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**The perspectives of older people and GPs
on depression in later life and its
management: the stories they tell and
ways they respond to each other.**

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**A thesis submitted in partial fulfillment of
the requirements of the University of
Sunderland for the degree of Doctor of
Philosophy**

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Dedication

To my husband James for unfailing support and companionship every step of the way, and to my boys Benjamin and William for bringing a lighter side to life.

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With particular thanks to:

All of the older people and GPs who gave me their time and entrusted me with their stories.

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Abstract

Depression in older people is under recognized and under treated in primary care. This is despite symptoms being similar across the lifespan and many older people with depression regularly seeing their general practitioner (GP). Problems specific to its management set it apart from depression in younger people, and include both disparities in the way older people and GPs perceive depression and a shared view that it is a normal part of aging, as well as barriers to the way older people talk about it and the help GPs provide. This evidence indicates a lack of understanding about the ways both groups perceive depression, and how their different situations, positions and needs may influence what they say and do and ways they respond to each other in consultations. The research aim is therefore to explore how older people's and GPs' different positions and situations influence the ways they perceive depression. Particular focus is on influences reported by older people over ways they talk about depression and influences reported by GPs over ways they respond. In doing this the study seeks practical solutions to help GPs identify depression in older people and provide them with appropriate help.

The methodology and methods of this study are informed by a recent version of grounded theory, *Situational Analysis* (Clarke, 2005), which is philosophically orientated between symbolic interactionism and social constructionism. Clarke (2005) builds on the work of Strauss and Corbin (1998), assuming a social constructionist approach to grounded theory to enable exploration of how people's views are formed and how this influences their actions. Theory can be generated and located within changing and multi-faceted contexts by considering the wider situations of both the researcher and the researched and looking at the data from multiple perspectives such as historical, geographical and biographical. Semi structured interviews were conducted with older people and GPs as the main form of data, with the researcher's (IG's) observations of interviews as contextual data.

Using this approach a theoretical model has been developed to explain how older people and GPs operate in consultations for depression, proposing how different types of older people and GPs are likely to respond to each other. The stories older people report telling about their depression and the ways GPs report responding show the "porous" and "flexible" (Clarke, 2005, p.111) positions they

can take in consultations: the interview data suggests that older people can move between stages of understanding and accepting their depression, and GPs can move between styles of working and employ different combinations of skills in response to older people's stories. This element of change is key to the findings of this study and indicates the fluidity of their positions, where they change depending on what they perceive to be influences over them at the time.

This study highlights the importance of recognizing differences between ways older people and GPs operate in consultations and the different factors that influence ways they respond to each other. It suggests how GPs working in different styles might help older people based on the different ways they tell their stories, and a key message is that GPs who can adapt their skills to those needs are likely to be most successful in managing it. For example some older people may need GPs to help them make sense of their problems before they will accept treatment or therapy for depression and others may need GPs to take the lead on decisions when they are at rock bottom. The theoretical model suggests how GPs can quickly identify depression in older people and the stage of depression they are at by the stories they tell, and how they might adapt their skills in response to provide them with the most appropriate help. This is intended as a step towards understanding the reasons underlying what happens in consultations for depression in later life, and finding solutions for problems existing in its management.

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Glossary of terms and abbreviations

Terms

Adult	between 18 and 65 years
Older person	over 65 years
Child/younger person	under 18
The researcher	Isabel Gordon

Abbreviations

AC	Professor Ann Crosland
APA	American Psychological Association
BMA	British Medical Association
CBT	Cognitive Behavioural Therapy
CH	Dr Catherine Hayes
CPN	Community Psychiatric Nurse
CRB	Criminal Records Bureau
ECT	Electroconvulsive Therapy
ESRC	Economic and Social Research Council
GP	General Practitioner
GR	Professor Greg Rubin
HMSO	Her Majesty's Stationary Office
IAPT	Improving Access to Psychological Therapies
IG	Isabel Gordon
LR	Professor Louise Robinson
MH	Mental health
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NRES	NHS Research Ethics Service
NSF	National Service Frameworks
NyReN	Northern and Yorkshire Research Network (now Primary Care Research Network Northern and Yorkshire, PCRN)
PCT	Primary Care Trust
PHQ9	Patient Health Questionnaire PHQ9 for Depression
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RCP	Royal College of Psychiatrists
SHADE	Self Help Manual for Anxiety and Depression
SSRI	Selective Serotonin Reuptake Inhibitor
WHO	World Health Organization

Introduction

Preliminary ideas

This study arose from a curiosity to find out how people understand the world. The researcher of this study (IG) developed her interest in this whilst doing a Masters of Philosophy degree (MPhil) in Philosophical Studies and subsequent work as a researcher.

The focus of the MPhil study is on how ideas found in contemporary visual culture have developed over time and where origins of their meaning can be found (Carter, 2002). It is philosophically based around social constructionist thought and examines processes by which society constructs ideas, exploring the context within which these ideas are embedded and how these contexts change if they are examined at different points in time. The research process involved de-constructing ideas by breaking them down to find their origins and then rebuilding a multi-faceted “story” around each idea to suggest how its meaning is positioned within today’s culture. This resulted in the production of conceptual “montages” representing how concepts can be seen to be made up of different components of our culture such as historical, narrative, biographical, social, and visual. Doing this MPhil provided IG with experience of theoretically locating concepts and an understanding of how meaning is generated by society and individuals. It also gave IG insight into a philosophical framework that has helped in understanding the methodology used in this study, and underlined the importance of being able to apply it to real world situations.

Subsequent work as a researcher in the field of primary care also influenced ideas underlying this PhD study. Although the research was principally qualitative research into health beliefs, it related to the previous MPhil study as it was about how people understand ideas and how they form beliefs. It also extended to real world situations with focus on how people’s understandings of their health influence their actions. Doing a study on parent’s beliefs about childhood asthma (Crosland et al., 2009) underlined how people’s beliefs can inform their behaviour and decisions about their health. This work built on IG’s developing interest in health beliefs and a link became clear between this practical qualitative research

and the theoretical MPhil research around how ideas were constructed. A natural progression was to do a PhD that brought these components together.

While these ideas for the PhD were developing, the government agenda and research climate pointed towards a gap in the evidence base around primary care provision for common mental health problems in older people (Philp, 2004; Department of Health, 2006a; Lee, 2007). The Department of Health policy documents showed that older people's mental health had been low on the agenda and there was a lack of recognition of their needs. For example the mental health needs of older people and adults had been treated separately in the National Service Frameworks (NSFs) for Older People (Department of Health, 2001) and Mental Health (Department of Health, 1999) and improvements to provision for depression in later life was left out of both. Clinical guidelines also showed only sufficient evidence for psychological therapies combined with antidepressants for those over 65 but insufficient evidence for other forms of management (NICE, 2004). While there was increased focus on making mental health services "age inclusive" (Department of Health, 2006b) and more closely aligned to the needs of all patients (Appleby, 2007) there was little that highlighted the specific needs of older people with depression as opposed to younger people with depression. Older people's mental health had become a priority on the government health agenda with organic diseases such as dementia being made a priority and with primary care being targeted as the main provider for mental health services, yet depression in later life was notable by its absence. With this increasing awareness of the growing problem of depression in our aging population and its lack of recognition in primary care, the need to address this in further research was clear.

Background to the research aim

Clinical symptoms of depression are similar across the lifespan, but in practice it needs to be recognized that older people's life experiences, circumstances and perceptions of what depression is are different to those of younger people. Depression in later life has also been overlooked in health policy, guidance and services, and there are a number of cumulative factors that have contributed to this.

Historically the way health services have been developed for older people has been separate to those for other adults, so that all health provision including their mental health has been addressed together. Within this umbrella of older people's health priority has been given to organic brain diseases such as dementia, whereas common mental health problems like depression have existed in the background (Mental Health Foundation, 2009). Mental health services for adults have addressed depression but they have been directed at people until the age of 65 where they stop, resulting in continuity of care being interrupted that can cause feelings of loneliness and isolation, and reduced interaction with both peers and support from staff (Age Concern, 2007). This cut off point illustrates the lack of recognition that depression can extend into later life or begin in later life, and older people with depression have thus slipped through the net to find there is very little help available to them beyond what they are offered in primary care.

Primary care is defined as providing basic or general healthcare, ideally focused on the point at which a patient first seeks assistance from the medical care system (WHO, 2004). It therefore provides the first point of contact with the healthcare system. In the UK the main source of primary health care is general practice. It is based on caring for people rather than disease, meaning that professionals working in this setting are generalists rather than specialists. Since many practitioners care for people over the long term, the relationship between the patients and doctor is particularly important (Bristol University Centre for Academic Primary Care, 2012).

Primary care is the first point of contact with health services for older people but within this setting depression in older people has been under recognized and under treated. This is despite major depression affecting 5-10% of older people who visit primary care (Blazer, 2003). Reasons for this are that older people may under report their symptoms (Lyness et al., 1995) or be reluctant to disclose their depression to GPs because of a fear of stigma or their views that it is not a legitimate illness (Murray et al., 2006; Burroughs et al., 2006). It can also be challenging for GPs to differentiate between symptoms of depression and early dementia (Satlin, 1999) as well as respond to multiple health problems within ten minute consultations (RCGP, 2010). In addition to these issues, the role of the GP in managing older people with depression has remained largely undefined despite

it being recognized some time ago as part of their everyday work (Goldberg & Huxley, 1980), and this may also contribute to problems in managing it.

The use of two screening questions developed by Whooley and colleagues to detect depression (Whooley et al., 1997) has now become routine in primary care. They were formally introduced in the NICE depression guidance (2004) and highlighted in the updated Quality and Outcomes Framework (British Medical Association and NHS Employers, 2011) where GPs can ask any patients who are at risk of depression:

During the last month have you often been bothered by

(i) feeling down, depressed or hopeless?

(ii) Having little interest or pleasure in doing things?

An answer of “yes” to either meant that depression was likely and a “no” response meant that depression was highly unlikely.

These two questions are used to identify depression initially and following this a questionnaire consisting of nine questions is used to determine its severity (PHQ9, Depression in Primary Care PHQ9 Toolkit, 2009). There has been an ongoing debate that these questionnaire scoring systems for depression compromise the delivery of GPs’ care including the identification and treatment of mild to moderate depression commonly found in older people (Mallen and Peat, 2008; Mitchell et al., 2011). They may also pose a threat to the doctor-patient relationship through a lack of individualized care (Leydon et al., 2011) and do not take into consideration the patient’s age, situation, life experiences or other contextual factors which may influence their experience of depression. This highlights a need for further understanding of how older people and GPs respond to each other when older patients seek help for emotional problems (Rogers et al., 2001, Middleton et al., 2005).

Compounding difficulties for GPs in detecting and managing depression in older people, there can be a mismatch between older people’s and GPs’ perspectives on depression where they can have differing views on what it is and how it should be treated (Barg et al., 2006; Lawrence et al., 2006a). Older people can struggle with talking about their depression to GPs, be averse to accepting treatment (Givens et al., 2006) and may share the view with GPs that it is normal in later life (Butcher and McGonigal-Kenney, 2005). These factors have resulted in a

significant number of older people living with unidentified, untreated depression, and this is set to increase with the aging population (Wale, 2011) if action is not taken.

New research into how older people's and GPs' perspectives on depression influence the stories they tell and ways they respond to each other in consultations would address this. It would provide more understanding about reasons for the ways older people talk to GPs about their depression, such as what they reveal and hold back, and reasons why GPs respond to older people with depression differently, such as why some are confident talking about depression in consultations and others prefer to focus on physical illnesses. Practical solutions could be developed from this to help GPs identify depression in older people and provide appropriate help in response to their stories. PhD study therefore seeks to explore the perspectives of older people and GPs on depression in later life and its management in primary care. It focuses on how their different positions and situations influence ways they perceive depression and tell their stories of having and managing it. The intention of this research is to inform practice about the management of depression in later life, to improve primary healthcare for older people presenting to GPs with depression.

Research aim

The principal research aim is to explore how older people's and GPs' different positions and situations influence the ways they perceive depression. Particular focus is on influences reported by older people over ways they talk about depression and influences reported by GPs over ways they respond.

Methodological ideas

Whilst working in the field of health beliefs IG was introduced to grounded theory, which combines methodological theory and research methods in order to develop theory from the data collected. Particularly intriguing was the way theory could be developed from situations of human interaction during the research process. The work of Glaser and Strauss (1967) and later developments of this show how grounded theory draws upon philosophical ideas of symbolic interactionism by looking at how people's ideas and actions are shaped by their experiences of social exchange. The work of Strauss and Corbin (1998) was particularly pertinent

as they introduce a social constructionist aspect to the grounded theory process by looking in detail at how subjective views are formed and how these views influence people's actions. This approach resonates with aspects of IG's previous MPhil study as it seemed to fit with exploring how people develop their understandings of the world and how this influences their actions.

Situational Analysis, by Clarke (2005) takes Corbin and Strauss' ideas from symbolic interactionism and social constructionism further by acknowledging multiple influences over the developing theory during the research process. In this way the position of the theory is recognized as being situated within a changing, multi-faceted context but is still directly grounded from the data. This approach seemed to fit the need to explore both older people's and GPs' perspectives on depression including their changing situations and positions, as well as understand more about the reasons underlying the complex problems existing in the management of depression in later life. These factors contributed to IG's decision to use Clarke's *Situational Analysis* (2005) as the methodological component of this PhD.

Position as a researcher

With no experience of working in primary care or as a health professional IG has approached this study with fresh eyes and a multidisciplinary perspective. Having two children during the course of the PhD study has also influenced IG's position, by experiencing a personal emotional journey at the same time as researching the journeys of others during their experiences of having and managing depression. The experience of having children and the way it can challenge personal boundaries gave IG an increased sense of empathy with what participants were experiencing with their depression. It also brought an intensity to the work which has compounded IG's interest in human feelings, experiences and interactions and driven her to seek answers to questions raised during the research process. Additionally it has brought the notion of change to the forefront while completing the research study, as IG's experiences of undergoing changes in her personal life reinforced to her the importance of considering how changes in participants' situations might influence their views on depression.

Terminology used in the thesis

There are different interpretations and tensions relating to the term depression which are recognized in this study, and the complexities of language and different models of depression will be explored in greater detail as the study progresses. However, for the purposes of clarity and convention the term depression is used throughout this thesis.

Consideration was given to how to refer to depression in older people in this study. Other researchers have referred to it as depression in later life, late life depression and depression in older people. In this research study, it is important to emphasize that depression extends into later life rather than being a different condition to depression in other groups of people, and that it does not begin at the age of 65 which the terms “late life depression” or “depression in older people” could suggest. Participants in the study include both those who have had depression all of their lives into later life and those who have experienced depression since becoming 65. For these reasons the term “depression in later life” is used in this thesis when the narrative is referring to it in a general sense e.g. factors to do with the management of depression in later life. Otherwise, the term “depression in older people” is used when the focus of the narrative is on issues specific to people with depression or its management e.g. perspectives of older people with depression.

Also considered were the age criteria for this study. Existing research into depression in later life primarily focuses on people over the age of 65 but in some studies this is not the case, for example studies conducted by Age UK include people over the age of 50 (e.g. Age UK, 2011b). The inclusion criteria for this study is people aged over 65 years, as this is based on the way mental health services have been developed and the traditional (recently abolished) retirement age of 65.

Structure of thesis

This thesis is structured with the intention of building a story, starting with contextual components relevant to the background and processes of the research,

and culminating in the presentation of a theory and discussion of it. This is to reflect the way grounded theory is developed as a reminder of the methodology throughout the thesis.

Chapter 1 presents the background and evidence relating to the field of enquiry. It starts with a discussion of the contextual landscape surrounding depression in later life, including a definition of depression outlining the degrees of severity and the different experiences of people suffering from it, the extent of the problem and why there are distinct problems relating to depression in later life that set it apart from depression in other age groups. It also highlights the configuration of mental health services as a factor that has contributed to depression in later life being overlooked. Next, the way primary care mental health has been developed is considered in order to explain the context within which GPs work to manage depression in later life and to illustrate the constraints and limitations over them. Specific issues that have been identified in research on treatments for depression in later life and problems and barriers to its management are then discussed, to give more insight into why it is under recognized and undertreated in primary care. The final section considers the existing evidence on older people's and GPs' perspectives on depression in later life and its management, including research focusing on the dual perspectives of both older people and GPs. This leads to discussion of where there are gaps in the evidence base and justification of the research aim.

Chapter 2 presents the methodology. It locates the philosophical framework of the study by introducing relevant ideas underpinning symbolic interactionism, social constructionism and grounded theory. The methodological approach that informs the study, *Situational Analysis* (Clarke, 2005), is discussed next with focus on aspects of it that have inspired the research process of this study.

Following this Chapter 3 discusses the methods employed in carrying out the research. These involve practical data collection and analysis procedures which feature in a grounded theory approach, many of which have been updated or adapted by Clarke (2005). The section on recruitment, sampling and data collection explains how theoretical samples of older people and GPs were developed and how topic guides evolved during the course of the research

process to explore issues relevant to the developing theory. The section on data analysis explains how analysis proceeded and which aspects of Clarke's *Situational Analysis* (Clarke, 2005) inspired these processes. This includes explanation of how coding, analytical maps and theoretical memos were used in this study to arrive at the findings and theoretical interpretation of the findings. Following on, consideration is given to how reflexivity and trustworthiness have been ensured during the research process.

Chapter 4 presents findings from the qualitative study of older people. The first section presents the sample of older people, and explains how this was developed through sampling, data collection and analysis. The next section presents findings from the first stage of analysis of interviews, which are different components of older people's stories of depression. The components identified give insight into how older people tell their story of depression and different aspects of their stories which they might tell or hold back. Following this the second stage of analysis is presented, which consists of a typology of different groups of older people. Firstly the journey of analysis from interview data to the typology is explained, for example how IG identified themes in the interview data and developed them to form the typology using coding, memos and mapping procedures. Examples of pathways through the data are given to illustrate this journey. The typology is then presented where three groups of older people are described, the characteristics of which are based on how they conceptualize and tell their stories of depression differently. Their changing positions are then discussed showing how and when they can move between groups in the typology. The chapter finishes with a summary of key messages of the older people's findings.

Chapter 5 presents findings from the qualitative study of GPs. The first section of the chapter describes the first stage of analysis which comprises GPs' stories of managing people with depression in later life. This includes ways they report managing it, including skills they use and challenges they face with different patients and situations. Following on, the second stage of analysis is presented, which consists of a typology of GPs based on their reports of working in different styles when managing older people with depression. Firstly the journey of analysis from interview data to the typology is explained, for example how IG identified themes in the interview data and developed them to form the typology using

coding, memos and mapping procedures. Examples of pathways through the data are given to illustrate this journey. The typology is then presented where three groups of GPs are described, detailing the different skills they report using and forms of help they report offering older patients when managing their depression. The changing nature of GPs' positions is then discussed, showing how and when they can move between styles of working by adapting their skills. The chapter finishes with a summary of the GP findings.

Chapter 6 presents the "crossover" findings where overlaps have been identified across the older people and GP data. Based on new data about the influences older people and GPs report over what they say and do in consultations for depression, the chapter offers an explanation for the different ways they operate and respond to each other in consultations for depression. The first section presents the influences reported by older people over the ways they tell their stories of depression, and influences reported by GPs over ways they respond. Following this a theoretical interpretation of the findings is presented, which proposes how older people and GPs are likely to respond to one another in consultations for depression, and how GPs working in different styles could offer older people at different stages of depression the most appropriate form of help at the times they need it most. A project map showing this theoretical interpretation visually is included.

Chapter 7 is the discussion of the findings, starting with an introduction and summary of the findings. The study findings are then compared to the literature presented in Chapter 1 to show what this study contributes to the evidence base and where it builds on previous research. In doing this there is discussion of key messages from both the older people's and GPs' findings followed by discussion of the theoretical interpretation of the findings. The strengths and limitations of the study are considered next, with particular reflection on the methodology and research methods of the study. Following on, personal reflections include consideration of how the position of the researcher influenced the study and her impact on the data collection and interpretation. The implications of the study for clinical practice, education and training and for future research are then discussed in light of the current context surrounding depression in later life. Lastly the conclusion reflects upon how the findings of this study addresses the research

aim, including where it fits into the wider context of research and policy. These final thoughts draw the study to a close.

Chapter 1: Background and Literature

Introduction

The evidence and literature relating to depression in later life covers a wide and complex variety of issues, many of which are interrelated. The multi-faceted nature of this evidence could be said to reflect the complex situations both older people and GPs face in managing people with depression in later life. The literature has been reviewed and updated in a consistent way during the course of the study and has been an ongoing process. The approach to this literature review is to start by presenting a wide contextual picture that progressively focuses towards the research aim at the end of the chapter. This is intended to give the same sense of building on previous knowledge in order to generate new knowledge as that involved in developing a grounded theory.

Table 1: Parameters of literature search

Electronic databases searched	PubMed, Medline, CINAHL, Ovid, SwetsWise, Cochrane Library, Database of Abstracts of Reviews of Effects, National Library for Health and the National Health Services Research Register.
Organizational websites searched	The Department of Health, World Health Organization (WHO), The Royal College of General Practitioners (RCGP), The Royal College of Psychiatrists (RCP), Age UK, The National Institute for Health and Clinical Excellence (NICE), MIND, Mental Health foundation, The Healthcare Commission, The McArthur Initiative on Depression and Primary Care and The NHS Information Centre for Health and Social Care.
Search terms	Depression in later life, older people with depression, older people and common mental health problems, GPs, primary care, management of depression, management of depression in older people/depression in later life/late life depression, qualitative research into depression, older people's views /beliefs /attitudes /patient conceptualizations of depression, GPs views/attitudes/beliefs, conceptualizations of depression in later life/late life, depression/in older people, beliefs about depression, doctor-patient relationship, theories of interaction between doctors and patients, grounded theory and depression/common mental health problems, management of common mental health problems, decision making and managing depression, consultation style, depression/ patient choices.

As indicated by the search terms shown in Table 1, the literature relating to depression in later life is broad and complex, so the task of completing this review and giving a focused context for the study was challenging.

This chapter firstly discusses the context surrounding depression in later life, including what it is and why its management within primary care is an important problem that needs attention. The next section discusses the development of primary care mental health in order to illustrate how depression in later life has come to be neglected in primary care. Within this, the development of the GPs' role in mental healthcare services is considered to give an insight as to why there are challenges and constraints over GPs in managing older people with depression. The way it is managed in primary care is also discussed with focus on the treatments and therapies available for older people with depression and the problems GPs encounter. Reasons why these difficulties are specific to older people with depression as opposed to other age groups are also considered. The last section of this chapter discusses the perspectives of older people and GPs on depression in later life and how it is managed, including research focusing on the dual perspectives of older people and GPs. This covers existing work revealing their perceptions of what depression in later life are, their views of what happens in GP consultations, their perspectives on problems they encounter as well as factors that influence these. This leads to discussion of where there are gaps in the evidence base needing further exploration in research to justify the research aim for this study.

Contextual landscape surrounding depression in later life

Defining depression

The current definition for depression set out by the World Health Organization is as follows:

“Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration... Depression can be long-lasting or recurrent, substantially impairing an individual’s ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide. When mild, people can be treated without medicines but when depression is moderate or severe they may need medication and professional talking treatments” (WHO, 2013).

This definition is suggested from a health perspective and captures the breadth of symptoms and severity that people with depression can experience. However it is also important to acknowledge the spectrum of perspectives on depression and individual experiences people with depression can have (MIND, 2012). This diversity coupled with the fact that many people do not feel they can talk about their depression (Mental Health Foundation, 2000) means that there is a sense of mystery about what depression is, how it shows itself and what it feels like for different people. This has not only led to society building a stigma around depression (Griffiths, Christensen & Jorm, 2008), but also difficulties for medical practitioners in identifying depression in different patients and determining the form of help they need.

As a result of this uncertainty there is an ongoing debate about what the term depression actually means, and it carries a spectrum of meaningful implications for both patients and GPs (e.g. Burroughs et al., 2006). There have been questions over its usefulness as a label for common mental health problems, for example it has been argued that the contemporary concept of depression is “confused, woolly and inadequate as a basis for formulating mental health problems” (Pilgrim & Bentall 1999) and the National Institute for Clinical Excellence (NICE) has in the past acknowledged that the concept is not specific enough, having “limited validity for effective treatment plans” (NICE, 2004). Further, patients and GPs can have differing perspectives on it that can influence decisions made in its management (Rogers, May and Oliver, 2001), which can cause tensions for GPs in choosing to diagnose depression or acknowledging “depressive symptoms” because of how patients may interpret the meaning (Karp, 1996). It may be more appropriate to manage patients’ depressive symptoms and avoid implications of using the label of depression, and instead assist the patient in finding some meaning from their distress (Dowrick, 2009). This debate highlights the importance in this study of recognizing the different ways of defining depression and the impact this may have on its management for older people and GPs.

Currently, the medical model of depression guides the care provided by GPs in the UK. It is unified by classifications, identification and diagnosis of depression, and treatment is divided between general practice and psychiatry depending on its

severity. Its presence is ascertained by classification systems and screening questions (Whooley et al., 1997) to identify and diagnose it. Depressive disorder, clinical or “major” depression is diagnosed on the basis of the presence of set symptoms persisting for two weeks or more. These symptoms have been recognized and recorded over the course of many years however in recent times strict diagnostic criteria have been set down in *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV), and the Tenth Revision of the *International Classification of Diseases and Related Health Problems* (ICD-10). Table 2 (p.41) shows the DSM-IV classification of major depression, showing the signs and symptoms practitioners look for in order to make a diagnosis. Criteria used by medical practitioners for diagnosing depression and schedules used in primary care are discussed in more detail later in this chapter.

Patients can experience depression in varying degrees of severity from sub threshold to severe, and assessment tools such as the PHQ9 (PHQ9, Depression in Primary Care PHQ9 Toolkit, 2009) are used in primary care to determine this initially. The levels of severity are outlined in the NICE guidance (2009a) and different levels of care and interventions for treatment are recommended ranging from that provided by primary care practitioners to specialist secondary care. Milder forms of depression may be helped with interventions such as diet, activity and exercise, social support, self help techniques and non drug treatments such as CBT, interpersonal therapy and counselling. Persisting or moderate and severe forms of depression may also be helped with these and/or antidepressant medication, mood stabilizers, psychological therapies and if necessary other high intensity forms of specialist medical help provided in secondary care (NICE, 2009a).

The differing experiences of depression people can have are wide ranging, and can be influenced by their individual experiences and views of their depression (Emeslie et al., 2007; Ridge & Ziebland, 2006; Kangas, 2001). Many of these experiences of depression are subjective and relate to life events, social relationships and living circumstances and people can find it difficult to frame their experiences within the objective biomedical frame (Lafrance, 2007). Older people in particular have highlighted the importance of reducing loneliness and social isolation as key to their recovery (Age UK, 2011b) and provision of help in the form

of talking therapies (Age UK, 2012) and trusting, empathic and continued social relationships (Lester et al., 2012; Bristow et al., 2011; Chew-Graham et al., 2011). This suggests a need for less medicalized approaches to helping some people with depression alongside the use of medical approaches for others.

Why depression in later life?

Depression is the most common mental health problem experienced in later life (Lee, 2007) and the most frequent cause of emotional suffering in older adults that can significantly decrease their quality of life (Blazer, 2003; Chew-Graham et al., 2004). At least two million people in the UK aged over 65 have depression (Age UK, 2012) and one in four people over 65 have depression severe enough to impair their quality of life (Lee, 2006). It can become a chronic or recurrent problem for up to 50% of older people who are affected, particularly those in poor physical health or with long term conditions (Moussavi et al., 2007; Aragonès, Piñol and Labad, 2007; Unützer, 2002) and is associated with serious morbidity and mortality including malnutrition, physical decline, poor medical outcomes and suicide (Montano, 1999). Older people are the age group most likely to be successful in committing suicide with about one in four attempts resulting in death, and this could be prevented with timely intervention for depression (Beeston, 2006). With the elderly population expected to increase from 9.6 million in 2005 to 12.7 million in 2021, action around tackling depression in older people needs to be taken (Appleby, 2007; Lee, 2007).

Despite clinical symptoms of depression being similar across the lifespan (See Table 2, 42) this age group receive less help than those under 65. This is partly because depression in later life is overlooked in health policy, medical guidance and health services. Older people have been excluded from adult mental health policy which has only addressed the needs of people with depression up to the age of 65 (Department of Health, 1999), and depression that occurs beyond 65 has been placed within an umbrella category of older people's health where priority has been given to organic brain diseases such as dementia (Department of Health, 2001). This lack of attention illustrated by the National Service Frameworks (NSFs) demonstrates how older people have also been seriously discriminated against in mental health services, where their needs have either not been met or neglected and where they do not have the same access to mental

health services as younger people (RCP, 2009). In this way depression in later life has become hidden amidst other priorities, which communicates a message that depression is not as significant in later life as it is for those under 65, or as important as other health problems when over 65. With this neglect and the aging population (Wale, 2011) depression in later life continues to be an extensive and urgent problem that remains unaddressed (Mental Health Foundation, 2009; Age UK, 2010).

There are specific risks and problems for older people with depression that are less likely to affect those who are younger (Godfrey et al., 2005). In later life there is a greater risk of major life events that can trigger depression, such as loss of employment, bereavement, changing social environments or situations (e.g. retirement or a move), increased risk of social isolation and feelings of loneliness as well as changes in health status (Koster et al., 2006; Brilman and Ormel, 2001; NICE, 2009a). Depression can be triggered by long term illnesses and multi-morbidity which are normal in later life, and some of these (e.g. heart disease or thyroid problems) can give symptoms similar to depression thereby masking it and causing it to be more difficult to identify. Memory loss and confusion which are symptoms of depression can also be mistaken for dementia by both older people and doctors, also contributing to its under recognition (RCP, 2012). For GPs multiple health problems can be challenging to respond to in ten minute consultations and may also draw attention away from older people's psychological needs (Godfrey et al., 2005; Satlin et al., 1999). It follows that less than 1 in 6 older people with depression discuss their symptoms with GPs, and only half of these people receive the treatment they need (Chew-Graham et al., 2011). All these factors contribute to depression being under reported by older people (Lyness et al., 1995) and under recognized and under treated in primary care (Age Concern, 2008; Skultety and Zeiss, 2006). In practice it needs to be recognized that older people's health problems, life experiences, circumstances and perceptions of what depression is are different to those of younger people with depression.

