



Patient Perspectives On The Benefits Of Psychotherapy For Late-Life Depression

By: **Emily K. Dakin** and Patricia Areán

Abstract

Objectives: The future of psychotherapy research lies in the development of easy-to-use, efficient treatments that target specific characteristics and needs of patients with a given disorder. Meeting this aim will involve understanding why people seek psychotherapy and the therapeutic features that they feel are most helpful in their recovery. Identifying key features of treatment that patients feel lead to improvement may help identify the active ingredients of psychotherapy and further refine treatment. **Design:** We selected 22 older adults who participated in a larger randomized trial of psychotherapy for late-life depression to participate in individual, semistructured qualitative interviews. **Setting:** Interviews took place at the University of California, San Francisco or in the participant's home. **Participants:** All participants were age 60 years or older with major depression and co-occurring executive dysfunction. **Measurements:** Participants were asked about their depression experience, their expectations for treatment, most and least helpful aspects of treatment, effects of treatment, and recommended improvements to treatment. Data were transcribed, coded, and analyzed using NVivo (QSR International, Cambridge, MA). **Results:** The most commonly noted causes for seeking treatment were depression related to interpersonal relationships, health conditions, grief/loss, finances, housing, and challenges due to executive dysfunction. Participants had few expectations about treatment and they found support, the problem-solving therapy process, and focus on interpersonal relationships to be the most helpful processes in treatment. **Conclusion:** Suggestions for psychotherapy include increasing the number of sessions, discussing problems in a more proactive way, and considering participant choice in treatment. This research demonstrates the value of mixed-methods approaches, in that qualitative approaches assist in contextualizing and interpreting quantitative data.

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Patient Perspectives on the Benefits of Psychotherapy for Late-Life Depression

Emily K. Dakin, Ph.D., Patricia Areán, Ph.D.

Objectives: *The future of psychotherapy research lies in the development of easy-to-use, efficient treatments that target specific characteristics and needs of patients with a given disorder. Meeting this aim will involve understanding why people seek psychotherapy and the therapeutic features that they feel are most helpful in their recovery. Identifying key features of treatment that patients feel lead to improvement may help identify the active ingredients of psychotherapy and further refine treatment.* **Design:** *We selected 22 older adults who participated in a larger randomized trial of psychotherapy for late-life depression to participate in individual, semi-structured qualitative interviews.* **Setting:** *Interviews took place at the University of California, San Francisco or in the participant's home.* **Participants:** *All participants were age 60 years or older with major depression and co-occurring executive dysfunction.* **Measurements:** *Participants were asked about their depression experience, their expectations for treatment, most and least helpful aspects of treatment, effects of treatment, and recommended improvements to treatment. Data were transcribed, coded, and analyzed using NVivo (QSR International, Cambridge, MA).* **Results:** *The most commonly noted causes for seeking treatment were depression related to interpersonal relationships, health conditions, grief/loss, finances, housing, and challenges due to executive dysfunction. Participants had few expectations about treatment and they found support, the problem-solving therapy process, and focus on interpersonal relationships to be the most helpful processes in treatment.* **Conclusion:** *Suggestions for psychotherapy include increasing the number of sessions, discussing problems in a more proactive way, and considering participant choice in treatment. This research demonstrates the value of mixed-methods approaches, in that qualitative approaches assist in contextualizing and interpreting quantitative data.* (Am J Geriatr Psychiatry 2013; 21:155–163)

Key Words: Psychotherapy, late-life depression, patient perspectives

An important focus for future interventions research will be on the personalization of interventions to maximize treatment outcomes and make treatments more efficient and easier to manage.^{1,2} The Road Ahead report³ issued by the

National Institute of Mental Health details how personalized intervention development will benefit greatly from patient perspectives; the positive and negative effects of treatment and the factors that contribute to illness and recovery in part be

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determined by the perspectives of people who have experienced the illness and recovered from it.

We recently completed and published the results from one of the largest psychotherapy trials for late-life depression, the Collaborative Outcomes of Psychotherapy for Executive Dysfunction Study.⁴ This study found that a structured intervention, namely problem-solving therapy (PST),⁵ eventually resulted in better treatment outcomes than a less-structured treatment, supportive therapy (ST); both interventions were effective in treating late-life depression overall.⁴ A unique feature of this study was that all participants met criteria for executive dysfunction (ED), which is impairment in the cognitive capacity to plan and initiate tasks and solve problems. People with this presentation of late-life depression tend to have a poor response to selective serotonin reuptake inhibitor treatment of depression,⁶ and thus the results of this former study suggest a viable treatment alternative for a population known to be resistant to antidepressant medications.

