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**Depressed Older Patients with Death Wishes: Experimental Evidence for
Psychotherapists' Age and Health Bias**

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Abstract

Objectives: When psychotherapists encounter an older patient with depression and death wishes, especially when burdened by physical illness, they may be subject to judgmental biases. This study investigates how this group of patients with highest suicide risk may experience discrimination both on age *and* health status. **Methods:** Using a 2x2 [chronological age x physical health status] vignette design, psychotherapists (N=147) were randomly presented one of four variants of a case describing a patient with depression and death wishes (i.e., 78 years old + poor physical health; 78 years old + normal physical health; 48 years old + poor physical health; 48 years old + normal physical health). Afterwards, participants' attitudes towards the case were assessed. **Results:** In case of the hypothetical patient's old age and poor health status, participants did not underestimate the pathological significance of his death wishes, but nevertheless showed less optimistic treatment attitudes and less confidence in psychotherapeutic treatment. **Conclusions:** Psychotherapists' age bias and health bias may serve as two potentially fatal factors influencing the provision of mental health services. **Clinical Implications:** Psychotherapists may contribute to better mental health care provision of older adults with depression and the prevention of late-life suicide by increasing awareness of their age and health bias.

Keywords: ageism, age discrimination, psychotherapy, mental health, older adults, depression, death ideation, late-life suicide

Introduction

High suicide rates in late life constitute a central public health problem, especially in older men. Even in countries with overall well-functioning health care systems such as Germany, suicide rates of adults over 70 years climb up to 16/100.000 and reach over 32/100.000 among the population 85+ (Federal Statistical Office of Germany, 2019). It is estimated that up to 97% of late-life suicides are committed as a result of mental disorder - especially affective disorders - and therefore likely preventable by mental health treatment including psychotherapy (Fiske et al., 2015). At the same time, a large discrepancy exists between the proportion of older adults who are in need of mental health care and those who actually receive it (Bogner et al., 2009). This study investigates how unfavorable attitudes of psychotherapists may serve as an important, potentially fatal factor in limiting access to and adequate quality of mental health services for a group of older patients with highest suicide risk, namely older adults with depression and death wishes (i.e., thoughts of being better off dead).

There is clear meta-analytic evidence that older people with depression respond positively to psychotherapy (Cuijpers et al., 2015), and there are effective evidence-based psychotherapeutic programs even for vulnerable depressed older adults with somatic illnesses and functional limitations (Hummel et al., 2017) as well as with death ideation (Gustavson et al., 2016). Since the early publications by Robert Kastenbaum and Robert Butler in the 1960ies, preliminary research has nevertheless suggested that even younger generations of psychotherapists may be skeptical and reluctant in treating older patients in general (Bodner et al., 2018, for an overview; Kessler & Blachetta, 2018). Furthermore, despite ample evidence that death wishes in older adults are a marker of psychological distress/depression and elevated suicide risk (Rossom et al., 2018; van Orden et al., 2013) and distinct from acceptance of dying (Ohnsorge et al., 2014) and tiredness of life (Barnow et al., 2004), older patients' death wishes may additionally be

considered a normal, unchangeable and even well-thought-out phenomenon in old age in the face of experienced losses and limited future prospects.

Rather than a so-described *age bias* alone, the stereotypical attribution of negative personal characteristics (e.g. inflexible, unproductive) towards those in poor physical health may also be one factor accountable for the finding that psychotherapists are not positive, differentiated, and confident when it comes to older patients (Gekoski & Knox, 1990). Even though relevant for patients of all ages, such a *health bias* might be especially relevant for older patients in the face of increasing health problems.

The present study

Against this background, we assumed that depressed older patients with death wishes might find themselves in double-jeopardy of being exposed to devaluative attitudes and stereotypes. Specifically, we investigated how old-age cues together with poor-physical health cues in patient descriptions (in contrast to those featuring middle-age cues and a normal health status) contribute to less favorable attitudes towards patients with death wishes on part of psychotherapists, as indicated by less conviction in the treatability of the patient, a poorer prognosis with psychotherapy, less interest in treatment provision as well as less subjective treatment competence and a greater belief in pharmacotherapy. Additionally, it was assumed that psychotherapists would view symptoms in older patients and patients in poor health as more understandable and less pathological, while at the same time underestimating underlying lethal intentions. We also explored multiplicative effects of old-age cues and poor-health cues on psychotherapists' attitudes. By using an experimental vignette-based design, we followed a conventional procedure used in previous experimental research on stereotype activation (Schneider, 2004).