Primary care is the first point of contact for most older people with depression (Unützer, 2002), and despite major depression affecting 5-10% of older people who visit primary care (Blazer, 2003) it has been under recognized and under

treated by GPs. This problem has led to government policy highlighting primary care as the setting where improvements in the recognition of depression in later life need to be made (Department of Health, 2011; Lester and Glasby, 2010). Currently the stepped care model recommended in the NICE guidance (NICE, 2004; 2009a) provides a framework for guiding the management of people with depression in primary care (NICE, 2009a, p. 16). It consists of a tiered system of care provision which starts in primary care settings, where GPs' and other primary care professionals' role is to identify and diagnose it and then to decide on the most appropriate level of care for the patient, depending on the severity of the depression. However despite the identification and management of depression long being part of GPs' everyday work, their role in doing this has remained largely undefined (Crosland and Kai, 1998) which may contribute to the existing problems.

The way depression is perceived can also increase challenges experienced by GPs in identifying and managing depression in older people. The attitudes older people can have towards depression may prevent them taking it to doctors, where rather than seeing it as an illness they may see it as a sign of weakness that is not worth seeing a doctor for and can be fearful of the stigma surrounding it (Lawrence et al., 2006b; Burroughs et al., 2006; Dowrick, 2009). Compounding these difficulties older people rarely complain of a low mood or other psychological symptoms (Brodaty et al., 1991) and can struggle with talking about their depression to GPs where they may be reluctant to disclose it (Kaddam et al., 2001). The likelihood of them reporting their depressive symptoms also decreases with age possibly because earlier generations were less aware of psychological symptoms and did not tend to report what they perceive as private distress (Lyness et al., 1995).

These perspectives highlight a disparity between the social and medical models of depression (Rogers, May and Oliver, 2001). The social model defines it according to the influence of social situations, exchanges with others and subjective experiences placing emphasis on understanding individuals' perspectives on these (Brown and Harris, 1978; Brown, 2002; Lauber et al., 2003), and the medical model is underpinned by identification of symptoms, diagnosis, treatment and management set out in medical classification and diagnostic systems (American Psychiatric Association (APA), 1994; WHO, 1992). Areas of conflict between these

social and medical perspectives can be found when practitioners diagnose and treat depression as an illness and lay people normalize it by finding common sense explanations such as their life's circumstances (Cornford et al., 2007, Pill, Prior and Wood, 2001). This may go some way to explaining why there are problems with more practical aspects of managing depression, including how GPs and patients of all ages talk about it to each other in consultations (Coventry et al., 2011) and how this influences what happens in consultations for depression (Hyde et al., 2005, Maxwell, 2005). For patients it can lead to problems negotiating an "illness identity" if they have an undeveloped understanding of their illness and for practitioners in detecting depression (Rogers et al., 2001). Patients may also reject clinical diagnostic labels and seek those relating to organic physical manifestations of the disease instead (May et al., 1999) suggesting they need a more concrete understanding of their depression in order to accept it as an illness needing treatment. Similar problems may occur if patients cannot rationalize their depression to fit in with the medical model and attribute the cause to social circumstances, making it difficult for them to justify depression as a medical problem (Lafrance, 2007). These differing perspectives may contribute to a mismatch between older people's and GPs' perspectives on depression, where they can have differing views on what it is and how it should be treated (Barg et al., 2006; Lawrence et al., 2006a). Older people may also be averse to accepting treatment (Givens et al., 2006) and or share the view with GPs that depression is normal in later life (Butcher and McGonigal-Kenney, 2005) leading them to do nothing about it. Older people's perspectives are focused on in detail later in this chapter.

This complex array of issues is different to those experienced by younger patients with depression yet this is not recognized in the approach taken to help older people in primary care. The failure to identify and manage depression in older people successfully in primary care has resulted in the significant numbers of older people living with unidentified, untreated depression in the community (Chew-Graham et al., 2011), and this is set to increase with the aging population if action is not taken (Appleby, 2007; Lee, 2006). A starting point may be to consider the way mental health services are organized and how appropriate services that address the needs of older people with depression could be provided. The way

health services for older people have been developed and how this has contributed to the neglect of depression in later life is considered next.

Configuration of services for older people

The way health policy and services have been developed for older people means that depression in later life has become neglected amidst other health problems in older age. Services for older people have historically been separate to those for other adults, and there has traditionally been a cut-off point between them of age 65 based on the previous age of retirement which has now been abolished (The Employment Equality Regulations, 2011). Within the umbrella of older people's health, mental healthcare provision has been split between old age psychiatry and primary care, and provision for depression in later life has not been incorporated into either setting.

The clinical specialty of old age psychiatry was developed to focus on mental ill health in old age like dementia which had been previously neglected by psychiatry, and the excessive use of institutional care for the mentally ill. It is concerned with the identification, assessment, management and care of older adults with mental disorders (Dening, 2008) and its origins can be traced back to the nineteenth century asylums. Developments since the second half of the twentieth century show how depression in later life fell outside its area of concern.

Old age psychiatry was established in the 1950s in order to address the challenges in differentiating between physical and mental illness in frail elderly people (Barton and Mulley, 2003). Various psychiatrists influenced the development of the field, including Professor Tom Arie, a champion of old age psychiatry whose approach is still in place today. In 1969 Arie pioneered a psycho geriatric department at Goodmayes Hospital (Fairburn, 2001), where psychiatrists and geriatricians worked together to deliver medical care to elderly patients. He also developed a psychiatric-geriatric assessment unit which had political support at the time, showing a raised public awareness of the need for action in this area. Clinical studies by Felix Post (e.g. Post, 1962; Post, 1965) offered evidence that there were different forms of mental disorders other than senility in the elderly, and major psychiatric disorders in old age were classified by Martin Roth in 1955 (Schulman, 2002). As well as laying the foundations of the clinical specialty, this

work in old age psychiatry also introduced the possibility of effective treatments for certain disorders particularly emotional (or affective) states.

The progress made during the 1950s and 1960s communicated an important message that physical and mental illness were not inevitable consequences of aging, and the use of effective physical and social treatments challenged the pessimism surrounding older people's health. Further, epidemiological research of mental disorders in the community showed that only a minority of elderly people were mentally ill (Dening, 2008) but consequently only those with severe mental illnesses and organic degenerative brain diseases, like dementia and Alzheimer's' were treated by specialists within old age psychiatry. Common mental health problems such as depression in later life were left to be identified and managed by primary care practitioners. It was not until the late 1980s and 1990s that research began to uncover the extent of unrecognized depression in older people and the importance of the GPs' role in detecting and managing it (McDonald, 1986; Small, 1986; Friedhoff et al., 1992; Rabins, 1996; Montano, 1999). It also helped prompt the development of policy touching on these issues, however older people's mental health needs were addressed separately to those of adults.

The NSFs for Mental Health (Department of Health, 1999) and Older People (Department of Health, 2001) are a recent illustration of the separation between adult and old age mental health services. They demonstrate how depression in later life has disappeared into the background of mental healthcare rather than becoming a priority, and how recommendations in policy have not been realistic for GPs to use in identifying it, or satisfactory in supporting them to manage it. The exclusion of people over 65 from *The NSF Mental Health* (Department of Health, 1999) emphasizes that older people are not part of the bigger mental health picture because they do not have the same access to specialist mental health services as those under 65. As a consequence of this mental health services for older people have been excluded from investment, and resources have been reduced in some areas (RCP, 2009). Depression is included in *The NSF for Older People* (Department of Health, 2001) as one of its targets in standard 7 "The Mental Health of Older People". The focus here is on its early recognition and management however there is nothing recommended for GPs to help them do this. The treatment of depression (para. 7.27) emphasizes the importance of

specialist mental health services and recommends referral to such services when the severity of the depression or complexities of the patients' health status fall outside the remit of GPs (para. 7.30). However these recommendations may be unrealistic since they do not take into account how oversubscribed these specialist services are (as they deal with all health problems for older people) and that many GPs are unable to refer patients with depression as a result. Other standards in *The NSF for Older People* (Department of Health, 2001) highlight the need for attention to falls, strokes, dementia as well as depression, but funding seems to have been given to all of these except depression possibly due to the stigma surrounding it (Chew-Graham, Bladwin and Burns, 2004).

To date there is still little focus on how provision for older people with depression within primary care can be improved, even though it is known that GPs are central figures in providing this care. The Quality and Outcomes Framework (QOF) depression indicator specifies few factors that would particularly help identify or provide care for older people with depression, even though the revised version (BMA, 2013-14) highlights the need for a bio-psychosocial history to be taken from patients to establish depression which includes issues relevant to older people. The Department of Health's recent *No Health without Mental Health* (Department of Health, 2011) reiterates messages communicated in other recent policy and influential reports, identifying aspects of a good mental health service for all, and highlighting the need to challenge stigma and discrimination (Carruthers & Ormondroyd for the Department of Health, 2009; Royal College of Psychiatrists, 2009; Healthcare Commission, 2009; Mental Health Foundation, 2009; Department of Health, 2005). However these recent reports and policy documents have brought mental health and older people together in a way that has not been done previously thereby addressing the separation between services for mental health and older people. The focus has shifted to positive action, prevention and promotion of good mental health in older age rather than the complexity of the area and the challenges that need addressing. *No Health without Mental Health* (Department of Health, 2011) takes a life course approach to mental healthcare by aiming to develop, support and promote comprehensive and holistic services across the life span from children and young people's mental health to very old age which underlines this marked shift from previous service provision. This more recent atmosphere of inclusion of all age groups rather than

them being separated is a step towards improving services for older people, but ways this could be done in primary care for older people with depression is an area that still needs further development.

According to this configuration of services all health provision for older people including mental health has been addressed together and specialist mental health services for older people have focused on organic brain diseases such as dementia that occur in later life rather than common mental health problems (Keady and Watts, 2011a). Therefore the way services have been developed means that there is little provision for older people with depression outside the primary care setting and the few that are accessible to this group are oversubscribed (Age UK, 2010; Lee, 2007). The development of primary care mental health and the role GPs have in managing older people with depression shows how it has also become a hidden problem within this setting.

Development of primary care mental health

The development of primary care mental health has happened in such a way that provision for depression in later life still does not exist formally, leaving GPs to manage it effectively with little support. Furthermore, even though there was recognition of the emotional content of a GPs' work in the 1950's (Balint, 1955, 1957), managing depression was not acknowledged as an everyday part of a GPs' work until the 1980s (Goldberg & Huxley, 1980) and 1990s (Kendrick, 1991; Kendrick et al., 1994).

Psychoanalyst Michael Balint (1890-1970) carried out prominent work that explored the therapeutic role of GPs (Balint, 1955 and 1957) which increased understanding of the emotional content of the doctor-patient relationship in order to improve their therapeutic capability. Two of his well-known ideas are that symptoms offered by patients may not be the reason for their attendance and there may be underlying problems for doctors to uncover; and the idea of the "doctor as a drug" where the doctor-patient relationship in itself can be therapeutic and helpful for patients in their recovery (Lakasing, 2005; The Balint Society, 2012). His work underlined the possibility of hidden emotional problems in patients, suggesting that GPs may need to read between the lines of the problems patients present to them in consultations rather than take them at face value, or

dig deeper to uncover the true problem which may not be physically visible (i.e. may be emotional). In his famous *The doctor, his patient and the illness* (Balint, 1957) Balint proposes the value of a therapeutic alliance established between doctors and patients where the “doctor is the drug”. This is where doctors positively influence patients’ health problems in a similar way to that of a drug through constructing a therapeutic relationship between them. This work suggests the beneficial impact of the doctor-patient relationship and how seeing and talking to GPs could help patients with emotional issues.

Despite Balint’s work, depression has only become recognized as an important part of GPs’ everyday work during the last 30 years, since Goldberg and Huxley (1980) identified that GPs were missing cases of depression. Before this there was neither an agenda for primary care mental health nor provision for late life depression, which meant that GPs were often seeing patients with depression but were ill equipped to provide the same level of care as for other physical illnesses. In 1980 Goldberg and Huxley identified an “iceberg” of unrecognized cases of common mental health problems including depression existing untreated in the community. Their work suggests that over a period of a year 90% of patients deemed to be suffering from a mental disorder made contact with their GP but had not been diagnosed. Despite Goldberg recently admitting that the patient and circumstances of the consultation are also factors contributing to whether patients disclose depression (Goldberg, 2009), at the time this research highlighted the under recognition and under treatment of depression in primary care and was a turning point as the GPs’ role in managing it could not be overlooked or hidden as it had been previously (Crosland and Kai, 1998; Kendrick et al., 1991). The work also indicates that a substantial part of a GPs role had long been to manage depression without any support or recognition. Although this knowledge underlined the critical need for improvements in detecting and managing depression in adults, the lack of recognition of depression in later life within this setting was a far greater and unacknowledged problem that has become clearer more recently (e.g. Schwenk, 2002; Unützer, 2002).

Inadequate provision for older people’s mental health has been a recurrent theme in health policy and reports by national organizations with an interest in older people (Department of Health, 2011; Carruthers and Ormondroyd for the

Department of Health 2009; RCP, 2009; Healthcare Commission 2009; Mental Health Foundation 2009; Department of Health, 2005). They have communicated messages about the need for improvements to rates of detection and treatment of depression in later life within primary care, yet GPs are still being left to face the challenges and barriers to identifying and managing it with little training and support (Age Concern, 2007).

It seems that the GP's role is central to providing the care older people with depression need since many go to their GPs first, but policy, medical guidance and other external influences have not supported or guided this aspect of their work, leaving their role in doing this poorly defined.

The importance of the GP's role in identifying and managing depression and problems they were encountering began to be recognized in research carried out in the early 1990s (Kendrick, 1991; Kendrick et al., 1994) following Goldberg and Huxley's work (1980). It reveals the high prevalence of common mental health problems managed in primary care and the extent of the GP's role in managing them (Kendrick, et al. 1991). This reiterates Goldberg and Huxley's observations that managing mental health problems had long been part of a GPs' everyday work without any recognition. Investigations of the mental health care they were providing revealed the extent to which they were dealing with long term mental illnesses as well as the challenges and constraints they face. (Kendrick et al., 1994). It underlines that few patients with depression were referred to psychiatry, which was mainly reserved for those with serious mental illnesses, and that those with depression were much more likely to be managed in primary care by GPs. It also highlighted constraints for GPs in managing patients with long term mental health problems caused by a lack of practice policies for reviewing the care of such patients (Kendrick et al., 1991). This research, together with the introduction of a stepped care model to guide GPs in diagnosing, treating and referring patients with depression (Department of Health, 1999; NICE, 2004; NICE, 2009a) began to formalize the role GPs played in managing depression and started to identify where there were problems in its management within the primary care setting. This emphasized the need for more understanding and definition in this aspect of their work, and although progress was made in further defining their role in managing depression it did not address specific problems existing with different age groups.

The medical guidance available to GPs on managing depression (NICE, 2004; NICE, 2009a, NICE 2009b) applies to all age groups and adopts a one size fits all approach which does not address specific needs of older people or the way services are organized for older people. This is exemplified in the NICE guidance (2004) which includes the recommendation for practitioners to follow a stepped care model (initially introduced in the *NSF Mental Health*, (Department of Health, 1999)). It outlines a tiered process by which GPs can identify and treat depression “depending on the characteristics of their depression and their personal and social circumstances” (NICE, p.57) and differentiates between what constitutes a serious mental illness and a common mental health problem. However these recommendations are based on a medical approach to managing depression, where identification (e.g. screening) and interventions such as “watchful waiting” (by GPs to see whether the depression progresses) or a range of therapies in primary and secondary care are accessed depending on severity of the depression.

A change in the NICE guidance from the phrase “watchful waiting” (NICE, 2004) to “active monitoring” (NICE, 2009a) during step 1 of the stepped care model suggests GPs take a more hands on approach to the initial assessment of depression by discussing the patients’ problems and concerns about depression and providing them with information. This may have been changed in response to the missed cases of depression by non psychiatric health professionals (Cepoiu et al., 2008). However despite increased emphasis in the guidance on GPs taking positive action and discussing depression with patients at an early stage, there is still little consideration of patients’ perceptions of what depression is, their preferences or social circumstances or the help they need for depression in conjunction with other health and situational needs. There is also little consideration of differences in the ways GPs manage depression in later life and why this might be, including their perceptions of what it is, what works for them and the challenges they face, as well as the availability of specialist therapies to support them. Furthermore, the guidance is aimed at all age groups of patients but in doing this does not differentiate between any of the characteristics and needs of specific age groups including those of older people.

The more recent NICE guidance recognizes sub threshold depression (NICE, 2009a) and depression in adults including those with a chronic physical health problems (NICE, 2009b). These overlap with some of the issues that are problematic in the management of depression in later life, such as identifying and treating mild symptoms of depression which do not meet the clinical criteria for depression, and risk factors for depression in those with chronic physical illness. However this newer guidance still does not take into account the situational problems and life events older people commonly experience, such as social isolation and bereavement that set depression in later life apart from that in other age groups. It seems that the factors described here, particularly older people's social context, bereavement, isolation, perceptions of depression and attitudes to treatment all underlie the importance of GPs hearing older people's stories of depression in consultations.

The exclusion of older people in adult mental health policy and medical guidance has meant that there are minimal services available within primary care for older people with depression or to support GPs in managing it. Referral to a geriatrician usually happens when a patient is acutely ill, especially confused, or has a life threatening physical illness in addition to having psychiatric symptoms (Graham and Robinson, 2008) so this does not include older people with milder forms of depression. In recent years initiatives to improve availability of mental health services within primary care have been introduced but have been intended for all groups of people rather than targeting specific needs. For example, Graduate Mental Health Workers were introduced by the NHS Plan in 2000 and were intended to "help GPs treat and manage common mental health problems" (Secretary of State for Health, 2000) and improve access to primary mental health care provision by sharing the workload across primary healthcare teams. Improving Access to Psychological Therapies (IAPT) was also introduced to assist GPs with the workload of managing common mental health problems by providing therapies such as cognitive behavioural therapy (CBT). However older people are less likely to be referred to CBT than adults of working age (Mental Health Foundation, 2007) possibly because it is unsuitable for older people who prefer to talk about their depression to people with whom they have a long term and trusting relationship (Mead et al., 2010). So despite these attempts to distribute the workload of GPs more evenly in managing common mental health problems, they

still have to work in isolation to address the many problems they face in managing people with depression in later life. In the following section there is an explanation of how patients with depression might present in primary care, and afterwards the problems outlined above are considered, including how depression in older people is different and why there are problems specific to its management in primary care.

Management of depression in primary care

The medical model of depression is dominant over the way it is addressed in primary care. This has been the case since the early days of psychiatry when it was first labeled as depression and defined by German psychiatrist Emil Kreaplin (1856-1926) as a psychological disorder needing medical intervention (Hilton, 2005). The medical model of depression is underpinned by the view that it is an illness needing medical treatment and the recommended approach for GPs is to identify symptoms with a view to diagnosis and treatment. However research carried out since the late 1970s has increasingly underlined the importance of hearing people's stories of depression (e.g. Brown and Harris, 1978, Rogers, May and Oliver, 2001, Coventry et al., 2011, Bristow et al., 2011; Chew-Graham et al., 2012) which has highlighted limitations of the biomedical approach, and shown that a wider, more holistic view of people's situations and perspectives is necessary in order to provide appropriate help. The clinical symptoms and characteristics of depression are exemplified in classification systems such as DSM -IV (APA, 1994) as detailed in Table 2, which sets out the aetiology, symptoms, treatments and prognosis of depression giving practitioners guidance on how they might expect adults of all ages to present and how they might help.

Guidance for practitioners to help them identify depression is also set out by the National Institute of Health and Clinical Excellence follows the ICD-10 (WHO, 1992; WHO, 1993) definition (NICE, 2004; NICE, 2009a). This definition sets out an agreed list of 10 symptoms which divide the common form of major depressive episode into four categories: not depressed (fewer than 4 symptoms), mild (4 symptoms), moderately depressed (5-6 symptoms) and severe (7 or more, with or without various psychotic symptoms). These symptoms must have been present for 2 weeks (NICE, 2004, p. 18). In addition QOF (BMA, 2013) demands the use of case finding using diagnostic tools such as screening questions and a questionnaire to assess severity of depression (PHQ9), however it is not targeted

at specific age groups. The PHQ9 questionnaire is a patient health questionnaire using a nine itemed depression scale. It is used to determine the severity of depression and is required by QOF when a diagnosis of depression is made in UK primary care (Dowrick, 2009). It is required as an objective measurement before or after an intervention (such as antidepressants or talking therapy) to show if there have been any improvements in the patient.

Depression is more likely in those with chronic physical illness, and although the use of two stem questions for case finding in those with diabetes and coronary heart disease is recommended in QOF it has become normal in primary care. It has been suggested that clinicians should not rely on case finding questions alone especially for those with chronic physical health problems as they can be limited in comparison to the development and maintenance of a trusting relationship (Chew-Graham, Sheers and Beeston, 2008). It has also been suggested that they should be confident to engage in a more detailed assessment of a patient's general health, mental state and risk (Meader et al., 2011). GPs' perspectives on their value in managing depression in older people are discussed later in this chapter.

Following its diagnosis, the treatment and management of depression can be undertaken.

Table 2: DSM-IV definition of Major Depressive Disorder (APA, 1994).

Aetiology	Research has shown that depression is influenced by both biological and environmental factors. Studies show that first degree relatives of people with depression have a higher incidence of the illness, whether they are raised with this relative or not, supporting the influence of biological factors. Situational factors, if nothing else, can exacerbate a depressive disorder in significant ways. Examples of these factors would include lack of a support system, stress, illness in self or loved one, legal difficulties, financial struggles, and job problems. These factors can be cyclical in that they can worsen the symptoms and act as symptoms themselves.
Symptoms	Symptoms of depression include the following: <ul style="list-style-type: none"> • depressed mood (such as feelings of sadness or emptiness) • reduced interest in activities that used to be enjoyed, sleep disturbances (either not being able to sleep well or sleeping too much) • loss of energy or a significant reduction in energy level • difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily • suicidal thoughts or intentions
Treatment	Treatment can either combine both pharmacotherapy and psychotherapy or utilize one or the other individually. Medications used to treat this disorder include Prozac, Paxil, Wellbutrin, and Zoloft. Other medications can be found, along with their descriptions can be found in the Medications page. Psychotherapy is useful in helping the patient understand the factors involved in either creating or exacerbating the depressive symptomatology. Personal factors may include a history of abuse (physical, emotional, and/or sexual), maladaptive coping skills/ Environmental factors involved in this disorder include, among others, a poor social support system and difficulties related to finances or employment.
Prognosis	Major Depressive Disorder has a better prognosis than other mood disorders in that medication and therapy have been very successful in alleviating symptomatology. However, many people with this disorder find that it can be episodic, in that periodic stressors can bring back symptoms. In this case, it is often helpful to have an ongoing relationship with a mental health professional just as you would a physician if you had diabetes or high blood pressure.

Alongside the medical model of depression, aspects of patients' situational factors have become recognized by medical practitioners as important influences over their depression. These have highlighted limitations of the biomedical approach to depression and the importance of hearing people's stories. Brown and Harris (1978) built on the "bio psychosocial" approach to depression developed by psychiatrist Meyer (1866-1950), whose approach to depression centres on life course, personality and patients' capacity to respond to their circumstances (Horowitz and Wakefield, 2007). They propose a model showing how people's depression can be influenced by their living environment and social context as well as their perceptions of depression itself. In a community study carried out in inner London with 458 young women, they identify four "vulnerability factors" for depression, including the loss of a mother before the age of 11, the absence of a confiding relationship with a partner, a lack of employment outside the home and the presence at home of three or more children under 15 years of age (Brown and Harris, 1978). These vulnerability factors show that influences within society can be a key reason for poor mental health. Brown and Harris (1978) were the first to make a link between what happens in society and poor mental health, showing how stressors in everyday living, such as stressful life events and living in difficult environments over the long term relate directly to poor mental health (Pilgrim and Rogers, 1993). This challenged the existing conceptualizations of the time that were based around medical assumptions, and alerted medical practitioners to considering multiple aspects of patients' lives when identifying and managing depression. The treatments and therapies for depression offered in primary care today combine the social and medical perspectives. However there are factors relating to the ways depression is diagnosed, treated and managed that are different in older people with depression.

Management of depression in older people

This section discusses the ways the identification and management of depression in older people in primary care is different to that in younger people. It is well documented that primary care is the setting where most older patients with depression are seen and prefer to be treated (e.g. Lee, 2007; Areán, Hegel and Reynolds, 2001) despite finding a variety of psychological services available in specialist and general hospital settings acceptable (Areán et al., 2002). However if they report their depression to GPs many older adults still do not receive treatment

(Davidson and Meltzer-Brody, 1999) even though a number of effective antidepressants and structured forms of psychotherapy exist (Cepoiu, et al., 2008).

There is a wealth of evidence on treatments and therapies for depression provided in primary care, most of which focuses on adults of all age groups rather than older people. The evidence discussed here mainly includes that specific to older people, and where this is not available evidence on adults of all ages including older people is discussed.

Much public focus has been on GPs not identifying, treating or managing people with depression in later life adequately, but there are problems they encounter that help explain this. Two main difficulties have been highlighted by research. Firstly there are differences in symptoms between older and younger people and the way they present depression to GPs, from their differing perceptions of what it is, different life experiences, circumstances and events happening to them (RCP, 2012; Godfrey et al., 2005). Secondly, co-morbidity with ill health and physical disability commonly exist alongside depression in later life, giving rise to many additional complexities. Depression becomes more difficult to identify as symptoms can be mistaken for those of other health problems in later life, or they can be hidden amongst the symptoms of other health problems (Butcher and McGonigal-Kenney, 2005; Reynolds and Charney, 2002; Rabins, 1996).

As multi morbidity is more common in later life, older people are more likely to have depression, but an array of symptoms signaling other illnesses can hide it (Godfrey and Denby, 2004). Unclear symptoms such as forgetfulness can cause difficulties for GPs as they can indicate brain diseases such as dementia, or may draw attention away from or perpetuate the patients' psychological needs (Satlin et al., 1999). In addition non-specific symptoms including tiredness and insomnia may reveal patients' depression but can also indicate other health problems. Rates of undiagnosed depression can also vary between age groups of older people, for example those over 85 have been shown to have a more positive outlook over their health but are also more likely to have both symptoms of depression and undiagnosed depression than those under 75 (Collerton et al., 2009). These factors mean that with older people there are added difficulties in distinguishing between symptoms of depression and other diseases and

symptoms that occur with age (Kaddam et al., 2001), which can lead to dilemmas for GPs in making a diagnosis of depression.

Challenging decisions for GPs in diagnosing older people with depression can include whether a formal diagnosis is appropriate (van Rijwijsk et al., 2009) and which terminology is most appropriate to use in consultations as this can be important to older people (Murray et al., 2006; Burroughs et al., 2006; Lawrence et al., 2006a; Butcher & McGonigal-Kenney, 2005). This can lead to dilemmas between choosing to diagnose “depression” and acknowledging “depressive symptoms” because of how patients may interpret its meaning (Karp, 1996; Lewis, 1995). For some patients use of the term depression when diagnosing can be beneficial to their understanding and acceptance of what has happened to them and provides them with a rational explanation, because knowing that psychological symptoms of depression (such as self loathing, feelings of guilt and suicidal thoughts) are caused by the illness can be an “antidepressant” on its own (Kumar and Clarke, 2002). Alternatively it may be more appropriate to manage a patient’s depressive symptoms and avoid the implications of using the label of depression altogether, instead assisting the patient in finding some meaning from their distress (Dowrick, 2009). It therefore seems important for GPs to understand older people’s different beliefs about what depression is and how this might influence the way they behave in consultations, however finding this out may increase the time needed for consultations.

Older people are known to consult for longer than younger age groups with average consultations lasting 13.3 minutes (RCGP, 2005) during which time GPs have to address a complex mix of medical, psychological and social problems. This is challenging because consultation times are currently set at 10 minutes, and there are financial incentives via QOF (Quality and Outcomes Framework) for GPs to allow this amount of time (Hill and Freeman, 2011). Older people are also less likely to present with depression to GPs, instead being more likely to return for follow ups of an already established chronic disease (Office for National Statistics, 2005, cited in Graham and Robinson, 2008). The under reporting of depressive symptoms is considered to be a key barrier in older age (Lyness et al., 1995) and has been attributed to forgotten early episodes of depression and low rates of diagnosis both in early life as well as later life. More recent qualitative research

has also attributed this to older people's attitudes to seeking help for depression from GPs (Bristow et al., 2011, Chew-Graham et al 2012) which are discussed later in the chapter. These factors can leave GPs to proactively identify depression in older people which can be a challenge when they are pressured for time. Coupled with this older people's reluctance to disclose their depression to GPs can lead to additional decisions and dilemmas for GPs.

In order to improve this situation case finding for depression in people with long term conditions is now suggested (NICE, 2009b) but nevertheless GPs frequently do not detect depression in older people. This may partly be because older people do not have their depression severity assessed as often as younger adults, and are therefore less likely to receive appropriate management if diagnosed (Harris et al., 2011). Categories for sub-threshold depression identified in the NICE updated guidelines for depression (NICE, 2009a) mean that there are now guidelines on milder forms of depression. They address the presence of depression alongside chronic illness, both of which are common in older people. However the framework adopted in primary care does not take into account the wider issues and contextual influences over depression in later life, including older people's beliefs about what it is (Murray et al., 2006).

The treatments and therapies available to GPs for managing older people with depression are limited as many are either not effective or accessible to older people (Godfrey and Denby, 2004) or do not take not account their preferences. Reasons for this include that mental health services and therapies for depression are often organized and designed around the needs of younger people and it is assumed that older people can be treated in the same way as younger people (Lee, 2007). Some psychological or alternative therapies are also not perceived to be suitable for older people (Charlesworth and Carter, 2011), so many are never referred to specialist services by GPs (Godfrey et al., 2005). These limitations to managing older people with depression influence the GP's role by increasing pressure on them and compelling them to provide much of the care themselves, as well as dealing with the multiple health problems that are often experienced in later life.

Treatments for depression include antidepressants, psychosocial and psychological interventions (and combinations of these), and while their effectiveness is the same for both younger and older people (Anderson et al., 2000) the evidence on their effectiveness with older people is limited. GPs are more likely to refer younger than older people to talking therapy (Kendrick et al., 2009), but may also feel powerless to offer help as the psychological therapies available are commonly oversubscribed and there are few strategies in place in both primary and secondary care to deal with common mental health problems (van Rijswijk et al., 2009; Nolan, 2003). In addition many of the therapies developed for depression do not take account of the specific needs of older people and instead focus on an “age inclusive” (e.g. Department of Health, 2011) approach that in reality leans towards the needs of adults under 65. This situation illustrates an assumption that older people are less likely to benefit from interventions than younger people and that it is less important that they recover, reflecting the ageism that exists at many levels in society (Lee, 2007).

