



# Depression

*Refer to supervisor immediately if you suspect that the client is a danger to herself or others.*

## Background

Depression is one of the most common forms of mental illness, but probably only 10 to 25% of depressed people seek treatment. These guidelines will focus on what mental health professionals call “clinical depression.” Depression is considered a “mood or affective disorder” because it involves the person’s feelings. Treatment depends on the availability of resources and the patient’s motivation. Psychological therapies may include individual or group counseling.

The symptoms may be major or relatively minor. The depression may or may not be related to what’s happening in the patient’s life.

Depression may be

- Chronic (a long term, continuous problem).
- Episodic (comes and goes).
- A one-time experience.

**Researchers have been unable to find a single cause for depression.** There seem to be many possible factors which include:

### **Biological Factors**

People with depression often have blood relatives who have also suffered the same

kind of problem. Chemical abnormalities of the brain that cause depression may be inherited.

### **Psychological Factors**

There are many theories about what kinds of life events and personality traits can cause a person to suffer from depression; for example, loss of a loved one, poor early mother-child interactions, low self-esteem, and anger turned inward.

## What to Look For

We all experience mood changes in our daily lives. Feelings of sadness and disappointment are normal. How can you tell if the client’s depression is serious enough to be considered clinical depression?

## Signs of Clinical Depression

### *Mood Problems*

- Feelings of sadness or discouragement over a long period of time.
- Crying for no apparent reason.
- Loss of interest in normal activities that once were enjoyable, such as eating, sex, social events or family gatherings.
- Difficulty in doing usual tasks, such as duties at work, housework, caring for her family.
- Feeling hopeless and helpless; feeling unable to cope and with no hope that things will be better in the future.



# Depression

- Being anxious. She may feel terrified of some unknown danger. She may experience physical signs of terror, such as sweating, rapid heartbeat, shaking, rapid breathing, and upset stomach.

## *Physical Problems*

- Disturbances of sleep, appetite and sexual activity. She may have trouble sleeping or sleep too much. She often will lose her appetite or, less commonly, overeat. She will often lack sexual interest.
- Lack of energy, without doing anything to get tired. Her speech, thought and movement may actually be slowed down.
- Agitation. The person suffers from unpleasant restlessness or tension. She may be unable to relax or sit still.
- Other bodily complaints such as backaches, headaches, hyperventilation, chest pain, shortness of breath, nausea and vomiting, constipation, heartburn.

## *Problems with Thinking*

- Difficulty in concentrating. She may be so wrapped up in her own thoughts that she has a difficult time paying attention to what is happening around her.
- Feeling guilty, worthless; poor self-esteem.
- Symptoms of psychosis, most commonly hallucinations and delusions. Refer to the *Emotional or Mental Health Concerns Guidelines* in this chapter for more information.

**A person you suspect is clinically depressed should have a thorough medical and psychiatric evaluation to determine an accurate diagnosis and the best possible course of treatment. Based on the woman's current symptoms and past psychiatric history, she may be prescribed medication. The physician and the client will consider the risks and benefits. The risk of certain medications on the fetus may be less than the risk of a mother with untreated depression.**

## **Steps to Take**

**Be understanding and supportive.** The client may feel isolated and helpless. Don't try to talk her out of her feelings of sadness by saying things such as "things aren't so bad."

**Get a brief history of emotional problems** in the client's family, especially blood relatives such as parents, grandparents, aunts, uncles, cousins. This discussion may also give clues as to the patient's cultural beliefs and personal attitudes toward emotional problems.

**Reassure and inform client that depression can be treated.**

**Discuss her available options.** Encourage her to accept a referral to a mental health counselor for evaluation and possible treatment.

**Raise the client's self-esteem** by pointing out what hardships she has overcome and her current strengths. She may be able to draw upon this strength to seek help.

**Help identify specific causes of her stress.** Help her find possible solutions that would relieve some of the stress that may be contributing to her depression.



# Depression

**Check for severe psychological symptoms,** such as:

- Delusions.
- Hallucinations.
- Disturbed thoughts.

Refer to *Emotional or Mental Health Concerns Guidelines* in this chapter for more information.

## ***Prenatal Depression***

**Many pregnant women suffer from some of the common symptoms of depression,** such as fatigue, sleep problems, eating disorders and lack of sexual interest. These women may or may not be clinically depressed.

