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'Justifiable depression': how primary care professionals and patients view late-life depression? a qualitative study

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Background. Depression is the commonest mental health problem in elderly people and continues to be underdiagnosed and undertreated.

Aim. To explore the ways that primary care professionals and patients view the causes and management of late-life depression.

Design. A qualitative study using semistructured interviews.

Setting. One Primary Care Trust in North West England.

Participants. Fifteen primary care practitioners comprising nine GPs, three practice nurses, two district nurses and one community nurse; twenty patients who were over the age of 60 and who were participating in a feasibility study of a new model of care for late-life depression [PRIDE Trial: PRimary care Intervention for Depression in the Elderly (a feasibility study in Central Manchester funded by the Department of Health)].

Results. Primary care practitioners conceptualized late-life depression as a problem of their everyday work, rather than as an objective diagnostic category. They described depression as part of a spectrum including loneliness, lack of social network, reduction in function and viewed depression as 'understandable' and 'justifiable'. This view was shared by patients. Therapeutic nihilism, the feeling that nothing could be done for this group of patients, was a feature of all primary care professionals' interviews. Patients' views were characterized by passivity and limited expectations of treatment. Depression was not viewed as a legitimate illness to be taken to the GP. Primary care professionals recognized that managing late-life depression did fall within their remit, but identified limitations in their own skills and capabilities in this area, as well as a lack of other resources to which they could refer patients.

Conclusion. This study highlights the complicated nature of the diagnosis and management of late-life depression. Protocols for the diagnosis and treatment of depression emphasis the biomedical model which does not fit with the everyday experience of GPs or elderly patients who share the views of primary care professionals that depression is a consequence of social and contextual issues. There is a need for the development of evidence-based provision for older people with depression within primary care, but also a need for elderly patients to be made aware of the legitimacy of presenting low mood and misery to their primary care professional.

Keywords. Depression, elderly, primary care.

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Introduction

Depression is predicted to be the most common illness associated with negative impact and disease burden by 2020.[1] It affects about 1 in 10 people over 65,[2] making it the most common mental health disorder of later life, and it can affect 5–15% of older adults who visit a primary care provider.[3] Depression can become a chronic or recurrent problem for up to 50% of affected older adults,[4] particularly in older adults with poor physical health.[5] Depression in later life is responsible for tremendous individual suffering, functional impairment and losses in health-related quality of life.[6] Depression can also affect health behaviours such as adherence to medical treatments[7] and increased mortality from physical illnesses.[8] Most patients with depression are managed in primary care with the GP being the responsible clinician for 90–95% of patients.[9]

There is evidence to show that there are effective physical,[10] psychological[11] and psychosocial[12] interventions for late-life depression, but these have yet to be adopted in primary care[13] where research continues to highlight low levels of detection and treatment.[14] Primary care is currently organized to care for acute medical problems and less well equipped to manage chronic problems such as late-life depression.[15] The value of UK primary care is that it could deal with patients with multiple morbidities in an effective way[16] and the nGMS. Contract offers the potential to develop improved services for patients with chronic diseases.[17]

The literature suggests that diagnostic difficulties of depression in later life occur largely in relation to four areas.

Patient factors

When depressed, older adults may complain less of depressed mood and present somatic symptoms which may not be identified by the clinician.[18,19] Physical co-morbidity may also make the interpretation of depressive symptoms difficult. Depressed patients may appear demented, and patients with early dementia may present with depression.[20] Older adults may have beliefs that prevent them from seeking help for depression such as a fear of stigmatization, or that antidepressant medication is addictive,[21] or they may misattribute symptoms of major depression for 'old age', ill health[22] or grief.[23] Although depression is more frequent in women, differential reporting of symptoms may lead to depression being underdiagnosed in men.[23]

Practitioner factors

Primary care practitioners may lack the necessary consultation skills or confidence to correctly diagnose late-life depression. They may be wary of opening a 'Pandora's box' in time-limited consultations and instead collude with the patient in what has been called 'therapeutic nihilism'.[24] In deprived areas primary care physicians have been shown to view depression as a normal response to difficult circumstances, illnesses or life events[25] and depression may be underdiagnosed because of dissatisfaction with the types of treatment that can be offered, especially a lack of availability of psychological interventions.[25] The patient–practitioner relationship is important in influencing the diagnosis and management of an illness such as depression.[26]