Methods

Sample

The sample included $N=147$ practicing Berlin-based psychological psychotherapists recruited via an online list of outpatient certified practitioners (www.therapie.de). Members of the list were contacted individually by email, while there were no inclusion/ exclusion criteria. In order to minimize potential non-response or other biases, the only information they received was that they would be asked about “general therapeutic beliefs and attitudes.” (There was no mention of psychotherapy with older/ ill patients or of ageism/ healthism.) Response rate was 14.2%. While the majority ($N= 141$) completed an online questionnaire, six participants requested a paper-pencil version. An a priori power analysis indicated that a sample size of $N= 128$ was needed for detecting a medium sized overall effect in the MANOVA with $1- \beta= 80\%$ and $\alpha=.05$. Expecting a certain number of dropouts because of missing data, we tried to recruit more participants, ending up with $N= 147$, resulting in an actual power of 88%. The average age was 42.69 years ($SD= 10.91$; range= 25 - 74), 72.8% were female. The majority were CBT therapists (73.5%), followed by psychodynamic therapists (18.4%) and therapists working with both approaches (8.2%). Average years in practice were $M= 9.58$ ($SD= 7.73$). None of the participants had undergone a special training or was working as a clinical geropsychologist.

Procedure and Design

Using a 2x2 [chronological age x physical health status] vignette design, participants received the cover story and then a naturalistic case description (see Supplementary Appendix A1). Participants were asked to imagine themselves working in a psychiatric clinic where the patient introduced himself during the anamnesis. The patient was described as displaying death wishes following the death of his wife three years ago, going along with other symptoms of depression, such as flattened affect, sleep disturbances, and rumination. Based on random assignment,

participants read one of four variants of the case description (old + poor physical health; old + normal physical health; middle-aged + poor physical health; middle-aged + normal physical health). The descriptions of the patient including his symptoms were identical with the exception that two old-age cues ('78 years old,' 'living in a senior living community') were replaced by a younger chronological age of the patient and more age neutral-cues ('48 years old,' 'living in a residential complex'). Similarly, two poor-health cues ('colon cancer'; 'physical illness is a great burden to him') was replaced by indication of normal health ('past medical history unremarkable'). The presentation of the case description was followed by several items to assess participants' attitudes towards the patient (see Measures) and a written debriefing.

Measures

Items were slightly adapted from earlier experimental research on practitioners' age bias (James & Haley, 1995; Kessler & Blachetta, 2018; Uncapher & Arian, 2000).

Patient's suicide risk. "How likely would you rate the probability of the patient attempting suicide?" (1= very low, 5= very high)

Patient's mental illness as a cause. "The patient's suicidal tendencies are caused by an underlying psychological disorder." (1= completely disagree, 5= completely agree)

Rationalization of suicidal tendencies. "It is normal for patients like the patient to have thoughts about ending their life." (1=not at all, 5=very; recoded)

Patient's motivation for psychotherapy. "How high do you think is the probability of the patient agreeing to psychotherapy?" (1= very unlikely, 5= very likely)

Patient's prognosis with psychotherapeutic treatment. "I would rate the patient's prognosis with psychotherapeutic treatment of psychological distress to be very good." (1= completely disagree, 5= completely agree)

Psychotherapists' interest in treatment provision. "I would like to accept Mr. M. as a patient." (1= not at all, 5= very)

Psychotherapists' subjective treatment competence. "I would feel competent in treating Mr. M." (1= not at all, 5= very)

Psychopharmacological treatment. "How appropriate do you consider psychopharmacological treatment (versus psychotherapeutic treatment) for the patient in contrast?" (1= not at all, 7= very)

Statistical Methods

Because we wanted to investigate the effect of the two factors (i.e., age and health status) including their interaction on the DV, we ran a multivariate general linear analysis (MANOVA). In order to analyze on which of the DVs the two factors and their interaction had a significant impact, we ran single ANOVAs.

