SSRIs AND WEIGHT GAIN: BALANCING OUTCOMES
FOR OPTIMAL MANAGEMENT

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SSRIs AND WEIGHT GAIN: BALANCING OUTCOMES
FOR OPTIMAL MANAGEMENT

Abstract

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Chair: Karen Busch

The purpose of this paper is to analyze available evidence related to the use of SSRIs and weight gain during the treatment of depression. Based on this review, nursing care implications aimed at improving outcomes are explored.

Depression affects millions of people and the direct and indirect costs of depression have risen to over 40 billion dollars each year. Depression can be treated successfully. However, recurrence occurs in 50% of the population.

Selective serotonin reuptake inhibitors (SSRIs) are the most common antidepressant prescribed today because of their ease of use, tolerability and reduced risk of overdose. The current SSRIs approved for depression include fluoxetine, paroxetine, sertraline, citalopram and escitalopram. Studies have documented problems of unwanted weight gain with SSRIs. Weight gain occurs most often after prolonged treatment with SSRIs although weight loss is common during the first few weeks of treatment. This weight gain may be considered a deferent pharmacological adherence with depressed patients.

Kozma’s, Reeder’s, and Schulz’s (1993) framework, The Economic, Clinical and Humanistic (ECHO) Model has been used to guide the analysis of existing research
related to the treatment of depression using SSRIs and possible weight gain. This conceptual framework combines the traditional medical model with humanistic and economic outcomes and guides the analysis formulated in this paper.

Nursing has the opportunity and responsibility to help patients cope with unwanted weight gain. Treatment strategies may include proactive education including nutrition counseling, exercise therapy, and weekly weight measurements. Partnerships between practitioners, nursing teams, and patients may empower patients to prevent unwanted weight gain while optimizing the outcomes of depression treatment.
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SSRIs and Weight Gain: Balancing Outcomes for Optimal Management

Depression affects approximately 121 million people worldwide (Rosmond, 2004). The total cost of depression for Americans has risen to over 40 billion dollars each year for direct and indirect costs (Shah, Eisner, Farrell, & Raeder, 1999). “Direct costs, such as hospitalization, outpatient care, and drug treatment, account for $12.4 billion, while indirect costs incurred by lost productivity and absenteeism ($23.8 billion) and suicide-related losses in productivity ($7.5 billion) comprise the remainder” (Shah et al., p. 33). Depression can be treated successfully in most cases; however, an estimated 50% of the population that has experienced a major depressive episode will have a recurrence (Shah et al.; Valuck, 2004).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) categorizes depression as a subset of mood disorders which result from changes in mood, medical, and substance abuse issues (American Psychiatric Association [APA], 2000). Depression can be described as a mental state with distinctive feelings of sadness, despair, worthlessness, decreased self esteem and poor self image (Johnston, Johnson, McLeod & Johnston, 2004). Other clinical signs and symptoms include thoughts of suicide, appetite and sleep disturbances, difficulty concentrating, cognitive impairments, irritability, psychomotor changes and physical symptoms that are resistant to treatment (APA).

Risk factors for depression include genetics, physical disease, situational losses and stressors, level of education, income, age and gender. Johnston et al. (2004) reported on a 1995 Nova Scotia Health Survey involving 5,578 participants, who were representative of age and gender of the region. Those who had incomes under $20,000
and less than a post-secondary education were at increased risk for depression (Johnston et al.). Depression occurs two times more frequently in women than in men (APA, 2000). Recovery from the acute clinical symptoms of depression is only the first step; continued therapy is essential for achieving full remission of the depression as well as preventing relapses (Aberg-Wistedt, Agren, Ekselius, Bengtson, & Akerblad, 2000). “There are increasing recognition and acceptance that depression may be a chronic or recurrent medical illness, and a greater understanding of the importance of long-term treatment is needed” (Zajecka, 2000, p. 20).

Understanding of the psychopharmacology of depression began in the 1950s when the function of norepinephrine in depression was first noted (Feighner, 1999). In the 1960s, the catecholamine hypothesis detailed a relationship between depression and decreased levels of norepinephrine at adrenergic receptor sites, while associating manic behavior with increased levels of norepinephrine (Feighner). The early antidepressants, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs), were used for depression based on their effects on norepinephrine, dopamine, and serotonin receptors (Feighner; C. St.Dennis, personal communication, July 22, 2005). However, major adverse events are a threat with MAOIs and TCAs. The MAOIs carry diet restrictions that can be dangerous when ignored, and an overdose of TCAs can be lethal to depressed, suicidal patients.

