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Narrative Review: Nursing Interventions for Managing Anxiety and Depression in Acute Care Settings

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Abstract

Background: Anxiety and depression are highly prevalent comorbidities in acute care settings, affecting up to 30-40% of inpatients. Despite their high prevalence and profound impact, these conditions are frequently under-recognized and sub-optimally managed within the fast-paced, biomedically focused environment of acute care units.

Aim: This narrative review aims to synthesize contemporary evidence on effective, nurse-led interventions for the screening, assessment, and management of anxiety and depression in adult patients within acute medical and surgical inpatient settings.

Methods: A comprehensive search of PubMed, CINAHL, PsycINFO, and the Cochrane Library was conducted for literature published between 2010 and 2024. Keywords included "acute care," "general hospital," "inpatient," "anxiety," "depression," "nursing interventions," "screening," and "management."

Results: Effective management is underpinned by systematic screening using validated tools like the GAD-2/7 and PHQ-2/9. Evidence supports a multi-modal approach: foundational therapeutic communication (active listening, validation); psychoeducation to demystify the illness experience; targeted psychological strategies (problem-solving therapy, behavioral activation, relaxation techniques); collaborative medication management; and structured family involvement.

Conclusion: Nurses are pivotal in mitigating the adverse effects of anxiety and depression in acute care. Moving from tacit to explicit, protocol-driven care requires empowering nurses with knowledge, skills, and systemic support. Integrating evidence-based psychosocial interventions into standard nursing practice is not an optional adjunct but an essential component of holistic, high-quality acute care that can improve patient experience, clinical outcomes, and healthcare efficiency.

Keywords: Anxiety; Depression; Acute Care Nursing; Inpatient; Psychosocial Interventions.

Introduction

The modern acute care hospital is a crucible of human vulnerability, where individuals confront not only the physiological assault of acute illness, surgery, or trauma but also the profound psychological distress that accompanies such events. Within this high-stakes environment, anxiety and depression are not rare outliers but endemic, yet often invisible, co-morbidities. Epidemiological studies consistently indicate that clinically significant symptoms of anxiety affect approximately 30% of general hospital inpatients, while depressive symptoms are present in 20-40%, rates substantially higher than those in the general community (Alruqi et al., 2024; Walker et al., 2022). These are not merely normative emotional reactions; they are serious conditions that interact bidirectionally with physical health. Anxiety can exacerbate cardiovascular strain, impair immune function, and intensify pain perception (Celano et al., 2018; Chernoff et al., 2022). Depression is linked to poorer adherence to treatment, increased functional disability, longer hospital stays, higher readmission rates, and greater mortality, particularly in conditions like myocardial infarction and stroke (Krittanawong et al., 2023).

Despite this compelling evidence, the "biomedical blind spot" persists. The acute care milieu, with its emphasis on vital signs, diagnostic procedures, and technical interventions, often relegates psychological distress to the background, viewing it as secondary to the "primary" physical diagnosis (Thornicroft et al., 2019). This results in significant under-recognition; fewer than half of inpatients with major depression are identified by their medical teams (Huang et al., 2023). Unrecognized and unmanaged, anxiety and depression create a vicious cycle: distress worsens the experience of illness and impedes recovery, which in turn deepens the psychological suffering.

This is where the unique and essential role of nursing comes to the fore. Nurses constitute the largest healthcare workforce and are the professionals who spend the most continuous time with hospitalized patients. They are positioned at the nexus of patient

experience, observing behaviors, hearing concerns, and managing the 24-hour trajectory of care. Consequently, nurses are ideally placed to detect early signs of psychological distress and to implement interventions that can alleviate it. Nursing's scope of practice inherently encompasses holistic, person-centered care, which logically includes the management of co-occurring anxiety and depression (Al-Moteri et al., 2019).

This narrative review, synthesizing literature from 2010 to 2024, argues that proactive, evidence-based nursing intervention for anxiety and depression is a critical component of high-quality acute care. It moves beyond the well-established imperative for screening to detail the "what next?"—the practical, nurse-led strategies that can be employed at the bedside. The review is structured to explore: the foundational importance of systematic screening and assessment; core communication-based interventions; specific psychoeducational and psychological techniques; the nurse's role in pharmacological management; the engagement of family systems; and the essential system-level supports required to translate evidence into consistent practice. The ultimate aim is to provide a comprehensive resource that empowers acute care nurses to view the management of psychological distress not as an optional adjunct, but as a core, indispensable element of their professional responsibility.

