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Negotiating Depression Treatment with Older Adults: Primary Care Providers' Perspectives

Marsha N. Wittink, MD MBE^{1,2}, Jane L. Givens, MD MSCE³, Kathryn A. Knott, RN MS¹, James C. Coyne, PhD⁴, and Frances K. Barg, PhD, MEd^{1,3,5}

¹Department of Family Medicine and Community Health, School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania USA

²Center for Epidemiology and Biostatistics, School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania USA

³Geriatrics Section, Department of Medicine, School of Medicine, Boston University USA

⁴The Leonard and Marilyn Abramson Family Cancer Research Institute, University of Pennsylvania, Philadelphia, Pennsylvania USA

⁵Department of Anthropology, School of Arts and Sciences, University of Pennsylvania, Philadelphia, Pennsylvania USA

Abstract

BACKGROUND—Whether and how primary care providers consider older patients' perceptions of depression may have an impact on patients' acceptance of treatment.

AIM—To explore how physicians view and experience the process of discussing depression diagnosis and care with older adults.

METHOD—Semi-structured interviews conducted with 15 providers involved with intervention studies of depression management for older adults. We used the constant comparative method to identify themes related to negotiating the diagnosis and treatment of depression with older adults.

RESULTS—Providers felt that older patients often attribute depression to non-medical causes. They talked about the challenges of treating older adults and described the need to “convince” them of the medical model of depression to enter them into standard treatment (medication).

CONCLUSION—How primary care physicians surmise patients' views of depression may influence whether and how depression is discussed in practice. Given that they most often provide medication for depression treatment, some may feel compelled to convince their patients of biomedical explanations while others may avoid treating depression altogether.

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Keywords

Depression treatment; primary care; providers

INTRODUCTION

Primary care occupies a strategic position for the evaluation and treatment of depression in late life (Rabins, 1992). According to epidemiologic and clinical studies conducted over the past two decades, the primary care setting is pivotal to improving depression treatment over a population level (Gallo & Lebowitz, 1999; Gallo et al., 1995; Gallo, Rabins, & Iliffe, 1997). However, under treatment, poor adherence to depression treatments and treatment drop-out remain high among older adults treated for depression in primary care (Alexopolous, 2001; Draper & Koschera, 2001). Many reasons have been cited as explanations for under-diagnosis and treatment of depression (Schulberg et al., 1998) but when asked about barriers to depression treatment, primary care physicians feel they are most often patient-centered and related to patient attitudes and beliefs about depression care (Nutting et al., 2002). In order to improve the quality of behavioral health in the United States, the Institute of Medicine *Quality Chasm* report called for “patient-centered care”, defined as respecting patients’ values, beliefs and preferences and customizing care to improving treatment uptake and benefit. However, it has been shown that in new visits for depressive symptoms, very few physicians incorporate patients’ preferences into care (Young et al., 2008).

Our previous work suggests that older patients come to the physician encounter with expectations about depression management that may have an impact on what patients are willing to tell physicians (Wittink et al., 2006). Specifically, some patients expect their physicians to “just pick up” their depression without having to tell the physicians about their emotions directly, while others may feel they are a “good patient” and chose not to burden the physician with their emotional distress. Additionally, while older depressed patients appreciated their doctors’ ability to identify depression; i.e. “put it all together” into a diagnosis, they felt that the doctor’s viewpoint omitted important information about the etiology and feeling of depression as it was personally experienced and situated within a social context (Wittink et al., 2008). In addition, some older adults appear to hold faith-based explanatory models for their depression (Wittink et al., 2009) which may have an impact on how depression is discussed and treated by the physician. While a number of studies, including our own, have explored how older patients think about depression and its treatment (Barg et al., 2006; Lawrence et al., 2006; Shellman, 2007), less is understood about how primary care providers approach older patients’ beliefs and preferences in their depression treatment discussions. In this preliminary study, we set out to explore the ways primary care providers conceptualize and negotiate depression management with older patients and their perceptions of the reasons older patients accept or refuse treatment. Our interviews, coupled with patient perspectives, may provide insights into some of the challenges of providing patient-centered depression treatment in primary care settings.

METHODS

Participants were primary care providers at our health system who were involved in one of two multi-center randomized trials of depression care delivery in older adults; the Primary Care Research in Substance Abuse and Mental Health for the Elderly trial (PRISM-E (Levkoff et al., 2004; Wittink et al., 2005)) or the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT; (Bruce et al., 2004)) between 1999 and 2003. Out of a total of 54 providers whose patients were in the two studies, we selected 33 providers (14 from PRISM-E, 19 from PROSPECT) with the largest numbers of patients in the parent studies.