Combined qualitative and quantitative methods have broad appeal in health research due to the ability of the two approaches to inform one another and the breadth of knowledge and insights that can be gained using multiple methods.⁷ A variety of qualitative mental health research studies have revealed the value of examining patients' perspectives on mental health treatment^{8–11} in terms of uncovering specific ways in which the treatment provided an impact. In particular, the inclusion of qualitative research methods in clinical research is an emerging methodologic approach that strengthens our ability to answer central questions about intervention effectiveness, why treatments do or do not work from the patient's perspective, and to explore any outcomes of the treatment not captured by current quantitative measures. This can lead to better refinement of behavioral interventions that have historically been difficult to widely implement because of their complexity. With an eye toward developing a more efficient form of psychotherapy, we elected to conduct a qualitative analysis to determine patient views on the following: 1) the most common issues that caused them to select psychotherapy as a treatment of choice; 2) expectations for how their depression should be addressed in therapy and

whether expectations were met in their therapy experience; 3) most and least helpful aspects of psychotherapy; 4) any observed outcomes or effects from therapy; and 5) recommended changes to improve treatment.

METHODS

Participants

All participants in this study were participants in a large randomized clinical trial of PST compared to ST for the treatment of depression and co-occurring executive dysfunction. To be eligible, participants had to 1) be 60 years or older, 2) be diagnosed with major depression (by *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria), 3) have scored 21 or worse on the Hamilton Depression Scale, and 4) have mild executive dysfunction. Exclusionary criteria included presence of dementia determined by the Mini-Mental State Examination (<25). Additional exclusionary criteria are detailed in the Arean et al. 2010 article.⁴

Participants in the parent study were randomized to receive 12 weekly sessions of PST or ST. PST teaches patients a series of steps to solve problems they see as causing their depression; participants use these steps each week to solve different problems. ST is an unstructured psychotherapy that helps patients overcome their depression by discussing their feelings and supporting patients in attempts to feel better. Twenty-two participants volunteered and consented to participate in this qualitative study and were not demographically different from the original sample (Table 1). The interviews for the qualitative study occurred during the window of time between completing psychotherapy and being disenrolled from the study after the final study assessment at 9 months.

Interviews

Three trained interviewers conducted individual, semi-structured interviews at the University of California, San Francisco or in the participant's home. Participants were paid \$15 for taking part in the qualitative interview. We made an effort to ensure that the wording of interview questions was understandable to our research participants. This article

TABLE 1. Demographic Data for Qualitative Sample and Original Study Sample

Demographic	Qualitative Study Subsample	Original Study Sample
Mean age, years	74	73
Mean education, years	16	15
Women, %	59	60
PST, %	41	50
Caucasian, %	91	72

Note: PST: Problem-solving therapy.

focuses on the following open-ended questions from the interview:

- What kinds of problems or difficulties were you experiencing when you first entered treatment through [this study]?
- What were your expectations for how your depression should be treated?
- Did this program meet your expectations? (*follow-up probe if participant does not expound: Can you tell me more about why it did/did not?*)
- What about this treatment was most helpful?
- What was least helpful?
- What effects, if any, did you notice from this treatment?
- If you could make changes to this treatment for future patients, what changes would you recommend?

Data Analysis

All of the interviews were digitally recorded and a template analysis was performed on the transcribed data. In template analysis, an initial coding structure is developed and successively refined through multiple iterations, until a final template is reached. As each new analytic template is developed, all previously analyzed transcripts are reanalyzed using the new template. Refinements of the template cease, and a final template arrived upon, once the template is refined to the point that it is judged to be inclusive of all the thematic categories within the transcribed data.¹²

Qualitative research de-emphasizes the search for a single, objective “truth” seen in quantitative research. Instead, it posits that there can be multiple, subjective ways of understanding reality.¹³ The term *credibility* in qualitative research, roughly analogous to “validity” in quantitative research,¹⁴ refers to the extent to which the researcher has adequately

represented participants’ realities. To ensure credibility of the conclusions, two coders performed all data analysis, including the development of the analysis template. Each transcript was independently read and coded by both coders and then discussed to arrive at an agreed-upon coding structure. The qualitative data analysis software NVivo was used to aid in the data analysis.