Women who have a personal or family history of depression are more likely to be depressed during pregnancy.

Refer the depressed woman to the medical provider for further evaluation and intervention. Based on the woman's current symptoms and past psychiatric history, she may be prescribed medication. Often a pregnant woman fears that medication may harm the unborn baby. The medical provider and the patient will consider the risks and benefits. The risks of certain drugs on the baby may be less than the risks of untreated maternal depression. Depression may lead to poor nutrition, substance use and suicide risk.

Strongly encourage the client to follow through on a referral for mental health evaluation and counseling.

## ***Postpartum Emotional Problems***

Postpartum emotional problems are common and may be present in one of several forms. They

may be caused by hormonal changes, genetic factors and psychosocial stresses. They include:

## ***Maternity or Baby Blues***

About half of all new mothers experience the mildest form of postpartum depression often called the maternity or baby blues. She complains of tiredness and has crying spells that usually start right after the baby is born or as late as two weeks following delivery. After a week or so, the mother starts to feel much better. If she experiences depression once, she will likely have the blues after her next deliveries.

Baby blues can't be prevented, but they can be lessened by knowing ahead of time that such reactions are common in postpartum women. Social support and reassurance are also effective.

## ***Postpartum Clinical Depression/Anxiety***

**Postpartum clinical depression is more serious, but also less common.** About one in every five new mothers experience the signs of clinical depression described above. The consequences of this disease to both mother and child are significant. Depressed mothers often show a more negative attitude toward their children, and a depressed new mother puts significant emotional and perhaps economic burdens on family relationships. Solid evidence is mounting that maternal depression is harmful to the baby's development. In addition, there is a possibility of maternal suicide.

The symptoms usually start a month after delivery, or as late as one year postpartum. It is more common in women who:

- Have a personal or family history of depression.



# Depression

- Are first time mothers.
- Have mixed feelings about the pregnancy.
- Have negative feelings about pregnancy outcome such as sex of baby or perinatal loss.
- Have other psychosocial stresses such as marital problems, financial or housing problems and others.

Many women may be afraid to tell someone about their negative or depressive thoughts and feelings. They often feel quite guilty since they believe that having a new child is a time when they should feel very happy. Postpartum depression is a condition that is very treatable. Leaving it untreated can sometimes affect the quality of bonding and relationship between a mother and her child.

**A woman with serious postpartum depression needs help.** Pay attention to suicidal thoughts and symptoms of severe mental illness.

Ask permission of the client to contact family and friends to see if they can provide additional social support. Refer to a new mothers' support group.

Try to help with the other psychosocial stresses in the new mother's life, such as lack of resources.

Be sure to refer the depressed woman to the medical provider for further evaluation and intervention. Based on the woman's current symptoms and past psychiatric history, she may be prescribed medication. The medical provider and the client will consider the risks and benefits. If the client is breastfeeding, the risk of certain medications on the baby may be

less than the risk of a mother with untreated depression. For healthy, full-term babies, the known benefits of breast milk outweigh the potential hazards of most antidepressant medicines.

Strongly encourage the client to follow through on a referral for mental health evaluation and counseling. She may benefit from counseling or short-term medication. In rare cases, she may need to be hospitalized.

## *Postpartum Psychosis*

This serious emotional problem is very rare (about one case in every thousand postpartum women) but can have dangerous consequences. Suicide or killing the baby is seen in up to 10% of untreated cases.

The symptoms usually appear rapidly one to two weeks after delivery or as late as one year after birth. The client at greatest risk is the person with:

- History of bipolar disorder (manic-depression).
- Previous postpartum mental problems, either psychosis or clinical depression.
- Family history of postpartum mental problems.

Some of the symptoms to look for are:

- Rapidly shifting moods.
- Manic symptoms such as extreme agitation, restlessness, and distractibility.
- Elation, insomnia, crying spells, and/or extreme confusion.
- Symptoms of psychosis such as auditory or visual hallucinations and delusions.



# Depression

See *Emotional Concerns or Mental Health Guidelines* in this chapter for more information.

- Obsessions which often focus on religious themes or an impulse to hurt or kill the infant.

