Older Adults’ Acceptance of Psychological, Pharmacological, and Combination Treatments for Geriatric Depression

Ashley E. Hanson and Forrest Scogin

Department of Psychology, University of Alabama, Tuscaloosa.

We examined older adults’ ratings of the acceptability of geriatric depression treatments. We presented 120 community-dwelling participants with vignettes describing an older adult experiencing either mild to moderate or severe depression. Participants rated the acceptability of three different treatments: cognitive therapy (CT), antidepressant medication (AM), and a combination treatment of CT and AM (COM). For general acceptability, participants rated COM as a more acceptable treatment for depression than both CT and AM. With respect to perceived negative aspects of treatments, they rated CT as a more acceptable treatment for mild to moderate depression than both AM and COM. Participants rated both COM and CT as more acceptable treatments for severe depression than AM. Results indicate that combining psychotherapy and AM may be viewed as most acceptable by community-dwelling, nondepressed older adults.

Key Words: Depression—Older adults—Acceptability of treatments.

There are several efficacious options available for the treatment of geriatric depression, including antidepressants and psychotherapy (Pinquart, Duberstein, & Lyness, 2006). Another approach to treating geriatric depression is a combination treatment involving both psychotherapy and antidepressant medication (AM). Although most treatment for geriatric depression is with antidepressants, this does not necessarily mean that older adults prefer pharmacological treatment over psychotherapy. In fact, several studies have suggested that older adults perceive some forms of psychotherapy as more acceptable than antidepressants for treating depression.

Rokke and Scogin (1995) compared acceptability ratings for AM, cognitive therapy (CT), and activity change (a form of behavior therapy) and found activity change to be more acceptable than AM and CT as comparably acceptable to AM. Landreville, Landry, Baillargeon, Guérette, and Matteau (2001) compared acceptability ratings for CT, cognitive bibliotherapy, and AM for an individual with either mild to moderate or more severe depression. The acceptability ratings were a function of the severity of the depressive symptoms. CT and cognitive bibliotherapy were more acceptable than AM for mild to moderate symptoms. However, for severe symptoms, CT was rated as more acceptable than both AM and cognitive bibliotherapy.

More recently, Gum and colleagues (2006) investigated the depression treatment preferences of depressed older adult primary care patients. At baseline assessment, the majority of respondents preferred counseling (57%) to medication (43%). Although several studies have examined ratings of single therapies, none have compared the acceptability of combined treatment. In previous studies, some participants have commented that a single treatment approach is not sufficient to adequately treat geriatric depression (e.g., Landreville et al., 2001). Thus, we examined whether combination treatments would be rated as more acceptable than monotherapy for geriatric depression.

In the present study, we compared the acceptability ratings for CT, AM, and a combination of both CT and AM (COM). We hypothesized that participants would consider COM to be more effective than a single therapeutic approach, especially for severely depressed patients. We also predicted that CT would be rated as more acceptable than AM for cases of both mild to moderate and severe depression.

METHODS

Participants

Participants (N = 120) were community volunteers recruited from a variety of sources. Table 1 presents selected sample characteristics.

Design

We implemented a 2 × 3 mixed model factorial design with repeated measures on the second factor, with the independent variables being depression case descriptions (mild/moderate and severe) and treatment descriptions (CT, AM, and COM). The dependent variables consisted of scores from the Treatment Evaluation Inventory (TEI; Landreville & Guérette, 1998).

Measures and Materials

Case descriptions.—Cases presented either mild to moderate or severe depressive symptoms based on diagnostic criteria for a major depressive episode as found in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994). Each case described a 75-year-old woman experiencing the same depressive symptoms but with different levels of severity. For example, the individual with mild to moderate depressive symptoms was described as...
having a decreased appetite and sometimes thinking that she would be better off dead. In contrast, the severely depressed individual was described as having no appetite and contemplating suicide.