RESULTS

Participants

Although our inclusion criteria specified that participants only needed to have completed one psychotherapy session, 21 of the 22 participants in this study had completed all 12 psychotherapy sessions. There were no statistically significant demographic differences between the qualitative subsample and the parent study sample, with the exception of ethnicity; the qualitative subsample was more likely to be Caucasian than the parent study participants, although both samples were predominantly Caucasian. Please see Table 1 for demographic data (age, education, gender, percent PST versus ST, and percent Caucasian) for the qualitative and original samples.

Template Analysis Coding Structure

Our initial template closely mirrored the interview questions and was refined in subsequent iterations. Codes relevant to the interview questions reported in this article are 1) reasons for participating in research; 2) expectations for psychotherapy (including extent that therapy met expectations); 3) helpful and unhelpful processes in treatment; 4) effects of treatment; and 5) recommended changes to treatment. The codes often had sub- and even sub-subcodes. For example, within the code “effects of treatment” was the subcode “functioning”, and within this were sub-subcodes “improvements in relationships or interpersonal functioning” and “more active.” Tables 2 through 5 show codes and percentages of sample endorsing these codes. In creating our final analytic template, we included only those codes that had been identified by 3 or more of the 22 participants.

TABLE 2. Reasons for Participating in Research

Code	PST		ST		Total (%)
	Male Subjects (n = 3)	Female Subjects (n = 6)	Male Subjects (n = 6)	Female Subjects (n = 7)	
ED issues	1	2	4	5	12 (54.5)
Relationship issues	2	4	3	2	11 (50.0)
Late-onset depression	0	3	3	3	9 (40.9)
Early-onset depression	2	0	3	3	8 (36.4)
Health	0	3	2	2	7 (31.8)
Grief/loss	1	4	1	1	7 (31.8)
Finances	1	1	2	1	5 (22.7)
Housing	0	2	1	0	3 (13.6)

Notes: ED: executive dysfunction; PST: problem-solving therapy; ST: supportive therapy.

Participant Reasons for Participating in Research and Prominent Problems Reported

A majority of the participants in this study had previous mental health treatment experience, with 16 of the 22 participants describing episodic or ongoing/long-term treatment, and many of these having had their first experience with mental health treatment as a young adult. Eight participants (36.4%) described experiences with early onset depression (Table 2). For example, one man stated:

I recognized that I have been depressed for most of my life and I think there’s a genetic component. My mother was depressive and immobilized at times. Her mother, my maternal grandmother, was depressive and bedridden off and on for periods of time in her life. So there probably is a genetic predisposition, and then I was—I think both from my childhood and from my adult life...

In contrast, nine (40.9%) participants described having late-onset depression. Describing depression originating from circumstances in late life, one woman stated:

I lost my brother a few years back, and normally on the anniversary of his death, at least one of his children call. [This past year] nothing happened, and it just struck me all of a sudden, my entire bloodline had disappeared from my life, and it just—I went right down to the bottom. I couldn’t understand what had happened, I couldn’t understand why I hadn’t heard from anybody, and I was going through physically a very bad time at that point, too, so it was just a—I crashed.

A variety of factors were described as contributing to participants’ feelings of depression. Most frequently cited as leading participants to seek treatment were

problems related to executive dysfunction (54.5%), interpersonal relationships (50.0%), health (31.8%), grief/loss (31.8%), finances (22.7%), and housing (13.6%).

Expectations for Therapy and Extent to Which Treatment Met Expectations

Although all 22 participants responded to the inquiry about expectations, the most common response, given by 12 participants (54.5%), was having no particular expectations about the treatment (Table 3). Eight participants, including four without specific expectations, simply voiced a desire to feel better or be helped. The desire for help was voiced in several ways, including in a general way, in terms of depression, and in terms of MCI issues. Three participants voiced a desire for assistance with coping or coping strategies. Individual expectations included help getting “unstuck” with tasks, help with a “writer’s block,” help with controlling anger, validation of relatives’ poor treatment of participant, becoming reacquainted with self; and a desire for focused/specific rather than open-ended treatment.

