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REVIEW ARTICLE

Depression: clinical characteristics and management for nurses

Depresión: características clínicas y manejo para enfermeiras

Depressão: características clínicas e manejo para enfermeiros

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Abstract

Depression is a prevalent and heterogeneous mental disorder, considered a leading cause of global disability, with a significant impact on individual suffering, clinical comorbidities, and suicide risk. It is characterized by persistent sadness, anhedonia, and cognitive, behavioral, and somatic symptoms that impair daily activities. It has a multifactorial origin involving genetic predisposition, neurochemical alterations, and psychosocial factors. This literature review, conducted in databases such as PubMed, CINAHL, and Google Scholar (2019-2024), identified evidence that reinforces the need to recognize specific subtypes, such as Major Depressive Disorder, Dysthymia, Postpartum Depression, Seasonal Depression, Depression with Psychotic Features, and Treatment-Resistant Depression, each with clinical and therapeutic particularities. Effective management requires a multimodal and individualized approach, including pharmacotherapy, psychotherapy, neuromodulation techniques, and lifestyle modifications. It is concluded that nursing practice must be supported by ongoing education and the development of specific protocols to consolidate evidence-based care, focusing on comprehensive patient care.

Descriptors: Depression; Nursing; Mental Health; Therapeutics; Nursing Care.

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Resumén

La depresión es un trastorno mental prevalente y heterogéneo, considerado una de las principales causas de discapacidad global, con un impacto significativo en el sufrimiento individual, las comorbilidades clínicas y el riesgo de suicidio. Se caracteriza por tristeza persistente, anhedonia y síntomas cognitivos, conductuales y somáticos que dificultan las actividades diarias. Tiene un origen multifactorial que involucra predisposición genética, alteraciones neuroquímicas y factores psicosociales. Esta revisión bibliográfica, realizada en bases de datos como PubMed, CINAHL y Google Scholar (2019-2024), identificó evidencia que refuerza la necesidad de reconocer subtipos específicos, como el trastorno depresivo mayor, la distimia, la depresión posparto, la depresión estacional, la depresión con características psicóticas y la depresión resistente al tratamiento, cada una con particularidades clínicas y terapéuticas. El manejo efectivo requiere un enfoque multimodal e individualizado, que incluye farmacoterapia, psicoterapia, técnicas de neuromodulación y modificaciones del estilo de vida. Se concluye que la práctica enfermera debe apoyarse en la formación continua y el desarrollo de protocolos específicos para consolidar una atención basada en la evidencia y centrada en la atención integral.

Descriptores: Depresión; Enfermería; Salud Mental; Terapéutica; Atención de Enfermería.

Resumo

A depressão é um transtorno mental prevalente e heterogêneo, considerado uma das principais causas de incapacidade global, com impacto significativo no sofrimento individual, nas comorbidades clínicas e no risco de suicídio. Caracteriza-se por tristeza persistente, anedonia e sintomas cognitivos, comportamentais e somáticos que comprometem as atividades diárias, tendo origem multifatorial que envolve predisposição genética, alterações neuroquímicas e fatores psicossociais. Esta revisão bibliográfica, realizada em bases como PubMed, CINAHL e Google Scholar (2019-2024), identificou evidências que reforçam a necessidade de reconhecer subtipos específicos, como Transtorno Depressivo Maior, Distimia, Depressão Pós-Parto, Depressão Sazonal, Depressão com características psicóticas e Depressão Resistente ao Tratamento, cada um com particularidades clínicas e terapêuticas. O manejo efetivo exige abordagem multimodal e individualizada, incluindo farmacoterapia, psicoterapia, técnicas de neuromodulação e modificações no estilo de vida. Conclui-se que a prática de enfermagem deve ser sustentada por educação permanente e pelo desenvolvimento de protocolos específicos, a fim de consolidar uma assistência baseada em evidências e voltada à integralidade do cuidado.

Descritores: Depressão; Enfermagem; Saúde Mental; Terapêutica; Cuidados de Enfermagem.

Introduction

Depression is one of the most prevalent mental disorders worldwide, representing a leading cause of disability and a significant challenge to global public health. Its high incidence is associated with profound individual suffering, severe functional impairment, clinical comorbidities, and an increased risk of suicide, overburdening health systems and society as a whole[1].

