# ATTITUDES AND CLINICAL PRACTICES OF PSYCHOLOGISTS WHEN TREATING THE MENTAL HEALTH OF ELDERLY PEOPLE

*Effrosyni Koutsouraki[1], Stavros Cheristanidis[2], Konstantina Athina Tsironi[3], Aikaterini Vasilaki[3], Dimitrios Michmizos[1], Theodora Papamitsou[3]*

[1] *1st Department of Neurology, Medical School, Aristotle University of Thessaloniki, Thessaloniki, Greece*
[2] *Centre for Interdisciplinary Research and Innovation - Aristotle University of Thessaloniki - Department of Physics, Aristotle University of Thessaloniki, Thessaloniki, Greece*
[3] *Faculty of Health Sciences, Medical School, Aristotle University of Thessaloniki, Thessaloniki, Greece*

**ABSTRACT**

**Aim:** Ageism intrudes into clinical assessment, leading to over/underdiagnosis of mental and neurocognitive disorders. The aim of this research was to investigate the existence of similarities or differences in the way that Greek psychologists assess an older adult's psychological problem in comparison with a younger adult's similar problem. **Method:** Questionnaires were sent by email and responses were received from a sample of 159 Greek psychologists. The instruments used were two detailed clinical vignettes of cases of women with depressive symptomatology differentiated only by age (42 years ***vs***. 72 years old), a questionnaire rating evaluative judgments regarding the symptomatology and treatment of the hypothetical patient, and a demographic characteristics questionnaire. Each of the two versions of the vignette was distributed to the participants according the double-blinded method. **Results:** Some of the results revealed prejudices of professionals in relation to the patient's age. The areas of variation were the prognosis, the aetiology of its symptomatology, and the choice of appropriate treatment for it. Regarding the other areas of clinical assessment that were investigated (diagnosis, therapeutic relationship, willingness to treat), no age biases were identified. **Conclusion:** Results indicate that age group was correlated with three important aspects of assessment.

**Keywords:** Ageism, older adults, mental health professionals

# ΣΤΑΣΕΙΣ ΚΑΙ ΚΛΙΝΙΚΗ ΠΡΑΚΤΙΚΗ ΨΥΧΟΛΟΓΩΝ ΓΙΑ ΤΗΝ ΨΥΧΙΚΗ ΥΓΕΙΑ ΗΛΙΚΙΩΜΕΝΩΝ ΑΤΟΜΩΝ

*Ευφροσύνη Κουτσουράκη[1], Σταύρος Χεριστανίδης[2], Κωνσταντίνα Αθηνά Τσιρώνη[3], Αικατερίνη Βασιλάκη[3], Δημήτριος Μιχμίζος[1], Θεοδώρα Παπαμήτσου[3]*

[1] *1ο Τμήμα Νευρολογίας, Ιατρική σχολή, Αριστοτέλειο Πανεπιστήμιο Θεσσαλονίκης, Θεσσαλονίκη*
[2] *Κέντρο Διεπιστημονικής Έρευνας και Καινοτομίας - Αριστοτέλειο Πανεπιστήμιο Θεσσαλονίκης - Τμήμα Φυσικής, Αριστοτέλειο Πανεπιστήμιο Θεσσαλονίκης, Θεσσαλονίκη*
[3] *Σχολή Επιστημών Υγείας, Ιατρική Σχολή, Αριστοτέλειο Πανεπιστήμιο Θεσσαλονίκης, Θεσσαλονίκη*