Twelve participants (54.5%) felt that treatment had met their expectations, whereas seven (31.8%) indicated that their expectations were not met or were partially met. Participants typically responded to the question of whether treatment met their expectations in terms of their satisfaction with treatment. Thus, for example, it was common for participants who had not indicated any particular expectations to say that treatment had met their expectations, meaning that they were satisfied with their treatment experience.

TABLE 3. Expectations for Therapy

Code	PST		ST		Total (%)
	Male Subjects (n = 3)	Female Subjects (n = 6)	Male Subjects (n = 6)	Female Subjects (n = 7)	
No expectations ^a	1	3	5	3	12 (54.5)
Feel better or be helped	1	2	2	4	8 (36.3)
Coping strategies	0	0	3	0	3 (13.6)
Expectations met ^a	2	4	2	4	12 (54.5)
Expectations not met or partially met	0	1	3	3	7 (31.8)

Notes: PST: problem-solving therapy; ST: supportive therapy.

^aParticipants typically responded to the question of whether treatment met their expectations in terms of their satisfaction with treatment. Thus, for example, it was common for participants who had not indicated any particular expectations to say that treatment had met their expectations, meaning that they were satisfied with their treatment experience.

The assigned treatment group played a role in terms of whether or not participants felt that treatment had met their expectations. For example, a man in the PST condition was very pleased with his treatment because he was in the condition that he believed would be most helpful to him:

Well, I knew that there were two components, that there was a supportive function, and there was a problem-solving function, and I knew that it was randomly assigned, and I was hoping for the problem-solving function because, as I said, I've had considerable insight therapy. I really don't need much insight therapy at this point. I'm very self-sufficient in that way. I need supportive therapy, but not exclusively. But what I really needed was problem-solving, so I was pleased when I got into that section. I would have made the best of the supportive section, but I really had so many practical issues that I couldn't manage, so I was very pleased when I got into that.

Three participants expressed that treatment had not met their expectations because they had been assigned to ST rather than PST. One woman in the ST group believed that she had not improved and believed that the more proactive nature of PST would have been a better match for her:

I think that the emphasis on the supportive is just to allow people to articulate their concerns, and sometimes getting it off your chest ... helps a lot of people, but it doesn't really help me. ... I can share my concerns, but that doesn't get rid of them. So that's why I was hoping for the other one.

Similarly, a man in the ST condition indicated that his expectations for treatment had not been met by the ST condition because

I didn't feel that there was much feedback to, you know, help me overcome the problem.

On the contrary, a woman in the ST condition had mixed feelings about being in ST:

Subject: Well, because I felt that I wasn't in a particular program, and I just got therapy, it didn't meet my expectations that way. I had a very wonderful therapist who I thought was just really great, and whom I was able to talk to very well, and she was smart, and she'd always have little insightful things that gave me things to think about. So I did think it was very worthwhile.

Interviewer: So it met some of your expectations.

Subject: Yeah. It exceeded my expectations (laugh) in many ways, because she was very excellent.

Helpful and Unhelpful Processes in Treatment

Participants described a wide range of techniques as being helpful in their therapy experience (Table 4). Eleven participants (50.0%) indicated that none of the techniques in therapy were unhelpful. Four participants (18.2%) described aspects of therapy that were unhelpful. A woman in the PST condition stated that although therapy was helpful personally, family problems remained unresolved. A man in the PST condition indicated that the interventions might have minimized the importance of spirituality to older adults and assumed that participants would be troubled about their age. A woman in the ST condition suggested that talking about painful aspects of her past in therapy had been harmful with no particular benefit. Another woman in the ST condition had wanted to receive PST because it was more focused on taking action, and she believed that the ST had not helped her.

TABLE 4. Helpful and Unhelpful Processes in Treatment

Code	Subcode	PST		ST		Total (%)
		Male Subjects (n = 3)	Female Subjects (n = 6)	Male Subjects (n = 6)	Female Subjects (n = 7)	
Helpful		3	6	6	6	21 (95.5)
	Providing support	2	2	2	3	9 (40.9)
	Explaining or assisting with the PST process	2	6	0	0	8 (36.4)
	Helping with interpersonal relationships	2	3	0	1	6 (27.3)
	Exploring options	2	1	1	0	4 (18.2)
	Promoting self-awareness	0	2	1	0	3 (13.6)
	Therapeutic reframing	1	1	0	1	3 (13.6)
Nothing unhelpful		1	4	3	3	11 (50.0)
Unhelpful		1	1	0	2	4 (18.2)

Notes: PST: problem-solving therapy; ST: supportive therapy.

