



Does psychological distress vary between younger and older adults in health and disease?

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ABSTRACT

Objective: The effect of age on psychological distress remains controversial and it is unclear how a chronic medical illness influences this association. We aimed to compare the level of psychological distress between younger and older patients with chronic medical conditions attending hospital specialty clinics and to test whether a different pattern emerges when comparisons with individuals without long-term conditions are made.

Methods: In 519 individuals without chronic medical conditions and 949 patients with established severe chronic medical illnesses, we compared psychological distress (GHQ-28 and SCL-90R) between younger (<65, N = 1040) and older (≥65, N = 428) participants after controlling for gender, marital status, education and primary diagnosis in multiple logistic regression models.

Results: Among the healthy participants, a greater proportion of older individuals presented mild/moderate psychological distress ($p = .026$), predominantly depressive and somatization symptoms. Among the medical patients, both age groups presented elevated levels of psychological distress, but a greater proportion of younger patients had severe psychological distress ($p = .016$), predominantly depressive, anxiety and hostility symptoms. Younger patients reported similarly high levels of somatization symptoms compared to older patients. The odds of being assessed with severe psychological distress were significantly greater for younger individuals with physical illnesses, independently of gender, marital status, education and primary diagnosis. **Conclusions:** Medical patients from both age groups had significant psychological distress symptoms scores. Younger patients with chronic medical illnesses were more vulnerable to severe psychological distress, including symptoms of anxiety, depression, hostility and somatization. Therefore, clinicians should direct efforts to recognize these symptoms in order to prevent further functional impairment.

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Introduction

Late adulthood is a life cycle phase that must be viewed from three perspectives: decline, change and development [1]. Despite notable inter-individual differences, old age is characterized by altered physical appearance, increased prevalence of physical illnesses, loss of friends and loved ones, as well as loss of role functioning, status and power [2–4]. Despite these occurrences, several late-life aspects can still be a source of considerable wisdom and pleasure [3]. Conceivably, individuals might, in certain circumstances, cope with these

life stressors in a more mature way protecting themselves from the development of psychological distress symptoms [5]. Therefore, there is ongoing controversy about the effects of aging on psychological distress development and whether its prevalence differs between younger and older individuals.

A review of community surveys did not elucidate a consistent pattern across studies regarding age differences in the occurrence of anxiety and/or depression [6]. The most commonly observed trend was an initial rise across age groups followed by a drop. However, there were studies showing U-shaped trends, linear increases or decreases, or no differences across age groups [6]. Such controversy persists according to recent community surveys. Some studies have shown age-related decreases in the prevalence of psychological distress [7,8]. Nevertheless, other investigations failed to confirm such

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findings [9–11]. These discrepant findings can be at least partially explained by two important factors, namely: (i) age-related bias on the measurement of psychological distress symptoms and (ii) different patterns of exposure to risk factors across age groups [6,12].

A well-known risk factor for the development of psychological distress (i.e., depression and/or anxiety) is the presence of a chronic medical condition. The prevalence rates of major depression tended to increase from 2–5% in community settings [13] to 5–10% in primary care [14], and to 6–14% among medical/surgical inpatients [15–18]. Our previous study in patients with rheumatologic diseases revealed a point prevalence of Major Depression of 25.4% [19]. Importantly, a number of studies have shown that depression and/or anxiety lead to negative outcomes in chronic medical conditions through different and interacting pathways, such as enhanced symptom burden, decreased adherence, increased disability and adversely affecting quality of life [18].

The prevalence of chronic diseases increases with age. However, age-related effects on the prevalence of psychological distress among individuals facing chronic medical conditions remain unclear. Primary care studies have shown that elderly patients had a lower probability of having a mental disorder [20]. Conversely, a recent Australian population survey found that young individuals experience a higher prevalence of psychological distress, regardless of the presence of chronic medical conditions [21]. Finally, another recent study in a representative sample of community-dwelling adults in the United States reported that although those presenting with one or more health-related disabilities were more likely to have a comorbid anxiety disorder, there were no significant differences between younger and older adults in the prevalence of mental comorbidity [22].

