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Depression Among the Elderly: Screening Practices and Attitudes Among Nurse Practitioners

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**SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING**

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Nurse Practitioners.

The project and the manuscript have been successfully completed and meet the standards of the School of Nursing University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Gayne Cohen

5/19/09

ADVISOR'S SIGNATURE

DATE

Toby Adelman RN, PhD

5/22/09

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Depression Among the Elderly: Screening Practices and Attitudes Among Nurse Practitioners

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Abstract

Purpose: To examine California's nurse practitioners' (NPs) screening practices and attitudes towards depression among the elderly using the Depression Attitude Questionnaire (DAQ) (Botega, Mann, Blizard, & Wilkinson, 1992).

Data sources: One hundred and fifty NPs, selected randomly from the membership of the California Association of Nurse Practitioners (CANP), were surveyed with electronic mailed questionnaires. Seventy-five (50%) self-reported surveys were completed and analyzed.

Results: The majority of NPs reported routinely screen for depression among the elderly. The majority thought that life events were not important in the development of depression, held a positive view with pharmacological and psychological treatments of depression, and felt comfortable in caring for depressed patients. However, one third of the respondents believed that it is difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder and that working with depressed patients is "heavy going". This attitude was reported predominantly in respondents who have a master's degree and worked as NPs for less than one year.

Implications: The findings indicate the need to offer educational programs for NPs with the aim of increasing the diagnostic and care management skills in regard to depression in the elderly.

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Results: The majority of NPs routinely screened for depression among the elderly. Most thought that life events were not important in the development of depression, held a positive view with pharmacological and psychological treatments of depression, and felt comfortable in caring for depressed patients. However, one third of the respondents believed that it was difficult to differentiate whether patients were presenting with unhappiness or a clinical depressive disorder and that working with depressed patients was difficult. This attitude was reported predominantly in respondents who have a master's degree and worked as NPs for less than one year.

Implications: The findings indicate the need to offer educational programs for NPs on depression in the elderly with the aim of increasing their diagnostic and care management skills.

Introduction

Depression is a common mental health problem in people aged 65 years and older. Major depression in older people living in the community ranges from less than 1 % to about 5 %, but rises to 13.5% in those who require home healthcare (Hybels, & Blazer, 2003). The World Health Organization [WHO] (2008) predicted depression to be the second leading cause of disability in 2020. Currently, depression is one of the conditions most commonly associated with suicide in the elderly (National Institute of Health [NIMH], 2007). According to Conwell (2001), up to 75% of elderly who committed suicide visited a primary care provider within a month before death. However, depression in the elderly remains widely under recognized and under diagnosed.

Literature Review

Although 40% of primary care providers routinely screen elderly patients for mental health issues, depression is often not detected (Collins, Wolfe, Fisman, Depace, & Steele, 2006; Olivera et al., 2008). The literature suggests that diagnostic difficulties related to depression occur largely in relation to two areas: patient factors and provider factors.

Patient factors

Patients are under-reporting signs and symptoms of depression. Elderly people perceive low mood, low energy, insomnia, loss of appetite, and loss of concentration as a normal part of aging (Burroughs et al, 2006). In some cultures, suffering from depression is seen as a natural part of life. In the Asian and African-American cultures, the notion of withstanding adversity without complaints leads people to perceive depressive feelings as a situation to be endured rather than a problem to be treated (Probst, Laditka, More, Harun, & Powell, 2007; Bernstein, Lee, Park, & Jyoung, 2008). This belief prevents many elderly from reporting signs and symptoms to their primary care providers, which leads to the under diagnosing of depression.

Provider factors

Detection of depressive disorders and its management mostly depends on the practitioner's personal characteristics and attitudes towards mental illness. Burroughs et al. (2006) studied primary care professionals' perspectives towards depression among the elderly and found several reasons why providers under diagnose depression. First, primary care providers perceive depression in the elderly as a normal part of aging. Some providers view depression in the elderly as part of their everyday work instead of an objective diagnostic category. They express that late life depression is justifiable, understandable, and that there is nothing they can do for this age group. This attitude towards the disorder minimizes depression screening in older adults and leads to under diagnosing the problem.

Second, the primary care providers identify limitations in their own skills and ability to manage depression in the elderly population who have multiple physical illnesses (Burroughs et al.). They express that they have no expertise in the mental health field and felt that they have inadequate training in the pharmacological management of depression. This view is particularly more prevalent among the nurse practitioners compared to the primary care physicians (Ademek, & Kaplan, 2000). Limitations in their training and skills in this area prevent primary care practitioners from initiating depression screening and treatments in the elderly.

