

Attitudes to depression in primary care attenders: effects of age and depressive symptoms

D. Zeitlin^{1,2}, C. Katona^{3,4},
P. D'Ath⁴ and P. Katona²

¹University of Birmingham,

²Lower Clapton Health Centre,
Lower Clapton Road, London E5

³Department of Psychiatry, University
College London Medical School, and

⁴Mental Health Unit, Essex and Herts
Community NHS Trust, UK

Correspondence to:
P. Katona at above address

Keywords:
Attitudes
Depression
Primary care

Introduction

Epidemiological studies suggest that depressive symptoms are common in elderly populations but are hardly ever treated [1,2]. In keeping with Macdonald [3], we have shown that this discrepancy between high prevalence and low treatment rate remains apparent in elderly attenders at GP surgeries [4], despite the fact that frequent surgery attendance it-

self appears to be a marker of increased likelihood of depression [3].

The Consensus Statement on Recognition and Management of Depression in Late Life in General Practice [5], produced as part of the Defeat Depression Campaign of the Royal Colleges of General Practitioners and of Psychiatrists, suggested that, because of the high prevalence of depression in elderly people consulting their GPs, screen-

ing for such depression in the primary care setting may be useful. Such screening is also recommended by the Royal College of General Practitioners as part of the Over-75 Health Check [6].

It cannot be taken for granted however that increasing a GP's awareness of his/her patients' depression will result in higher levels of appropriate treatment or of reduced prevalence or severity of the condi-

A cross-sectional study was designed to examine the effect of age on a person's perception of how depression relates to themselves, to others and of methods of treatment. The setting was a general practice health centre in urban East London, list size 11 200 patients. Subjects were one hundred 18-64 year olds (control group) and 80 patients aged 65+ selected randomly from those attending the practice during the study period and who consented to answer the questionnaires. The main outcome measures used were prevalence of depression by the Geriatric Depression Scale (subjects aged 65+), and the Goldberg Depression Scale (aged 18-64), and attitudes to, self-attribution and knowledge of depression and its treatment as assessed by the Attitudes to Depression Questionnaire (both age groups). Prevalence of depression was similar in both groups, yet approximately one-third of depressed individuals denied ever having been so. Older subjects were less likely to recognize depression in others and were also less willing to seek help for themselves. The majority of both groups viewed antidepressants to be very addictive and not very effective, counselling being the treatment of choice. However, more of the older age group thought that depression should be treated with antidepressants. It was also apparent that the older age group had more confidence in their GPs. It is concluded that there are attitudinal barriers to appropriate treatment for depression at all ages. The findings imply that there is considerable scope for educational intervention aimed at increasing self-recognition of depression and knowledge of effective treatment options.

tion. Indeed, Iliffe *et al.* [7] have shown that screening for depression within the Over-75 Health Check and feedback of such information back to GPs had no effect on its management (even in highly regarded practices with active academic links).

The limited efficacy of screening for depression in old age is probably due in part to reluctance on the part of GPs to initiate treatment. This in turn may reflect "ageist" attitudes (e.g. that depression is a legitimate or inevitable part of the ageing process) on the part of GPs. Their relative lack of knowledge of and confidence in treating depression in old age (as demonstrated by Collins *et al.* [8]) are also important.

Patients' own knowledge of and attitudes to depression may also contribute to undertreatment. Indeed, a MORI poll conducted under the auspices of the Defeat Depression Campaign in 1992 [9] revealed that, for example, most people make no distinction between anxiolytic and antidepressant drugs, and regard the latter as addictive. In keeping with this, most people would be reluctant to consider any treatments other than "talking treatments" for depression. A repeat poll in 1995 [10] showed only very modest changes in patient attitudes. A further possible factor mitigating against depressed patients' acceptance of treatment might be lack of awareness or recognition of their own depression. Older people are less likely to display overt depressed mood as part of the presentation of their depressive illness [11], and may therefore be particularly unlikely to label themselves as having a depressive illness. Depression in old age may also be associated with reluctance to comply with medication; Carney *et al.* [12] have recently shown that elderly people whose cardiovascular disease was complicated by depression were significantly less likely to comply with aspirin prophylaxis than their non-depressed counterparts.

The aim of the present study was to examine the presence of depressive symptoms as well as attitudes to, self-attribution of, and knowledge of depression and its

treatment in older and younger subjects attending their GPs. Specific hypotheses to be tested were as follows.