This mood disorder is characterized by profound and persistent sadness, anhedonia (loss of interest or pleasure), and a constellation of cognitive, behavioral, and somatic symptoms that directly impact an individual's ability to perform their daily life activities. Its pathophysiology is complex and multifactorial, involving interactions between genetic predisposition, neurochemical alterations, endocrine dysfunctions, and psychosocial factors[2]. Although often referred to as a single entity, depression manifests itself through a spectrum of clinical presentations, each with specific nuances in its symptomatology, course, and therapeutic response. This clinical heterogeneity demands from healthcare professionals a keen eye and specific knowledge for accurate diagnosis and effective management[3].

Among the various classifications, the following stand out: Major Depressive Disorder (MDD), the most classically recognized form; Persistent Depressive Disorder (Dysthymia), of a chronic nature; Postpartum Depression, with critical implications for the mother-baby dyad; Seasonal Depression, linked to variations in ambient light; and Depression with psychotic features, a severe presentation[4,5]. Correctly identifying the depressive subtype is a fundamental step in guiding treatment. Inadequate or generic interventions can result in insufficient therapeutic responses, prolonged suffering, and chronicity of the condition, culminating in worse outcomes for patients[6].

In this context, the nursing team, being the professional category that maintains the most prolonged and continuous contact with patients in various care settings, plays a significant role. The nurse's role ranges from the early detection of warning signs and the application of assessment scales to crisis management, health education, and psychosocial support throughout the therapeutic process[7,8].

Therefore, this study aims to identify the main types of depression, elucidating their concepts, distinctive characteristics, clinical examples, and current evidence for

their correct management, with a special focus on nursing practice.

Methodology

This is a literature review conducted between March and April 2024. The search was performed in the electronic databases PubMed and CINAHL (Cumulative Index to Nursing and Allied Health Literature) and Google Scholar. The controlled descriptors (MeSH and DeCS) and keywords "Depression", "Depressive Disorder", "Classification", "Nursing Care", "Management", "Clinical Features", combined by the Boolean operators AND and OR, were used. The temporal filter applied was for articles published in the last 5 years (2019-2024). Original articles, systematic reviews, meta-analyses, and reflection articles, available in full text, in English, Portuguese, or Spanish, were included. Editorials, letters to the editor, and studies whose focus was not the characterization or management of depressive subtypes were excluded.

The selection of studies was carried out in two stages: first, by analyzing titles and abstracts, followed by reading the pre-selected articles in full. Data were extracted using a standardized instrument containing information on authors, year, objective, sample, main results, and conclusions. Laurence Bardin's Thematic Content Analysis was used for data analysis[9], which consists of disaggregating the text into units of registration, coding, and categorization, allowing the identification of core meanings relevant to the object of study. The corpus of analysis was organized into three emerging thematic categories: 1) The phenotypic heterogeneity of depression; 2) Evidence-based therapeutic approaches; 3) The central role of nursing in management.

Results and Discussion

Based on the analysis of the corpus, three thematic categories emerged that synthesize the evidence.

The phenotypic heterogeneity of depression

Recent literature reinforces that depression is not a monolithic condition. The studies analyzed detail subtypes with distinct symptomatic profiles. Major Depressive Disorder (MDD) is characterized by one or more depressive episodes lasting at least two weeks, with depressed mood and anhedonia as cardinal symptoms, accompanied by changes in sleep, appetite, energy, concentration, and feelings of guilt or worthlessness. Persistent Depressive Disorder (Dysthymia), on the other hand, is defined by a depressive mood that persists for most of the day, on most days, for at least two years; its symptoms are less severe, but extremely chronic and debilitating[2,3].

Postpartum Depression is highlighted as a subtype with onset in the perinatal period, with manifestations that may include intense anxiety, extreme emotional lability, and, in rare cases, suicidal or infanticidal ideation, requiring special monitoring. Seasonal Affective Disorder (SAD) is closely linked to reduced sunlight at certain times of the year, manifesting as hypersomnia, increased appetite (especially for carbohydrates), and lethargy. Finally, Depression with Psychotic Features is a psychiatric emergency in which the depressive episode is accompanied by delusions or hallucinations, usually with content congruent with mood, such as hearing critical voices or delusions of ruin[4,5,10].

In addition to these classic subtypes, recent evidence has highlighted Treatment-Resistant Depression (TRD), defined as the failure to respond to at least two adequate antidepressant trials from different classes. This presentation is associated with poorer quality of life and higher socioeconomic costs, demanding specific therapeutic strategies, such as combination medication and neuromodulation. The pathophysiology of TRD appears to involve distinct inflammatory mechanisms and genetic factors, which pave the way for biomarkers and personalized treatments in the future[11,12].