Results

Sample characteristics

There were no significant differences between conditions with regards to age ($F(3,147) = 1.06$, $p = .367$), gender ($\chi^2(3, N=147) = 1.09$, $p = .137$), years of practice ($F(3,147) = .853$, $p = .467$), and psychotherapeutic approach ($\chi^2(3, N=147) = .239$, $p = .181$).

Manipulation and awareness check

At the end of the questionnaire, participants of all experimental groups correctly remembered the patient's age group (middle-aged, old) and the physical health status (normal, poor). None was aware of the study's purpose.

Results of the multivariate analysis

The eight dependent variables (DV) were weakly to moderately correlated. In line with our hypothesis, MANOVA results demonstrated significant multivariate main effects (with effect sizes exceeding convention for a large effect) for both age ($F(8, 136) = 4.86; p < .001; \eta^2 = .22$) and health ($F(8, 136) = 5.05; p < .001; \eta^2 = .23$) as well as a significant interaction effect ($F(8, 136) = 2.05; p = .045; \eta^2 = .11$). Applying the Bonferroni adjustment, ANOVA results demonstrated that motivation for psychotherapy, prognosis, and treatment competence turned out to be significantly influenced by participants' age while prognosis with psychotherapeutic treatment and belief in medical treatment turned out to be significantly influenced by participants' health (Table 1). Participants in the 'old-patient condition' reported a poorer prognosis, less motivation, and less subjective treatment competence than participants in the 'middle-aged patients' condition'. Participants in the 'poor-health patient condition' reported a poorer prognosis and a stronger belief in psychopharmacological treatment than participants in the 'normal-health patient' condition'. For the univariate analyses, there were no significant interaction effects.

Discussion

Despite less serious than suicidal ideation which includes thoughts about taking one's own life, death wishes in older adults with depressive episodes, such as the wish to die during sleep, to be killed in an accident, or to develop a fatal disease are high-risk clinical scenarios, particularly when patients desire to develop competencies that would hasten their death in the immediate future (Ohnsorge et al., 2014). At the same time, they allow psychotherapists a time window for clinical interventions. However, when psychotherapists encounter a depressed older patient with death wishes, especially when the patient is burdened by physical illness, they may be subject to perceptual and judgmental biases which stem from stereotypical views, regardless of the individual's actual conditions. Our results provide substantial evidence that - in contrast

to what was sometimes believed - psychotherapists do probably *not* attribute less pathological significance to distress symptoms of patients of higher ages and patients with poor physical health. This is a positive message. However, our results suggest that both ageism and 'healthism' may make psychotherapists less optimistic that an individual depressed patient with death wishes would be willing to undergo and profit from psychotherapeutic treatment in terms of mental health problems, independent of the patient's additional characteristics, particularly motivational reserve capacity (Forstmeier & Maercker, 2008) including realistic goal setting and tenacious goal pursuit. These attitudes are in line with the stereotype of the rigid and resigned old person on one hand (Kornadt et al., 2019) and devaluative thinking about people in poor health's personality on the other hand (James & Haley, 1995). As a result, older adults who regularly present with depression and death wishes in the context of chronic physical diseases may experience discrimination on more than one ground. The consequences of such *intersectional discrimination* may be fatal in suicidal ideation.

Our results also demonstrate that psychotherapists do not show a lack of interest in treating older and ill patients, but they seem to be less confident about what they have to offer them, indicated by lower subjective treatment competence (in case of older patients) and a stronger belief in psychopharmacological treatment (in case of ill patients). In addition to negative stereotypical beliefs, the latter finding might mirror real shortcomings in clinical training of psychological psychotherapists (Laidlaw & Pachana, 2009). Despite the existence of well-elaborated approaches to training psychotherapists, education modules on gerontology and on psychological interventions for chronic physical illnesses are still very limited in reality (Hinrichsen et al. 2018).

Limitations

The extent to which results extend to real-life therapeutic decision making is unclear. Whether psychotherapists' age and health bias can be generalized for patients with other psychological symptoms than depression and death wishes should be investigated by future research. Furthermore, studies of health conditions other than colon cancer and less/more severe health problems would be of interest. Future studies should investigate whether psychotherapists with special professional training in clinical geropsychology or longer work experience with older adults show more, or rather less, favorable attitudes. In addition, further research is needed to investigate whether positive aging perceptions buffer the effect of age cues on treatment attitudes.

