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Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups

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ABSTRACT

Background. Research suggests high levels of depression and low levels of service use among older adults from UK minority ethnic groups. This study aimed to explore older adults' attitudes and beliefs regarding what would help someone with depression, and to consider how these may facilitate or deter older people from accessing treatment.

Method. In-depth individual qualitative interviews were conducted with older adults with depression (treated and untreated) and the non-depressed older population. A multi-cultural approach was used that incorporated the perspectives of 32 black Caribbean, 33 South Asian and 45 white British older adults.

Results. Participants felt that the responsibility for combating depression was an internal and individual task with support considered secondary. However, the majority expressed a willingness and desire to discuss psychosocial problems. Within the black Caribbean group, conversing with God through prayer was seen as an effective means of overcoming depression, while a large proportion of South Asian and white British participants identified families as an important source of help. There was wide variation in how older adults construed the role of the general practitioner (GP) and many expressed acute awareness of the demands on GPs' time.

Conclusions. Efforts to socialize and remain active may provide a useful and acceptable adjunct to clinical interventions. However, there is a need to communicate that depression often necessitates formal help, and that it is acceptable to voice concerns regarding emotional states in a GP consultation. The findings suggest that older adults would welcome the opportunity to discuss their feelings with health-care professionals.

INTRODUCTION

Depression is the most common mental disorder in later life, affecting up to 15% of those over 65 (Copeland *et al.* 1987; Livingston *et al.* 1990). This high prevalence appears to be shared by minority ethnic groups in the UK such as the South Asian and black Caribbean elderly population (Nazroo, 1997; Bhui *et al.* 2001; O'Connor & Nazroo, 2002). It is therefore of concern that older adults from minority ethnic groups appear to have lower levels of service use compared with the majority population (Boneham & Williams, 1997). Suggestions of unmet need among elders from minority ethnic groups with depression (Manthorpe, 1994;

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Ebrahim, 1996) require an exploration of the potential barriers and facilitators to service use.

Goldberg & Huxley (1980) described a succession of filters in the 'pathway to care' that determine whether people access mental health services. Before considering help-seeking, it is first necessary to understand the concepts that individuals have concerning depression in later life. We have completed such an analysis of beliefs about the nature and causes of depression in older people from South Asian, black Caribbean and white British backgrounds (Lawrence *et al*. 2006). In this we found that the social model of depression in which adverse circumstances were believed to underlie the onset of depression was shared by all ethnic groups. The white British and black Caribbean groups tended to define depression in terms of low mood and hopelessness, while South Asian and black Caribbean groups conceptualized depression in terms of worry.

Beliefs regarding what is appropriate help for someone with depression may subsequently act as barriers at each of the stages on the pathway to care (Goldberg & Huxley, 1980), influencing whether and from whom to seek help, the idioms for expressing the condition, and the acceptability of various treatments (Levkoff *et al*. 1988; Howse *et al*. 2005). Research suggests cultural variation in these beliefs, which may underlie discrepancies in service use.

There is evidence that South Asian adults favour self-help strategies for depression rather than seeking professional treatment (Karasz, 2005). In the UK, the National Centre for Social Research (O'Connor & Nazroo, 2002) reported that Indian and black Caribbean adults advocated 'getting on with things' as a means of dealing with emotional distress. Cinnirella & Loewenthal (1999) argued that a greater alertness to community stigma associated with seeking help for mental disorders might lead to a preference for private coping strategies (e.g. prayer), and religious practices have been identified as important ways of coping among black Caribbean and South Asian adults living in the UK (O'Connor & Nazroo, 2002). Therefore, traditional healers or religious leaders may be considered a more appropriate and acceptable source of help than Western models of psychiatric care (Bhui, 1999; Cinnirella & Loewenthal, 1999). In a focus group of Punjabi women, talking to friends and family was considered to be the first line of treatment (Bhugra *et al*. 1997); talking to counsellors, social workers or primary-care physicians was held to be out of the question because of fears of loss of confidentiality.

