Published in final edited form as:

J Gerontol Nurs. 2008 August ; 34(8): 17–22.

Older Home-Care Patients' Preferred Approaches to Depression Care:

A Pilot Study

Denise C. Fyffe, PhD, Ellen L. Brown, EdD, RN, Jo Anne Sirey, PhD, Elizabeth G. Hill, PhD, and Martha L. Bruce, PhD, MPH

Dr. Fyffe is Assistant Professor, Institute for the Elimination of Health Disparities, School of Public Health, University of Medicine and Dentistry of New Jersey, Newark, New Jersey; Dr. Brown is Associate Professor of Nursing, Florida International University, College of Nursing and Health Sciences, Miami, Florida; Dr. Sirey is Associate Professor of Clinical Psychology in Psychiatry, Weill Medical College of Cornell University, and Associate Attending Psychologist and Clinical Director, Geriatric Outpatient Clinic, New York Presbyterian Hospital, New York, New York; Dr. Hill is Assistant Professor of Biostatistics/Bioinformatics and Epidemiology, College of Medicine, Medical University of South Carolina, Charleston, South Carolina; and Dr. Bruce is Professor of Sociology in Psychiatry, Department of Psychiatry, and the Clinical Epidemiology Program, Graduate School of Medical Sciences, and Associate Vice-Chair for Research, Department of Psychiatry, Weill Medical College of Cornell University, New York, New York

Abstract

The purpose of this pilot study was to explore the approaches to depression care preferred by older home-care patients and examine characteristics associated with those preferences. Twenty-eight long-term home-care patients, ages 62 to 95, were interviewed. Patients ranked their depression care preferences and provided rationale for their responses. Results indicated prayer was preferred by the highest percentage of patients (50%). Comparing patients with and without depression experience, prayer was preferred by the latter group. The results highlight the importance of addressing patient preferences during care planning to improve participation in geriatric depression care management.

Geriatric depression is a prevalent, often unrecognized, but treatable medical condition (Charney et al., 2003; Lebowitz et al., 1997). Untreated depression has been associated with increased disability, complications of comorbidities, poorer medical outcomes, and risk of institutionalization for older adults (Charney et al., 2003). Geriatric mental health experts recommend a range of approaches to depression care, including medication, psychotherapy/counseling, combination therapy, watchful waiting, and electroconvulsive therapy (Alexopoulos et al., 2001).

Home-care visits performed by a skilled geriatric nurse clinician provide a potential opportunity for depression care initiation and management for depressed older adults.

However, research has established that depression among older home-care patients is often inadequately treated (Bruce et al., 2002). Limited access to geriatric mental health services in the home-care sector may be a factor contributing to the undertreatment of depression and the primary use of antidepressant agents among older adult home-care patients (Zeltzer & Kohn, 2006).

Although expert guidelines do not include religious activities, such as prayer, as a component of depression care, other studies have found participation in religious activities mediates depressive symptoms among hospitalized older adults (Koenig, George, & Titus, 2004) and home-care recipients (Milstein et al., 2003). Studies of complementary and alternative medicine have found older adults participate in religious activities, such as prayer, to promote their well-being (Dunn & Horgas, 2000; King & Pettigrew, 2004). Prayer is the most commonly recognized and used form of religious expression that is defined as a

“form of communication with the deity or Creator” (Levin, 1996, p. 67). Prayer has been classified as a spiritual-cognitive-behavioral intervention to promote psychological and functional well-being that can be readily used by frail older adults (Hawley & Irurita, 1998; Hicks, 1999; Koenig et al., 2004).

Interest in learning about patient preferences to promote adherence and satisfaction in depression care

Geriatric nurses interested in improving depression care should consider that many older homebound patients may prefer prayer as part of their care plan.

has increased (Bedi et al., 2000; Dwight-Johnson, Unutzer, Sherbourne, Tang, & Wells, 2001). Although older adults' preferences for depression care have been examined in primary care settings (Gum et al., 2006), little is known about the preferences of older home-care patients. Patient-centered care that incorporates an understanding of patients' preferences for depression care may help geriatric nurses promote patient acceptance of prescribed treatments and improved quality of life (Dossey, Keegan, & Guzzetta, 2005; Lauver et al., 2002).

