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Practice Matters: Screening and Referring Congregants with Major Depression

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The latest edition of *Foundations for Faith Community Nurses* was published in 2014 and is required for use by educational partners as of September 1, 2015 (Church Health Center, 2014). This newly revised curriculum acknowledges an important aspect of Faith Community Nursing; the need for Faith Community Nurses (FCNs) to be trained in assessment of and care for those with behavioral health issues. The FCN must be able to educate patients, families and the faith community about the nature of common mental health conditions and how the faith community can be a resource for those with behavioral health conditions (Anabere & DeLilly, 2012; Church Health Center, 2014).

Major depression is one of the most common mental health concerns in the general population and FCNs will encounter patients across the lifespan with this potentially debilitating illness. Faith communities have a long tradition of being a point of initial contact and assistance for those with depression, particularly in rural communities (Bryant, Greer-Williams, Willis, & Hartwig, 2013). The purpose of this article is to assist FCNs in better understanding the prevalence of depression, signs and symptoms necessary for diagnosis, screening tools that can be utilized in community settings and necessary components of treatment and education for patients with depression.

Epidemiology of Major Depressive Disorder

According to the World Health Organization (WHO, 2012a), 350 million individuals across the world experience depression. A report by the U.S. Department of Health and Human Services (DHHS, 2014) indicates that 6.7% of U.S. adults aged 18 and over experienced an episode of major depression in 2013, with the highest rates being among individuals 18 to 25 years old. Women were more likely than men to experience an episode of major depression (8.1% vs. 5.1%). Pratt & Brody (2014) reported in a survey that nearly 8% of Americans aged 12

years and older experienced moderate or severe depression within the previous two weeks. Individuals living below the poverty level were 2.5 times more likely to report depressive symptoms (Pratt & Brody, 2014). The authors noted that teens (12-17 year olds) and older adults (60 years and older) reported similar symptoms of depression (Pratt & Brody, 2014). The statistics on major depression from the United States are reflected worldwide (WHO, 2012b).

Rates of major depression were highest for individuals who reported a multi-racial background (11.4%) and were lowest among Native Hawaiians or Other Pacific Islanders (1.6%). Among adults who experienced a major depressive episode in 2013, 28.3% reported significant thoughts of suicide. Rates of substance abuse, including illicit substances, alcohol, and cigarettes, were higher among adults who reported a major depressive episode verses those who did not report an episode of major depression (DHHS, 2014). Episodes of major depression have been found to worsen the outcomes of other medical disorders (Weihs & Wert, 2012).

A comprehensive, coordinated response to depression and mental disorders was addressed through a resolution at the 65th World Health Assembly in Geneva, Switzerland in May of 2012 (WHO, 2012c). In the resolution, each country acknowledged the need for health and social sector interventions to support physical and cultural care in mental health budgets (WHO, 2012c). According to Maurer and Darnall (2012), depression costs the U.S. medical system $43 billion on an annual basis, and will become the second leading cause of disability in the U.S. by the year 2020. Depression has a significant negative influence on the outcomes of other chronic illnesses, such as diabetes and cardiovascular disease (Maurer & Darnall, 2012). It has been found that 90% of respondents with severe depressive symptoms experience problems with work, home, and social activities, although many of these individuals are not receiving adequate care (Pratt & Brody, 2014). The majority of individuals (57.2%) with major depressive

symptoms seek treatment from their general health care or family provider (DHHS, 2014). When a patient suffering from depression is a member of a faith community, the FCN may be the first point of contact and care (Bryant et al., 2013).

Diagnosing Major Depressive Disorder

In order to be diagnosed with major depressive disorder (MDD), an individual must meet a specific set of criteria that have been established by American Psychiatric Association (APA, 2013). According to the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) (APA, 2013), an individual is diagnosed with MDD when he or she meets at least five pre-determined symptoms on a daily, or almost daily basis, for at least a two-week period. These symptoms must significantly interfere with an individual's daily functioning. Out of these symptoms, one symptom must be a depressed mood (reported by the individual or observed by others), or a reported loss of interest and pleasure in activities. The remaining symptoms are as follows:

- A significant change in appetite or weight
- Sleep disturbance (insomnia or hypersomnia)
- Psychomotor agitation or retardation
- A report of decreased energy or fatigue
- Feelings of guilt or worthlessness
- Difficulty with concentration and decision-making
- Recurrent thoughts of death or suicide (APA, 2013)

According to the U.S. Department of Veterans Affairs and the Department of Defense (VA/DoD, 2009) MDD treatment guidelines, individuals with major depression tend to report somatic symptoms to their primary care providers, as opposed to depressive symptoms. It is

important that providers, including FCNs, fully investigate these symptoms to determine if the individual needs to be screened for MDD. The VA/DoD (2009) also points out that symptoms of depression can be indicative of an underlying medical disorder, such as thyroid disease. It is important to refer patients to their primary care provider for a physical exam and laboratory or diagnostic tests, if indicated (VA/DoD, 2009).