Research suggests that South Asian and black Caribbean adults do not always envisage primary-care consultations as an appropriate response to depression (Marwaha & Livingston, 2002; Commander *et al*. 2004). Negative attitudes towards antidepressants, and mental health services in general, may discourage help-seeking within minority ethnic groups (Wilson, 1993; Schnittker, 2003). Service providers need to understand the beliefs that underlie help-seeking behaviour in order to generate accessible and acceptable services. However, these beliefs have rarely been explored within older adults from minority ethnic groups. In this paper we present data from a study designed to elucidate what older adults from the three largest ethnic groups in the UK regard as appropriate help for depression.

METHOD

Participants

This was a qualitative study involving 110 older adults (aged 65 and over). The sample was stratified by ethnicity and by the participants' experience of depression. In-depth individual interviews were conducted with:

(1) Older people with depression who were being treated (Depressed & Treated).
(2) Older people with depression who were not being treated (Depressed & Not Treated).
(3) Older people without depression (Not Depressed).

Table 1 shows the composition of the sample in terms of key variables. Each group included black Caribbean, South Asian and white British older adults; this enabled us to compare and contrast attitudes between the two largest minority ethnic groups in the UK with the majority population. A 'case' of depression was defined as a score of 7 or above on the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), which has been shown to be reliable across medical settings

Table 1. *Sociodemographic characteristics of participants*

	Ethnic group		
	Black Caribbean	South Asian	White British
Total	32	33	45
Treatment group			
Depressed & Treated	9	6	15
Depressed & Not treated	13	12	12
Not Depressed	10	15	18
Age (yr)			
65–70	12	17	8
71–80	13	11	26
81–90	6	5	10
⩾90	1	0	1
Gender			
Male	10	9	19
Female	22	24	26
Origin			
India	0	20	0
Pakistan	0	3	0
East Africa	0	7	0
Caribbean	32	0	0
UK	0	0	45
Other	0	1	0
Religion			
Christian	27	3	42
Hindu	0	20	0
Muslim	0	5	0
Sikh	0	5	0
Other	5	0	3
Interview language			
English	32	20	45
Hindi	0	10	0
Punjabi	0	2	0
Urdu	0	1	0

and age groups (Flint & Rifat, 2002). Treatment was not limited *a priori* to pharmacological interventions (i.e. antidepressants) but in the event no participants were receiving psychological treatments alone.

All participants were recruited from primary care or day centres and lunch clubs. We avoided recruitment of any group through mental health services as our focus was on help-seeking in the general population rather than those who had been referred to and who had accepted psychiatric care. Participants were identified through seven participating general practitioners (GPs) located in areas of varied sociodemographic characteristics. GPs provided access to information on age, ethnicity and treatment status. Eligible patients were sent an invitation letter, followed by a phone call from a member of the research team. The 'Depressed & Treated' group were identified by GPs from their practice lists. The 'Depressed & Not Treated' and the 'Not Depressed' groups were identified by interviewing people from the same lists and screening with the HADS. We augmented recruitment to the last two groups from attenders at day centres and lunch clubs serving older people from the black Caribbean, South Asian and white British community. A research worker discussed the study with the group and then recruited members individually.

Instruments

Topics for the interview guide were generated from a review of the literature on depression, illness beliefs, cultural beliefs and help-seeking, which is summarized in the introduction to this paper. Following a detailed exploration of what the term 'depression' meant to participants, as reported elsewhere (Lawrence *et al.* 2006) key topics included: what should someone with depression do; should they seek help and in what circumstances; what help might someone with depression need; who should help them and how? Participants were then asked to give their opinions on a range of treatments and services.

Information sheets, consent forms and the HADS were available in four Asian languages: Gujarati, Hindi, Punjabi and Urdu. Interviews lasted around an hour, and were conducted in the participants' homes and preferred language. All were recorded on audio-tape and transcribed verbatim.

Analysis

Analysis of the data was based on the grounded theory approach (Glaser & Strauss, 1967). We have described our analytic strategy in detail elsewhere (Lawrence *et al.* 2006). Three members of the research team scrutinized and coded the initial transcripts. Emerging themes were identified and labelled with codes. A constant comparison technique was used to delineate the properties of the codes and to develop categories and subcategories.

