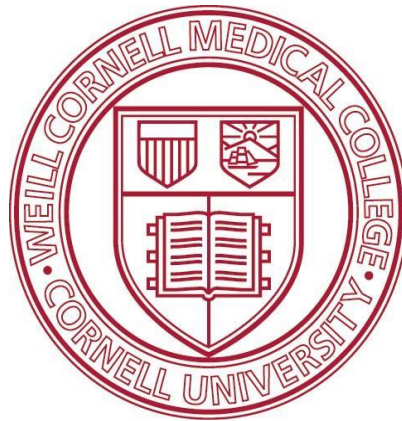


# Personalized Intervention for Patients with Major Depression and COPD (PID-C)



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## PRINCIPLES OF PID-C

### A. Introduction

COPD afflicts 10 million Americans. Following an increase in smoking among women, COPD had become as common in women by the end of the 1990's as it had been in men earlier. COPD mortality continued to increase over the past 30 years while mortality due to heart disease, stroke and cancer declined. Currently, COPD is the fourth most frequent cause of death in the US and its prevalence is increasing in minority populations.

Depression is the most common psychiatric disorder in COPD and worsens its outcomes. Thirty percent of COPD patients have a depressive syndrome and 24% have major depression. Approximately 23% of primary care patients with COPD and major depression received the diagnosis of depression prior to the COPD diagnosis. Depressive symptoms are associated with worse general and pulmonary health, a higher risk for exacerbation of COPD and increased all-cause mortality. Further, depression is a strong determinant of disability in COPD patients.

Available treatments can improve the outcomes of both COPD and depression. Pulmonary rehabilitation can reduce disability and even ameliorate depressive symptoms of COPD patients (1). Psychotherapy-based interventions may reduce depression and improve the health status of COPD patients. Antidepressants are also moderately efficacious. Mental health referrals reduced mortality in a large cohort of veterans with COPD. Accordingly, the ACCP/AACVPR Pulmonary Rehabilitation Evidence-Based Guidelines stated that "... the most important behavioral aspect of pulmonary rehabilitation is the extent to which patients comply with the exercise program or with other medical therapies."

Despite the availability of treatments, poor adherence remains a barrier to the care. Only 50% of COPD patients engage in walking exercises and use oxygen above minimal levels of efficacy. Depression reduces adherence to treatment in medical patients and compromises the outcomes of medical illnesses. However, many depressed COPD patients refuse antidepressants.

Most causes of poor adherence fall within five domains:

1. Misconceptions about COPD, depression, and their treatment;
2. Dissatisfaction with treatment and aftercare plans;

3. Practical barriers to treatment;
4. Poor acceptance of depression interfering with treatment adherence; and
5. Hopelessness and helplessness of depression.

These factors prompt patients to minimize the need for care and reinforce the belief that they are incapable of participating in their outpatient rehabilitation regimen. Aspects of depression, such as hopelessness and helplessness, as well as lack of knowledge about the illness and treatment are known barriers to adherence (2). A relationship of misconceptions about depression and lack of acceptance of depression to poor treatment adherence has been documented (3).

PID-C is a brief and structured intervention aiming to increase treatment adherence of depressed COPD patients to recommendations offered by the patients' own physicians. Therefore, the intervention consists of a review of adherence to medical, rehabilitative, and psychiatric recommendations, as well as an approach that addresses factors reducing treatment adherence in the individual patient (4). In 138 patients with major depression and severe COPD, we have shown that PID-C led to a higher remission rate and a greater reduction in depressive symptoms and in dyspnea-related disability than usual care over 28 weeks and 6 months after the last session (5).

## B. Approach

Reasons for poor treatment adherence vary from patient to patient. While the above domains cover most of the reasons, poor adherence may be also be promoted by others factors. For example, the principal reason for poor treatment adherence may be depression-related hopelessness in one patient; inability to arrange transportation to a doctor's office in another patient; and poor understanding and/or resistance to accepting the presence of depression in a third patient. For this reason, the care manager's *initial interview* should identify potential contributors to poor treatment adherence in each *individual patient* and then begin to address them.