The search for an agent that would target serotonin receptors specifically began in Scandinavia and resulted in research leading to the development of the first selective serotonin reuptake inhibitors (SSRIs) (Feighner, 1999). The SSRIs first were prescribed in the United States in the late 1980s (Ferguson, 2001) and are now the most widely
prescribed class of antidepressant medications (Aberg-Wistedt et al., 2000). Petersen, Dording, Neault, Kornbluh, Alpert, Nierenberg et al. (2002) reported the results of a survey completed by psychiatrists attending a review course at Massachusetts General Hospital. Of the 800 who attended, 439 responded to the 10 survey questions (Petersen et al.). Of the 439 respondents, 378 reported that the first-line antidepressant they would prescribe would be a SSRI (Petersen et al.). Today, over two-thirds of the prescriptions for SSRIs are written by non-mental health practitioners (Gesensway, 2004). Kingsbury and Simpson stated, “Although no antidepressant is ideal, many clinicians begin with one of the SSRIs because of their ease of use, safety in overdose, and generally high tolerability” (2001, p. 1435). Ease of use and increased tolerability leads to greater patient compliance, while reduced risk of overdose leads to more frequent practitioner prescribing. Thus, as Ferguson (2001) states, “Consequently, more patients are now successfully treated for depression than ever before” (p. 22).

At this time, the Food and Drug Administration (FDA) has approved the following SSRIs for the treatment of depression: fluoxetine (Prozac®), paroxetine (Paxil®), sertraline (Zoloft®), citalopram (Celexa®) and, the newest addition, a second generation SSRI—escitalopram (Lexapro®) (Stahl, 2005). Valuck (2004) notes in his review that escitalopram more precisely targets specific receptors related to depression than the first generation SSRIs, and offers an improved side effect profile. The table displays the common side effects of the SSRIs approved for depression treatment.

Reuptake of serotonin (5-HT) is blocked by all the SSRIs (Shah et al., 1999; Stahl, 2000) resulting in increased synaptic concentrations of serotonin available to the receptors (Roose, 1999). “Although the SSRIs clearly share the same mechanism of
Table. SSRI Common Side Effects *

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<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Common Side Effects</th>
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<tr>
<td>fluoxetine</td>
<td>Prozac®</td>
<td>nausea, headache, insomnia, somnolence, nervousness, &amp; anxiety</td>
</tr>
<tr>
<td>paroxetine</td>
<td>Paxil® (IR)</td>
<td>nausea, somnolence, weakness (loss of body strength), insomnia, &amp; abnormal ejaculation</td>
</tr>
<tr>
<td>sertraline</td>
<td>Zoloft®</td>
<td>nausea, headache, insomnia, diarrhea, abnormal ejaculation, &amp; somnolence</td>
</tr>
<tr>
<td>citalopram</td>
<td>Celexa®</td>
<td>nausea, somnolence, headache, insomnia, &amp; excessive sweating</td>
</tr>
<tr>
<td>escitalopram</td>
<td>Lexapro®</td>
<td>nausea, insomnia, abnormal ejaculation, diarrhea, &amp; somnolence</td>
</tr>
</tbody>
</table>

*Data collected from various studies – not necessarily comparable (St.Dennis, 2003)

action, therapeutic profiles, and overall side effect profiles, individual patients often react very differently to one SSRI versus another” (Stahl, 2000, p. 234). The SSRIs possibly induce weight gain through alteration in serotonin activity, and this alteration of serotonin may increase appetite and induce carbohydrate craving while improving depression (Deshmukh & Franco, 2003; Sussman & Ginsberg, 1999). In addition to increasing synaptic serotonin levels, some SSRIs also may antagonize 5-HT2C receptors in the hypothalamus, which can change appetite (Sussman & Ginsberg, 1998). Because appetite and food intake is regulated by the central nervous feedback systems which include 5-HT2C receptors, antagonism by SSRIs could cause weight gain (Zimmermann, Kraus, Himmerich, Schuld & Pollmacher, 2003). Carbohydrate craving or “food craving” (Zimmermann et al.) is another possible mechanism for SSRI-induced weight gain and presents as an increase in appetite, especially for sweet and pleasant tasting foods (e.g.
candy bars and doughnuts). Alternatively, others have reported that carbohydrate intake can possibly be decreased by SSRIs (Vanina, Podolskaya, Sedky, Shahab, Siddiqui, Munshi et al., 2002). Possible causes of weight change during SSRI treatment are varied and may reflect individual differences between patients and individual SSRIs. Pharmacists are an excellent resource for practitioners when selecting pharmacotherapy, as they can often help sort out these differences.

