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When Do Older Adults Seek Primary Care Services for Depression?
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Research suggests many older adults suffer from depression with clinically significant levels of depressive symptoms found in 10% or more of noninstitutionalized older adults (Roberts et al., 1997). Moreover, depression is the most common psychiatric condition encountered in primary care, often associated with such chronic illnesses as Parkinson’s disease, cardiovascular disease, stroke, and Alzheimer’s disease (Burns, 1991; Cummings, 1992). Hence, primary care providers frequently are the first line of intervention for depression and have a broad armamentarium of treatments and referrals that may help older adults cope with dysphoria, anhedonia, and the other symptoms of depression (Borson et al., 2001; Luber et al., 2001). Unfortunately, only a small percentage of depressed older adults actually receive treatment of this disabling disorder. One reason for service under-use is that older adults who choose not to discuss depressive symptoms with their doctor thereby blocking an important avenue to care. This paper examines two sets of possible barriers to discussing depressive symptoms with a primary care physician: individual perceptions of disapproval from one’s support system and perceived unaffordability of services.

The relationship between one’s support system and seeking services for depressive symptoms is complex. On the one hand, the older adult’s perception of the supportiveness of his or her social network has been shown to correlate inversely with depression; older adults who feel supported by their social network have diminished risk for developing depression (Russell and Cutrona, 1991; Stallones et al., 1990). Research has shown that those with sufficient social support are more resilient to life stress and less likely to be overwhelmed by depression and other psychiatric problems (Brandtstaedter, 1999; Hybels et al., 2001). This would suggest that older adults who report general satisfaction with their support network will experience less depression and hence, be less likely to need psychiatric services from their physician. Alternatively, willingness to receive help from others (which is a component of perceived social support) may be a proxy for general openness to discuss health problems with professionals. This assertion may also be understood in terms of its opposite; those who do not generally want help from others are unwilling to discuss depression (or most health concerns) with a physician. This leads to a competing hypothesis; namely, people who report good social support and willingness to receive help may also
report more discussion with their physician.

Finally, failure to pursue services for depression may be affected by socioeconomic factors. Older adults may not seek psychiatric services because they are perceived to be unaffordable (Halgin and Caron, 1991). This effect may appear as a general relationship between income and discussing depression with one's physician. Alternatively, real income may be less relevant than perceived affordability; those who believe most health services are unaffordable are less likely to discuss depression with their physician. Our study includes variables that represent annual income and perceived affordability of services to address these hypotheses.

METHODS

Data for this study were collected from community dwelling older adults in the City of Chicago. As part of a service-seeking survey, participants were asked the central question of this analysis, “Yes or no: Have you and a physician discussed depression?” We expected the answer to this item to be affected by current depression as assessed using the Geriatric Depression Scale screen (GDS-screen; Stiles and McGarrahan, 1998). The GDS-screen comprises 5 items representing common depressive symptoms in older adults to which participants answer “yes” or “no” (e.g., I feel worthless).

The survey also included items assessing participants’ perceptions of social support. “Receives help from others” represents 6 yes/no items about whether the respondent receives assistance in a variety of life domains (e.g., with housework or nursing care). The Cronbach’s alpha for the aggregated score was 0.80. “Counts on others” was the sum of two 4-point Likert scale items representing how much respondents feel they can count on family or on their friends (4 = never); the correlation between these items was 0.22 (p < 0.001). “Satisfied with others” was the sum of two 6-point Likert Scale items (6 = very dissatisfied) representing satisfaction with family and with friends (r = .53, p < 0.001). Two sets of items were proxies for stigma and represented comfort with mental health treatment. The first, “tell others about treatment”, was the sum of 5 yes/no items whether the respondent would tell family, friends, and others about receiving mental health treatment (alpha = 0.35). The second was a single 5-point Likert scale item representing the person’s “comfort talking to mental health providers” (4 = very uncomfortable).

Two variables represented economic solvency and ability to afford services. The first, “can afford treatment”, was a sum of five, 4-point Likert scale questions (e.g., I can afford to see a physician (1 = always true, 4 = never true); Cronbach’s alpha was 0.76. The second variable grouped respondents’ self-reported annual income into one of 11 categories (1 = less than $4,000; 11 = $90,00–$99,000).

RESULTS

Two hundred and thirty-two older adults agreed to participate and completed the survey; 230 provided useable data for the analyses reported here. The average age was 77.5 years (SD = 9.2) and the majority of the respondents were female (67.1%). Participants identified themselves as mostly European American (89.3%), in addition to African American (2.6%), Latino (3.4%), and other (4.7%). A little more than half of the respondents were widowed (52.6%), while 17.9% were currently married. An equal percentage of respondents were separated/divorced or single, never married (13.7% each); and 2.1% other. Education and income are discussed
The goal of this study was to identify correlates of older adults who talk to their primary care physician about depression. We expected a community-based population of survey participants to vary in their rates of discussion of depression with a physician, depending on their actual level of depression; in this study, depression was assessed using the Geriatric Depression Scale screen (GDS-screen). For the remainder of the analyses, we split the sample four ways: depressive symptoms (none, GDS-screen = 0; some, GDS-screen = 1) by discussed depression with primary care physician (yes, no). This 4-way split allows identification of variables associated with talking to one’s physician by an independent measure of current depressive symptoms.