The care manager should elicit the patients' views about: 1. COPD, depression, and their own treatment regimen (medical, psychiatric, and rehabilitative recommendations); 2. Sources of dissatisfaction with their treatment and aftercare; 3. Practical barriers to care (e.g., limitations in mobility); 4. Poor acceptance of depression; and 5. Beliefs related to the efficacy of treatment (hopelessness) and to their ability to follow treatment recommendations

(helplessness). This interview should provide the care manager with a list of target areas that can begin to be addressed and then reinforced in subsequent visits. In each follow-up visit, the care manager should review adherence to all prescribed treatments, assess the impact of his/her earlier interventions on problem areas, and identify any emerging new barriers to adherence.

### **C. Identification of Potential Barriers**

**C1. Misconceptions about COPD, Depression, and their Treatment:** The care manager reviews the patient's perceptions on the need for their current medical, rehabilitative, and psychiatric regimen and identifies thoughts and attitudes that are problematic, e.g. taking *all* medication consistently (not only antibiotics), performing exercises consistently, keeping doctors' appointments, asking doctors to clarify poorly understood aspects of treatment.

*Open-ended questions*, phrased in a non-judgmental way, can be useful for initial identification of problem areas. Examples are: What is your most troublesome health problems? Which of your medications are most helpful? Are there medications that you think you can do without? Have you tried to stop smoking? Do you still crave cigarettes? Do you think that the walking and breathing exercises are helpful? Do you think that you have depression? Do you think that antidepressants can be helpful to you? Do you know how long it takes for antidepressants to work? Follow the lead provided by these open-ended questions to identify in greater depth *individual views* that may interfere with treatment adherence.

Some of the barriers to treatment are misconceptions about COPD, depression and their treatments. Examples of common misconceptions are:

#### *On COPD*

When I exercise I feel worse. I never feel better.

I follow my exercise regimen for a whole week and I do not breathe any better.

I feel better when I am sitting.

I've smoked all my life. I can't stop now.

Smoking is the only pleasure I have left.

It is too late to stop smoking.

I am taking too many drugs for my lungs. This is not healthy.

Using oxygen makes me feel like an invalid.

My doctors do not like to see me because I continue to smoke.

### *On Depression*

I have been a strong person. Depression is only for the weak; I cannot have depression.

You would be depressed too if you were as disabled as I am.

Antidepressants won't help. I am depressed for good reasons.

I never feel better after I take an antidepressant pill.

I am not depressed now. I do not see why I should continue treatment.

I do not want to depend on a pill of any kind.

Drugs for depression can be addictive.

### *Misattribution of Depressive Symptoms*

I am not depressed. There is just nothing to look forward.

If you were in my shoes, you would be depressed too.

I am not depressed. Simply, my future is bleak.

Nothing makes you feel good if you have COPD. I wouldn't call that depression.

All my worries come from my medical health not from depression.

These and other beliefs can be expressed in a variety of ways depending on the individual patient. It is important for the care manager to *use the patient's language* when he/she refers to these beliefs.

**C2. Dissatisfaction with Treatment or Aftercare Plans:** Specific attention should be given to the patient's understanding or misunderstandings about his/her treatment. Misunderstandings about treatment and overestimation of the energy needed to perform daily activities as well as recommended exercise may contribute to dissatisfaction with treatment. It is important to ask patients to describe:

- 1) The exact recommendations about medication, exercise, method for smoking cessation, oxygen use, antidepressant treatment, physical activity, social activity, etc.
- 2) Frequency of appointments with physicians, rehabilitation therapists, social agencies.
- 3) The time and energy needed to follow treatment recommendations.
- 4) The role of each therapy in improving dyspnea, depression, physical and social functions, and identify misunderstandings.