Weight gain most often occurs after prolonged SSRI therapy. In fact, weight loss is often observed during the first weeks of treatment during the acute phase (Fava, Judge, Hoog, Nilsson, & Koke, 2000); Sussman & Ginsberg, 1998). Croft, Settle, Houser, Batey, Donahue, and Ascher (1999) described an 8 week placebo-controlled study comparing sertraline and bupropion and reported an average weight loss of 1.74 pounds in the sertraline group. Chouinard, Saxena, Belanger, Ravindran, Bakisk, Beauclair et al. (1999) reported on a 12 week double-blind study involving 203 participants randomized to receive either fluoxetine or paroxetine. Weight loss occurred in 12% of the fluoxetine participants and in 3% of the paroxetine participants (Chouinard et al.).

Michelson, Amsterdam, Quitkin, Reimherr, Rosenbaum, Zajecka et al. (1999) described a 62 week trial in which 839 participants receiving open-label fluoxetine for a 12 week lead-in period lost an average of 0.66 pounds, most of which occurred during the first 4 weeks of treatment. The 395 participants whose depression remitted by the end of week 12 were randomized into one of four groups as follows: 96 received placebos for the remaining 50 weeks of the trial; 97 received fluoxetine for 14 weeks before being switched to placebo; 100 received fluoxetine for 38 weeks before being switched to placebo; and 102 received fluoxetine for the entire 50 weeks (Michelson et al.). Average
weight gain for fluoxetine-treated participants versus placebo were as follows: 26 weeks of fluoxetine (2.2 pounds versus 4.18); 38 weeks of fluoxetine (4.62 pounds versus 5.72); 50 weeks of fluoxetine (6.6 pounds versus 7.04) (Michelson et al.) Thus, the fluoxetine groups demonstrated a steady increase in weight from 14 to 50 weeks of dosing (Michelson et al.). These increases were not significantly different than placebo, although a high rate of drop-out occurred in the placebo group (Michelson et al.). The authors concluded that the weight gains reported probably reflected recovery from depression (Michelson et al.); although this conclusion assumes participants receiving fluoxetine had lost weight during their depressive episode prior to treatment.

In another study, Fava et al. (2000) compared weight changes in 284 depressed patients who were randomly assigned to either receive paroxetine, sertraline, or fluoxetine for 26 to 32 weeks in a double-blind trial. Percent weight changes from baseline were: -0.2% for fluoxetine; +1.0% for sertraline; and +3.6% for paroxetine (Fava et al.). The slight increase noted for sertraline and the decrease noted for fluoxetine were not significantly different from baseline or from each other (Fava et al.). The paroxetine change was significantly different versus baseline and the other two SSRIs (Fava et al.). Perhaps more importantly, the incidence of clinically-significant major weight gains (7% or greater from baseline) was reported as follows: 25.5% of paroxetine treated patients versus 6.8% for fluoxetine versus 4.2% for sertraline (Fava et al.). In summary, although controlled studies have produced conflicting results concerning SSRI-induced weight gain, the majority point to possible decreases in weight during the early phase of treatment, with weight gain appearing after several months in susceptible patients. In addition, there may be differences between individual SSRIs.
In contrast to these published findings, patients and practitioners report that weight gain is common and may be a factor causing patients to elect to discontinue therapy (Sussman, Ginsberg & Bikoff, 2001). Sansone, Sansone, Gaither and Morris (2004) have examined the rates of acceptance of potential weight gain as a side effect of medications. The sample for their study consisted of 241 suburban middle-aged participants. The majority of the participants (79%) were women, highly educated, and Caucasian (Sansone et al.). Participants completed a one page survey measuring their respective acceptance of weight gain with medication use under varying conditions. Sansone et al. reported that 13 participants were unwilling to gain any weight, while only 2 participants would accept gaining more than 20 pounds. The rest of the participants were willing to gain an average of (1) 5.51 pounds under non-life-threatening medical conditions; (2) 13.30 pounds under life-threatening medical conditions; (3) 5.37 pounds for psychiatric (non-life-threatening) conditions; and (4) 12.70 pounds under life-threatening psychiatric conditions (Sansone et al.). The small homogeneous sample reported in this study may limit the generalizability of these findings, but does suggest that weight gain may be an unacceptable side effect for many patients.