For this study, we examined ways in which older home-care patients prefer to cope with depression. This study addressed the following research questions:

- Which approaches to care do older home-care patients prefer to use to cope with depression?
- Are specific clinical or sociodemographic characteristics associated with older home-care patients' preferences?
- Why do older home-care patients prefer specific approaches to cope with depression?

METHOD

Design

This exploratory pilot study integrated quantitative and qualitative research designs. This mixed methods approach identified patients' preferred approaches to care and the reasons for those preferences (Frewer, Salter, & Lambert, 2001). All study procedures received full review and approval from the medical college institutional review board and HIPAA committee and participating home-care agency senior administration.

Sample and Setting

The study, conducted between July 2003 and March 2004, recruited patients from the long-term home health care program (LTHHCP) of a certified home health agency serving New York City and surrounding counties. The LTHHCP coordinates care services to disabled and chronically ill adults, including recipients of the New York State Medicaid waiver program (CDHS/Research Foundation of SUNY/BSC, 2006). To qualify for the LTHHCP, patients are required to be eligible for placement in a hospital or residential health care for an extended period of time.

At the time of recruitment, 110 patients were in the LTHHCP. The home-care agency mailed a letter about the study to 70 patients who met the following eligibility requirements:

- Age 60 and older.
- Able to provide informed consent.
- Able to speak and understand English.

- Not aphasic.

Of the 40 patients who responded to the recruitment letter, 1 refused to participate in the study, 2 were unable to complete interviews due to medical concerns, and 9 were identified as ineligible by family members or nurses' clinical judgment. A total of 28 patients completed the semi-structured interview in their homes.

Measures

Data were collected from semi-structured interviews and medical records (CMS-485 Form, The Outcome and Assessment Information Set [OASIS]). OASIS is federally mandated documentation for certified agencies that includes data items for monitoring and measuring home health outcomes. A depressive disorder diagnosis was determined and validated by two clinical psychologists (D.C.F., J.A.S.) using the Structured Clinical Interview for Axis I Diagnosis (First, Spitzer, Gibbon, & Williams, 2001). Information on medical diagnoses, medications, functional disability in activities, and instrumental activities of daily living were obtained from medical records. Cognitive functioning was assessed using the Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) and items from the MOS 36-item Short-Form health survey (SF-36) assessed pain intensity (Ware & Sherbourne, 1992).

Patients' preferences for different approaches to depression care were ranked. In this study, we defined *depression care* broadly as a strategy or approach to manage or cope with symptoms of depression and *depression treatment* narrowly as the provision of evidence-based care. On the basis of consensus guidelines and evidence-based practices in geriatric mental health care (Alexopoulos et al., 2001; Bartels et al., 2002), four approaches to treatment were identified:

- Medication.
- Psychotherapy/counseling (i.e., talk therapy).
- Combination therapy (i.e., medication and psychotherapy/counseling).
- Watchful waiting (i.e., do nothing).

Prayer was included from the complementary and alternative medicine literature (Dossey et al., 2005; King & Pettigrew, 2004). Patients were given a list (in large bold type) and asked to rank different approaches to depression care from 1 to 5 (1 = *most preferred* to 5 = *least preferred*). Approaches to depression care were presented in the same order, and patients were asked: "People who are experiencing depression have a choice to take medicine, go for psychotherapy/counseling, combine medicine and psychotherapy/counseling, pray, or not do anything at all. If you were depressed, which treatment would be your first choice (and why), second, etc.?"

Descriptive Summary

Analyses of patients' preferences were based on their first-ranked choice for depression care. Continuous variables were summarized using means and standard deviations, whereas categorical variables were summarized using frequencies and percentages.

The analyses of patients' reasons for preferring certain approaches to depression care were guided by a grounded theory approach (Glaser & Strauss, 1967). Themes were created and applied using an iterative process of reading, summarizing, and rereading the interview transcripts. Frequency, extensiveness, intensity, and specificity of comments were considered in determining themes.