Organizational factors

The trend in the UK for mental health services to be 'carved out' from mainstream medical services may disadvantage older depressed people who may have difficulties in attending different sites for mental and physical disorders.[27] New contractual arrangements for primary care provide no new incentives to offer re-configured services for older people with depression.[28,29]

Societal factors

Unlike sex, race and disability discrimination, no law exists as yet in the UK to prevent age discrimination. The National Service Framework (Older People)[30] has as its first standard the rooting out of age discrimination, but little is known about the efficacy or implementation of the NSFOP at local level. The barriers described are likely to be particularly difficult for economically poor and minority populations who tend to have more ill health and are more disabled.[31]

There is increasing evidence that a collaborative care approach may be effective in the management of late-life depression.[32] This paper reports the results of qualitative work embedded within a feasibility study (the PRIDE trial)*, of a complex intervention (a simple psychosocial intervention, with an emphasis on developing strategies for self-care, medicines management and close liaison between primary care teams and secondary care old age community mental health teams) for the management of late-life depression in one Primary Care Trust (PCT).

This paper explores the ways that primary care professionals frame their ideas about depression in their elderly patients, and also the way that elderly people view depression as a problem and their views on help-seeking. We report the views of health professionals on current management strategies used and barriers to the effective management of late-life depression from both health professional and patient perspective, exploring the subjectivities and experiences of the health professionals and patients, and how this may impact on patient care.

*Primary care Intervention for Depression in the Elderly (a feasibility study in Central Manchester funded by the Department of Health)

Methods

This study was approved by Local Research Ethics Committee and within the PCT Research Governance Framework.

GPs, Practice Nurse (PNs) and District Nurses (DNs) within the one PCT were invited to participate in semistructured interviews. The sample was initially purposive to ensure that health professionals from a variety of practices and nursing teams were sampled. As the work progressed, health care professionals who were active in referring to the study and those who did not refer to the trial were invited to be interviewed. All those who were approached agreed to be interviewed and most of them expressed an interest in mental health issues in primary care. The interviews were conducted between October 2003 and May 2004, just before, at the start of, and 3 months into the trial. The respondents consented to take part in an interview which consisted of open-ended questions exploring their views on the aetiology and diagnosis depression in later life, and the management approaches they used.

Interviews with health professionals were carried out by authors HB and CCG either at the health professionals' place of work or in the researcher's office. Interviews were audio-taped with consent, and transcribed verbatim.

Patients were recruited from the group of patients referred into the PRIDE trial [PRimary care Intervention for Depression in the Elderly (a feasibility study in Central Manchester funded by the Department of Health)]. The criteria for inclusion in the trial was for the patient to be aged 60 or over and to have a diagnosis of mild to moderate depression demonstrated by a score of 5 or above on the Geriatric Depression Scale (GDS 15). The patients were purposively sampled to ensure that the sample contained of a mix of male and females, older and younger patients within the age range (>60 years), and usually had physical co-morbidity. The patients who participated in the trial were no different from the group that declined to participate. The sample interviewed was no different from the larger group in the trial. Later in the qualitative work, we purposively sampled to ensure we had patients whose depression had improved and those who had not. Patients were invited to participate in a semistructured interview, which lasted about an hour and were conducted by HB or CCG, in the patients' homes. The interviews were audio-taped, transcribed and analysed using the same methods employed for the health professionals' interviews.

Transcripts formed the material for analysis using Constant Comparison[33] in which thematic categories were identified in subjects' accounts. These themes were then pursued on a developmental basis through the course of the study, with the interview being modified in the light of emerging themes. Interpretation and coding of data were undertaken by the main authors (HB and CCG): the transcripts were coded individually, then through discussion to achieve agreement on interpretation of the data. The qualitative data analysis package N-Vivo[34] was also used to manage and arrange the data.

Results

This paper presents the data and analysis of interviews with 15 primary care professionals (9 GPs, 3 PNs, 2 DNs and 1 community nurse, CN), and 20 patients who had been referred to the PRIDE trial. The themes that will be presented in this paper are the major themes identified in the data: the aetiology of depression, negotiating the diagnosis and the management of a patient with depression in primary care. In addition how health care professionals view each other and how this may influence patient care, an important theme not included as an *a priori* theme, will be discussed.