The care manager should identify dissatisfaction with specific treatment, providers or services and explore the history of dissatisfaction. The patient, then, can be focused on areas that can be changed and helped to accept areas that cannot be changed (e.g. scheduling delays).

**C3. Practical Barriers:** The care manager reviews the patients' practical concerns about treatment, including scheduling appointments, access to office and rehabilitation visits, transportation, insurance, taking medication and conducting exercises. Review should include earlier failed attempts by the patient to address these practical problems as well as any plans the patient may have.

**C4. Poor Acceptance of Depression:** The care manager reviews with the patient his/her views about depression and its treatment, and asks about the views of others in the patient's environment, e.g. who knows about your psychological and physical symptoms and treatment? What has their reaction been? Attention is paid to shame and low self-esteem related to depression and reinforced by poor acceptance of depression.

**C5. Hopelessness and Helplessness:** Many of the above negative attitudes may be accentuated by hopelessness and helplessness resulting from depression. The care manager identifies patients' views about their future and focuses on their medical and psychiatric health as well as their expectations. Open-ended questions can help the care manager to identify specific thoughts and actions influenced by hopelessness and helplessness. Nonetheless, since the main goal of the care manager's visits is to improve treatment adherence, the interview should identify specific beliefs interfering with treatment. Examples are:

Nobody with COPD is cured. There is no good reason to keep trying since it won't make a difference (hopelessness).

COPD makes me useless and a burden to my family (helplessness). That can never change (hopelessness).

Oxygen is useless. I do not believe that it can make any difference (hopelessness).

Everybody has given up on me, what is the use to go on (hopelessness).

I do not have the will power to stop smoking (helplessness).

I do not see how any treatment can help somebody like me (hopelessness).

I am not able to exercise. All this is just a torture (helplessness).

#### **D. Interventions**

**D1. Misconceptions about COPD, Depression, and Treatment:** The care manager discusses the nature of COPD and depression and addresses the misconceptions of the individual patient. Emphasizing that depression is a medical illness like COPD is generally well received by patients and may improve their acceptance of antidepressant treatment.

In patients who misattribute symptoms of depression and disability, the care manager may explain their causes in a way that encourages treatment. For example, if a patient argues: "If you were in my shoes, you would be depressed too.", the care manager might respond: "Perhaps, and I would like to be treated".



The care manager discusses the role of medications used for COPD and their potential side effects. He/she explains what oxygen treatment does and the anticipated benefits and limitations. Among patients who still smoke, the care manager reviews their reasons for continuing, any failed attempts to stop, and encourages plans for attending a smoking cessation program. The care manager reviews and explains the benefits of the prescribed exercise regimen.

It is often useful to emphasize that going through the prescribed exercise routine with regularity is important even when one feels fatigued and disinclined to do so. Helpful statements may be: "You, like athletes, need to keep your muscles conditioned. This way you can use the oxygen offered to your muscles efficiently. Athletes exercise regularly in order to help their muscles make the best use of the oxygen that they breathe. The same principle applies for you. If you follow your exercise schedule, your oxygen will go a long way." The care manager works with the patient to identify symptoms and impairments in functioning that are distressing and could be helped by treatment. The patient is encouraged to identify 2-3 reasons to remain in treatment that they can review when uncertainty arises.

The care manager provides information about depression in general, and reviews with each patient's specific depressive symptoms. It is helpful to *link the patient's symptoms* to the DSM-IV criteria for depression and come to an agreed upon label or description of the illness.

The care manager explains the role of antidepressants, side effects, timetable of response, nature of anticipated changes, and need for relapse prevention. The patient's specific concerns about medication and their effect on his/her life are addressed. The care manager may emphasize that antidepressants can enhance quality of life and provide the *motivation and energy needed in order to engage in COPD rehabilitation*. The care manager should provide patients with the Information Booklet on Late Life Depression (by the National Institute of Mental Health).