Effects of Psychotherapy

Improvements in functioning—in terms of interpersonal functioning and/or becoming more active—were the most commonly noted effects from treatment, identified by 13 (59.1%) of the participants (Table 5). A slight majority of participants (12, or 54.5%) noted an improvement in mood as an effect of treatment, whereas seven (31.8%) did not endorse an improvement in mood. Seven participants (all in the PST condition) indicated that they had continued to implement techniques learned in therapy after therapy had ended, including techniques and abilities in terms of problem solving and decision making, completing tasks, and changed thinking patterns. Similarly, participants commonly desired a referral to continue treatment. In the case of PST participants, the desire for further treatment was often based on the wish for continued learning about the PST process in a structured environment with expert oversight.

There was a wide range of comments among the nine participants who discussed the impact of treatment on their ED, with three participants (a man and a woman who had received ST and a woman who had received PST), indicating that they believed treatment had helped their ED symptoms, one participant, a woman in the PST condition believing that her ED would improve with continued treatment, and a man in ST condition indicating that he was engaged in working on his memory as a result of treatment. Another four participants (two women receiving ST, a man receiving ST, and a woman

receiving PST) did not believe that treatment had helped their ED; however, the woman in the PST condition poignantly observed that her depression had lifted so much as a result of treatment that she had become less worried about these issues:

I know I thought when I first came that I was having Alzheimer's or something. ... But I think so much of it had to do with how frightened I was about, you know, feeling so bad. So I do think somehow those two things are connected, and I'm not sure I understand how, but I feel a lot better about that. ... even if I am going to get worse, it's not so important right now.

Recommended Changes to Treatment

Sixteen participants provided comments regarding recommended changes to treatment. Three participants wished that the therapy could have lasted longer; this included both the recommendation of having the therapy session last longer than an hour and the recommendation of having a greater number of sessions. A fourth participant recommended that the therapist talk with the participant about whether the participant would be interested in continued therapy beyond the 12 sessions. Two female participants indicated a desire for treatment to take place in a group format. One participant recommended that a therapist formally assess, before embarking on a course of psychotherapy, whether a given participant would be likely to benefit from a particular chosen therapeutic model. Some practical recommendations included a comment about the importance

TABLE 5. Effects of Psychotherapy

Code	Subcode	PST		ST		Total (%)
		Male Subjects (n = 3)	Female Subjects (n = 6)	Male Subjects (n = 6)	Female Subjects (n = 7)	
Functioning		2	5	4	2	13 (59.1)
	Improvements in relationships or interpersonal functioning	0	2	2	1	5 (22.7)
	More active	1	3	3	2	9 (40.9)
Mood improved		2	4	2	4	12 (54.5)
Mood not improved or not sure if improved		1	1	2	3	7 (31.8)
Interested in further treatment		1	3	1	3	8 (36.4)
Implementation of learned techniques posttherapy		2	5	0	0	7 (31.8)
Positive reframing of earlier life events		0	1	1	1	3 (13.6)
Increase in knowledge about depression, MCI or PST process		1	1	1	0	3 (13.6)
MCI		0	3	3	3	9 (40.9)

Notes: MCI: mild cognitive impairment; PST: problem-solving therapy; ST: supportive therapy.

of therapists who speak non-English languages (e.g., Spanish), and the recommendation of having alternate locations (e.g., client's home) for therapy to take place because of transportation difficulties within an older population.

Participants stated a variety of recommendations about the therapeutic process and not specifically related to the type of therapy given per se. One recommendation was that therapists explore with each participant his or her feelings about being in therapy, for example, whether the participant has any sense of shame, because these feelings can impact what happens in the therapy session. One participant suggested that perhaps providing a same-gender therapist could make the therapeutic experience easier for some, whereas another participant suggested the value of trying to match client to therapist by personality. Similarly, one participant appreciated that her therapist was of similar age to her. One unique recommendation was to have two therapists for each client to provide the client with a wider range of perspectives.

Other recommendations were specific to the PST and ST therapeutic conditions. Recommendations for PST included more in-depth exploration into family issues but in combination with the skill building that is the hallmark of PST. As quoted by one participant:

I think the supportive therapy alone, now that I've been through a great deal, is not sufficient. I think there has to be a practical component, particularly

practical application, and I think it's really important, especially at the beginning, to have someone listen to your story in a nonjudgmental, you know, appropriate manner and to help you exhaust your need to tell that story, and while that's being done, you know, toward the end of that storytelling, there has to be a real practical application ... So I think, you know, the most effective therapy is a combination of supportive and practical.