1. Older subjects with significant depressive symptoms are less likely than their younger counterparts to regard themselves as depressed.
2. Older subjects are less willing to recognize standard treatments for depression as effective.
3. Older subjects are less willing to accept treatment for depression.
4. Depressed subjects (older and younger) are less willing to accept treatment for depression.

Methods

Subjects were identified from attenders at the Lower Clapton Health Centre, a seven partner (and three trainee) general practice providing primary health care for approximately 11 200 patients. The practice has a computerized appointment system with age/sex details relating to each patient, thus allowing easy identification of patients under and over 65 years of age.

The research was carried out during the routine and emergency weekday surgeries over a 4 month period (from March to June 1995). All patients aged over 65 and waiting for an appointment with their GP were approached in the general waiting room by a researcher. For those patients aged under 65, every third attender waiting was approached. Patients who attended weekend surgeries or required home visits were excluded from the survey. However, emergency patients (seen at the end of each surgery) and those attending the antenatal clinic were included.

Each patient, when approached, was asked if he/she would consent to answering two short questionnaires that would aid doctors in their understanding of depression in the patients they treat. It was made clear that the mood state of the patient being interviewed was irrelevant and unknown to the interviewer. If the patient was willing to

participate then a mood rating scale was administered. For subjects aged 65 and over, the 15-item version of the Geriatric Depression Scale (GDS15) [13] was administered. For those aged under 65 years, the 9-item Goldberg Depression Scale [14] was used.

Both scales have been validated in the context of UK general practice [14,15]. For the GDS15, 10 out of the 15 questions answered "yes" is a positive score; for the remaining five questions the answer "no" scores positively. The positive points are then totalled, with a score of 5 or more indicating significant depressive symptomatology. In the Goldberg Depression Scale questionnaire, each question answered "yes" scores positively, and a total score of over 4 indicates significant depression.

In addition, the Attitudes to Depression Questionnaire (ADQ) used in the Royal College of Psychiatrists' MORI poll [9,10] was administered to all subjects. The ADQ consists of 26 questions relating to personal opinions about depression. For each question there are a range of possible answers: "agree", "neither agree nor disagree", "don't know" and "disagree".

Statistical analysis was carried out using the Statistical Package for the Social Sciences for PC (SPSSpc) [16]. For the purposes of between-group (older/younger; depression "cases"/"non-cases") comparisons, ADQ responses were condensed into two general categories: "agree" and "disagree" (with "don't know" and "neither agree nor disagree" responses excluded) prior to analysis by chi-square test.

Results

The sample recruited consisted of 100 subjects aged over 65 and 80 aged 65 or less. Table I shows the demographic characteristics of the two groups. In the "younger" group, Goldberg scores ranged between 0 and 9, with a mean score of 3.5. In the older group, the GDS range was 0-10, with a mean of 2.4. The proportion scoring within the "de-

TABLE I. Demographic details

	< 65 years (n = 100)	≥ 65 years (n = 80)
Gender		
Males	25 (25%)	29 (36.3%)
Females	75 (75%)	51 (63.8%)
Age		
Range	18-64	65-86
Mean	35.3	73.1
Depression "cases" n (%)	31 (31%)	17 (21%)

pressed" range did not differ significantly between the two groups.

Comparisons in ADQ responses by age

A significantly higher proportion of younger subjects (50/99; 51%) than those aged ≥ 65 (12/80; 15%) answered affirmatively to the question "has a close member of your family or close friend ever suffered from depression?" ($\chi^2 = 23.09$, $p > 0.00001$). In keeping with this, significantly more older subjects said that no one they knew had suffered from depression [24/80 (30%) vs 15/99 (16%); $\chi^2 = 4.89$, $p < 0.05$]. A higher proportion of older subjects agreed with the statements "Depression mainly affects women" [27/71 (38%) vs 17/87 (20%); $\chi^2 = 5.76$, $p > 0.02$] and "Children are very unlikely to suffer from depression" [21/74 (28%) vs 6/90 (7%); $\chi^2 = 12.39$, $p < 0.001$].

Table II sets out the findings of the question "who if anyone, would you approach if you suffered from depression?" It is apparent that younger subjects were significantly more willing to seek both informal and professional help.

TABLE II. "Who, if anyone, would you approach if you suffered from depression?"

