

Patient-Centered Care for Depression Patients

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People have specific and unique individual and contextual characteristics, so healthcare should increasingly opt for person-centered care models. Care planning focused on people with depression and/or anxiety disorder must be individualized, dynamic, flexible, and participatory. It must respond to the specific needs of the person, contemplating the identification of problems, the establishment of individual objectives, shared decision making, information and education, systematic feedback, and case management, and it should meet the patient's preferences and satisfaction with care and involve the family and therapeutic management in care.

[anxiety](#)[depression](#)[patient-centered care](#)[patient care planning](#)[symptom assessment](#)[patient health questionnaire](#)[patient-centered nursing](#)[patient-focused care](#)

1. Introduction

In 2001, the final report of Institute of Medicine's Quality of Health Care in America recommended that in order to improve the quality of healthcare, these should be safe, effective, person-centered, timely, efficient, and equitable ^[1]. Moreover, according to the same report, person-centered care can be defined as the provision of healthcare that respects and is representative of patients' individual preferences and needs. In addition, it must ensure that patient values guide all clinical decisions ^[1].

In this context, it is clear that healthcare must be personalized and marked by shared decision making between patients and healthcare professionals. The concept of shared decision making implies that patients' preferences and cultural values influence clinical decisions. However, shared decision making is demanding and can be time consuming, and it may be necessary to integrate the views of both generalists and experts. In these circumstances, the values, preferences, and needs of patients must be highly considered ^[2], because the patient is the central focus of the care process. Shared decision making has four key characteristics: (1) Health professionals and the patient must be involved; (2) both must share the information they have; (3) a consensus must be reached based on the patient's treatment preferences; and (4) a consensus must be reached on the treatment to be performed ^[3]. Thus, shared decision making must be the central principle of person-centered care, and health professionals should seek to look at the experience of healthcare through the eyes of their patient ^[4].

Depressive and anxiety disorders are common and recurrent mental illnesses, affecting more than 300 million people worldwide. Due to their clinical characteristics, they affect psychosocial functions, decreasing the quality of life of those who suffer from them ^[5].

Taking into account the current pandemic context, the prevalence of depression and anxiety tends to increase, as several studies have indicated that the pandemic has been causing an increase in the levels of stress, anxiety, and depressive symptoms [6][7][8][9][10][11][12][13]. In this sense, it is necessary and urgent to adopt healthcare aimed at surveillance, prevention, and intervention during and after the current global pandemic crisis [14]. In addition, the high prevalence of these pathologies leads to a high social and economic burden, so it is important to implement effective treatment strategies.

A recent meta-analysis concluded that person-centered care is more effective than standard healthcare for people diagnosed with depression, improving depressive symptoms and increasing the likelihood of remission [15]. In addition, he concluded that this type of care improves health-related quality of life and self-management results and decreases hospital admissions [15]. A study on late-life depression highlighted, as priority areas of research to improve health services for this clinical condition, the focus on the individual needs of the person, through patient-centered care [16]. The same study also highlighted the importance of involving informal caregivers and alternative scenarios in the care process [16]. Studies have indicated that shared decision making improves the decision-making process and the quality of healthcare in people with depression [17][18], reducing depressive symptoms in young patients [18].

Regarding anxiety disorders, little is known about the effect of person-centered care, although some studies have indicated positive results in the case of post-traumatic stress disorder [19]. Another study indicated that the cost of anxiety disorders can be reduced with greater health education, early detection, and person-centered interventions. It adds, that person-centered care planning should encourage patients to identify their strengths, preferences, and abilities to carry out activities and to focus on areas they have control over [20].

That said, it is therefore essential that health professionals carry out a timely diagnostic assessment of the person, create an appropriate care plan adapted to their characteristics and the context in which they are inserted [21], and implement person-centered healthcare. However, we did not find in the scientific literature studies that clearly define diagnostic assessment strategies, care planning, and intervention centered on people with depression and/or anxiety disorders.

2. Diagnostic Assessment

Self-assessment instruments have been inserted in the new models of healthcare to promote person-centered care, and must satisfy their needs [22]. In addition, a systematic review of the literature concluded that self-assessment and hetero-assessment tools for depression are complementary and have identical clinical results. Therefore, these must be used to assess health results [23].

Most of the studies used scales to assess a person's "depressive and/or anxious symptoms, the most used being the Patient Health Questionnaire Depression Scale" (PHQ-9) [24][25][26][27][28][29]. In fact, this scale was considered by a recent study as the best tool for evaluating the results reported by patients with depression [22]. In addition,

unlike other depression scales, the PHQ-9 includes nine items that are based on the Diagnostic and Statistics Manual for Mental Disorders, 4th Edition (DSM-IV) [30].

