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Concepts and Causation of Depression:

A Cross-Cultural Study of the Beliefs of Older Adults

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Purpose: This U.K. study explored how older adults with depression (treated and untreated) and the general older population conceptualize depression. A multicultural approach was used that incorporated the perspectives of Black Caribbean, South Asian, and White British older adults. The study sought to explore and compare beliefs about the nature and causes of depression, and to suggest ways in which these beliefs act to facilitate or deter older people from accessing treatment. *Design and Methods:* One hundred and ten in-depth separate interviews were conducted for 45 White British, 33 South Asian, and 32 Black Caribbean individuals. The interviews explored what the word *depression* meant to participants, and their beliefs regarding depression's causes. *Results:* Depression was often viewed as an illness arising from adverse personal and social circumstances that accrue in old age. White British and Black Caribbean participants defined depression in terms of low mood and hopelessness; South Asian and Black Caribbean participants frequently defined depression in terms of worry. Those receiving antidepressants were more likely to acknowledge psychological symptoms of depression. Differences in attribution were found between the ethnic groups. *Implications:* A social model of depression is closer to the beliefs of older people than the traditional medical model. Culturally appropriate inquiries about recent life events could be

used to facilitate discussion about depression. Our data suggest that many older adults would respond to probing by primary care physicians about their mood. Health and social care professionals need to be sensitive to the language of depression used by different ethnic groups.

Key Words: Depression, Qualitative methodology, Ethnicity, Cultural differences, Mental health

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Depression is the most common mental disorder in later life, affecting up to 15% of those individuals over the age of 65 (Livingston, Hawkins, Graham, Blizard, & Mann, 1990). It is a serious disorder associated with a profound decrease in quality of life (Gurland, 1992), suicide (Conwell, Rotenberg, & Caine, 1990), and nonsuicidal excess mortality that is unexplained by physical disorder. It also places a substantial burden on family carers and the health and social services (Livingston et al.). Despite this, only around 15% of older people with depression receive appropriate treatment from primary or secondary care services (Blanchard, Waterreus, & Mann, 1994). High levels of depression and low levels of active management are not confined to the mainstream White British population. Research indicates similarly high levels of depression among South Asian and Black Caribbean older adults (Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001; O'Connor & Nazroo, 2002), and even lower levels of service use (Boneham & Williams, 1997).

Suggestions of unmet need among ethnic elders (Ebrahim, 1996) require an exploration of the potential barriers and facilitators to service use. The process of help seeking, identifying need, help offering, and help accepting is complex and poorly understood. In their pathway-to-care model, Goldberg and Huxley (1980) described a succession of filters within this process that determine whether people access specialist care. They argued that people's beliefs and attributions about illnesses are fundamental to the way individuals respond to symptoms; they inform individuals' decisions to seek help and the manner in which they present to services. At present, much of our data on these issues has been derived from studies focused on the needs of working-age adults (Commander, Odell, Surtees, & Sashidharan, 2004; Jacob, Bhugra, Lloyd, & Mann, 1998; Karasz, 2005; O'Connor & Nazroo, 2002); among older adult research, very few studies have examined conceptual models of depression across ethnic groups (Marwaha & Livingston, 2002). We know of no other qualitative study that has combined the perspectives of depressed and nondepressed older adults among the three largest ethnic groups in the United Kingdom.

A major reason for elderly people not to report psychological symptoms to their General Practitioner (GP) may be that such symptoms are seen as a normal part of aging, rather than an illness amenable to treatment (Levkoff, Cleary, Wetle, & Besdine, 1988). This is an example of how an individual's decision to seek help may be fundamentally linked to differing explanatory models of mental distress (Goldberg & Huxley, 1980). Attributions of the causes of depression have been found to vary between different ethnic groups (Beliappa, 1991; O'Connor & Nazroo, 2002). Bhugra (1996) found that South Asian women of all ages had a clear understanding of psychosocial aspects of depression but were not predisposed toward medical models or explanations. Abas (1996) suggested that older Caribbean people construe mental disorders as secondary to other unmet needs (e.g., physical, social, spiritual).

Despite high attendance among depressed older adults, depression is both underrecognized and poorly managed in primary care (Blanchard et al., 1994). It appears

that the stigma of mental illness is keenly felt by elderly individuals: Schulman (1989) argued that older adults are less likely to report lowering of mood as this generates feelings of shame; Levkoff and colleagues (1988) hypothesized that elders' discomfort in admitting symptoms of a psychological nature leads them to legitimize their help seeking with an overly negative appraisal of their physical health. Research has pointed to even higher levels of stigma surrounding depression within minority ethnic groups (Cinnirella & Loewenthal, 1999; Marwaha & Livingston, 2002; Rack, 1982).