	< 65	≥ 65	χ^2	p
Spouse	59% (58/99)	11% (9/80)	40.33	< 0.0001
Parents	30% (29/99)	1% (1/80)	22.97	< 0.0001
Friends	71% (70/99)	35% (28/80)	21.35	< 0.0001
Psychiatrist	35% (34/99)	12% (10/80)	10.24	< 0.002
Psychologist	31% (30/99)	9% (7/80)	11.25	< 0.001
Health visitor	25% (24/99)	6% (5/80)	9.27	< 0.005
Social worker	23% (22/99)	9% (7/80)	4.96	< 0.05
Counselling Colleagues	74% (73/99)	22% (18/80)	44.45	< 0.0001
at work	31% (30/99)	4% (3/80)	19.01	< 0.0001
No one	3% (2/99)	10% (8/80)	3.94	< 0.05

As far as type of help was concerned, the older and younger subjects did not differ significantly in their views on counselling for depression, which almost all subjects felt was appropriate [76/79 (96.2%) vs 97/97 (100%); $\chi^2 = 1.82$, N.S.]. However, a significantly higher proportion of older subjects [31/64 (48%) vs 13/63 (21%); $\chi^2 = 9.65$, $p < 0.002$] agreed that "People suffering from depression should be treated with antidepressant tablets". Older and younger subjects did not differ in their views on either effectiveness or addictiveness of antidepressants; 41/56 (73%) of the older and 68/81 (84%) of the younger subjects considered antidepressants "very addictive"; only 14/53 (26%) and 16/75 (21%) respectively considered them "very effective" (χ^2 for trend not significant in both cases).

Effects of age on attitudes towards GPs

Significantly more of the younger sample agreed with the statement "People with depression feel embarrassed to consult their GP" [81/94 (86%) vs 52/72 (72%); $\chi^2 = 4.14$, $p < 0.05$] and 34/74 (46%) of this group compared with only 12/62 (19%) of the elderly sample agreed that "GPs feel irritated and annoyed when people suffering from depression consult them" ($\chi^2 = 9.5$; $p < 0.005$). In keeping with this finding, significantly more elderly patients [38/61 (62%) vs 17/50 (34%)] felt that "GPs are well trained to deal with depression" ($\chi^2 = 7.7$, $p < 0.01$) as well as agreeing that "GPs are generally understanding and sympathetic towards people

with depression" [64/67 (96%) vs 52/68 (76%); $\chi^2 = 8.6$; $p < 0.005$]. Significantly more of the younger sample agreed that "When GPs see a depressed patient, they tend to just give them pills" [54/82 (66%) vs 29/62 (47%); $\chi^2 = 4.51$, $p < 0.05$].

Effects of age on understanding of the causes of depression

Significantly more younger people than those aged 65 and over felt that virus infections [63/99 (64%) vs 34/80 (42%); $\chi^2 = 7.12$; $p < 0.01$], biological changes in the brain [80/99 (81%) vs 48/80 (60%); $\chi^2 = 8.41$; $p < 0.005$] and premenstrual tension [88/99 (89%) vs 60/80 (75%); $\chi^2 = 5.03$; $p < 0.05$] were likely to cause depression.

Effects of depression on attitudinal responses

Depression "cases" were more likely to admit to having been depressed. This was statistically significant in both age groups [older, 11/17 (65%) vs 14/63 (22%), $\chi^2 = 9.36$, $p < 0.005$; younger, 19/31 (61%) vs 24/69 (35%), $\chi^2 = 5.1$, $p < 0.05$]. The proportion of depression "cases" admitting to depression was similar in the two age groups. Comparisons between "cases" and "non-cases" did not yield any significant differences between groups, except that older "cases" were less likely than older "non-cases" to agree that redundancy was likely to cause depression [12/17 (71%) vs 58/63 (92%), $\chi^2 = 3.85$, $p < 0.05$].

Discussion

The broad aim of this study was to explore attitudes to depression and its treatment in primary care attenders in the hope of identifying some of the reasons why most people with significant depressive symptoms (particularly those aged 65 and over) do not receive treatment despite being frequent surgery attenders.

The demographic characteristics of the subjects studied suggest that they are broadly representative of primary care attenders. Rates of depressive symptomatology in both groups are also in keeping with those found in other primary care

subjects [3,17], though the relatively low "caseness" rate in older subjects is surprising and suggests that the GDS15 may have a higher threshold than the Goldberg scale.