**Treatment descriptions.**—Participants read descriptions of three depression treatments (CT, AM, and COM); Landreville and Guérette (1998) developed and validated AM and CT descriptions. CT was described as a treatment that helps patients learn to identify situations that increase their depressive feelings, determine if their interpretation of these situations is overly negative and unrealistic, and learn ways to interpret these situations less negatively and more realistically. AM was described as acting on chemical substances in the brain (neurotransmitters) to improve the functioning of brain cells. AM was described as being prescribed by a health care professional who monitors the patients’ functioning and adjusts medication doses accordingly. The COM description incorporated aspects of both the CT and AM descriptions. The efficacy and side effects of the treatments were not described to minimize bias in the acceptability ratings (Landreville & Guérette, 1998).

**Treatment acceptability.**—The 11 items on the modified TEI measure positive or negative reactions to treatments. Examples of individual items include asking the participants to rate how effective the treatment is likely to be for the individual in the case description, how much discomfort the person is likely to experience during the course of the treatment, and how likely the treatment is to make permanent improvements in the person. Landreville and Guérette (1998) identified two subscales of the modified TEI. The General Acceptability (GA) subscale consists of eight items that reflect positive qualities of treatment, such as effectiveness. The Negative Aspects (NA) subscale, consisting of three items, assesses undesirable consequences of treatment, such as side effects. Adequate concurrent validity, internal consistency, and test–retest reliability were found for the subscales.

**Background information.**—We collected information concerning participants’ age, sex, race, education level, marital status, health status, and annual household income. In addition, we asked participants about depressive episodes that they may have experienced during their lifetime, as well as the types of mental health treatments they may have received.

**Results.**—We used an alpha level of .05 in all analyses to test for significance. We conducted preliminary analyses to test for effects from the order in which the treatment types were presented; we found none. We performed a mixed factor analysis of variance on the scores from the TEI for each treatment and case description (see Table 2). For the GA subscale, we did not find a significant interaction between treatment type and case description. We found a significant effect for treatment, $F(2, 236) = 22.51, p < .05, \eta^2 = .16$. COM was more acceptable for treating depression than both CT, $t(119) = -6.24, p < .05, \eta^2 = .14$; and AM, $t(119) = -5.98, p < .05, \eta^2 = .13$. The GA ratings for CT and AM were not significantly different. In addition, we found a significant effect for case description, $F(1, 118) = 7.73, p < .05, \eta^2 = .06$. GA scores across treatment types were higher for the severe depression case description than for the case description of mild to moderate depression.

For the NA subscale, we found a significant interaction between treatment type and case description, $F(2, 236) = 3.30, p < .05, \eta^2 = .03$. For the case description of mild to moderate depression, CT was more acceptable than both COM, $t(59) = 2.43, p < .05, \eta^2 = .05$; and AM, $t(59) = 3.95, p < .05, \eta^2 = .12$. COM was more acceptable than AM, $t(59) = -2.63, p < .05, \eta^2 = .05$. For the case description of severe depression,
Discussion
Participants rated a combination treatment consisting of CT and AM as more acceptable for treating depression than either treatment alone. Although participants rated all of the treatment choices as at least moderately acceptable for treating geriatric depression, COM was perceived to be the most acceptable treatment regardless of the severity of the depressive symptoms presented. The preferences expressed by older adults are different from the most common treatment practice: medication only. Participants may have preferred COM because of the belief that it would provide individuals with both relatively quick symptom relief (through AM) and specific skills to combat depression (through CT).

In addition, we found a significant main effect for case description. Thus, participants perceived that treatment for depression, regardless of the type, was most acceptable for an individual presenting severe depressive symptoms. Participants may have believed that because this individual was experiencing significant symptoms and distress, including suicidal gestures, she was in greater need of any available beneficial treatment.

When we considered negative aspects of treatment, we found a significant interaction between treatment type and case description. For an individual presenting with mild to moderate symptoms, participants rated CT as having fewer negative aspects than either AM or COM. Moreover, participants preferred COM over AM in terms of negative aspects. Participants rated CT and COM as having fewer negative aspects than AM for the treatment of a severely depressed individual.