Evidence suggests that Asian and Black Caribbean patients have their psychological problems identified less frequently than their White counterparts (Comino, Silove, Manicavasagar, Harris, & Harris, 2001). This may be a function of the variable ways in which depression is manifested and reported by different ethnic groups (Bhui et al., 2001; Odell, Surtees, Wainwright, Commander, & Sashidharan, 1997). Somatization by the patient appears to hinder recognition of depression by GPs (Bridges & Goldberg 1985), especially within patients originating from the Asian subcontinent (Wilson & MacCarthy, 1994). However, Krause (1992) found that although Punjabi immigrants tended to somatize, they were able to articulate their distress in psychological language. Practitioners have been urged to inquire beyond the initial somatic presentation (Weiss & Kleinman, 1998) and to be aware of the subtle variations in presentation that occur across ethnic groups (Paykel et al., 1997). Fenton and Sadiq-Sangster (1996) noted that South Asian women of working age used culturally specific expressions for mental distress (e.g., "thinking too much in the heart"). Research suggests that older Caribbean people rarely use the terms *sad* or *unhappy* but instead articulate that they are *low spirited*, *fed up*, *weighed down*, or *feeling low* (Abas, 1996; Baker, Parker, Wiley, Velli, & Johnson, 1995; Mallet, Bhugra, & Leff, 1994).

In order to generate services that are accessible and acceptable to older adults across different ethnic groups, service providers need to understand the illness beliefs that underlie help-seeking behavior and the likelihood of help being offered and accepted. In this article, we report the findings of a qualitative study exploring how White British, South

Asian, and Black Caribbean older adults conceptualize depression. The data incorporate the perspectives of older adults with depression (treated and untreated), and the general older population from majority and minority ethnic groups.

Methods

We conducted in-depth individual interviews with (a) older people with depression who were being treated (D&T); (b) older people with depression who were not being treated (D&NT); and (c) older people without depression (ND). Comparing and contrasting the attitudes of these groups enabled us to explore how the beliefs of older adults relate to the experience or treatment of depression. Each group comprised White British, South Asian, and Black Caribbean participants. Among older people, Black Caribbean and South Asian individuals represent the two largest ethnic groups in the United Kingdom. We explored their views alongside the perspectives of White British older adults to identify the extent to which they differed or overlapped with the majority population. Using British census categories, we had participants self-designate their ethnicity (Office for National Statistics, 1991). We identified participants through seven primary care practices, located in areas of varied sociodemographic characteristics. GPs provided access (either directly or through notes) to information on age, ethnicity, and treatment status. We sent eligible patients an invitation letter, which we followed with a phone call from a member of the research team. However, despite selecting general practices located in areas with a high concentration of South Asian and Black Caribbean patients, we found that older people within these groups were difficult to identify; very few were receiving treatment for depression. Therefore, we also recruited from day centers and lunch clubs: four primarily serving the Black Caribbean community, four serving the South Asian community, and two serving the White British community.

We defined a *case* of depression as a score of 7 or above on the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), which was developed to be unaffected by coexisting general medical conditions (Snaith, 1987) and reliable across medical

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

We determined the number of interviews completed in each group by saturation of data, that is, the point at which no new themes emerged from the interviews. One hundred and ten older adults participated in the study. Among the older people in the White British group, ages ranged from 67 to 93 years ($M = 76$); in the Black Caribbean group, from 61 to 93 years ($M = 74$); and in the South Asian group, from 60 to 84 years ($M = 71$). Table 1 shows the composition of the sample in terms of the key sampling variables.

We generated topics for the interview guides from the literature. We revised them in an iterative way, incorporating new topics emerging from the interviews. We constructed a vignette describing an older person with symptoms typical of depression from a version successfully used in a cross-cultural study of concepts of depression in working-age adults (Bhugra, Baldwin, & Desai, 1997). We used the vignette as a starting point to enable us to explore the idioms used to express mental distress and attitudes toward mental illness in our sample (Bhugra et al.; Fenton & Sadiq-Sangster, 1996; Marwaha & Livingston, 2002).

We then asked participants what the word *depression* meant to them; whether they considered depression to be an illness; whether they viewed it as being a serious condition distinct from feelings of sadness or grief; and what they thought might cause depression. Follow-up questions focused on who might be vulnerable to depression and whether particular times in life or circumstances increased the likelihood of developing depression.

