INTRODUCTION

Major depressive disorder (MDD) is the second leading disease causing functional impairment, disability and workforce loss worldwide. It is a prevalent health problem which is associated with substantial mortality, direct medical cost, diminished life quality, and significant physical and psychosocial impairment. Currently, more than 140 million people around the world are suffering from depressive disorder **(Okasha, 2014).**

As reported by **WHO (2014)** MDD is sometimes referred as clinical or unipolar depression and is more intense than any of the other depressive disorders, with a prolonged duration of feelings of loss, hopelessness, and helplessness. Research suggests that unipolar depression is the most prevalent of all mental disorders. As reported in the Medical Outcome Study (MOS), patients with depression were found to function at a lower level and to have poorer well-being compared to patients with other chronic condition **(Wells, 2014).**

Depression negatively impacts a myriad of facets of an individual's life including functioning, satisfaction with work, relationships, leisure, physical health, mental health, sexual functioning, sleep patterns, future outlook and overall sense of fulfillment or contentment with one's life.

Studies have demonstrated that patients with MDD have significant impairments in quality of life (QOL). Consequently, there is a high need for effective treatment **(Trivedi et al., 2014)**.

A growing body of evidence suggests that psychotherapy used in conjunction with medication gives better results in the patient's condition than either medication or psychotherapy alone **(Malan, 2012).** Supportive psychotherapy (SP) is the treatment of choice for severely impacted depressive patients who have a limited range of interests and activities, and improvised social worlds. The goal of SP is to help patients gain an understanding of conflicting relationship patterns in the context of supportive relationship **(Abbass, 2011).**

Hence, development of supportive psychotherapy program becomes an important element of psychiatric nursing management for helping the patients suffering from depression to improve adaptation by whatever means available and to teach depressed patients supportive techniques to help them to overcome symptoms of depression which consequently; improve their quality of life **(Connolly et al., 2012).**

Significance of the Study:

Depression has now become a universal health problem and the outcome of such disorder is physical, psychological, mental and social problems. Several studies have shown that depression results in impairment in the quality of life. Therefore, the aim of this study is to enhance quality of life and decrease depressive symptoms for patients with depression through utilization of supportive psychotherapy.

Nevertheless, there are no Egyptian nursing research studies that investigated the application of supportive psychotherapy with adult depressed patients. The current study would increase the knowledge about how depressed patients would benefit from supportive psychotherapy. In addition, it focuses on nursing care measures utilized through supportive psychotherapy that can be used in the future by psychiatric nurses in clinical settings for depressed patients.

AIM OF THE STUDY

The aim of this study is to enhance quality of life and decrease depressive symptoms for patients with depression through utilization of supportive psychotherapy.

This aim was achieved through:

1. Assessing the severity of depressive symptoms of patients with depression.
2. Assessing the quality of life for patients with depression.
3. Accordingly, developing and implementing supportive psychotherapy program for meeting the identified needs of depressed patients to decreasing depressive symptoms and enhancing their quality of life.
4. Evaluating the effectiveness of supportive psychotherapy program on decreasing depressive symptoms and enhancing quality of life among depressed patients under study.

Hypothesis:

Depressed patients who participate in a supportive psychotherapy program will have better outcomes on their posttest scores regarding QOL and depressive symptoms.

REVIEW OF LITERATURE

Overview of Depression:

The term depression itself was derived from the Latin verb deprimere, "to press down". From the 14th century, "to depress" meant to subjugate or to bring down in spirits. It was used in 1665 in English author Richard Baker's Chronicle to refer to someone having "a great depression of spirit **(Lepine et al., 2013).**

The term Major depressive disorder (MDD) was introduced in the mid-1970s as part of proposals for diagnostic criteria based on patterns of symptoms (called the "Research Diagnostic Criteria). In this context, depression has been described as a condition that is "chronic and recurrent in nature, impairs family life, reduces social adjustment, and is a burden on the community **(Tylee, 2012).**

Depression is categorized as one type of mood disorders. According to **APA, (2010)** mood disorders are placed into four categories: (1) major depressive disorder, (2) bipolar disorder, (3) mood disorders due to a medical condition, and (4) substance-induced mood disorders. The first category includes major depressive disorder which becomes one of the major health problems across the world community causing phenomenal burdens and disabilities.

