Depression an obstacle in treating older patients

Scenario

How can you best treat an aging patient with quality-of-life issues?

Millions of aging men and women with chronic medical conditions complicated by social and psychological problems resist elective treatments, even those that could significantly improve their quality of life. What can, and should, primary care physicians do?

Ethics Forum

From the Ethics Standards Group

Reply

THE REASONS FOR THIS ARE multifaceted, but there are ways that primary care physicians can properly assess psychosocial barriers to treatment and, more important, begin to help patients overcome them.

Marty Smith's situation is representative of this phenomenon.

Smith (not his real name) is 73; he has hypertension, hyperlipidemia and arthritis.

When his wife of 50 years died two years ago, Smith began losing weight. His physician discovered that the weight loss was due to Smith's lack of appetite and to the fact that he had never prepared meals for himself while his wife was alive.

Smith's son convinced his dad to move to Texas to live with his wife and him but, once there, Smith stayed in his room, watching TV most of the day.

Smith needed encouragement to eat. His son convinced him to visit a doctor in his new home after Smith complained of being tired all the time.

The new physician noted Smith's antalgic gait, and a subsequent workup revealed severe left hip degeneration.

Smith minimized his pain, saying "it's nothing" and declined a surgical consultation stating, "I'm just not interested in any hip replacement."

The physician recommended an antidepressant and a psychiatric consultation because Smith's presentation, self-isolation and history of not eating since his wife's death suggested severe clinical depression. But he denied being depressed, and stated: "I'm 73 years old, I've lived a long life; I can't do anything any more, and I don't want to be a burden."

How to assess depression

PHYSICIANS WHO SEE PATIENTS such as Marty Smith should begin by assessing the multiple barriers to effective medical care:

Establish a collaborative and authoritative relationship with the patient. Some patients want authoritarian physicians to tell them what to do, but patients who resist rational standard medical and surgical treatments might respond better to physicians who are collaborative and give authoritative advice regarding different treatment options with advantages and disadvantages of each. To be collaborative, we must understand how the resistant patient thinks and why he or she is declining treatment.

Learn the patient's psychosocial history, and clarify the patient's goals, values and objectives regarding quality of life. In addition to medical history, assess the patient's psychiatric history, personality style and premorbid lifestyle. This information might come from family members.

Rule out an immediate life-threatening depression. Assess suicide risk and, if necessary, facilitate an emergency inpatient psychiatric evaluation. Suicide rates increase with age and are significantly higher among those 65 years and older. According to the Dept. of Health and Human Services, most elderly suicide victims are seen by their primary care physician just weeks before their suicide attempt. Additionally, if a patient has a history of psychiatric disorder, the physician might need to refer the patient to a psychiatrist or psychologist.

Learn about the patient's social relationships. Social support and healthy interpersonal relationships are good predictors of high functionality and well-being among the aging. Social isolation and lack of social/recreational participation have been found to impact negatively on independent activities of daily living, such as mobility, preparing meals and shopping. Thus, the lack of social activity might be an important component of the patient's depression.

Assess levels of pain. Pain is estimated to be as much as three times as prevalent among the elderly as among younger adults. Our research indicates that higher levels of pain are related to resistance to medical care, social involvement and activities of daily living.

Identify possible cognitive impairment. Screening and early detection of dementia are important because fewer treatment options are available as dementia progresses. Symptoms that resemble dementia actually might be caused by a depressive disorder called pseudodementia. True dementia is defined as an acquired persistent impairment in intellectual functioning, as exhibited by impairment in memory, language, visual-spatial skills and cognitive abilities such as abstraction, calculation or judgment.

Identify the patient's stage of change. Like many of his generation, Smith has a tendency to repress negative emotions, believing that "when the going gets tough, the tough get going." Thus, when an observant physician correctly assesses Smith's obvious depression, Smith denies it. Research has indicated that this phenomenon is not *denial*, in the truest sense.

More accurately, the patients don't *realize* they have a problem. This is known in the literature as being in a *precontemplative stage of change*.

According to the work of Prochaska and DiClemente, stages of change are temporal dimensions of the behavior change process that explain why some patients resist reasonable medical care and are poor compliers with treatment. The stages are:

- **Precontemplation.** The patient does not recognize a need to change a problematic belief or behavior, and hence has no intention of changing it.
- **Contemplation.** The patient recognizes a need to change the behavior or attitude, and is seriously considering changing, but has not made the necessary commitment to change.
- **Action.** The patient is actively attempting to change an attitude or behavior.
- **Maintenance.** The patient is working to maintain gains and to prevent relapse.

With *precontemplative* patients such as Smith, all the physician can do is educate. We have found that using motivational interviewing techniques enables the physician to understand empathically and validate the psychological perspective of the patient and his or her reasons for not cooperating with standard medical treatments.

Then, using the patient's own historical values and current goals, the physician can help Smith realize that his depression and chronic pain are real problems that can be significantly and relatively improved.

After assessing potential barriers outlined above, the physician can proceed into a collaborative dialogue regarding the advantages and disadvantages of each of the patient's treatment options.

The following are some suggestions for the physician's dialogue with the patient that acknowledges and respects specific personality and coping styles for each patient:

- **Surgical consultation.** The patient could have distorted fears of the risks associated with hip replacement surgery based on his possible knowledge of poor surgical outcomes experienced by friends or family. Thus, the physician must discuss how the hip replacement would improve the patient's quality of life based on his historical values.
- **Pain management.** Interdisciplinary pain management clinics can be a great resource for physicians who are treating patients like Smith.

Interdisciplinary evaluations normally include an assessment and cognitive-behavioral treatment by a psychologist specializing in psychological factors that affect medical outcomes. Clinical geropsychologists who work in private practice, assisted-living facilities and long-term-care facilities are also a valuable resource to physicians.

- **Treatment for depression.** The physician might need to explain what clinical depression is: a loss of interest or pleasure, sleep disturbance, fatigue or loss of energy, decreased ability to think or concentrate, thoughts of death, loss of appetite and weight loss, feelings or thoughts of worthlessness. We suggest that the physician engage in a respectful and simplified discussion of what selective serotonin reuptake inhibitors (SSRIs) do to the brain.

For example: "Our brains naturally produce serotonins, which are chemicals associated with having motivation to accomplish and enjoy things in life. When we're physically inactive, or medically ill, serotonin levels sometimes get very low. SSRIs increase the level of naturally occurring serotonin in the brain. Most important, these medications are not habit forming."

Remember that the cost of antidepressants can be significant, and effects are often subtle, so attempt to establish realistic expectations for effects of antidepressants and criteria for discontinuing the medications beyond the occurrence of adverse side effects. For example, "I recommend a three-month trial to see whether it helps you sleep better and increase your appetite, which in turn might increase your energy levels and motivation to do more enjoyable things with your family. Once you have gained back some of your weight and are more active, we can discuss tapering off the medication."

Smith is a difficult but not an unusual case. People of Smith's age and stage of life often experience a true loss of independence. They can feel hopeless when they lose their spouses, their homes and their friends.

Elderly people who experience such change often need to establish a new approach to life — a prospect that can seem overwhelming.

Patients' eventual agreement to elective medical treatment is more likely if the treating physician is able to work collaboratively within the patient's own personality style, recognizing the extent to which he or she is ready to address emotional problems, and be ready to engage in a thorough, but condensed, education regarding various treatment options. ◆

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