metabolic testing, or vitamin measurements are selected when clinically indicated rather than ordered as a universal depression panel. New focal findings, abrupt personality change, or altered consciousness require their own diagnostic pathway. (VA/DoD, 2022)

CASE 2 | Irritability is not an explanation

Maya, 16, has stopped seeing friends, missed several school days, and lost interest in music for a month. Her caregiver describes “attitude.” In private, Maya says she sometimes wishes she would not wake up. She denies a current intent to act, but the nurse does not end the interview at that answer.

The nurse clarifies current and recent thoughts, access to dangerous means, past self-harm or attempts, substance use, and available support, then

Table 2. Choose a measure for its task—not as a substitute for assessment

Measure / approach	Useful role	Important limit
PHQ-9	Adult symptom screening and repeated severity measurement; some adolescent pathways use adapted versions.	Total 0–27; common bands start at 5, 10, 15, and 20. Diagnosis and safety need clinical evaluation.
PHQ-A; MFQ; CDI	Developmentally oriented assessment of depressive symptoms in young people.	Version, age validation, permissions, and clinical context matter. Informants may differ.
EPDS	Perinatal symptom screening within a linked assessment-and-treatment system.	Not a stand-alone diagnosis. A positive self-harm response requires prompt assessment regardless of total.
Geriatric Depression Scale	Support for recognizing depressive symptoms in older adults.	Interpret with cognition, language, hearing, vision, and the overall clinical picture.
Ask Suicide-Screening Questions (ASQ) and subsequent safety assessment	Brief suicide screening followed by a clinical safety assessment when indicated.	Not equivalent to a depression score or a prediction that a person will remain safe.

Sources: American College of Obstetricians and Gynecologists, n.d.; Kroenke et al., 2001; National Institute of Mental Health, n.d.-a; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2022; Walter et al., 2023.

obtains the assessment required by the local pathway. The team makes a concrete safety and follow-up plan, involving a safe caregiver as appropriate while respecting the adolescent’s privacy. Irritability and school withdrawal require evaluation; neither automatically proves depression. A passive death wish is clinically important even without a stated current plan. (NIMH, n.d.-d; Walter et al., 2023)

Safety takes priority over routine treatment

Ask directly and calmly about thoughts of death, self-harm, and suicide when indicated. Clarify what the person means rather than assuming that every reference to death is the same. Assess whether thoughts are occurring now, whether there is intent or a plan, access to means, past attempts, recent escalation, intoxication, agitation, psychosis, and the ability to engage in a safety plan. Protective relationships and reasons for living matter, but they do not cancel acute warning signs. (NIMH, n.d.-a; NIMH, n.d.-d)

A current wish to act, current suicidal thoughts requiring urgent assessment under the pathway, a recent attempt, or inability to maintain safety calls for

immediate supervised evaluation. Do not leave the person alone while arranging the response. Activate local emergency or behavioral-health procedures, reduce access to hazards safely, and communicate directly with the receiving clinician. Medical instability, ingestion, injury, severe intoxication, or altered consciousness also requires emergency medical assessment. Figure 3 separates urgent protection from planned follow-up. (NIMH, n.d.-a; NIMH, n.d.-d)

Risk assessment is not a prediction with certainty. A checklist score cannot certify that someone will be safe, and a denial of intent should be considered alongside observed behavior, collateral information, and recent events. Document the findings, the clinical rationale, the consultation, and the disposition. Use an appropriate level of observation under policy; an emergency pathway should not depend on whether a routine outpatient appointment can be obtained. (NIMH, n.d.-a)

For a person who does not require emergency disposition after assessment, develop a collaborative written safety plan. It identifies warning signs, personal coping actions, supportive people and places, professional and crisis contacts, and steps to reduce access to potentially lethal means. Confirm that the patient can actually locate and use the plan. A promise