As the analyses proceeded, we verified and developed existing codes and added new codes when necessary. The researchers compared their coding strategies throughout the study. Any instances of disagreement were discussed and

resolved by the wider research team. NVivo qualitative data analysis software (QSR International, 2002) was used to process the transcripts and enabled us to systematically code and retrieve concepts. Interpretation of the data involved the whole research team.

RESULTS

Self-help

General

The majority of participants felt that the impetus to combat depression must come from the individual, with formal and informal support considered to be secondary or even inconsequential.

I think the main helping with depression, any kind of depression, physical, mental, it's self-help. If you help yourself the way you want to do it, you will get over the depression 100%, I am that sure. But if you don't want to do it, there's nothing you can do. Treat yourself. (South Asian/Not Depressed 13)

Views on self-efficacy were unaffected by both ethnicity and experience of depression. Members of all groups spoke about drawing strength from inner resources and the necessity of self-motivation and positive attitudes.

Cognitive techniques

The belief that you must help yourself was manifested in the various cognitive strategies that were adopted to combat depression. A small number of depressed and non-depressed South Asian elders proposed that the most effective way to help yourself was to adjust your outlook on life.

It's a mental attitude, mental attitude. If you change the mental attitude and all that and you become cheerful and start activities it will go. (South Asia/Depressed & Not Treated 12)

Another strategy was avoidance. This involved actively putting negative thoughts and worries from your mind. The desire not to 'dwell on things' characterized this approach.

It's easier said than done, to not concentrate on one particular thing, especially bad things, especially bad things. Don't concentrate on it a lot. Let it go away as quickly as you possibly can. (Black Caribbean/Not Depressed 10)

Taking your mind off it

The most frequently cited technique for coping with depression was doing things to take your mind off negative thoughts.

You think a bit differently you know with the way you think about things, it's different but I don't keep it in my mind. I like to read, I'm really interested in reading, papers, books, so then I forget everything. I kind of do it myself. (South Asian/Not Depressed 1)

However, distraction did not necessarily involve engagement in specific activities. Participants from all ethnic groups communicated a distinct awareness that 'it can be bad looking at the four walls every day' and explained that they often went out simply as an end in itself, walking up and down the same roads, going for rides on buses and sitting in the local shopping centre. For those receiving treatment for depression, especially those of black Caribbean or South Asian origin, going out represented a valued opportunity to improve their mental health.

Getting out of the house helps me enormously. I have been paying someone to take me out usually once a week, at the weekend, but she's moving to Norfolk and that's been sort of my life-saver because I thought I would go mad if I didn't get out the house … Yes, it's the one thing that is guaranteed to help. (White British/Depressed & Treated 15)

However, some recognized that the very essence of depression could leave the individual unable to 'rise above it'. Those suffering from depression spoke of the inherent lack of motivation and energy that undermines attempts to remain active, to 'make a big effort' and to 'get on with it'. Depression often left sufferers painfully overwhelmed.

Social support

Family

Many participants, especially within the South Asian group, agreed that family support plays an important role in preventing and coping with depression. References were made to the pleasure derived from family trips and spending time with grandchildren. Emotional support was also provided in direct response to individuals' depression: families listened, offered encouragement and advice, and occasionally sought professional help on their behalf.

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There did not appear to be any distinct trend in the type of support received by different ethnic groups. However, it was striking that while those of white British background were the most frequent advocates of family support, they seemed to have lower expectations of receiving it.

Well yes because they can help you by being there for you and you see, but young people haven't always got time to bother with you too much. I mean you have to understand that. (White British/Depressed & Not Treated 10)

There was a reluctance to lean too heavily on family members, and recognition of clear limits to what was acceptable. Despite rationalizing the situation in this way, many white British elderly were left longing for increased family contact and support.

Friends

Great importance was attached to the value of social interaction. While a level of unanimity existed across the ethnic groups on this issue, there was apparent variation in the preferred nature of interaction. Participants of black Caribbean origin believed in the cathartic value of talking about their worries and concerns with friends. Friends were considered to be a source of encouragement, advice, reassurance and, above all, through providing a comfortable environment to 'talk it out', a valued outlet for distress.