Aetiology of depression

Primary care professionals conceptualized late-life depression as a problem of their everyday work, rather than as an objective diagnostic category. GPs described depression as part of a spectrum including loneliness, lack of social network, reduction in function and very much saw depression as 'understandable' and 'justifiable':

> ''our local population often have quite good reasons to be dissatisfied with life, so it's a normal response to a situation rather than a sign of pathology''. GP5

Some GPs questioned whether depression was actually a separate clinical entity:

> ''...I wonder whether actually we've got... patients being treated for depression... as a way of medicalising their discontent''. GP4

Nurses similarly saw depression as an understandable reaction to ageing, reduction in function and disability. They seemed to normalize patients' distress or want to treat it as a separate (mental health) problem and then refer the patient onto someone else to manage the problem. There was a tension between nurses' knowledge of depression as a clinical condition and their perception as a social or existential problem:

> ''I think it's probably loneliness, 'cos they don't have much family around... and their partner's gone... and they don't have anywhere to go''. PN 2

> ''sometimes I think people are depressed because that's where their life is at that time . . . So So I think there's almost an acceptance sometimes that it's justifiable depression, it's, you know, there are reasons for it''. CN

This view of depression as understandable and justifiable is echoed by the patients' descriptions of their problem:

> ''And the way I was, my worries, the things that had happened last year, the do with me back. And me leg, then the robbery. You know. As I say it's knocked me for six kind of thing''. ID41

Both clinicians and patients tend to move away from the boundaries of medicalization through their recognition of the social context of depressed patients', or their own, lives.

This, however, leads to problems when attempting to make a clinical diagnosis of depression and offer treatment within the biomedical model offered by the health service.

Making the diagnosis

GPs described how they experienced the identification of psychological problems in elderly people to contrast with that in younger patients who were seen to be more forthright in their presentation of depression:

> ''you come to know the patient over a period of time . . . you're talking about things in general . . . in contrast with younger people who come in and present their depression''. GP7.
>
> ''The older generation, [presenting with depression] it's not something that they do, it's not something, they admit to themselves. It's not something that they allow [to] happen to them . . . contrasting the sort of the teens, 20s generation, they're very much geared up to being depressed and being treated for it and I wonder whether actually we've got an awful lot of skew of what's really just people being unhappy with their life and it's actually they're no more depressed than I am, that are being treated for depression as a way of medicalising their discontent''. GP4

This reluctance of elderly people to present with depressive symptoms was confirmed in the patient interviews, in which reluctance to share their distress with primary care professionals was described, but mainly due to a feeling that nothing could be done for them:

> Interviewer: Can I ask why you don't tell him [*the GP*] about your nerves?
>
> Respondent: I don't want to bother him.
>
> I: Sorry?
>
> R: He's busy enough.
>
> I: But you are quite upset, do you think he might help?
>
> R: No, what can he do?
>
> ID46

Health care professionals should be aware of cues indicating psychological distress, and it perhaps use more formal schedules to assist them in making a diagnosis of depression. None of the respondents reported using such schedules:

> ''Tick-boxing doesn't seem to work with the elderly . . . I have my own kind of mental ways in finding out if people are depressed . . . these [assessment schedules] . . . are only a way in. I think it's more . . . maybe I overcomplicate it but I think it's more subtle than it seems. You can't deduce management from answers to those questions. Well I don't think you can''. GP3

GPs seemed to have adopted their own routine and style of questioning. GPs described the use of intuition and a 'gut feeling' (GP5), yet recognized that making the diagnosis was difficult. They all linked managing elderly people with low mood to managing uncertainty, which was part of their everyday work. Most of the GPs reported diagnosing depression by placing the symptoms in the context of what they knew about that particular patient's life. Diagnostic scales were said to exclude these contextual clues.

Other patients described the potential value of an ongoing relationship in allowing the GP to be alert to the patient's feelings:

> ''. . . my doctor knew, he knows me inside out. He knew immediately. He's a lovely doctor''. ID48

This patient described the importance of the personal relationship with their doctor, which might aid at least a discussion of feelings.