A positive screen starts a safety process

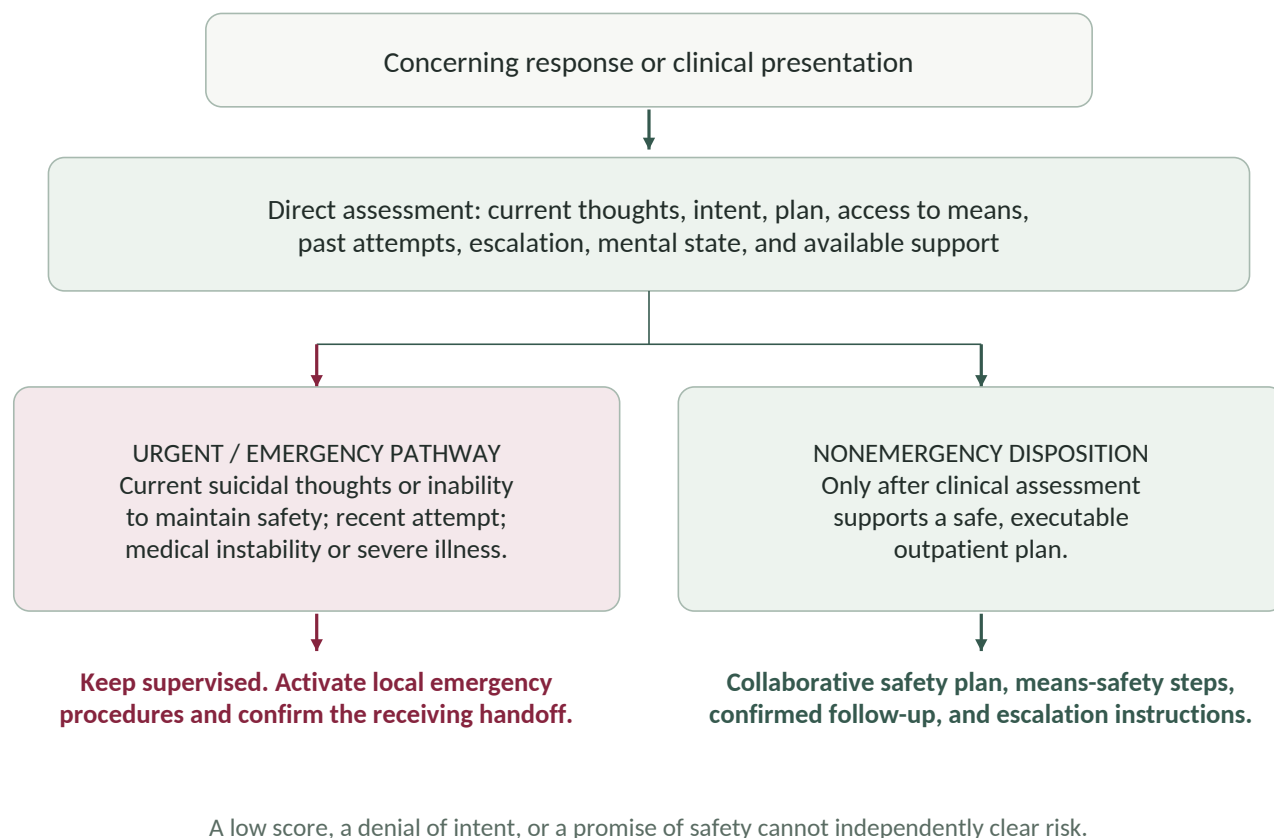


Figure 3. An educational synthesis of assessment and disposition principles. Follow the validated local pathway and authorized clinical assessment. A screening score or safety promise cannot establish safe discharge. Original decision diagram. Sources: National Institute of Mental Health, n.d.-a; National Institute of Mental Health, n.d.-d.

or “no-suicide contract” is not an adequate substitute and must not be used as proof that discharge is safe. (NIMH, n.d.-a)

Means-safety conversations should be concrete and respectful. Ask who can help secure medications or other dangerous items and how the agreed steps will occur. Do not simply advise the patient to “be careful.” Where appropriate, involve a trusted support person and verify what has been arranged. When serious risk overrides usual confidentiality boundaries, follow applicable law and organizational policy while explaining the safety purpose to the patient as clearly as circumstances allow. (NIMH, n.d.-a; NIMH, n.d.-d)

A referral is not complete because its name appears in a discharge summary. Confirm the appointment or handoff, who will contact the patient, and what happens if contact fails. NIMH’s outpatient pathway supports prompt follow-up after a positive screen, including a check-in within 48 hours when possible and timely

mental-health evaluation according to disposition. These intervals do not justify waiting when risk becomes acute. Give instructions for obtaining urgent help between appointments. (NIMH, n.d.-a)

In the United States, patients can call or text 988 for suicide and mental-health crisis support; immediate physical danger or a medical emergency requires emergency services such as 911. Outside the United States, provide verified local crisis and emergency contacts. A printed number does not replace emergency action by the care team when a patient is currently unsafe. (SAMHSA, n.d.)

Also recognize severe illness without an explicit suicide statement. Psychotic depression, catatonia, refusal or inability to take food and fluids, profound self-neglect, and postpartum psychosis may threaten life or rapidly impair safe care. These presentations need urgent specialist and medical assessment. They should not be managed by simply increasing a routine medication

dose and scheduling a distant follow-up. (ACOG, n.d.; VA/DoD, 2022)

Treat symptoms, patterns, and barriers together

Treatment selection is a shared decision informed by severity, duration, prior response, safety, comorbidity, access, and preference. For less severe adult depression, a structured psychological intervention or supported self-management may be a reasonable initial approach. More severe, persistent, or recurrent illness often warrants medication, structured psychotherapy, or their combination. Severe risk can require a higher level of care regardless of a preferred routine approach. A meaningful choice includes an explanation of benefits, burdens, and what will trigger reassessment. (National Institute for Health and Care Excellence [NICE], 2022; VA/DoD, 2022)

Cognitive behavioral therapy helps the patient examine links among thoughts, feelings, and actions and test alternatives in everyday situations. It is not an instruction to “think positively.” For example, someone who predicts that every invitation will end in rejection might plan a small, supported social contact and review what actually happened. The nurse can reinforce agreed skills and ask about obstacles without assuming the role of a psychotherapist beyond training and authorization. (Lam et al., 2024; Walter et al., 2023)