Major Depressive Disorder (MDD)

Definitions of MDD

Major depressive disorder (MDD) (also known as clinical depression, major depression, unipolar depression, or unipolar disorder; or as recurrent depression in the case of repeated episodes) is a mental disorder characterized by a pervasive and persistent low mood that is accompanied by low self-esteem and by a loss of interest or pleasure in normally enjoyable activities **(APA, 2011).**

Major depression is a disabling condition that adversely affects a person's family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who commit suicide had depressive disorder **(Akiskal & Mckinney, 2012).**

Major depressive disorder, or major depression**,** is characterized by a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience only a single episode within their lifetime, but more often a person may have multiple episodes **(Altman & Bland, 2013).**

Prevalence of MDD

Major depressive disorder (MDD) is a common and invalidating mental illness affecting approximately 2.5% of the general population **(WHO, 2014).** MDD is one of the leading causes of disability and the lifetime prevalence of MDD in the general population is about 5-10%. Lifetime prevalence varies widely, from 3% in Japan to 17% in the US (**Jorm, 2012).**

According to **WHO(2014)**, each year 6% of adults will experience an episode of depression and over the course of their lifetime more than 15% of the population will experience an episode of depression. The average length of an episode is between 6 and 8 months. Recurrence rates are high; there is a 50% chance of recurrence after a first episode, rising to 70% and 90% after a second or third episode respectively.

Data from the National Co-morbidity survey showed that the prevalence of a major depressive disorder (MDD) is 21.3% in women and 12.7% in men**.** Similar female/male prevalence ratios have been documented across different countries and ethnic groups (**Stewart et al., 2011& Waraich et al., 2014).**

People are most likely to suffer their first depressive episode between the ages of 30 and 40, and there is a second, smaller peak of incidence between ages 50 and 60. Depressive disorders are more common to observe in urban than in rural population and the prevalence is in groups with stronger socioeconomic factors i.e. homelessness **(Zimmerman et al., 2011).**

Community studies in the Arab world demonstrate higher rates of depression that vary across nations and study populations **(Abu-Hijleh, 2013).** For instance, a study done by **Alonso et al. (2013)** to assess the lifetime prevalence of mental disorders in 2,857 adults aged > 18 years old, in this study the diagnosis for mental disorders was done using the WHO Composite International Diagnostic Interview (CIDI 3.0). The findings revealed that 12.6% of the surveyed population had mood disorders; and 9.9% of this percent had MDD**.**

Signs and symptoms of MDD

People with depressive illnesses do not all experience the same symptoms. The severity, frequency, and duration of symptoms vary depending on the individual and his or her particular illness **(Rush, 2012))**. However, **Fleck et al. (2013**) stated that "There is no one characteristic of MDD. In fact, MDD represents a

collection of patients who likely have different etiologies to their condition, different clinical courses, and different symptom profiles.

One patient may be anxious and agitated and sleepless and another patient may have psychomotor retardation, over sleeping, Suicidal behavior may be overt in some patients and hidden in others. Some patients have profound co morbidity and some patients only have depressive symptoms. Thus, it is impossible to characterize a single type of presentation or symptomatology **(Fleck et al., 2013).**

Depressed people may be preoccupied with, or ruminate over thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred, and in severe cases, depressed people may have symptoms of psychosis these symptoms include delusions or, less commonly, hallucinations, usually unpleasant **(Whalley & McKenna, 2010)**.

Commonly, mood and affect in a major depressive illness are unreactive to circumstance, remaining low throughout the course of each day, although for some people mood varies diurnally, with gradual improvement throughout the day only to return to a low mood on waking. In other cases a person's mood may be reactive to positive

experiences and events, although these elevations in mood are not sustained, with depressive feelings re-emerging, often quickly (**Gerber et al., 2013).**

As mentioned by **Ballard et al (2012),**behavioral and physical symptoms typically include tearfulness, irritability, social withdrawal, an exacerbation of pre-existing pains, and pains secondary to increased muscle tension and other pains, a lack of libido, fatigue and diminished activity, although agitation is common and marked anxiety frequent. Typically there is reduced sleep and lowered appetite (sometimes leading to significant weight loss) but for some people it is recognized that sleep and appetite are increased.

A loss of interest and enjoyment in everyday life, feelings of guilt, worthlessness and deserved punishment are common, as are lowered self-esteem, loss of confidence, feelings of helplessness, suicidal ideation and attempts at self-harm or suicide. Cognitive changes include poor concentration and reduced attention, pessimistic and recurrently negative thoughts about oneself, one's past and the future, mental slowing and rumination **(Fava & Kendler, 2014).**

Some patients have a more severe and typical presentation, including marked physical slowness (or marked agitation), complete lack of reactivity of mood to positive events, and a range of somatic symptoms including appetite and weight loss, reduced sleep with a particular pattern of waking early in the morning and being unable to get back to sleep. A pattern of the depression being substantially worse in the morning (diurnal variation) is also commonly seen. This presentation is referred to as major depression with melancholic features in DSM-IV and a depressive episode with somatic symptoms in ICD-10 **(Thompson et al., 2013)**.