These findings suggest that participants may have felt that when treating mild to moderate depression, CT was the optimal treatment because of its fewer perceived side effects compared to medication. Although the potential negative aspects of a treatment are largely stable regardless of the severity of depression being treated, participants nevertheless rated them as changing as a function of depression severity. Participants found that, for the treatment of severe depression, the potential negative aspects of combination treatment were less risky than for mild to moderate depression, rating both CT and COM comparably acceptable. Thus, negative aspects changed as a function of depression severity. Participants may have performed a cost–benefit analysis of COM, perceiving that regardless of the negative aspects of AM, the individual’s level of depression was sufficient to require both medical and psychological components of treatment.

The present study’s results are similar to those found in two different treatment preference studies. In one study, older adults rated CT as comparably acceptable to drug therapy (Rokke & Scogin, 1995). Landreville and colleagues (2001) found that for the treatment of both mild to moderate depression and severe depression, CT was rated as more acceptable than AM. We also found these results in the current study for the NA subscale, suggesting that the preference for CT may be due in part to the perception of greater negative side effects with a medication-based therapy.

Readers need to consider the limitations of the present study. The mean education level of the sample was 15.44 years, with 57% of the participants reporting an annual household income of $50,000 or more. In addition, the sample was predominantly Caucasian (92%). These demographic variables suggest that the study sample may not be fully representative of the general community-dwelling older population, thus limiting the generalizability of the study’s results. Also, these results reflect the attitudes of typically functioning older adults and not depressed older adults actually at the point of deciding on a course of treatment.

It would be useful for future studies examining treatment acceptance to incorporate qualitative approaches to examining these preferences. For example, they could ask participants to provide rationales for their treatment preferences. In addition, it would be helpful to assess older adults’ preexisting knowledge of depression treatments. Because combination treatments are more costly, it would also be informative to include this information and determine the effects on acceptability. Further studies examining depression treatment preferences of older adults would be useful, as acceptability attitudes may affect treatment adherence. Improving adherence can enhance the effectiveness of

### Table 2. Modified Treatment Evaluation Inventory Subscale Scores as a Function of Treatment and Symptom Severity

<table>
<thead>
<tr>
<th>Symptom Severity</th>
<th>Treatment</th>
<th>COM</th>
<th>CT</th>
<th>AM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild to moderate</td>
<td><strong>M</strong></td>
<td>39.67</td>
<td>33.45</td>
<td>32.93</td>
</tr>
<tr>
<td></td>
<td><strong>SD</strong></td>
<td>11.22</td>
<td>12.61</td>
<td>13.13</td>
</tr>
<tr>
<td>Severe</td>
<td><strong>M</strong></td>
<td>45.37</td>
<td>35.27</td>
<td>37.15</td>
</tr>
<tr>
<td></td>
<td><strong>SD</strong></td>
<td>8.44</td>
<td>12.52</td>
<td>10.37</td>
</tr>
<tr>
<td>Mild to moderate</td>
<td><strong>M</strong></td>
<td>13.67</td>
<td>15.00</td>
<td>12.12</td>
</tr>
<tr>
<td></td>
<td><strong>SD</strong></td>
<td>3.72</td>
<td>4.21</td>
<td>3.75</td>
</tr>
<tr>
<td>Severe</td>
<td><strong>M</strong></td>
<td>14.27</td>
<td>13.82</td>
<td>12.68</td>
</tr>
<tr>
<td></td>
<td><strong>SD</strong></td>
<td>2.87</td>
<td>3.87</td>
<td>3.03</td>
</tr>
</tbody>
</table>

*Note: COM = combination treatment of CT and AM; CT = cognitive therapy; AM = antidepressant medication; SD = standard deviation.*
treatments, thus leading to improved quality of life for older adults.

CORRESPONDENCE

Address correspondence to Forrest Scogin, Department of Psychology, University of Alabama, Tuscaloosa, AL 35487-0348. E-mail: fscogin@as.ua.edu

REFERENCES


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