A weight change of 7% from baseline is considered clinically significant in a healthy adult (Deshmukh & Franco, 2003; Sussman et al., 2001). A 7% weight change translates to 11 pounds for a 150 pound person. According to Sansone et al. (2004), patients are willing to gain only an average of 5.37 pounds as a side effect of medication use in the treatment of a non-life-threatening psychiatric condition. Therefore, in this example (a 150 pound person), an approximate 5 pound weight difference exists between clinical significance (the area of practitioner’s concern) and the weight gain patients are
willing to tolerate from SSRIs. According to Lin, Von Korff, Katon, Bush, Simon, Walker et al. (1995), discontinuation of antidepressants occurs 62% of the time during the acute phase of treatment and 66% during the late phase of treatment due to side effects. This paper will use the Economic, Clinical and Humanistic Model (ECHO) to analyze available evidence related to the use of SSRIs and weight gain during the treatment of depression. Based on this review, nursing care implications aimed at improving outcomes will be explored.

Conceptual Framework

The ECHO conceptual framework developed by Kozma, Reeder, and Schulz (1993) is a multidimensional model which balances the impact of clinical outcomes from the traditional medical model with humanistic and economic outcomes (see Figure). The traditional medical model focuses on the clinical relationship of “disease, [clinical indicators,] clinical outcomes, and treatment alternatives” (Kozma, Reeder & Schulz, 1993, p. 1123) and does not consider humanistic aspects of care, including the impact of clinical costs, economic outcomes, and treatment modifiers (Kozma et al.). The ECHO model provides a more holistic framework that includes these aspects of care as well as the more traditional treatment features.

The ECHO model begins with a disease or condition. “Clinical indicators are defined in the model as measurements of a patient’s physical and biomedical status used to infer the degree of disease; clinical outcomes are defined as events that occur as a result of disease or treatment” (Kozma et al., 1993, p. 1122). The humanistic intermediaries acknowledge the patients’ subjective evaluation of treatment, and represent the patient’s satisfaction with treatment in the humanistic outcomes (Kozma et
Depression Treatment With SSRIs

Humanistic Intermediaries:
- Side effects of weight gain
- Satisfaction with SSRI treatment

Humanistic Outcomes:
- Social satisfaction
- Increased self esteem
- Tolerability of weight gain

Clinical Indicators:
- Feelings of sadness, despair, worthlessness
- Decreased self esteem
- Poor image
- Thoughts of suicide
- Appetite
- Sleep disturbance
- Difficulty concentrating
- Cognitive impairments
- Irritability
- Psychomotor changes

Clinical Outcomes:
- Outpatient care
- ER visits
- Inpatient hospitalization
- Suicide
- Undesired weight gain

Treatment Modifiers:
- Weekly weights
- Exercise therapy
- Nutrition education
- Adjusted medication dosage
- Nurse/patient partnership

Treatment Alternatives
- Adjunct medication
- Change SSRI

Costs:
- Cost of depression
- Cost of SSRIs
- Cost of practitioner visits
- Hospitalization cost
- Secondary costs of weight gain

External Controls:
- Formularies
- Prior authorization

Economic Outcomes:
- Cost of successful treatment
- Work income

Figure. The Economic, Clinical, and Humanistic (ECHO) Model Applied to the Treatment of Depression Using Kozma, Reeder, and Schulz (1993) Framework.
Treatment modifiers represent partnerships and give direction for treatment based on clinical indicators that may affect clinical outcomes (Kozma et al.). Treatment alternatives provide choices in addition to the current treatment or as the sole treatment alternative (Kozma et al.). The external controls of this model signify the approval or availability to provide the treatment modifiers or treatment alternatives affecting the cost and economic outcome, and ultimately the humanistic outcome and satisfaction with treatment (Kozma et al.). Economic outcomes include the cost of direct and indirect care and loss of productivity as a result of the disease or condition (Kozma et al.).