Nurses described similar difficulties in making the diagnosis of depression, but for different reasons. DNs reported spending inadequate time with the patient to allow them to make the diagnosis of depression and PNs recognized that while the over-75 health check offered a potential opportunity for screening for depression, in reality this did not happen:

> ''But no, there's very little about depression in it, but that doesn't mean to say that there needn't be''. PN1.

All clinicians described difficulties in negotiating a diagnosis of depression with a patient. GPs suggested that even if depression was suspected and felt to be a problem by the health professional, it was hard to 'sell' this diagnosis to the patient:

> ''. . . and in the elderly you can't say to them 'Are you depressed?' because only weaklings get

depressed and they'll never say yes to that question. It's the wrong question''. GP3

GPs perceived a reluctance on the part of their elderly patients to accept depression as a diagnosis, and that felt that depression still carries a stigma in this age group.

Health care professionals described the added influence of ethnicity and culture on the presentation of depression in elderly people:

''... and they [*ethnic minority patients*] come in with total body pain...''. GP2

GPs described how this added to the difficulties in negotiating the diagnosis and subsequent discussion about treatment:

''Sometimes I will ask them how their spirits are but they think that you're saying that it's all in their head and you don't believe them. If you mention that they might be depressed they say, 'But what about my bad arm?'''. GP9

In order to overcome these problems, GPs reported referring to depression as 'loneliness' or 'homesickness', particularly in patients of south Asian origin, in an effort to try to persuade a patient both of the diagnosis and to take an antidepressant.

This extra difficulty in diagnosing depression in elderly people of different cultures is well documented[35] and it is said that depression may be a specifically Western concept which is not necessarily analogous to descriptions of sadness from other cultures.

Management of late-life depression in primary care

GPs described the ideal management of patients with depression, but went on to describe barriers that made it difficult for them to provide this care for their elderly patients. Only a minority of GPs described feeling comfortable managing an elderly person with depression themselves, and described investing time and effort into supporting patients:

''I visited him every week for a bit, which is very unusual''. GP3.

The majority of health care professionals described a reluctance to make the diagnosis of depression in an elderly person because of a feeling that they had nothing to offer the patient:

''I think you're probably reluctant to go looking for the diagnosis...if it's presented then it's a lot easier...but unlikely to go looking for it... I would feel. If there isn't a huge amount of support for following it up, and often there isn't''. GP4

''It's unfair to start delving and then say, 'Right fine. We've found that out [*that you're depressed*] but [there's] nothing we can do...You do have a tendency not to think about it too much''. PN3

Reluctance on the part of the GP to prescribe antidepressants because of poly-pharmacy was commonly reported: and described concerns over the side-effects of antidepressants in this age group:

''I've used fluoxetine, but again they get very agitated and it can be a bit disturbing to elderly people''. GP8.

In addition, GPs described uncertainty over the effectiveness of antidepressants, not based on evidence, but on their own experience and many GPs described structural or systematic factors in the practice that limited monitoring of patients on antidepressants:

''... what actually happens is there's a sort of general collusion or inaction, people just stay on antidepressants forever, without getting better. And don't change and nothing happens except they're on more treatment and the NHS is paying for more drugs''. GP 6.

Perceptions of patient resistance to the use of antidepressants was mentioned in most GP accounts, and strategies to get around this described:

''... we're sort of saying, you know, this might help with your pains, and you're not sleeping very well, and take it at night ...''. GP7

Our sample of patients were participants in a trial for late-life depression, so were likely to be those patients who did not find the label of depression to be stigmatizing, although most did not use the term 'depression' in the interviews, but euphemisms such as 'my nerves' or 'being sad'. Their views on the use of antidepressants echoed the concerns expressed by the GPs, that with so many other things being wrong in their life, what difference could a tablet make:

Respondent: No, I don't want tablets, they can't be right.
Interviewer: What bothers you about tablets?
R: Well I take them for my blood pressure.
I: And are they OK?
R: Yes.
I: So what do you think stops you taking them for depression?
R: Not sure really.
Daughter: Well he wanted to give you prozac, didn't he? That's no good, she just needs her eyes sorting.
I: So what can Dr Y do for you and your nerves?
P: Nothing except get my eyes sorted.
ID 46

Patients viewed the treatment of depression in much broader terms than taking tablets, often suggesting that improved symptom control of physical illness or a change in their social situation (moving house or different neighbours) would solve their problem of feeling sad.