The first thing is communicating, that somebody is listening to what I am going through. You are pouring out your heart to that person and you feel a bit better that you have passed on your worries and problems to another person. (Black Caribbean/Depressed & Not Treated 11)

White British and South Asian participants valued one-to-one chats as an opportunity to enjoy friends' company. A large, predominately white British group emphasized the importance of 'being with people', 'mixing', 'meeting people' and 'making friends'. Within these interactions, talking about your feelings was often circumscribed and individuals adopted an upbeat manner so as not to 'depress other people'.

You've got to try and keep cheerful when you are with people, it's difficult, you want them to know but no I put on a brave face and make out I've got no troubles. If they ask me how I am, 'I'm all right, I'm fine' I don't, best to look on the bright side I find otherwise people get fed up, 'Oh she's a misery'. (White British/Depressed & Not Treated 2)

Despite the widespread value placed on the support of friends and family, some feared that people might think badly of them, possibly seeing depression as 'some kind of self-indulgence on that person's part'.

Religion

Religion was thought to help people cope with depression in a number of ways. Black Caribbean participants described a distinctive relationship with God. Having a 'personal relationship with your Father' meant communicating with God in a direct and informal manner.

But of course, religion means that you are in talk with God and if God can't help you what else will help you? God will help you if you believe in him. (Black Caribbean/Not Depressed 9)

Many Caribbean elders reported religion to be central to overcoming depression, some asserting that the absence of a relationship with God, underlined by a lack of faith, would prolong suffering. Black Caribbean participants also set store by the support networks incorporated in their religious way of life. For a number of South Asian older people of Hindu, Sikh and Muslim faith, 'going to the temple' represented a fundamental aspect of their lives. The value of meeting friends was juxtaposed with the value of 'putting your mind with God'. Visiting the temple, praying and meditating were considered to bring an enduring sense of peace and calm.

Day centres

Those who had attended day centres or lunch clubs valued the opportunity to get out and meet people. For some, this represented their only contact with the outside world and inadequate day centres were occasionally endured for this reason alone. There was agreement about inadequate provision of places and fear that this was going to deteriorate further. Others complained that it was difficult to acquire information about day centres.

Day centres take the sting out of it anyway, even if you sit there and say nothing and there's nothing to

do, you are at least with other human beings. (White British/Not Depressed 17)

Health care

General practitioners

Within each ethnic group the number of participants making positive and negative assessments of GPs' management of depression was approximately equal. Black Caribbean participants presented as both the chief advocates *and* the critics of GPs; South Asian participants were the least positive *and* the least negative of the GPs contribution while the assessment made by white British participants fell midway between the two. Differing expectations of the GP's role may underlie the apparent polarity within the ethnic groups.

Among the black Caribbean group, broad criteria for consultation were given: 'not feeling well' or 'not functioning right' justified seeking help. A large proportion of these participants believed that going to see their GP was an opportunity to discuss their worries and concerns. While they praised GPs for this service, they were highly critical of GPs spending insufficient time with their patients or appearing to take insufficient interest. The dual belief that GPs *could* and *should* help, together with the experience that they often *did not* help, resulted in polarized positive and negative evaluations.

You see the GPs are so tied up with so much work they don't have time to talk to their patients and they find a lot of people don't get the necessary benefit that they would get from the GP if the GP talked to them. Even give them less medication and have a talk because it makes them feel good within themselves you see and that feeling within themselves is like a self-healing power you know. That builds them up. (Black Caribbean/Depressed & Not Treated 3)

South Asian participants expressed the most deferential attitudes to GPs, valuing them as a source of knowledge, for prescribing medication or referring for further help if required. However, in contrast to the black Caribbean group, there was little evidence that this was a service valued for depression. White British participants held more diverse opinions, variously describing the GP as somebody who would listen, give information and advice and provide medication and referrals.