Within primary care, treatments available for depression in adults of all ages include cognitive behavioural therapies (CBT) and antidepressants, and these are shown to be effective in treating depression in later life (Baldwin et al., 2003; Orell et al., 1995). While there is an increasing abundance of research into CBT for adults in all age groups showing its effectiveness (Cuijpers et al., 2008a) such as reduced symptoms and increased well-being (Cuijpers, 2008b), there is a limited amount focusing on older adults using CBT alone. Research into CBT focusing on older people with depression tends to be on its effectiveness in conjunction with or compared to other therapies such as antidepressants (Laidlaw et al., 2008; Cuijpers, et al., 1998), or on a combination of mental health problems such as anxiety and depression (Kraus, Kunik and Stanley, 2007). There is also some research into CBT for anxiety in later life both alone and in conjunction with other interventions (Stanley et al., 2003; Schuurmans et al., 2006). One small scale research study shows the effectiveness of CBT for older people with depression and highlights a need for larger scale studies (Wilkinson et al., 2009).

Despite the limited evidence it is clear that older people find psychological therapies valuable in helping with their depression as they are effective and empowering for them (Kuruvilla, 2006). It has been suggested that CBT could be

used on its own as an effective alternative treatment for older people who cannot or will not tolerate physical (e.g. antidepressant) treatments for depression (Laidlaw et al., 2008) as it poses no risk of interaction with other treatments (Serfaty, et al., 2009; Cujipers et al., 2008a; NICE, 2004). One study has shown that 57% of older people prefer counselling to medication (Gum et al., 2006) and different types of talking therapy are beneficial, such as counselling, CBT and interpersonal psychotherapy which is more effective than usual GP care for moderate to severe depression in older people (van Schaik et al., 2006). However despite these benefits older people are rarely referred for psychological therapies like CBT (Mental Health Foundation, 2007). It is known that GPs are less likely to refer those over 65 for psychological therapies including CBT because they may be more reluctant to accept treatment if their depression is identified through screening rather than presenting it to GPs themselves (Kendrick et al., 2009). It has also been argued that ageist attitudes of some GPs can prevent older people from having access to the right treatment (Age Concern, 2008). This, alongside the fact that older people often express a preference for CBT over antidepressants (Givens et al., 2006) but are not being referred, suggests a limited understanding of the reasons why GPs fail to refer which needs further exploration.

Despite some older people's preferences for psychological therapies, antidepressants are the most common form of treatment for depression in later life, where 13 per cent of patients over 65 take them (Charlesworth and Carter, 2011). In general however, older people are less likely to be started on antidepressants than younger patients (Kendrick et al., 2009), and there is evidence that even if antidepressant medication is offered to older people many do not receive an adequate course of treatment as either the dose is too low or they are not prescribed it for long enough (Callahan, 2001; Coyne and Katz, 2001), or they fail to take the full course because of their beliefs about it (Fawzi et al., 2012). While SSRIs have been shown to be effective for older people, GPs can be deterred from prescribing antidepressants due the increased possibility of interactions with other medications for many of the chronic illnesses found amongst older people and the possible negative side effects (Coupland et al., 2011). Other influences over GPs not prescribing them to older patients can be their reluctance to take them (Givens et al. 2006) and with adults of all ages it can be their perception of patients' attitudes towards antidepressants (Hyde et al.,

2005). The effectiveness of SSRI antidepressants for less severe depression in adults of all ages is also uncertain (NICE, 2004) and this may deter GPs from prescribing them when they believe patients' depression stems from their living circumstances (Department of Health, 1999).

Certain newer interventions for depression are shown to be successful and acceptable for older people. Valuable aspects of these include being offered opportunities to talk to other people about their emotions and reducing loneliness, and include process focused interventions that allow older people to feel "useful" and valued (Charlesworth and Carter, 2011), befriending which provides emotional support and affirming relationships thereby decreasing loneliness (Lester et al., 2012; Mead et al., 2010), support for bereavement (Age UK, 2011b) and educating older people about depression and the antidepressant treatments available to them (Givens et al., 2006). Other interventions consist of psychotherapies used in combination with antidepressants that are effective and accessible for both GPs and older people (Hunkeler et al., 2006; Bruce et al., 2004). Although research shows the benefits of these interventions for older people there has still been little improvement to the numbers of older people who are offered them (Chew-Graham, Baldwin and Burns, 2004). This evidence suggests that services for depression in later life are not available or are not offered, and Age UK suggest that there also needs to be improved access to talking therapies for older people so that the full range of treatments are available to this age group (Age UK, 2012). Improvements to research and clinical care provided for older patients with depression within the primary care setting have been recommended (Skultety & Zeiss, 2006).

Evidence of older people's and GPs' beliefs and perspectives on depression reveal additional explanations for problems in the management of depression in later life. The assumptions that depression is normal in later life and that it should remain "hidden" are two constructions that have now become key barriers to tackling it in primary care today (Lee, 2007). Evidence on older people's perspectives of depression are considered in the next section, after which those of GPs are examined.

The perspectives of older people and GPs on depression

Evidence on the perspectives of people over 65 and GPs about depression in later life and how it is managed is not extensive. However, there is plenty that focuses on the views of adults over 18 on depression, some of which is included in this section for the purposes of comparison and to elaborate on particular points of interest. This is especially the case where there is a lack of evidence on older people's views.

Older people's perspectives

Less than one in six older people with depression talk to GPs about their symptoms (Chew-Graham et al., 2011) even though they respond well to probing about their mood by primary care professionals (Lawrence et al., 2006a). The notion that depression is almost impossible to describe has emerged from work focusing on non age specific patient narratives, where there are observations that many people struggle to explain and make sense of their depression (Wolpert, 2006; Wolpert, 2001; Lewis, 1995; Styron, 1990). Patients have also acknowledged how depression can negatively influence their sense of self and act as a barrier to describing their experiences of it (Rogers, May and Oliver, 2001). The use of language and the way GPs and patients talk about depression has been highlighted as particularly important with older people (Burroughs et al., 2006; Murray et al., 2006; Lawrence et al., 2006a; Butcher and McGonigal-Kenney 2005). Older people have been shown to communicate their symptoms of depression in line with their perceptions of it, which may not fit with today's medical model of depression resulting in it not being identified by doctors (Bristow et al., 2011; Cohen, Singh and Hague, 2004). It is therefore important to recognize the different ways depression is perceived and communicated by older people and the implications these different viewpoints may have in its management.

The ways older people perceive depression can influence whether they seek help from GPs and how it is managed. They may see depression as a normal part of aging brought about by life's circumstances e.g. loneliness rather than a "real" illness and not worthy of taking to the GP (Lawrence et al., 2006a; Barg et al., 2006). Reasons for this can be that they do not recognize symptoms like irritability, lack of sleep or feeling down as a medical problem and see them as problems of

living (Prior et al., 2003). Alternatively they can see depression as a non medical problem which is outside the responsibility of GPs to deal with (Bristow et al., 2011; Lawrence et al., 2006b), or a moral failing that they do not want to burden their doctor with and instead wish to come across as a “good patient” who does not complain (Wittink et al., 2006). They may also not consider themselves candidates for care because of previous experiences of help seeking (Chew-Graham et al., 2012). These factors mean that they can be reluctant to go to the doctor about depression as they feel they should be able to handle it themselves or do not recognize it as an illness in its own right needing treatment (Reynolds and Charney, 2002; Rabins, 1996).

Older people also can be reluctant to accept antidepressant treatment because of the symbolism that it can hold for them, which reflects their beliefs about depression and concerns about treatments (Givens et al., 2006). They often find counselling preferable but are unable to access it since it is infrequently available to them in primary care (Gum et al., 2006). This could be due to a lack of recognition of depression by GPs or their failure to refer and provide appropriate treatments when they do identify it (Age Concern, 2008; Callahan, 2001; Coyne and Katz, 2001). A stigma and a lack of knowledge about depression can also affect older patients' perceptions of its severity and the need to seek treatment which can lead to it being undetected or becoming worse (Bristow et al., 2011; Kessing et al., 2005).

Insight into ways older people conceptualize depression can be helpful in understanding ways they talk about it (Barg et al., 2006; Lawrence et al., 2006a), however there are points of tension between it being framed as a medical illness or a normal experience of later life. It has been suggested that older people verbalize their depression within the conceptual framework of loneliness rather than the medical framework of depression (Barg et al., 2006) which illustrates their ability to communicate about depression to GPs more effectively if it is framed as something they find acceptable and normal in old age. However if GPs share their views that loneliness is the root of their problems rather than it being an illness positioned within the medical domain, they may not make a diagnosis and the depression can remain untreated. In contrast older people can also be more comfortable with the idea of depression and more accepting of treatments if it is

framed as a “normal” chronic disease rather than a psychiatric “brain” disease (van Schwenk, 2002). The need for it to be normalized may be because of cultural and generational attitudes to mental illness existing during their lifetimes such as stigma, nihilism and prejudice (Reynolds and Charney, 2002). However if depression is viewed as a disease rather than a normal part of later life this may validate older people seeking medical help (Burroughs et al., 2006).

Older people’s differing beliefs about depression are the focus of a qualitative study by Lawrence et al. (2006a), which shows that differences between older people’s perceptions of depression can originate from their cultural backgrounds. It shows that while many older people believe that the causes of depression are due to circumstances in their life that come with old age, variations between them can be wide ranging and multi faceted which underlines the extent to which depression can influence multiple aspects of their lives. Since the impact of depression extends far beyond older people’s physical and mental health the characteristics and symptoms recognized in medicine seem to exist in the background, supporting the well evidenced argument that the social model of depression is more expressive of what older people attribute to depression (e.g. Murray, 2006). The Lawrence et al. (2006a) study is particularly important as it focuses on differences between older people with depression and the reasons for these, as well as seeking understanding beyond the words they use when describing their depression. By focusing on one aspect of patients’ context (i.e. cultural origins) and how this impacts on the management of depression, the Lawrence et al. (2006a) study suggest the importance of other factors relating to older people’s backgrounds and situations which can explain the different ways they operate in consultations.

Older people have been characterized as passive in consultations for depression (Burroughs et al., 2006) and are reluctant to accept antidepressant treatment (Givens et al., 2006) and these are factors contributing to the problems in its identification and management in primary care. It is also common for patients of all ages to withhold their ideas about what is wrong with them in GP consultations because they have different ways of communicating in consultations as opposed to their own social contexts, which can lead to major misunderstandings between patients and GPs about patients’ preferences and needs (Barry et al., 2000).

Patients with medically unexplained symptoms make choices about what to tell their GPs and what to withhold, which are based around whether they trust the doctor with emotional issues (Peters et al., 2008). For these patients part of building trust relates to whether they feel the doctor understands the complexity of their problems and whether they feel the doctor is able to help them in the most appropriate way. Since older people can find it difficult to verbalize their depression in many situations, it seems that exploration into influences over how they verbalize their depression in consultations may help uncover reasons underlying their decisions not to seek help from GPs and give further insight into how they discuss depression with GPs. This information could be used to help older people voice their preferences for the type of help they would prefer for depression, such as counselling (Gum et al., 2006) which is not readily available to them, and may also give GPs a clearer picture of the patients' views and experiences of depression.

While little is known about the influences over older people in communicating their depression to GPs, it seems that the way GPs communicate about depression can influence how older patients perceive it and what they expect in consultations when presenting their symptoms. Based on older people's accounts of their experiences Wittink et al. (2006) found that older patients' assumptions about their relationship with their doctor can have a bearing on how they perceive GPs responding to them. On this basis Wittink et al. (2006) identify GP approaches to managing older people with depression, determined by the skills they use: the doctor may uncover depression without the patient being explicit about their emotional state, or the doctor and patient co construct a role as a "good" patient" where the doctors' positive expectations of them do not allow for patients to reveal they are depressed. Alternatively doctors may signal to patients that they only deal with physical problems in some way by never asking about the patients' feelings or bringing up emotional problems. These cues from doctors either encourage patients to allow their depression to be discovered by the doctor or to bury it in some way. In these instances patients may instead take problems that fit with the doctor's perceived expectations of them or those that are perceived to be valid. What is particularly important here is that non verbal interactions between older patients with depression and their GPs seem to hold valuable information about

the dynamics of their relationships, and that these cues can influence patients to withhold their depression.

This evidence has underlined the importance of GPs hearing older people's stories of depression, in order to understand more about their individual needs as well as the reasons underlying ways they reveal or withhold information about their depression in consultations. Insight into the other side of this story from the perspectives of GPs would help give a fuller picture of how older people and GPs communicate about depression and how this impacts on the management of depression.

GPs' perspectives

To date there has been ample attention to the under recognition and under treatment of depression in older people by GPs (e.g. MacDonald, 1986; Unützer, 2002) and it is clear that the nature of a GPs' work and the constraints and boundaries that define their role may not fit with the demands involved (as discussed earlier in this chapter). Evidence on GPs' views of managing depression in patients of all ages identifies important factors that are both beneficial and detrimental to its management that need to be explored with regard to depression in later life (van Rijswijk et al., 2009; Oopik et al., 2006; Baik et al., 2005; Hyde et al., 2005; May et al., 2004; Andersson et al., 2002; Chew-Graham et al., 2002; Chew-Graham et al., 2000). Research into GPs' perspectives on depression in later life is less common and focuses on ways they conceptualize it and how this influences its management (Murray et al., 2006) and their attitudes to identifying and managing it (Rothera et al., 2002). There is also some valuable work exploring the views of both older patients and GPs on depression and its management, which is considered later in this chapter.

While family doctors consider identifying and managing depression to be an important part of their job (van Rijswijk et al., 2009) they perceive a number of constraints over them as barriers to this, both in the UK and elsewhere. They often feel they have a lack of time in consultations to counsel patients to help them define and accept their problems as depression (Oopik et al., 2006). They also feel that a lack of management options and the cost of prescribing influence their decisions to prescribe antidepressant treatment (Hyde et al., 2005). They may also

have doubts about the usefulness of classification criteria for depression revealing a mismatch between the recommendations in guidelines of pharmacological approaches and patients' preferences (van Rijswijk et al., 2009). GPs can also see the circumstances they work in as influential over their successful identification of depression rather than a lack of knowledge about depression (Baik et al., 2005), including familiarity with the patient, clinical experience and the time they have available for dealing with depression, alongside the multiple issues and symptoms patients bring to them.

GPs' attitudes to dealing with depression are also important, for example whether they feel comfortable talking about emotional problems and whether they have time to "open the door" to patients from uncovering clues signaling their depression. If they work in areas of social deprivation GPs may view depression as a normal consequence of patients' circumstances and life events, and can feel powerless when they are unable to offer changes to patients' circumstances and life problems for which the treatments they can offer are limited in their effectiveness (Chew-Graham et al., 2000; Chew-Graham, May and Perry, 2002). These factors underline the importance of exploring situational factors that influence a GPs' likelihood of identifying depression and being able to manage it successfully, especially clinicians' ability to appropriately respond to patients with depression in short consultations. Exploration of these factors may build on work identifying why depression can be perceived as a normal circumstance of older age (Burroughs et al., 2006) and why it can be overlooked when veiled by multiple physical health problems (Coventry et al., 2011; Chew Graham et al., 2011).

GPs' consider aspects of their relationships with patients and their skills gained from personal experiences to be valuable factors in managing depression (Nolan et al., 2003; Andersson et al., 2002; Oopik et al., 2006). They believe that patients who feel listened to and reassured by their GP choose to do everything they can to recover from depression, highlighting the importance of GPs' interpersonal skills (Nolan et al., 2003). In addition, having a greater capacity for empathy and better listening skills are also perceived to be advantageous by GPs in their work with depressed patients, with personal life experiences and professional experiences of depression as influential, and for some more valuable, than their university education and training in psychiatry (Andersson et al., 2002). Building a good

quality doctor-patient relationship is also a motivating factor for GPs in the management of depression, especially when they can see a patient's confidence in their relationship growing and greater cooperation in the management of their depression (Oopik et al., 2006).

GPs' perspectives also reveal that the way in which they conceptualize illness can influence the ways they respond to patients, including their delivery of care and the patients' experience of receiving care. May et al. (2004) suggest that with chronic illnesses including depression there are fundamental conditions which GPs see as influencing their relationships with patients and therefore what happens in consultations. At the core of this is their perception of the different combinations of "social", "psychological" and "medical" symptoms which patients present, and May et al. (2004) propose that variations on this can influence the way patients and doctors respond to each other and consequently how treatment and management of the illness is handled. This not only serves as a reminder of the different and individual ways GPs can approach illness and interactions with their patients, but also introduces the idea that there can be different combinations of symptoms and presentations by patients who have the same illness. Considering the existing problems of identifying and managing older people with depression which have been primarily based upon the medical model of depression, this research suggests that if GPs adopt different ways of conceptualizing components of patients' presentations of their illness, it may lead them to respond to one another differently.

An early UK investigation into GPs views of depression in later life by Rothera and colleagues (2002) indicates that GPs see depression in older people as an illness triggered by both physical and social circumstances for which they mostly prescribe antidepressants (Rothera, et al., 2002). While GPs say they are confident in treating it they would also like more information and extra training on it, leaving question marks over why this is contradictory and where they lack confidence. Rothera and colleagues (2002) also suggest that GPs who have been in practice for longer may especially benefit from ongoing training informing them of developments in treatments for older people with depression, despite previous work showing that training GPs does not lead to improvement in patient outcomes (Thompson, Kinmouth and Stevens, 2000). Further, the focus of the Rothera

(2002) study is on their prescribing of antidepressants with little consideration of other forms of help they could offer. This may reflect the limited evidence on GPs' views of depression in later life or the method of the study which uses surveys that may not have given opportunities for GPs to explain their reasoning. It may also indicate that GPs are not considering the wider possibilities of their approach which they demonstrate in their views of managing it in patients of all ages, suggesting a difference in GPs' attitudes to managing depression older and younger people.

A recent qualitative study by Murray et al. (2006) explores the perceptions of GPs and other primary care professionals' views on depression in older people, and provides more insight into reasons underlying their views. Murray and colleagues (2006) suggest that the way GPs view depression in later life and how they perceive older patients to view it leads them to put other health problems first rather than addressing the depression. It shows that they often see depression as a psychosocial problem which is inevitable in later life, and that many GPs have concerns about medicalizing this "understandable" distress caused by isolation and social circumstances. This can leave them feeling unable to help and prevent them diagnosing and treating the depression. Further, their decisions to do this may be reinforced by their perception of the patients' preferences and views of depression, which are that they are reluctant to acknowledge their depression as they see it as a sign of weakness that is stigmatized rather than a valid medical problem they can take to GPs. The complex picture presented by Murray et al. (2006) of GPs' views on depression in later life and how it "should" be handled raises questions about whether GPs have accurate perceptions and misconceptions about depression in later life and older people's views of it. It also highlights the importance of knowing whether or not there is consistency between the views of older people and GPs about how depression in later life should be handled in primary care.

Also revealed by the Rothera et al. (2002) and Murray et al. (2006) studies is that GPs' views of managing older people with depression can be characterized by expectations of being unable to help and feeling overwhelmed by the multi-faceted and interrelated issues that can be involved in its management. This can increase GPs' uncertainty around their decisions to identify depression in older people, as

they may be concerned about uncovering a “Pandora’s Box” of problems that need addressing in time-limited consultations (Montano, 1999). GPs’ beliefs about aging can also influence their identification, diagnosis and management of depression in older people (Collins, Katona and Orrell, 1995), and they may disregard talking therapies as a treatment option because of an assumption that they will not work in the elderly or that older patients are reluctant to use them (Burroughs et al., 2006). Accordingly when they are not confident about how older patients will react to their approach to depression they tend to deal with other medical problems instead (Chew-Graham, 2004).

Uncertainty amongst GPs about their roles and responsibilities in dealing with depression in later life has also contributed to the problems in managing it. Some GPs who are not certain about how to access services for older people see themselves as generalists with no expertise in mental health and with limited options to refer to secondary care (Burroughs et al., 2006). Others are uncertain of whether some patients should be treated in primary or secondary care (Nolan et al., 2003). Even when GPs recognize depression in later life is within their remit and express an interest in mental health, their limited training and lack of support can mean they are more certain of their limitations than capabilities in this area (Burroughs et al., 2006; Murray et al., 2006). These issues may be partly due to unresolved dilemmas relating to their role set against the changing context of primary care mental health.

The evidence discussed above shows that many GPs lack confidence in dealing with emotional problems with patients of all ages, and that there is limited evidence of their perceptions of managing depression in older people specifically. It therefore seems particularly important to explore the reasons for this when seeing older people who are reluctant to bring up their depression in consultations. Their views of where they feel their knowledge is lacking and where they need support in their skills could help address the problems already identified managing it, and how this could be achieved within their role. However, valuable information on this can be found in research that explores the dual views of both older people and GPs on depression, which has identified some explanations for their behaviours in consultations. This research is considered next.

Dual perspectives

Research into both patients' and GPs' perspectives on depression reveals where their views diverge and meet, and how their experiences of aspects of its management compare. Evidence includes how patients' of all ages and GPs' experiences of having and managing depression compare (Maxwell, 2005; Rogers, May and Oliver, 2001), their views on management goals, strategies and antidepressant treatment for depression in later life (Dowrick et al., 2009, Johnston et al., 2007, Givens et al., 2006), exploration of interactions between older people and GPs in consultations for depression (Cape et al., 2010; Wittink et al., 2006; Burroughs et al., 2006), and barriers to detecting and managing depression in people with long term conditions (Coventry et al., 2011).

In patients of all ages, problems in the management of depression can arise due to different ways patients and doctors conceptualize depression according to the social and medical models of depression. This can be apparent when practitioners diagnose and treat depression as an illness and lay people normalize it by finding common sense explanations for it such as their life's circumstances (Cornford, Hill and Reilly, 2007; Pill et al., 2001). It can also happen when they have contrasting views on how it should be treated (Kadam et al., 2001). These differing perspectives may go some way to explaining why there are problems with more practical aspects of managing it, including difficulties GPs and patients have in talking to each other about depression in consultations (Coventry et al., 2011) and reasons underlying the decisions they make (Hyde et al., 2005).

For patients this disparity in their perspectives can lead to problems negotiating an "illness identity" if they have an undeveloped understanding of their illness and for practitioners in detecting depression (Rogers, May and Oliver, 2001). A study on back pain showed that patients may reject clinical diagnostic labels and seek ones that relate to organic physical manifestations of disease instead (May, Doyle and Chew-Graham, 1999), which suggests patients with depression may also need a more concrete understanding of their depression in order to accept it as an illness needing treatment. Similar problems may occur if patients cannot rationalize their depression to fit in with the medical model and rather attribute the cause to social circumstances, making it difficult for them to justify depression as a medical problem (Lafrance, 2007). Comparatively, when patients with serious mental

illnesses experience a crisis a main challenge is for health professionals to be available without patients having to exaggerate symptoms (Lester et al., 2005). This supports the suggestion that a clinician's understanding of patients' constructions of depression can be beneficial to making decisions about managing it (Brown et al., 2001) and improve their patients' responses to treatments (Heim, Smallwood and Davies, 2005).

Alternatively it can be helpful for GPs to facilitate patients' own understanding of their depression, which can help them accept their problems and talk about them more freely. A qualitative study by Cape et al. (2010) focuses on how patients and GPs perceive this process in mental health consultations, revealing that it is a patient-led process which is facilitated by the GPs' use of certain skills. The study shows that skills patients find valuable in GPs are questioning, listening, validating and elaborating on aspects of their story that are important to them. This can help them validate what has happened to them and even arrive at different perspectives or a "refreshed" understanding. However there are some patients who do not find this process helpful in increasing their understanding of their problems, without further information of why they are different to the other patients. This underlines that the same approach is not always helpful for all patients and suggests it may be important to explore the differences between patients in their need to understand their problems to ascertain their differing needs. It may also be important to look at these differences specifically between older people who have depression, especially to help GPs determine which approach to treatment would best meet their needs. This could include whether the approach of talking through their problems is better for them and whether they would like to come to a greater understanding of their depression, or whether they would find another form of help preferable.

Supporting this notion, an in-depth exploratory study into the views GPs and patients (Rogers, May and Oliver, 2001) found that GPs and patients can respond differently to depression as a result of their views coming from differing medical and social perspectives. For patients although their need to seek help is pressing, their experiences in primary care are of relatively little significance compared to the magnitude of their experiences of depression. However their perception of the care provided and whether or not their problem is perceived to be legitimate

influences their expectations. For GPs dealing with depression, their responses to patients are not only shaped and constrained by individual patients' preferences but also by the wider formulation of medical knowledge and practice as well as professional interactions and the political organization of resources in primary care. This draws attention to wider issues outside primary care, showing the different contexts within which patients and GPs operate and how they may be influenced in different ways when they interact in consultations. The study also highlights the importance of looking at contextual influences over patients with depression and GPs in order to explain the different ways they respond to one another in consultations for depression.

Influences over patients' and GPs' views of how depression should be managed can also be driven by similar motivations, despite there being areas of conflict caused by differing perspectives. Maxwell (2005) draws parallels between how patients and doctors are both influenced by social and moral reasoning, for example female patients can seek help and accept a diagnosis of depression and advice from their GP because of a sense of duty to other family members or to preserve relationships. For GPs the act of diagnosing and managing depression can lead to contemplating their professional role and what is "legitimate work" which can influence the help they offer such as spending time and listening to patients. These examples of social and moral reasoning appear to lean towards the social model of depression rather than the medical model. This highlights both the importance of exploring similarities underlying the ways patients with depression and GPs view depression and how this influences its management. It also raises questions about how their different positions as patients and GPs might influence ways they operate in consultations.

Evidence on depression in later life shows that there are specific problems caused by the beliefs older patients and GPs can share about depression. They may construct an understanding together that it is normal in later life or with chronic conditions (Coventry et al., 2011), and that it is not a legitimate illness to take to GPs because little can be done to help (Montano, 1999). Burroughs et al. (2006) suggest that older people and GPs' can share the belief that depression arises from social and contextual issues and is therefore not within the remit of the GPs role (Burroughs et al., 2006). They identify "therapeutic nihilism", which refers to

the dual misconception of both the patient and doctor that nothing can be done to help with depression in old age. This exists because expectations of older people and GPs regarding successful treatment of depression tend to be low, and this reinforces the feeling of pessimism and powerlessness to change the problem on the part of both patients and GPs. This shared view that depression is normal can also happen when the GP and patient have together created a role that might inhibit any discussion of emotions without happy or positive content (Wittink et al., 2006).

Collusion to overlook depression can occur when the relationship between older people and GPs is such that emotional health is not mentioned (Goldberg, 2009). The combination of older patients' passivity to their treatment and the way health professionals perceive older people's attitudes to depression can also give health professionals unspoken permission to disregard depression and concentrate on other health problems (Burroughs et al., 2006). Exploration of what is left unsaid in consultations for depression in older people may therefore be an equally important influence over its management as what is talked about. Furthermore an understanding of older patients' perspectives of depression is also important for health professionals to improve patients' engagement with health care services (Murray et al., 2006) and their acceptance of treatment (Givens et al., 2006).

Research into the dual perspectives of patients and GPs shows that it can be beneficial to look at both sides of the same story, in order to identify similarities and tensions between their views and compare their lived experiences. It can also provide valuable evidence about what both older people and GPs find acceptable in practice, giving different perspectives on the same story and a more complete picture of why there are problems. Obtaining the dual perspectives of older patients and GPs can also be a way of exploring how they interact with each other and finding out how management of depression in later life in primary care could be improved to better meet the needs of both groups.

Gaps in the evidence

Evidence goes some way to explaining problems older people have in seeking help within primary care and accepting treatment for depression (e.g. Chew-Graham et al., 2012; Bristow et al., 2011; Kessing et al., 2005). It is known that older people struggle with revealing their depression to GPs (e.g. Chew-Graham et al., 2011), and with verbalizing their views and preferences relating to the management of their depression (Givens et al., 2006; Gum et al., 2006). Yet there is minimal insight into the underlying reasons behind what they say and do, such as why they might see depression as a non-medical problem and reasons why they have different needs and preferences in its management. Importance has been placed on patients gaining an understanding of their depression including its cause (Lauber et al., 2003; Brown et al., 2001) and what has happened to them so they can explain their experiences to others (Lewis, 1995). However it is not known what is important for older people with depression to help address the problems they face in seeking and accepting help for depression within primary care, or what influences the ways they talk to GPs about their depression.

The evidence shows that older people's and GPs' perspectives on depression can be both contrasting and shared. These overlaps and diversions in their views have been found in studies where barriers and challenges to its management have been identified in stories told by older people (e.g. Chew-Graham et al., 2012; Gum et al., 2006; Rogers, May and Oliver, 2001) and GPs (e.g. Murray et al., 2006; Rothera et al., 2002), and particularly in studies that have looked at the views of both simultaneously (e.g. Coventry et al., 2011; Burroughs et al., 2006). This valuable evidence comparing the perspectives of both older people and GPs on depression shows that they can have a shared view that depression is a normal part of aging which can lead them to construct a view together that nothing can be done, and that other health problems should be a priority. To address this barrier it seems that a greater understanding is needed of which older people and GPs do this and why. What happens with other combinations of older people and GPs could also help ascertain combinations that respond to each other well and those that encounter specific problems. A first step towards finding out why depression is identified and treated successfully for some older people and not others would be

to explore whether there are different types of older people and GPs, and if so what the differences between them are.

Previous research identifying differences between older people has been carried out, and focuses on the ways they conceptualize depression. It has been found that their cultural background or ethnicity can explain their different beliefs about what depression is (Lawrence et al 2006a) and ways they seek help for depression from GPs (Lawrence et al., 2006b). It also highlights aspects of its management they are able to accept and talk about (Barg et al., 2006; van Schwenk, 2002; Burroughs et al., 2006). Other work has identified that older people may not recognize depression as an illness needing treatment (Reynolds and Charney, 2002) see depression as a non medical problem (Prior et al., 2003) a normal part of aging brought about by life's circumstances e.g. loneliness (Barg et al., 2006), or a moral failing (Wittink et al., 2006) all of which mean that they do not see it as a real illness worthy of taking to GPs.