**D2. Dissatisfaction with Treatment or Aftercare Plans:** The care manager helps the patient to develop a plan for addressing his/her specific concerns about treatment, including concerns related to misunderstandings, previous experiences, unrealistic expectations, overestimation of time and energy needed to follow treatment recommendations. Interventions may include coaching the patient to report and discuss side-effects early on with their physician.

**D3. Practical Barriers:** The care manager should engage the patient in a discussion aiming to jointly develop concrete strategies to address treatment barriers. These may include ways to deal with scheduling of appointments, insurance, cost of medication, transportation, reminders for taking medication, and conducting exercises. Often, it is helpful for the patient to enlist the help of family members, friends, and social services.

If the patient has given up and is unwilling to address treatment barriers, the care manager may identify symptoms and functional limitations that are distressing and could be helped by treatment. This discussion can be used to increase patient motivation. The patient may be encouraged to identify 2-3 concrete reasons to follow treatment recommendations (on exercise, oxygen, smoking cessation, antidepressants, etc.) that they can review when uncertainty arises.

**D4. Poor Acceptance of Depression:** When poor acceptance of depression by the patient or others is identified, the care manager acknowledges the social prejudice against depression. He/she works with the patient to identify persons with whom the patient wishes to share issues related to their treatment, and to enlist their support and help when needed. The care manager encourages the patient to think about ways to disclose, or clarify reasons for not disclosing depression, and helps him/her with these decisions.

Metaphors/analogies may be helpful in reducing self-blame, e.g. "Depression is an illness. In fact, depression is a chronic illness like COPD, diabetes, etc. With good care, you can keep depression under control." When appropriate, the care manager mentions public figures known to have experienced depression and attempts to counter views of mental illness as a character weakness. It is important to emphasize that eliciting support and help can improve the outcomes of both depression and COPD.

**D5. Hopelessness and Helplessness:** Hopelessness and helplessness are identified as symptoms of depression with a *central role* in fueling poor expectations about treatment and an attitude of resignation. Helpful statements may be: "Depression is the disease of hopelessness and helplessness. You feel pessimistic and unable to do much because you are depressed. When your depression improves, you will feel differently about your treatment and your ability to continue with it. What is most important for you now is to follow the treatments that would improve your

breathing, your walking, and your depression. I am confident that you will feel less hopeless and helpless after you start to see results."

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## PID-C: THE INITIAL INTERVIEW

Subject Initials:                      ID# \_\_\_\_\_                      Care Manager:

Initial Interview Date:                      Doctors:

**Directions:** The primary tasks of the first interview (30 min) are to:

1. Describe your role and develop rapport with the patient.
2. Identify potential contributors to poor treatment adherence pertinent to the individual patient.
3. Complete the Barriers to Treatment Adherence List. The List should be updated in each subsequent session and used it as a guide for your interventions.

Early in the session, use statements that the patient is most likely to accept. Doing so may be a *vehicle to establishing rapport* with the patient.

Follow the steps outlined below. Check every action that you have taken. Make notes next to each item that requires attention, e.g., problem areas, areas of progress.

After you finish the first interview, review your notes and make a *list* of the potential barriers to treatment adherence for this patient (last chapter of this Manual). *Review this list before each follow-up visit* and plan how to address these barriers. Update the list with any new barriers to treatment adherence that you identify during follow-up visits.

### A. Introduction and Description of your Role

All inquiry and recommendations should be carried out in a supportive manner.

- Identify yourself and describe your function during the next 28 weeks (e.g., "I will be assisting both you and your physicians with your care").

- Offer examples on the assistance that you may provide:
  - Answer questions about the nature of your illness
  - Discuss the role of your medications, rehabilitation, smoking cessation, etc.
  - Discuss any side-effects you may have
  - Help you schedule and be faithful to your exercise program
  - Answer questions about the role of oxygen in your treatment
  - Plan some helpful activities with you
  - Communicate with your doctor (with your permission) and make him/her aware of the stage of your treatment and ongoing treatment needs
  - Inform your doctor of any new health developments that may require his/her attention

### **B. Identification of Factors Contributing to Poor Treatment Adherence**

- Is the patient aware of his/her diagnoses of COPD and depression?
  