Reservations about seeking help from GPs were similar across the ethnic groups: doctors were too busy and were overly reliant on medication as a form of treatment. Others explained that limited GP consultation time forced them to prioritize their physical, rather than their psychological, complaints.

There's so much to say and so little time. So you always feel like you haven't got enough time with the doctor. Yes so then you think to yourself, ah well, the important thing, first, cure your pains and then think about the depression later on. (Black Caribbean/Depressed & Treated 3)

Compromises of this sort were viewed as regrettable but inevitable in such an overstretched service. Others described instances when their GP had dismissed their complaint as being a normal part of ageing, reinforcing their belief that the elderly have low priority in the health service.

It was striking that participants who were receiving antidepressants assessed their GP's contribution most negatively. Conversely, non-depressed older adults evaluated GPs' ability to manage depression in the elderly most positively. Those who were currently depressed but not receiving treatment were ambivalent in their views of the role of GPs. Although initial remarks tended to be positive, they often went on to express dissatisfaction about the amount of time and attention devoted to older patients like themselves. There were also concerns regarding whether experiencing such problems 'at their age' warranted a GP's attention.

Medication

Participants from all three ethnic groups positively endorsed medication for the treatment of depression, with white Britons expressing this view in the greatest numbers. Descriptions of its benefits included 'calm the nerves', 'ease the pain', 'build up the strength' and 'help you lead a normal life'. Medication was generally depicted as a temporary crutch although a minority recognized it as an essential constant in some people's lives. The greatest fear associated with medication was that it could create dependency.

I mean you hear of people taking these drugs for years and years and they get so dependent on them. (White British/Depressed & Not Treated 3)

Those who were currently depressed but not receiving treatment were the least positive about the value of medication and the most fearful of dependency. There were also common concerns about side-effects such as dry mouth, nausea and decreased libido. South Asian participants in particular appeared to view side-effects as inevitable and were reluctant to take medication for this reason. Others were reluctant to be 'a pill popper' and believed medication signified the severity of the condition.

Counselling

There was strong belief in the benefits of counselling and psychotherapy for those suffering from depression. There was a tendency to conceive counselling as an opportunity to express feelings, to talk and to 'relieve some of the stress that you are carrying around with you'. Participants from black Caribbean backgrounds expressed this view emphatically.

When you get a counsellor to talk to you, what the person says to you is encouraging, strengthen your body, strengthen your mind and whatever is there, it come right out. (Black Caribbean/Depressed & Treated 2)

The attraction of counselling often lay in the opportunity to speak to a professional who was distanced from the situation. However, only a small number had any direct experience of counselling and very few spoke of the value of specific theoretical approaches. While some participants, often of South Asian origin, were confused about the exact role of counsellors, they tended to expect that company, advice and a protected time with counsellors would be beneficial. Counselling services were also seen as potentially helpful in reducing the pressure on GPs' time.

Counsellors would be able to spend more time with them, to chat with them, to make them feel at home and things like that you know. Whereas a GP, they would be considered to be an official, authority, while these counsellors are normal people who give their time in counsel. I suppose that's what it is, so that would help them, the counsellors would be more helpful. (South Asian/Not Depressed 10)

However, there was also some scepticism and apprehension surrounding counselling. Among South Asian participants there was a strong belief that it would be inappropriate to discuss personal problems, perhaps concerning family members, with strangers.

Psychiatrists

Just over one in 10 participants recommended seeking help for depression from a psychiatrist. As with medication, this was seen as a testament to the severity of the condition and some were explicitly concerned with the stigma.

I would feel that if someone was to say we are going to make an appointment for you to see a psychiatrist, straight away I would think oh I am going off me rocker kind of thing. (White British/Depressed & Not Treated 1)

However, those who had regular contact with psychiatrists often described the reassurance of monitoring and the opportunity to speak frankly about their condition.