Data collection

Semi-structured telephone interviews lasting 20-30 minutes were conducted in the summer of 2005 by a physician-researcher. Our previous work based on interviews with older patients suggest that there may be a lot of give and take between patients and their providers when talking about depression and its treatment (Wittink et al., 2006; Wittink et al., 2008). These findings led us to wonder about the process of treatment negotiation from the providers' frame of reference. The goal of this study was to investigate primary care providers' perspectives on treating depression in the elderly, with a focus on providers' assessments of patients' views towards depression. We did not inquire about the care of specific patients, but rather asked about how providers care for older adults with depression in general. The topic areas covered in the interview were about managing depression in older primary care patients. For this paper we focused on the providers' answers to semi-structured questions about the challenges of managing depression in older patients, how their patients feel about a diagnosis of depression and how they feel about the different types of treatment for depression. (The complete interview guide is available upon request.). Informed consent was obtained from all participants and this study was approved by the Institutional Review Board of the University of Pennsylvania.

Analysis

The telephone interviews were digitally recorded and sent to a professional transcriptionist who produced a verbatim transcript of the interview. These were checked for accuracy prior to data being entered into QSR N6 (QSR International, Melbourne, Australia), a software package designed to facilitate qualitative analysis. We used the constant comparative method (Boeije, 2002), moving iteratively between codes and text to derive themes related to physicians' discussion of negotiating depression diagnosis and treatment with their older patients (Glaser & Strauss, 1967; Malterud, 2001). An interdisciplinary team consisting of a geriatrician, a family physician, a geriatric psychiatry nurse and a medical anthropologist reviewed the data and discussed coding. Differences in coding were resolved by consensus.

RESULTS

Sample characteristics

Of the 33 providers who were invited to participate, 15 completed interviews. Ten providers were male, 10 were less than 50 years of age, 9 were internists, 4 were family doctors and 2 specialized in geriatric medicine. The most common reason given when refusing to participate was "lack of time." There were no differences between providers who participated in the study and those who did not with respect to gender, age or specialization.

Themes

Convincing patients that depression is a medical illness—The providers in our sample described conversations with patients about depression treatment as being predicated on getting patients to "accept the diagnosis": This concept of accepting the diagnosis was directly related to the providers' assessment that older adults do not see depression as a medical illness or a condition, just like high blood pressure, that can be treated, but as a lack of moral fortitude. To contrast the notions commonly held by their patients, providers used terms such as "neurobiology," "neural-biological," "bio-medical" or "biological" models of depression. They spoke of having to "convince," "educate," and "sell" when referring to the discussions they have with their older patients. The difference in doctors' and patients' explanatory models was frequently cited as a source of difficulty in the negotiation around depression treatment.

While convincing was a prevailing component of the way the providers described their conversations about treatment, and most of these discussions centered on treatment in the form of medication, some providers noted that they weren't always comfortable with selling the biomedical model of depression. For example, one provider noted that he will only prescribe medication for folks whom he believes are more likely to share in a biomedical notion of depression. Other physicians worried that the focus on “convincing” would have a detrimental effect on the doctor-patient relationship.

In contrast, while the majority of the providers seemed to view their role as being the one to convince patients to take medication (a treatment consistent with a “biomedical model” of depression), some providers were willing to consider alternative treatments or supportive options that they felt would be more in-line with the patient's concept of depression such as a spiritual model where they get comfort from going to church or talking with their pastor.

Furthermore, when treatment is initiated, providers often attribute the fact that patients stop treatment to patients' lack of belief in the medical model of depression:

Treating depression in the context of aging—When providers were questioned about negotiating treatment decisions with their older patients, they frequently brought up the differences between older patients and younger patients. As discussed above, many of the providers discussed the need to convince their older patients of a medical model in order to accept treatment; additionally some physicians felt the *reason* older patients don't ascribe to a medical model of depression is related to patients' beliefs about aging. Older patients might think differently about depression than younger patients because depression, and its causes, is talked about more openly among younger patients:

Despite prevalent concerns about needing to convince older patients about depression, some providers felt that older patients “are not so head strong about their role in decision making.” One physician echoed this sentiment: “I think they are likely to say they will take meds as long as I recommend it.” They suggested that older patients are more willing to please and accept the doctor's orders, consistent with a paternalistic model of patient care familiar to older patients. However it was also noted that apparent compliance with initiating treatment might not necessarily translate into actual adherence to the treatment:

DISCUSSION

Patient-centered care is predicated on the notion that patients and their doctors share information and come to a consensus about proceeding with treatment (Stevenson et al., 2000; Charles et al., 1997). The providers in our preliminary study described a different process for coming to a decision about treatment for depression with their older patients. Whether or not providers formally or systematically elicit the patients' beliefs, they appear to either discover or assume that patients do not agree with the prevailing biomedical model. Given that many primary care providers will rely on pharmacotherapy, antidepressants, as first-line treatment, assessing whether the biomedical model holds sway with the patient may be seen by the providers as paramount to successful implementation of the biomedical treatment the doctor has to offer.