RESULTS

Demographic and Clinical Characteristics

Participants ranged in age from 62 to 95 (mean age = 77, $SD = 9.7$ years). More than half (64%) were women. Forty-six percent of the patients were Black, and 54% White. Almost half of the patients were widowed, and more than two thirds (68%) lived alone. Less than one third (32%) had completed high school.

According to medical charts, all patients had multiple medical conditions. The most common primary diagnoses were chronic obstructive pulmonary disease ($n = 8$, 29%), diabetes mellitus ($n = 4$, 14%), congestive heart failure ($n = 3$, 11%), and hypertension ($n = 3$, 11%). Seven patients (25%) met criteria for a current depressive disorder, and 6 (21%) scored below 24 on the MMSE, indicating mild to severe cognitive impairment.

The number of prescribed medications ranged from 3 to 27, with a mean of 13 medications ($SD = 5.2$). Almost half of the patients ($n = 12$, 43%) were prescribed at least one psychotropic medication. The two most common psychotropic medications prescribed were antidepressant ($n = 9$, 32%) and antipsychotic ($n = 4$, 14%) agents.

Preferred Approaches to Depression Care

The Table shows the percentage of patients who preferred each approach to depression care. Compared with the other approaches to depression care, the highest percentage (50%, $n = 14$) of patients preferred prayer. Combination therapy was preferred by 6 patients (21%), and psychotherapy/counseling was preferred by 4 patients (14%). Medication ($n = 2$, 7%) and “do nothing” ($n = 2$, 7%) were least likely to be ranked as patients' most preferred approach to depression care.

Related to the second research question, preferred approaches to depression care did not vary by age group, gender, race, marital status, education, or living status. However, 91% of patients who did not have experience with depression were more likely to prefer prayer, whereas 73% of patients who had experienced depression were more likely to prefer evidence-based approaches to depression care. Experience with depression was operationalized as patients with a current depressive disorder and/or antidepressant medication prescription. The “do nothing” approach to depression care was removed from the preference analyses to restrict the inference to participants who preferred active approaches to care.

Regarding the reasons older home-care patients prefer specific approaches to cope with depression, themes and quotations that most accurately exemplify the themes are presented in the Table.

Prayer—Patients described prayer as the first thing they need to do to cope with depression and illness. A history of success with prayer in coping with depression was an important aspect of prayer to some other patients. A few patients believed praying was important to their initiating evidence-based approaches to depression care and having successful outcomes.

Combined Approaches—The majority of patients who preferred combined approaches to depression care recognized the increased value (or benefit) of receiving antidepressant medication and psychotherapy concurrently.

Psychotherapy/Counseling—Patients who preferred psychotherapy/counseling described it as an unbiased interpersonal approach that offered cognitive-behavioral insights

about the etiology and consequences of depressive symptoms, as well as interventions to reduce symptoms.

Medication—Patients preferred medication because of the benefits associated with improving their depressive symptoms, particularly when their symptoms were severe.

Do Nothing—The 2 patients who preferred this approach to depression care explained that their preference was based on the belief that shame was associated with being depressed.

DISCUSSION

The primary finding of this study indicates that prayer is important to older home-care patients in potentially coping with depression. Our study provides interesting preliminary findings about an understudied patient group. Other studies confirm that older adults rank prayer as the most commonly used therapy to stay healthy (King & Pettigrew, 2004) and cope with illness (Dunn & Horgas, 2000). Further, samples of medically ill older adults have found a widespread use of prayer that is associated with better psychosocial and cognitive functioning (Koenig et al., 2004).

Most of the patients in this study identified prayer as a familiar way of coping with emotional distress and physical illness that had been successful in the past. Several described prayer as necessary to facilitate their acceptance of and success with other approaches to depression care (e.g., medication, counseling). Contrary to previous studies, no differences were found in depression coping preferences among Black and White older adults (Lawrence et al., 2006).

