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ORIGINAL ARTICLE

Attitudes to depression in hospital inpatients: a comparison between older and younger subjects

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Abstract

High rates of depression in medically ill inpatients have been reported, much of which goes unrecognized. Patients' own attitudes about seeking help and their beliefs about treatments may contribute to this. We examined the relationships between age, the presence of depressive symptoms and attitudes to depression in physically ill inpatients. One hundred and sixty patients in a district general hospital were recruited to the study and completed an Attitudes to Depression Questionnaire and a depression screening scale. Both older and younger patients showed attitudinal barriers to treatment. In addition to that, the older subjects were less willing to seek help and less likely to acknowledge depressive symptoms than the younger group. Educational interventions would seem to be warranted in increasing the self-awareness of depression in the elderly and encouraging patients to seek help more readily.

Introduction

Depression is a major cause of psychiatric morbidity, with a prevalence at any one time of around 5% (Bebbington *et al.*, 1981). It has been found that up to 50% of cases go untreated (Goldberg & Huxley, 1980). There are a number of possible explanations. Clinicians' own attitudes and beliefs about depression may influence the degree to which it is diagnosed and treated (Main *et al.*, 1993). Patients' own attitudes and perceptions of mental illness may also be important factors.

A joint initiative by the Royal Colleges of Psychiatrists and of General Practitioners, the Defeat Depression Campaign, which was launched in 1992, aimed to improve recognition and treatment of depression and enhance public awareness of its nature, cause and treatment, to encourage patients to seek help more readily, and to reduce associated stigma. An initial poll conducted by MORI regarding public attitudes to depression showed a number of misconceptions, including the belief that anti-depressants are addictive (MORI, 1992). Thus patients' own views may contribute to the under-treatment of depression. Some people suffering from depression may not only fail to identify their symptoms, but have negative attitudes towards the illness. They may also be ignorant of the treatment options and therefore be less likely to seek appropriate help.

There is a suggestion that older people are less likely to perceive major depression as a psychological or emotional problem (Hasin & Link, 1988). The hypothesis that older age is associated with a decrease in self-reported depressive symptoms was confirmed in a study by Lyness *et al.*, 1995, who, in 97 subjects with DSM-III-R major depression, compared self-reported symptoms of depression with examiner-rated symptoms. Age was not associated with examiner-rated symptoms, but showed a highly significant negative correlation with self-reported depressive symptoms; older patients having much lower rates of self-reported symptoms. A further study has shown that older informants were less likely to report episodes of major depression in their relatives (Shapiro *et al.*, 1984).

The prevalence of depression in physically ill elderly inpatients has been reported as being between 6 and 59%, depending on the instrument used, gender, age and type of ward (Ramsay *et al.*, 1991). Overall, the prevalence of affective disorder in elderly medical inpatients appears to be similar to that in comparable younger groups (Koenig *et al.*, 1992). Despite this high prevalence of depression in physically ill older people, a considerable number of patients are undiagnosed and untreated (Koenig, *et al.*, 1988; Rapp *et al.*, 1988, Walker *et al.*, 1995).

The aim of our study was to examine the presence of depressive symptoms as well as attitudes to and knowledge of depression in a group of physically ill

TABLE 1. Demographic details and depression scale scores

	Younger group	Older group
Age	18–64 yrs mean 41.4 SD 14.1	65 yrs and over mean 77.3 SD 7.8
Sex	M = 39 (48.8%) F = 41 (51.3%)	M = 34 (42.5%) F = 46 (57.5%)
Living alone	Y = 6 (7.5%) N = 74 (92.5%)	Y = 35 (43.8%) N = 45 (56.3%)
Marital status	Married 45 (56.3%) Single 20 (25%) Other 15 (18.8%)	Married 44 (55%) Widowed 31 (38.8%) Other 5 (6.3%)
Screening questionnaire scores	Goldberg range 0–9 mean 3.5 cases 26 (32.5%)	GDS range 0–14 mean 4.3 cases 24 (30%)

inpatients. Our hypothesis was that patients aged 65 years and over would be more likely to have negative attitudes to depression than younger patients. In addition we hypothesized that the presence of depressive symptoms may be associated with negative attitudes, particularly in the elderly.