Regarding the assessment of anxious symptoms, only three studies used assessment scales [19][25][31]. A study of veterans with post-traumatic stress disorder used a specific scale for this anxiety disorder [32].

The quality of life was assessed in two studies [19][33]. Of note is the fact that one of the scales used focuses on functionality with regard to mental and physical health, assessing physical functioning, anxiety, depression, fatigue, sleep disturbance, social functioning, and pain interference [19]. Another study assessed the functional state of mental health [34]. Still, regarding functionality, a study assessed psychiatric functioning and distress using the Outcome Rating Scale (ORS), which is a self-assessment instrument with four dimensions: (a) Anguish or individual or symptomatic well-being; (b) anguish or interpersonal–relational well-being in intimate relationships; (c) anguish or social well-being at work/school or in the wider social domain; and (d) general sense of well-being [35]. The aforementioned literature review recommends that for the diagnostic evaluation of people with depression, tools should be used to assess symptoms and health-related quality of life [23].

Two conducted studies involved a very comprehensive diagnostic evaluation, evaluating beyond the symptomatology the perception of self-care abilities, the assessment of self-management of mental health, positive mental health, and social participation and the use of coping strategies [25]. Another of the studies assessed the care process and the characteristics of patients with major depression using the Depression Outcomes Module, psychiatric comorbidities, the acceptability of treatment with antidepressants, the perception of treatment for depression, and the state of mental and physical health and social support [29]. The assessment of patients' perception of the patient-centered care process was carried out in another study with dichotomous questions such as: "Asked about your concerns and questions?," "Told about changes you could make in your daily life that could improve depression (e.g., exercise)?," or "Given written information about depression/treatment?" [24].

Two of the studies also carried out a family assessment using the Family Assessment Device (FAD) [31] and two instruments for assessing family functionality [36]. The latter also evaluated the psychiatric symptoms of the parents [36].

In addition to the application of scales, we emphasize the fact that the diagnostic evaluation was mostly carried out by health professionals using interviews [19][29][31][34][32].

A review of the literature concluded a scarcity of studies evaluating the functionality and side effects of medication [23], despite its importance. This was equally verified in this revision. In addition, most studies, focused on the assessment of depressive and/or anxious symptoms, while studies assessing other areas such as satisfaction with the care process, quality of life, or an evaluation are still rare, despite its importance for person-centered care.

3. Care and Intervention Planning

With regard to care planning, in the studies selected in this review, it was possible to find several recommendations, many of which converged on the need to target the plan to patients and their individual conditions. An example of this is a study carried out with people with cardiac pathology and depression, whose conclusion was that interventions at the level of mood must be flexible to respond to the unique needs of each person. In addition, care planning must be personalized, identifying the problems that contribute to depression and that patients choose to work on [37]. It also appears that considering the preferences, concerns, and needs of a patient's daily life in care planning, in addition to contributing to positive results in the treatment of depression, is strongly related to satisfaction with the care provided [24]. Thus, it is recommended that there is a personalization of care, focusing on the patient's daily life. Meeting patient preferences, especially with regard to self-care and treatment, represents a criterion of quality of care [26][31][34][32][36][37][38].

Still within the scope of respect for the individuality of the person, it is recommended that patients be involved as partners in the identification of care and treatment planning objectives, taking into account the problems identified by each one [25][34][32]. In this sense, a literature review concluded that psychological support techniques, such as problem solving techniques, behavioral activation, and motivational interviews, are useful in supporting the involvement of persons with depression in their care plan in order to achieve their goals [39].

There are studies that have gone further and concluded that patient participation in decision making regarding their therapeutic plan is beneficial for the development of treatments and their results, the so-called shared decision-making process [25][31][34][32][35][37][38][40].

In this sense, one of the studies aimed to develop a strategic tool for the promotion and implementation of shared decision making in the use of antidepressants by patients with major depression. Based on the opinions of patients and doctors, six main themes were identified: Summary of treatment options; correct ways of taking medication; potential side effects of medication; sharing the case study regarding treatment options; cost of treatment options; and information from the pharmacist [40]. In addition to patient involvement were recommendations for the involvement of the caregiver/family—something highly valued and identified by patients as important [26][29][34].