Diagnosis of MDD

Major depression is generally diagnosed when a persistent low mood and an absence of positive affect are accompanied by a range of symptoms. The number and combination of symptoms needed to make a diagnosis is operationally defined by ICD-10 and DSM-IV-TR**;** although some people will show an atypical presentation with reactive mood, increased appetite, weight gain and excessive sleepiness **(Quitkin, 2013).**

Diagnosis of MDD is based on the presence of depressed mood or loss of interest or pleasure, along with at least 4 additional MDD diagnosis criteria symptoms for a duration of at least 2 weeks. Depressive symptoms

include depressed mood, loss of interest in most activities (anhedonia), significant change in weight or appetite, insomnia or hypersomnia, decreased concentration, decreased energy, inappropriate guilt or feelings of worthlessness, psychomotor agitation or retardation, and suicidal ideation (**Johansson et al., 2013)**. .

Table (1): Diagnosis of MDD.

MDD diagnosis is based on the following list of symptoms, and requires the presence of symptom 1, 2, or both; and at least 5 of 9 symptoms overall; these symptoms must persist for at least 2 weeks.	
1.	Depressed mood nearly every day for most of the day, based on self report or observation of others
2.	Marked reduction or loss of interest or pleasure in all, or nearly all, activities for most of the day, nearly every day
3.	Significant non-dieting weight loss or weight gain (> 5% change in body weight)
4.	Insomnia or hypersomnia nearly every day
5.	Psychomotor agitation or retardation (should be observable by others)
6.	Fatigue/loss of energy nearly every day
7.	Feelings of worthlessness or excessive/inappropriate guilt (possibly delusional) nearly every day
8.	Diminished cognitive function (reduced ability to think or concentrate, or indecisiveness) nearly every day
9.	Recurrent thoughts of death and/or suicide, suicide planning, or a suicide attempt

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th ed, Text Revision. Washington, DC: A P A; 2012

The most widely used criteria for diagnosing depressive conditions are found in the American Psychiatric Association's revised fourth edition of the

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD-10), which uses the name depressive episode for a single episode and recurrent depressive disorder for repeated episodes **(WHO, 2010 & APA, 2012) .**

A major depressive episode is characterized by the presence of a severely depressed mood that persists for at least two weeks. Episodes may be isolated or recurrent and are categorized as mild (few symptoms in excess of minimum criteria), moderate, or severe (marked impact on social or occupational functioning) **(Zimmerman et al., 2011)**.

An episode with psychotic features—commonly referred to as psychotic depression—is automatically rated as severe. If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder is made instead **(Megna & Simionescu, 2013).** DSM-IV-TR excludes cases where the symptoms are a result of bereavement, although it is possible for normal bereavement to evolve into a depressive episode if the mood persists and the characteristic features of a major depressive episode develop (**Wittchen et al., 2011)**.

Causes of MDD

The enormous variation in the presentation, course and outcomes of depressive illnesses is reflected in the breadth of theoretical explanations for their etiology, including genetic, biochemical, endocrine and neurophysiological, psychological, and social processes and/or factors **(Brown & Harris, 2013).**

Advances in neuroimaging have reinforced the idea of depression as a disorder of brain structure and function and psychological findings emphasise the importance of cognitive and emotional processes **(Beck, 2011).** Most researches now reported that all these factors influence an individual's vulnerability to depression, although it is likely that for different people living in different circumstances, precisely how these factors interact and influence that vulnerability will vary between individuals **(Harris, 2012).**

Nevertheless, the factors identified as likely to increase a person's vulnerability to depression include gender, genetic and family factors, adverse childhood experiences, personality factors and social circumstances. In the stress-vulnerability model, vulnerability factors interact with social or physical triggers such as stressful life events or physical illness to result in a depressive episode **(Nuechterlein & Dawson, 2012)**

A family history of depressive illness accounts for around 39% of the variance of depression in both sexes, and early life experiences such as a poor parent–child relationship, marital discord and divorce, neglect, physical abuse and sexual abuse almost certainly increase a person's vulnerability to depression in later life **(Fava & Kendler, 2014).**

Personality traits such as 'neuroticism' also increase the risk of depression when faced with stressful life events, depressed individuals demonstrate elevated levels of broad traits such as negative emotionality, negative affectivity, and harm avoidance, as well as more specific vulnerability factors such as self- criticism, dependency, and perfectionism. Although, the nature of the association between personality traits and depression is still unknown, however, numerous studies have suggested that personality may create vulnerability or predisposition for depression **(Ormel et al, 2013).**

However, different personalities have different expectancies of stressful life events, and some personalities have different rates of dependent life events, which are directly related to their personality – such as breaking up a relationship. The possession of a specific variation in particular genes has also been reported to make individuals more likely to experience depression when faced with life events **(Hammen et al., 2013).**