These studies highlight the importance of looking at the older person's position, situational context and factors outside the medical model of depression that may influence the way they operate in consultations. While cultural reasons can explain ways older people of some ethnic origins consult for depression, there is no other evidence looking at the general population of older people in the UK, identifying which types of older people view depression in certain ways and how these differences influence what they disclose to GPs in consultations. There are also unanswered questions around why many find verbalizing their depression to GPs a particular problem, and the reasons for what they choose to reveal and withhold about their depression to GPs. Further steps in research could be taken to move towards understanding older people with depression more as individuals with different needs rather than a homogenous group. Information on the different ways older people tell their stories of depression may build a fuller picture of how their different experiences and situations shape what happens in consultations. This may help GPs understand more about how they present their stories of depression differently in consultations in order to find new ways of identifying it in older patients and providing the most appropriate help.

Differences between GPs have also been looked at in previous research, although the evidence is minimal. They can have different attitudes towards managing depression, where many younger GPs are confident in their abilities to manage it (Rothera et al., 2002) whereas others lack confidence and have low expectations of being able to help (Murray et al., 2006). Reasons for this could be the different sets of skills GPs have in managing older people with depression, however this has not been evidenced or explored in detail. Other research from the U.S. strongly emphasizes the importance of situational influences over making a timely diagnosis of depression (Baik et al., 2006) but this has not been explored in relation to GPs in UK primary care. The work so far indicates that more research into the differences between GPs and influences over them could provide explanations as to why some are able to manage depression in later life successfully and why others experience more problems and challenges. Exploring the influences over which skills they use successfully in managing older people with depression could be a way of identifying what is possible for them within the constraints of their role and individual situations, and help explain why they respond in different ways to older people with depression.

The different positions of patients and GPs can influence the different ways they operate in consultations for depression (Maxwell, 2005). This has not been explored in relation to older people with depression and GPs, where their positions in relation to each other and how this influences ways they relate to each other in consultations is not clear. Finding out more about this could help gain further insight into why some older people may not disclose their depression to GPs and the reasons why certain GPs may decide on different management options to others, or to address other health problems in older people rather than depression. In addition the constraints and boundaries that different GPs experience may be linked to their positions and situations, possibly influencing the ways they manage it. This may be problematic if the help they are able to offer does not fit with older people's needs. It seems that exploring the different ways GPs respond to older patients with depression and why they encounter different problems may be a step towards this.

It is apparent that older people's and GPs' shared belief that depression is normal in later life does not fit with the medicalized framework that primary care provision

for depression is based around. New evidence showing how older people's and GPs perceptions of depression influence what happens in consultations, particularly the ways they communicate and respond to each other would address this. Practical solutions could then be developed to help older people clearly communicate their depression and preferences to GPs, and to help GPs identify it and provide them with appropriate help.

Although research has recognized a number of factors underlying the ways older people and GPs conceptualize depression and how this has influenced its management, there has been little exploration of the impact of their wider contexts and situations and how these influence what happens in consultations. The existing research also tends to categorize both older people and GPs as large homogeneous groups rather than recognizing the differences and subtleties between them and the reasons for these. More focus on these differences and the reasons underlying them in primary care provision for depression in later life would promote an individual approach for both groups, and potentially address existing problems in its identification and management. A next step could be to explore how their different positions and situations influence the ways they talk about depression and respond to each other in consultations. The research aim of this PhD study is therefore:

To explore how older people's and GPs' different positions and situations influence the ways they perceive depression. Particular focus is on influences reported by older people over ways they talk about depression and influences reported by GPs over ways they respond.

The intention of this research is to inform practice about the management of depression in later life, to improve primary healthcare provision for older people presenting to GPs with depression.

Chapter 2: Methodology

Introduction

The methodological approach of this study is the philosophical and practical framework underpinning the exploration of the research aim: To explore how older people's and GPs' different positions and situations influence the ways they perceive depression. Particular focus is on influences reported by older people over ways they talk about depression and influences reported by GPs over ways they respond.

To do this a methodological approach that allows for consideration of multiple perspectives on the topic of enquiry is needed, to develop an explanation for the interactions between older people and GPs in consultations for depression in later life.

The first section of this chapter focuses on the theoretical orientation of the methodology. It explains why certain aspects of grounded theory, symbolic interactionism and social constructionism have been used, what they are and where they come from as well as justification of why they are appropriate for this study. There is also discussion of how the different theoretical approaches interrelate and work together in this study. Since grounded theory is both a philosophical discourse and method, the philosophical and theoretical aspects of grounded theory are focused on in this chapter and practical procedures that are used this study are discussed in the methods chapter. There is also an overview of Clarke's *Situational Analysis* (2005) which is a recent development of grounded theory and the methodological model which has informed the conduct of this study.

Theoretical orientation

“Theory” is central to research at a number of levels, where larger world views or sets of presumptions frame any given social inquiry. These presumptions underlie the research question and shape how the researcher has arrived at the research question as a puzzle that needs explaining (Green & Thorogood, 2004). In this study symbolic interactionism and social constructionism are “macro”, or large scale theoretical perspectives that frame the issues central to this study as questions requiring research. Grounded theory is an approach to qualitative analysis based on aspects of these theories that allows the research of these issues to be put into action. The theoretical orientation of this study is therefore at a juncture between grounded theory, symbolic interactionism and social constructionism.

This theoretical framework is positioned within the interpretivist paradigm; a movement in social thought associated with qualitative research aiming to understand human behaviour and people’s interpretations of the world (Green and Thorogood, 2004). Interpretivism is an umbrella term bringing together a number of interpretivist theories including symbolic interactionism and social constructivism which have been “blurred” to produce methods for social research (Lincoln, 2004). Research guided by interpretivism is based on people’s experiences in their social environment and the way they construct meanings from these experiences that make up their unique world views (Flick, von Kardoff and Stenke, 2004). It explores social phenomena, such as people’s attitudes, values, cultures and beliefs to find out the meanings people recognize in them and reasons underlying them. It also looks to uncover how people’s experiences of social interaction influence these views and in turn the relationship between their views and actions (Holstein and Gubrium, 1998). Qualitative research into health can be theoretically positioned within the interpretivist paradigm when it seeks to find out what patients’ and clinician’s understandings about health or illness are and how they rationalize their behaviours in coping with illness or providing healthcare. If, like this study, the topic of inquiry concerns understanding an experience (e.g. depression) and the phenomenon in question is a process (e.g. the management of depression), the method of choice is grounded theory (Morse, 1998).

Traditional grounded theory (Glaser and Strauss, 1967) derives from symbolic interactionism which focuses on how individuals choose to make sense of the world through their experiences of social interaction (Denzin, 2004). Like symbolic interactionism, grounded theory is concerned with understanding how people choose to see the world and how their views have been influenced by their experiences (Hildenbrand, 2004). They both maintain that individuals' social experiences are how they come to understand the world and that these perspectives are unique. Deriving from this a key principle of grounded theory is the avoidance of preconceptions being made by the researcher before data collection starts. However a main difference is that symbolic interactionism is a theoretical discourse that grounded theory adds to by incorporating a number of practical procedures intended to help develop theory and avoid preconceptions (Bohm, 2004).

The goal of grounded theory is to develop an explanatory theory grounded in the data given by participants. To do this it employs practical ways of collecting and analyzing data whilst developing an explanatory theory, which are carried out in an iterative cycle. These procedures are carried out in stages and include theoretical sampling and three types of coding to aid analysis. They are carried out in parallel, continuing throughout the research process so that concepts identified in early data collection can guide the next stages of data collection (Strauss and Corbin, 1998).

Symbolic interactionism can exist in multiple varieties and at a methodological level can include aspects of other theoretical perspectives (Denzin, 2004). For example an overlap between symbolic interactionism and social constructionism is where they both seek to illuminate and further understand meanings generated within society by individuals and groups of people. In exploring the perspectives of older people and GPs there may be individual or group understandings about the management of depression in older people which they perceive to be influential over information they share with each other about depression or what they do in consultations (e.g. Givens et al., 2006). Their reports of patient-GP exchanges in consultations may also contribute to their respective constructions of depression in later life, and may be influenced by lay and medical perspectives on what depression in later life is (e.g. Barg et al., 2006), social attitudes such as a fear of

stigma surrounding depression (e.g. Lawrence et al., 2006a) or the way they talk about depression with each other (e.g. Wittink et al., 2006). Their reported perceptions of each other and the way they respond to one another may also influence their constructions of depression formed as a result of the consultation (Burroughs et al., 2006; Coventry et al., 2011). In this way individuals' interpretations of depression and the way both individuals and groups of people construct understandings about it through reported exchanges with each other in consultations mean that symbolic interactionism and social constructionism are closely intertwined in this study.

Social constructionist thought brings an additional dynamic to the methodological approach of this study by seeking to uncover the processes by which groups of people develop common understandings and meanings (Green and Thorogood, 2004) for example through generating conceptual language (Corbin and Strauss, 2008). In the present study this may include exploring how public understandings of depression can influence how depression in later life is managed, how attitudes found in society during older people's lifetimes may influence what they reveal to GPs in consultations, or how the use of clinical guidelines or the way depression is addressed in government health policy can influence what happens in its management.

The factors outlined here mean that the methodology of this study is theoretically positioned between grounded theory, symbolic interactionism and social constructionism. The next sections of this chapter explain more about which theoretical and practical elements of each approach are involved in this study and why they are appropriate for the field of enquiry.

Grounded Theory

Grounded theory is a combination of philosophical discourse and method. Its philosophical influences derive from symbolic interactionism as it seeks meaning in individuals' interpretations of the world, and it uses certain methods to explore and theorize on how individuals have arrived at their views (Denzin and Lincoln, 1998). Grounded theory is regarded as suitable for exploratory research into people's experiences over time which may have brought about change in their views of the world (Morse, 1998). Research that follows a grounded theory

approach has been used particularly in research into the health beliefs and behaviours of both patients and healthcare professionals (e.g. Kumar, Little and Britten, 2003), including those relating to mental health problems such as depression (e.g. Feely et al., 2007) where an understanding of them is needed to help explain why there can be problems managing people's health and how health services can address patients' and clinicians' needs.

Grounded theory was originally developed by Glaser and Strauss in their work *The Discovery of Grounded Theory* (1967). Central to this work is the idea that theory can be uncovered directly from empirical data, which is done by carrying out methods of data collection and analysis which facilitate the building of theory. Building theory during the research process is an alternative to using a hypotheses developed before research starts, and this component of grounded theory sets it apart from other social science approaches. Glaser and Strauss justified this by their premise that looking for ideas established by other researchers "hinders the searching for new concepts" (Glaser and Strauss, 1967). This new approach challenged the dominant quantitative social science methods of the time by arguing that qualitative (as opposed to quantitative) research can provide systematic social scientific inquiry (Charmaz, 2000).

Two routes of grounded theory were later established separately by Glaser and Strauss when their ideas on how to conduct grounded theory diverged. Differences were fundamentally based around the position of the researcher and his role in the process of analysis and interpretation of data. Glaser's stance was that the researcher should remain passive and neutral, remaining separate to the data which was seen to represent itself. This approach disregards the researchers' perspectives and subjective interpretations of data, assuming an objective external reality which is often regarded as closer to positivism (Charmaz, 2000). In Strauss' work however, the researcher actively takes part in the construction of theory with the use of analytical procedures. Strauss developed his ideas further in his *Qualitative Analysis for Social Scientists* (1987) with focus on methods of systematic scientific coding and microanalysis together with recognition of changes that come with the passing of time and the contextual situation. Strauss' more recent developments of grounded theory are produced with his co-author Juliet Corbin (Strauss and Corbin, 1990; Strauss and Corbin, 1998) who later went

on to develop their work further (2008). It is these aspects of Straussian grounded theory that have inspired more recent constructionist developments of grounded theory.

Newer constructionist approaches to grounded theory include those of Charmaz (Charmaz, 2000; Charmaz, 2006), Clarke (2005) and Corbin and Strauss (2008). Main departures from the Glassarian route of grounded theory are that they focus on how analysts' interpretations have been formed, how perspectives of participants have been influenced by their contexts and experiences, and promotes first-hand knowledge of the topic of inquiry, which is that shared and created by the researcher and researched (Charmaz, 2006). Points of difference between these newer approaches were considered by IG when choosing the most suitable version of grounded theory for this study.

Depression is a subjective experience which indicates that it requires an approach allowing the subjects' view to be central. In grounded theory ideas are developed during data collection using what participants say and exploring this further with more participants, rather than using a theoretical framework already identified. This means that theories are directly based on the raw data rather than any hypotheses made before the research is carried out. In doing this no preconceptions about data are made leaving the theoretical framework open. In keeping with grounded theory, this openness allows for new ideas that the researcher may not have considered previously to come out of the research and to be developed.

Clarke's (2005) version of grounded theory inspired this study because of its focus on the multiplicity, fluidity and changing nature of ideas, as well as on points of difference rather than commonality. These aspects of Clarke (2005) can facilitate recognition of the complex and changing experience of depression in later life and the range of differences that older people report in their experiences of having depression. The focus on differences rather than similarities also promotes the further definition of both older people with depression and GPs, rather than either group being seen as homogenous, which is in line with developing a more individualised approach to managing it.

Methods employed in grounded theory

Certain methods employed in grounded theory are consistent in many of the versions developed since Glaser and Strauss (1967) and some of these inform the research process of this study.

Theoretical sampling has been a fundamental principle of grounded theory from the outset and is used as a tool to help develop theory during the analysis of interview data:

*“ ‘sampling’ is driven...explicitly by **theoretical** concerns that have emerged in the provisional analysis to date. Such theoretical sampling focuses on finding **new data sources** (persons or things – and not theories) that can best explicitly address specific theoretically interesting facts of the emergent analysis” (Clarke, 2005, p..xxxi)*

The technique was originally developed by Glaser and Strauss (1967) and later by Strauss (1987) where he distinguished three stages of data collection, coding and theoretical memos. These processes are carried out in an iterative cycle, and on the basis of coding and theoretical memos it may be necessary to collect new data. This process is repeated until “data saturation” is reached and when no new concepts are being found in the data (Glaser and Strauss, 1967).

In theoretical sampling participants should be deliberately selected on the basis that the information they give will inform theoretical ideas that are developing during the data collection and analysis cycle. When no new material is being uncovered from the lines of enquiry focused on, additional participants are sought with the intention of challenging and exploring these concepts further. Ideally, the theoretical sampling technique ensures that few assumptions are made by researchers before data is collected, and participants directly influence the theory that results from the research. This is necessary because following this approach ideas are vague at the beginning and materialize during the course of the investigation (Merkens, 2004).

The process of semi structured interviewing is positioned on a scale between structured and unstructured interviewing techniques (Lincoln and Guba, 1985) and is used in a range of approaches to qualitative research as well as grounded approaches. Participants primarily lead the topics of conversation and may explore

ideas out loud which they may not have verbalized or thought about before. Observing this process can be valuable for identifying ways people make sense of things or talking about issues that they may find easier talking about to someone they do not know (Corbin and Strauss, 2008). It can allow participants freedom to give as much or as little detail as they feel is necessary on a topic area. This may provide depth and richness in the data where a lot of detail is given, and which may not be gained if a structured approach to interviewing is employed and where the researcher defines the route of enquiry (Guba and Lincoln, 1981, cited in Lincoln and Guba, 1985). The observations about what is said made by the researcher also allow opportunities for revisiting aspects of what participants say. Doing this can also provide more depth about the situation of the interview and behaviours of participants from the researcher's perspective (Janesick, 1998).

The procedures of theoretical sampling and semi structured interviewing can be used in conjunction with the model of *Situational Analysis* (Clarke, 2005), alongside other key procedures either found in grounded theory and updated by Clarke or new approaches devised that are specific to her model. The research processes of this study incorporate aspects of these procedures whilst at the same time being informed by aspects of Clarke's *Situational Analysis* (Clarke, 2005).

Symbolic interactionism

Symbolic interactionism derives from the work of sociologist and philosopher George Mead (1863-1931) who laid the foundations of symbolic interactionism, and offered an explanation for this individual-centred view of the world in *Mind, Self and Society* (1934). This was that individuals are divided between their mind which concerns cognitive, inward looking thought processes (internal) and their self which concerns social experiences and the side of individuals seen by others (external) (Denzin, 2004). The idea that individuals develop internal and external "stories" which reveal how they make sense of the world to themselves (internal) and to others (external) is central to symbolic interactionism, and parallels can be drawn between this feature of symbolic interactionism and the topic of depression in later life and its management. This is because the subjective nature of depression coupled with it being a social experience suggests a two sided experience consisting of individuals' internal (mind) and external (self) stories. Since people with depression meet the social world in situations such as primary

care consultations, this aspect of symbolic interactionism seems an appropriate philosophical framework from which to explore the stories of older people and GPs and interactions between them.

Another principle of symbolic interactionist thought is that concepts and lived experiences acquire meaning through social interactions. This means that individuals build their understandings of the world through social relationships or exchanges and experiences with other people. Their responses to each other are based on their perceptions of the other's actions rather than the direct actions of another. This principle was introduced by Herbert Blumer (1969) who built on the work of Mead (1934) in *Symbolic Interactionism. Perspective and Method* (Denzin, 2004). The approach to this study is guided by this aspect of symbolic interaction in its exploration of exchanges between older people and GPs and how they decide to respond to each other.

The concept of choice, particularly the process of responding to others (based on individual's interpretations of the world) is a main feature of symbolic interactionism. Regarding this study, evidence shows that older people and GPs can make these choices based on how they conceptualize depression and their experiences of it (Wittink et al., 2006; Maxwell, 2005; Rogers, May and Oliver, 2001) showing decision making to be an important influence in the management of depression in later life. This study explores how older people's and GPs' positions and situations influence the way depression is managed, particularly influences over how older people report telling their stories and how GPs report responding. This applies the aspect of symbolic interactionism that seeks underlying reasons for the way people act by considering their exchanges with each other and consequent interpretations of the world.

Social constructionism

Close links between symbolic interactionism and social constructionism are that they look at how knowledge is derived from social interactions, including taken for granted knowledge and assume that meanings and perceptions of reality are formed as a collective process. However the former focuses on individual understandings based on interactions with others while the latter includes how society or cultures generate common understandings. Social constructionism is a

theoretical perspective that assumes people create social reality (or realities) through individual and collective actions (Charmaz, 2006). It is about how they form collective understandings (e.g. cultures and traditions), what social phenomena are and how they become everyday entities. Reality and the meanings people find in it are seen as a social construction rather than a given, external reality that can be objectively identified (Charmaz, 1990; Berger and Luckmann, 1966), and the approach questions what people at a particular time and place take as real, how they form their views and actions, when different constructions arise and how that process of difference happens (Charmaz, 2006). Aspects of social constructionism that resonate with this study are about how individuals and groups form a story or multiple stories from their experiences and meetings with others (e.g. consultations for depression); and how these exchanges can bring together all of the history, culture and other multiple influences over their stories to form unique interpretations of the world (Flick, 2004a).

Theories of social constructionism recognize that objects and subjects are different in their own right and objects can represent themselves independently of humans. This idea resonates in a methodological work by Foucault *The Archaeology of Knowledge* (1972) where he traces the meaning of concepts to their origins constituting an “archaeological” approach to understanding the world. In doing this he examines the contexts of particular concepts (e.g. a statement) and the influences of contextual factors over them to interpret its meaning. More recently Clarke’s (2005) *Situational Analysis* (a development of grounded theory) brings symbolic interactionism and social constructionism together with the addition of contextual evidence to compliment interview data. This approach looks at the statements of individuals within their context thereby bringing the archaeological aspect of Foucault’s (1972) work up to date by positioning the data within its multifaceted context (Clarke, 2005, p. xxxv). In this way *Situational Analysis* (Clarke, 2005) brings both a subjective and objective perspective to analysing qualitative data, and this aspect of it informs the methodological approach of this study. This is discussed in more detail later in this chapter.

A social constructionist influence on the philosophical framework of this study is underlined by Schütz (1962) who specified that it was “the thought objects

constructed by ...man living his everyday life among his fellow men” which were the focus of this aspect of social constructionism but differentiated between those of individuals and “the constructs of social science” which are constructions of group knowledge (Schütz, 1962 cited by Flick, 2004a p.90). In this study the group constructions of older people and GPs living their “everyday lives” are considered. Influences brought into consultations for depression by older people and GPs are considered, such as those which may come from social understandings of mental illness constructed during older people’s lifetimes, or GPs’ constructions of depression formed through working in the “culture” of primary care or the medical discipline. This idea of group knowledge being generated is different from symbolic interactionism that focuses on the individual’s development of understanding the world through exchanges with others.

Why symbolic interactionism?

Research underpinned by symbolic interactionism can give an insight into how illness can affect patients’ sense of self (Lewis, 1995; Oatley and Bolton, 1985), as well as how their experiences of illness have impacted on the actions they take (Thompson, 1995).

Lewis (1995) draws upon aspects of symbolic interactionism and social constructionism to explore the meaning of the experience of depression for people, as both a subjective and socially constructed experience. This approach to research allows for insight into how social constructions of depression come into conflict with those of medicine and how these understandings have impacted on patients’ conceptualisations of depression and in turn their sense of self. This has generated further understanding of how meanings about depression have been built up and how it impacts on the way patients and doctors communicate with each other.

In an exploration of individuals’ experiences of depression Oatley and Bolton (1985) identify the loss of self to be a common experience for sufferers of depression. However within this concept of loss of self they locate multiple meanings which vary between individuals, and are illustrated by their stories. A theory of reaction to life’s events is presented through adopting a symbolic interactionist approach to the research. Their approach allows for an explanation

of how the mind and world are connected and show how events in a persons' life can impact on their identity. Unique experiences of depression were also taken into account, thereby reflecting the subjective nature of mental illness. Symbolic interactionism can also be used to explore the underlying reasons for people's actions as a result of their illness. Women's experiences of depression and their resulting sense of powerlessness have been attributed to them hiding aspects of their true personalities from their partners and the silencing of their "true selves" in intimate relationships with men (Jack, 1991 cited in Thompson, 1995). Here symbolic interactionism allows for the development of a theory about how womens' actions of hiding aspects of their true personality from their partners can be explained by their reported experiences of depression.

Qualitative research of this kind can be used to corroborate quantitative research into medicine and healthcare. It enriches common trends identified by statistics and scientifically deduced facts by providing individual explanations, perspectives and a picture of lived experiences as well as details about similarities and differences between individuals and their views of the world. The evidence surrounding depression in later life indicates a need for further understanding in this area, since it largely considers rates of prevalence, service provisions in secondary and primary care, the identification, assessment, management and care of depression in older people and some work around older people's and GPs' views of treatment options and conceptualisations of depression in later life. Drawing on influences from symbolic interactionism could add to this evidence by allowing for exploration of why older people and GPs take certain views and actions in the management of depression and how their experiences of interacting with each other have influenced them.

Situational Analysis (Clarke, 2005)

Aspects of Clarke's model of grounded theory, *Situational Analysis* (Clarke, 2005) have informed the research processes used in this study. This section introduces theoretical principles of the model which have influenced the study and how they have done this. It then outlines data collection and analysis procedures set out in *Situational Analysis* (Clarke, 2005) that have guided the methods of this study.

Explanation of how these inspired the research methods of this study is given following this in Chapter 3.

Clarke (2005) has been influential in the development of grounded theory since the 1990s. Following in the same vein as Corbin (1998) and Charmaz (2000), Clarke was a student of Strauss and has built on the Straussian route of grounded theory. She has done this by introducing a multi-faceted approach to data collection and analysis, thereby adapting it to fit with the more contemporary postmodern context, “pushing grounded theory more fully around the postmodern turn” (Clarke, 2005, p.xxi). This is an alternative to the two-dimensional approach of the interview transcript and researcher’s interpretation belonging to previous grounded theory approaches. This key feature of Clarke’s approach sets it apart from other grounded approaches and is a principle that has influenced the way data has been analysed in this study. This multi faceted approach fits with the intention of this research study to recognise the complexity of older people’s and GPs’ reported experiences of having and managing depression and the multiple influences they report over ways they perceive, tell their stories and respond to each other in consultations for depression.

Situating the data within its context

Clarke’s (2005) model emphasizes situating data within its context. This way of exploring individual’s views entails drawing on the researcher’s interpretation of what the participant says and “situating” or positioning the data within the field of enquiry and acknowledging multiple factors found within the context of the research field. Situating the data involves looking within a wide range of influences over what participants are saying such as observations during data collection and biographical, geographical and historical information that can be found in the field of inquiry. It may also involve looking into available secondary data (e.g. photographs, newspapers, reports) to corroborate interview data if these have been influential. In this way Clarke has broadened the Straussian route of grounded theory to include subjective interpretations of the researcher alongside contextual evidence. Clarke’s acknowledgement of the active role of the researcher in constructing interpretations of data is recognised in the analysis process of this study particularly in the researcher’s development of topic guides to carry out data collection and in data mapping procedures (explained later in this section).

Situating the data by addressing participants' perspectives as well as many contextual influences around them is a way of tackling "complex situations of action and positionality" (Clarke, 2005, p. xxii). This departs from previous versions of grounded theory by recognizing static and fluid elements of the research field and including them as part of the final product of research. This principle of *Situational Analysis* (Clarke, 2005) informs this study by opening up routes of exploration to help explain the complex and changing field of the management of depression in older people within primary care.

Sensitization

The process of "sensitization" in *Situational Analysis* (Clarke, 2005, p.29) is when data is organized and coded in the preliminary stages of analysis. It is a way of preparing for developments of later theory by identifying lines of exploration for future interviews. The focus is on the possible lines of enquiry that may reveal differences rather than similarities in the data (although similarities can be included), complexities and varying positions taken in the field of enquiry. The end point is not intended to be a formal theory in a static, concrete sense but a way of "theorizing" (Clarke, 2005, p.28) which recognizes the transient and changing nature of ideas and what influences this. This principle inspires this study as a means of opening up lines of enquiry in interviews with participants. The focus on differences rather than similarities is also central to this study as a way of further defining individuality between older people with depression and GPs.

Saturation of data

Clarke's (2005) model follows the classical model of Strauss and Corbin's (1998) grounded theory with its inclusion of data saturation as a measure of knowing when a situational, social or positional map has been achieved. Strauss and Corbin's (1998) explanation of data saturation is "when all the concepts are well defined and explained" (Strauss and Corbin, 1998, p.145) which means that no new data is emerging in the topic areas in question and the dimensions, properties, variations and relationships between categories of categories is justified. Clarke (2005) transfers this notion onto her analytical maps by accounting for variations and relationships between multiple factors influencing the story of the data. Where Strauss and Corbin's (1998) saturation of data places

emphasis on eliminating categories that cannot be well defined and explained, the saturation of data in Clarke's (2005) model happens when the most important elements that "make a difference" to the story are found (Clarke, 2005, p.108). This is a more dynamic approach to data saturation than other versions of grounded theory because it emphasizes inclusion of diverse factors in explaining the data. This notion guides the analysis of data in this study where difference and individuality within the diverse groups of older people and GPs is recognized. This approach also fits with the complexity of older people's and GPs experiences of having and managing depression which lends itself to including rather than excluding ideas, allowing for maximum opportunity to capture the complexity of participants' perceptions, experiences, positions and situations.

Analytical Maps

Clarke's "maps" are analytical methods she has added to Strauss's version of grounded theory where he writes about social worlds and arenas (Clarke, 2005, p. xxii). Three types of map, situational, social worlds/arenas and positional maps are central to her approach and introduce additional perspectives to the data field. This sets it apart from other forms of grounded theory which traditionally comprise the two perspectives of the researched and the researcher. Clarke's three types of analytical map are ways of accounting for the context of the participant during collection and analysis of data, and provide different perspectives on the research field of enquiry thereby reflecting the multiplicity of the contemporary social science framework (Hildenbrand, 2004).

The inclusion of analytical maps in *Situational Analysis* (Clarke, 2005) enables a visual, conceptual mapping process, and can replace stages of open, axial and selective coding and memo writing which derive from other versions of grounded theory. This happens through the production of textual and diagrammatic maps (including information in memos) in the analysis process. This procedure of drawing up maps is a practical addition to previous forms of grounded theory, where thought processes and inter relationships between concepts are recorded visually rather than being read in text, coding lists or memos. Producing maps can assist with presenting many interrelated ideas in one place clearly, and is a way of navigating a story through the data with the outcome of unifying the interrelated ideas while acknowledging their disparities.

In this study the process of visually mapping out ideas found in the data supports coding and memo writing processes, and is used as a tool for recording and grouping ideas found in the data into themes and then larger categories. This is done so that relationships in the data are identified and linked together visually, aiding the production of textual explanations. Clarke (2005) also describes boundaries between categories (e.g. social worlds, positional and situational factors) as “porous” which means they can overlap and change depending on changes in the research situation. This brings more flexibility than traditional grounded theory approaches, and recognition that the field of enquiry can change. It is suitable for studies into subjective views or beliefs as these may change depending on influences over the individual. This idea of porosity has also inspired analysis of data in this study since it allows for the recognition of changing and overlapping ideas which are common in the field of enquiry. In addition multiple elements of the context and secondary data are considered together in analytical maps. Examples of analytical maps and explanations of how they were developed are provided in the Methods chapter.

The inclusion of secondary data in Clarke’s situational, social and positional maps bring opportunities for objective evidence to be considered alongside the subjective interview/observed data when it was being analysed. This also allows opportunity for increased understanding of interview and observed data from supporting secondary objective data.

Situational Maps

Clarke’s (2005) situational maps are set out as an analytical process to take into consideration certain aspects of the field of enquiry, including observations of the interview situation. They can be used as a way of “lay[ing] out the major human, non-human, discursive and other elements in the research situation of enquiry and provoke analysis of relations among them” (Clarke, 2005, p. xxii). This includes recording the researcher’s observations of what happens during the interview situation such as the interview setting. This aspect of situational maps inspires this study in order to bring together and compare observations of interviews and as a way of linking ideas from other analytical maps together.

Social Worlds/Arenas maps

In *Situational Analysis* (Clarke, 2005) social worlds/arenas maps are carried out to record “meso-level” interpretations of the situation of enquiry which comprise social action and outside influences over what is being said by participants. With these maps Clarke (2005) places emphasis on the participants’ actions and interactions with either humans (e.g. other people present in the interview) or non-humans (e.g. technologies) (Clarke, 2005, p.110). This may include collective actions or actions which influence the level of participation with others, showing “patterns of collective commitment” and most important, social worlds to participants. They can also include other social influences such as the workplace, ways of coping e.g. religion, groups, friends. These maps are included in *Situational Analysis* (Clarke, 2005) as they are “where individuals become social beings” and are a form of “analysis of social/symbolic interactionism” (Clarke, 2005, p.110). The idea of situational maps has informed part of the analytical process in this study where observations of social interactions within the research field were made. Ways this idea is reflected in this study are described further in the methods in Chapter 3.