Behavioral activation focuses on patterns of avoidance and reduced reinforcement. The patient and therapist identify small, achievable activities connected to values, pleasure, or mastery, then review their effect. Waiting for motivation before attempting any activity can perpetuate inactivity. An initial task might be opening the curtains and eating breakfast at the table rather than immediately returning to a full exercise or work schedule. Figure 4 illustrates how a modest action can interrupt a maintaining cycle without blaming the person for symptoms. (Lam et al., 2024)

Interpersonal psychotherapy addresses current relationship difficulties and role transitions, including grief, conflict, and isolation. A new parent, a recently bereaved person, and someone facing retirement may have different interpersonal treatment goals despite similar symptom scores. Problem-solving therapy helps define a manageable problem, consider alternatives, choose an action, and evaluate the result. Its usefulness depends on a specific attainable problem rather than

repeated general advice to solve everything at once. (Lam et al., 2024)

The cognitive behavioral analysis system of psychotherapy was developed for chronic depression and emphasizes the consequences of interpersonal behavior. Short-term psychodynamic therapy explores recurring emotional and relational patterns. Mindfulness-based cognitive therapy may be useful, especially in relapse prevention. These approaches are not equivalent in evidence, availability, or fit. The Canadian Network for Mood and Anxiety Treatments (CANMAT) places CBT, interpersonal therapy, and behavioral activation among first-line adult psychotherapies, with several other structured approaches in later-line roles. Adult recommendations must not be automatically transferred to young children. (Lam et al., 2024; Walter et al., 2023)

Acceptance and commitment therapy, emotion-focused approaches, rational emotive methods, and self-system interventions offer additional conceptual tools. Their use should be guided by the evidence for the specific population and intervention rather than a claim that all named therapies are equally established. The number of sessions is individualized; a rigid session count from a textbook does not establish that an intervention has been delivered adequately. Therapist skill, fidelity, engagement, and the clinical formulation all affect interpretation of nonresponse. (Lam et al., 2024; Walter et al., 2023)

Digital and telehealth delivery can improve access when the intervention is structured and appropriate. Check privacy, technology, literacy, language, emergency procedures, and whether the patient has sufficient support. A patient who cannot speak freely at home may not have usable access even when video works perfectly. Unguided apps and conversational systems should not be assumed to provide the assessment, confidentiality, crisis response, or treatment fidelity of a qualified clinician. (Lam et al., 2024)

Practical support complements rather than substitutes for treatment. Collaborate on regular meals, a realistic sleep schedule, tolerable physical activity, social contact, and reduction of harmful substance use. Match goals to disability, resources, and readiness. Progress should be described in achievable steps rather than as a test of determination. Worsening symptoms, persistent inability to function, or emerging risk should trigger

Changing a maintaining cycle

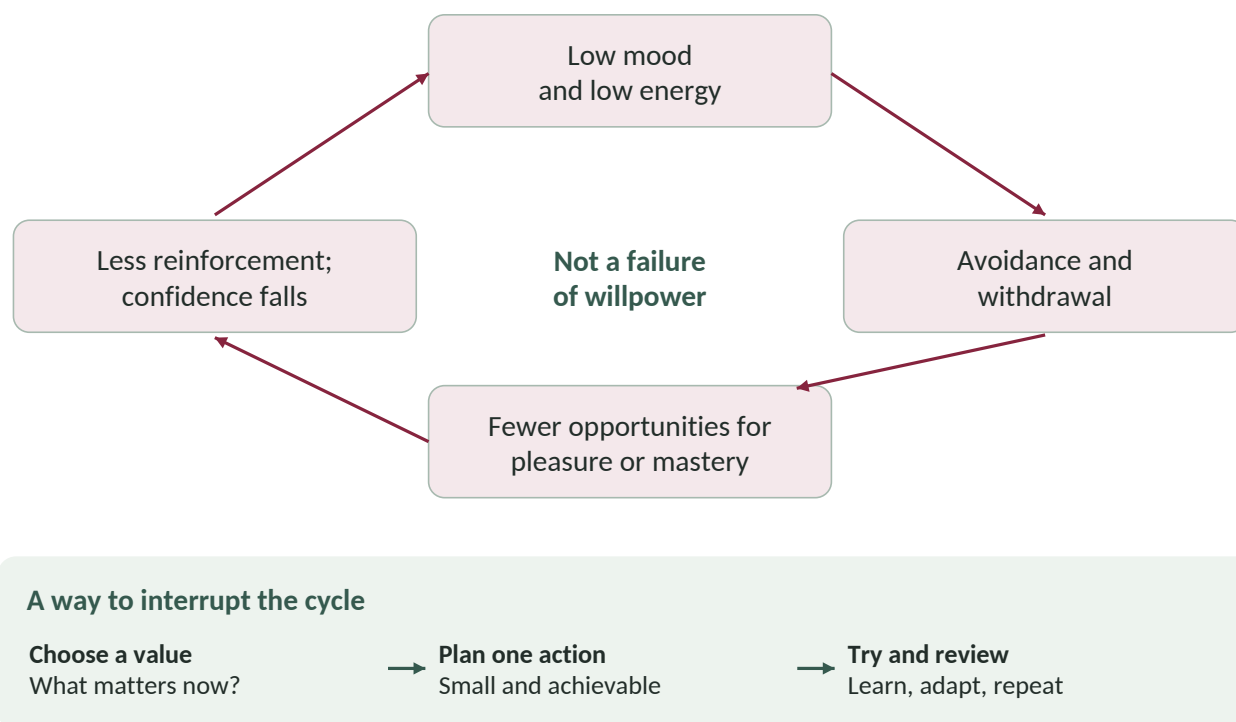


Figure 4. Behavioral activation links a personally meaningful, achievable action to review and repetition. It does not demand that the patient feel motivated before beginning or treat inactivity as a moral failure. Original conceptual diagram. Sources: Lam et al., 2024.