**ΠΕΡΙΛΗΨΗ**

**Σκοπός:** Έχει αποδειχθεί από την διεθνή βιβλιογραφία ότι το φαινόμενο του ηλικιακού ρατσισμού παρεισφρέει στην κλινική εκτίμηση οδηγώντας σε υπερ/υποδιάγνωση ψυχικών και γνωσιακών διαταραχών. Στόχος της παρούσας έρευνας ήταν να ανιχνεύσει την ύπαρξη ή όχι ηλικιακών προκαταλήψεων σε επαγγελματίες ψυχικής υγείας. **Μέθοδος:** Για αυτόν τον σκοπό ένα τυχαίο δείγμα ψυχολόγων έλαβε λεπτομερείς κλινικές βινιέτες περιπτώσεων μιας γυναίκας με συμπτωματολογία κατάθλιψης με μόνη διαφορά την ηλικία αυτής (42 ετών και 72 ετών). Οι συμμετέχοντες συμπλήρωσαν ένα ερωτηματολόγιο βαθμολογώντας βάσει της κλίμακας Likert επιλογές απαντήσεων σχετικά με τη συμπτωματολογία και τη θεραπεία της υποθετικής ασθενούς. **Αποτελέσματα:** Μερικά μόνο από τα αποτελέσματα φανέρωσαν προκαταλήψεις των επαγγελματιών σε σχέση με την ηλικία της ασθενούς. Οι τομείς που υπήρξε διαφοροποίηση ήταν η πρόγνωση, η αιτιολογία της συμπτωματολογίας της και η επιλογή της κατάλληλης θεραπείας για αυτήν. Αναφορικά με τους άλλους τομείς της κλινικής εκτίμησης που ερευνήθηκαν (διάγνωση, θεραπευτική σχέση, προθυμία ανάληψης) δεν εντοπίστηκαν ηλικιακές προκαταλήψεις. **Συμπέρασμα:** Περισσότερη έμφαση θα πρέπει να δοθεί στη γνω-

στική ενημερότητα των επαγγελματιών ψυχικής υγείας αναφορικά με ζητήματα ηλικιακού ρατσισμού και του τρόπου που μπορεί να αλλοιώσουν την κρίση τους.

**Λέξεις-Κλειδιά:** Ηλικιακός ρατσισμός, τρίτη ηλικία, επαγγελματίες ψυχικής υγείας

## INTRODUCTION

The increase in the elderly population has become a global phenomenon, which can have serious economic consequences and impacts on the way age groups are treated over the years.[1] Regarding the share of people aged 65 and over, Greece is in fifth place (23.0%) among European countries with the highest percentage of this age group.[2]

The term ageism was first used by Robert Butler, who described it as "the prejudice of one age group against another."[3] Research has shown that perceived ageism can affect an individual's self-image, subjective sense of age,[4] and body image.[5] Experiences of ageism throughout life can affect mood, causing symptoms of depression, anxiety,[6] and generally deteriorating a person's mental health.

The phenomenon of ageism as expressed in the attitudes of health professionals (both medical and paramedical) and mental health had not been studied in Greece. It seems that older adults are marginalised in the field of mental health despite research showing that they correspond to the group most amenable to treatment and improvement.[7] One possible reason is the negative attitudes that many psychologists hold toward this age group.[8,9] Depression is the second most common mental illness in older adults.[10,11] Mental health professionals who are not trained in geriatrics and gerontology may overdiagnose[12] or underdiagnose depression[13] due to confusion with other neurocognitive disorders. There is also unnecessary prescription of medications by physicians without consideration of potentially harmful interactions.[14,15]

The following study may be used as a starting point: James and Haley[16] were the first to examine mental health professionals' attitudes toward patients of different ages using vignettes. Other researchers studied different mental illnesses in a similar way,[17] assessing how professionals evaluate two age groups. In Australia, Helmes and Gee[18] presented hypothetical patient cases to psychologists and counsellors, and found that older patients were more often assessed with worse prognosis, had poorer expected therapeutic alliance, and were considered less suitable for their ascribed treatment compared to younger patients with identical symptoms. The present study is the first to examine similar biases among psychologists in Greece using vignettes.

## METHODS

### *Sample*

The study included 159 participants (22–74 years old), of whom 79 completed the questionnaire with the older woman and 80 with the younger woman. Women constituted 84.3% of the sample, and 15.7% were men. The mean age was 33.18 years (SD 10.4). Regarding education, 41.5% reported a university degree, and 57.9% reported postgraduate education.