Another clinically relevant presentation is Lifespan Depression, which manifests particularities in the elderly and adolescents. In the elderly, depression often presents prominent cognitive and somatic complaints, masking depressed mood and being confused with dementia. In adolescents, irritability is a central symptom that can replace depressed mood, and risky behavior and social isolation are key indicators that demand attention from the healthcare team[13,14].

Mixed Anxiety Disorder is another common presentation in clinical practice, recognized as a specifier in the DSM-5. Patients with this condition present symptoms of tension, excessive worry, and hypervigilance in addition to classic depressive symptomatology. This subtype is associated with greater severity, poorer response to conventional SSRIs, and a higher risk of suicide, requiring a pharmacological approach that targets both symptom spectrums, such as some SNRIs. The subclassification of depression is based not only on symptomatology but also on emerging biological markers. Neuroimaging studies have consistently shown alterations in the volume of limbic structures, such as the hippocampus and amygdala, in patients with MDD. Furthermore, inflammatory biomarkers, such as elevated levels of C-reactive protein (CRP) and interleukin-6 (IL-6), have been correlated with specific symptoms, such as anhedonia and fatigue, suggesting an inflammatory subtype of depression that may respond better to immunomodulatory interventions[15-18].

Evidence-based therapeutic approaches

Effective management is multimodal and should be individualized according to the subtype. Pharmacotherapy remains a cornerstone, with Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) being the first-line classes. Evidence suggests that for seasonal depression, light therapy is an effective adjunct. For resistant cases, electroconvulsive therapy (ECT) maintains robust efficacy, especially in psychotic depression[5,6,10].

For Treatment-Resistant Depression (TRD), pharmacological optimization protocols are essential. Strategies include potentiation with atypical antipsychotics (such as aripiprazole or quetiapine) or mood stabilizers (such as lithium), which have demonstrated efficacy in increasing

response and remission rates in randomized clinical trials. Lithium maintains a prominent role in potentiation for patients with a family history of bipolar disorder or with psychotic features[19,20].

The most significant advance in the treatment of RSD was the introduction of esketamine, an NMDA receptor antagonist administered intranasally under medical supervision. Its rapid efficacy (within 24-48 hours) in reducing suicidal ideation and severe depressive symptoms makes it a revolutionary option for acute cases, although it requires rigorous monitoring due to the risks of dissociation, blood pressure issues, and potential for abuse. Administration protocols involve an initial weekly induction phase, followed by a maintenance phase with bi-weekly or monthly applications[21,22].

Non-invasive neuromodulation interventions have gained traction as effective and well-tolerated alternatives. Transcranial Magnetic Stimulation (TMS) stimulates the dorsolateral prefrontal cortex with magnetic pulses and is approved for MDD and RD. Its accelerated treatment protocols, such as theta-burst stimulation (TBS), allow for shorter sessions with efficacy comparable to the standard protocol, increasing access to treatment. Transcranial Direct Current Stimulation (tDCS) emerges as a portable and low-cost modality, with studies showing efficacy, especially when combined with psychotherapy, making it a promising option for expansion in Primary Care[23,24].

Psychotherapy, particularly Cognitive Behavioral Therapy (CBT) and Behavioral Activation, demonstrates significant results and is necessary in relapse prevention. Dialectical Behavior Therapy (DBT), originally developed for borderline personality disorder, has proven effective for depression with comorbidities of emotional dysregulation and suicidal risk, focusing on skills of tolerance to suffering and emotional regulation. For postpartum depression, psychotherapeutic interventions focused on the mother-infant bond and the reorganization of parental identity have shown superior results to standard CBT[6,25,26].

Group interventions and psychoeducation for patients and families are widely recommended to improve treatment adherence and understanding of the illness. Structured physical exercise programs, particularly moderate-intensity aerobic exercise performed three times a week, have demonstrated significant antidepressant effects, with mechanisms involving increased BDNF (brain-derived neurotrophic factor) and modulation of the HPA axis. Nutritional therapy is also noteworthy, with the Mediterranean diet, rich in omega-3, antioxidants, and polyphenols, being associated with up to a 30% reduction in the risk of depressive episodes in observational studies[7,8,27,28].