These findings suggest that personal experiences with depression and its disabling effects on functional status increase patients' acceptance of and preference for medication and/or counseling. Patients who had experienced depression and had prior experience with traditional mental health care were more likely to prefer evidence-based approaches to depression care, whereas those who did not have personal experience with depression preferred prayer.

These findings are consistent with studies suggesting that patient treatment preferences are shaped by previous treatment experiences (Gum et al., 2006). In addition, patients with a history of depression were stating their preference for a problem they have actually experienced, while patients without a history of depression were stating their preference on the basis of a hypothetical clinical condition and approach to care (Montgomery & Fahey, 2001). Patients familiar with the social, emotional, and functional impairments associated with depression may prefer evidence-based approaches to avoid recurrence; however, prayer may be a protective strategy for older home-care patients without depression (Milstein et al., 2003).

LIMITATIONS

A number of limitations should be considered in interpreting these findings. First, this exploratory pilot study used a convenience sample of patients in one home-care agency and may not represent older adults in long-term home care across the nation. Despite this sample bias, eligible patients who refused to participate in the study did not differ from study participants in age or race. The long-term home-care patients in this study had clinical and functional characteristics similar to those of nursing home residents, which is consistent with the purpose of the long-term home-care program—to keep residents in their communities and avoid institutionalization (CDHS/Research Foundation of SUNY/BSC, 2006). The study

also provides insight into a growing patient population in need of home-based mental health services that will allow them to stay in their homes.

The generalizability of our results is also limited by the lack of a comparison group or adjustment for potential confounders. However, the study benefited from the use of quantitative and qualitative methods to provide an overview of patients' preferred approaches to care, as well as explanations of their choices.

NURSING IMPLICATIONS

These results have important implications for the provision of geriatric depression care for homebound older adults. The results suggest that geriatric nurses interested in improving depression care should consider that many older homebound patients may prefer prayer as part of their care plan. However, some geriatric nurses may not be familiar with integrating spirituality into the management of emotional distress (Sellers & Haag, 1998) and would benefit from advanced clinical training in holistic, complementary, and alternative interventions. Such training opportunities are offered through schools of nursing (Fenton & Morris, 2003), professional organizations (e.g., the American Holistic Nurses Association), and continuing education programs (e.g., the Healing Touch Program™, <http://www.healingtouch-program.com/>). Advance training in these areas could increase geriatric nurses' confidence and ability to help their older patients with depression management plans. Future studies should continue to examine how older home-care patients engaging in prayer and geriatric treatment plans that incorporate patient preferences affect clinical outcomes, quality of life, treatment adherence, and satisfaction with care.

CONCLUSION

Older home-care patients' depression care preferences were explored in this pilot study. Increasing gerontological nurses' awareness and understanding of patient preferences is an important aspect of patient-centered care that can promote quality of care and quality of life for their depressed patients. Quantitative and qualitative methods were used to rank and describe patients' reasoning for their preferences, respectively.

Older home-care patients identified a unique pattern of preferences for depression care. Prayer was preferred by half of the patients. Interestingly, prayer was primarily preferred by patients who did not have experience with depression, whereas patients who had some experience with depression preferred evidence-based approaches to depression care. The results provide new insights about the importance of religious preferences and spirituality in depression care for an understudied patient population that is at risk for experiencing depression. Understanding older home-care patients' preferences for depression care can help gerontological nurses in the management of this treatable illness.

Acknowledgments

Funding support was received from the Cornell Center for Aging Research and Clinical Care, National Institute of Mental Health R01 MH56482, R24 MH 64608, T32 MH19132, K02 MH01634. The authors thank the nurses, administrators, and other staff of the Dominican Sisters Family Health Care Services for their support on this project.