**Consult with your clinical supervisor or the health care provider for an immediate psychiatric referral for evaluation and treatment.** A client who refuses can be considered a danger to herself or others and held for emergency psychiatric evaluation and treatment. See *Emotional or Mental Health Concerns Guidelines* in this chapter for additional information.

## Suicide Risk

Suicidal clients have reached a state of unbearable emotional pain. Often the expression of suicidal thoughts are cries for help instead of serious wishes for ending their lives.

It is impossible to absolutely predict who will attempt suicide, but some factors make it **more likely**:

- Past history of suicide attempts especially if there is a history of impulsiveness.
- History of suicide by one or more close relatives.
- Females are two to three times more likely than men to attempt suicide, but half as likely to succeed.
- High degrees of stress, particularly stress associated with medical illness or the loss of a loved one.
- Social isolation.

- Depression, substance abuse and schizophrenia.

A client with suicidal thoughts may be at highest risk **after** the improvement of some of the signs of clinical depression because it gives her enough energy and motivation to carry out the plan.

## What To Do if You Think a Client Might be Suicidal

### If a client has symptoms of clinical depression:

Listen for indirect statements about wishing to die such as the client saying:

*They would be better off without me.*

*I don't think that I can go on much longer.*

*I wish that I had never been born.*

*I might as well give up because I can't make things better.*

### Look for certain behaviors, such as:

- Giving away prized possessions.
- Frequent risk-taking behavior and accidents.

*Don't be afraid to bring up the subject of suicide. Respectful questioning does not increase the patient's interest in making a plan.*



# Depression

Don't be afraid to bring up the subject of suicide. Respectful questioning does not increase the patient's interest in making a plan. Often a suicidal person has no one to listen to her scary, desperate feelings and will be relieved by your willingness to discuss the subject.

## **Ask a series of questions to get at her possible suicidal feelings:**

- *How bad does it get?*
- *Do you sometimes feel like giving up?*
- *Have you ever thought of ending your life?*
- *Have you ever thought you might lose control and actually hurt yourself?*
- *Do you have a plan on how you might kill yourself?*
- *Do you have a way of carrying out your plan?*
- *How close have you come to killing yourself?*
- *Do you feel that you will kill yourself in the near future?*
- *What has kept you from killing yourself?*
- *Does anyone know of these feelings?*

If she denies any suicidal thoughts, express your concern for the patient's sadness and tell her that you want to know if she has any thoughts of hurting herself in the future.

If she admits to suicidal thoughts, listen to her talk about her pain. Try not to express shock. Don't try to cheer her up or give advice. Don't try to talk the person out of it by using guilt.

**Don't try to handle the situation on your own.**

**Let her know that you care about her safety and will need to refer immediately to your clinical supervisor or the health care**

**provider who has more experience with such situations.** Try to remain calm and communicate a sense of hope to the client. If possible, assure her that you will remain with her until she gets the special help she needs.

Try not to leave her alone while you consult with your supervisor. Have another staff person stay with her.

Contact your clinical supervisor or the health care provider who will assess her suicide risk and take the appropriate action, according to your on-site, high risk protocols. **Know your protocols before this situation occurs.**

## **Referrals**

- Outpatient mental health services available through public and private agencies.
- For referrals call your local departments of health or social services, family service agencies, community mental health centers, Veteran's Administration hospitals, medical societies or universities, mental health associations.
- Psychiatric emergency room at local hospital.
- Suicide prevention crisis line.
- Self help groups.
- Religious community.
- Support groups for families of the mentally ill.
- In-home support such as Public Health Nursing.
- Prepared childbirth classes.



# Depression

## Resources

**Postpartum Support International**  
[www.postpartum.net/](http://www.postpartum.net/)

Listing of local Postpartum Depression support groups.

## Complicated Situations

**Immigrant clients** have their own emotional concerns which may include homesickness, problems of cultural adjustment, lack of social support, worries about immigration status, post-traumatic stress disorder and others.

You may have a difficult time finding resources that are linguistically and culturally appropriate. The client may be unable to pay for services. If she is undocumented, she may be concerned that she will be reported to USCIS (United States Citizenship and Immigrants Services) formerly known as INS (Immigration and Naturalization Services). See *New Immigrant Guidelines* in this chapter for additional suggestions.