Concerns about healthcare costs, quality of care, access to healthcare, and patient satisfaction are increasingly important to the healthcare delivery system as well as individual patients (Kozma et al., 1993). The ECHO model provides a framework to better evaluate humanistic treatment approaches in clinical care. The focus of this paper is related to a humanistic intermediary that must be considered to obtain optimal outcomes when treating depression with SSRIs and the possible side effect of weight gain.

Humanistic Intermediaries

Several studies have documented the problem of weight gain in patients treated with SSRIs (Deshmukh & Franco, 2003; Fava et al., 2000; Ferguson, 2001; Michelson et al., 1999; Sussman et al., 2001; Zimmermann et al., 2003). Sussman and Ginsberg (1998) believe the underreporting or underestimating of weight gain is related to the short duration (6 to 8 weeks) of many studies because other research suggests that weight gain occurs in later versus early treatment phases. “More significantly, doubt has emerged not only as to whether it is inaccurate to describe SSRIs as being weight-neutral, but also
whether SSRIs actually promote weight gain in more patients than clinical trial data suggest” (Sussman & Ginsberg, 1998, Introduction section, ¶ 4). As noted, reports of weight changes have not been always in agreement (Hirschfeld, 2003). Exemplifying this phenomenon is data from a pooled analysis of 6 studies (N=513) in which 4.3% of the participants had an average weight loss of ≥ 7% of their baseline weight after 6-8 weeks of therapy, but 17.9% of the participants gained ≥ 7% of their baseline weight after 16-46 weeks of therapy (Sussman et al.). Results from clinical trials may be limited by insufficient dosages, length of study, design of the trial, patient reporting, clinician questions, lack of physical exams and lab values (Ferguson).

More importantly, it must be acknowledged that there are no definitive studies that clearly demonstrate the use of SSRIs cause weight gain in a majority of participants. However, many of the current studies demonstrate weight gain in some subjects, especially during long term treatment. Treatment for clinical depression is essential and should be continued for at least 1 year after response to prevent relapse and provide maintenance treatment (Stahl, 2000). Michelson (1999) believes recovery from acute depression could account for weight changes. However, Baptista, Teneud, Contretras, Alastre, Burguera, de Burguera et al. (1995) believe treatment medication may be partially responsible for weight gain. Also “the prevalence of weight gain associated with social, cultural, genetic, and other medical conditions is very difficult to differentiate from weight gain caused specifically by antidepressant treatment” (Hirschfeld, 2003, p. 22).

The relationship between SSRI use and weight gain is difficult to consistently demonstrate in a majority of participants enrolled in rigorous, scientifically controlled,
placebo-double-blind studies. Ethically, practitioners must offer antidepressant medications to those diagnosed with depression. To withhold antidepressants from suffering and depressed individuals, who are at risk for suicide, makes highly controlled empirical studies difficult. Nevertheless, the frequency of studies reporting undesired weight gain demonstrates and documents significant clinical issues for patients and healthcare practitioners who use or prescribe SSRIs.

Humanistic Outcomes

Weight gain caused by SSRIs can affect a patient’s physical health, appearance, self-confidence, self-esteem and feelings of self-worth (Sussman et al., 2001). A positive body perception is an important part of self image. Also, the effects of weight gain can lead to patient opposition to medications (Vanina et al., 2002). “Drug-associated weight gain does not regress easily” (Vanina et al., p. 846). Patient satisfaction issues influence healthcare choices; quality of life concerns represent the desire of the patient; therefore healthcare choices should reflect these values (Kozma et al., 1993).

Weight Gain as a Clinical Outcome of SSR1 Use

Weight gain and obesity can result from many different influences and factors including disease processes, environment, genetics, socio-economic status, lifestyle behaviors, and pharmacologic side effects and interactions of medications. Zimmermann et al. (2003) assert that “Independently of the underlying cause, overweight and obesity not only induce aesthetic problems affecting well-being, but profoundly increase morbidity and mortality” (p. 195). Weight gain is perceived as a common undesired effect of SSRIs, and the consequences on health and a sense of well-being can be serious.
Treatment Modifiers: An Opportunity for Nursing Intervention

Nursing professionals have a responsibility to help patients cope with unwanted weight gain by offering proactive educational counseling. Healthcare professionals need to be aware of the drug’s pharmacological effects, including weight gain. “Knowledge of the differences that exist among the SSRIs with respect to their safety and tolerability can aid in the selection of the most beneficial treatment” (Valuck, 2004, p. 236). Better treatment outcome expectations can occur by informing the patient about the side effect of weight gain and by offering proactive solutions to possible increased weight from an antidepressant (Deshmukh & Franco, 2003; Zajecka, 2000). Zajecka reports, “Several introductory and educational messages need to be emphasized during the acute treatment, including encouraging the patients to increase their physical activity while lowering caloric intake to a reasonable portion” (p. 22). Similarly, Gesensway (2004) states, “As for weight gain, experts again say that patients need to be counseled up-front, with recommendations on what patients can do to counteract the side effect” (Side effects section, ¶ 7). Zajecka reports discussion with the patient about side effects does positively affect the success of the treatment.