Positional maps

Positional maps are an opportunity to record interpretations of “the major positions taken and not taken in the data vis á vis” (Clarke, 2005, p.xxii). In them anything about the situation which is notable including factors of concern or controversy are noted. They should be an end product of the situational analysis process and take the data analysis to the level of explaining and unifying it. In this way positional maps seek to move beyond “the knowing subject” (Foucault 1973, cited in Clarke, 2005, p.126) in order to capture positions taken by participants that are not correlated or associated with persons, groups or institutions. They represent the variation and uniqueness of positions that can be held by individuals and groups and can be multiple, complex and contradictory. This way of analyzing data seems to counter a tendency in social science research methods to use thematic or content analysis (Green and Thorogood, 2004) focuses on similarities rather than the differences in the data. The idea of positional maps inspires this study by helping to set out the points of difference between older people and GPs and their relationship to each other, taking into account their contexts observed by IG.

Project maps

Project maps are developed in order to bring the findings of the study together and “tell an analytic story” (Clarke, 2005, p.137). They should represent the culmination of the research project and show how everything has been drawn together using the three types of analytical maps (previously specified) to assist in doing so. They can include “the crossings between text and fieldwork, the narrative and literariness of fieldwork data, and the final papers and book(s) produced from them” (Clarke, 2005, p.137).

Project maps are therefore an end product of *Situational Analysis* (Clarke, 2005) and are a representation of how all interrelated factors in the research are linked together and influence one another. The idea of the project map informs this study to visually illustrate how the older people and GP data has been brought together in the theoretical proposition made in Chapter 6.

Thick analyses

The goal of Clarke’s approach is to produce “thick analyses...which take into account the full array of elements in the situation and explicate their interrelations” (Clarke, 2005, p. xxiii) thereby producing a multi-dimensional picture of what is happening both in the data and the research situation. Thick analyses should also show aspects of “the big news” (Park, 1954 cited in Clarke, 2005) as well as the detailed glimpses of segments illuminating the data and framed by the bigger picture.

Doing thick analyses means that conclusions drawn by the researcher can be based on interpretations of the primary data as well as secondary data. This arguably increases the validity of the findings depending on whether the analytical processes of situational analysis are seen to be forms of evidence that lead the development of theory, or a product of an intuitively led co-construction of reality between the researcher and researched. Doing thick analyses may promote transparency in decision making processes because part of the research is to record and map influences over conclusions drawn.

Thick analyses is the main product that takes account of the elements identified to be of importance within the field of enquiry, and makes explicit their interrelations.

This is different from producing a concept or theory which is the end product of traditional versions of grounded theory, as it not only captures a snapshot in time but acknowledges situations which may cause change or which are changing at the time. This brings a new layer of depth to the outcome of the research and allows it to also become flexible and adaptable. In the current study, the fields of research span older people's situations (and the possible social, community, biographical and other influences) as well as the situations of GPs working in primary care (together with the possible influences of the workplace, personal, external factors etc). Clarke's (2005) concept of thick analyses informs the development of an explanation for the complex and diverse older people's and GPs' data in this study and recognition of differences and changing elements within the two data sets. Thick analyses informs the suggestions of interrelationships between data sets by proposing how older people and GPs might communicate and respond to one another about depression, based on what they have reported in interviews.

Thick analyses has been translated to this study taking the form of a theoretical interpretation of the data. This is a proposition of what could happen in different situations which is suggested by the data. The fluid and changing capacity of people's perspectives and actions is recognised and in this way the boundaries between ideas are "porous" and "flexible" (Clarke, 2005, p.111) rather than concrete and static.

Reflexivity

Reflexivity involves accounting for qualitative research by showing that it has been carried out to a level of high quality, in ways that are reliable and valid. It should also show that there has been reflection on the researchers' position and where the study is located within the current knowledge of the field (Morse, 1998).

The researcher's reflexivity is intrinsic to Clarke's approach because examination of the researcher's position is part of the data mapping and analysis process.

Situational Analysis (Clarke, 2005) relies on both the interpretation of participants as well as researchers during analysis, plus justification of how the secondary data used informs the primary interview/observational data. The role of the researcher in *Situational Analysis* (Clarke, 2005) builds on Strauss and Corbin's (1990)

constructionist approach where the researcher uses procedures to construct interpretations from the data in a cyclical process alongside data collection, thereby co-constructing meaning with the researched. Glaser (1992) disputed this approach to analysis and saw this as “forcing the data” through procedures rather than “letting the data speak for themselves”. However since *Situational Analysis* (Clarke, 2005) relies on mapping processes and memos which track decisions made about routes of further exploration and interpretations it is a more transparent and justified process than the researcher taking the neutral and positivist position advocated by Glaser’s individual work (e.g. Glaser, 1992).

Clarke (2005) refers to the activity of the researcher in interpreting data as “pushing grounded theory around the postmodern turn” (Clarke, 2005, p.19) where Strauss and Corbin’s ideas of “opening up” the data (Strauss and Corbin, 1998) are brought in line with postmodern thinking. As well as doing situational analysis by mapping the research process, the researcher’s active role in this is also carried out by assuming “simultaneous truths” (Clarke, 2005), using a variety of discourses as data, focusing on differences rather than similarities, considering the whole situation of the data field in analysis and positioning concepts within them.

Clarke’s (2005) approach to grounded theory of situating data in its wider context fits with the topic area of this study, particularly as it explores the views of older people and GPs on depression. Older people’s life history is longer and it follows that they have a greater wealth of experiences and more possible influences over the way they see their depression. For example, there may be geographical, cultural, historical, family influences as well as different personal circumstances which may affect their views. Similarly a GPs’ role is situated between many different points of reference (e.g. patient, family, primary and secondary care, personal views, medical knowledge, etc) which may all influence the way they manage depression as well as their views on depression. Therefore using an approach which takes situational influences into account will allow for a more rounded and thorough view of what is happening with both older people and GPs, particularly as participants are guiding the theory. In addition depression is a subjective experience which can vary enormously between individuals, so being able to explore the wider context of each participant allows for more opportunity to further our understanding of what is happening and differences between them.

The theoretical and methodological orientation of this study has been considered so far in this chapter. The findings of this study found in Chapters 4, 5 and 6 are set out according to this conceptual and practical framework. The Methods section of this chapter will now be considered with discussion of how the practical procedures from traditional grounded theory and Clarke's *Situational Analysis* (2005) have been applied to this study.

Chapter 3: Methods

Introduction

This chapter describes the methods used in this study. The first section considers ethical issues relating to research with older people who have depression and GPs. Following this the practical procedures used to carry out the research are described including recruitment, sampling, data collection and methods of data analysis. This chapter also examines the procedures in place for maintaining trustworthiness and ensuring validity of the findings.

Methods used in this study have been informed by *Situational Analysis* (Clarke, 2005) which features methods deriving from traditional Straussian versions of grounded theory. Descriptions of the sampling, data collection and analysis procedures for the older people and GP studies are described separately in this chapter, but were carried out simultaneously due to the iterative nature of the methodology. In addition, areas of crossover in the older people's and GPs' data were noted by IG as interviews and analysis progressed, and ideas relating to both groups were explored in later interviews and analysis, and are described in Chapter 6 in the section entitled "The journey from interview data to theory".

Ethical issues

Ethical approval was sought and obtained from the local NRES (NHS National Research Ethics Service) and from the five relevant PCTs within which recruitment of participants was carried out. The study was also approved by Sunderland University ethics committee. Other requirements were obtaining an enhanced disclosure Criminal Records Bureau (CRB) check due to working with older people who had mental health problems. An honorary contract with the PCT was also obtained to carry out research with GPs in the relevant PCTs. Obtaining this included an occupational health check.

The research in this study was carried out with participants who may have been vulnerable on a number of levels due to mental ill health, old age, possible disability or co-existent illnesses. Guidelines on research with vulnerable people

require that researchers have CRB disclosures to ensure that they do not have a history that will make them unsuitable for working with vulnerable groups. This was obtained by IG and kept up to date during the period of data collection.

Participants were fully informed about what was involved in the research prior to consenting and taking part in the study. Every effort was made to secure informed consent from all participants. The definition of informed consent used was that stipulated by The Economic and Social Research Council (ESRC, 2010). Obtaining informed consent was addressed through a stepped approach that allowed participants time to consider the written information provided and to ask any questions to the researcher prior to agreeing to participate. Detailed written information sheets were used to inform older people and GPs what was involved in the research (see Appendix, p.325).

During recruitment it was recognized that convincing GPs of the value of taking part in research can be challenging (Salmon et al., 2007) and that they might be concerned with having too little time, funding or skills to take part (Rosemann and Szecsenyi, 2004). Therefore initially GPs belonging to practices with an expressed interest in mental health were informed of the research by practice managers. If they were interested to take part in the study they returned reply slips by post. This meant that there was no influence over their decision to take part other than the information supplied to them by practice managers about the project. It was also recognized that GPs may be concerned about introducing research to distressed patients because of its impact on the doctor-patient relationship, even though patients often rate altruism and friendly research staff as factors influencing their decisions to participate (Tallon et al., 2011). To address this GPs were able to choose whether they wished to be interviewed without recruiting patients to the study, and therefore take part in the research without involving patients.

Factors concerning older people with depression taking part in research were also considered in relation to this study. It was recognized that older people may not like talking about their depression and they were reassured on information sheets and verbally that they could stop the research at any time (see Appendix, p.325). Deference - where older people may have a greater sense of a doctor's position of authority and power over them because of the way they perceive their position in

society - was considered as a potential influence between GPs and older patients throughout all stages of the research process. For example it was recognized that older people may have felt obliged to take part in the research if their GP requested them to do this in exchange for being treated by them, and patient information sheets emphasized that their decision to take part would not affect the care they received from the GP.

It was recognized that it may be distressing for patients to talk about their depression or bring about some painful memories. Participants were reminded at the beginning of interviews that if they showed signs of distress during interviews they would be given the opportunity to end it immediately. It was also acknowledged throughout the research that participants may have had concerns about commenting on the care they have received. This could have included feeling anxious about criticizing their GP or primary care services, or that they could have been anxious not to. Participant information sheets therefore stressed that data was to be kept anonymous during the collection and analysis processes and that they could withdraw at any time (see Appendix, p. 325).

A risk associated with carrying out research with older people is the possibility of them having memory problems or dementia. To minimize this risk an exclusion criteria for the study was a diagnosis of dementia. Alongside the possibility of other health conditions in older patients, the presence of dementia may have affected the research, such as when and if people could take part. Therefore GPs were asked only to invite people to take part who they considered competent to consent and well enough to take part. The possibility of memory problems was also addressed whereby consent was an ongoing negotiation during the research process. There was also an awareness that patients may not have been able to take part in the research at various times because of their condition worsening, or another illness preventing them from participating at various points during the research.

Recruitment, sampling and data collection

For both the older people and GP studies, recruitment, data collection via interviewing, development of topic guides and sampling were carried out iteratively.

The recruitment process for both studies started with information about the study being sent to 169 practices in five PCTs across Tyne & Wear. This included 29 practices in North Tyneside, 33 practices in Newcastle, 34 in Gateshead, 30 in South Tyneside and 43 in Sunderland. Letters (with information sheets and reply slips) invited practices to either take part in recruiting patients to the study and/or for GPs to participate in interviews.

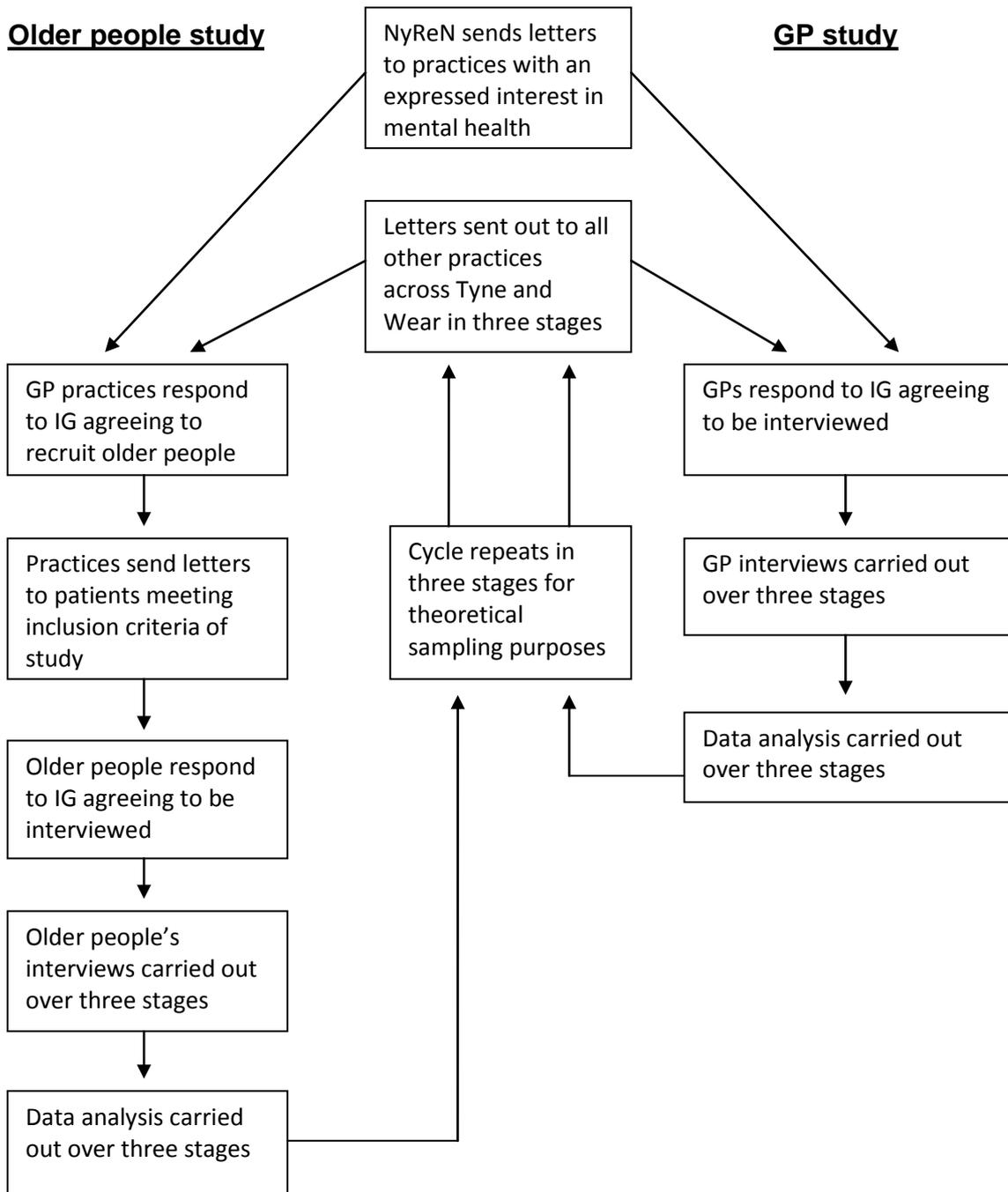
These first letters were sent via Northern and Yorkshire Research Network (NyReN) to GP practices who had expressed an interest in mental health research. This included a letter to GP practices inviting them to participate in the study, the study proposal, an information sheet to GPs about the study and a reply slip to return to IG at Sunderland University if they were willing to take part. If GPs expressed an interest to identify patients to the study on the reply slip they were sent a further letter explaining what they would need to do. These documents are included in the Appendix (p. 325 onwards).

Three GP practices responded and agreed to be involved in the identification and recruitment of patients. Criteria for inclusion of older people were for patients to be over 65 years old, and to have had treatment for depression since they were 65. Older people who had a diagnosis of dementia were excluded from the study due to the possibility of fluctuating capacity. GPs were also asked only to approach older people who they assessed as having capacity to consent to the research study. GPs then sent letters and information about the study to identified patients. It was not known by IG how many letters GP practices sent out to patients, or who they sent letters to, as patients had not yet given permission to take part in the study.

Interviews for both the older people and GP studies were carried out on a single occasion with each participant, in three stages, where five participants were interviewed at each stage. After each stage, the data was analyzed to determine the types of participants needed to inform the next stages of interviews. This was

carried out as part of the theoretical sampling process and the cycle of recruitment was repeated for the next stage of interviews. The theoretical sampling and data analysis processes are described separately for each study (below). The flowchart below, Figure 1, visually sets out the recruitment, interviewing and sampling processes for the two studies.

Figure 1: Flowchart of methods processes used in older people and GP studies



The semi-structured method of interviewing was used in both the older people and GP studies. This is because the subjective nature of the topic of enquiry (i.e. depression) is an experience which cannot be pre-empted by the researcher

(Schmidt, 2004) and therefore designing questions would not be appropriate. Instead a list of topics around which to prompt participants as opposed to questioning them was used as an interview guide if this was needed. During this process of data collection, sampling was also carried out with the intention of recruiting participants who could inform theories that were being developed from the data. This was repeated until data saturation was reached. In this study it was decided that seeking disconfirming cases was unnecessary to challenge theories developed in the previous interviews. This is because *Situational Analysis* (Clarke, 2005) disregards negative cases and instead focuses on differences between participants as well as similarities, and the process of sampling ensures unexplored areas are investigated and developing theories are challenged.

Older people: development of a theoretical sample

The sample of older people consists of 16 older people living across 5 PCTs in the Tyne and Wear area: Sunderland, Gateshead, Newcastle, and North and South Tyneside. This sample size is determined by the number of participants needed to achieve data saturation and allow for the production of a full and detailed account of theory developed during analysis, akin to Clarke's concept of thick analyses (Clarke, 2005). The level of deprivation in the area where they live drove recruitment as it was publicly available information, and this alongside their age, severity and duration of depression were factors that shaped the theoretical sample developed during data collection and analysis. The development of the theoretical sample of older people and factors that drove recruitment is discussed next.

Stage 1

A first set of participants (OP1-5) were identified by GPs who responded to recruitment letters and who had agreed to send recruitment material to their patients. Reply slips were returned to Sunderland University by older people who wished to take part and initial contact was made with them by IG by telephone to answer any questions they had about the study. Interviews were carried out on a single occasion, within one month of receipt of the reply slip or as soon as possible thereafter. Written consent was sought from all participants prior to data collection and all interviews took place at older people's homes. Interviews took between one and two hours, were audio-taped with consent and transcribed verbatim.

Decisions made regarding the recruitment of further participants to the sample were made on the basis of coding, or “sensitization” (Clarke, 2005), carried out after interviews. With interviews OP1-5 this process showed emerging ideas about ways participants living in affluent areas perceived depression, and it seemed necessary to explore these ideas with older people living in less affluent areas. This led to the decision to seek further participants from less affluent areas to explore their attitudes and beliefs about depression. GPs working in less affluent areas who had agreed to take part in the research were therefore asked to send out recruitment material to patients meeting the criteria for the study.

Another theoretical sampling criteria was the age of participants (within those over 65). Participants OP1-5 were all in their early to mid 70s, or late 60s. It seemed important to explore whether the ideas emerging were different with age and therefore participants aged between 65 and 70 or in their eighties and above were sought. GPs were aware of the need to recruit these age groups to the study, and could include patients in these age ranges when sending out recruitment material if there were any. However the age of participants was not known by the researcher until the time of the interview, if the older person was willing to disclose their age. Therefore the researcher could not recruit older people according to their age directly; this was at the discretion of GPs. The sample achieved fortunately included a range of older people from age 67-88.

Stage 2

A second set of participants OP6-10 were recruited with the sampling criteria described, via GPs who responded to recruitment letters and who agreed to send recruitment material to their patients. Interviews were then carried out with OP6-10 using a topic guide which had been modified to include ideas that needed exploration with the further participants in the sample.

Participants OP6-10 lived in semi rural affluent areas, rural and affluent rural areas. At this stage there was no developing theory linking the affluence of the area people lived in to their perspectives on depression, but it was clear that participants living in deprived inner city areas were needed since the views of people from these areas were missing. This was therefore a criterion of the next

stage of theoretical sampling, and GPs working in deprived inner city areas who had agreed to take part in the research were asked to send out recruitment material to their patients meeting the inclusion criteria for the study.

There were other criteria, such as the duration and severity of participants' depression, that would have ideally been used as theoretical sampling criteria but this information was not accessible to IG prior to recruitment. Participants in the sample so far (OP1-10) had experienced different levels of severity of depression over different lengths of time and reported this during interviews. During the analysis of interviews OP6-10 strong ideas began to emerge that seemed to be influenced by the duration and severity of their depression. To develop these ideas further more information from people who had experienced lifelong depression, both severe and mild-moderate were needed in the sample.

Although the sample was not selected according to the duration or severity of depression, GPs who had agreed to help with recruitment were made aware that more participants with lifelong or long term depression were needed. They were asked to prioritize sending recruitment information to these patients as well as to other patients who met the criteria for the study. Since this information was confidential to GPs it was not known until interviewing participants whether they had experienced lifelong or long term depression if they discussed it, and this meant that sampling could not proceed on this basis. Selecting patients on this basis, at the discretion of GPs, fortunately allowed for exploration of these ideas to saturation.

Another ideal sampling criteria at this stage would have been the age of participants, since the views of people in their 90s were missing. GPs who had agreed to help with recruitment were asked to prioritize sending information to those in their nineties, if available, as well as sending it to other patients who met the criteria of the study. As before, the age of participants was not known until the time of the interview, if the participant was willing to disclose their age. Therefore selecting patients of this age was also at the discretion of GPs.

The constraints of theoretical sampling due to information that cannot not be obtained by researchers prior to recruitment is discussed in more detail later in this chapter.

Stage 3

The third set of participants OP11-16 were recruited from deprived inner city areas, and included those in their eighties and those who had experienced long term or lifelong depression. Interviews OP11-16 were carried out until saturation of data had been reached, where a detailed explanation of important lines of enquiry had been obtained.

The sex of participants was distributed by chance sufficiently enough to explore any emerging ideas relating to it. However this idea did not influence the development of the theoretical sample as it was explored to saturation at an early stage in interviewing. Ethnicity was considered as a potential sampling criteria however other studies have explored the influence of ethnicity over older people's perspectives on depression and its management (Lawrence et al 2006a; Lawrence et al 2006b).

There were enough participants who had had recent episodes of both mild-moderate and severe depression with whom to explore developing theories, as well as those who had had lifelong or long term episodes of mild-moderate and severe depression. Although GPs were made aware that more participants with long term or lifelong depression were needed, this information was confidential to GPs and it was fortunate that participants who responded had mostly experienced long term depression. This was not known before interviews were carried out and it was the choice of the participant whether they revealed this information in interviews; it was assumed that GPs had sent out recruitment letters to those patients first and some had responded. In addition, no participants in their 90s were recruited to the study, and after discussions with the supervisory team and developing analytical maps it was decided that this did not affect saturation of the important themes identified within the data since the developing theories had no relation to participants' age. There was also a range of ages represented within the sample which included people in their sixties, seventies and eighties. For these

reasons it was decided that the sample OP1-16 was large enough and it was an appropriate point at which to stop interviewing.

GPs: the development of a theoretical sample

The sample of GPs consists of 14 GPs working in primary care at the time of the interviews, in practices across the Tyne and Wear area in 5 PCTs: Sunderland, Gateshead, Newcastle, and North and South Tyneside. As with the sample of older people, this sample size is determined by the number of participants needed to achieve data saturation and allow for the production of a full and detailed account of theory developed during analysis, akin to Clarke's concept of thick analyses (Clarke, 2005). The level of deprivation of the practices they worked in drove recruitment of GPs as it was publicly available information. This, alongside the location and number of GPs in practices and GPs' expressed level of interest in mental health, were factors that shaped the theoretical sample developed during data collection and analysis.

Recruitment material was sent to GP surgeries by NyReN, to whom they had expressed an interest in mental health. Reply slips were returned to Sunderland University by GPs who wished to take part. Initial contact was made with them by IG by telephone to answer any questions they had about the study.

Interviews were carried out on a single occasion, within one month of receipt of the reply slip or as soon as possible thereafter. Written consent was sought from participants prior to data collection. They were mostly conducted in GPs' own surgery rooms however 3 GPs requested that interviews were carried out elsewhere, such as at their home or in a meeting room within their practice, and 2 GPs from the same practice chose to be interviewed in a GPs' common room. Interviews took between one and two hours, were audio-taped with consent and transcribed verbatim.

Stage 1

First participants responded to recruitment material sent out by NyReN (see Appendix, p. 325 onwards) to practices that had an expressed interest in mental health, so this was an initial selection criteria for GPs.

The first stage of GP interviews were carried out with five participants using an initial topic guide (see Appendix, p. 356). The interview data was then analysed to identify important ideas brought up by participants, some of which needed to be explored with further participants. Decisions made regarding the recruitment of further participants who could inform developing ideas were made on the basis of coding or “sensitization” (Clarke, 2005) carried out after interviews GP1-5. A list of open codes and possible axial codes were identified (see the Appendix, p. 357), and the topic guide was modified according to the ideas that needed further exploration. Decisions about the next stage of sampling were also made with this in mind.

Three participants recruited within GP1-5 reported a strong or moderate level of interest in mental health, and two reported a low level of interest. This formed the basis of an emerging idea and guided the decision to sample further participants based on their level of interest in mental health. NyReN were then involved in sending out more recruitment material to practices with an expressed interest in mental health. Recruitment material was also sent out randomly to other practices across the 5 PCTs (i.e. those who had not been sent information by NyRen), in order to recruit GPs with a low or moderate level of interest in mental health since GPs with all levels of interest were needed to explore ideas that were developing.

A theoretical sampling criterion for the next stage of recruitment was to seek GPs from smaller practices. Participants GP1-GP5 were from larger practices consisting of four or more GPs, so the views of GPs working in smaller practices of less than 4 GPs were needed, to explore their ideas in relation to the developing theory. This sampling was carried out using public information on numbers of GPs working in practices available on NHS or practice websites, and priority was given to interviewing GPs working in smaller practices in the next stage of interviewing, where possible.

Stage 2

A second set of participants were recruited with the theoretical sampling criteria described above. A second stage of interviews were then carried out with GP6-10 using a topic guide that had been modified to include areas that needed further

exploration with new participants in the sample. GP6-10 interviews were analyzed to identify what appeared to be the most important emergent concepts. The topic guide was then adapted accordingly for the next stage of interviews to be conducted in conjunction with theoretical sampling.

Participants GP1-10 worked in practices located in a variety of levels of deprivation, including deprived semi rural, affluent rural and inner city deprived. At this stage there was no developing theory linking the level of deprivation of the practice to GPs' perspectives on managing older people with depression, however it was clear that those working in deprived rural and affluent urban areas were needed as the views of these GPs were not represented in the sample. This guided the sampling criteria to seek further GP participants working in practices located in either deprived rural or affluent urban areas

Stage 3

A third group of GPs GP11-14 consisted of GPs all working in larger practices of 6 or more GPs located in areas of high deprivation, where two had high level of interest in mental health and two had a low level of interest. Three out of the four GPs were in their 30s and were younger than others in the sample. Fortunately from the outset there had been a sufficient age range of GP participants with which to explore developing theories, including those in their 30s, 40s and 50s. There were no GPs who were in their 20s or 60s who had been recruited to the study, however age was not a line of enquiry that related strongly to any of the developing theories. Also, due to the length of time taken to qualify it seemed likely that there would be few participants working as GPs in their 20s. Age was therefore not used as a criterion for sampling.

As with the sample of older people the sex of GP participants was distributed by chance sufficiently enough to explore any related ideas, so this was not a factor that guided recruitment or the development of the theoretical sample.

Ethnicity was considered as a possible criteria for recruitment of GPs, however it was felt that this would shift the focus of the study to a different area which has been looked at by others with reference to the perspectives of older people of different ethnic origins who have depression (Lawrence et al, 2006a; Lawrence et

al., 2006b). The employment status of GPs' within the practice (e.g. principal, salaried or locum) was also considered as a possible factor that guided recruitment but this has not been identified as factor influencing GPs views or one needing further exploration in the literature and did not emerge as an idea needing further exploration in the present study. This information was therefore not asked of GPs during recruitment, but was not discounted as a line of enquiry if GPs reported it in interviews.

The most important themes developed during the sampling and data collection process were followed up until saturation of data was achieved. Within the sample of GP1-14 there were sufficient GPs who were male and female, from a range of practice locations and sizes, as well as those with differing levels of interest in mental health to explore the main lines of enquiry to saturation. On the basis of these ideas being developed to saturation and a theory being developed it was decided that the sample GP1-14 was large enough and this was an appropriate point at which to stop interviewing.

Data Analysis

A variety of analytical methods were used in this study that are informed by aspects of Clarke's *Situational Analysis* (2005) including sensitization, production of different types of analytical map and theoretical memos as well as the production of thick analyses. These were carried out as part of the iterative cycle of data collection and analysis and took place simultaneously. These methods are described in more detail below. The lists of coding and analytical maps, together with the theoretical memos in the Appendix are interrelated and demonstrate how aspects of *Situational Analysis* (Clarke, 2005) informed the development of theory from the interview data (see p. 349 onwards).

All of the older people's and GPs' interview data were coded throughout analysis, from the first interview onwards. This proceeded in parallel with interviews and sampling, and was used to inform topic guides for later interviews, sampling and other analysis processes including development of analytical maps, discussion with the supervisory team and memo writing. Important lines of enquiry that

emerged from interviews and explored further to develop the theory are described in the older people's and GPs' findings in Chapters 4 (p. 111) and 5 (p.159). An explanation for how the theoretical interpretation derives from the interview data is given in Chapter 6 (p.210).

Older people's data sensitization

The codes identified in the older people's data (see Appendix, p. 349) were identified by reading the transcribed interviews and highlighting words, phrases or sentences that suggested a code and then an appropriate label being given to the code. If a code was identified and more data was found to be related, it was labeled with the same code. Codes were also grouped together and interrelationships were noted in memos. Codes that were considered to be important were used as lines of enquiry in topic guides and analysis, and are highlighted in bold in the list of codes identified in the older people's data included in Appendix (p.349). Other codes were not followed up in later stages of analysis as they did not inform emerging ideas.

Decisions about which codes to discount or follow up were made in various ways including through the development of observational memos during interviews, writing reflective memos after interviews, development of analytical maps, discussion with the supervisory team, checking literature for existing evidence, development of theoretical memos that build stories around the codes by putting them with quotes and explanatory text. These procedures are described later in this section and examples of these memos, lists and maps are included in the Appendix.

GP data sensitization

A list of codes identified in the GP data at different stages of data collection and analysis is included in the Appendix (p.357). These were identified in the same way as those in the older people's data. Important codes were used as lines of enquiry in topic guides and analysis, other codes were discounted as they did not inform emerging themes. Decisions about which codes to discount and follow up were made in the same way as with the older people's data. Examples of the memos, lists and maps which were used in this process are included in the Appendix.