These findings illustrate that sampling procedures might influence the effects of age on the prevalence of mental disorders among the medically ill across different studies. Since patients with more severe disease forms receive care in hospital or specialty clinics, large-scale studies in such settings might shed more light on these inconsistencies. Although a limited number of studies in patients attending hospital specialty clinics included age as a variable possibly contributing to psychological distress development [23–25], age-related differences in psychological distress have not been well addressed in the medical outpatient population [26]. To the best of our knowledge no study has systematically investigated differences in psychological distress between younger and older patients attending hospital specialty clinics and whether different prevalence figures emerge when comparisons with people without any primary medical condition are made. These comparisons are important for planning mental health care for different age groups of patients with severe chronic physical illnesses. Therefore, the present study aims to compare psychological distress symptom scores between younger and older patients with chronic medical conditions attending hospital specialty clinics and to test whether a different pattern emerges when comparisons with people without chronic diseases are made.

Methods

Setting

The Greek health system is a mixture of public integrated, public contract and public reimbursement models, incorporating principles of different organizational patterns [27]. The public sector comprises the national health service-type system (ESY), and the social insurance system consists of a wide variety of schemes, all of which are under the jurisdiction of the Ministry of Employment and Social Protection. Access to services is based on citizenship as well as on occupational status. The ESY provides for emergency pre-hospital, primary and inpatient health care through rural surgeries, health centers and public hospitals. A gatekeeping mechanism and a referral system have not been developed as yet in Greece. Patients can choose to visit the emergency department of any public or private contracted hospital,

bypassing primary health contact points. Public hospitals are used more than private hospitals. Patients prefer to visit large university hospitals offering expensive and high-technology services. Secondary and tertiary health care is provided by ESY hospitals, other non-ESY public hospitals and private clinics. The most complex and technologically sophisticated services are offered by hospitals linked to the country's medical schools. These provide a wide range of services in addition to inpatient services: outpatient services, day care services, diagnostic services, and emergency services. A comprehensive description of the Greek healthcare system may be found in Economou [27].

Our tertiary teaching hospital is an 800-bed general hospital linked to the medical school of the University of Ioannina, and provides secondary and tertiary care for a catchment population of approximately 350,000 individuals living in the Epirus county, a mainly rural county situated in north-western Greece, which is the poorest EU county (EU convergence region) [28]. The county has a dispersed settlement structure, with a mean population density of 33/km², while frequently, geographical conditions render hospital visits from villages an arduous task. Our general teaching hospital includes specialty clinics established within the department of medicine (rheumatology, gastroenterology, oncology [reference center], nephrology, pulmonary medicine) or within the department of surgery (ophthalmology, otolaryngology) and departments of pediatrics, obstetrics and gynaecology, psychiatry or rehabilitation, supported by imaging and pathology services, and in combination with one smaller general state hospital, is jointly on-call 24 h a day. During on-call days the outpatient departments are used as accident and emergency departments.

Participants

This cross-sectional survey enrolled 1468 participants. The sample comprised 519 adults without chronic physical illnesses and 949 patients with at least one established long-term medical condition. Although it is possible that some participants in the sample with no medical conditions might have common mental disorders, the term 'healthy participants' is used from this point forward to refer to participants with no chronic physical illnesses. Healthcare workers from all departments and clinical units of the hospital, medical students attending their last semester's clinical practice, and inpatients' relatives were asked to participate in the study. Exclusion criteria were history of any chronic medical illness, and history of psychotic illness or dementia. A letter was sent to each department director, informing them about the study and asking for their permission to distribute the questionnaires in their departments. All contacted departments agreed to participate. Out of 184 invited inpatients' relatives, 159 were eligible and 135 agreed to participate (response rate: 84.9%). All 114 invited medical students were eligible and all agreed to participate (response rate: 100%). For hospital staff and administrative staff recruitment, blank questionnaires with sealed boxes for collection of responses were placed at various designated work areas in each participating unit or department. Two-hundred and twenty three hospital staff and 47 administrative staff returned the survey after an informed consent was obtained. An accurate estimation of the hospital staffs' response rate was difficult, because the number of staff who could have been contacted during the period the study took place is difficult to be estimated. Based on the hospital employment records, though, the response rate for both categories was approximately 48%.

The medical patient sample comprised consecutive patients with colorectal and breast cancer, glaucoma, rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), systemic sclerosis (SSc), primary Sjogren's syndrome (SS) and inflammatory bowel disease (IBD) attending the specialty clinics at the Oncology, Ophthalmology, Rheumatology and Gastroenterology departments of the University General Hospital of Ioannina, Greece. Exclusion criteria were inability to read and write Greek and history of psychotic illness or dementia.

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