DISCUSSION

The results of this study illustrate the complex issues at work in seeking help for depression in later life. Our participants stressed personal responsibility for coping with depression above all other strategies, and that forcing oneself to get out and engage in activities was the most effective means of self-help. However, little is known about the effectiveness of such self-help strategies and it remains a fact that up to one in six older adults are depressed at any one time (Livingston *et al*. 1990). Public education must communicate that the nature of depression often necessitates help from others, and that primary-care services are well placed to provide the support needed. Our findings suggest that many older people would be positively inclined to behavioural strategies that encourage efforts to interact and remain active; these may provide an acceptable adjunct or alternative to pharmacological and psychotherapeutic interventions.

Before considering the data generated, it is important to consider their limitations. The data were drawn from urban South London, and the first limitation is one of generalizability. However, most ethnic elders live in such urban areas and individuals were recruited from London boroughs in which a broad range of socio-economic diversity exists, including

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deprived inner-city areas and wealthy suburbs. Therefore, we feel that our findings have reasonable theoretical generalizability to black Caribbean, South Asian and white British older adults living in the UK, as well as relevance in other developed economies.

Second, we carried out a large number of interviews and have chosen to report broad themes inclusively rather than focus on a small number of selected issues. There is a paucity of evidence in this area, and the data identified here can also inform further more detailed studies of help-seeking in depression and cultural differences.

The tendency of South Asian participants to identify families as a prominent source of help for depression is consistent with previous research in younger age groups (Sonuga-Barke & Mistry, 2000). The black Caribbean group placed less emphasis on the role of the family but stressed the cathartic value of discussing worries and concerns with friends, suggesting a willingness within this group to discuss emotional problems in a candid way. Our results echo the importance and acceptability of religion in helping many black Caribbean people of all ages cope with emotional distress (Cinnirella & Loewenthal, 1999; Marwaha & Livingston, 2002; O'Connor & Nazroo, 2002). Prayer was allied to the concept of self-help, and it was implied that without a true relationship with God, depression would be difficult to overcome. Seeking informal or formal help might signify insufficient faith in this context. Health-care professionals may need to work closely with religious leaders if they are to challenge these deep-seated beliefs.

Research indicates that younger South Asian people tend not to medicalize emotional distress (Beliappa, 1991; Fenton & Sadiq-Sangster, 1996; Patel & Prince, 2001). The South Asian group within our study was most likely to view the nature of depression as incompatible with the GP's role, which they conceived as prescribing medication and making referrals. This may account for the tendency among South Asian older adults to remain uncritical of GPs despite evaluating them as rarely helping with depression. Promoting the concept of depression as a treatable medical condition might resolve this problem and help legitimize help-seeking. However, it is also likely to be of value to reassure older adults that it is appropriate to voice concerns about their emotional state in a GP consultation.

The idea of counselling was embraced by the black Caribbean group in particular. Their limited experience of counselling paralleled that of other groups, yet their greater enthusiasm possibly reflects the high value placed on confiding in others (Priest *et al.* 1996) and being genuinely 'listened to' by professionals (Abas, 1996). Participants communicated both a willingness and a desire to discuss how they feel. This was especially pronounced among the black Caribbean participants, yet members of all groups valued the opportunity to talk, without fear of boring others, becoming a burden, or being judged. This has implications for referral to practice counsellors and practice nurses. It also suggests that active probing might precipitate depressed older adults to enter into a dialogue with their GPs about how they feel.

Psychiatrists were generally regarded negatively and participants were conscious of the stigma attached to receiving help from this profession. This was especially pronounced within the ethnic minority groups, as reported in other studies (Rack, 1982; Marwaha & Livingston, 2002). There is a need for education concerning the role of psychiatrists, as well as for accurate information regarding the risks of dependency and actual side-effects with medication.

Those participants who were receiving medication for depression were least positive about the GP's contribution. This was partly due to a feeling that medication represented an insufficient response to their needs. However, the prevailing attitude was that the amount of time and attention given to them by GPs was insufficient. It has been reported that groups receiving treatment for depression are more prone to adopt medical models of depression that conform to the GP's approach (UMDS MSc in General Practice Teaching Group, 1999). However, our sample of older adults appeared to attach greater significance to the role of psychosocial factors. These findings underline the need to develop a wider psychosocial response to depression in older adults if we are to provide services that are acceptable to those who need them.

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DECLARATION OF INTEREST

None.

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