The central role of nursing in management

Studies emphasize the expanded role of the nurse. This goes beyond medication administration, encompassing: continuous assessment using validated scales (PHQ-9); monitoring of adverse medication effects and suicidal ideation; and the implementation of non-pharmacological nursing interventions[7,8].

Specialized nursing assessment is the foundation of care. In addition to applying scales, the nurse should conduct a detailed history of sleep patterns, appetite, energy levels, and psychosocial functioning, identifying subtypes and comorbidities. Suicide risk assessment should be continuous, using approaches such as the Columbia scale and motivational interviewing to engage the patient in a collaborative safety plan, which is an effective strategy for reducing suicide attempts[29,30].

The nurse is the key professional for monitoring and managing adverse drug effects, which are a common cause of early discontinuation. Interventions such as guidance on managing nausea (associating medication with food), insomnia (adjusting dose timing), and sexual dysfunction (communicating with the prescriber for dose adjustment or change) significantly improve adherence. For patients on lithium potentiation regimens, the nurse assumes responsibility for educating patients about the importance of regular serum monitoring and recognizing early signs of toxicity[31,32]. These interventions include building a strong therapeutic bond, active listening, promoting healthy sleep and nutritional habits, encouraging physical activity, and conducting psychoeducational sessions. The development of nurse-led Self-Management Groups has proven to be a powerful tool. In these groups, patients learn techniques for self-monitoring symptoms, problem-solving, planning enjoyable activities, and relapse prevention, empowering them to manage their own chronic condition[8,33].

The nurse acts as a link between the patient, the family, and the multidisciplinary team, being fundamental in coordinating care and providing support throughout the entire therapeutic journey, from primary care to specialized services. In Primary Health Care (PHC) settings, the nurse is central to collaborative care models, acting as a case manager, conducting initial screening, protocol-based follow-up, and timely referral to a psychiatrist, optimizing flow and resolution[7,34].

The role of nurses in Psychosocial Care Centers (CAPS) involves co-facilitating therapeutic workshops, administering long-acting injectable medications, and conducting home visits to assess adherence and the patient's psychosocial environment. In hospital settings, the psychiatric liaison nurse is crucial for managing depression in patients with clinical comorbidities, acting at the interface between physical and mental health and preventing complications such as failure of self-care syndrome[35,36].

Evidence-based practice requires nurses to be up-to-date on scientifically supported non-pharmacological interventions. Problem-solving therapy and behavioral activation are modalities that can be effectively incorporated into nursing practice through structured short-term sessions aimed at breaking the cycle of inactivity and mental rumination, being particularly useful in primary health care[37].

Final Considerations

It has been observed that depression is a complex and heterogeneous clinical phenomenon, far from being a single, uniform condition. Recognizing this diversity is not

merely a theoretical exercise, but a practical requirement for effective care. Each depressive subtype presents distinct pathophysiological mechanisms, particular clinical manifestations, and specific therapeutic needs. Neglecting these differences can result in generalist, often insufficient, approaches that perpetuate suffering and favor the chronicity of the condition. Effective management of depression therefore requires a thorough clinical assessment and the integration of different areas of expertise in a multidisciplinary approach. Although pharmacotherapy plays a central role, it is not sufficient in isolation. Evidence reinforces the relevance of non-pharmacological interventions, including psychotherapies, neuromodulation techniques, and lifestyle modifications such as regular physical activity and the adoption of healthy eating habits. The careful and individualized combination of these strategies tends to substantially increase the chances of therapeutic success, especially in resistant cases that defy conventional approaches. In this context, nursing takes on a leading role that goes beyond administering medication and performing routine care procedures. The nurse, through their continuous and prolonged contact with the person experiencing psychological distress, occupies a strategic position in the early identification of changes, in risk assessment, including suicide prevention, and in strengthening the therapeutic relationship. Their role enables the translation of the therapeutic plan into concrete practices in the patient's daily life, through psychoeducation, monitoring of adverse effects, and facilitation of self-management groups that promote autonomy in self-care. It is necessary to recognize that the science of mental health care is constantly evolving. New evidence regarding biomarkers, neuromodulation therapies, and psychotherapeutic modalities continually emerges. Considering this, not only is the complexity of depression and the relevance of an interdisciplinary approach reaffirmed, but also the urgency of investments in continuing education, especially for nursing professionals. Advancing research that develops and validates specific nursing protocols for different subtypes of depression is fundamental to consolidating a truly evidence-based practice, capable of promoting humanized, effective care oriented towards restoring the well-being and hope of affected individuals.

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