- Does the patient know how to take each medication?
  
- Is the patient aware of the need for rehabilitative exercises, smoking cessation, oxygen, etc.
  
  
- If the patient still smokes, does he/she plan to quit?
  
  
- Is the patient aware of his/her overall treatment plan?

## **Misconceptions about COPD and Depression**

- Review patient's view of the need for treatment for COPD and depression. Describe:
  
- Misconceptions or misattribution of symptoms of COPD and/or depression. Describe:
  
- Misconceptions about treatment for COPD and depression. Review prior treatment experiences (positive vs. negative, effective vs. ineffective). Review prior adherence patterns. Describe:
  
- Overestimation of time and energy needed for exercise, physical activities, attendance to rehabilitation clinic. Describe:

## **Dissatisfaction with Treatment or Aftercare Plans**

- Ask the patient about his/her experience with care so far. Identify sources of dissatisfaction (positive vs. negative, effective vs. ineffective). Describe:
  
- Does the patient believe that change is possible?
  
- Identify patient behaviors that may promote change:

**Practical barriers to medical visits, medication taking, exercise, oxygen use, walking, and leaving the house.**

Ask the patient:

- ❑ Do you drive? Do you have a car? How often do you use it?
- ❑ Do you need help to go to your doctor's appointments or to your session at the outpatient rehabilitation unit? Who can help you? Who often helps you? Is there any time that you feel embarrassed to ask?
- ❑ Have you missed treatment appointments because you could not get to them?
- ❑ Do you need assistance in using your oxygen? How do you have your oxygen tank refilled?
- ❑ How often you go out? Do you need assistance in order to go out? Who can help you? Who usually helps you?
- ❑ Do family or friends visit you at the house? Would you like to have more visitors? How could that happen?
- ❑ Other. Describe:

**Views contributing to poor treatment adherence.**

- ❑ Is the patient concerned about seeking treatment for depression?
- ❑ Identify individual's view of the "sick" role and feelings associated with being ill.
- ❑ Who knows about your care?
- ❑ Who does not know? Why?
- ❑ Are there any significant people in patient's life who insist that the patient does not have depression? (e.g. spouse, children, neighbors, community)
- ❑ How are their beliefs expressed?
- ❑ What is the impact on the patient?
- ❑ Other concerns. Describe:

**Hopelessness and Helplessness Related to Treatment**

- ❑ Does the patient believe that the progression of COPD can be slowed down?



- ❑ Does the patient believe that he/she can perform strengthening exercises?
- ❑ Does the patient believe that he/she can stop smoking?
- ❑ Does the patient believe that his/her function can improve?
- ❑ Does the patient expect to increase his/her physical activities?
- ❑ Does the patient expect to increase his/her socialization?
- ❑ Does the patient expect that some or all of his/her treatments will not work?
- ❑ Other. Describe:

### **C. Interventions**

**Directions:** Give the patient a *schedule of your home visits*, your card (for changing appointments when needed), and explain that your role is to assist him/her and his/her physicians with treatment. You will *not have time* to go through all interventions during the first visit. However, you should selectively offer some interventions. *Start with COPD.* Most patients know and accept this diagnosis but may be less aware and less accepting of depression. The following two interventions are usually sufficient for the first visit:

- ❑ Help the patient understand the role of specific treatments and their anticipated impact on depression, breathing problems, walking, and other disabilities.

Offer basic education about COPD and its treatment, e.g. "COPD is a chronic condition. While the condition of the lungs is difficult to improve, smoking cessation, medication, exercise, walking, and social activities can do a great deal to improve your function and quality of life and prevent flare up of the disease. Most of the benefits of treatment are not obvious right away. For example, walking or doing the rest of the exercises may make you short of breath but conditions your muscles to work more efficiently." Answer the patient's questions about COPD treatment.