Information sheets, consent forms, the Hospital Anxiety and Depression Scale, and the vignette were available in four Asian languages: Gujarati, Hindi, Punjabi, and Urdu. Interviews lasted up to 1 hr, and we conducted them in participants' own homes and their preferred language. We recorded them on audiotape and transcribed them verbatim (those conducted in an Asian language were first translated by the interviewer). Three members of the research team scrutinized and coded the initial transcripts; two of the

researchers were directly involved in the fieldwork, and the third was a senior researcher experienced in qualitative research and the area of mental health and aging. The team identified and labeled initial themes and developed categories. The researchers cross-checked their coding strategies; after detailed discussion, they achieved consensus. We compared the content of subsequent interviews with the categories on an ongoing basis; we verified and developed existing codes and added new codes when necessary. We performed our analysis with the aid of NVivo qualitative data-analysis software (QSR International, 2002). Decisions regarding conclusions and interpretations were made in team meetings involving all of us. Quotations used in the text are labeled by the participant's ethnicity (Black Caribbean, or BC; South Asian, or SA; and White British, or WB), experience of depression (ND, D&T, D&NT, and control, or C), and identification number (e.g., BC/ND4).

Results

Table 2 details the distribution of themes across the ethnic groups. We acknowledge that the table represents a profound simplification, but we think it is important to provide a clear summary of the similarities and differences across the ethnic groups.

Concept of Depression

Depression as Illness.—We asked participants whether they considered depression to be an illness. Approximately three fourths of the Black Caribbean participants and two thirds of the White British participants believed that it was. However, only one third of the South Asian group defined it in this way: "No it's not an illness; it's just that you shouldn't worry too much" (SA/ND1).Varying interpretations of the word *illness* were adopted, but the most common criterion for depression as an illness was that it had a profound effect on a person's ability to live his or her life: "Yes it is [an illness] because when you are depressed you don't eat dinner, you don't feel like doing anything, you feel like 'oh I am just going to sit'" (BC/D&T3).

7

Only five participants stated that they didn't know what depression was; they explained that they felt unqualified to offer a description of depression because they lacked personal experience of it.

Depression as Sadness and Grief.—Whereas the majority of White British participants argued that depression and sadness or grief represent distinct conditions, only one in three Black Caribbean participants and one in four people of South Asian origin shared this view.

A common opinion, shared across the ethnic groups, was that feelings of sadness or grief were distinct from depression in that they were transient and would eventually pass. In contrast, depression was portrayed as an immutable and formidable condition: "depression is a blanket that holds you down and keeps you there"; "the depressive state, untreated, can go on forever." Another common view was that sadness and grief, unlike depression, were normal and explicable reactions to difficult life events and circumstances: "With sadness it's got to be something happen to make you sad, but depression I think it just comes on" (BC/D&NT8).

A large group, predominantly from Black Caribbean backgrounds, stipulated that, although they did not directly equate sadness or grief with depression, they did perceive them to be strongly interrelated. It was noticeable that participants in this group not only spoke about grief for loved ones, but also for days gone by: "Grief causes depression … yes thinking of what you used to do when you was younger and still you cannot do anything, you think about it, grieving about it" (BC/ND6).

Depression as a Serious Condition.—Only minor differences existed between the three ethnic groups in the extent of belief that depression is a serious condition. Although the view was most prevalent among White British older adults, the majority of Black Caribbean and South Asian elders also evaluated depression in this way. As one person said, "I am aware that depression is a most shocking terrible thing to be in, fearful, fearful, shocking" (WB/ND10). Another stated that, "when someone becomes really depressed they can

actually die, they can die in depression … just through worry, you know they say 'Why, why is this happening to me' and day by day their depression gets worse" (SA/D&NT12). There was recognition that if help was not found, depression had the potential to get worse and worse and could sometimes cause people to take their own lives.

Loss of Confidence.—Loss of confidence was a feature of depression recognized and experienced by participants in all three ethnic groups. The principal manifestation was apprehension and self-doubt when mixing with others. As one person said, "[You feel] inadequate, don't relate to people, you don't feel confident that people respond to you in a positive way, you feel lacking in confidence" (WB/ND13). Others described "shying away from people" to such an extent that they experienced an overwhelming desire to hide or to be alone. One man spoke about his "compelling desire to stay at home" and others explained how you "shut yourself into a little shell." One person said this: "Sometimes I want to be alone, nobody should come near me, I couldn't, any little noise affect me, sometimes I feel like running away never to come back" (BC/D&NT8).

South Asian participants, in particular, commonly perceived individuals with depression as becoming introverted and disengaged from society. Similarly, there was a common view that sufferers become emotional and oversensitive.

Ability to Function.—A central theme concerned the effect that depression has on an individual's ability to function on a day-to-day basis. The majority of participants who expressed views on this theme were themselves suffering from depression. One recurring issue, principally voiced by those from Black Caribbean backgrounds, was that depression both stems from, and exacerbates, loss of independence:

> Well to me it means like, em, if you sit down and everything just comes in your mind, you are depressed over it, saying I had this to do and I can't do it. That's how I feel depression is, when you can't do it for yourself. You are depressed, you want to do it, but you can't manage to do it. (BC/D&NT3)

Participants from all backgrounds described the way in which depression had left them feeling unable to cope with self-care, paying bills, and everyday tasks. A large number of depressed White British participants defined it in terms of loss of motivation. Participants described lacking impetus in the mornings: "you just don't have no desire to get up," "everything is an effort," and "[you] can't be bothered with anything." Across the ethnic groups, those who had experienced depression tended to give specific examples of how they lacked the motivation to wash, dress, do the housework, or even eat.