When discussing alternatives to medication, clinicians consistently referred to a lack of statutory agencies available to refer elderly patients on to and some GPs also admitted to managing elderly people with depression differently to younger adults, either due to simply forgetting about talking therapies or because of an assumption that they will not work in the elderly:

> ''We don't have a counsellor attached... Psychology? In the elderly I have to confess I probably... virtually never do''. GP7.

Respondents described referring patients to voluntary agencies, but perceived patient reluctance to use them:

> ''It's like a vicious circle once they get depressed they won't go to a lunch club. By the time they come to us they don't want to go anywhere like that''. GP2

Some GPs were not sure how to access voluntary services:

> ''I don't know any way of getting elderly people into the whole day centre system other than through elderly care CPNs. I actually don't know how you organize it''. GP6

Thus, primary care professionals perceived their own skills to be limited, that their time was limited and the resources in primary care perceived to be limited, but limited referral options to secondary care were also bemoaned:

> ''There isn't really any further care... the mental health service won't see anybody who hasn't got severe and enduring mental illness''. GP1
>
> ''You've got to be pretty sick or mad to get any extra help. We used to have a counsellor on site but she moved a couple of years ago and we haven't made a replacement. For any depressed person you've really got the services of the GP... so you've got a 10 minute appointment''. PN1

Both PNs and DNs described themselves as '*generalists*' and stressed that they had no expertise in the field of mental health. They all reported that they currently have a limited role in the detection of depression and reported limited skills in the ongoing support of a depressed patient. One DN described the training in her undergraduate course:

> ''They had specialist nurses come in to talk about everything under the sun, and their final parting shot to us was 'You district nurses could do that'. And then by the time the last one came we were laughing at her, saying that the last twenty have said that, 'cos we have such a variety of things to deal with ...''. DN1.

Most PNs and DNs reported feeling that they have a limited role in the management of elderly patients with depression; they had received little training, no ongoing support, no protocols to assist in either making the diagnosis or to guide them in the management of an elderly patient with depression, and only a minority of nurses felt that management of late-life depression was an area that they should be involved in, but all reported inadequacies in their training if they were to take on this role.

Thus, clinicians recognized that managing depression in late-life did fall within primary care, but were unsure of their own remit, and identified limitations in their training, skills and capabilities in this area.

Primary care relationships

GPs viewed PNs and DNs as having a limited role in the identification or management of late-life depression and none recalled a nurse referring them patients with suspected depression. GPs reported that the 'nurses had enough to do' (GP4) so they could not refer a depressed patient to a practice or district nurse for support:

> ''... the district nurse is snowed under with physical work''. GP4

Most nurses stressed that if they felt a patient was depressed, they would endeavour to refer that person to the GP, although a number expressed uncertainty about what to do if they suspected a person they visited at risk of self-harm:

> ''You leave and you think 'Oh my god, I hope she doesn't [harm herself]'''. DN1

A practice nurse described the difficulties she had experienced when she suspected that an elderly patient is depressed:

> ''... it's the dilemma of a Friday afternoon... you then have a corridor consultation with someone else (a GP in the practice), you know, and whether he'll see them then or whether we'll get them a proper appointment on the Monday''. PN1

The PNs and DNs, however, also saw some GPs as demotivated and unwilling to engage with depressed patients:

> ''... these patients drive GPs demented... they know they have seen this particular patient for thirty seven different times, what for, something like this, which they think is probably going to be depression''. PN1

This confusion of roles and responsibilities within the primary care team particularly described around the management of late-life depression permeated all accounts, and this will obviously affect how patients who may be distressed are responded to by primary care practitioners.

Discussion

This paper reports the qualitative component of a feasibility study of an intervention for the management of late-life depression in primary care (the PRIDE trial). The outcome data for the trial will be reported in a separate paper.

As well as being an important part of the study, enabling an exploration of the acceptability of the intervention, one limitation of the qualitative work reported here is that it is embedded in this feasibility study and thus may not have allowed a full exploration of the strengths as well as the weaknesses in the current management approach to late-life depression in primary care. The data reported here, however, were collected in very loose semistructured interviews that allowed a broad dialogue between the interviewer and the respondent, and which did not focus on the model of care in the trial.