Untreated depression is associated with significant mortality from physical illnesses (Unutzer, Patrick, Marmon, Simon, & Katon, 2002). Depressed elderly with diabetes, asthma, and hypertension have a 41% higher mortality risks compared to non-depressed elderly (Schoevers et al., 2008). Symptoms of depression are identified as a high risk factor for coronary artery disease and myocardial infarction (Ahto, Isoaho, Puolijoki, Vahlberg, & Kivela, 2007). Thus, prognosis of undetected depression in the elderly is poor (Strunk, Beekman, Haan, & Marwijk (2008).

Treatments for depression are associated with significant improvement in health-related quality of life (Sobocki et al., 2007). However, treatment will not be initiated if depression is not diagnosed or detected. Greater understanding of providers' attitudes towards depression among the elderly might help clarify why depression in this population is under detected. There were several studies conducted with physicians on attitudes towards depression (Botega, Mann, Blizard, & Wilkinson; Botega, & Silverira; Kerr, Blizard, & Mann, 1995; Mbatia, Shah, & Jenkins, 2009). One investigation was conducted with the advanced practices nurses (ANPs) in Wyoming (Burman, McCabe, & Pepper, 2005). Nurse practitioners' attitudes towards depression have received minimal attention.

Purpose

Nurse practitioners in California play an important role in health promotion and disease prevention. Screening and treating patients with uncomplicated mental health conditions such as anxiety and depression are in the NPs scope of practice (Klein, 2004). The purpose of this research study was to examine the California's nurse practitioners' screening practices and attitudes towards depression among the elderly, those aged 65 years and older. It specifically examined if the NPs in California regularly assess and screen for depression in the elderly, their comfort level in assessing for depression, and their attitudes in regard to depression measured by the Depression Attitude Questionnaire (Botega, Mann, Blizard, & Wilkinson).

The target population was NPs in California who are practicing as family nurse practitioners (FNPs), adult nurse practitioners (ANPs), and gerontology nurse practitioners (GNPs). The research focused on these NPs because they tend to practice in settings that allow exposure to elderly at risk.

Methodology

Research Sample

This study used a non-experimental, descriptive design. The target population included 150 NPs randomly selected from the membership of the California Association of Nurse Practitioners (CANP). The sample was stratified into 50 family nurse practitioners (FNPs), 50 adult nurse practitioners (ANPs), and 50 gerontology nurse practitioners (GNPs). The sample was chosen from Northern and Southern California to enhance generalization.

Procedures

Upon the University's Institutional Review Board approval, an electronically mailed packet with an implied consent and a web link containing the: 1) demographic questionnaire; 2) the screening practices questionnaire; and the 3) Depression Attitude questionnaire, were sent to the participants via email. Data were gathered electronically. Confidentiality was assured by the survey web link configured to not save the respondents' IP addresses. Three weeks were allowed for the sample to respond to the questionnaires. After three weeks, a follow up email with the survey web link was sent to the target population.

Instruments

The investigators developed the demographic and the screening practices questionnaires. The demographic questionnaire was comprised of 8 questions covering the respondent's age, gender, county of residence, ethnicity, education, time working as a NP, specialty, and employment setting. The screening practices questionnaire comprised of two questions measuring the respondent's screening practices and comfort level in assessing for depression.

The Depression Attitude Questionnaire (DAQ) was developed by a group of British researchers (Botega, Blizard, Mann, & Wilkinson). It consisted of twenty statements that measure the health care providers' knowledge and attitude towards the etiology, treatment, and management of depression. Each statement has five possible responses: strongly agree, agree,

neutral, disagree, and strongly disagree. The DAQ was first administered to a random sample of British general practitioners (Botega, Mann, Blizzard, & Wilkinson). The measure was then used in other countries, including Brazil (Botega, & Silveira) and Tanzania (Mbatia, Shah, & Jenkins).

Data analysis

Descriptive statistics were generated in frequencies and percentages for demographic characteristics, screening practices, and attitudes towards depression. Correlational analysis was used to compare relationships among specific demographic characteristics including years of clinical experience and education to some practitioners' attitudes towards depression. The categories of strongly agree and agree were collapsed into a single category of agree for the purpose of analysis. The same was repeated for the two categories of disagree.