### Vignette

The vignette used was designed by James and Haley.[16] It described a woman presenting with loss of interest in activities, early-morning awakening, and weight loss. The two versions differed only in the client's age (42 vs. 72 years old). Questions examined potential professional biases regarding diagnosis, therapeutic relationship, prognosis, intention to take on the client, and perceived competence. Responses were given on a 4-point Likert scale.[19] Participants completed informed consent and demographics beforehand. The questionnaire consisted of eight questions examining: diagnosis ("According to your first impression, which diagnosis would you assign to this patient?"), prognosis ("In your opinion, what would be the prognosis for this patient?"), therapeutic relationship ("Based on your judgment, how would you evaluate this patient's ability to form a therapeutic relationship?"), therapist competence ("To what extent do you think you are able to take on this patient given your current level of experience?"), intention to take on the client ("How would you rate your willingness to take on this patient?"), perceived treatment benefit ("To what extent do you think patients with these characteristics would benefit from treatment?"), treatment choice ("Please select, at your discretion, the most appropriate treatment option for this specific case."), and symptom aetiology ("How likely do you consider the patient's complaints to stem from an organic mental disorder—such as delirium or amnestic disorders—or from an underlying physical illness?").

### *Design*

This research has the approval of the Research Ethics and Ethics Committee. Psychologists from across Greece completed the questionnaires remotely via an electronic form. A double-blind distribution method randomly assigned one of the two versions.

**Table 1.** Demographic characteristics.

| Client age | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 42 years | | | | 72 years | | | |
| | N | Mean | SD | Percent | N | Mean | SD | Percent |
| Age | 80 | 32.5 | 10.5 | - | 78 | 33.8 | 10.3 | - |
| Sex | 80 | - | - | | 79 | - | - | |
| Female | 69 | - | - | 86.3 | 65 | - | - | 82.3 |
| Male | 11 | - | - | 13.8 | 14 | | | 17.7 |
| Level of education | 80 | - | - | | 78 | - | - | |
| Bachelor's Degree | 34 | - | - | 42.5 | 32 | - | - | 41.0 |
| Master's Degree | 46 | - | - | 57.5 | 46 | - | - | 59.0 |

Participants were informed about anonymity, voluntary participation, and exclusive research use of their data. Their responses were automatically sent to the research team.

### *Statistical Analysis*

After data collection, analysis was done using SPSS. Independence and correlation tests were conducted, with the client's age group as the independent variable and diagnosis, prognosis, treatment choice, therapeutic relationship, willingness to take on the case, and symptom aetiology as dependent variables.

## RESULTS

### *Correlation of age group with prognosis, treatment choice, and aetiology*

Age was significantly correlated with prognosis, with older patients receiving worse prognoses ($p = .009$). The patient's age also significantly affected treatment choice ($x\text{Ç} = 7.6$, $p = .006$), confirmed by the Likelihood Ratio ($p = .006$). The Cochran–Mantel–Haenszel Test showed an Odds Ratio of 2.56 ($p = .009$), meaning professionals were 2.56 times more likely to choose combined treatment for older adults.

Professionals were also more likely to attribute symptoms to organic causes in older adults, whereas symptoms in middle-aged adults were more often attributed to psychological causes ($x\text{Ç} = 9.1$, $p = .01$), again supported by the Likelihood Ratio ($p = .01$).

### *Association of age with diagnosis, therapeutic relationship, and willingness to take the case*

Differences in diagnosis between age groups were not statistically significant ($p = .29$). Likewise, the ability to form a therapeutic relationship showed no significant age effect ($p = .09$), although some trends appeared. Willingness to take on the case also showed no significant difference ($p = .693$).

## DISCUSSION

This study examined the influence of age on Greek psychologists' evaluations of two identical depressive vignettes. Consistent with expectations based on ageism theory, age affected some aspects of clinical judgment.