A second limitation is that the health care professionals and patients were all from one economically deprived PCT—it is likely that the results would be different in other parts of the country. The method of sampling of the health professionals also limits the generalizability of the study: GPs who agreed to participate in the trial were interviewed initially, and later we purposively sampled those health professionals who had referred patients into the trial. All those invited expressed an interest in mental health issues and service development. This does, however, make the pessimism among clinicians about late-life depression an important finding, as these were primary care professionals who were interested in the clinical area and aware of late-life depression as an issue, but still expressed negative feelings about the care they were providing. This demonstrates the value of qualitative work exploring the subjectivities of professionals[26] as this will impact on the delivery of services to patients at the level of the patient–professional interaction.

The data supports other research which reports limited use of assessment schedules to assist in the diagnosis of depression in the elderly and low levels of detection and treatment.[36] The reluctance of GPs to use depression scales and lack of referral for talking treatments (either because of lack of such resources or because GPs do not consider such a referral to be appropriate) are important issues that makes it difficult to foresee how the National Service Frameworks for mental health[37] and old age[30] will be implemented against this background.

Primary care practitioners described the 'therapeutic nihilism'[38] reported in other studies, suggesting that depression is understandable and, indeed, justifiable in elderly people. Thus patients' feelings of distress are normalized. All clinicians expressed views that suggested a move away from the biomedical view on the causation of depression to a social view, compatible with other studies.[39] As a result, depression was regarded as the result of wider social and economic problems in the face of which primary care practitioners feel that they are powerless to intervene. It has been argued elsewhere that the contemporary concept of depression is 'confused, woolly and inadequate as a basis for formulating mental health problems'.[40] Even the NICE guidelines[41] on depression acknowledge that the concept of depression has limitations and 'is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans'.

This dissonance between the medical and social model of depression, however, does not help the clinicians identify and manage depression and leaves the patient to suffer with their symptoms. Instead of empowering practitioners within a consultation to consider psychosocial factors and enable them to describe a patient-centred model of care, this dissonance leaves the practitioner feeling impotent in the face of patient distress. Clinicians were pessimistic about the therapeutic options available to them, a finding compatible with previous studies.[42,43] This led GPs particularly to describe difficulties within the consultation itself, and negotiating a diagnosis of depression, echoing previous work in which the clinical encounter has been shown to centre on the nature of the illness and prospects for further treatment.[43]

Elderly patients seem to share clinicians' views that depression is understandable and is a product of social and contextual issues, and they also have similarly low expectations of treatment[45] indeed suggests that primary care patients may be more comfortable and accepting of depression being framed as a 'normal' chronic disease rather than a 'psychiatric brain disease', subject to cultural and generational stigmas, nihilism and prejudice. Elderly patients typically held a very passive position in relation to their treatment, and this no doubt makes it easier for the clinicians to choose not to open the 'Pandora's box'.

Some of the GPs in this sample described not openly discussing the diagnosis, or the prescription of antidepressants with their elderly patients, instead themselves using euphemisms to describe their intended prescription. This can only serve to reinforce the passive role of the patient. Primary care practitioners perceived the diagnosis of depression to be stigmatizing for elderly patients and this is why they avoided raising it as a possible diagnosis. Whether, in fact, clinicians were constructing this as a reason for their own resistance to mention and negotiate the diagnosis of depression with the patient needs further investigation.

At a National level, assuming that secondary care services continue to focus on serious mental illness, then this study highlights a number of areas that primary care must address. These include provision

of psychological therapies within primary care, perceived lack of social care or voluntary services, the need for improved local knowledge of services as well as education and training of primary care professionals in the management of late-life depression. These policy imperatives are not just applicable in the UK, in the USA, late-life depression is recognized as a significant problem and there is an accumulating evidence-base to support new collaborative care approaches across the primary–secondary care interface.[46] This qualitative study demonstrates the need for the policy imperatives in the NSFs[30,37] to be translated into changes in attitudes and actions at practice level. In addition, initiatives such as Royal College of Psychiatrists[46] and other health promotion activities need to reach their target audience, encouraging elderly people who feel sad to recognize that this is a legitimate reason to consult their GP. Unless there is investment in all these areas, late-life depression will continue to go undiagnosed and undertreated.

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