Another way of involving the patient in their therapeutic process was mentioned in one of the studies included in this review that studied, in patients with diabetes and depression, the use of a technological platform for self-monitoring symptoms of depression and to alert health professionals. This study concluded that the self-monitoring system for the depressive symptoms under study has the potential to make healthcare more patient-centered by improving depression monitoring and care management, even in resource-limited settings [27].

In addition to the above, patient satisfaction should be considered when planning care for people with depression, as well as the factors that influence this satisfaction [24][29][34][41]. Regular proactive follow-up and collaborative patient-centered care were considered by people with depression to be factors of satisfaction. On the contrary, the lack of empathy and the mechanization of care delivery were factors of dissatisfaction [29][34][41]. Attending to patient satisfaction during the care process is an important indicator and is strongly related to the quality of healthcare. In 77.8% of the studies, patient satisfaction was positively related to an improvement of the clinical

results and patient safety [42]. The evidence also demonstrates a relationship between adherence to the therapeutic regime and satisfaction with the care provided, since patients tend to trust health professionals more when they are satisfied with the care process [43].

One of the studies also used a systematic patient feedback system that obtained positive results, with readmission rates below the national reference values [35]. Meanwhile, yet another study recommended carrying out a relapse prevention plan [26].

Still following the logic of patient care centrality, some studies included in their healthcare planning the improvement of health literacy through information and education [26][29][34][35].

Management of adherence to the therapeutic regimen should also be taken into account in the planning process [27][29][40]. It is important to know which strategies guarantee better adherence to the therapeutic regimen. Likewise, the management of the side effects of medicine must be considered in the planning of care provision, in order to ensure the best adherence to treatment [29][38][40].

In addition to the above, in some of the studies, we found that the management of care planning was carried out by a case manager [33][34][37][41]. Regular patient follow-up was also mentioned [29][33][41]. In this sense, one of the studies in the present review developed a complex intervention carried out by nurses based on case management and user preferences [37]. In fact, a literature review concluded that nurses play a key role in managing care for people with depression and other complex medical conditions, as they have a significant impact on depressive outcomes having been trained to see the patient as a whole [39]. Now, this approach is fundamental for the development of person-centered care plans [39]. Successful interventions by nurse case managers include regular patient follow-up, symptom registration, treatment monitoring, goal setting, and education [39]. However, these indicators were also found in some studies of the present review, as mentioned above.

There is also the recommendation of the provision of care to respect a model of collaboration in the community [26]. One of the studies focused on the provision of collaborative care, centered on persons with major depressive disorder, which were compared to the standard intervention. Although there were no differences between groups in reducing depressive symptoms, health professionals were perceived as more “participatory” in the therapeutic process and as being more useful in identifying the individual needs of each person and in promoting their adherence to treatment [34]. Also noteworthy is telemedicine-enhanced antidepressant management (a type of intervention in a stepped care model for people with depression), which substantially improved user satisfaction and perceptions that care was centered on their individual needs [29].

Regarding the treatment of post-traumatic stress disorder (PTSD), a study identified the need for treatment to address common problems such as anger, nightmares, sleep, depression, or relationship difficulties, and suggested that if trauma-focused psychotherapy does not resolve these, joint strategies should be looked into [32]. Two studies addressed the use of complementary and alternative medicine, such as yoga, meditation, tai chi, and mindfulness, considering them as care models centered on patients with PTSD [19][44].

Regarding person-centered pharmacological interventions, the relevance of antidepressants should be selected according to the individual needs of each person, and, for this, four clusters of symptoms should be considered: Anxiety, fatigue, insomnia, and pain [45]. Of note also is the fact that women in the perinatal period prefer non-pharmacological interventions rather than the use of antidepressants [31].

Patients tend to highlight the importance of empathic listening and empathic action as a vehicle to feel more understood, valued, and truly cared for [46]. Health professionals, on the contrary, tend to emphasize the importance of familiarity with the user, teamwork, and the flexibility/continuity of care, so that they are more centered on the person [26].

Despite the above, it is necessary for clinicians to consider the limitations of person-centered care for patients with depression. For example, the decision-making ability of a person with major depression or psychotic depression may be affected, limiting the provision of person-centered care. A review of the literature concluded that depression can impair decision-making skills, with appreciation being the most impaired skill [47]. As limitations of this review, we highlight the great heterogeneity of the extracted results, which makes narrative analysis difficult. In addition, the search was carried out by title, abstract, and/or keywords, given the exhaustive number of articles identified, with languages limited according to the domains of the researchers.

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