> Depression is when you are sitting down somewhere and you keep on sitting and whether you have not eaten, you don't know that you have not eaten, and you cannot fetch anything for yourself. … If you haven't changed, you will be sitting in the same nightie all day. That I call depression. (SA/D&NT11)

Loss of appetite and disrupted sleeping patterns (i.e., functional disturbance) were mentioned in all three ethnic groups. It was striking that those participants receiving antidepressants tended to interpret depression in a distinctive way; they identified loss of confidence, motivation, and independence and variations in mood as principal features of depression: "You can't do anything … there's no impulse in you to do something. That bit of you seems to have died and you don't feel things in the same way" (WB/D&T15).

Hopelessness.—Some concepts of depression emerged as more culturally specific. Hopelessness was an experience described predominately by White British participants and to a lesser extent by those of Black Caribbean origin. The experience of depression was often encapsulated in the belief that "you will never find a way out" and was typically conveyed through metaphors of darkness. As one individual said, "I have had depression, it's like a menace. I feel, everything just seems dull and black and horrible. … Like a big black tunnel, that's the only way, that's how it used to be for me" (WB/D&NT6). Another said this:

I think you feel you are in a black hole somewhere and no light at the other end …
what I hear people say is that there is no escape, everything looks dark, everything
is bleak and there is no tomorrow. (WB/D&NT)

Others talked more generally of lacking hope for the future, and a small number of
individuals acknowledged the gravity of depression by introducing a discussion of suicide.

Low Mood.—Overall, the most common mode of describing depression was in
terms of low mood. As with feelings of hopelessness, low mood was most frequently
articulated by White British and Black Caribbean participants, whereas these descriptors
were largely absent from the South Asian accounts. Expressions such as "low in spirits,"
"down in the dumps," "miserable," and "feeling fed up" were exclusively used by the White
British group. Over one third of black Caribbean participants described depression in
terms of "feeling low" or "feeling down."

Worry.—South Asian and black Caribbean elders frequently defined depression in
terms of worry, emphasizing troubles within the mind. Excessive worry was believed to
characterize depression both as a cause and as a defining symptom:

What's depression? You tell me. Depression is this, isn't it? It's when you just
worry all the time, you keep thinking, this is depression, isn't it? You know, you
stop and you think, oh what's happening here, what shall I do, I want to do
something but I can't do anything. (SA/D&T2)

You know what causes it, worries, worries, some people worry until they go mad.
(BC/D&NT13)

South Asian participants in particular tended to articulate the experience of worrying in terms of recurring or persistent thoughts: "thoughts go around in your head," "thinking inside the mind," and "thinking too hard." Other South Asian and Caribbean participants described the experience of depression in terms of the loss of a healthy mind, using metaphors such as "when your mind gets tired" and even "when the mind has died."

Personality.—A predominantly nondepressed South Asian group believed depression to be a "mental attitude" or a "state of mind," suggesting a nonpathological condition that stemmed from personal characteristics. One individual said this: "I think it's the attitude of the person isn't it? Some people have so much suffering and still they are happy, laughing, and things, but some people for every little cause they become so sad" (SAD10).

Other related concepts of depression included "not clear thinking" and a "negative outlook."

Causes of Depression

Loss.—Loss was seen as the primary cause of depression across the ethnic groups. Participants cited the grief that they had experienced at the loss of loved ones and for the loss of the freedom and insouciance of their younger days. Depression was also attributed to the loss of good health, of their established role in life and of hope for the future. The sense that individuals were grieving for how things once were permeated these accounts.

Aging and Loss of Independence.—We found that *old age* was used as an umbrella term to encapsulate many causal factors in depression. Over half of the participants in the sample believed that the aging process, with accompanying health, personal, and social problems, precipitates depression. These negative perceptions tended to be expressed in a matter-of-fact and unequivocal manner, suggesting that depression was seen as an inevitable consequence of aging: "Well I suppose if you are

old and you are going to die you are going to get depressed, that's fairly straightforward isn't it?" (WB/ND17).

Physical health problems and loss of independence were seen as important causes of emotional distress in all three ethnic groups. Words such as *frustration*, *annoyance*, *fear*, and *helpless* were used to characterize the experience of being forced to rely on others. One man described it as "like being in prison." The transition from employment to retirement also emerged as a principal issue. Older people spoke of their struggle to adapt to their change of role; a small number believed retirement to be a direct cause of depression as it evoked feelings of being useless and unwanted: "you are chucked on the scrap heap."