The results suggest that there are attitudinal barriers to appropriate treatment for depression both in older and younger subjects. Broadly in keeping with the Royal College of Psychiatrists/MORI polls [9,10], the majority of subjects in this study regarded antidepressants as being addictive and, equally importantly, as not being appropriate treatment for depression. In contrast (and again in keeping with the Royal College of Psychiatrists/MORI polls), almost all subjects regarded counselling (which is often not available in primary care and which is also of much less well proven efficacy) as the treatment of choice for depression. A further barrier to treatment identified in our study is the fact that a third of subjects identified as having significant current depressive symptoms did not consider themselves as ever having been depressed. These findings suggest that there is considerable scope for educational intervention aimed at increasing self-recognition of depression and knowledge of effective treatment options. In contradiction to our original hypothesis, these results suggest that depressive symptoms are not, after all, associated with increased reluctance to accept treatment.

Our results provide some clues to the particularly low treatment rates for depression in old age, in that older people are less willing to

seek any form of help (informal or professional) for depression. Surprisingly however, older people do not seem any less likely to admit to having depression and are more positive than their younger counterparts about antidepressants and about discussing depressive symptoms with their GPs. Educational intervention aimed at carers of older people may contribute usefully both to increasing recognition of depression in old age and to reducing the reluctance that older people have to seeking help.

References

1. Copeland JR, Davidson IA, Dewey ME *et al.* (1992) Alzheimer's Disease, other dementias, depression and pseudodementia: prevalence, incidence and three-year outcome in Liverpool. *British Journal of Psychiatry*, **161**, 230-239.
2. Livingston G, Hawkins A, Graham N *et al.* (1990) The Gospel Oak Study: prevalence rates of dementia, depression and activity limitation among elderly residents in inner London. *Psychological Medicine*, **20**, 137-146.
3. Macdonald AJD (1986) Do general practitioners "miss" depression in elderly patients? *British Medical Journal*, **292**, 1365-1367.
4. Mullan M, D'Ath P, Katona P and Katona C (1994) Screening, detection and management of depression in elderly primary care attenders. 2. Detection and fitness for treatment: a case record study. *Family Practice*, **11**, 267-270.
5. Katona CLE, Freeling P, Hinchliffe K, Blanchard B and Wright A (1995) Recognition and management of depression in late life in general practice: a consensus statement. *Primary Care Psychiatry*, **1**, 107-113.
6. Williams EI and Wallace P (1993) Health checks for people aged 75 and over. *British Journal of General Practice*, Occasional paper no. 59.
7. Iliffe S, Mitcheney S, Gould M and Haines A (1994) Evaluation of the use of brief screening instruments for dementia, depression and problem drinking among elderly people in general practice. *British Journal of General Practice*, **388**, 503-508.
8. Collins E, Katona C and Orrell MW (1995) The management of depression in the elderly by general practitioners. 2. Attitudes to ageing and factors affecting practice. *Family Practice*, **12**, 12-17.
9. MORI (1992) Attitudes towards Depression. Research study conducted for the Royal College of Psychiatrists, London.
10. MORI (1995) Attitudes towards Depression. Research study conducted for the Royal College of Psychiatrists, London.
11. Kivela SL and Pakkala K (1988) Symptoms of depression in old people in Finland. *Zeitschrift für Gerontologie*, **21**, 257-263.
12. Carney RM, Freedland KE, Eison SA, Rich MW and Jaffe AS (1995) Major depression and medication adherence in elderly patients with coronary artery disease. *Health Psychology*, **14**, 88-90.
13. Sheikh JA and Yesavage JA (1986) Geriatric Depression Scale (GDS): recent findings and development of a shorter version. In: *Clinical Gerontology: a Guide to Assessment and Intervention* (Ed TL Brink). Howarth Press, New York.
14. Goldberg D, Bridges K, Duncan-Jones P and Grayson D (1988) Detecting anxiety and depression in general medical settings. *British Medical Journal*, **297**, 897-899.
15. Evans S and Katona C (1993) Epidemiology of depressive symptoms in elderly primary care attenders. *Dementia*, **4**, 327-333.
16. SPSS (1992) Statistical Package for the Social Sciences: PC Edition (SPSS/PC + Version 3.1). Chicago.
17. Freeling P, Rao BM, Paykel ES, Sireling LI and Burton RH (1985) Unrecognised depression in general practice. *British Medical Journal*, **290**, 1880-1883.

(Received 30 April 1996; accepted as revised 20 June 1996)