The older patient was associated with a worse prognosis, consistent with prejudices about limited mental recovery in older age or genuine clinical challenges.[16–18] This judgment may reflect beliefs about limited change in later life[9,20] or assumptions about proximity to end of life.[20]

Age also influenced treatment decisions. Combined therapy was selected more often for the older patient, whereas psychotherapy alone was preferred for the younger patient. Although evidence suggests combined therapy may be beneficial for older adults,[11] this pattern may reflect assumptions that elderly individuals are more resistant to change[20,22] or that pharmacotherapy is more necessary or effective at older ages.[21] Additionally, older adults often seek help first from physicians, who may more easily prescribe antidepressants.[15]

Age also influenced symptom attribution, with older adults' symptoms more often considered organic in origin.[16] This misattribution may contribute to the underdiagnosis of depression in older adults,[13] and the belief that depression is a natural consequence of aging.[20,22]

No significant age effects emerged regarding diagnosis, therapeutic relationship, or willingness to take the case, diverging from previous studies.[16–18] Cultural factors, sample characteristics, or increased

awareness of ageism since earlier decades may explain the discrepancy.

The findings of the present study highlight the added value of incorporating standardized and validated assessment scales into the clinical evaluation of depressive symptomatology, particularly in older adults. Reliance solely on unstructured clinical judgment may increase vulnerability to implicit age-related biases, potentially influencing prognosis estimation, symptom attribution, and treatment planning. Structured assessment tools provide operationalized criteria that can improve diagnostic accuracy and reduce subjectivity in clinical decision-making.[23,24]

Several depression rating scales have demonstrated strong psychometric properties and clinical utility across age groups. Instruments such as the Hamilton Depression Rating Scale (HAM-D), the Montgomery–Åsberg Depression Rating Scale (MADRS), and the Cornell Scale for Depression in Dementia (CSDD) are widely used in both clinical and research contexts and allow for a more nuanced evaluation of symptom severity, course, and treatment response.[25-27] Importantly, the CSDD was specifically developed for use in older adults, including individuals with cognitive impairment, and integrates information from both patient interviews and informant reports, thereby enhancing diagnostic validity in complex geriatric populations.[27,28]

Several limitations of the present study should be considered. First, the vignette-based methodology, while effective in isolating attitudinal variables, may not fully capture the complexity of real-life clinical encounters, including nonverbal communication and therapeutic dynamics.[31]

Second, the cross-sectional design of the study precludes causal inferences regarding the relationship between patient age and clinical judgment. Longitudinal designs could provide further insight into how professional attitudes evolve over time or in response to targeted educational interventions.[32]

Third, although the use of a forced-choice 4-point Likert scale was intended to reduce neutral responding, this format may have limited response variability and sensitivity to subtle attitudinal differences.[33]

## CONCLUSION

Ageism has not been sufficiently studied in Greece. This research may serve as a starting point for further investigation. Future studies might incorporate qualitative methods, examine professional demographics such as experience, and continue raising awareness regarding ageism in clinical judgment. The findings highlight the importance of specialised training in geriatric psychology and psychogeriatrics.

## CONFLICT OF INTEREST

The authors declare no conflicts of interest.