Participants from all ethnic groups spoke about having nothing to look forward to and their resignation that circumstances would not improve. These comments were strongly associated with age and communicated their consciousness of death. One person stated that, "you get the feeling that you are just waiting to die."

Bereavement and Loneliness.—More than one in two of the White British participants, in contrast to fewer than one in five people from a Black Caribbean background, cited bereavement as a precursor to depression. White British older adults who were receiving treatment for depression appeared to regard loss of a spouse as the key cause: "With elderly people it is mostly sadness and loss of a loved one, left on your own, and as I say after about 60, nearly 60 years I was married, it is not easy" (WB/D&NT2).

South Asian elders were alone in giving equal emphasis to the loss of a spouse and the loss of other family members: "It's the balance. Say you have six, seven, eight brothers, things like that, a large family, and suddenly they all disappear by the time you are old enough, [then] you get depressed" (SA/ND13).

Depression was often presented as an inevitable accompaniment of loneliness, an emotion that was felt to permeate all areas of life. More than half the participants emphasized lack of social support, isolation, and feelings of loneliness as direct causes or

vulnerability factors for depression. These complaints frequently dominated the Black Caribbean accounts.

> Some people are more likely to become depressed than other people, yeah, some people, you see some people live a lonely life and when they are lonely they become depressed. Depression starts in loneliness, Miss, I can tell you, it starts from loneliness. (BC/D&T4)

Relationships.—Although participants from all ethnic groups identified marital problems and breakdowns as causes of depression, these problems were not experienced in a uniform way. Among White British and Black Caribbean participants, mistreatment and abandonment by partners were recognized as possible causes, whereas in the South Asian group, problems centered on being in an incompatible marriage or being compelled to tolerate a partner who was "no good." As one individual stated, "some people are married and their husband leave them and all them kind of things worry them and the children not doing things that they would like, all those things bring depression" (BC/ND8). Another said, "also then it's the marital happiness, if there is unhappy circumstances that also brings depression, that you haven't found the right person" (SA/D&NT11).

Worry about family members emerged as a marked source of distress. South Asian participants in particular viewed problems within the family and a difficult "home atmosphere" as being integral to depression. Many of these participants worried extensively about their children, and several spoke about their distress following their children's marital difficulties or divorce. They were troubled by the different values and lifestyles of the younger generation and the conflict this caused.

> I mean the Sikh community suffers more from depression than anybody else because the coming generation is different, they have gaps. … Generation gap and that is why a lot in the Sikh community are suffering from that because their

customs, religion is different. The coming generation their behavior is different, it is

not acceptable to the parents or grandparents, that is why they get depressed.

(SA/ND7)

Within the White British group, concerns about the health of the participants'

spouses were paramount. There were also noticeable ethnic group variations in the

numbers mentioning lack of family contact or support as a contributing factor in

depression. Very few Black Caribbean participants raised the subject, although those that

did reflected on the absence of support networks within their current community compared

with how things had been in the Caribbean:

Sometimes you have a big family and they all drifted apart … you begin to think

back and say you know, especially those of us who have come from the West

Indies from a large family, we used to have them around, there to listen to you.

(BC/ND2)

Within the South Asian group, comments were directed at the level of support

provided by the participants' children. There was a feeling that some children were

unsupportive because this was not a priority in their lives. However, these comments were

infrequent and did not appear to be of primary concern. In contrast, this was an area

heavily emphasized by White British participants, who spoke a great deal about their

unhappiness that their children moved away, limiting opportunities for contact with children

and grandchildren. Lack of contact had led to feelings of neglect, abandonment, and

loneliness and a sense that there was little to look forward to.

Biological Factors.—A small number of White British participants suggested that

depression was a hereditary condition outside the control of the individual.

I think it's possibly to do with the genes, possibly. I can't think of any other reason why you and I are born differently. I am depressive and you are not, so I think it's the genes. … If it's in the genes what can you do? (WB/ND10)

White British participants were most likely to argue that depression has an organic or physiological basis, for example, "it's embedded in the brain." Those who had firsthand experience of depression were more likely to attribute the cause to a chemical imbalance.

Personality.—Personal attributes were among the most frequently identified vulnerability factors for depression, with large proportions of each ethnic group stating that specific personality traits increase the likelihood of depression. Expressions such as "mentally weak," "oversensitive," and "weak nerves" were especially common among nondepressed participants, particularly those from South Asian or Black Caribbean backgrounds.