Codes found in the older people's and GPs data that had relevance to both data sets were noted by IG as part of the sensitization process and were referred to as "crossover themes". These were used as lines of enquiry in topic guides for both older people and GPs and in analysis to explore possible explanations accounting for both older people and GPs data. A list of codes showing those selected for further exploration, with emerging ideas in bold, is included in the Appendix (p.366).

Analytical maps

Clarke's (2005) analytical maps inspired the methods of this study as a way of organising interview data and constructing relationships between ideas that were emerging as interviews progressed. The inclusion of situational, social and positional maps allowed for IG to position and locate the data about different elements of the research field within their respective contexts. This assisted IG in generating explanations about what participants said and where influences over their views might come from.

Situational maps

Clarke's (2005) idea of situational maps inform this study as they are used as a form of memo to record reflections on the interview and the situation of each participant. They record IG's observations of participants during interviews and the interview settings, including IG's instincts about what was said or implied in interviews, observations of participants' situations and environments, notable gestures made by participants or their visual expressions of feeling, suggestions of underlying meanings or unresolved issues, the atmosphere of the interview, and anything else that IG perceived to be notable which would help illuminate lines of enquiry. IG used these maps to inform topic guides for further interviews, analytical discussions with the supervisory team, and the development of later analytical maps. She also used them to open up lines of enquiry into reasons underlying what older people and GPs reported doing and saying in consultations for depression during their interviews.

Situational maps were developed continuously throughout the course of the research process and included written reflections (rather than visual

representations) during and after each interview. Examples of situational maps are included in the Appendix (e.g. p. 350 and p.359).

Social worlds/arenas maps

In this study Clarke's (2005) social worlds/arenas maps inform key analytical tools which are used to track interactions between older people and GPs. This is because the management of older people with depression is a social interaction on many levels, with exchanges between patients and doctors at the centre. IG used the idea of social worlds/arenas maps to help her map out how older people's and GPs' reported interactions with each other and their surroundings might influence the stories older people tell and how GPs report responding. In constructing these maps IG recorded participants' accounts of social and outside influences over them, such as people or things that they interacted with at the time of data collection. For example with older people this included their reports of conversations with GPs about depression, their social circle and other social situations they talked of in relation to their depression. IG also recorded her own ideas about what might have influenced participants' perspectives some of which were observations made during interviews and others noted on reflection afterwards.

The construction of these types of maps played a key role in the development of the theoretical interpretation presented in Chapter 6. "Crossover themes" that identified areas of overlap between the older people's and GPs' data were noted in these maps during a later stage in analysis. They map the stories older people report telling about depression and influences over them in what to say to GPs, as well as recording how GPs report responding to their stories by offering different forms of help.

Positional maps

Positional maps were constructed in this study to help illustrate how IG interpreted the points of difference between participants and their relationship to each other (separately for both the older people and GPs data). They were therefore used as a tool to assist IG in taking analysis from a descriptive to an interpretive level as echoed by Clarke (2005). Doing this helped IG develop an explanation about the

differences between them and the positions older people and GPs take in relation to each other regarding the management of depression.

The end products of doing positional maps are the older people's and GPs typologies which are presented at the end of Chapters 4 and 5. The typologies bring together elements of the coding lists, social worlds/arenas maps and other analytical data which were drawn up. Doing positional maps also helped IG set out preliminary ideas for the theoretical interpretation proposed in Chapter 6, including notes about differences in the influences reported by older people over telling their stories of depression and differences in influences reported by GPs over how they respond.

Theoretical memos

Theoretical memos (see the Appendix e.g. p.351 and 360) are not featured in Clarke's *Situational Analysis* (2005) but in this study were carried out in addition to theoretical sampling, interviews, coding, discussions with the supervisory team and analytical maps. Their purpose is to build textual stories around important lines of enquiry, and to help establish their relationships with the rest of the data. The end product of this study is a written thesis so doing theoretical memos meant that a textual story to describe the analytical maps could be developed. Doing theoretical memos contributed to the writing up of the research findings, helped confirm or discount possible lines of enquiry as well as focus analysis onto theoretical interpretation. Theoretical memos also helped inform theoretical sampling and interview topic guides, especially those in the later stages of the research process.

Project maps

Clarke's (2005) project maps inform this study as a way of unifying and explaining the perspectives of the diverse groups of older people and GPs. They are based around overlapping or "crossover" ideas found within both the older people's and GPs interview data and ideas emerging from earlier stages of analysis. They position these ideas in relation to each other as an aid to building a theory about older people's and GPs' possible responses and reactions to each other, areas of difference or similarity between the two data sets, or anything notable about observations, interview data, previous analytical maps or secondary data e.g.

policy concerning both older people and GPs' that appeared to be prominent. The starting points set out in the project maps led to the generation of thick analyses (Clarke, 2005, p.29) which was the end goal of the analysis process.

To illustrate how project maps were used in analysis, see Figure 2 (p.109) as an example of an early project map developed during later stages of analysis. Lines of enquiry prompted by doing this map discounted the idea of "core beliefs" as central to the management of depression in older people, and it was identified as one of many influences over what older people and GPs report saying and doing in consultations. This led to the idea of "influences" instead of "core beliefs" being explored in relation to the other factors and it was found that detailed textual explanations could be constructed around influences which unified many of the ideas emerging strongly in analysis from both data sets (including core beliefs). The production of a full textual explanation of the interrelationships between influences and other factors happened alongside the development of the final project map, which is presented in Chapter 6 (p.220).

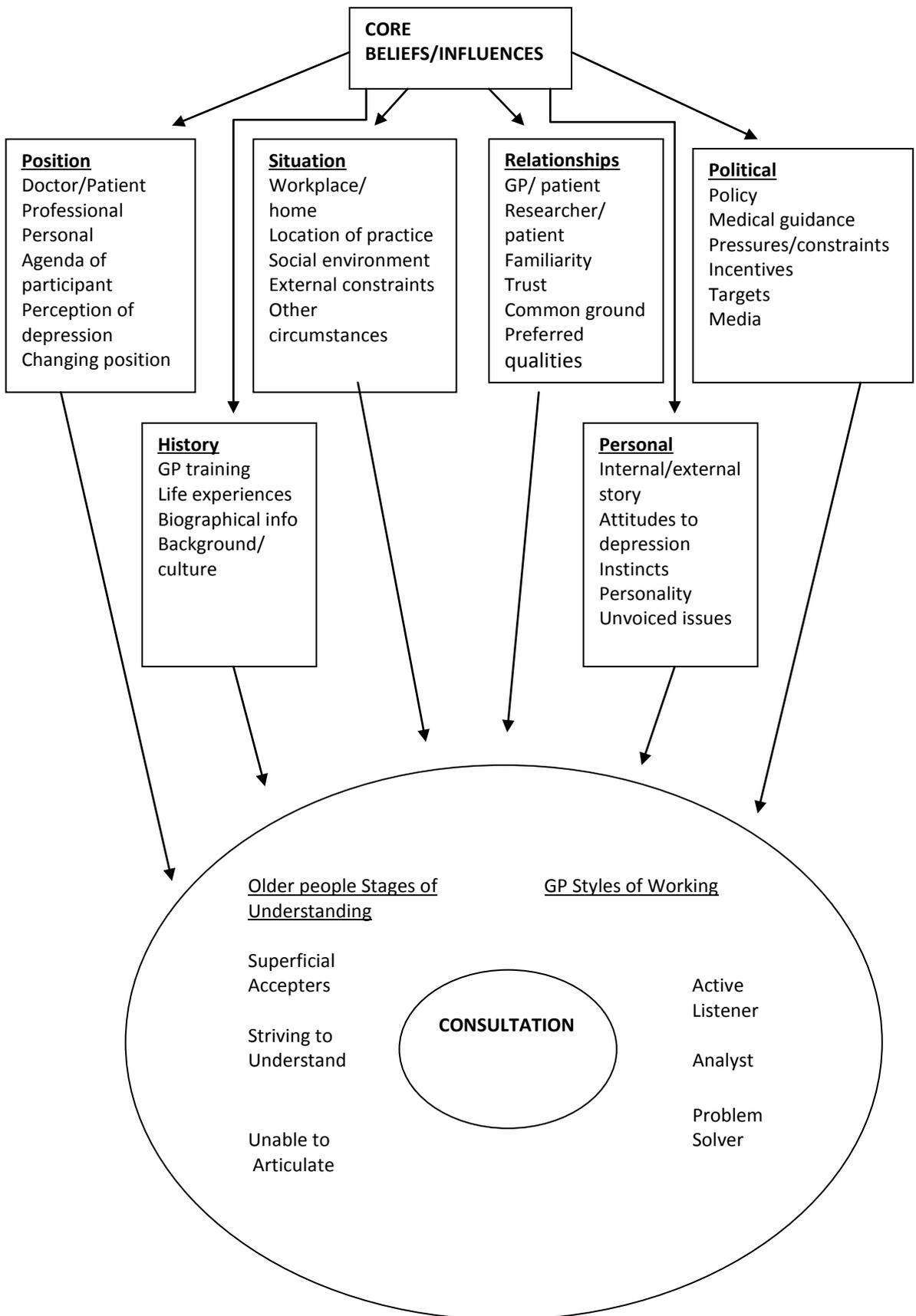
Thick analyses

Clarke's "thick analyses" (Clarke, 2005, p.29) are narratives that explain ideas set out in the project maps developed during analysis. Unlike a selective theory used in traditional methods of grounded theory, thick analyses is equivalent to Glazer and Strauss' (1967) process of "substantiation" which in turn leads to "substantive theory". This is where theory emerges from new data which has arisen from links and comparisons made between concepts and categories of the preceding data. In contrast to the static end result of the production of a theory, the production of thick analyses allow for a flexible outcome which recognizes the changing nature of the study field of enquiry. This means that boundaries identified can be seen as temporary and permeable and open to new influences as time passes and situations change. Clarke (2005) stipulates that because of thick analyses the findings should "travel" better, and be more adaptable to the changing times.

The idea of thick analyses has informed this study by taking the form of a "theoretical interpretation of the findings". This is a textual account of the project maps developed, and is presented in Chapter 6. Here, key factors relating to both the older people's and GPs' findings are interpreted, and an attempt to explain the

relationships between many of the factors included in the project maps is made. This includes how participants responded and reacted to each other, areas of difference and divergence and possible reasons for this relating to situational, social and positional factors which stood out throughout the process of data collection and analysis. The intention of doing a version of thick analyses in this study was to unify and make sense of the multiple factors and complexities involved in the management of older people with depression, as reported by older people and GPs in their interviews. The theoretical interpretation proposes an explanation for the underlying reasons behind their perceptions, ways they respond to each other and influences over them within the field of enquiry. Figure 2 sets out an early version of the project map, showing a diagrammatic representation of the developing thick analyses.

Figure 2: Early project map showing the developing thick analyses



Discussions as part of analysis

Interpretation of data was undertaken by IG and discussed with supervisors AC, LR, GR and CH at regular intervals.

Mapping processes required records of IG's interpretations of the interview situations, the participants and what was said by them, as well as her own perspectives and thought processes that occurred during interview and reflection afterwards. These notes became incorporated into the thick analyses, since ideas from them were included in the situational, social and positional maps developed.

Developing trustworthiness

Trustworthiness has been ensured in this study by exploring ideas further with participants as they arise, and maintaining an iterative approach in the data collection and analysis processes to ensure developing ideas were explored with newer participants. In addition a theoretical sample was developed where participants were selected on the basis of their potential ability to illuminate issues that needed further exploration.

Other procedures to ensure trustworthiness were carried out in line with methods of building trustworthiness and making the subjectivity of IG's interpretations of data explicit, as set out by Lincoln and Guba (1985, p.281-286). Firstly, a record of day to day activities was kept, showing interview times and dates, meetings, seminars, and conferences attended, informal conversations, telephone calls and other activities relating to the research process or field of enquiry. This shows when research processes took place and when possible ideas started.

A personal log was also kept, detailing the IG's reflections at each stage of the research process. Included in this were IG's thoughts about the way research was going, challenges, opportunities, possibilities and ideas about what worked and areas of success. It also kept a record of IG's feelings about the research and the data collection, things that were enjoyed, IG's observations in interviews and reflections about doing the research, including things considered to have been done well and things which could have been done differently. Also included in this personal log were records of supervisory meeting notes which gave an overview of what happened during the research process including how and when decisions

were made, what they were about and possible solutions to problems. These factors were all relevant to how IG's constructions of the data were developed, areas of possible bias and ideas for what would happen next, all of which were valuable contextual information which informed the developing analytical maps.

A separate research student log required by the University of Sunderland was also kept which recorded milestones in the design and execution of the research study, university monitoring procedures, records of supervisory meetings, training, professional development relating to the PhD, conferences and a reflections diary. These also give insight into how the research was developed and provided valuable information on aspects of decision making at all stages of the study.

A methodological record was made on decisions relating to ideas which were to be developed further and those which were not. Reasons for this were recorded in order to discuss with members of the supervisory team as part of the data triangulation process.

Triangulation of data was carried out as a validation strategy for qualitative research (Flick, 2004b) and derives from the method originally set out by Denzin (Denzin, 1978). In this study there was discussion of data which was obtained at separate times e.g. at separate interviews or analysis sessions. This was carried out with one or more members of the supervisory team at regular and frequent meetings, throughout the course of the study. The intention was to obtain the perspectives of different listeners of the interpretations of data and decisions made in the analysis process, as well as developments of emerging thick analyses or ideas for analytical maps. This is where information that comes into the study at various times is considered with the multiple perspectives of those involved in the discussion. They set "various theoretical points of view side by side to assess their utility and power" (Denzin, 1978, cited in Flick 2004b, p.178). This means that the subjective nature of decision making in the analysis process is assessed by others to maximize its validity.

The methods outlined and discussed in this chapter were used to develop the older people's and GPs findings, and a theoretical interpretation of these. These are presented next in the findings Chapters 4, 5 and 6.

Chapter 4: Older people's stories of depression

Introduction

This chapter describes findings from the interviews carried out with older people. The sample of older people is described first, detailing the characteristics of participants and how they were sought on the basis of ideas needing further exploration in order to develop a theoretical sample.

Data from the older people's interviews is then presented in two sections. The first section describes older people's stories of depression that they report in interviews, illustrating the different experiences of depression they can have.

These stories derive from open codes identified in analysis and focus on components of their stories that were prominent across the data. These include what depression feels like for older people, their definitions and explanations of it, stories where they minimize it or deny it, their private and public stories, how they talk about depression generally and how they talk to GPs. This first section presents a descriptive analysis of the data, where information participants report in interviews has been categorised into the different "components" of their stories. These are supported with relevant quotes from interview transcripts and contextual data consisting of IGs observations and reflections noted in memos.

The second section presents a typology of older people, which consists of axial categories identified during data analysis. Firstly there is an explanation of how ideas from the interview data guided the development of the typology, showing how analysis progressed from open to axial coding. The typology suggests that older people are at different stages on a continuum of understanding and accepting their depression, which can be determined by their reports of different ways they tell their stories of depression. What happens when they are moving between stages of understanding is also considered, highlighting the porous and fluid nature of the topic of enquiry and the capacity for change in the way older people talk about and understand their depression. The chapter ends with a summary of the key messages put forward in these findings.

The sample of older people

The sample consists of 16 older people who were interviewed across 5 PCTs in the Tyne and Wear area: Sunderland, Gateshead, Newcastle, North and South Tyneside and Northumberland. The age range of participants is from 67 to 88 years old. They live in a variety of locations including deprived inner city, isolated and affluent rural and affluent inner city areas. Participants are all diagnosed by their GP as having depression, with a range of severity from mild to severe. Some participants have experienced depression recently, others over the long term, some have had single episodes and a few were experiencing it at the time of being interviewed. All participants' depression has been managed in primary care, and some report additional experiences of receiving help in specialist care for their depression.

Details of participants are included in Table 3 p.113. Following this there is an explanation of how the interview data influenced the development of a theoretical sample.

Table 3: Older people participants and characteristics

<u>Participant code</u>	<u>Age</u>	<u>Sex</u>	<u>Depression episodes</u>	<u>General Practice</u>	<u>Occupation history</u>	<u>Circumstances</u>
OP1	Mid 70s	Female	Severe lifelong episodes	Rural affluent	Housewife	Lives with spouse
OP2	Early 70s	Female	Episodes for 3 years	Rural affluent	Housewife	Sheltered accommodation, bereaved
OP3	68	Male	3 severe episodes over 14 years	Rural affluent	Successful career	Lives with wife
OP4	76	Female	Severe lifelong	Rural affluent	Successful career	Lives alone
OP5	77	Male	Mild-moderate recent episodes	Rural affluent	Successful career	Lives with wife
OP6	Early 80s	Male	Recent severe	Semi-rural affluent	Successful career	Lives alone, recently bereaved
OP7	88	Female	Episodes over last 5 years	Rural, affluent	Housewife	Sheltered accommodation, lives alone
OP8	78	Male	Long term over 48 years	Rural affluent	Successful career	Lives with wife
OP9	72	Male	Recent episodes	Rural	Successful career	Lives with wife
OP10	68	Female	Recent moderate	Semi rural, affluent	Housewife	Lives alone
OP11	67	Female	Severe lifelong	Urban deprived	Housewife	Sheltered accommodation, lives alone
OP12	81	Female	Long term over 18 years	Urban deprived	Housewife	Care home
OP13	77	Male	Episodes over previous 8 years	Urban deprived	Worked until retirement	Lives alone in flat
OP14	73	Female	Lifelong severe	Urban deprived	Worked until retirement	Lives with husband
OP15	85	Female	Long term	Urban deprived	Housewife	Lives in care home, bereaved
OP16	Late 70s	Female	Long term	Urban deprived	Housewife	Lives alone

The development of the theoretical sample of older people

First interviews were carried out with OP1-5 using an initial topic guide (see Appendix, p. 346). These interviews explored: overall views of depression, views about what depression is, experiences in primary care, communication about depression and views of what works well and what could be changed in primary care management of depression. These interviews were then analyzed to identify important concepts brought up by participants, and ideas that needed to be explored with further participants. A list of open codes and possible axial codes were identified (see Appendix, p.349), and the topic guide was modified according to ideas that needed further exploration. Decisions about the next stage of sampling were also made with this in mind.

Participants OP1-5 all lived in affluent rural areas, and either described having successful careers or being married to a partner who had a successful career. Most seemed to struggle in accepting their depression or denied it in some way, and there was a tendency to be doubtful or dismissive of the GPs' diagnosis of depression. Many placed importance on explaining their rationale behind having depression, and central to their stories was the status they had lost when their career had ended, and concerns about the way others perceived them. It seemed necessary to explore whether older people's attitudes and beliefs about depression were different in less affluent areas with people who may not have had the same life experiences. This led to the decision to seek further participants from less affluent areas to explore their attitudes and beliefs about depression, how they told their stories of depression and whether the help they received from GPs and their preferences in ways they helped them were different.

OP6-10 lived in semi rural or rural affluent areas and deprived urban areas. New topics of enquiry included: experiences of depression, explanations for depression, talking about depression, talking about depression with other people, depression and identity, impact of life events on depression, coping with depression, preferred qualities in GPs, views of help received for depression. In addition some of the earlier topics discussed in interviews OP1-5 were included or came up without probing.

During the analysis of interviews OP6-10 strong ideas began to emerge about how older people told their stories of depression, how they understood their depression and the role they took in how their depression was managed. The sample OP1-10 included older people who had experienced depression of a varied duration and it was noticeable that some people's perspectives changed over time. It seemed necessary at this stage to explore why their ideas about depression changed over time, and whether this related to the duration or severity of their depression.

Interviews to explore these ideas further focused on ways older people told their stories of depression, what they kept private and information they shared about their depression, preferences about how their depression was managed and views of the help they received from GPs, decisions made regarding the management of their depression, whether their views had evolved during their lifetimes and the impact of life events over their depression. During analysis differences between ways they told their stories were sought. This line of enquiry together with what had already been established led to the identification of a number of components of older people's stories (presented in the next section of this chapter).

Observations made by IG during interviews OP1-10 suggested that the age of participants could affect what they were sharing about their depression, and it was felt that this needed to be explored further. In particular the way people of different ages talked about depression, their beliefs about what it is and explanations for having it, their reasons for talking to some people and not others and their preferred qualities in GPs.

Participants OP11-16 lived in deprived inner city areas, which meant that developing ideas could be explored in relation to this factor as this had not been done previously. Some earlier topics were still included or came up without probing in order to explore how the views of people living in deprived inner city areas differed from those living in other areas. New ideas added to the topic guides included: private and public stories of depression, what older people tell different people/GPs about depression, influences over what they tell people, their role in the management of their depression and views of how depression influences their sense of self.

Interviews were explored until saturation of important themes shaping the development of theory had been reached. These included: talking about depression, components of stories that were shared and kept private, preferences in GPs, explanations for depression, beliefs about what depression is and influences over how their depression is managed.

The sex of participants was an idea that was explored in interviews OP1-16 to determine its relevance to the developing theory. Particular lines of enquiry explored included whether males or females talk about their depression differently and whether they have differing views of what depression is. However it was found that these were not relevant to the stronger ideas being developed such as the decisions they report making about their depression, and influences they report over the way they talk about depression. The most important factor relating to sex appeared to be that many of the male participants who live in more affluent areas report having successful careers.

The influence of ethnicity was also considered in relation to the developing ideas, however none of the participants brought it up in interviews. This indicates that for the older people interviewed it was not an important issue, and therefore did not have a bearing over either the ways they told their stories of depression or their stage of understanding and accepting their depression.

Components of older people's stories of depression

This section presents different components of older people's stories of depression, showing that their stories can be multifaceted and may vary between individuals. The information they report indicates how they conceptualize and explain their depression, what they regard as private and public information about their depression and how they talk about their depression to others including their GP. It should be noted that information participants give to a researcher in interviews may not be the same as what they may share outside this situation (Richards and Emslie, 2000; Hoddinott and Pill, 1997), and so what older people report saying and doing in the interviews alone is described here. Also what is presented here is

based on the reports from a small sample of older people and any suggestions made are on the basis of small groupings of older people developed during analysis.

What depression feels like

Descriptions of what depression feels like is a component of many older people's stories of depression, but the level of detail they give about this varies. Some report having experienced physical feelings of being tied up inside and not wanting to sleep or eat, or describe something snapping or kicking inside them, being removed from the rest of the world or being plunged into something. Others convey a strong sense of being unable to think straight or maintain a normal life, and describe feeling that their mind is overloaded, that they have lost the ability to see reason, being helpless to carry out their usual everyday activities or that they feel isolated from the rest of the world.

“you feel pretty helpless really, you feel you're out of control of your thoughts... I suppose because you can't overcome it.” (OP10, p.2)

Others describe an increasing feeling of “bleakness” and liken it to being immersed in water:

“...it was just a plunge, almost as those like a dive into the sea, you know, and went under water, and just plunged and I thought, strange, bleakness...the whole architecture of the mind wasn't there.” (OP3, p.2)

Some older people appear to liken their depression to something familiar and objective like the sea or rain, as if to try and make sense of it. The variety of descriptions of what depression feels like for older people shows the wide range of feelings it can encompass and how subjective the experience of depression is. A familiar theme running through these descriptions is the impression of a loss of control over their sense of self.

Some older people describe their more severe experiences of depression, including hallucinations and/or feelings of wanting to harm themselves or others. OP14 describes chronic depression starting with postnatal depression where she experienced thoughts about murdering her baby. OP8 also describes experiencing feelings of dread that he was going to harm his children in some way. OP6 describes suicidal feelings he had experienced as well as having “visions” of his late wife.

"I was really, really depressed a must admit, terrible, couldn't sleep, heard voices, heard her voice you know, feeling, touching like you know like you have when you're in bed like... I used to look and look for clues of what to do with myself jump under a train like." (OP6, p.2 and 11)

Only three participants open up about such things, out of eight whose report severe depression and/or feeling suicidal at some point. The three who do talk about it beyond just a mention give no more than a few sentences of information.

There also appears to be uncertainty amongst some older people about their experiences of depression. A few report being unsure of how they had felt when depressed or why they had it, others say they are unsure of whether their experiences were real or imaginary, and some report being unable to find the words to describe their experiences at all.

"I come back the next day...to all these problems, real or imaginary."
(OP13, p.3)

Similarly, OP10 describes her experiences of having depression as if she is guessing how she had felt or cannot remember, as if it had happened to someone else. OP8 also says he wasn't sure if his depression had been real or imaginary. In contrast, others describe viewing their depression as a normal feeling in old age and therefore nothing to speak of, or that it was so unlike normality that it could not be real and therefore must be imaginary.

"It is serious, it's horrible, I think it's worse than having real disease."
(OP14, p.8)

This uncertainty about what depression is suggests these older people either do not believe it actually exists or they do not trust their own memory of it.

Feelings of uncertainty that come with having depression seem to extend to the uncertainty older people convey about how others will react to them in the knowledge of their depression. Even if they say they have told other people and appear comfortable talking about depression, they may describe a fear of what others think. It is as if their attitudes about it are so ingrained that nothing is really going to change this perspective.

“...a lot of people don’t understand depression, they don’t, they just think you’re being, I don’t know, you’re alright snap out of it sort of thing but it’s easier said than done.” (OP15, p.22)

Situational data – from IG’s observations of participants noted after interviews were completed

There is a common sense amongst participants that they feel misunderstood and that other people just put depression down to being mad, and that they do not know how to communicate with people who have it.

Older people’s stories about what having depression feels like suggests a separation between their inner and outer selves, and a sense that what is happening to them is removed from the rest of the social world. Telling their stories of this indicates that there are differences between individuals in how much they are prepared to share.

What depression means

Older people’s definitions of depression are another aspect of their stories, giving an insight into what depression means to them. Their definitions are seemingly personal and reveal their true beliefs about what depression is rather than adapted versions of their story which are acceptable to others. Within the sample there is a prominent division between participants who say they define depression as a normal and expected part of getting older and others who describe seeing it as an illness or problem which can be addressed medically.

Older people’s views about what depression is seem to play a part in how they accept and deal with it. Those who say they expect to get depression as they age appear to accept it more easily and either report playing a more passive role in its management or say they are less inclined to go to their GP with depression at all.

“I don’t really think about depression, it’s a state of your aging....it’s just nature isn’t it.” (OP7, p.3 and 9)

Those who see it as an illness seem less able to accept that it could happen to them, and are more likely to challenge what their GP said or express distrust at the way their GP manages their depression. They also speak more about the stigma

of depression in later life which suggests a reason for their reluctance to accept they have it.

Older people sometimes report perceiving depression in themselves differently to that in other people, and tend to define it differently in themselves than others. For example those who have experienced depression themselves but have also had family members with depression report viewing their own depression as less significant, or even non-existent. OP5 illustrates this by describing his wife's depression in comparison to his own. He reports that his wife could not physically do anything at all during her bad days but he describes his own depression as the opposite where he was unable to stop doing things. Because his wife's depression was completely different from his own and much more severe he says he did not believe that he had depression despite it being diagnosed by his GP. This indicates that he sees "true" depression as similar to his wife's, rather than existing in different forms for different people.

"I used to be always manic but never depressed... Having a wife who went through a traumatic time with this depression, I have seen depression in its true form." (OP5, p.1 and 18)

Other older people indicate a similar perspective when comparing their own depression to their partner's or friends' depression. They do this by rationalizing theirs as something other than depression if they consider others' state to be worse than their own.

Older people's definitions of their depression would sometimes lead them to explain the causes of their depression in their interviews; these explanations are considered next.

Explanations for depression

Giving explanations for their depression appears to be a common way for older people to present and frame their stories of depression, including how they describe telling their stories to GPs. Their explanations seem to be like an extension of their definitions that they describe adapting in different situations, as if to show themselves to others in different ways.

The different ways older people explain their depression appear to not only give an insight into their beliefs about depression but also the relationship between their depression and outward identity. Some give their explanations at the beginning of interviews without prompting suggesting it is important for them to inform others of the reason for their depression from their own perspective. OP13 starts talking without prompting with the following:

"I intend to come clean today, because I tend when the family ring me up I'm always alright, even when I'm not, and you're probably familiar with people like me but I do not want to be a burden." (OP13, p.1)

Situational data – from IG's reflections on interviews noted during later stages of analysis

Some older people give an impression that they need to justify their depression to others by explaining why they have depression and their views about it before being asked. Perhaps they offer an explanation quickly because of their fear of stigma associated with depression or fears about how others will react.

There is a sense that these types of explanations are part of their outward identity, offered to influence how others portray them and explain their position before people make assumptions.

Other older people give an explanation only when probed by IG and tend to describe their depression as severe or lifelong. OP11 and OP15 say they feel their depression is part of their personality and deeply ingrained in them, or that they have had depression since they were born.

"I think this depression, I have been born with it." (OP15, p.9)

They say they have both suffered depression all their life and unlike the other participants do not seem to care what others think of them having it. They tend to describe being resigned to their depression in some way, as if being born with it clears them of any responsibility and possibly helps them cope with the idea better.

"I didn't know what was the matter with us, just accepted it I think 'cos I had been like that all the time, just accept it like." (OP11, p.3)

Situational data – from IG’s observations of participants noted after interviews were completed

Some people in the sample who report severe or lifelong depression appear passive in their views of their depression and its management and do not appear as concerned about how others portray them. These older people seem to have become so resigned to having depression that it is part of them and feel it does not need explaining. It is as if their depression has taken over their outward identity leaving them unable to convey their own image of themselves to others.

A wide variety of other explanations for their depression are given by older people. They include bereavement, physical symptoms, their childhood, traumatic life events, their personality and loneliness. Some differences are apparent between groups of people where some describe a deeper insight into what had happened to them and others seem unable to face or accept their depression to the same extent since they seem unable to talk about it beyond a superficial level. Some say they believe their depression has been caused by a single factor such as bereavement, whereas others say it is caused by a number of things such as an accumulation of circumstances that have built up and led to a crisis. Others seem less definite about why they have it and speculate on a number of possible causes as if to test out their views on why it had happened to them. Participants who are confident in their reasoning for depression seem more definite in their beliefs about what depression is as well as being optimistic about taking steps to get better, whereas those who are not clear about what depression is seem less willing to accept treatment and take steps to recover.

There are subtle differences between male and female’s explanations of depression. With some male participants their explanation for depression seems to be related to their outward persona and how others perceive them, since they often describe their concerns about how others will react to them if they know about their depression. This is because they tend to give explanations before talking about anything else. Quite often the reasons men give for their depression are to do with loss of status in a career that they describe as being pivotal to their identity.