REFERENCES

Alexopoulos GS, Katz IR, Reynolds CF 3rd, Carpenter D, Docherty JP, Ross RW. Pharmacotherapy of depression in older patients: A summary of the expert consensus guidelines. *Journal of Psychiatric Practice*. 2001; 7:361–376. [PubMed: 15990550]

- Bartels SJ, Dums AR, Oxman TE, Schneider LS, Areán PA, Alexopoulos GS, et al. Evidence-based practices in geriatric mental health care. *Psychiatric Services*. 2002; 53:1419–1431. [PubMed: 12407270]
- Bedi N, Chilvers C, Churchill R, Dewey M, Duggan C, Fielding K, et al. Assessing effectiveness of treatment of depression in primary care. Partially randomised preference trial. *British Journal of Psychiatry*. 2000; 177:312–318. [PubMed: 11116771]
- Bruce ML, McAvay GJ, Raue PJ, Brown EL, Meyers BS, Keohane DJ, et al. Major depression in elderly home health care patients. *American Journal of Psychiatry*. 2002; 159:1367–1374. [PubMed: 12153830]
- CDHS/Research Foundation of SUNY/BSC. Long term home health care program reference manual: A guide for local district staff and LTHHCP providers. Author; New York: 2006.
- Charney DS, Reynolds CF 3rd, Lewis L, Lebowitz BD, Sunderland T, Alexopoulos GS, et al. Depression and Bipolar Support Alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. *Archives of General Psychiatry*. 2003; 60:664–672. [PubMed: 12860770]
- Dossey, B.; Keegan, L.; Guzzetta, C. *Holistic nursing: A handbook for practice*. 4th ed.. Jones and Bartlett; Sudbury, MA: 2005.
- Dunn KS, Horgas AL. The prevalence of prayer as a spiritual self-care modality in elders. *Journal of Holistic Nursing*. 2000; 18:337–351. [PubMed: 11847791]
- Dwight-Johnson M, Unutzer J, Sherbourne C, Tang L, Wells KB. Can quality improvement programs for depression in primary care address patient preferences for treatment? *Medical Care*. 2001; 39:934–944. [PubMed: 11502951]
- Fenton MV, Morris DL. The integration of holistic nursing practices and complementary and alternative modalities into curricula of schools of nursing. *Alternative Therapies in Health and Medicine*. 2003; 9(4):62–67. [PubMed: 12868254]
- First, M.; Spitzer, R.; Gibbon, M.; Williams, J. *User's guide for the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID)-research version*. Biometrics Research; New York: 2001.
- Folstein MF, Folstein SE, McHugh PR. "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*. 1975; 12:189–198. [PubMed: 1202204]
- Frewer LJ, Salter B, Lambert N. Understanding patients' preferences for treatment: The need for innovative methodologies. *Quality in Health Care*. 2001; 10(Suppl. 1):i50–i54. [PubMed: 11533439]
- Glaser, B.; Strauss, A. *The discovery of the grounded theory: Strategies for qualitative research*. Adline; Chicago: 1967.
- Gum AM, Arean PA, Hunkeler E, Tang L, Katon W, Hitchcock P, et al. Depression treatment preferences in older primary care patients. *The Gerontologist*. 2006; 46:14–22. [PubMed: 16452280]
- Hawley G, Irurita V. Seeking comfort through prayer. *International Journal of Nursing Practice*. 1998; 4:9–18. [PubMed: 9748926]
- Hicks TJ Jr. Spirituality and the elderly: Nursing implications with nursing home residents. *Geriatric Nursing*. 1999; 20:144–146. [PubMed: 10661104]
- King MO, Pettigrew AC. Complementary and alternative therapy use by older adults in three ethnically diverse populations: A pilot study. *Geriatric Nursing*. 2004; 25:30–37. [PubMed: 14976501]
- Koenig HG, George LK, Titus P. Religion, spirituality, and health in medically ill hospitalized older patients. *Journal of the American Geriatrics Society*. 2004; 52:554–562. [PubMed: 15066070]
- Lauver DR, Ward SE, Heidrich SM, Keller ML, Bowers BJ, Brennan PF, et al. Patient-centered interventions. *Research in Nursing & Health*. 2002; 25:246–255. [PubMed: 12124719]
- Lawrence V, Banerjee S, Bhugra D, Sangha K, Turner S, Murray J. Coping with depression in later life: A qualitative study of help-seeking in three ethnic groups. *Psychological Medicine*. 2006; 36:1375–1383. [PubMed: 16854247]

