

The Double-Edge Sword: PCPs' Views on Family Involvement in Depression Care for Older Men

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Background I

- Older men, particularly among minorities, have low rates of depression treatment.
- Untreated depression is associated with higher rates of suicide, poor co-morbid management, higher risk for cognitive decline and mortality, and higher healthcare costs.

Background II

- Primary care is the main setting for depression diagnosis and treatment for older adults.
- Family members are often involved in health management of older adults in the home.
- Family are often present in clinical encounters involving an older adult.

Gap

- How do various stakeholders (i.e. family, PCPs) interact in older men's depression care?
- Are there any socio-cultural differences in how these stakeholders interact in depression care for older men?
- How do clinicians view the role of family in depression care for older men?

Study Aim

- To describe how primary care physicians view family as a facilitator and/or barrier in older men's depression care.

Methods & Data Analysis

- In-depth qualitative interviews with PCPs (N=12) from a county (safety net) hospital outpatient clinic.
- PCPs recruited as part of the Men's Health and Aging Study (MeHAS).
- Data analysis of PCPs' interview transcripts per standard qualitative techniques (i.e. thematic coding)

PCPs' Characteristics (N=12)

Gender	6 M, 6 F
Ethnicity	3 Asian, 6 Indian, 2 WNH, 1 Hispanic
Age	28 to 56 years old
Specialty	Family Medicine
Years of practice	2.5 to 29 years
Practice Type	Outpatient county hospital
½ Session:	8 to 10 patients

Main Findings

- Family members (i.e. spouse, children, grandchildren) are often involved (i.e. in clinic, by phone).
- Family involvement can be both a barrier and facilitator of older men's depression care.
- PCPs have to negotiate family involvement over time.

Example

“It would be great if everybody would be like that [having family involved in their depression care], but some people don’t want to burden their family, or don’t want the other family members directly involved in care. I get some people [that] the whole family comes in, the wife, the daughter, and the son... I have one or two [cases] where I wished the family wasn’t involved... [Family involvement is] good and bad. Bad in the fact that is time consuming sometimes and it’s draining” [009].

Family as Facilitator

- Provide general health information.
- Help in symptom disclosure.
- Persuade older men to accept diagnosis.
- Assist in treatment adherence.
- Provide on-going social support and encouragement.

Example

“So yeah... [family is] a very valuable asset, especially in older people. Their [older men] kids are giving them medications or doing other caretaking things. I... use it [family] as a check and balance to see if I am really actively reflecting on how they [older men] are behaving. ...they [family] are a key component... and it's very important to have them onboard with the plan and to give me information. I think that's very, very important” [006].

Family as Barrier

- Incongruent accounts between older man & family.
- Source of distress and conflict.
- Impediment to disclosure.
- Extant biases, agendas, and interests of multiple family members involved.
- Negative attitudes toward depression & treatment.
- Less prominent barriers: burden, unsupportive, overbearing.

Example

“I would like to [have the family members of older men involved] but of course within limits. Confidentiality [is an issue]... Often I see depressed [older men and] the family members are the ones that are causing all the stressors. And stressors cause the depression. So I can see what their [family members’] perspective is and see how they interact [but]... If the family member is the stressor, you don’t want it there all the time because I don’t want my patient to be more nervous and anxious” [003].

Discussion I

- PCPs viewed family as a **potential ally** in depression care for older men.
- When possible they relied on family for help in the clinical encounter and at home.
- However, family can also be a significant barrier to diagnosis, treatment initiation, and long-term management.

Discussion II

- The double-edge sword:
 - PCPs have to negotiate in an on-going basis when and how to involve family.
 - Negotiation does not always pay-off in getting family and older man on board.

Discussion III

- The costs of negotiation:
 - Emotional labor
 - Greater time needs.
 - Unclear pay-off.
 - Potential for increasing conflict & burden given unfavorable conditions at home.
 - Older men's autonomy as patients.
 - The clinician/patient private relationship.

Conclusion

- Family involvement is not by de facto good.
- Clinicians should have broader, more in-depth and more contingent understanding of family dynamics and circumstances.
- Clinicians should consider the ups and downs of family involvement--it can add but it can also complicate depression care for older men.