Dimension 3

Condition-Related Factors

This section covers the following topics:

- Chronic conditions
- Lack of symptoms
- Depression
- Psychotic disorders
- Mental retardation/developmental disability

CHRONIC CONDITIONS AND LACK OF SYMPTOMS

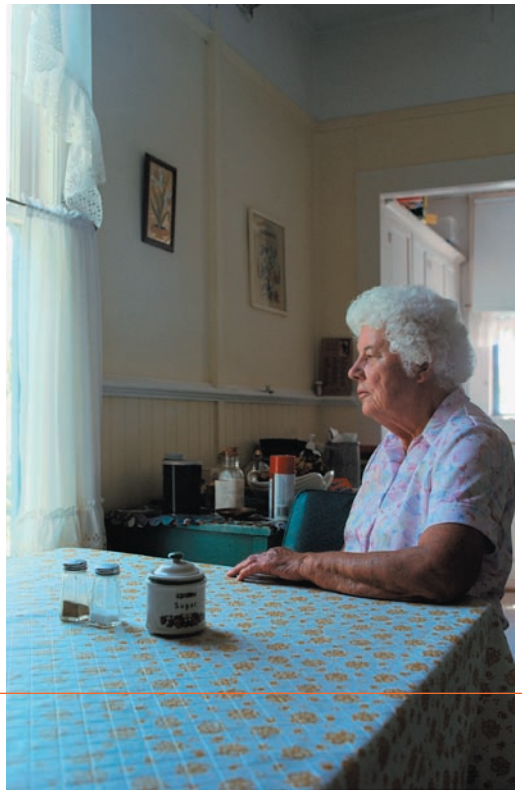
Medications have to be taken indefinitely for many chronic illnesses, and adherence to such treatment regimens often declines significantly over time (Berger et al., 2004). This is especially true for chronic illnesses that have few or no symptoms—e.g., high blood pressure, osteoporosis, and hyperlipidemia—and lack the "cues" that may remind people to take their medication. Without symptoms, a person may not be motivated to adhere to a treatment regimen. It is important that the older adult understand the illness and what will happen if it is not treated.

BARRIER	STRATEGIES
Therapy for asymptomatic conditions	Inform about disease process, importance of treatment or prevention, and consequences if not treated
Preventative therapies with no immediately discernible benefit	Reinforce benefits of prevention/treatment versus risks

Depression and psychiatric disorders are associated with poor medication adherence (Krueger et al., 2005). This discussion will be limited to depression and psychosis, and medication adherence issues associated with these conditions.

DEPRESSION

Studies show that persons with chronic illnesses who are depressed have significantly lower rates of medication adherence (Krueger et al, 2005, Appendix A). Professionals working with older adults should be aware of the effects of depression on adherence, and should evaluate older adults who appear sad or withdrawn or have unexplained physical complaints or sleeping problems to identify or rule out clinical depression (National Advisory Council on Aging, 2002).



For older adults receiving medications to treat depression, one factor that may decrease adherence is the delayed onset of action of antidepressants, which may take four weeks or longer to exert effects. Side effects are most likely to occur early in therapy, therefore the person may experience side effects prior to the relief of symptoms, which can lead to early discontinuation of therapy (Keller et al., 2002). Some people may discontinue antidepressant therapy once they begin to "feel better" (Demyttenaere, 2003). People who prematurely discontinue antidepressant therapy are at greater risk for relapse (Geddes et al., 2003).

BARRIER	STRATEGIES
Lack of knowledge regarding nature of depression	Discuss depression as a common, treatable condition Refer to depression as a medical condition
Guilt associated with diagnosis of depression	Discuss chemical basis for depression
Need for reassurance and support	Reinforce that depression is treatable Discuss appropriate duration of treatment
Lack of belief in treatment's effectiveness	Discuss efficacy of medications
Belief that treatment does not help with symptoms associated with depression	Discuss delayed onset of therapeutic effects of antidepressants
Fear of side effects	Review most common side effects Reinforce that most people do not have to stop therapy because of side effects Reassure person that over time side effects should be less of a problem
"Felt better" and stopped taking medication	Discuss the importance of an adequate duration of therapy and risk of relapse

Source: Bucci et al., 2003

PSYCHOTIC DISORDERS

Medication nonadherence is a significant problem in persons treated with antipsychotic medications; as many as one-fourth may be nonadherent (Nose et al., 2003). Nonadherence is responsible for up to 50% of hospitalizations for patients with schizophrenia (Perkins, 2002). An individual's experience with unpleasant side effects is commonly cited as a reason for discontinuing antipsychotic therapy. Newer antipsychotic agents, which have fewer movement-related side effects, may have a modest impact on improving adherence (Dolder et al., 2002; Lacro et al., 2002).

Interventions to improve adherence to antipsychotic medications are more likely to be successful if they focus on the person's attitudes and beliefs about medications, rather than focusing only on knowledge (Zygmunt et al., 2002). Compliance therapy, which combines cognitive behavioral techniques with motivational interviewing, has been shown to improve medication adherence and outcomes (Kemp et al., 1996).

BARRIER	STRATEGIES
Patient-related	Cognitive therapy Education about the illness Education about the treatment Memory aids (phone reminders, alarms) Involvement in therapeutic alliance
Physician-related	Provide information on common side effects and strategies to address Use of "patient-centered" approach Address patient's attitudes and beliefs about medications
Social/Environment-related	Involve and educate family Improve access to mental health services (case management, home visits, convenient clinic hours and locations) More attractive clinic environment Improved coordination among service providers
Treatment-related	Minimize complexity of medication regimen Titration to optimum dose Provide clear instructions on medication use Minimize impact of side effects Select medication with fewer side effects

Source: Perkins, 2002

MENTAL RETARDATION/DEVELOPMENTAL DISABILITY

A developmental disability is associated with many conditions that originate prior to birth, at birth, or in early adulthood, but the primary disability is intellectual. Developmental disability presents with varying degrees of intellectual deficiency, as well as other physical and/or sensory incapacities and health risks (National Advisory Council on Aging, 2004). As a result of progress achieved in medical science and health care, persons with developmental disabilities now have a life expectancy that extends beyond mid-life.

Older adults with developmental disabilities have the same prevalence of sensory, visual, and auditory impairments as the general older adult population; however, the degree of impairment may be more severe due to preexisting problems or undiagnosed conditions resulting from the older person's inability to clearly communicate needs. Physical changes that more severely affect older adults with a developmental disability include loss of flexibility, as age-related changes in joint function and bone density combine with their existing mobility problems; in addition, they may be more prone to arthritis at an early age (National Advisory Council on Aging, 2004). Severe physical and sensory impairments coupled with inability to clearly communicate, increase the risk of nonadherence in older adults with developmental disabilities.

Caregivers of developmentally disabled adults play a crucial role in providing emotional, functional, and instrumental support, including managing medications. Two factors have changed the role of caregiving for adults living with developmental disabilities: the deinstitutionalization movement over the past decades, and the increased longevity of developmentally disabled adults. Many parents in their eighties or nineties may find themselves caring for a developmentally disabled "child." Siblings, usually a sister, may have assumed the primary caregiving role. With this demographic change, adherence messages and support should focus on the caregiver.