Treatment strategies for weight gain associated with SSRI use may include nutrition counseling/therapy, exercise/physical therapy, behavior therapy or a combination of the above. The Evidence Report recommends nutritional, diet, and exercise therapies along with prescribed antidepressants for at least 6 months before additional pharmacotherapy is considered or added to reduce a weight gain (National Heart, Lung, and Blood Institute, 1998). Adjunct medications also may be an option (Hirschfeld, 2003). However, changing an effective antidepressant because of weight
gain would be considered a last treatment choice, as this often can compromise the treatment and is medically questionable.

Increasing the time healthcare professionals spend interacting with patients could enhance treatment and improve outcomes. Training health professionals such as exercise physiologists, dietitians, psychologists, pharmacists, and nurses during their educational processes and exposing each of the various disciplines to the knowledge, strengths and potential contributions of other disciplines would help promote a more comprehensive treatment paradigm (National Heart, Lung, and Blood Institute, 1998; Pi-Sunyer, 2003). Gesensway (2004) reports, “While many patients with mental health issues need more than just a pill and an occasional follow-up appointment, those interventions are all that some receive in the new age of SSRIs” (¶ 4).

In the absence of a comprehensive, multidisciplinary team approach to depression treatment, nursing professionals have an opportunity to significantly improve care. Nutritional consultation, exercise training, weekly weight measurements, and evaluating activities and food intake recorded in patients’ journals can be conducted and implemented by nursing professionals (Deshmukh & Franco, 2003). Educating and coaching patients may empower them to prevent weight gain while optimizing the outcomes of depression treatment.

Partnerships between practitioners and nursing teams can offer better patient care, and partnerships between nurses and patients can be a powerful tool toward patient management and self care. Today, a patient sees a psychiatric practitioner for approximately 50 minutes, and a primary care practitioner sees depressed patients for about 15 to 25 minutes (Petersen et al., 2002). The time constraints experienced by the
primary care practitioner may limit the opportunities to educate and counsel patients and provide opportunities for nursing professionals. Nursing professionals can bridge the gap between the practitioner and the patient. However, the literature offers limited information about specific strategies nurses may use to prevent or encourage patient success in avoiding or coping with drug induced weight gain.

A possible cost effective strategy envisions nursing team professionals monitoring patients' responses to SSRIs, recording weights and offering education on nutrition and diet programs during “nurse appointments”. The advantages of this approach may encourage better patient involvement and communication, decrease costs and improve treatment outcomes. Nursing team care, patient empowerment, patient education and prevention interact to create a powerful partnership for balancing and optimizing depression treatment and resultant outcomes.

Conclusion

Selective serotonin reuptake inhibitors are effective in treating depression. A potentially important adverse effect is weight gain. Choosing a SSRI with a good tolerability profile will influence patient success, build a healthcare professional team trust, and facilitate successful treatment.

Differences of opinion exist concerning the amount of weight gain that is acceptable to a given patient during the treatment of depression. Evidence suggests that patients' tolerance of weight gain as a medication side effect is much less than practitioners believe (Sansone et al., 2004). Therefore, healthcare professionals must be aware that their patients could be confronted with weight gain during successful treatment of depression, making educational recommendations essential.
Practitioner and nursing team professionals must be prepared to encourage patient participation in preventing unwanted excess weight gain through monitoring programs and diet and exercise education. The nurse/patient partnership can be a powerful tool. Patient education about the potential adverse effect of weight gain with SSRIs and proactive interventions to modify diet and encourage exercise during depression treatment with SSRIs are needed. Currently, the proposed interventions for nursing team professionals to monitor and educate patients’ responses to SSRIs have yet to be researched and tested for effectiveness. The available literature supports a potentially positive outcome for education in the acute phase of depression.
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