Results

NP Demographic Characteristics

Seventy-five completed surveys were returned. The majority of the respondents were female with the reported age range from 27-67. Eighty percent were Caucasian. Sixty percent resided in Northern California and forty percent resided in Southern California. Approximately 87% were master's-prepared, with an additional 9.3% having doctorates and 4.0% holding a bachelor's degree. The majority of the respondents (46.7%) reported they have been NPs for 10 years and over with 58.7 % reported being employed in an outpatient setting. The practice specialties included 65.3% FNPs, 17.3% ANPs, and 8% GNP's (See Table 1).

Screening Practices

The majority of the respondents (66.7%) reported routinely screening for depression in patients aged 65 years and older. Of those who did not routinely screen, 50% were master's-prepared NPs who worked less than 1 year in the field. Sixty-four percent reported being

comfortable with assessing for depression in the elderly. This was more prevalent among the doctorally and master's-prepared NPs who have worked as a NP for eight or more years.

The Etiology of Depression

Some of the respondents acknowledged the role of life events in the development of depression. However, the majority (53.3%) disagreed that depressed patients are more likely to have experienced deprivation in early life. In addition, forty-five percent disagreed that the majority of depression seen in general practice originates from patients' recent misfortunes. Seventy-three percent believed that an underlying biochemical abnormality is at the basis of severe cases of depression.

Diagnosing and Categorizing Ability

One third of the respondents (33.3%) agreed that it is difficult to differentiate whether the patients are presenting with unhappiness or a depressive disorder. Forty-eight percent did not believe that it is possible to distinguish between the two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms.

Stigmatizing Attitudes and Depression

The majority (74.6%) did not believe that becoming depressed is a way that people with poor stamina deal with life difficulties. In addition, ninety-six percent disagreed that becoming depressed is a natural part of being old. Eighty-four percent disagreed that depression reflects an individual's character, which is not amenable to change.

Depression Treatment Preferences

Sixty percent of the respondents disagreed that most depressive disorders seen in general practice improve without medication. More than half believed that antidepressants usually produce a satisfactory result in the treatment of depressed patients. The majority (80%) disagreed

that psychotherapy tends to be unsuccessful with depressed patients. However, almost 50% were neutral with the statement that psychotherapy is more beneficial than antidepressants, with one third of the respondents agreeing with this statement. Although 56% of the respondents believed that psychotherapy for depressed patients should be left to a specialist, ninety-six percent agreed that the practicing NP could be a useful person to support depressed patients. The vast majority (90.6%) disagreed with the statement that there is little to be offered to those depressed patients who do not respond to help from practitioners.

Attitude to Depression Management

More than half (57.4%) of the respondents felt rewarded spending time caring for depressed patients. However, one third expressed that working with depressed patients is “heavy going” (See table 2).

Limitations

Limitations included the study design and the use of self-reported tools. In addition, the sample size was small and was drawn from a subset of members of one professional organization in one state. Variables such as the quality and amount of academic content and continuing education among the sample related to depression in the elderly might have affected the results. The wording of some of the questions posed an additional limitation. A number of respondents commented that some questions on the DAQ were unclear and needed further clarification. These factors could limit the ability to generalize the results of the study to other NPs

Discussion

This is the first study of California’s NPs’ screening practices and attitudes towards depression in patients aged 65 year and older. It found that the majority of NPs screened for depression routinely, felt that life events were not important in the development of depression,

held a positive view of pharmacological and psychological treatments of depression, and felt comfortable in caring for depressed patients.

In addition, study results found that NPs in California do not hold stigmatizing attitudes towards depression in the elderly. The findings that the majority of the respondents did not believe that becoming depressed is a way people deal with life difficulties, is a natural part of being old, and is a characteristic not amenable to change, is similar to observations among physicians in other studies (Botega, & Silveira; Mbatia, Shah, & Jenkins). This is encouraging because a stigmatizing attitude can lead to under diagnosing depression and failure to treat (Burroughs et al.).

It is concerning that one third of the respondents found difficulty in differentiating between unhappiness and a depressive disorder and almost half did not believe that it is possible to distinguish between two main groups of depression, psychological and biochemical. This can impede detection since symptoms identification is an important component in screening and assessing for depression.

The findings that NPs held positive attitudes towards depression treatments are essential in depression management. More than half of the NPs disagreed that depressive disorders seen in general practice improve without medication, and the majority agreed that antidepressants produce a satisfactory result in the treatment of depressed patients in general practice, findings consistent with observations among general practitioners in other studies (Kerr, Blizard, & Mann; Botega, & Silveira; Mbatia, Shah, & Jenkins). Their positive attitudes will encourage them to initiate treatment with depressed patients.