Clinical implications

- Therapists with an increased awareness of their age bias and health bias are in a better position to avoid making biased decisions based on a patient's age and health status as opposed to his/her *individual* needs and resources.
- Psychotherapists may contribute to a better mental health care provision of older adults with depression and the prevention of late-life suicide by increasing awareness of their potential age and health bias.
- Appropriate awareness programs for generalist psychotherapists are needed.

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Disclosure Statement/ Ethics

No conflict of interest. This study follows the principles of the Declaration of Helsinki.

Informed consent was obtained by all participants. An ethical vote was not required.

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Appendix A1

The naturalistic case vignette (presented in German language) was adapted from Barnow et al. (2004). To identify the most salient old-age cues (versus middle-aged cues; **bold font**) well as poor-physical health cues (versus normal-health cues; *italic font*) within the case description, the first author of this article divided the case description into coding units (N=19, see identification marks below). A coding unit was defined to be constituted by an aspect of the case description characterizing the patient.

Twenty psychologists recruited from an inhouse training were asked to identify “those coding units in the case description that inform you that this is an old individual”, followed by the request for identifying “those coding units in case description that this an individual in poor health.” Interrater reliability was high ($\kappa=.95$).

“Mr. M. is a 78 year-old [replaced by 48 year-old] man/ who is living in his apartment in a senior living community [replaced by in a residential complex]/ since his wife died unexpectedly three years ago. During the last couple of years,/ he has undergone surgery many times because of colon cancer [replaced by Scanning the patient information sheet he has completed while waiting for the appointment, you note that his medical history is unremarkable]/. He looks pale/ and somewhat sallow/. During the conversation, he is withdrawn/, reserved/, and does not want to complain/. He is engrossed in the conversation/ and shows good affective modulation/. He has tears in his eyes as he talks about the unexpected death of his wife./ Also, his physical illness is a great burden to him, he thinks he no longer tolerates pain well [OMITTED]/. He has been suffering from severe sleeping problems/ and constant rumination for three weeks/. Also, he worries a lot about his financial situation./ He often, but not continuously, feels down-hearted./ Additionally, his former optimism has diminished./ Death is no longer a taboo./ He wants to be dead but considers himself too timid

to take his own life./ If he were going to do so, he would look for an absolutely reliable method (e.g., poison)./”

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Table 1: ANOVA results and effect sizes for the effects of the independent variables (IV) on the dependent variables (DP)

IV										
DV	Age				Health				Age*Health	
	middle	old	<i>p</i>	<i>d</i>	healthy	sick	<i>p</i>	<i>d</i>	<i>p</i>	η^2
	<i>M (SD)</i>	<i>M (SD)</i>			<i>M (SD)</i>	<i>M (SD)</i>				
Suicide risk	3.06 (.83)	3.09 (.84)	.834	.04	3.01 (.81)	3.13 (.84)	.412	.14	.224	.010
Mental illness as a cause	3.28 (.99)	3.29 (1.01)	.982	.01	3.26 (.96)	3.31 (1.04)	.820	.04	.393	.005
Suicide rational	3.75 (.75)	3.76 (.75)	.922	.02	3.68 (.75)	3.83 (.74)	.240	.20	.899	.001
Motivation for therapy	3.89 (.60)	3.41 (.77)	<.001	-.70	3.69 (.76)	3.59 (.67)	.379	-.15	.034	.031
Patient's prognosis	3.28 (.76)	2.74 (.66)	<.001	-.77	3.18 (.83)	2.83 (.65)	.003	-.48	.019	.038
Interest in treatment	3.82 (.70)	3.54 (1.09)	.079	-.30	3.76 (.81)	3.59 (1.02)	.284	-.19	.393	.005
Treatment competence	4.10 (.51)	3.61 (1.01)	<.001	-.62	3.85 (.85)	3.84 (.84)	.973	-.01	.288	.008
Psychopharmacologica l treatment	4.21 (1.67)	3.63 (1.67)	.144	.25	3.74 (1.51)	5.09 (1.57)	<.001	.89	.629	.002

Table legend: significant effects are bold (adjusted Alpha level: .05/8=.006)