Don’t let depression derail your staff’s morale and motivation

Depression affects 9% of adults in the US and 18% of hospital-employed nurses, including those who work in perioperative settings.

Nurses with depression not only suffer themselves, but their illness can impact their productivity and quality of care as well as their coworkers’ work lives.

Nurse managers need to be proactive in recognizing and caring for depressed staff, says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

“Untreated, depression will sap the energy and motivation out of your most productive employee or yourself. But with the right help, depression can be managed, overcome, and worked around,” says Letvak, who has been researching the health and safety of the nursing workforce for more than 10 years.

Letvak presented “Looking out for the staff’s mental well being” at the 2013 OR Manager Conference.

Perceptions create barriers

“Anyone who has had depression or who works with someone with depression knows that it is a condition that is very difficult to live with. It is painful,” says Letvak.

Clinical depression has been described by sufferers as a black dog, a suffocating blanket, or an endless dark hole.

The 2 main signs of depression are:

• a persistent feeling of sadness or anxiety
• loss of interest or pleasure in usual activities that lasts for more than 2 weeks.

As part of her research, Letvak interviewed groups of nurses who admitted they had depression. She says she listened to their stories about what it took for them to get through a day, and “their stories were horrific.”

Letvak also talked with the depressed nurses’ healthy coworkers. Their responses were often less than sympathetic, she says. Some examples include:

• “We know they are down, but we are sick of it.”
• “We are tired of picking up the burden.”
• “We are tired of their affect.”
• “Why isn’t our manager doing something about them?”

When Letvak asked the managers about the depressed nurses and their coworkers, they told her:

• “The nurses take care of each other.”
• “They pick up the burden when someone is down.”
• “I am not needed here.”
• “I really don’t know what to do.”

These responses show a knowledge gap, says Letvak, because managers are aware of a staff health problem but they don’t know what to do about it.

Fear leads to avoidance

Letvak learned from focus groups of managers the reasons they ignore mental health issues among their staff members.
Ignorance. “We all know it is happening, but we really don’t know what to do. We are afraid to call out our nurses. We are afraid to tackle anything more than we already have on our plates,” the managers told Letvak.

Fear of reprisal, physical harm. Some managers said they were afraid they could get hurt by some of their employees who were about to snap. Though these comments were made while discussing nurses with anger and high stress issues rather than nurses with depression, Letvak says she found the comments concerning. “These managers are afraid to go to the parking lot because of certain employees, yet they let them come to work and take care of patients.”

Fear of being tough. Managers fear they will earn a reputation as being tough and unforgiving to employees experiencing difficult periods in their lives. “Managers are being evaluated at a level they have never been evaluated at before,” says Letvak. It used to be that managers weren’t questioned, but now more evaluations are being performed on managers than on their staffs. “It’s coming from all sides. They are managed by their staff. They are managed by their senior administrators. And the manager is blamed for all patient and doctor issues.”

Because it is an incredibly difficult time to be in management, notes Letvak, managers don’t want to seem cold; they want to be supportive of their employees.

Fear of litigation. Managers are afraid that if they talk about personal issues or mental health concerns with an employee, they could be sued for interfering in that person’s life.

Address the issues
Managers have to be able to recognize when staff members have mental health problems that impact performance and interpersonal relationships. This doesn’t mean managers should go on a “seek and destroy” mission to look for nurses with depression, notes Letvak, but they should be aware of performance issues such as:

- medication or charting errors
- poor quality of care
- tearfulness
- increase in absences and tardiness
- complaints by coworkers (eg, not finishing work, being hard to work with, or being prone to adverse changes in mood or behavior).

Topping the list of how to manage a depressed employee is to not ignore the problem, says Letvak. Managers should seek support and guidance from human resources and their nurse leadership team. Letvak recommends the following free online tools for those who are reluctant to seek diagnoses and treatment from professionals:

- **MoodGYM** ([https://moodgym.anu.edu.au/welcome](https://moodgym.anu.edu.au/welcome)) is a cognitive-based therapy program that starts with a depression scale and works through a series of exercises and journaling. It has been clinically proven to reduce depression with or without medication.
- **PHQ-9** ([Patient Health Questionnaire-9](http://www.phqscreeners.com/overview.aspx)) asks people whether any of 9 items have happened to them in the past 14 days on a scale of 0 (never happens) to 3 (happens every day). Among the items are little interest or pleasure in doing things, feeling tired or having little energy, and having trouble concentrating, reading the newspaper, or watching television.
- **CUDO** ([Clinically Useful Depression Outcome Scale](http://www.scribd.com/doc/6449363/CUDOS-form)) contains 18 items that assess major depressive disorder criteria as well as psychosocial impairment and quality of life. These include having problems with concentrating or making decisions and having insomnia or hypersomnia. Symptoms are rated on a 5-point Likert scale indicating how well the item describes the person in the past week.

Free online tools offer alternative to professional help
Studies have shown that depression is the most prevalent mental health problem in adults, with 9% meeting the criteria for depression, including 3.4% with major depression that is debilitating and doesn’t allow them to work, says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

Approximately 80% of people with depression have some level of functional impairment, and 27% report serious difficulties in work and home life.

Yet, only 29% of all depressed individuals report having contacted a health professional in the past year, and among the subset with severe depression, only 39% reported having done so.

“One of the biggest reasons they don’t seek help is the stigma and fear it will be on their records,” she says.