Foundations: Systematic Screening and Holistic Assessment

The first and most critical step in managing any condition is its identification. In the context of anxiety and depression in acute care, reliance on intuition or passive observation is insufficient and leads to the documented gaps in recognition. Therefore, the implementation of systematic, nurse-administered screening using brief, validated tools is the essential foundation for any intervention protocol (Table 1).

Evidence strongly supports the use of ultra-brief instruments integrated into routine nursing admission assessments. For depression, the Patient Health Questionnaire-2 (PHQ-2), which asks about anhedonia and low mood, serves as an excellent initial screen. A positive score (typically ≥3) should trigger administration of the full PHQ-9, which provides a severity score and diagnostic aid (Bianchi et al., 2022). For anxiety, the Generalized Anxiety Disorder-2 (GAD-2) screen, followed by the GAD-7 if positive, is equally effective and efficient (Plummer et al., 2016). These tools are psychometrically robust, quick to administer (taking 2-5 minutes), and designed for use in medical settings. Their routine use empowers nurses to objectify their clinical suspicions and ensures that psychological distress is given the same structured attention as pain or fall risk (Richardson et al., 2020).

However, screening is only the entry point. A positive screen must be followed by a focused nursing assessment to contextualize the symptoms. This assessment is bio-psycho-social in nature. Biologically, the nurse must explore the relationship between symptoms and the physical condition: Is the anxiety related to dyspnea from heart failure? Is the depressed mood a side effect of corticosteroids or beta-blockers? Psychologically, it involves exploring the patient's understanding and meaning of their illness, their coping resources, and any history of prior mental health conditions (Happell et al., 2023). Socially, it assesses the support system, financial worries triggered by hospitalization, and fears about returning to work or home responsibilities. This holistic assessment, often framed as "therapeutic inquiry," differentiates normative distress from a clinically significant disorder and guides the selection of appropriate interventions. It also strengthens the therapeutic alliance, signaling to the patient that their emotional experience is a legitimate and important part of their care (Martínez-Martínez et al., 2022).

Table 1: Nurse-Administered Screening Tools for Anxiety and Depression in Acute Care

Tool	Items	Purpose & Cut-off	Administration Time	Nursing Implications
PHQ-2	2	Ultra-brief depression screen. Score ≥3 warrants further assessment.	<1 minute	Ideal for initial nursing admission assessment. Normalize its use as a "vital sign for mood."
PHQ-9	9	Assesses depression severity & DSM-5 criteria. Scores: 5-9 (mild), 10-14 (moderate), 15-19 (moderately severe), 20-27 (severe).	2-3 minutes	Guides intervention intensity. Item 9 on suicidal ideation requires immediate safety assessment and referral.
GAD-2	2	Ultra-brief anxiety screen. Score ≥3 indicates likely anxiety disorder.	<1 minute	Effective for detecting generalized anxiety in medically ill patients.
GAD-7	7	Assesses anxiety severity. Scores: 5-9 (mild), 10-14 (moderate), 15-21 (severe).	2-3 minutes	Useful for monitoring response to nursing or medical interventions over the hospital stay.

| Distress Thermometer | 1 visual scale (0-10) | Screens for general psychological distress. Often paired with a problem checklist. | 1-2 minutes | Quick, patient-friendly. A score ≥4 typically triggers a more detailed conversation or referral. |

Core Nursing Interventions: Communication, Psychoeducation, and Psychological Strategies

With the assessment complete, the nurse moves into the active intervention phase. These interventions exist on a continuum from fundamental communication skills to more structured psychological techniques, all within the scope of generalist nursing practice when supported by appropriate training (Table 2).

Therapeutic communication and the therapeutic alliance are the bedrock of all effective interventions. In acute care, where patients often feel depersonalized and powerless, a nurse's communication style can itself be anxiolytic or iatrogenic. Evidence-based communication strategies include active listening (giving full attention, using silence); validation (acknowledging the normality and difficulty of their feelings, e.g., "It's completely understandable to feel scared about this surgery"); reflective statements (paraphrasing to show understanding); and empowerment (offering choices within the constraints of care) (Hazazi, 2025). Building a trusting relationship makes the patient more receptive to other interventions and provides a profound sense of safety. Conversely, dismissive or purely task-oriented communication ("Your vitals are fine, try to relax") can exacerbate feelings of isolation and distress.