“I got a golden handshake... so after that I started my own business and I felt as though em, I’d failed.” (OP5, p.4, male)

Their descriptions suggest that giving an explanation to others may be a way of helping some men to feel better about having depression, and a way of accepting it. In contrast, female participants are less likely to give their explanation for having depression as quickly as men, however tend to go into more detail when they do come to explain it. They explain it in their own time, as if building a rapport first and gaining trust of the person they are offering the explanation to is more important than giving the explanation itself. Worrying about other people, especially family, is one explanation that female participants give for their depression that male participants did not.

Bereavement is an explanation given by a small group of participants but is notable because it stood apart from other explanations. If they mention bereavement they tend to use other words for depression relating to the bereavement. OP15 says she had a *“broken heart”*, OP6 describes being consumed with sadness about his loss and OP12 describes the loneliness she experienced after her husband died. The way they speak of their feelings of sadness suggests that they feel bereavement is an acceptable reason for feeling down and seeking help.

“After, after the death....em, well I went and seen him [the doctor]...I just used to cry like, upset myself, it wasn’t normal for a man so tearful and upset like, and I couldn’t talk about her” (OP6, p.2)

Although from a small group, these explanations for depression caused by bereavement suggest that older people may see bereavement as unrelated to depression and as something they find more acceptable. Despite this they all speak about it differently and reveal different levels of detail about this component of their story. This indicates there may be other influences over their views that explain the differences between them.

Some older people say the reason they have depression is because of physical illness, which seems to make it more justifiable to them. OP16 gives the impression that her physical symptoms legitimize her having depression. OP4

gives the doctors' explanation of a urine infection and having salmonella for her depression, as if to make it more believable.

"Well the doctor explained to me...this all happened because I was so run down with the salmonella food poisoning and this urine infection that's what brought it on." (OP4, p.3)

There is also a sense that she is displacing the responsibility for having depression onto the doctor when sharing her story with others, and that doing this saves face by avoiding the stigma of mental illness.

A number of participants attribute their depression to traumatic life events. These include abusive relationships, dealing with suicide, broken family, difficult relationships and coping with alcoholism, that they report either happening during adult life or in childhood. Those who attribute the impact of their childhood on their depression give reasons such as the way they were brought up, experiencing suicide of family members, or being an only child which affected the way they dealt with things.

"Well I've had a very traumatic life you see, I lived abroad a lot and my husband was an alcoholic ... then my daughter became ill and to cut a long story short she killed herself. I had two breakdowns from depression after she died and then it went away and I didn't have any psychiatric nurse or any help I sort of got over it myself." (OP4, p.1).

OP9 says he had "a very unhappy childhood" where amongst other serious traumas he was dealing with his mother's suicide. His childhood is a topic that he keeps returning to in the interview and because of this it seems central to his depression.

"My family history is so appalling...it's important that you know. I probably had one of the unhappiest childhoods [I've] ever heard of in my life... father committed suicide, sister committed suicide, mother who attempted suicide on numerous occasions... But that childhood, whether that has any bearing, I don't know." (OP9, p.9)

OP14 describes being deeply affected by the uneasiness between her mother and father "living in a state of tension" which she says had stayed with her all her life and that she believed this had triggered her long term depression when she had children. OP7 describes being unsettled in childhood since his father had died

when he was young and he had been sent to live with his French teacher for much of his childhood. Out of the four participants who attribute their depression to their unhappy childhood, three participants have a tendency to make light of their depression by using humour as a way of diverting conversation when they need to. All of them report finding it very difficult to tell people about having depression, including their GPs, to the extent that they had hidden it from their families, friends and colleagues at work, and in one case from his wife for a time, giving the sense they thought it was not something worthy of complaining about.

Minimizing depression

Many older people minimize their depression despite being diagnosed with it by their GP. They have constructed their own stories around this which can be about why their condition isn't "proper" depression, why it is not as bad as other people's depression or that the doctor has got the diagnosis wrong and does not know as much about it as they do.

Some seem to try to protect themselves from stigma by showing anger or disapproval towards a healthcare professional involved with their mental health e.g. their psychiatrist or the way their depression has been managed. They may say their doctor has got it wrong about them and give their own explanation e.g. that they do not have depression but a problem sleeping. Others feel they are on the wrong medication e.g. that sleeping pills would be better medication for them than antidepressants, or that they are just tired not depressed or do not want to take any medication at all because they believe they do not need it.

"[An] absolute charlatan he is I think, most of them are, these psychiatrists. And then when I complained about it, I was furious you see, I rang my doctor and I said I think this is the limit coming telling me that I don't know what I was doing and I was disgusted." (OP7, p.2)

Showing feelings of anger and disapproval towards doctors not only gives a sense that they are showing they can take control of their depression by expressing their views, but may also be a way of distracting the focus of their conversations from their depression. This also gives a sense that it is an important part of their outward story of depression.

There were other older people who explained their symptoms as an overactive mind rather than depression.

"I don't think am depressed or have been.

But what do you call it? (IG)

Overactive mind, in terms as you grow older your body can't keep up...your mind is still going but you can't relax." (OP5, p.9)

Men commonly highlight more successful aspects of their lives by telling their stories of their achievements in their careers or education. Some of the women in the sample who believed they had an overactive mind rather than depression spoke of busy or demanding family lives or turbulent family histories but also of extensive travels abroad, socializing in wealthy circles and their husbands' successful careers. For these older people it may be that showing themselves to be from an affluent background is a way of demonstrating they do not have depression, or that having a successful career demonstrates their capability despite having depression.

Some older people deny having depression completely. It seems that usually this is because they are concerned about the stigma linked to depression and the image they are projecting if they disclose depression. This is illustrated by participants who report they acknowledge having depression in the past but deny having it at the time of the interview, despite being under the supervision of a psychiatrist or on medication at the time of the interview.

"I went into the... hospital for people that, like their minds go... I had to sit like them and I thought what am I sitting like this for? Go out my mind sitting like this." (OP12, p.17)

For these participants the depression might have been under control with medication and they were not seeing symptoms at the time, so it is as if there is an "out of sight out of mind" mentality about facing their depression.

A few older people do not believe they have "proper" depression. They either rationalize it as something else like nerves or "*only child syndrome*" (OP5) or compare themselves to other older people with depression, or their idea of what an older person with depression is like.

“So it wasn’t your normal type of [depression]....more like a nervous breakdown of a kind I imagine.” (OP3, p.6)

In doing this they take responsibility for something being wrong but refuse to acknowledge it as depression. Some of these participants also report having a close family member with more severe depression and in comparison tend to believe their own depression is not “proper” depression. In this way they seem to perceive depression as black and white rather than on a scale of severity. This view may also relate to what attitudes were like when they were growing up, where depression was not considered to be an illness or was stigmatized, and so finding other reasons for their depression is important for them now as a way of rationalising it. This indicates that some older people with depression may need to revisit their attitudes about depression and question them at certain times, in order to account for changing contemporary understandings of depression.

Private and public stories

Older people reveal private and public components of their stories about depression to varying degrees and in varying combinations. These components of their story are evident in their reports of differences between what they tell different people in different situations.

“We all have our public faces when you go out and when you talk which is totally different to what you might be with your friends and people who know you better.” (OP3, p.11)

The private story is the more internalized story which older people mostly do not share. It can include more personal aspects of their story, such as descriptions of their feelings about events that have happened (suicide, abuse, bereavements), how depression makes them feel, their ingrained beliefs about why they have it and how depression has impacted on their close relationships. When telling these stories they also reveal how they think they “should” be acting e.g. hiding their depression from other people and their expectations of how people may react to their depression.

Situational data – from IGs observations of participants noted during interviews

During interviews some older people reported not talking about their experiences of depression and its treatment before. This part of the story often came across as jumbled. Bolstering and reassurance from IG during these parts of the interview seemed to help them continue talking. They also sometimes appeared lost in their thoughts e.g. OP6 or became emotional or uncomfortable whilst talking.

To tell you the truth it [death of wife] hit me very hard....it's been 18 months...[appears emotional and choked] and that's when...yes well, it is to me recently...(OP6, p.1)

OP6 who describes losing his wife appears lost in his thoughts during his interview, especially when remembering how he felt, and becomes very tearful. His interview is intermittently incoherent at these times where he seems to forget he is with IG. This is an example of an older person telling the more private components of their story in an interview.

The public story is the externalized part of older people's stories of depression. It is the story told to other people and includes explanations about why they have depression, what it feels like, medication they take for it and chronological events such as where and by whom they are treated. It tends to be the more rehearsed part of their story, told in a more formal and emotionally removed way. The public story is also about how they want others to see them, the side of their personality that they want to emphasize and the image of themselves that they project, for example their persona as a "joker" (OP9), or their role as a mother who holds the family together (OP10). The public story can also be entwined with their ideas of what others might think of depression, as if they are adapting it to the stigma surrounding depression or their own stigma about depression. By talking about events that have happened rather than how they feel, older people seem to use their public story as a means of distracting the listener from their depression.

Older people's private story is sometimes intermingled with their public story, but the differences between the two are clear. For example OP5's private story is jumbled when talking about particularly traumatic events, as if he does not talk about them very often, and then moves from this way of speaking to a more formal and practiced way of talking that comprised parts of his external story. OP15 does not go into much detail about her depression but reveals "*I've talked more to you than I've ever talked to anybody*". She reports not believing depression is an illness but when telling her story she seems to be trying to work out why she has depression and to justify it to herself.

Telling their story to GPs: older people's preferences

Talking about their depression appears to be an important and complex issue for older people and a way of influencing what kind of help they get from their GPs. Their preferences for talking to GPs include qualities they prefer their GP to have, and many older people say they want a GP they feel they can talk to and open up with about their depression. For this to happen they say they need a GP they trust and who they have preferably known over the long term. OP6 described benefitting from his GP knowing about his life history and remembering events relating to his late wife that influenced his depression.

".....Dr [name] was good in as much as, he made an appointment for me once and it was our anniversary, and he worked that out and cos I got married on 21st March... and then on her birthday he would see us" (OP6, p. 11)

However there also appear to be broader issues for older people about verbalizing their depression regarding their choice of what to say and factors which prevent them from talking. Their conditions about talking seem to apply not only within the consultation but in other areas of their lives. It seems that for many older people there are multiple reasons for either opening up about their depression or not which are influenced by many things, particularly their beliefs about what depression is, the situation they are in and whether they have a stigmatized view of depression themselves. For example OP7 describes not being able to talk to most doctors (both GPs and in specialist care) as it is important to her that they do not make her feel as if she is mad.

"He [the GP] knows I am not a nutcase so I can talk...he just treats me like a human being you see..."(OP7, p4)

OP4 reports feeling it is easier to talk to her GP as she knows she has had her own mental health problems.

"I talked to her about it cos she has had; she hadn't had depression but she was on tranquilisers (OP4, p.2)

What is consistently apparent in older people's interviews is an awareness of how they come across to others and the image they project while talking, which apart from rare glimpses of unselfconsciousness in some older people, seems to be in the background most of the time. The influences they report over telling their story of depression are discussed in more detail in Chapter 6.

Some older people with less severe forms of depression report talking to their GP as the most beneficial and preferable form of help for their depression. This is especially if they report a trusting, long term relationship with their GP and feel listened to. A few of these patients say they feel no need to take medication and attribute this to talking to their GP regularly. These are mostly patients who describe their GP in friendly terms which evokes the image of an archetypal old-fashioned family doctor.

"I got close to Dr [...] and he is a terrific man, I do believe he helped us, he did help.

How did he help? (IG)

Well, talking, just talking all the time, very, very clever making notes and then he would see you next time, look at his notes and say you said this last time." (OP6, p.10)

Other older people also report the value of shared experiences with their GP and feeling understood which is important in helping them open up.

"You can't tell everybody because not everybody wants to know, but I do unload to a few good friends, they have been through it themselves a couple of them, you know." (OP16, p.7)

However this is unusual as many feel their GP does not have enough time to give them or do not have that type of relationship with their GP.

Having enough time to talk also appears to be very important to older people.

OP12 describes successful visits she has had from a community mental health

worker at her home, and suggests that feeling as though she has enough time to talk is important in her being able to open up about her depression.

Eee I fell in love with him, he was such a lovely man, lad, er, he used to sit for hours with us...

Talking? (IG)

That got me better, it honestly did...I think it was just because he made time to sit with me (OP12, p20)

This indicates OP12 feels strongly that she had benefitted from talking about her depression to somebody. This resonates with reports from other older people in the sample who also say they feel there is a therapeutic value in talking about their depression.

It seems that some older people may feel more comfortable opening up about depression in their home environment. This is indicated by reports of those who describe experiencing successful visits from mental health workers at home, such as OP12 (above), and by the way participants who open up about their depression for the first time in interviews appear when they are talking. OP13 reports anticipating the interview as an opportunity to tell his story and appears relieved to be able to do this.

"You are the first person I've talked to about my problems...I thought, when the lady [IG] comes on Tuesday, tell her the bloody truth, let it all hang out, no pride, no hiding anything, and erm, so this is it" (OP13, p4)

Situational data - from IG's observations of participants noted during interviews, and reflections noted after interviews

OP9 started to talk about having depression only when he had shut the sitting room door firmly. It seemed that being in control and being able to do things on his terms, in his own private environment, helped him open up.

OP10 looked more physically relaxed when she sank back into her sofa, her talking slowed down, and then she started her story of depression for the first time. She said she did not talk to the GP in detail because he didn't have time, but the interview went on for nearly two hours so she may have felt as if she had more time to open up.

Older people seem to prefer to talk to somebody at home because it makes their depression more normal, and they are outside a medical environment which they find more relaxing. They may feel they have more time and opportunity to tell their story.

These factors illustrate that aspects of the situation, especially being made to feel as if there is enough time, can be important factors for older people when telling their stories of depression.

In their interviews some older people talk freely about their lives and give an insight into their depression this way. They avoid using the term depression as they say it makes them feel more depressed.

"When you say you get down in the dumps then it all becomes too much....sometimes I am not sure whether it is a good thing to drag these things up and whether it's better to just get on with it." (OP10, p.9)

Despite appearing open and happy to talk some older people do not open up about their depression. They tend to talk about the events that had happened rather than personal opinions and feelings e.g. what the depression felt like for them, and do this in such a way that it is hard to notice they are only touching the surface of their story of depression.

Situational data – from IG’s reflections noted after interviews

Participants who minimize their depression appear to be sociable people whose image does not convey signs of having depression. They seem to want to keep their depression out of public view. Their attitude towards depression seems to be stigmatized because they feel it is not something people like to see or talk about.

OP2 describes her story of depression in one or two sentences and this is the only direct reference to depression during her hour-long interview:

“I sat here for weeks you know, couldn’t go out anywhere it affected me so much, but luckily I’ve got over it.” (OP2, p.3)

During the rest of the interview she talks about her living situation, family and experiences of healthcare for other physical problems which give an insight into her story of depression and her views and attitudes towards it. This data suggests that older people can have firm boundaries about what they are prepared to share about their depression, which may be related to their attitudes towards depression.

Some older people do not engage at all in a conversation about depression and dislike talking about it. These people tend to be more introverted and disengaged and it seems that blocking depression out is not only important for their self preservation but also prevents them from telling certain parts of their stories to GPs. Those who have long term and severe depression seem particularly closed if they have been through traumatic life events or if it is too painful for them to face their depression.

“It’s difficult you know talking about how you feel, I always feel it’s like... I don’t want to, that depresses me.” (OP15, p.3)

These older people often describe having long term physical symptoms, or say that talking about it makes them feel even worse.

Some older people use other topics as a metaphor for depression, allowing them to tell their story about it without it becoming depressing for them. In her interview OP1 starts to talk about her depression but then gets very upset and asks to end the interview. It seems as if she sees using the term depression as a way of giving into it since she says that it makes her feel even more depressed talking about it.

"I just don't like talking about depression because the imagination is round the corner and you have got to battle with it...your imagination turns a corner and drags you down with it." (OP1, p.4).

However she starts talking about other topics without prompting and continues the interview, still giving an insight into what she feels triggers her depression, how she feels with it, how she reacts to big events in her life and in turn how these have an impact on her depression. She talks about her friends, family, life and by doing this gives a good insight into her views about depression without it appearing to upset her further. After mentioning her depression once and establishing boundaries in what she was comfortable talking about, OP1 seems to feel freer to go into more depth on her terms. This example illustrates the definite boundaries older people can have in talking about their depression and the impact that language can have on them when they describe their experiences of it. It seems that if they are able to find a way of overcoming these fears and talking in a way which is acceptable to them, it would be easier to talk about depression more freely.

Labels older people use for depression can give clues as to how they see their depression and their attitudes towards it as well as where they are in terms of accepting and understanding it. Some avoid using the word depression and describe it in less medical terms such as by what caused it e.g. heartbreak, worry, anxiety or stress. Those in denial of their depression tend to be more comfortable calling their depression worry, nerves or stress as if they do not want the constant reminder that they have something that they do not want to have. OP15 suggests that the word itself makes her feel even worse.

"I have never been depressed, no...I worried about everything, you know, about myself...but to be labelled like that is a bit rich." (OP7, pp.3)

OP11 comments about changes in the way depression was labeled during her lifetime. She says she prefers the label bi-polar to manic depression because *"it doesn't say really what it is unless you know you have it"* thereby making it more acceptable to talk to other people about. OP5 says he feels the word depression should not be used unless someone has it severely, which echoes what many older people seemed to imply in their beliefs about depression not being a proper illness.

Typology of older people

This section presents a typology of groups of older people identified during the analysis process, and is derived from what older people say in their interviews. It is a theoretical construct rather than a model of how they operate because consultations have not been observed, and suggestions are based upon participants' reports of what they say and do in consultations. The typology derives from the process informed by Adele Clarke (2005) on the development of different positions taken within the data. This section firstly explains how the typology derives from ideas found in the older people's interview data. Following this the older people's typology is presented suggesting their different "stages of understanding and accepting depression", with an explanation of how these stages are characterised. Also highlighted is the fluid nature of their positions and older people's capacity to move between the groups identified in the typology.

While the typology derives from a small sample of older people who were interviewed on single occasions, the data consists of older people's detailed accounts of their experiences and perspectives, obtained during 1-2 hour in depth interviews. Other qualitative research inspired by grounded theory also proposes explanations for what people say or do developed using data from similar sized samples (Kumar et al., 2003; Murphy et al., 2003). The detailed insights gained from in depth interviewing can be valuable in understanding more about reasons underlying people's views of the world or their actions that larger scale studies may not provide (Kinmouth, 1995; Britten, 1995;). Information of this kind may also be used as a starting point for testing these explanations out with a larger sample (Mays & Pope, 2000; Bloor, 1997).

Since the typology is based on interview data rather than observed consultations, it is also recognized that what older people report in interviews may be different to what they do (Corden and Sainsbury, 2006; Richards and Emslie, 2000). However interviews give older people a chance to talk without being overheard by the GP and they may reveal different things to a researcher than to a GP, especially considering some older people say they feel depression falls outside the remit of a GPs' role. They are also able to talk to the researcher with the knowledge that the

interview is carried out on a single occasion and they will not have to see the researcher again. In interviews participants also have more time to give their full explanations story and be listened to uninterrupted than in consultation situations. The typology which is derived from the interview data is intended to provide a basis for further exploration in an observational study, where consultations between older people and GPs are observed.

From interview data to the older people’s typology

This section accounts for the analysis and interpretation of data which led to the development of the older people’s typology.

Different components of older people’s stories of depression are evident in the interview data, as presented in the first section of this chapter. These components derive from open codes identified in preliminary stages of analysis and map out different types of information about depression that older people report sharing with other people. An extract from this list of open codes is below, where text in bold indicates strong lines of enquiry.

Early analysis: open codes relating to older people’s reports of talking about depression.

Talking about depression	Being a burden
Rehearsed story	Different stories for different people
Unrehearsed story	Relief in talking
Agenda unshakeable	Not telling people
Chronology	
Just wanting company	
Mantras	
Monologues	
Minimising depression	
Need bolstering	
Question and answer	
Internalising story	
Boundaries	
Conditions attached to talking	
Preferences of who to talk to	
Private and public stories	
Giving selective information	

A full list of these codes can be seen in the list of codes provided in the Appendix (p.349).

Open codes identified in the older people's interview data were then explored in relation to one another, which led to the identification of axial categories that form the typology. To do this IG identified differences between the ways older people spoke in interviews, language they used when talking about their depression and components of their stories they reported telling and holding back. These were all factors that shaped characteristics of each group identified in the older people's typology. In this way a pathway through the data was established whereby relationships between codes and explanatory narratives were developed. Extracts from contextual data below illustrate how the data was interrogated and how stories were built around the data. They show where IG noted observations about some male participants, the ways they spoke in interviews, and the ways they spoke about their depression. When this was compared to later interviews it seemed that a group was forming with certain characteristics:

From observational memo following interviews OP1-5:

Male participants who live in more affluent areas report having successful careers – does this influence the way they talk about their depression? Do those who do not report successful careers talk about depression differently?

From reflective memo after interview with OP9:

Many males who report successful careers convey a particular image of themselves to others that minimizes their depression. Other similarities include providing an explanation for their depression which seems to be a priority, reporting that depression is not a “proper” illness, appearing to talk freely but not disclosing similar information about depression. Need to explore why in further interviews.

From theoretical memo during development of narrative around axial codes:

A group seems to be developing where relationships between codes are becoming established. Linked codes include: minimizing depression, image of self, explanations for depression, attitude to depression, stigma, justify as normal and rehearsed story. Interviews with these codes occurring may indicate characteristics of participants in the developing group. The next step is to return to the data and seek differences between participants within the group.

Positional maps were also drawn up to map out the relationships established in this way. In doing these, IG noted differences between participants in their attitudes about depression, what appeared to influence these and differences between what they said and did regarding depression in later life. The positional map shown in Figure 3 (p.141) sets out relationships identified between the open and axial codes around which narrative was developed to form categories of the typology. The main relationships identified are groupings of older people based around the components of their stories that they tell and hold back on as well as the ways in which they report telling their stories in interviews. Observational comments are included in the map which also illustrates how they talk about depression in their interviews. All of this data was used to develop each group included in the typology.

Many of the open codes in the older people's interview data occur repeatedly, sometimes frequently, and some occur infrequently or once. Examples of those occurring infrequently or once include: suicide of close family (OP9), postnatal depression (OP14), childhood depression (OP11). After further exploration, these codes revealed more differences, complexities and varying positions taken in the data, and were important lines of enquiry that helped to define or discount characteristics of the groups in the older people's typology.

Further interrogation of the interview data was made, where answers to new questions emerging during the analysis process were sought by revisiting the data. New questions came up through IG writing reflections and observational memos both during and after interviews, triangulation with supervisors and during analysis of the data. An example of finding answers to new questions was to find out whether or not older people's perceived reasons for having depression influence the ways they describe seeking help from their GPs. Interrogating the data in this way led to differences being found between participants. These were noted as memos, and groups were formed depending on which components of their stories they reveal and hold back on in their interviews, their reports of how they perceive depression and their reported experiences of consultations with GPs for depression. This interrogation also led to lines of enquiry being discounted, which happened when the questions asked of the data did not lead to any relationships being identified or any explanations for the data being formed. An example of this

was the differences between men and women explored as a result of some male participants (OP3, OP9) focusing on their careers more when talking about their depression in interviews and some female participants being particularly closed (OP2, OP11). This line of enquiry was discounted when explored with the other transcripts and other explanations were identified for these characteristics. A memo written during analysis of interviews OP1-10 illustrates questions arising from IG's observations in interviews.

Theoretical memo: Older people themes to explore further from analysis of interviews OP1-10

Talking about depression

Many people who volunteered for interviews seem to have set agendas of what they want to talk about and/or clear boundaries of what they are prepared or not prepared to go into.

Those who appear to like talking tend to describe themselves as having something other than depression and spend a long time explaining what is wrong with them.

Do those who do not appear to like talking about their depression tend to have had it more severely? Are they more likely to not want to go beyond a certain point and talk about depression on a superficial level? If so can this be explained?

Is talking about depression tied up with attitudes to depression and its validity as an illness – i.e. withhold information and do not want to complain? Does the level of deprivation where participants live have a bearing on their attitudes i.e. is this attitude largely middle class?

Some older people report being uncomfortable going on about it (e.g. OP10) - are there similarities between people who have this attitude?

Contextual data indicating differences in older people's situations and possible influences over what they were saying in interviews were considered in relation to all of the interviews and therefore influences became a strong line of enquiry. Contextual data included in the analysis consisted of IG's observations and reflections after interviews alongside situational maps and social worlds/arenas maps. This contextual data gave indications of how participants told their story, such as how they appeared to speak, IG's comments about the way they talk

during their interview about depression e.g. if it flows or is hesitant, and IG's observations about their story e.g. is it consistent/contradictory etc. At this stage patterns became visible between the ways older people report telling their stories, their reported perceptions of what depression is and their reports of how depression is managed.

By drawing these categories together and developing textual "stories" around them to explain their relationships to each other, typologies were formed detailing characteristics of the different positions older people can take in relation to their depression. Open codes which were previously identified within their interviews, which have been grouped together: the way they conceptualize their depression, how far they are able to accept their depression, its impact on themselves and the way it is managed, the ways they seek or accept help from GPs, their concerns about externalizing their depression and what their different needs are at different times. Figure 3 (p.141) shows the way open codes were grouped with axial codes in the centre of each group, forming the basis of the older people's typology. The narrative that comes afterwards explains the diagram.

Figure 3: Positional map showing open and axial codes selected for the older people's typology

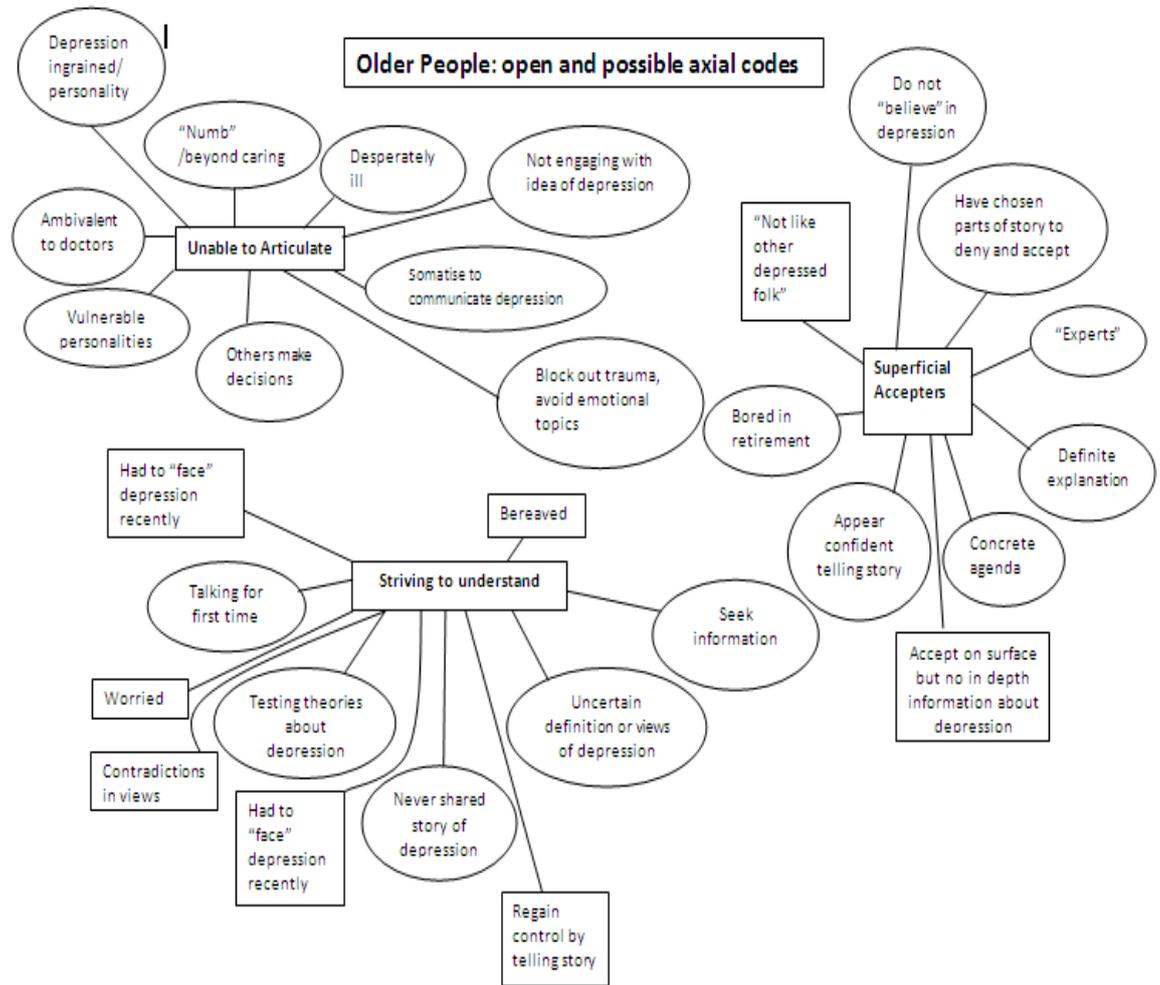


Figure 3 sets out how codes were grouped together during the development of the older people's typology. It shows how ideas in analysis moved from describing the data (open codes) to interpreting it (axial codes). The oval boxes show the open codes identified in the older people's interview data, which were selected and grouped together as relationships were found between them that explained the way older people told their stories of depression in their interviews. They describe the different components of older people's stories identified from the interview data, how they reported telling GPs about their depression and how IG perceived them to tell their stories in interviews (observational and contextual data). The square boxes show the axial codes, which are IG's interpretations of the groups of open codes. They are the basis for "types" of older people suggested in the older people's typology, and describe the different stages of understanding and accepting depression older people may be positioned at.

What stood out in the older people's data most prominently to IG were the differences in the ways they tell their stories and the differences in the ways they perceive depression. These factors seemed to influence how they report dealing with most aspects of their depression including how they report seeking help from GPs, and telling their stories of depression. IG was able to build textual stories about this and establish relationships with other categories identified. e.g. "telling story" and "denial" became two linked categories that formed a characteristic of the Superficial Accepters group.

Taking this pathway through the data led to the development of the older people's typology and the suggestion that the way older people tell their story of depression can indicate their stage of understanding and accepting depression.

Older people's stages of understanding and accepting depression

The analysis process described in the preceding section has led to the suggestion that the way older people report telling their stories of depression may indicate their stage of understanding and accepting it. It also appears that older people can move between stages of understanding and accepting their depression due to their changing situations and influences over them, which indicate the fluid and non static nature of their positions.