We need to consider some potential limitations before discussing the results further. First of all, this is a preliminary study with a small sample size, consistent with an exploratory investigation. Secondly, providers who consented to an interview may have consisted of a sample of providers who were particularly keen to speak to us and may not be representative of all community providers. Nonetheless, providers who have an interest in a study about treating older adults for depression may be particularly informative with regard to factors

affecting treatment acceptability. Thirdly, by specifically asking the providers to differentiate between treating older and younger patients we may have inadvertently suggested that there is a difference in approach as opposed to letting the provider tell us whether age was important. However, since we were interested in provider experiences with older patients it seemed important to make the distinction in our line of questioning. While we used the broad term “treatment” in our questioning, most providers focused on medication as a treatment modality in contrast to counseling or referral. However, at least a few of the providers did discuss alternative approaches to depression treatment, such as spiritual counseling.

With respect to discussing treatment with their older patients, the providers rarely mentioned a specific discussion of a range of treatment options or any shared-decision making process. Instead, the providers suggest that medication is the main treatment option they offer and rather than work with patient preferences and explanatory models of depression, they felt the need to “convince” patients that they have a depression and that depression is indeed a medical illness that warrants medical treatment. The need to treat with medication may reflect what primary care providers know best to do, but it may also reflect their dissatisfaction with referrals to mental health specialists (Gallo et al., 1999; Kushner et al., 2001) and limited training in mental health (Williams et al., 1999). The providers in our sample additionally note that the need to convince older patients stems from the fact that their older patients appear more likely to hold a different explanation for their depression. This idea corresponds to our findings that older adults may consider depression as a consequence of loneliness (Barg et al., 2006); or as a moral failing (Switzer et al., 2006), rather than as a disorder requiring treatment with medication. However, just because older patients may have different beliefs about the causal reasons for depression doesn't mean that they won't simultaneously hold other beliefs about depression or be willing to take conventional treatments for depression (Wittink et al., 2008) especially, if given the chance to discuss and address their explanations of depression.

Despite discussing the need to convince patients about depression, the same providers felt that older patients may be more likely to please the doctor and agree to a recommended treatment. This finding is consistent with studies that show younger patients tend to be more likely to expect active participation in decisions about their care (Guadagnoli & Ward, 1998), while older patients prefer to defer decision making to the doctor (Charles et al., 1998). However, as one provider in this study noted, agreeing to take a medication does not necessarily mean the patient will, especially if the “biomedical” model of depression, or indeed depression itself doesn't comport with the patient's idea of what is wrong. While the providers in this study seemed very aware of issues that may be more relevant to older adults vis-à-vis depression treatment, such as different beliefs about the causes of depression and possibly decision-making preferences, the providers also hint at frustrations they feel with offering only limited treatment options (in this case, the providers primarily discuss medication management).

CONCLUSION

Respect for the patient's model of illness appears to be important in creating a therapeutic alliance and in assuring adherence, (Reif, Egli, Baker, & Kassekert, 1997; Nunez, 2000; Robins, et al., 1998) but there is little specific advice for providers about how to adapt the presentation of treatment options to the explanatory models of patients. The providers in our study already appear aware that patients may hold differing explanatory models of depression. Our preliminary findings suggest that while primary care providers feel they need to convince patients of the biomedical model, some may have reservations about doing so because they are worried about losing the patient's trust or in other ways altering the

doctor-patient relationship. Other researchers have found that promoting conventional biomedical etiologies (biochemical or genetic causes) for mood disorders may lead to fatalism or pessimism (Cunningham et al., 2007; Phelan, et al., 2006). Future studies may help elucidate what underlies both the need to convince and the occasional reluctance to do so on the part of primary care providers. Furthermore, future interventions aimed at improving depression treatment for older primary care patients might explore what feasible aspects of depression management fit with the patients' depression models. If systematically studied, existing depression treatment services can be adapted to serve the psychological and social needs of older patients to reduce the need to convince patients to accept a biomedical paradigm.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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