Psychoeducation is a powerful, low-resource intervention that directly targets the uncertainty and catastrophic thinking that fuel anxiety and depression. Nurses are ideally suited to provide clear, consistent information about diagnoses, procedures, what to expect during recovery, and the management plan. Effective psychoeducation is not a one-time data dump but is tailored, repeated, and delivered in a calm, confident manner. For an anxious patient, knowing that post-operative pain is expected and how it will be managed can significantly reduce anticipatory anxiety (Bello, 2017). For a depressed patient, explaining the bi-directional link between their heart condition and low energy can help depersonalize the fatigue, reducing self-blame. Providing written or multimedia materials can reinforce verbal explanations (Suraya et al., 2024).

For patients with moderate symptoms, more structured psychological strategies can be incorporated. These require additional training but are highly effective. Problem-Solving Therapy (PST) allows nurses to guide patients to identify a specific, hospital-related stressor (e.g., "I'm worried about who will feed my cat"), brainstorm practical solutions, evaluate them, and implement a plan. PST empowers patients, counteracting helplessness, a core feature of

depression (Zhang et al., 2018). Behavioral Activation (BA) counters the cycle in which inactivity and social withdrawal worsen mood; nurses can collaborate with patients to schedule simple, pleasurable, or mastery-oriented activities within the hospital environment—a short walk down the hall, a visit to the day room, a phone call to a friend, or completing a personal care task independently (Farrand et al., 2014; Gilbody et al., 2022).

For anxiety, teaching relaxation techniques such as controlled diaphragmatic breathing (to counter hyperventilation), progressive muscle relaxation (for generalized tension), or guided imagery can provide immediate symptom relief and a sense of self-efficacy—skills patients can use during stressful procedures or at night to aid sleep (Traeger et al., 2013; van Klinken et al., 2023). Basic Cognitive Restructuring, although full cognitive-behavioral therapy remains a specialist role, enables nurses to help patients identify and challenge overly negative or catastrophic thoughts (e.g., "This pain means the surgery failed") by gently offering alternative, evidence-based perspectives (e.g., "This level of pain is common on day two, and here's our plan to manage it") (Wand et al., 2021). Figure 1illustrates the nurse-led intervention for managing anxiety and depression in an acute care setting.

Figure 1: Nurse-led intervention for managing anxiety and depression in an acute care setting.

The Nurse's Role in Pharmacological Management

While nurses do not prescribe, they play a critical role in the safe and effective use of psychotropic medications in the acute care setting. This involves several key responsibilities. First, monitoring and advocacy: nurses are the primary observers of treatment response and side effects, watching for therapeutic effects of anxiolytics (e.g., benzodiazepines) or antidepressants as well as adverse effects such as oversedation, orthostatic hypotension, anticholinergic effects, or increased fall risk; accurate reporting is crucial for dose adjustment (Haddad et al., 2014). Second, patient education: nurses explain the medication's purpose, expected onset of action (e.g., "This antidepressant can take 2–4 weeks to work fully,

but we're starting it now to help with your recovery"), potential side effects, and the importance of adherence, thereby reducing "pharmacophobia" and improving compliance (Mohammed et al., 2024).

Third, collaboration with the team: nurses communicate patient responses to the prescribing physician or psychiatric consultation-liaison team. They are often the first to identify drug–drug interactions or contraindications based on their comprehensive knowledge of the patient's full medication profile and medical condition (Avery et al., 2020). Fourth, non-pharmacological first approach: a core nursing responsibility is to advocate for and utilize non-pharmacological interventions as first-line treatment for mild to moderate anxiety, especially given the risks of delirium and dependence associated with benzodiazepines in medically ill, often elderly, inpatients (Perez et al., 2018; Stanley et al., 2023).

Family and System-Centered Interventions

Hospitalization affects the entire family system, and family dynamics can significantly influence a patient's psychological state, while a distressed family can increase patient anxiety. Nursing interventions, therefore, extend to family engagement. Family assessment and support—assessing family anxiety and providing clear information—can indirectly calm the patient, as a frantic family member at the bedside is a potent source of distress (Olding et al., 2016). Facilitating therapeutic presence involves creating opportunities for the family to provide comfort while guiding them on supportive behaviors (e.g., encouraging calm conversation and avoiding excessive questioning about medical details).