Table 1 summarizes the means and standard deviations of social support, cognition, and affordability variables across the four cells. Subsequent $2 \times 2$ (depression level by physician discussion) ANOVAs were completed with each of these as dependent variables. First, we examined how perceptions of others interacted with this distinction. In terms of counting on others, a main effect was found for depression level with those who believed they could NOT count on others reporting some GDS-screen depression; $F(1,229) = 8.65, P < 0.01$. Although no main effect was found for physician discussion, $F(1,229) = 0.04$, n.s., a significant interaction was evident, $F(1,229) = 3.34, P < 0.05$; people who reported not being able to count on others and reported some GDS-screen depression were most likely to discuss depression with their physician. This finding was further supported by social satisfaction levels. A nonsignificant trend was found for the main effect representing discussion with physician, $F(1,229) = 2.84, P = 0.09$; older adults who were satisfied with the support of others were less likely to discuss depression with their physician. A significant effect was also found for depression level, $F(1,229) = 10.00, P < 0.01$; those who were more likely to report depression on the GDS-screen also reported less satisfaction with others. Finally, a significant interaction was found, $F(1,229) = 6.07, P < 0.01$; people who reported some GDS-screen symptoms and less satisfaction with others were more likely to discuss depression with their physician.
How does social support affect this pattern when helping behavior is added to the picture? Receiving help from others was found to yield a main effect for depression level, $F(1,229) = 6.37, P < 0.05$; those who reported receiving more help from others also reported some symptoms on the GDS-screen. No significant main effects were found here for physician discussion, $F(1,229) = 1.70, n.s.$, or the interaction, $F(1,229) = 0.13, n.s.$

Stigma may enter this equation when older adults decide not to tell others in their support network about possible treatment of depression. A main effect was found here for discussing symptoms with a primary care physician, $F(1,229) = 4.29, P < 0.05$. Those who reported discussing depression with their physician were generally more likely to talk to others about mental health treatment. This variable did not yield a significant effect for depression level, $F(1,229) = 2.06, n.s.$, nor a significant interaction, $F(1,229) = 1.98, n.s.$ Another way to consider the effect of stigma is in terms of reported level of comfort talking to a mental health provider. Results failed to show significance for depression level, $F(1,229) = 0.45, n.s.$, or physician discussion, $F(1,229) = 1.34, n.s.$, but a nonsignificant trend was found for the interaction, $F(1,229) = 2.97, p = 0.08$. Those who were more...
comfortable talking to mental health providers were more likely to report discussing depressive symptoms with a physician when they were depressed.

Two analyses were conducted to determine the effects of economic solvency on the pursuit of health care services. First, a $2 \times 2$ ANOVA was completed with perception of service affordability as the dependent variable. Nonsignificant results were found for depression level, $F(1,229) = 1.60$, n.s.; physician discussion, $F(1,229) = 0.15$, n.s.; and the interaction, $F(1,229) = 0.39$, n.s. A similar picture is discovered when reported income is the dependent variable. Nonsignificant findings resulted for depression level, $F(1,229) = 0.03$, n.s.; physician discussion, $F(1,229) = 1.02$, n.s.; and the interaction, $F(1,229) = 0.75$, n.s. Note that the sample showed a broad range of income categories; hence, these findings do not result because all the participants enjoyed a comfortable income where such worries are not evinced. We conclude, therefore, that income considerations do not seem to affect whether a person discussed depression with his or her primary care physician.

DISCUSSION

The purpose of this study was to examine why some older adults who might benefit from primary care services for depression do not discuss these options with their physician. The sample was divided into 4 groups: those with no and some depression on the GDS-screen crossed with those who had or had not discussed depression with their primary care physician. Subsequent analyses showed that perceptions of social support and willingness to discuss mental health treatment explained this four-group distinction. In particular, people who reported satisfaction with others, and believed they can count on family and friends were less likely to discuss depression with their primary care physician. The results suggest older adults with better social support reported less depression. But there also seemed to be less willingness to discuss depression with physicians when they had supportive others with whom they could talk about life problems. Perhaps having a support network of family and friends decreases the need for primary care service. Future research needs to determine whether this finding may arise because the person is able to deal with depression through the assistance of others.

Perceptions of others yield a more complex impact when the perceived stigma of mental health treatment is added to the mix. Two proxies of perceived stigma were used in the study: comfort talking to mental health providers and willingness to discuss mental health issues with family and friends. Both were found to be significant and positive correlates of who had discussed depression with their physician. This finding supports other research that has shown a positive association about concerns that family and friends do not approve of mental health services and subsequent participation in care.

These data add further support to the need for education programs that will change public openness to discussions of mental illness and corresponding treatments (Corrigan and Penn, 1997). Education programs that undermine the stigma related to mental health treatment might focus on messages like “Seeing a psychiatrist does not mean you are weak,” or “There is nothing bad about people who see psychotherapists.” Results have shown that relatively brief education programs can lead to significantly improved attitudes about mental illness (Corrigan and Penn, 1999). However, research has yet to show that change in attitudes is maintained over time or that improved attitudes lead to behavior change. Future research will need to more directly address questions like these.
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