It is encouraging that the majority of the NPs in California working with an elderly population felt comfortable caring for depressed patients. They believed that they could be a useful person

to support depressed patients and they disagreed that depressed patients are better off with a psychiatrist, a finding inconsistent with observation of physicians in Brazil (Botega, & Silveira). In addition, they found it rewarding to work with depressed patients. However, the majority of NPs found working with depressed patients was difficult, a finding consistent with general practitioners (Kerr, Blizzard, Mann; Botega, & Silveira; Mbatia, Shah, & Jenkins).

The study findings indicate a need to strengthen educational programs and offer continuing education workshops for NPs with the aim of increasing the diagnostic and management skills in regard to depression in the elderly. Future research can focus on identifying the barriers to depression screening among the elderly and examine the most effective and efficient screening methods and treatment modalities available to NPs. Reducing the barriers will improve the quality of care among this at risk group.

Table 1

Nurse Practitioner Demographic Characteristics N = 75

<u>Characteristic</u>	<u>n</u>	<u>(%)</u>
Gender		
Female	72	97.3
Male	2	2.7
Ethnicity		
African American	1	1.3
Asian	6	8.0
Caucasian	60	80.0
Hispanic	2	2.7
Other	6	8.0
Education		
BS in nursing	3	4.0
MS in nursing	65	86.7
Doctorate	7	9.3
Length of Time Practicing (Years)		
Under 1 year	6	8.0
1-2 years	6	8.0
3-5 years	14	18.9
6-7 years	6	8.0
8-9 years	8	10.7
10 years and over	35	46.7
Specialty		
FNP/ANP	1	1.3
Family NPs	49	65.3
Adult NPs	13	17.3
Gerontology NPs	6	8.0
Other	6	8.0
Practice Setting		
Inpatient/Outpatient	2	2.7
Inpatient (Hospital)	4	5.3
Outpatient (Clinic)	44	58.7
Private Office	9	12.0
Other	17	22.7

Table 2

Nurse Practitioner's Responses to the Depression Attitude Questionnaire N = 75

	Disagree n (%)	Neutral n (%)	Agree n (%)
1. During the last 5 years, I have seen an increase in the number of patients presenting with depressive symptoms.	13 (17.3)	23 (30.7)	39 (52.0)
2. The majority of depression seen in general practice originates from patients' recent misfortunes.	34 (45.3)	19 (25.3)	22 (29.4)
3. Most depressive disorders seen in general practice improve without medication.	42 (56.0)	24 (32.0)	9 (12.0)
4. An underlying biochemical abnormality is at the basis of severe cases of depression.	5 (6.7)	15 (20.0)	55 (73.3)
5. It is difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder that needs treatment.	43 (57.4)	7 (9.3)	25 (33.3)
6. It is possible to distinguish two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms.	36 (48.0)	17 (22.7)	22 (29.3)
7. Becoming depressed is a way that people with poor stamina deal with life difficulties.	56 (74.7)	13 (17.3)	6 (8.0)
8. Depressed patients are more likely to have experienced deprivation in early life than other people .	40 (53.3)	20 (26.7)	15 (20.0)
9. I feel comfortable in dealing with depressed patients' needs.	6 (8.0)	18 (24.0)	51 (68.0)
10. Depression reflects a characteristic response in patients which is not amenable to change	63 (84.0)	8 (10.7)	4 (5.3)
11. Becoming depressed is a natural part of being old.	72 (96.0)	2 (2.7)	1 (1.3)
12. The practice nurse could be a useful person to support depressed patients.	1 (1.3)	2 (2.7)	72 (96.0)
13. Working with depressed patients is heavy going.	18 (24.0)	31 (41.3)	26 (34.7)
14. There is little to be offered to those depressed patients who do not respond to what GPs do.	68 (90.7)	4 (5.3)	3 (4.0)
15. It is rewarding to spend time looking after depressed patients.	8 (10.6)	24 (32.0)	43 (57.4)
16. Psychotherapy tends to be unsuccessful with depressed patients.	60 (80.0)	10 (13.3)	5 (6.7)
17. If depressed patients need antidepressants, they are better off with a psychiatrist than with a general practitioner.	54 (72.0)	12 (16.0)	9 (12.0)
18. Antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice.	6 (8.0)	29 (38.7)	40 (53.3)
19. Psychotherapy for depressed patients should be left to a specialist.	19 (25.4)	14 (18.6)	42 (56.0)
20. If psychotherapy were freely available, this would be more beneficial than anti-depressants for most depressed patients.	16 (21.4)	34 (45.2)	25 (33.4)

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14-May-2009

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