- ❑ Educate the patient about the relationship of depression to COPD.

Offer basic education about depression and its treatment, e.g. "Depression is a medical disorder that usually responds well, although not immediately to antidepressant medication. Antidepressants take 3-6 weeks to work and may work somewhat slower in older people. Most patients require long-term treatment with

antidepressants in order to prevent depression from coming back. Antidepressants are not addictive."

"If left untreated depression may affect your treatment for COPD. Depressed people often give-up too easily on their treatment. As your depression improves, you will have energy for exercise, walking, going out, and doing pretty much what you like to do." Answer the patient's questions about depression.

### **If Time Permits**

If time permits, you may offer additional interventions from the list provided below. *Chose interventions that the patient is likely to accept.*

#### **Misconceptions about COPD and Depression**

- ❑ Review the patient's symptoms and link them to COPD, depression and their interactions.
- ❑ Are there precipitants of depression?
- ❑ Clarify for the patient that both COPD and depression are chronic medical conditions that can be kept under reasonable control when patients participate actively in their treatment (medication, exercise, smoking cessation, keeping doctor's appointments, maintaining activities). Communicate the following as applicable:
  - ❑ Exercise causes fatigue but conditions your muscles and improves your ability to walk.
  - ❑ Even if you failed in the past, it is worth trying to quit smoking.
  - ❑ Most medications for COPD do not act fast.
  - ❑ You may not experience a direct benefit on your breathing when you take some of your medications, but your breathing may gradually worsen if you do not take your medications regularly.
  - ❑ Continuing to do as much as you can has great value for your care.
  - ❑ Keeping up with people and with your hobbies is important even when you do not feel like it.
  - ❑ Activity is important even if you are not feeling active.
  - ❑ Using oxygen can improve the quality of your life.
  - ❑ Be sure to report all medications to your doctor, including over the counter and herbal supplements.

- ❑ Depression is an illness.
  - ❑ Depression can worsen your COPD and your overall medical health.
  - ❑ Untreated depression can make you give up on all your treatments and cause your condition to deteriorate.
  - ❑ Depression is not a natural part of COPD.
  - ❑ Depression is treatable.
  - ❑ Depression responds to antidepressants even when there are reasons to be depressed.
  - ❑ Do not make changes in your medication or your exercises on your own.
  - ❑ Identify a behavior that could change if depression symptoms improved.
  - ❑ It is important to make your doctor aware of any problems and questions that you have with your medication. Make a list before your doctor's appointment.
  - ❑ Other interventions. Describe:
- 
- ❑ Review the availability of effective treatments for COPD and depression. Indicate that poor adherence is a known problem.

### **Misconceptions about Treatment**

- ❑ Describe how each of the treatments given for COPD and depression works.
  - ❑ Exercise
  - ❑ Oxygen
  - ❑ Smoking cessation
  - ❑ Activities
  - ❑ Actions of medication (What symptom does each drug address?).
  - ❑ Expected experiences regarding antidepressants
    - ❑ Medication works gradually, antidepressants are not "not happy pills".
    - ❑ Side effects may occur when you start medication but usually subside later.
    - ❑ Benefits may take time.
    - ❑ Do not change your medication schedule. Adjustments should be made only after consultation with your physician.
    - ❑ Antidepressants are not addictive.
    - ❑ Antidepressants do not change personality.

- It is important to keep your doctor's appointments (e.g. review payment, transportation, scheduling).
  - Inform the patient of the timetable of improvement of depression.
- Address the patient's specific concerns about medication. Comment:
  
- Encourage the patient to keep a list of all medications and directions with him/her.