Interviewer: What kind of people do you think are more likely to get depression?
Individual: Well I always say that the weak people, weakness of the character. If you are a strong person it is unlikely that you will suffer from depression. (SA/ND6)

Among White British older people who were being treated for depression, there was a strong feeling that those who lacked social skills and had a more introverted character were at greater risk of depression:

Some people sort of don't mix very well and don't get on with other people. It's not everybody that mixes in with other people and will do that, you can't. I mean all right some people can't help it, all right I mix with other people but I'm not lively company, you know not the best of the bunch sort of thing but I get by. … If you can talk to people and make yourself heard even if you say the right or wrong thing you are better off I think. (WB/D&NT2)

Social Causes.—A common view was that depression often followed difficult life events and circumstances, with financial problems the most frequently mentioned. Participants in all three ethnic groups spoke of their difficulties in adapting to a society with changing values. Some reported feeling unsafe going out, and others articulated their belief that there is little respect for elderly people.

Past Experience: Childhood Experience and Racism.—A small proportion of individuals associated depression with childhood experiences and life events. Half of the White British participants within this group (all of whom were depressed) explicitly attributed their current depression to a traumatic childhood or poor maternal relationship.

Those who had been born overseas occasionally discussed the difficulties of establishing a life in an unfamiliar, sometimes hostile country. Racist attitudes were implicated in the causes of depression:

> I think it has something to do with the lifestyle, nothing to do with race as such because you will find depression in all the races. …You know some people say that the Afro-Caribbean people or West African people are more generally depressed than the others, but I don't think so. They are depressed not because they are West African or Afro-Caribbean, because of their status. … Poor they are, always looked down upon and therefore their depression, that causes more depression in them because nobody accepts them first of all. (BC/D&NT10)

Discussion

The majority of participants in our study regarded depression as an illness arising from the adverse personal and social circumstances that can accrue in old age. It has been suggested that there is a propensity among older adults to "explain away" depression as a normal part of aging, and this prevents their seeking help for the condition

(Levkoff et al., 1988). However, in our study, an acceptance of the social and aging precipitants of depression was not incompatible with the concept of depression as an illness, or the view that depression is a serious condition distinct from sadness and grief. Categorizing depression as an illness appeared to validate and legitimize the experience.

The understandings of White British participants were closest to the western biomedical model of depression. The constellation of beliefs in the South Asian group, in which depression was least likely to be seen as an illness or a serious condition and most likely to be equated with "normal" feelings of sadness and grief, might make this group less likely to seek or accept health services for depression. A public education challenge exists in the recurring belief among South Asian and, to lesser extent, Black Caribbean participants that depression stems from a weakness or deficiency in character. This is consistent with previously reported high levels of stigma surrounding depression in these cultures (Rack, 1982). Fear of being ostracized by peers can act as a deterrent to help seeking within minority communities (Cinnirella & Loewenthal, 1999). A small number of White British participants attributed depression not to a failing of the individual but to a genetic predisposition. This presented as a means of enabling individuals with depression to rationalize the experience, and it is consistent with the view that White British older adults are more inclined to adopt a medical explanation (Beliappa, 1991).

The language used to describe depression also appeared to be culturally influenced. The propensity of the Black Caribbean participants to define depression in terms of feeling low or down is consistent with previous findings in younger age groups (Mallet et al., 1994). The White British participants spoke of variations in mood and feelings of hopelessness with even greater frequency, often employing metaphors of darkness to illustrate their point. The tendency of these groups to describe depression in terms of its emotional impact implies both an ability and willingness to enter into a psychological discourse. This is an encouraging indication that older adults would respond to discussion with health and social care professionals about their mood.

Only a small number of South Asian elders described depression in terms of hopelessness or low mood. Along with Caribbean elders, they frequently defined depression in terms of worry, with emphasis repeatedly being placed on troubles within the mind. Notably, the South Asian participants often articulated this worry in terms of "thinking too much," a phrase previously identified as a descriptor of mental distress within South Asian younger adults (Fenton & Sadiq-Sangster, 1996). Practitioners therefore ought to be aware of the different language that different ethnic groups may use to express depression. Those individuals receiving antidepressants were much more likely to acknowledge the psychological symptoms of depression: loss of confidence, loss of motivation, and a sense of diminished independence were cited across ethnic groups. Participants who were depressed but not receiving treatment appeared less aware of these symptoms of depression, suggesting that they would be less likely to spontaneously mention them to their doctor. Primary care staff should explicitly inquire about these symptoms.

We found differences in attribution in the themes emerging from the three ethnic groups. Complaints of loneliness were the focus of the responses from Black Caribbeans, although they were unique in the relatively modest emphasis that they placed on bereavement, family problems, and lack of family contact or support as a cause of depression. The view that older Black people in the United Kingdom reside within supportive extended family networks has been rejected as an inaccurate stereotype (Abas, 1996). Participants reflected that they now lacked the wider family presence that had existed in their country of origin. Research suggests a desire in the Caribbean elder community of the United Kingdom to return "home"; in addition to their families, these individuals also miss the community structures that characterize the social networks of Caribbean society (Stephenson, 2002). The use of the more diffuse descriptor *loneliness* may signify the loss of traditional social networks.