Including family in care planning, especially discharge planning, and teaching them to recognize signs of depression or anxiety at home, promotes continuity of care and reduces patient fears of abandonment post-discharge (Duong et al., 2024).

System-Level Enablers and Implementation Challenges

For individual nurses to consistently deliver these interventions, they must be supported by deliberate system-level structures. Key enablers include mental health liaison (MHL) Services that provide specialized backup, complex case support, and clinical supervision, thereby building general nurses' confidence and skills (Wand et al., 2021); integrated care pathways that mandate screening at admission, define clear referral pathways, and outline stepwise nursing interventions to standardize care (Coates et al., 2020); and nursing education and competency development that integrates therapeutic communication, distress screening, and basic psychological strategies into fundamental acute care nursing curricula rather than treating them as specialty topics (Happell & Platania-Phung, 2005).

Significant barriers persist, however: time constraints in understaffed units, stigma among professionals and patients, lack of confidence and training, and a biomedical culture that often fails to value or reward psychological care (Moreno-Poyato et al., 2020). Overcoming these barriers requires intentional leadership, resource allocation for training, and the measurement of psychological care outcomes as a key performance indicator.

Table 2: A Stepped-Care Model for Nursing Management of Anxiety/Depression in Acute Care

Step & Severity	Nursing Interventions	Collaboration & Referral
Step 1: All Patients (Universal Prevention)	- Therapeutic communication & alliance building. - Routine psychoeducation about condition/treatment. - Creating a calming, predictable environment.	- Social work for concrete needs (finance, housing). - Spiritual care per patient request.
Step 2: Mild Symptoms (Positive Screen, PHQ-9 5-9, GAD-7 5-9)	- **Enhanced psychoeducation:** Focus on mood-illness link. - Teach & practice **relaxation techniques** (breathing). - Initiate **Behavioral Activation** (schedule activity). - **Basic problem-solving** for hospital stressors.	- Inform primary medical team of positive screen. - Consider referral to MHL nurse for brief follow-up.
Step 3: Moderate Symptoms (PHQ-9 10-19, GAD-7 10-14)	- All Step 2 interventions, more intensively. - Structured **Problem-Solving Therapy** for key issues. - **Basic cognitive challenging** of negative thoughts. - Close monitoring of safety (suicidality).	**Mandatory referral to Mental Health Liaison (MHL) service.** - Collaborate with MHL on care plan. - Support medication initiation/management as ordered.

	- Family assessment and engagement.	
Step 4: Severe Symptoms/Safety Risk (PHQ-9 ≥20, active SI, psychosis)	- Maintain therapeutic rapport. - **Constant observation/safety precautions** as per protocol. - Administer medications as ordered. - Provide clear, simple communication.	**Immediate, urgent referral to Psychiatry.** - Active collaboration in crisis management and transfer planning if needed.

Synthesis and Conclusion

The evidence synthesized in this review presents a compelling and actionable blueprint for acute care nursing. Anxiety and depression are not epiphenomena of hospitalization; they are integral to the pathophysiology of recovery. Managing them effectively is, therefore, not a diversion from "real" nursing work but is central to it. The nurse's role is multifaceted: detective (screening), scientist (assessing biopsychosocial links), therapist (employing communication and psychological techniques), educator, collaborator, and advocate.

The most effective approach is a stepped-care model (see Table 2), where the intensity of the nursing intervention matches the severity of the patient's distress, supported by clear protocols and specialist collaboration. This model is efficient, scalable, and person-centered. It begins with the universal foundation of compassionate, skilled communication and progresses to specific techniques like PST and BA for those in greater need.

Ultimately, integrating these interventions requires a paradigm shift. It demands that healthcare systems acknowledge the economic and clinical imperative of addressing psychological co-morbidities by investing in nurse education, supporting MHL services, and creating a culture that values psychosocial care as a marker of excellence. For the bedside nurse, it requires the confidence to believe that their time and attention given to a patient's fear or despair is as therapeutically vital as administering medication or changing a dressing. By embracing this holistic mandate, acute care nurses can profoundly alter the trajectory of a patient's hospital journey, transforming an experience defined by terror and helplessness into one of supported healing and resilience. The management of anxiety and depression is, unequivocally, core nursing business in the acute care setting.

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