## REFERENCES

[1] Lamnisos D, Giannakou K, Jakovljevic M. Demographic forecasting of population aging in Greece and Cyprus. Health Res Policy Syst. 2021;19(1).
[2] European Commission. The 2021 Ageing Report. 2021.
[3] Butler RN. Age-ism: another form of bigotry. Gerontologist. 1969;9(4):243-6.
[4] Hess M, Dikken J. The association between ageism and subjective age. Int J Soc Sci Humanit Stud. 2010;2(1):99-109.
[5] Ward R, Holland C. "If I look old, I will be treated old." Ageing Soc. 2011;31(2):288-307.
[6] Vogt Yuan AS. Perceived age discrimination and mental health. Soc Forces. 2007;86(1):291-311.
[7] Tegeler C, Beyer AK, Hoppmann F, et al. Psychotherapy for vulnerable older adults. Z Gerontol Geriatr. 2020;53(8):721-7.
[8] Dix E, Van Dyck L, Adeyemo S, et al. Ageism in mental health. Curr Psychiatry Rep. 2024 Nov;26(11):583-90.
[9] Lee KM, Volans PJ, Gregory N. Attitudes toward psychotherapy with older people. Aging Ment Health. 2003;7(2):133-41.
[10] Panza F, Frisardi V, Capurso C, et al. Late-life depression and cognitive decline. Am J Geriatr Psychiatry. 2010;18(2):98-116.
[11] Wang SC, Yokoyama JS, Tzeng N-S, et al. Treatment-resistant depression in elderly. Prog Brain Res. 2023:25-53.
[12] Bodner E, Palgi Y, Wyman MF. Ageism in mental health assessment. In: International Perspectives on Aging. 2018:241-62.
[13] Burns A, Jolley D. Pseudodementia: history and management. In: Troublesome Disguises. Wiley-Blackwell; 2015:218-30.
[14] Duerden M, Payne R. Polypharmacy: what is it and how common? Prescriber. 2014;25(21):44-7.
[15] Lerner Y, Levinson D. Who gets mental health treatment from GPs? Fam Pract. 2012;29(5):561-6.
[16] James JW, Haley WE. Age and health bias in clinical psychologists. Psychol Aging. 1995;10(4):610-6.
[17] Ray DC, McKinney KA, Ford CV. Differences in ratings of older and younger clients. Gerontologist. 1987;27(1):82-6.
[18] Helmes E, Gee S. Attitudes of Australian therapists toward older clients. Educ Gerontol. 2003;29(8):657-70.
[19] Likert R. A technique for the measurement of

attitudes. Arch Psychol. 1932;22(140):1-55.
[20] Laidlaw K, Pachana NA. Aging, mental health, and demographic change. Prof Psychol Res Pract. 2009;40(6):601-8.
[21] Grover S, Mehra A, Chakrabarti S, Avasthi A. Attitude toward psychotropic medications. J Geriatr Ment Health. 2019;6(2):38-45.
[22] Taylor WD. Depression in the elderly. N Engl J Med. 2014;371(13):1228-36.
[23] Spitzer RL, Williams JBW, Kroenke K, et al. Utility of a structured clinical interview for diagnosing depressive disorders. Arch Gen Psychiatry. 1994;51(8):593-602.
[24] Garb HN. Clinical judgment and decision making. Annu Rev Clin Psychol. 2005;1:67-89.
[25] Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry. 1960;23(1):56-62.
[26] Montgomery SA, Åsberg M. A new depression scale designed to be sensitive to change. Br J Psychiatry. 1979;134:382-9.
[27] Alexopoulos GS, Abrams RC, Young RC, Shamoian CA. Cornell Scale for Depression in Dementia. Biol Psychiatry. 1988;23(3):271-84.
[28] Alexopoulos GS. The Cornell Scale for Depression in Dementia: administration and scoring. Int Psychogeriatr. 2002;14(4):447-53.
[29] Fiske A, Wetherell JL, Gatz M. Depression in older adults. Annu Rev Clin Psychol. 2009;5:63-389.
[30] Conner KO, Copeland VC, Grote NK, et al. Mental health treatment seeking among older adults. Am J Geriatr Psychiatry. 2010;18(7):531-43.
[31] Evans SC, Roberts MC, Keeley JW, et al. Vignette methodologies in clinical psychology research. Clin Psychol Rev. 2015;36:1-13.
[32] Twenge JM, Campbell WK. Generational differences in psychological traits. J Pers Soc Psychol. 2008;95(4):918-34.
[33] Garland R. The mid-point on a rating scale: is it desirable? Marketing Bulletin. 1991;2:66-70.
[34] Karel MJ, Gatz M, Smyer MA. Aging and mental health in clinical psychology training. Am Psychol. 2012;67(3):184-95.