As in research in younger adults (O'Connor & Nazroo, 2002), Black Caribbean and White British participants tended to consider mistreatment and abandonment by partners

to be a likely cause of depression, whereas South Asian participants often associated depression with being in an incompatible partnership. The inclination of the South Asian group to relate wider family problems to depression is also consistent with work in younger age groups (Bhugra et al., 1997). Participants discussed the negative impact of a difficult "home atmosphere," and they expressed concerns about the discordance in values between their children and themselves. Guglani, Coleman, and Sonuga-Barke (2000) argued that this could cause older Asians to feel stripped of their role as "wisdom-givers" and transmitters of cultural heritage. A major cause of unhappiness within the White British group was the feeling that they enjoyed very little contact or support from their family. Increased contact was both longed for and highly valued when received. It seems likely that this absence of family support is related to the predominant role occupied by spouses within the White British group, where loss of the spouse is likely to leave an even greater vacuum in emotional support. A large proportion of White British participants receiving antidepressants cited bereavement as the key cause of depression, suggesting that bereavement may have been used to initiate discussion about depression in this group.

We drew our sample from five south London boroughs in which a very broad range of socioeconomic and ethnic diversity exists; they include some of the most deprived inner-city areas and some of the wealthiest suburbs in the country. Therefore, we believe that our findings have reasonable theoretical generalizability to Black Caribbean, South Asian, and White British older adults living in urban areas in the United Kingdom. There is a paucity of evidence in this area, and we felt that it was important to investigate broad issues inclusively rather than focus on a single highly defined population. The analyses have identified key themes that can enable and inform further, more detailed studies of cultural differences in beliefs about depression in these and other minority ethnic groups in the United Kingdom and worldwide.

Conclusions

The results of this study are likely to have implications for policy, practice, and education. For many people, depression represented a dysfunctional consequence of old age, thus providing an opportunity for clinicians to enter into a therapeutic dialogue with the shared intention of alleviating the depression and its associated handicaps. However, the model used by older adults from all ethnic groups was more akin to a social than a biomedical schema. This suggests that the approach clinicians need to take in engaging older people with depression in a therapeutic alliance would benefit from being framed in social as well as physical terms. Inquiries about recent life events and losses could be used to facilitate discussion with older adults about depression. More emphasis in medical training in how symptom attribution differs across ethnic groups can enable practitioners to frame their questions within an appropriate cultural framework. However, this is only a first step; clinicians have to explain the interaction of the social, psychological, and biological elements of causation, thus generating a shared understanding of the value of biological (such as antidepressant medication), as well as social and psychological, interventions.

Ethnic differences were evident in the conceptualization and attributions of depression. Practitioners need to stress, particularly with patients from minority ethnic groups, that depression is not a sign of weakness and that anyone can become depressed.   In turn, cultural- and language-specific public education could be directed as modifying public attitudes and understanding of depression not only to reduce stigma, but also to enable self-identification of the disorder.

In the United Kingdom, primary care is an important stage in an individual's pathway to specialist care. GPs should utilize the willingness of White British and Black Caribbean older adults to disclose emotional difficulties associated with depression. This may require reassurance from GPs that disclosure of feelings is appropriate in a medical consultation. Sensitivity to the "language of depression" used by different groups (e.g., "excessive thinking" within the South Asian group) will increase the likelihood of reaching an acceptable diagnosis and treatment plan. An understanding of cultural variation in the

expression of mental illness is fundamental to good health care, and this should form a normal part of training for health care professionals.

References

Abas, M. A. (1996). Depression and anxiety among older Caribbean people in the UK: Screening, unmet need, and the provision of appropriate services. *International Journal of Geriatric Psychiatry, 11*, 377–382.

Baker, F. M., Parker, D. A., Wiley, C., Velli, S. A., & Johnson, J. T. (1995). Depressive symptoms in African American medical patients. *International Journal of Geriatric Psychiatry, 10*, 9–14.

Beliappa, J. (1991). *Illness or distress? Alternative models of mental health.* City, England: Confederation of Indian Organisations.

Bhugra, D. (1996). Depression across cultures. *Primary Care Psychiatry, 2*, 155–165.

Bhugra, D., Baldwin, D., & Desai, M. (1997). Focus groups: Implications for primary and cross-cultural psychiatry. *Primary Care Psychiatry, 3*, 45–50.

Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). Cultural influences on the prevalence of common mental disorder: General practitioners' assessments and help seeking among Punjabi and English people visiting their general practitioner. *Psychological Medicine, 31*, 815–825.

Blanchard, M., Waterreus, A., & Mann, A. H. (1994). The nature of depression in older people in Inner London, and the contact with Primary Care. *British Journal of Psychiatry, 164*, 396–402.