### **Dissatisfaction with Treatment or Aftercare Plans**

- Describe what the patient should expect from his/her care and address unrealistic expectations. Comment:
  
- Identify the limitations and difficulties of those who provide care to the patient, e.g. "Sometimes doctors are unable to answer a phone call. Sometimes you need to call several times in order to be able to speak with your doctor".  
Comment:
  
- Help the patient to make a plan for change. Comment:

### **Practical Barriers**

- Discuss with the patient ways to:
  - Scheduling appointments with doctors and rehabilitation clinics
  - Deal with insurance
  - Transportation
  - Reminders for taking medication and conducting exercises

- Discuss with the patient appropriate ways of getting help from family or friends so that he/she can:
  - Go to doctor's appointments.
  - Go out.
  - Socialize.
  - Other. Describe:

Coping strategies for unchangeable barriers. Describe:

### **Poor Acceptance of Depression and its Treatment**

- "Medication is a freely chosen strategy to enhance quality of life" (Kemp & David).
- Examples of sufferers (Mike Wallace, Tipper Gore).
  - Analogy to other chronic illnesses, e.g. "Depression is an illness similar to hypertension and diabetes. It requires long-term treatment, but with treatment most people do well".
  - Depressed people are not "crazy" or defective.
  - Challenge any other irrational ideas about depression.
  - Other. Describe:

### **Hopelessness and Helplessness**

- Depression is the disease of hopelessness and helplessness. You feel hopeless and helpless because you are depressed.
- When you say that there is no use in trying, it is not you, it is the depression speaking!

- If you were not depressed, it would have been easier to believe that treatment can help you and that you can do much of what your doctors advise you to do.
  
- You may not believe that treatment can help you now that you are depressed. What is most important for now is to follow the recommendations for walking, breathing, oxygen antidepressants etc. reliably. When your depression improves, I am confident that you will feel more hopeful.

## PID-C: FOLLOW-UP SESSIONS

Subject Initials: ID# \_\_\_\_\_

Care Manager:

Date:

Doctors:

**Directions:** Review the Barriers to Treatment Adherence List before each meeting.

The primary tasks of follow-up meetings with the patient are to:

1. Identify clinical changes in COPD and depression that may require changes in treatment.
2. Address barriers to treatment adherence identified during the initial interview.
3. Inform the physicians about any significant changes in the patients' status as well as any problems with adherence, and engage them in addressing them.

If changes in depression are identified, consult with the treatment algorithm and advise the patient's physician accordingly. In the course of your follow-up meetings with the patient, you may identify additional barriers to treatment adherence. Add them to the Barriers to Adherence List so that you can address them in subsequent meetings.

### **Interventions**

Give the patient a schedule of your home visits, your card (for changing appointments when needed).

**Use selectively from the interventions listed below those that are most relevant to the individual patient.**

**Misconceptions about COPD and Depression**

- Review the patient's symptoms and link them to COPD, depression, and their interactions.
- Are there precipitants?
- Clarify for the patient that both COPD and depression are chronic medical conditions that can be kept under reasonable control when patients participate actively in their treatment (medication, smoking cessation, exercise, keeping doctor's appointments, maintaining activities). Communicate the following as applicable:
  - COPD cannot be slowed down.
  - Exercise causes fatigue but conditions your muscles and improves your ability to walk.
  - Even if you failed in the past, it is worth trying to quit smoking.
  - Most medications for COPD do not act fast.
  - You may not experience a direct benefit on your breathing when you take some of your medications, but your breathing may gradually worsen if you do not take your medications regularly.
  - Continuing to do as much as you can has great value for your care.
  - Keeping up with people and with your hobbies is important even when you do not feel like it.
  - Activity is important even if you are not feeling active.
  - Using oxygen can improve the quality of your life.
  - Be sure to report all medications to your doctor, including over the counter and herbal supplements.
  - Depression is an illness.
  - Depression can worsen your COPD and your overall medical health.
  - Untreated depression can make you give up on all your treatments and cause your condition to deteriorate.
  - Depression is not a natural part of COPD (other myths about depression).
  - Depression is treatable.
  - Depression responds to antidepressants even when there are reasons to be depressed.
  - Do not make changes in your medication or your exercises on your own.
  - Identify a behavior that could change if depression symptoms improved.
  - It is important to make your doctor aware of any problems and questions that you have with your medication. Make a list before your doctor's appointment.