reassessment rather than an ever-longer list of lifestyle assignments. (NIMH, n.d.-b; VA/DoD, 2022)

Medication selection and safe follow-through

Before starting or changing an antidepressant, verify the diagnosis, previous trials and adverse effects, bipolar history, suicide risk, concurrent prescriptions, nonprescription products, substances, pregnancy or lactation considerations, and relevant organ function. Ask about actual doses taken and missed doses, not only what was prescribed. Explain that benefit develops over time, while adverse effects may appear earlier. Agree on a follow-up and contact plan before the first dose, including what warrants urgent assessment. (Lam et al., 2024; VA/DoD, 2022)

Selective serotonin reuptake inhibitors are commonly used first-line options. Their inhibition of serotonin reuptake describes a drug action, not a diagnostic test for serotonin deficiency. Nausea, sleep changes, sexual dysfunction, and activation can affect adherence. Serotonin–norepinephrine reuptake inhibitors have overlapping risks; venlafaxine also requires attention to

blood pressure and potentially troublesome symptoms after missed doses or discontinuation. A drug that suits one symptom profile may be unsuitable because of a comorbidity or interaction. (National Library of Medicine [NLM], n.d.-d; NLM, n.d.-e)

Bupropion has a different pharmacologic profile and may be considered when sexual adverse effects or certain other tolerability concerns influence selection. It is not appropriate for a patient with a seizure disorder or a current or previous diagnosis of bulimia or anorexia nervosa. Abrupt withdrawal from alcohol or sedatives can create additional seizure risk. Avoid duplicate bupropion-containing products, and do not crush extended-release tablets. A missed dose should not be followed by an extra dose to catch up. (NLM, n.d.-a)

Mirtazapine may be useful when appetite and sleep are prominent concerns, but sedation and weight gain may be burdensome. Tricyclic antidepressants carry anticholinergic, orthostatic, cardiac, and overdose hazards; they require particularly careful selection and are not routine first-line treatment for pediatric depression. Monoamine oxidase inhibitors require

specialist attention to interactions and dietary restrictions. The presence of newer options does not make any one medication universally superior or remove the need for an individualized safety review. (Lam et al., 2024; VA/DoD, 2022; Walter et al., 2023)

U.S. labeling supports fluoxetine for major depressive disorder in children and adolescents aged 8 years and older, and escitalopram for major depressive disorder from age 12. Indications are drug-, age-, and disorder-specific: an approval for another pediatric condition does not establish approval for pediatric depression. Other medication use may be off-label and require a defensible specialist plan, appropriate discussion, and monitoring. Young people receiving an SSRI also need monitoring of weight and growth, alongside mood, functioning, and adverse effects. (NLM, n.d.-b; NLM, n.d.-c)

Antidepressant boxed warnings identify an increased risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. This is not a reason to leave significant depression untreated. Discuss benefits and risks, monitor for deterioration and emerging suicidality, and involve appropriate supports. New agitation, marked restlessness, impulsivity, or a reduced need for sleep warrants prompt evaluation. These findings may reflect activation, akathisia, evolving bipolar illness, or another cause; do not assume they are harmless signs that the treatment is working. (NLM, n.d.-b; NLM, n.d.-c)

Serotonin syndrome is a potentially life-threatening adverse drug reaction. A concerning combination is new mental-status change, autonomic disturbance, and neuromuscular findings such as clonus or hyperreflexia after a serotonergic exposure or interaction. Review recently added agents, including tramadol, some migraine drugs, dextromethorphan-containing products, linezolid, and supplements. Suspected toxicity requires urgent medical evaluation and management of implicated agents under the emergency pathway. A patient with fever, confusion, and clonus should not be sent home with reassurance about expected startup nausea. (NLM, n.d.-c; NLM, n.d.-d)

Switching regimens requires product-specific planning. Fluoxetine and its active metabolite persist for a long time; its U.S. labeling requires at least five weeks after stopping fluoxetine before starting a psychiatric monoamine oxidase inhibitor. The reverse direction generally requires at least 14 days after stopping that

MAOI before fluoxetine is started. Cross-tapering is therefore not a universal strategy. Verify the exact drugs, direction, dates, and instructions with the prescriber and pharmacist. (NLM, n.d.-c)

Hyponatremia can present as headache, weakness, confusion, unsteadiness, or seizures rather than a complaint about a medication. Older adults, patients taking diuretics, and volume-depleted patients can be particularly vulnerable with serotonergic antidepressants. Select baseline and follow-up sodium testing according to risk and the clinical plan. New neurologic symptoms demand assessment even when a scheduled laboratory check is not yet due. SSRIs and SNRIs can also increase bleeding risk when combined with anticoagulants, antiplatelet agents, or nonsteroidal anti-inflammatory medicines. (NLM, n.d.-d; NLM, n.d.-e)

CASE 3 | A change in cognition after treatment starts

Ruth, 78, takes a thiazide diuretic and recently started sertraline. Ten days later she develops nausea, confusion, and an unsteady gait. Her sodium is 124 mmol/L. A family member believes the depression is getting worse because she is less engaged.