This opinion appeared to be mirrored by participants in the ST condition. Two participants in the ST condition wished that their therapy had been more directive and less open-ended, with one indicating that she wished that her therapy had specifically targeted her MCI symptoms. A third ST participant stated that although he was personally happy with the therapy that he had received, he conjectured that other participants might prefer a more structured and directive therapeutic approach.

DISCUSSION

We used qualitative interviews to determine patient perspectives about their experience in two forms of psychotherapy for depression. Our intent was to use this information to identify what patients felt were the most effective elements of treatment, with the goal of creating a more targeted intervention. In addition, patients had a near uniform host of problems they felt

had contributed to their depression, problems that have been documented in epidemiologic studies to be quite common in older adults with depression.^{15–18} It should be noted here that when asked about improvements attributed to psychotherapy, 59.1% of the participants indicated that participation in therapy resulted in marked improvements in functioning (social functioning or improved activity levels), and 54.5% indicated marked improvements in mood.

There is considerable interest in the psychotherapy field in streamlining psychotherapies into their basic elements, including nonspecific therapeutic elements, so they can be efficiently implemented in community practices. The results of this study suggest that to create a more efficient psychotherapy that retains the effective treatment ingredients, the treatment should include the following elements. First, the therapeutic relationship should be collaborative rather than reflective; participants preferred to work toward active solutions for their problems, rather than simply talking about them. Second, treatment should acknowledge and integrate patient spirituality. Third, participant recommendations included the importance of discussing shame associated with seeking treatment as an important engagement tool; the current cohort of older adults may fear disclosure in therapy due to perceived stigma, and discussing thoughts and feelings about engaging in psychotherapy with older adult clients could address this concern and build therapeutic rapport. Fourth, the treatment should focus on strategies to address problems commonly seen among older adults, for example social functioning (e.g., behavioral activation),¹⁹ cognitive skills (e.g., PST, memory remediation),²⁰ family therapy strategies, and financial counseling.²¹ Fifth, the treatment may need to be lengthened given the needs of the patients, particularly if suffering from ED (e.g., both therapies were 12 sessions and may need to be extended to 24 sessions). Finally, participant choice in treatment approach (e.g., type, format, and length of treatment) should be considered given the finding that ST participants commonly perceived that they would have been helped more by PST and the various participant treatment recommendations noted earlier.

Limitations

Although any participant who had completed one session of therapy through the COPED study was

eligible to be interviewed for this qualitative study, all but one of our participants had completed all 12 sessions specified by the COPED protocol. None of the participants who dropped out of COPED and were contacted regarding this qualitative study were interested in being interviewed for it. Therefore, our interviews may have overrepresented the true level of participants' satisfaction with the therapy that they received through the COPED study. On the other hand, relatively few participants dropped from the study because of dissatisfaction, so this concern may be relatively minor.

An additional possible limitation is that our sample was generally highly educated and Caucasian, and so our findings present a limited picture of the needs and treatment experiences of older adults in general who are experiencing depression and ED. In addition, because 16 of the 22 participants described prior experiences with mental health services, this was a group that was experienced with psychotherapy, so results may not be generalizable to people without prior mental health treatment. Further study is warranted to determine to what extent these results may be relevant for more diverse elderly populations.

CONCLUSIONS

Evaluating patient perspectives about the treatments they receive could be particularly useful in the development of efficient and focused psychotherapies. The data from this study suggest that treatments that work toward active solutions for problems, integrate spirituality, proactively address stigma concerns, incorporate patient choice, and target features of depression common in late life may provide more efficient methods for treating depression in older adults. We suggest that the integration of behavioral activation, problem solving, and cognitive skills training be considered in the development of efficient treatments. Finally, this study demonstrates the value of mixed-method approaches; qualitative methods provide rich data that are helpful in understanding and contextualizing quantitative data. The data in the parent study indicated that although both ST and PST were effective interventions, PST had better treatment outcomes in the long run. The qualitative data support and help interpret these findings by indicating the most

beneficial aspects of treatment, which could lead to refinement of PST and, potentially, a more potent intervention.

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