Method

Subjects

Subjects were recruited from all patients over the age of 18 admitted to hospital via the Accident and Emergency (A&E) department of a district general hospital over a six-month period. The only exclusion criteria were admissions to the psychiatric wards, obstetric admissions that went directly to the labour ward, and patients deemed by nursing staff to be too ill to be approached. Admissions from other sources were not considered. The subjects were randomly selected from the A&E log book which recorded all patients seen in A&E and admitted. They were seen on the first working day following an admission.

Assessments

The subjects were approached by a doctor or a psychologist. If they consented to participate, an Attitudes to Depression Questionnaire (ADQ), adapted from that used in the MORI poll, was completed. The ADQ consists of 26 questions on aspects of depression, including its treatment, causation, help-seeking behaviour and whether the subject has ever been depressed. The ADQ has yes/no answers or a choice of agree, disagree, neither agree or disagree and don't know responses. In addition a number of demographic data were collected.

Within 24 hours of being seen, a second member of the research group, blind to the first interview, administered the following questionnaires. The 18–64-year-old group were administered the nine-item

Goldberg Depression Scale (Goldberg *et al.*, 1988), with a total score of over four indicating 'caseness'. Those aged 65 and over were administered the 15-item Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986) to assess significant depressive symptomatology. A score of five or more on GDS was the cut-off for 'caseness'.

Statistics

Statistical analysis was carried out using SPSS PC + 6.0. For the purposes of between-group comparisons, ADQ responses were condensed into two categories, agree and disagree, with the other two possible responses excluded, prior to analysis using chi-square test or Fisher's exact test where indicated.

Results

Of the 176 patients approached, 160 patients completed both interviews; 80 were aged 18–64 and 80 were 65 years and older. The other 16 patients either declined to take part ($n = 9$), or, prior to the second interview, went to theatre, deteriorated, died or had been discharged ($n = 7$).

Demographic details and scores on GDS and Goldberg depression scale are shown in Table 1.

Comparisons in ADQ responses by age

The responses of the older subjects to the ADQ were compared to those of the younger subjects. The numbers in both age groups agreeing with certain statements are shown in Table 2. All significant results are shown, together with results to questions about treatment options which are of particular interest.

Patients aged 65 and over. The older cases were less likely than older non cases to approach a spouse

TABLE 2. Comparisons in subjects agreeing with selected ADQ questions by age

ADQ questions	Older group	Younger [group]	χ^2	<i>p</i> value
Depression mainly affects women	30/62 (48%)	15/73 (21%)	10.4	< 0.002
Children are very unlikely to suffer with depression	53/66 (80%)	11/56 (20%)	42.2	< 0.0001
Elderly people are very unlikely to suffer with depression	17/69 (25%)	1/72 (1%)	15.1	< 0.0002
People with depression should be treated with antidepressant tablets	23/50 (46%)	14/40 (35%)	0.7	NS
People with depression should be offered counselling	69/73 (95%)	77/78 (98%)	0.9	NS
Antidepressants are very addictive	30/49 (61%)	32/53 (60%)	0.03	NS
If suffering with depression, I would approach no one for help	10/80 (13%)	0/80 (0%)	8.6	< 0.004
If suffering with depression, I would be happy to consult my GP	59/75 (79%)	73/76 (96%)	9.7	< 0.002
GPs are well trained to deal with depression	40/61 (66%)	17/50 (34%)	9.7	< 0.0002

NS not statistically significant

(3/24 (13%) versus 21/56 (38%); χ^2 5.0; $p < 0.03$) and were more likely to say that they would approach no one (7/24 (29%) versus 3/56 (5%); χ^2 8.7; Fisher's exact test $p < 0.007$). There was a trend for cases to be less likely to approach their GP, but this did not reach statistical significance (12/24 (50%) versus 40/56 (71%); χ^2 3.4; $p = 0.06$). Very few patients in either the cases or non cases group were willing to approach friends (1/24 (4%) versus 6/56 (11%); ns). The cases were less likely to agree that 'depression is a medical condition like any other' (17/22 (77%) versus 48/51 (94%); χ^2 4.5; $p < 0.04$) and were also less likely to agree that 'GPs are generally understanding and sympathetic towards people with depression (11/18 (61%) versus 43/50 (86%); χ^2 5.0; $p < 0.03$). However, cases were no more likely to say that they had ever suffered from depression.