This is an urgent medical problem, not a reason to increase the antidepressant. The nurse escalates the symptomatic hyponatremia, protects Ruth from falls, and reports the medication timeline and recent intake. The treating team evaluates causes and manages the sodium disturbance and implicated medicines. The case does not prove a single-drug cause, and sodium correction requires careful medical supervision. A medication adverse effect can resemble psychiatric or cognitive deterioration. (NLM, n.d.-d)

Do not stop an antidepressant abruptly solely because the patient feels better or develops a tolerable nuisance effect. Withdrawal symptoms can include dizziness, nausea, sleep disruption, sensory disturbances, and anxiety; timing after dose reduction or missed doses is informative. Relapse and withdrawal may overlap, so neither should be diagnosed from one symptom alone. Agree on an individualized taper when appropriate, with a way to slow or revise it if symptoms emerge. A taper is a monitored clinical process, not simply an instruction

Table 3. Antidepressant selection: examples of safety checks

Medication / class	Selection and tolerability	High-value safety check
SSRIs	Common initial options; GI, sleep, and sexual effects can affect adherence.	Activation or suicidality; serotonergic interactions; sodium risk; bleeding with NSAIDs/antithrombotics.
SNRIs	May suit selected patients with coexisting pain; individual indications differ.	Blood pressure with venlafaxine; withdrawal after missed doses; serotonergic and bleeding risks.
Bupropion	Alternative when certain tolerability concerns influence selection.	Seizure disorder, current/prior anorexia or bulimia, abrupt alcohol/sedative withdrawal; duplicate products; do not crush XL.
Mirtazapine	Appetite and sleep effects may be useful or unwanted.	Sedation, weight gain, and falls; reassess whether these effects match the patient's priorities.
Tricyclic antidepressants	Not routine first-line pediatric depression treatment; selected later-line roles.	Anticholinergic burden, orthostasis, cardiac effects, and dangerous overdose toxicity.
MAO inhibitors	Specialist-selected therapy with substantial interaction requirements.	Dietary and medication restrictions; product-specific washouts. Fluoxetine-to-MAOI requires at least 5 weeks.

Sources: Lam et al., 2024; National Library of Medicine, n.d.-a; National Library of Medicine, n.d.-c; National Library of Medicine, n.d.-d; National Library of Medicine, n.d.-e; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2022.

to skip increasingly random doses. (NICE, 2022; NLM, n.d.-e)

Teach-back should establish what the patient will take, when, how they will handle a missed dose, which symptoms require urgent help, and whom they will contact about other adverse effects. Ask directly about sexual effects and emotional blunting rather than waiting for spontaneous disclosure. Document medication access and a refill plan. A follow-up visit that records only “tolerating well” can miss the very effect that leads the patient to stop treatment at home.

When improvement is incomplete

Nonresponse should trigger a structured review before a treatment is declared ineffective. Recheck the diagnosis, adequate dose and duration, adherence, adverse effects, substance use, sleep, medical contributors, and psychosocial barriers. A prescription that could not be obtained was not an adequate trial. A therapy referral without attended sessions was not a completed course. Clarifying these differences protects patients from unnecessary escalation and from repeated exposure to

treatments they never had a fair opportunity to use. (Lam et al., 2024; VA/DoD, 2022)

Response commonly means at least a 50% reduction in a standardized symptom score; remission means symptoms are minimal according to an appropriate clinical and measurement framework. These are not interchangeable. A person whose PHQ-9 falls from 20 to 10 has improved by half but still has clinically important symptoms. Residual insomnia, hopelessness, poor concentration, and functional limitations need attention even when the improvement feels substantial. (Cuijpers et al., 2020; Kroenke et al., 2001)

CASE 4 | Better is not the same as well

Daniel, 45, has taken the prescribed therapeutic antidepressant dose consistently for eight weeks. His PHQ-9 falls from 20 to 10. He is eating regularly again but remains unable to concentrate at work and has stopped social activities. There is no current suicidal intent, mania, or medication intolerance on reassessment.