- Other interventions. Describe:
  
- Review the availability of effective treatments for COPD and depression. Indicate that poor adherence is a known problem.

### **Misconceptions about Treatment**

- Describe how each of the treatments given for COPD and depression works.
  - Exercise
  - Oxygen
  - Activities
  - Smoking cessation
  - Actions of medication (What symptom does each drug address?).
  - Expectable experiences with medication
    - Medication works gradually, antidepressants are not "not happy pills".
    - Side effects may occur when you start medication but usually subside later.
    - Benefits may take time.
    - Do not change your medication schedule. Adjustments should be done after consultation with your physician.
    - Antidepressants are not addictive.
    - Antidepressants do not change personality.
    - It is important to take your medicines as prescribed.
    - It is important to keep your doctor's appointments (e.g. review payment, transportation, scheduling).
    - Inform the patient of the timetable of improvement of depression (Most patients would have been exposed to antidepressants for approximately 1 week. Most patients may have not experience any change in depression).
  
- Address the patient's specific concerns about medication. Comment:
  
- Encourage the patient to keep a list of all medications and directions with him/her.

## **Dissatisfaction with Treatment of Aftercare Plans**

- Describe what the patient should expect from his/her care and address unrealistic expectations. Comment:
  
- Identify the limitations and difficulties of those who provide care to the patient, e.g. "Sometimes, doctors are unable to answer a phone call. Sometimes you need to call several times in order to be able to speak with your doctor". Comment:
  
- When appropriate, help patient to make a plan for change. Comment:

## **Practical Barriers**

- Discuss with the patient ways to:
  - Scheduling appointments with doctors and rehabilitation clinics
  - Deal with insurance and copayment
  - Transportation
  - Reminders for taking medication and conducting exercises
  
- Discuss with the patient appropriate ways of getting help from family or friends so that he/she can:
  - Go to doctor's appointments.
  - Go out.
  - Socialize.
  - Other. Describe:

- Coping strategies to adapt to unchangeable barriers. Describe:

### **Poor Acceptance of Depression and its Treatment**

- "Medication is a freely chosen strategy to enhance quality of life" (Kemp & David).
- Examples of sufferers (Mike Wallace, Tipper Gore).
- Analogy to other chronic illnesses, e.g. "Depression is an illness similar to hypertension and diabetes. It requires long-term treatment, but with treatment most people do well".
- Depressed people are not "crazy" or defective.
- Challenge any other irrational ideas about depression.
- Other. Describe:

### **Hopelessness and Helplessness**

- Depression is the disease of hopelessness and helplessness. You feel hopeless and helpless because you are depressed.
- When you say that there is no use in trying, it is not you, it is the depression speaking!
- If you were not depressed it would have been easier to believe that treatment can help you and that you can do much of what your doctors advise you to do.
- You may not believe that treatment can help you now that you are depressed. What is most important for now is to follow the recommendations for walking, breathing, oxygen antidepressants etc. reliably. When your depression improves, I am confident that you will feel more hopeful.

# BARRIERS TO TREATMENT ADHERENCE LIST

Subject Initials:

ID# \_\_\_\_\_

Care Manager:

Date:

Doctors:

**Directions:** After you complete the first intervention visit, create a list of factors that may contribute to poor treatment adherence for your patient. Consult with this list prior to each follow-up visit. Update the list with any new barriers to treatment adherence that you may identify in subsequent visits.

## Misconceptions about COPD and Depression

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## Dissatisfaction with Treatment or Aftercare Arrangements

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**Practical Barriers to Medical Visits, Medication Taking, Smoking Cessation, Exercise, Oxygen Use, Walking, Leaving the House.**

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**Poor Acceptance of Depression Interfering with Treatment Adherence**

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**Hopelessness and Helplessness**

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