The cases were further subdivided into those who admitted that they have ever suffered with depression ($n = 11$) and those who said they had never been depressed ($n = 13$). In response to a question about treatment for depression, those admitting to depression were more likely to say antidepressants were very effective than those denying depression (5/6 (83%) versus 0/9 (0%); χ^2 11.4; $p < 0.004$).

Patients aged 18–64. There were no significant differences between the cases ($n = 26$) and non cases ($n = 54$) for sex ratio or whether they lived alone. In contrast to the older cases, the younger cases were more likely to say that they had ever suffered from depression than the younger non cases 16/26 (62%) versus 11/54 (20%); χ^2 13.3; ($p < 0.0008$). There were no other significant results.

There were no significant differences between those cases admitting to depression and those cases not admitting to depression on ADQ.

Discussion

In this study we have aimed to explore the attitudes to depression and its treatment in general hospital inpatients in relation to their age, presence of depressive symptoms and self-attribution of past or current depression. Negative attitudes may contribute to low treatment rates in depressed inpatients. Depressed medical inpatients have been shown to have significantly longer hospital stays than patients who are not depressed (Ames & Tuckwell, 1994; Verbosky *et al.*, 1993; Walker *et al.*, 1995) and they also comply less well with medication (Carney *et al.*, 1995). Targeting depression in physically ill patients may be rewarding, not only in relieving symptoms, but also in improving these factors.

In keeping with other studies (Katona, 1994; Mayou & Hawton, 1986), our 160 subjects yielded a substantial number who had significant depressive symptoms. The screening questionnaires used were different in the two age groups, with a specific scale for the elderly used in the older age group. We considered it important, in view of the differences in clinical presentation of depression in old age, to use an old-age specific scale (the GDS) in the 65+ sample. For both scales the established cut-off scores for significant depressive symptomatology were used. It is, however, a limitation of the study that different scales were used to identify 'cases' in older and younger groups.

The sample consisted of patients recently admitted to hospital as emergencies and this event in itself may have provoked acute stress or adjustment reactions contributing to the high levels of depressive symptoms.

In our study, we found that in all subjects there were a number of attitudinal barriers to the treatment of depression, similar to those of the original poll and a large number in each group believed

antidepressants to be very addictive, although counselling was perceived more favourably. Our results very much support the need to improve public knowledge about depression and its treatment options.

From our findings, increased age and the presence of depressive symptoms both had a negative effect on willingness to seek help. The older group, and particularly the older cases, being less likely to approach anyone. The older group were also more likely to have negative attitudes towards consulting their GP and to believe that the elderly were unlikely to suffer from depression, highlighting the danger of older people perceiving depressive symptoms as a normal part of aging and therefore not seeking appropriate help.

Among the older age group, just over half of those identified as having significant depressive symptoms did not consider themselves as ever having been depressed. In the younger group, the number was lower, with only ten out of the 26 identified as cases stating they had never suffered with depression. The proportion of younger individuals with a mental disorder who are in treatment is higher than the corresponding proportion of older individuals. Since the first stage of entering voluntary treatment is the recognition of an emotional problem, non self-attribution in the elderly may be an important factor in under-treatment.

It is uncertain whether our findings can be generalized to other settings. A similar study in primary care using the same depression screening tools (Zeitlin *et al.*, 1997) also found that older people were less willing to seek help; but in contrast to our results, found older people no less likely to admit to having depression. They suggest involving carers as a possible strategy to reduce the reluctance that older people have to seeking help.

The elderly cases who admitted to suffering with depression were more likely to view antidepressants as very effective, with non self-attribution being associated with a more negative attitude. Early subjective reactions to treatment can predict outcome for hospital treatment for depression (Priebe, 1987). Thus public education about available options may be worthwhile. Educational interventions would also seem to be indicated to increase self-recognition of depression in the elderly and encouraging people to seek help more readily.

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