The team acknowledges the improvement while identifying residual symptoms and Daniel's priorities. Appropriate options include optimizing the current strategy or adding an evidence-supported psychotherapy after shared review. The plan specifies the next assessment, target symptoms, and a functional goal, such as resuming a manageable work task. Calling this remission or stopping treatment would disregard continuing impairment. No single next prescription can be selected from the score alone. (Cuijpers et al., 2020; VA/DoD, 2022)

Combining psychotherapy and pharmacotherapy can improve outcomes compared with either alone, particularly in populations with moderate or more severe depression. Evidence does not establish that every patient needs both, or that benefits are identical across interventions and settings. Starting both together may be appropriate when severity or persistence warrants it; sequential addition is another option after incomplete response. A combination plan must account for cost, treatment burden, preference, and access, not only theoretical superiority. (Cuijpers et al., 2020)

When care is split between prescriber and therapist, clarify who monitors symptoms, adverse effects, safety, and missed appointments. Share the treatment formulation and relevant changes with consent and under applicable rules. A patient should not receive contradictory explanations about whether improvement is expected or whether medication should be stopped. Coordinated care also makes it easier to distinguish a psychological barrier from an adverse effect or a recurrence. (Lam et al., 2024; VA/DoD, 2022)

After inadequate response to adequate trials, specialist options may include switching treatment, adding psychotherapy, medication augmentation, or a brain-stimulation treatment. "Treatment-resistant depression" commonly refers to failure of at least two adequate antidepressant trials, but operational definitions differ. Lithium augmentation requires renal, thyroid, interaction, and serum-level monitoring. Adjunctive antipsychotics can cause metabolic effects, movement disorders, and akathisia; their use should not be confused with a diagnosis of psychosis. (Lam et al., 2024; VA/DoD, 2022)

Electroconvulsive therapy is an established option when a rapid or robust response is needed, including selected

cases with severe suicidality, psychotic depression, catatonia, or inability to maintain nutrition. Nursing preparation includes the ordered anesthesia and fasting plan, medication reconciliation, consent support, baseline cognition, and post-treatment monitoring. Repetitive transcranial magnetic stimulation is another evidence-supported option for selected adults; screening addresses seizure risk and relevant implanted devices. Neither treatment should be described as a punishment or as a guarantee against recurrence. (Lam et al., 2024; VA/DoD, 2022)

Intranasal esketamine has two distinct U.S. indications. Adults with treatment-resistant depression may receive it alone or with an oral antidepressant. For depressive symptoms in adults with major depression and acute suicidal ideation or behavior, it is used with an oral antidepressant. The label explicitly does not establish prevention of suicide or reduction of suicidal ideation or behavior, and early improvement does not remove a need for hospitalization. (Janssen Pharmaceuticals, 2026)

Esketamine is administered in a certified, supervised setting under its restricted Risk Evaluation and Mitigation Strategy (REMS) program. Monitor sedation, dissociation, respiratory status including pulse oximetry, and blood pressure; observation lasts at least two hours and discharge requires clinical stability. Blood pressure is assessed before administration and around 40 minutes afterward, with further checks as indicated. Patients need transportation and must not drive until the next day after restful sleep. Product contraindications and vascular history must be checked. Intravenous ketamine for depression is a separate, off-label practice, not an interchangeable take-home substitute. (Janssen Pharmaceuticals, 2026; VA/DoD, 2022)

Adapt treatment to developmental and reproductive context

Children require developmentally informed assessment rather than a smaller version of an adult interview. Play, behavior, school functioning, caregiver observations, and the child's own account contribute different information. For adolescents, collaborative goals may include returning to friendships, school, sport, or music rather than simply lowering a score. Evidence-supported psychological treatments and appropriately selected medication should be integrated

with safety monitoring, family support when safe, and attention to the young person's developing autonomy. (Walter et al., 2023)

Caregiver participation can improve understanding and implementation, but it should not eliminate private clinical contact or conceal abuse and coercion. Explain warning signs and how to obtain help; clarify who will supervise medicines when that is needed. Monitor attendance, functioning, sleep, appetite, and emerging activation as well as symptom ratings. A school plan may reduce avoidable stress and support a gradual return, but teachers and school programs do not replace a clinical treatment and safety pathway. (NIMH, n.d.-d; Walter et al., 2023)

Pregnancy and the postpartum period require active attention to mood, anxiety, bipolar history, and safety. ACOG recommends standardized screening at the initial prenatal visit, later in pregnancy, and postpartum, linked to assessment and treatment systems. The Edinburgh Postnatal Depression Scale and PHQ-9 can support this process. Screen for bipolar disorder before initiating pharmacotherapy for depression when it has not already been assessed. A positive self-harm response requires immediate clinical follow-up rather than waiting for the total score. (ACOG, n.d.)

Treatment decisions should compare the risks of illness, undertreatment, and the specific intervention. Do not abruptly discontinue a helpful medication solely because pregnancy is disclosed; obtain an individualized prescriber review. Consider previous treatment response, symptom severity, pregnancy stage, breastfeeding, infant exposure, maternal sleep, and available support. Postpartum depression is not explained away by the fact that caring for an infant is difficult. Delusions, severe confusion, or marked behavioral disorganization after delivery raise concern for postpartum psychosis and require emergency assessment. (ACOG, 2023b; ACOG, n.d.)