Bridges, K., & Goldberg, D. (1985). Somatic presentation of DSM-III psychiatric disorders in primary care. *Journal of Psychosomatic Research, 21*, 473–483.

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on the beliefs about mental illnesses: A qualitative study. *British Journal of Medical Psychology, 72*, 505–524.

Commander, M. J., Odell, S. M., Surtees, P. G., & Sashidharan, S. P. (2004). Care

    pathways for South Asian and White people with depressive and anxiety disorders

    in the community. *Social Psychiatry & Psychiatric Epidemiology, 39*, 259–264.

Comino, E. J., Silove, D., Manicavasagar, V., Harris, E., & Harris, M. F. (2001). Agreement

    in symptoms of anxiety and depression between patients and GPs: The influence

    of ethnicity. *Family Practice, 18*, 71–77.

Conwell, Y., Rotenberg, M., & Caine, E. D. (1990). Completed suicide at age 50 and over.

    Journal of the American Geriatrics Society, 38, 640–644.

Ebrahim, S. (1996). Ethnic elders. *British Medical Journal, 313*, 610–613.

Fenton, S., & Sadiq-Sangster, A. (1996). Culture, relativism, and the experience of mental

    distress: South Asian women in Britain. *Sociology of Health and Illness, 18*, 66–85.

Flint, A. J., & Rifat, S. L. (2002). Factor structure of the Hospital Anxiety and Depression

    Scale in older patients with major depression. *International Journal of Geriatric*

    psychiatry, 17, 117–123.

Goldberg, D., & Huxley, P (1980). *Mental illness in the community: The pathway to*

    psychiatric care. London: Tavistock.

Guglani, S., Coleman, P. G., & Sonuga-Barke, E. J. (2000). Mental health of elderly

    Asians in Britain: A comparison of Hindus from nuclear and extended families of

    differing cultural identities. *International Journal of Geriatric Psychiatry, 15*, 1046–

    1053.

Gurland, B. (1992). The impact of depression on quality of life of the elderly. *Clinics in*

    Geriatric Medicine, 8, 377–386.

Jacob, K. S., Bhugra, D., Lloyd, K. R., & Mann, A. H. (1998). Common mental disorders,

    explanatory models and consultation behaviour among Indian women living in the

    UK. *Journal of Royal Society of Medicine, 91*, 66–71.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science*

    and Medicine, 60, 1625–1635.

Krause, I. B. (1992). Sinking heart. A Punjabi communication of distress. *Social Science and Medicine, 29*, 563–575.

Levkoff, S. E., Cleary, P. D., Wetle, T., & Besdine, R. W. (1988). Illness behavior in the aged: Implications for clinicians. *Journal of the American Geriatrics Society, 36*, 622–629.

Livingston, G., Hawkins, A., Graham, N., Blizard, B., & Mann, A. (1990). The Gospel Oak Study: Prevalence rates of dementia, depression, and activity limitation among elderly residents in Inner London. *Psychological Medicine, 20*, 137–146.

Mallet, R., Bhugra, D., & Leff, J. (1994, month). *African-Caribbean perspectives on depression.* Paper presented to the Royal College of Psychiatrists Defeat Depression consensus meeting, city, location.

Marwaha, S., & Livingston, G. (2002). Stigma, racism, and choice: Why do depressed ethnic elders avoid psychiatrists? *Journal of Affective Disorders, 72*, 257–265.

O'Connor, W., & Nazroo, J. (Eds.). (2002). *Ethnic differences in the context and experience of psychiatric illness: A qualitative study*. London: National Centre for Social Research and Department of Epidemiology and Public Health, Royal Free and University College Medical School.

Odell, S. M., Surtees, P. G., Wainwright, N. W., Commander, M. J., & Sashidharan S. P. (1997). Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner-city health district. *British Journal of Psychiatry, 171*, 537–541.

QSR International. (2002). *NVivo*. Victoria, Australia: QSR International Pty Ltd.

Schulman, K. (1989). Conceptual problems in the assessment of depression in old age. *Psychiatric Journal of the University of Ottawa, 14*, 364–371.

Stephenson, M. L. (2002). Travelling to the ancestral homelands: The aspirations and experiences of a UK Caribbean community. *Current Issues in Tourism, 5*, 378–423.

Weiss, M. G., & Kleinman, A. (1998). Depression in cross-cultural perspective: Developing

    a culturally informed model. In P. R. Dasen, J. W. Berry, & N. Sartorious, *Health*

    and cross-cultural psychology (Vol. 10, pp. 179–206). Newbury Park, CA: Sage.

Wilson, M., & MacCarthy, B. (1994). General practitioner consultation as a factor in the low

    rate of mental health service use by Asians. *Psychological Medicine, 24*, 113–119.

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta*

    Psychiatrica Scandinavia, 67, 361–370.