Letvak recommends the following free online tools for those who are reluctant to seek diagnoses and treatment from professionals:

- **MoodGYM** ([https://moodgym.anu.edu.au/welcome](https://moodgym.anu.edu.au/welcome)) is a cognitive-based therapy program that starts with a depression scale and works through a series of exercises and journaling. It has been clinically proven to reduce depression with or without medication.
- **PHQ-9** ([Patient Health Questionnaire-9](http://www.phqscreeners.com/overview.aspx)) asks people whether any of 9 items have happened to them in the past 14 days on a scale of 0 (never happens) to 3 (happens every day). Among the items are little interest or pleasure in doing things, feeling tired or having little energy, and having trouble concentrating, reading the newspaper, or watching television.
- **CUDO** ([Clinically Useful Depression Outcome Scale](http://www.scribd.com/doc/6449363/CUDOS-form)) contains 18 items that assess major depressive disorder criteria as well as psychosocial impairment and quality of life. These include having problems with concentrating or making decisions and having insomnia or hypersomnia. Symptoms are rated on a 5-point Likert scale indicating how well the item describes the person in the past week.
resources. They should never try to counsel depressed employees by themselves.

“As the manager, your role is to set up a private meeting with the employee, state what you are observing, and then listen when the employee starts talking to you,” says Letvak.

She suggests using SET—a program mental health groups are recommending for managers with depressed employees.

• **S** stands for support. Identify the problem. Let the employee talk about the problem. Use a personal statement of concern, such as: “I am sincerely worried about how you are feeling.” The emphasis should not be on the manager’s feelings; avoid statements such as: “Your behaviors are causing me extra work and stress.”

• **E** is for empathy. Attempt to acknowledge the depressed employee’s shut-down feelings with a phrase such as: “How awful you must be feeling.” It is important not to confuse empathy with sympathy. If a manager says, “I feel sorry for you,” it could elicit anger or withdrawal from the employee.

• **T** stands for truth or reality. “This is the hard part,” says Letvak. Managers have to emphasize that the depressed employees are ultimately responsible for their work commitments and that others’ attempts to help them cannot preempt this primary responsibility. The manager makes a “truth statement” that a problem exists, it can’t be hidden any more, and something has to be done about it.

Communication with the depressed person needs to include all 3 messages, says Letvak. However, even when all 3 parts are enacted, sometimes the employee will become defensive and disregard anything the manager has said. Then a corrective action plan is essential.

Finally, managers must document that they met with the employees and that they agreed on corrective action plans.

**Federal laws make accommodations for depressed employees**

Managers must be aware of 2 federal worker laws to properly manage a staff member with depression.

**Americans with Disabilities Act (ADA)**

A disability is a physical or mental impairment that substantially limits 1 or more major life activities (seeing, hearing, or performing manual tasks).

“What managers don’t realize about the ADA is that it does not legally require specific accommodations for an employee if that employee’s restriction causes ‘undue hardship’ on the operation of the unit in terms of cost and available resources,” says Susan Letvak, PhD, RN, FAAN, professor and department chair at the University of North Carolina School of Nursing, Greensboro.

The law still requires that the employee satisfy the requisite skill, experience, education, and other job-related requirements to perform job functions with or without reasonable accommodations. In addition, under this law, nurse managers have to consult with human resources before honoring or refusing restricted duty requests. “Don’t take it upon yourself to refuse, or you will be in trouble with the ADA,” she says.

Letvak recommends the federal government’s Equal Employment Opportunity Commission website (http://www.eeoc.gov/) for more information.

**Family and Medical Leave Act (FMLA)**

The Act, which is administered through the Department of Labor, says employees can take up to 12 weeks a year of unpaid time with job-protected leave, and health benefits will still be provided to care for themselves or a family member. The time can be taken at 1 time or in increments, and the absences cannot be held against the employee.

There is also an amendment to FMLA called the National Defense Authorization Act that allows for 6 months of unpaid leave (with job protection) for an employee to take care of a family member who has been injured while on active duty (and some of these are soldiers with mental problems) or 12 weeks of leave when an employee’s family member has been called up for active duty.

**Document and discuss**

Using a standardized corrective action form helps the manager document in a consistent manner and protects the manager, says Letvak.

In the documentation, the manager should:

• Identify the issues and policies discussed in the conversation.
• Summarize the events and facts that led up to the meeting.
• Use clear statements in factual, nonpunitive language.
• State the action plan in clear, measurable steps to improve performance by a spe-
specific date. “If you leave the date open ended, the employees won’t feel any pressure to change and will just go on doing what they are doing,” says Letvak.

• Document what will happen if the employee does not follow through. “This is hard to do,” says Letvak, “but if you don’t, they will think they are not being held accountable.”

• Sign and date the document. The manager and employee both have to sign and date the document. Employees can document a response if they choose. “Some employees will refuse to sign, but managers can tell them that signing doesn’t mean they acknowledge it, it only means they heard it, says Letvak. “They have to sign,” she adds. “If they don’t sign, they can go home right now.”

• Set a follow-up meeting (date and time) while the employee is in the room.

Be proactive
The manager sets the tone on a unit and must have a commitment to a healthy workforce, placing a high value on employees’ physical and mental health, notes Letvak.

To ensure a healthy work environment, managers need to do regular risk assessments for increased stress on their units—either doing the assessments themselves or bringing in an outsider.

Letvak recommends the latter approach. “Ask these people to look around and tell you what they are seeing and feeling. You won’t believe what they will tell you,” she says.

If managers do risk assessments themselves, says Letvak, more than likely the employees will say: “Everything is great. I am doing great. Please rate me as great because I want a raise.” They are not going to tell you how they really feel, she says.

Finally, once stressors are identified, something has to be done about them, says Letvak.

“I still remember all those nurses saying, ‘my manager knows and isn’t doing anything about it.’”

—Judith M. Mathias, MA, RN

References