Zuranolone is an oral neuroactive-steroid treatment approved in the United States for postpartum depression in adults. The usual labeled regimen is 50 mg once nightly for 14 days with fat-containing food; it may be used alone or with an oral antidepressant. The label provides a 30 mg regimen for moderate or severe renal impairment, severe hepatic impairment, or strong CYP3A4 inhibitor use. CYP3A4 inducers should be avoided. These dose details require verification against

the patient's organ function and full medication list. (Biogen, 2026)

Zuranolone can impair alertness and driving. Patients must not drive or undertake hazardous activities requiring full alertness for at least 12 hours after each dose, even when they feel capable. Alcohol and other central nervous system depressants can worsen impairment. Discuss safe infant care, transportation, breastfeeding, and effective contraception during treatment and for one week afterward. For dialysis or an estimated glomerular filtration rate below 15 mL/min/1.73 m², the label reports a lack of study data; do not invent an extrapolated regimen. (Biogen, 2026)

CASE 5 | A practical barrier to a postpartum plan

Leah, 29, is prescribed zuranolone for postpartum depression after diagnostic and safety assessment. She plans to take it at 9 p.m. and drive a sibling to school at 7 a.m. She expects that coffee will make the trip safe. Her partner works overnight, leaving her as the only caregiver during the evening.

The nurse identifies that the planned drive is only ten hours after dosing, shorter than the labeled minimum restriction. Feeling alert or drinking coffee does not establish safe driving. Before treatment begins, the team arranges transportation and an individualized plan for infant care if sedation occurs, reviews interacting substances, and confirms follow-up. If practical support cannot be secured, the prescriber needs to revisit the plan rather than accept an unsafe routine. (Biogen, 2026)

Brexanolone should not be presented as a routinely available contemporary U.S. option without checking status. FDA withdrew approval of Zulresso effective April 14, 2025, at the manufacturer's request because it was no longer marketed. The notice allowed remaining inventory to be dispensed until depleted or expired; it did not describe a new safety-based withdrawal. Availability and authorization elsewhere require local verification. (U.S. Food and Drug Administration [FDA], 2025)

For older adults, align treatment with frailty, falls, cognition, sensory impairment, polypharmacy, and renal or hepatic function. Start cautiously when clinically appropriate, but do not leave severe symptoms indefinitely undertreated on a token dose. Reassess orthostasis, sodium risk, bleeding interactions, sedation,

and medication management at home. Depression is not a normal consequence of aging. With the patient's permission, a caregiver may help with monitoring and appointments while preserving the patient's voice in decisions. (NLM, n.d.-d; VA/DoD, 2022)

Prevention needs more than a program label

Prevention and treatment address different populations and outcomes. Universal programs are offered broadly; selective programs target elevated risk; indicated programs address early symptoms that do not yet meet a disorder threshold. A student already experiencing a major depressive episode needs assessment and treatment rather than being assigned only to a prevention class. Distinguish a change in knowledge, a short-term symptom improvement, and prevention of a future depressive episode when evaluating results. (Werner-Seidler et al., 2021)

School-based programs often teach cognitive, behavioral, emotional-regulation, and problem-solving skills. Reviews support benefits in some settings but show variation by population, design, and follow-up. The name of a program does not establish effectiveness after it is moved to a different age group or delivered with less training. Consider baseline symptoms, family stress, attendance, cultural fit, facilitator competence, and fidelity. These are potential influences to investigate, not proven explanations for every success or failure. (Werner-Seidler et al., 2021)

A useful implementation question is what happens when a program reveals serious symptoms. There should be a private route to clinical evaluation, a safeguarding process, and an urgent response for self-harm concerns. Screening without that capacity can identify distress without addressing it. Include caregivers and community services appropriately, reduce stigma, and protect students from having sensitive information exposed in a classroom activity. Educational participation should not be used to assign a psychiatric diagnosis. (USPSTF, 2022; Walter et al., 2023)

In adults and older adults, prevention work may address persistent insomnia, isolation, harmful substance use, chronic-disease burden, and a previous depression history. A randomized trial in older adults with insomnia found that cognitive behavioral therapy for insomnia reduced subsequent incident or recurrent major depression compared with sleep education over follow-up. This is evidence for a specific intervention

and population, not proof that a sleep-hygiene handout prevents depression in everyone. (Irwin et al., 2022)

Do not judge a prevention strategy only by an immediate satisfaction survey. Track uptake, retention, access to needed treatment, symptoms over time, and any unintended distress or exclusion. An average benefit may conceal groups that did not benefit. Nurses can contribute by noticing who is not reached, whether referrals are completed, and whether program demands are realistic. Prevention remains a clinical and social task, not solely an exercise in teaching individual resilience.