- Lebowitz BD, Pearson JL, Schneider LS, Reynolds CF 3rd, Alexopoulos GS, Bruce ML, et al. Diagnosis and treatment of depression in late life. Consensus statement update. *Journal of the American Medical Association*. 1997; 278:1186–1190. [PubMed: 9326481]
- Levin JS. How prayer heals: a theoretical model. *Alternative Therapies in Health and Medicine*. 1996; 2(1):66–73. [PubMed: 8795874]
- Milstein G, Bruce ML, Gargon N, Brown E, Raue PJ, McAvay G. Religious practice and depression among geriatric home care patients. *International Journal of Psychiatry in Medicine*. 2003; 33:71–83. [PubMed: 12906344]
- Montgomery AA, Fahey T. How do patients' treatment preferences compare with those of clinicians? *Quality in Health Care*. 2001; 10(Suppl. 1):i39–i43. [PubMed: 11533437]
- Sellers SC, Haag BA. Spiritual nursing interventions. *Journal of Holistic Nursing*. 1998; 16:338–354. [PubMed: 9849257]
- Ware JE Jr, Sherbourne CD. The MOS 36-item Short-Form health survey (SF-36). I. Conceptual framework and item selection. *Medical Care*. 1992; 30:473–483. [PubMed: 1593914]
- Zeltzer BB, Kohn R. Mental health services for homebound elders from home health nursing agencies and home care agencies. *Psychiatric Services*. 2006; 57:567–569. [PubMed: 16603756]

TABLE

PREFERRED APPROACHES TO DEPRESSION CARE AND EXPLANATIONS ($N = 28$)

Approach	<i>n</i> (%)	Themes of Patient Explanations	Examples of Comments
Prayer	14 (50)	<ul style="list-style-type: none"> • First coping mechanism initiated 	<ul style="list-style-type: none"> • “Anytime someone is sick and depressed, they really need to pray first” • “The first thing you think of when you're down is God.”
		<ul style="list-style-type: none"> • History of successful outcomes 	<ul style="list-style-type: none"> • “It [prayer] always makes me feel good and gives me the push I need to get moving when I'm down.”
		<ul style="list-style-type: none"> • Guides the choice and/or success of other approaches to depression care 	<ul style="list-style-type: none"> • “We have to pray.... If we want any of these other things [pointing to the approaches to depression care] to help us, we have to pray.”
Combined approaches	6 (21)	<ul style="list-style-type: none"> • Patients highlight the benefits of using both approaches concurrently, rather than separately 	<ul style="list-style-type: none"> • “You get more out of these two together.” • “I get counseling to help me in the day and medication at night.”
		<ul style="list-style-type: none"> • History of successful outcomes 	<ul style="list-style-type: none"> • “They have been my lifesaver. I can't have one without the other; they have both helped me tremendously.”
Psychotherapy/Counseling	4 (14)	<ul style="list-style-type: none"> • Unbiased source of depression care 	<ul style="list-style-type: none"> • “It is very good when you speak to someone; you feel free because they are not judging you, they are helping you.”
		<ul style="list-style-type: none"> • Offers cognitive-behavioral insight to improve depressive symptoms 	<ul style="list-style-type: none"> • “To get feedback about your behavior and learn about it so you can change it.”
		<ul style="list-style-type: none"> • Interpersonal benefits 	<ul style="list-style-type: none"> • “Psychotherapy is all about love, compassion, and sharing.”
Medication	2 (7)	<ul style="list-style-type: none"> • Last resort due to severity of depressive symptoms 	<ul style="list-style-type: none"> • “If it's really that bad, and I need help, then I need it [medication]; I guess I have to take it.”
		<ul style="list-style-type: none"> • History of successful outcomes 	<ul style="list-style-type: none"> • “Because I'm happy with them right now; they [the antidepressants] are helping me.”
Do Nothing	2 (7)	<ul style="list-style-type: none"> • To avoid shame associated with being depressed 	<ul style="list-style-type: none"> • “I would be embarrassed. And because I wouldn't want anyone to know about it [the depression], I probably wouldn't do anything about it.”