Screening Tools

The U.S. Preventative Services Task Force (USPSTF, 2009) recommends routine screening and management of MDD in primary care settings, if an adequate system is in place for diagnosing and treating this disorder. FCNs should be aware of basic screening tools and referral sources, should a patient have a positive screening for MDD. The VA/DoD (2009) guidelines discuss how providers can manage the majority of MDD cases within the outpatient setting, with the exception of more severe or complicated cases, which should be referred to a mental health specialist. The VA/DoD (2009) guidelines recommend that primary care providers screen individuals for MDD on an annual basis. The VA/DoD (2009) and the USPSTF (2009) recommend the use of a standardized MDD screening tool, such as The Patient Health Questionnaire (PHQ).

The PHQ is a tool that has been developed to assist providers with diagnosing MDD. An abbreviated version of this screening tool, the PHQ-2, was designed to detect or rule out a diagnosis of MDD in an efficient and timely manner (Maurer & Darnall, 2012). The PHQ-2 contains two items that assess for the frequency of depressed mood and anhedonia (a lack of pleasure in normally enjoyable activities) within the past two weeks. The individual will simply need to answer yes or no to both of these items. If an individual answers yes to one, or both of the screening items, the screening result is considered to be positive. A longer version of the

PHQ (the PHQ-9) should be administered to confirm a positive PHQ-2 result. The PHQ-9 contains nine items that screen for a diagnosis of MDD. These items are based on diagnostic criteria listed in the DSM. The PHQ-9 has been found to be a valid tool for confirming a diagnosis of MDD and takes no more than five minutes to administer (Maurer & Darnall, 2012). The PHQ-9 scoring system can also assist the provider with differentiating between the different levels of MDD, including mild, moderate, and severe depression (VA/DoD, 2009). A qualified healthcare provider must then complete an in-depth diagnostic interview to confirm a diagnosis of MDD (Weihs & Wert, 2012).

Management of Major Depressive Disorder

There are a variety of methods to manage MDD, with the most popular being anti-depressant medications and/or psychotherapy. It is important that providers collaborate with their patients when making decisions regarding the management of MDD. Through the process of shared-decision making, there is a higher likelihood that the patient will adhere to the agreed upon treatment plan (VA/DoD, 2009). FCNs can assist patients by providing education on common medical treatments and therapies for the patient and family as needed.

Recommended treatment approaches

Initial treatment of MDD within the outpatient setting is based on the severity of the patient's symptoms and the patient's treatment preferences. For mild to moderate symptoms, it is recommended that patients be referred for psychotherapy, or begin a trial of anti-depressant therapy (VA/DoD, 2009). For moderate to severe MDD, it is recommended that the patient receive both psychotherapy and anti-depressant therapy (VA/DoD, 2009). Response to the treatment regimen can be monitored with the PHQ-9 (Weihs & Wert, 2012).

Antidepressant medications

Serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) are recommended as first line anti-depressant therapies for MDD (Weihs & Wert, 2012). These medications typically have a higher tolerability profile and a reduced rate of adverse effects. Providers may also consider tricyclic antidepressants (TCAs) or monoamine oxidase inhibitors (MAOIs), although these drugs tend to have a lower tolerability profile and a higher risk of adverse effects (Weihs & Wert, 2012). FCNs should be aware of the common side effects of these medications, length of time until symptoms relief is expected, and their possible interaction with other medications patients may be taking.

Psychotherapy

Primary care providers will need to make a referral for specialized psychotherapy services. Cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have proven to be effective therapies for the management of MDD (Varcarolis, 2013). CBT takes an approach that combines cognitive and behavioral therapy. CBT assists individuals with restructuring negative thought processes and changing negative behavioral patterns, which may be contributing to depression. IPT assists individuals with improving interpersonal relationships, which may be causing or worsening depressive symptoms. Evidenced-based research supports the combination of CBT and anti-depressant therapies for the management of MDD (Varcarolis, 2013).

Patient Education

The VA/DoD (2009) guidelines stress the importance of patient education as part of the management of MDD. It is important that providers, including FCNs, educate patients on the nature and causes of MDD, as well as, available treatment options. Patients should be informed

of the risks and benefits of the various treatment options, possible adverse effects from treatment, and the expected duration of treatment (VA/DoD, 2009).

The guidelines also recommend talking with patients about self-management techniques to improve and/or prevent the occurrence of depressive symptoms (VA/DoD, 2009). Patients should be educated on importance of proper nutrition and regular exercise. Bibliotherapy, or the use of self-help books, may also be recommended as an alternative way to manage depressive symptoms. Patients should be educated on the importance of proper sleep hygiene. Proper sleep hygiene includes the avoidance of stimulating agents and/or activities in the evening, and the avoidance of daytime napping. It is recommended that providers also speak with patients on the importance of avoiding the use of alcohol and drugs while experiencing an episode of MDD, because these substances can worsen depressive symptoms and can interact with anti-depressant medications (VA/DoD, 2009).

Conclusion

Depression affects millions of Americans each year, and it is likely that some of those suffering depressive symptoms will seek assistance from a FCN within their church or synagogue. With an integrative perspective on health and wellness, the FCN is well suited to care for those with MDD. FCNs can assist those with depression by understanding who may be at risk for this condition, being knowledgeable of common screening tools, and educating patients on this illness and its common treatments. Because of the risk for negative health outcomes if depressive symptoms persist, the FCN must be prepared to refer to a primary care provider or mental health specialist for appropriate medical care. The FCN can be a knowledgeable and accessible provider to assist patients in managing their condition. As part of

the healthcare team, the FCN can help patients return to a full level of function, both emotionally and physically.

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