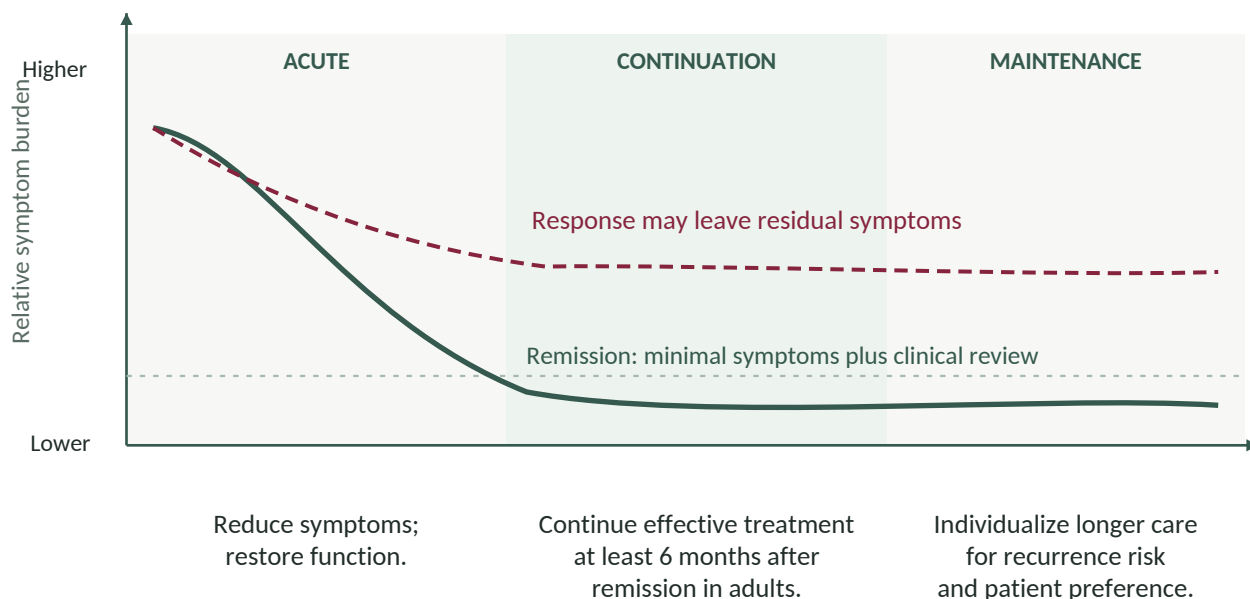
Sustain recovery beyond the first improvement

Treatment is often described in acute, continuation, and maintenance phases. The acute phase aims for remission and restoration of function; it commonly takes several weeks and may require adjustments. Continuation treatment stabilizes improvement and reduces relapse into the same episode. Maintenance treatment aims to prevent later recurrence in people whose history and circumstances justify ongoing care. The boundaries are clinical, not a signal to stop care automatically when a calendar interval ends. Figure 5 illustrates the distinction. (VA/DoD, 2022)

For adults who remit with an antidepressant, the VA/DoD guideline recommends continuing the therapeutic dose for at least six months after remission to reduce relapse. Recurrent, chronic, severe, or difficult-to-treat illness, residual symptoms, and ongoing stressors may support longer treatment after shared review. Pediatric and perinatal plans need population-specific follow-up. A patient who improved last week has not completed a continuation phase merely because the prescription was started several months ago. (VA/DoD, 2022; Walter et al., 2023)

Review function in specific terms: preparing meals, attending school, completing essential work, reconnecting with others, caring safely for a child, or managing physical illness. Ask which gains matter most to the patient and which remain fragile. A person may have a low symptom score and still need rehabilitation or practical support. Conversely, a meaningful functional gain deserves recognition even when full remission has not yet occurred. (Lam et al., 2024; VA/DoD, 2022)

Recovery is a trajectory, not a single lower score



Time is schematic, not a fixed scale. Track safety, adverse effects, and everyday function throughout.

Figure 5. Qualitative illustration of acute, continuation, and maintenance goals. Response can leave residual symptoms; remission and continuing function require follow-up. Curves are illustrative, not measured patient data or predicted timelines. Sources: Cuijpers et al., 2020; Kroenke et al., 2001; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2022.

Create an individualized relapse plan while the patient is relatively well. Identify their early warning signs, such as withdrawing from messages, waking early, abandoning routines, or increasing alcohol use. Write down the actions to take, whom to contact, and when to seek urgent help. Include supports chosen by the patient and review changes in medications or life circumstances. Rehearsing how the plan would work is more informative than simply documenting that a brochure was provided. (NICE, 2022; VA/DoD, 2022)

When discontinuation is considered, discuss the reasons, expected benefits, potential withdrawal symptoms, relapse risk, and follow-up. The patient's preferences matter, but feeling well should be considered alongside how that recovery was achieved and sustained. Psychological relapse-prevention strategies may support the plan. Continue monitoring during and after tapering rather than interpreting the final dose as the end of care. (Lam et al., 2024; NICE, 2022)

Transitions create predictable gaps. A hospital discharge, a change in insurer, leaving pediatric services, the end of postpartum care, or relocation can interrupt treatment even after a good response. The handoff should include the working diagnosis and important uncertainty, suicide-safety findings and plan, actual medicines and response, adverse effects, completed and incomplete treatments, patient priorities, and the named follow-up clinician. Verify that the receiving service has accepted the referral. (VA/DoD, 2022; Walter et al., 2023)

A closed-loop handoff sounds different from a vague referral: "The patient has persistent symptoms after an adequate trial, is taking the listed dose, and reports this adverse effect. The safety plan is documented, the next appointment is booked, and this clinician will contact the patient if attendance is missed." This structure makes responsibility visible. It also preserves the distinction between a treatment ordered, a treatment obtained, and a treatment actually completed.

Clinical synthesis

Depression care is a sequence of informed, revisable decisions. Establish the syndrome without overlooking bipolar or medical explanations; assess safety directly; match treatment to the person and evidence; and monitor both benefit and harm. Biological and psychological models are most useful when they improve care without becoming deterministic stories. Across the lifespan, recovery means more than a lower score: it means sustained safety, restored participation, and a plan that remains workable when symptoms or circumstances change.

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