Three stages of understanding and accepting depression are identified here, which have been called Superficial Accepters, Striving to Understand and Unable to Articulate. These groups are shaped by the way older people speak about depression in their interviews, the way they report telling their stories of depression to other people including the GP, the information about their depression they share and withhold in comparison to each other, and what they say about their experiences of consultations for depression.

The stages of understanding and accepting depression presented in the typology are positioned on a continuum (see Figure 3, p.141). The use of a continuum is a way of emphasising the "porous" boundaries (Clarke, 2005, p.111) that are likely to exist between groups of older people in the typology. These boundaries are porous and changeable to recognize the possible influences of changing situational and contextual circumstances. The continuum is intended to reflect the capacity for older people's narratives to change and their ability to move between stages of understanding and accepting their depression. They tend to move between positions as a result of their situation changing in some way (e.g. they report becoming isolated) or influences over them changing (e.g. they report medication for depression helping them and challenging their perceptions of depression). Some people appear not to move e.g. because they may be stuck or may not respond to opportunities for change. The findings do not account for whether older people experience all of the stages of depression (and who does/does not), or whether they can move through the stages in any particular sequence. However further explanation of the ways they move between stages and in which situations are given after the typology is presented (p. 155).

The groups identified showing older people's stages of understanding and accepting their depression are described next, and following this there is a section that considers how and when older people may move between stages.

Superficial accepters

Participants identified in the sample leaning towards the Superficial Accepters group are OP3, OP4, OP9, OP14, OP15, OP5.

These older people talk about their depression freely so it appears on the surface as if they have accepted the idea of having it. When probed further they reveal they do not believe depression is a proper illness or do not think they have it. There is a strong sense of pride amongst these participants and their outward image is important to maintain. This shows itself in different ways such as wanting to keep up appearances, showing themselves as an expert about depression or giving their own valid explanation for why they have it. They tend to have an inflexible agenda of what they want to say in their interviews and usually go back to this story regardless of any probing. These participants also tend to minimize their depression or deny they have it, especially when comparing themselves to others they know with depression. In this way they appear to mostly reveal versions of their story which are public as opposed to those which they feel are private and should be kept hidden.

Additional characteristics of this group include that they are mostly male and focus on achievements in their education or careers, and speak articulately and confidently in conversation. They describe facing a loss of status in some way e.g. through career or position in family. They also seem to attach a lot of importance on the image of themselves they project to others and seem proud of how other people see them. OP9 illustrates this when describing his position in the community and past career as well as his role within his social circle.

"I would like to know what's causing it... I have been very successful I have been a head in four schools, successful as an artist, if I say so myself I am well liked in the village... so there is none of those things. It's just...tiredness." (OP9, p.5)

OP9 does not appear as confident in his reason for having depression as others in the group but tentatively suggests here that he suffers from tiredness rather than

depression. This is despite using the term depression to describe his problems elsewhere in the interview.

“...it’s only the second time in my life I’ve had depression, em, like most people my main source is embarrassment...” (OP9, p1)

The way they minimise their depression and reveal a desire to hide it from others indicates that these older people may have only been able to partially accept having depression themselves.

Superficial Accepters are also likely to hold back on revealing their depression to others in their community or workplace as they have insecurities about the knowledge of their depression would tarnish their outward image. OP14 reports keeping her depression a secret from colleagues all her working life due to a fear that it would influence others’ perception of how well she did her job.

“I still did me job alright you know, I didn’t have any problems. If I did I didn’t let anybody know about them I can tell you... It’s was a secret. My secret you know, I just got on with me job. Was never off sick.” (OP14, p.2)

People in this group have a definite agenda of what they want to say and what they hold back on. In this way they have clear boundaries, which include being matter of fact about their experiences of depression and not giving much detail of how it feels or their views about it. This is as if their story is practiced and they include the parts they feel are “safe” to tell other people. This agenda is usually completely inflexible to the extent that in interviews probing did not affect the direction the interview went in. Part of this group’s agenda is often giving an explanation about why they have depression.

Interviews with these participants often start with them explaining the reason they have depression in great detail, underlining how important it is for them as if to ensure the listener understands their reasoning behind it, and their conviction that their beliefs about depression are right. In doing this older people in this group give the impression they want to “keep up appearances” by maintaining the image they may have lost with their status e.g. that of a high achiever in their career or joker in their group of friends. In some cases this comes with minimising their depression

such as hiding it from colleagues, family or friends in order to maintain their outer image.

"I've always just got on with my life, worked and erm, as a say I can hide it, put a brave face on." (OP15, p.9)

Some older people in this group portray themselves as experts on depression in interviews, by their reports of having greater knowledge of their depression than healthcare staff or that their symptoms are not fully understood. This conflicts with their non acceptance of depression and indicates that those who portray themselves as experts may be closer to wanting to explore its impact on their sense of self further than others. This shows itself in different ways; some are distrustful of healthcare staff and express dissatisfaction with many aspects of their treatment, giving a sense that they know more about it. Others are angry with doctors for putting a label on depression as if they perceive them to have got the diagnosis wrong.

"Have you got any ailment that you always think oh well I know more about that than any of the doctors do? Well it's the same thinga given a lot of thought to it and read it myself and understand exactly what my condition is, but a lot of them don't you see." (OP3, p.7 and 13)

As well as feeling that doctors knew less about depression than him OP3 was also angry about being in hospital with others who he perceived to have depression much worse than his. This reflects the feelings of others in this group who may be angry and portray themselves as experts by backing up theories about their depression with "evidence" such as reporting what they had found out from media or what the doctors had told them. This sensitivity and seeming resentment about the healthcare they receive seems to be guided by their anger about having depression and their fear of how it affects the way others see them.

Making light of their depression in a stoical way is also common amongst this group, and could be seen as a form of minimising their depression rather than denying it completely. They see depression as a sign of weakness and do not want to tarnish the image they project to others. Even though they appear open and accepting of their depression initially, they seem to harbour insecurities and stigma about it because of the negative effect on their outward image. Making light

of their depression is supported by them not wanting to whinge as they believe people do not like hearing about it. They just seem to want to get on with it, and this attitude is perhaps influenced by past attitudes towards depression which they grew up with.

Another clue that this group have not fully accepted their depression is when they compare themselves to others who they think have it worse than them, and appear to use this as a reason for not believing they have proper depression.

"I would feel a bit down but not to the state that I couldn't get out of the chair like I'd seen in my wife." (OP5, p.2)

They may comment on other people who are depressed and the problems they have, appearing not to see themselves in the same category.

Striving to understand

Participants identified in the sample leaning towards the Striving to Understand group are OP6, OP8, OP9, OP10, OP13, OP15.

A key characteristic of this group is that many use the interview to talk about their depression for the first time. These older people are the most emotionally open of all the groups showing their thoughts and feelings about their depression. They often talk in long narratives without any prompting, needing to unburden themselves by talking immediately on contact and being adamant to tell their story. There is a sense that by telling their story they are coming to terms with having their depression out loud and trying to articulate their understanding of it in order to clarify it for themselves. The narratives may be very confused when they are running through chronological descriptions of events and when they appear to be thinking out loud. This group can be particularly concerned about being a burden on family members and friends and for this reason some may not have told their family or friends about their depression.

This group are not used to telling their story and appear to be confirming it or reminding themselves of what had happened to them when they are talking. OP13 reports not talking about his depression to anyone else and seems to be testing different explanations out loud. He explains that for him the interview is an exercise in going back over events that had happened, reasons for the depression

and how he felt in order to get his story straight in his own mind and gain some understanding about his depression. OP10 says she feels she needed to practice her story to feel reconnected with the rest of the world after having depression, and then tells her story of how she did this, which was initially by writing down how she felt at the time.

“I was detached from everybody else, I didn’t know why, and I didn’t know how then to reconnect and re communicate, it was very difficult.” (OP10, p.7)

Another concern expressed by people in this group is feeling out of control, and talking through their story seems to increasingly give them a renewed sense of control and confidence in talking about depression.

Some people in this group may not have made decisions about key components of their stories. This may include whether they believe depression is an illness, a weakness of character, a normal feeling in old age or whether it exists at all; and may talk about the possibilities around this. OP15 illustrates this with numerous contradictions in her story. She appears undecided about what she thinks depression is; on the one hand she acknowledges depression is an illness of varying severity but on the other she reports spending most of her life hiding it from other people and says she felt she just had to get on with it and considered it to be not justifiable as an illness. She seems to make light of her own depression and regard it as “silly” yet talks about how it is always with her and how upsetting it is for her. Even though she says she feels it would be beneficial to talk to somebody about it and is willing to talk in the interview, she seems unable to describe it beyond a certain boundary and cannot reveal her depression to her family. Her understanding of depression appears divided between the wartime mentality she had grown up with and the feelings of sadness she faces in her daily life. She appears to benefit from talking about depression, and indicates this in the middle of her interview when she says *“I’ve talked to you more than I’ve ever talked to anybody.”* (OP15, p.10). By the end of the interview she seems to have confirmed to herself that it is a good idea to talk saying she feels older people with depression should *“talk to their family if they can and get them to understand, a lot of people don’t understand depression.”* (OP15, p.22). This gives an example of how people in this group are experiencing a changing period in their perspectives of their depression and these can be influenced by talking about it to people.

Others in the group speak of having to “face” their depression more recently having encountered a recent episode, or have ignored it in the past and feel ready to explore their understanding of it further. OP8 describes having blocked out his traumatic memories of treatment and details of depression during his life, and he gives the impression in his interview that he had never faced his depression even though he had experienced it over a long period.

“There was the possibility of me having to go into mental hospital which I, the fact that I would have to do this, I couldn’t face up to it at all.” (OP8, p.6)

His agenda for the interview seemed to be to put things into chronological order and test out explanations for depression, possibly as a step towards coming to some kind of understanding about it. He exemplified that talking out loud in interviews about their story seems beneficial to some older people since it helps them confirm their story.

Older people who are bereaved tend to belong to this group, and report that this has triggered their depression. They also tend to report experiencing a crisis point at the time of the death but at the time of the interview seem more able to look back on it and reflect. At the time of being interviewed OP6 reports that he is coming out of a long depression following the death of his wife. He says at the time had not been able to face talking about how he felt when his depression was at its worst and because of this counselling had not worked for him. He seems to use his interview to put his story into chronological order and whilst doing this appears to be clarifying details for himself.

“She [the counsellor] said what I want you to do is write a letter, put your thoughts on paper, and you know I couldn’t do that, not at that time I couldn’t, I was too upset like.” (OP6, p.2)

It is clearly painful for him to talk about such things as he appears upset and depressed during the interview, and both his story and visible emotions give insight into what is happening to him inside. He appears at times to be so absorbed in his thoughts and emotions that he seems to forget IG is listening to him during the interview, and at one point the distraction of IG prompting him seems to startle him as if he has forgotten anyone is there. This indicates he has lost himself in his memories during the interview and in doing so shows a very

private side to his story. He later reports this is the first time he has spoken about it. Telling this largely private story is very unusual amongst the older people interviewed and indicates that this group are the most open in their storytelling because of the stage they are at in their depression.

Unable to articulate depression

Participants identified in the sample leaning towards the Unable to Articulate group are OP1, OP2, OP4, OP7, OP9, OP11, OP12, OP16.

Older people in this group are unable to articulate, or verbalize, their understanding of depression or their feelings about having it, and can appear not to engage with idea of it at all. They seem to accept they have depression but at the same time appear defeated by it.

Most of this group have encountered severe episodes of depression throughout their lifetimes which have been managed in both primary and secondary care. They have usually tried a number of different medications and treatments over the years and can appear quite resigned to it, generally seeming indifferent about giving their opinions on things or recounting their experiences. They appear to be vulnerable personalities, lacking in confidence and self esteem and are mostly female. They seem to deal with having depression by blocking it out or appearing to block it out by not talking about it directly, or by expressing it through physical symptoms.

“When it [depression] first happened can you remember... (IG)

I try not to remember

You want to forget? (IG)

I want to forget, I don't want to think about it cos it just brings it all back to me.” (OP1, p.2)

Others in the group appear so used to having it that it seems normal to them, and because of this they may feel it does not warrant talking about. In addition people in this group are likely to describe having experienced traumatic events in their lives and appear unable to put their experiences, views or feelings about depression or past events into words. When they talk about their depression it

therefore tends to be about their lives or day to day activities, but in talking about such things they give an insight into their stance on depression.

These older people seem to struggle to put their views about depression into words in a number of different ways. They either avoid talking about it completely in interviews and talk about other things giving a picture of their viewpoints indirectly, or they come across as lost for words and completely detached from it as if they cannot bear to think about it or face up to it. After briefly starting to talk they might quickly draw the story to a close.

"I sat here for weeks you know, couldn't go out anywhere it affected me so much, but luckily I've got over it." (OP2, p.2)

They mostly do not give any explanation about why they think they have depression, and those that do liken it to something permanent say they are born with it or it is part of them, but do not elaborate further. The focus of OP12's interview is her heartbreak from losing people she loved in her life and this seems to be how she defines her depression. She has a stoical restraint and comes across as detached from her depression, not wanting to talk about it at all. However she is an example of how people in this group talk about something else but give a picture of their depression.

Others in this group may talk about physical manifestations of their depression which may be a way of avoiding engaging with it emotionally. OP16 describes many physical problems including tinnitus and pain on her face and explains her depression by talking about these; she does not seem to be able to explain it any other way. It is as if she cannot face her psychological distress and finds this the best way of expressing it. In the same way OP1 completely avoids talking about her depression and instead talks about pain in her back and that seems to be a way of expressing her feelings about her depression.

In contrast to all of the others in the group OP11 appears completely lost for words, giving the impression she is numb to her feelings and the traumatic events that she describes happening during her life. It is as if she does not care about her depression or herself any more. She is the only older person in the group to appear completely closed and only says a few words at a time about her life.

Although unusual for this group it illustrates how extreme this stage of being unable to articulate can be. However this may also be a symptom of her seemingly socially isolated life and living situation.

This group express a preference for GPs who “just knew” (OP1) what was wrong with them, so that they do not have to talk about having depression in consultations. They appear more comfortable having their GP taking the decisions and control out of their hands, as perhaps this is the most familiar way they know of having their depression managed.

*“He [the GP] doesn’t mention it [depression], but I still have the tablet.”
(OP2, p.2).*

They say they do not want to talk about their depression they still say they want a GP who understands them, but this does not mean they want to see the same GP all the time, it seems to be more about how the GP makes them feel.

Older people in this group seem to have lost control of most aspects of their lives including taking responsibility for decisions in the management of their depression. There is a feeling that their depression has completely taken them over for a long time and that they have no hope of things changing and no desire for exploring their own feelings and understanding depression. They describe other people (e.g. doctors or family) or the medication to be in control of most aspects of their lives.

“So how do you feel about having it [depression]? (IG)

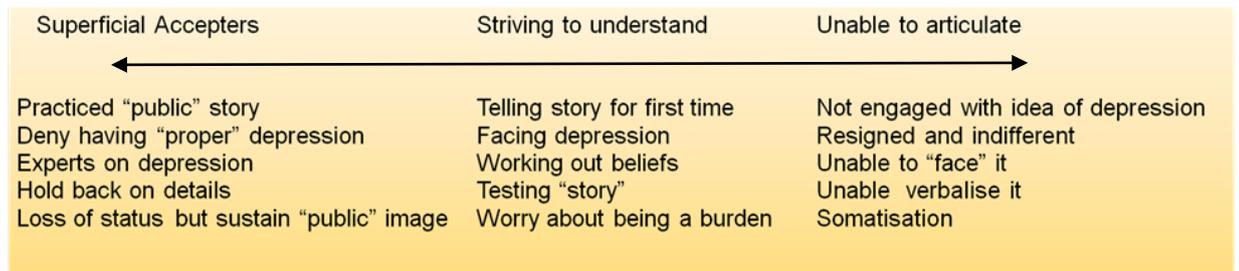
Well I’ve more or less accepted it, I’ve not got much choice.” (OP11, p.10)

It is as if it has been happening to them for such a long time that they are used to these things being taken out of their hands and not giving much input or making decisions. The traumatic events that have happened to them during their lifetime may have contributed to this but they tend not to give this reason themselves.

OP7 demonstrates many characteristics of this group, however stands out because of her ability to verbalize certain experiences of having treatment for depression. In keeping with others in the group she appears closed and unable to talk about her story of depression, including views of what depression is, what it feels like and how it has influenced her. However she appears angry talking about her experiences of treatment for depression, and reports feeling that healthcare

staff lied to her about her having depression, that she could not talk to them and that she did not feel listened to. She reports feeling completely under their control in terms of her depression and that she could not make any of the decisions herself. Demonstrating this level of emotion and being able to verbalize experiences relating to depression in this way was unusual in this group.

Figure 4: Older People’s typology of stages of understanding their depression as a continuum with characteristics of each stage



Moving between stages of understanding and acceptance

The stories older people tell suggest that they can move between stages of understanding and accepting their depression. The presentation of the typology on a continuum is intended to reflect this (see Figure 4, p.154). In their interviews older people describe different situations and contextual factors that can influence them moving between positions. Their ability to move does not derive from how long they have had their depression, but partly from their knowledge and interpretations of it. In addition not everybody goes through the same stages of understanding.

Older people indicate they can move between positions despite reporting fixed or longstanding beliefs about depression accumulated during their lifetime. Some describe what happened to them to prompt a change in their perspectives of depression and others describe this process of realization less directly. OP8 indicates that recovery from depression has prompted a change in his position.

“...all of a sudden the ECT [electroconvulsive therapy] had obviously sorted out my head, and I said to myself, look this is silly, they are obviously not treating you for cancer they are treating you for mental problems. Once I started to realize that then it [the depression] sorted itself out (OP8, p.8)

Some older people say that changes in their perspectives of depression can happen with a GPs' influence, such as when they persuade them to try something new or persuade them that depression is a justifiable illness. It appears this can influence their stage of understanding and accepting it as they may start to accept her depression more or start to talk about it more. This seems to happen when older people report having a particularly trusting relationship with their GP and/or have a long term relationship them. OP5 describes not realising he needed to do anything about having depression until he had completed the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009) questionnaire during a routine health check. He reports that doing this and seeing the “evidence” had changed his perspectives about the impact depression had had on him.

“ I didn't think I had depression....I went for a healthy check, a healthy man check before I realised anything like this... it wasn't a voluntary effort but I realized that something had to be done.”(OP5, p.2)

Other older people report that GPs can change their views by simply talking to them, suggesting it is the skills of the GP in talking to them which is effective.

“He [the GP] solved the problem for me by saying that a lot of people with heart problems that are on 3 to 4 tablets a day and they will take them for the rest of their lives, this is not for your heart it’s for your brain, it was a good way he put and I sort of accepted it a bit better, I accepted that I may be on it for ever like.” (OP6, p.12)

Superficial Accepters also describe GPs helping them realise depression is a justifiable illness by likening it to a physical illness e.g. thinking of it as a physical change in their brain rather than an unexplained mental illness, or by comparing it to a broken leg.

Some older people in the Striving to Understand group report that experimenting with taking medication can change their views of depression and antidepressants. OP2 and OP13 both describe taking themselves off their medication and realizing the benefits afterwards.

“I thought I was getting better so I stopped taking them, but I realized that I should have kept on taking them...I still have the tablets.” (OP2, p.2)

They report that previously they had seen the medication as controlling them, whereas they now see the medication as a way of controlling the depression. This seems to help remove the stigma of taking antidepressants and help them come to terms with their depression.

Changes in perspectives for these reasons do not seem to be encountered by those who are Unable to Articulate their depression, possibly because they are more accepting of their depression and resigned to management decisions. OP6 who attributes his depression to bereavement, seems to have shifted from being Unable to Articulate his depression when at crisis point to being in the Striving to Understand group 18 months later. He describes struggling to verbalize his feelings at the worst point of his depression and in hindsight reports feeling it had been beneficial that his doctor had intervened and made decisions for him when he needed it.

“I couldn’t talk about her [his wife], and Dr [name] put me under....a psychiatrist and I’ve seen him monthly since then and he has been a big

help to me; and then he put me on to a psychologist who you talk to more...I am on a three month visit now...and I never think of suicide or anything like that. Easier now.” (OP6, p.2)

Others in the Striving to Understand group report the process of coming out of depression to bring about a shift in their stage of understanding. For example OP16 describes beginning to want to talk about his depression and understand more about his experiences after he had been on antidepressants which had worked for him. Like OP6 he had previously been at the Unable to Articulate stage and later after successful treatment had shifted to being at the Striving to Understand stage.

It therefore seems that people Striving to Understand their depression appear to be the most likely to undergo changes in their stage of understanding their depression, or to have recently experienced changes. They tend to report these changes starting as a result of reaching their limits in some way, such as feeling unable to hide it from others any longer. They are usually beginning a journey of talking to other people about depression, coming to terms with having it and working out what this meant to them. Their reports of new experiences of sharing their stories of depression suggest that they are making sense of their own experiences and forming new constructions of depression. This indicates that those who are Striving to Understand their depression may be more open to influences from GPs than other groups about what depression is and their choices in how it is managed.

Key messages of older people’s findings

These findings suggest that older people report telling their stories of depression in different ways. Different components of their stories are evident in the interview data, and derive from open codes identified in preliminary stages of analysis. The components of older people’s stories map out different types of information about depression that older people report sharing with other people.

Comparison of interview data across the sample reveals that older people report telling and holding back on different components of their stories. Further exploration of why this might be using interview and contextual data has led to the identification of different positions taken by older people in the data. This indicates that the different ways older people report telling their stories can determine their stage of understanding and accepting depression. Explanations for these different positions have been developed by IG and form the basis of the older people's typology.

The different stages of understanding and accepting depression are presented in the older people's typology. The different groups that form the typology are based on relationships established between the open codes during analysis and stories developed around these, which form axial codes that are used to describe the groupings. Groups in the typology are shaped by the way older people talk about depression, the way they tell their stories, the information they give and do not give in comparison to each other and what they say about their experiences of GP consultations for depression.

An important element of the findings is that the boundaries between groupings is "porous" and "flexible" (Clarke, 2005, p.111), which means that older people's stages of understanding are not static, and they may change between stages depending on their reported situation or other contextual factors. The typology is therefore presented as a continuum, and this allows for recognition that some people do not move and others move in different situations.

The analysis process of the older people's findings points towards the need to explore what influences the way older people report telling their stories, and how far these influences are likely to guide the way their depression is managed. This is therefore explored in Chapter 6. Chapter 6 is the third findings chapter that puts forward a theoretical proposition derived from IG's interpretation of the data that is presented in the older people's and GPs findings (Chapters 4 and 5).

Chapter 5: GPs' stories of managing older people with depression

Introduction

This chapter presents the findings from interviews carried out with General Practitioners (GPs). It focuses on their stories of managing older people with depression and their different styles of working. This is to reveal a different side to older people's stories of having depression and to give an insight into what happens in consultations from the perspectives of GPs.

Data from the GPs' interviews are presented in two sections. The first section sets out skills GPs report using when managing depression in older people, those they describe using at different times and some of the challenges they encounter. The skills they report include starting a dialogue about depression, recognizing depression, changing ways of thinking, developing the doctor-patient relationship, sharing experiences, seeking advice from colleagues and referring older patients to mental health services. These skills derive from open codes identified in analysis of GPs' stories of managing depression in older people, and present a descriptive level of analysis of the data. The different skills reported by GPs are described and supported with relevant quotes from interview transcripts and contextual data consisting of IG's observations and reflections recorded in memos.

The second section of this chapter presents a typology of the different styles of working that GPs report when managing older people with depression. This typology is based on axial categories identified during data analysis. Firstly there is an explanation of how ideas from the interview data guided the development of typologies, showing how analysis progressed from a descriptive to an interpretive level. The typology suggests that GPs take different positions on a continuum of styles of working in managing older people with depression, which is based on particular combinations of skills they use that characterize each style. What happens when they move between styles of working is also considered. The chapter ends with a summary of the key messages put forward in these findings.

The sample of GPs

The sample of GPs consists of 14 GPs who were interviewed across five PCTs in the Tyne and Wear area: Sunderland, Gateshead, Newcastle, North and South Tyneside and Northumberland. The sample of GPs interviewed includes those in their 30s, 40s and 50s, and there are six male and eight female GPs. They work in a variety of practices including those in deprived inner city, semi-rural deprived, rural and affluent rural areas. The size of practices they work in varies, where the smallest practices consist of two GPs and the largest practice consists of ten GPs. All GPs work in primary care practices and report varying levels of interest in mental health. Details of participants are included in Table 4 (p.161). Following this an account of how the interview data influenced the development of a theoretical sample is provided.

Table 4: GP participants and characteristics

<u>Participant code</u>	<u>Age</u>	<u>Sex</u>	<u>Practice demographics</u>	<u>No. of GPs in practice</u>	<u>Expressed level interest in mental health</u>
GP1	40s	Male	Semi rural, deprived	10 GPs	Low interest
GP2	40s	Female	Semi-rural, deprived	6 GPs	Strong interest
GP3	50s	Male	Rural, affluent	8 GPs	Strong interest
GP4	Early 40s	Male	Rural	4 GPs	Low interest
GP5	Early 30s	Female	Inner city, deprived	6 GPs	Moderate interest
GP6	40s	Male	Semi-rural, deprived	5 GPs	Low interest
GP7	50s	Male	Rural, affluent	2 GPs	Strong interest
GP8	30s	Female	Semi rural, deprived	3 GPs	Strong interest
GP9	50s	Female	Inner city, deprived	2 GPs	Moderate interest
GP10	50s	Female	Inner city, deprived	6 GPs	Low interest
GP11	Late 30s	Female	Inner city deprived	6 GPs	Strong interest
GP12	Early 50s	Female	Inner city deprived	6 GPs	Low interest
GP13	Early 30s	Female	Inner city deprived	9 GPs	Low interest
GP14	Early 30s	Male	Inner city deprived	6 GPs	Strong interest

The development of the theoretical sample of GPs

First interviews were carried out with GP1-5 using an initial topic guide (see Appendix, p. 356). These interviews explored: views of working with older people who have depression, what depression is and ways of tackling it, decisions they make in managing older people with depression, talking about depression with older people, opportunities and barriers to managing older people with depression and ideas for what could change in future. These interviews were then analyzed to identify important concepts brought up by participants, and ideas that needed to be explored with further participants. A list of open codes and possible axial codes were identified (see Appendix, p. 357), and the topic guide was modified according to ideas that needed further exploration. Decisions about the next stage of sampling were also made with this in mind.

Participants GP1-5 report varying levels of interest in mental health and it quickly became apparent to IG that it may be a strong influence over the way they view managing depression in older people and the ways they work. For example it seemed to IG that the ways GPs report approaching depression in older people was related to their level of interest in mental health, where those who appear confident in their abilities and skills in managing it are mainly those with a strong interest in mental health, and those who have a moderate or low level of interest seem less confident in their skills in managing it or report referring onto specialists. IG noted that GPs reporting a low or moderate level of interest in mental health also tend to describe the challenges they face in managing depression and constraints over them which they are unable to control. In contrast those reporting a high level of interest tend to describe approaches that work well for them and more positive aspects of managing older people with depression. IG felt these stories seem to centre on successful ways of talking to older people about depression. It seemed necessary to explore these ideas further with more GPs who report low, moderate and high levels of interest in mental health, particularly reasons for their different attitudes to depression, differences in ways they report talking with patients about depression and approaches that work well for them all.

Participants GP1-5 are from practices employing higher numbers of GPs. It seemed to IG that the different ways they describe working could be related to the number of GPs working at the practices, since two GPs from larger practices

describe having a particular role in managing depression in older people which was recognised by their practice. At this stage it was not clear to IG whether this was because of their interest in mental health (they both reported a high level of interest) or whether this related to the size of the practice. IG also felt it was important to explore whether constraints and challenges reported by other GPs were related to the number of GPs working at practices, since those who were more positive gave the impression of being well supported by their practice. Therefore size of practices seemed important in order to inform the development of ideas about how GPs worked. Ideas that IG felt needed further exploration included whether GPs could be flexible in their use of skills in managing older people with depression, and how the skills and interests of other GPs working in the practice influence the way they manage it and their experiences of managing it. IG included these ideas in the topic guide for the next stage of interviewing.

GP6-10 were mostly from smaller practices which were located in areas of varied levels of deprivation. Their reported level of interest in mental health was also varied. New topics of enquiry for the second stage of interviews included: identifying depression, talking to older people with depression, how GPs make decisions about management of older people with depression, the skills they use, GPs' preferences and unmet needs, challenges and concerns, views on different types of older depressed patient, relationships with different types of patient, and practice or external influences over their approach to depression. In addition some of the earlier topics discussed in interviews GP1-5 were included or came up without probing.

During the analysis of interviews GP6-10 IG felt that there were strong ideas about skills different GPs report using in managing older people with depression. In their interviews they report certain influences over them which appear to guide which skills they use, and they describe using different skills at different times depending on various factors to do with their situation and the patient. However GP2, GP3 and GP7, who all report a high level of interest in mental health and being well-established in their practices, do not describe changing the skills they find work well for them. Reasons for this were not clear to IG at this stage and so she felt they needed to be explored in further interviews. It did not seem to be related to the level of deprivation of the area, the size of their practice, their reported

experience, the length of time they report practicing as GPs or whether they are male or female. However it did seem that their practices made allowances for them to work in a certain way, e.g. by allowing them to take more time to see patients. It seemed that more GPs with a reported high interest in mental health needed to be interviewed to explore other factors that may have influenced this way of working.

IG felt that ideas emerging from interviews GP9 and GP10 who work in inner city deprived areas also needed exploration along with other GPs. Strong ideas were being developed about GPs who use different skills and why they change their skills in different situations. But there were some ideas emerging that IG felt did not fit with the main groups of GPs being developed and reasons for this needed to be explored. Both GP9 and GP10 give a sense of being disillusioned about managing older people with depression and describe feeling unable to help; however both are seemingly confident in adapting their skills to provide patients with the help they need such as being able to empathize with them. After examining the data further this was not found by IG to be related to the size of practice they work in or their level of interest in mental health, but it was unclear if this was related to sex or other factors, so exploring these ideas with other GPs working in inner city deprived areas seemed important. This guided IG's decision to seek more GPs working in inner city areas to ascertain whether GPs adapt their skills in particular types of practices such as those working in inner city deprived practices, whether it was female GPs who did this more, or whether adapting was related to something else.

Participants GP11-GP14 all worked in deprived inner city areas in larger practices. Two reported a high level of interest in mental health and three a low level of interest. New topics of enquiry included: influence of working situation, influences over skills used to manage depression, when skills are adapted and reasons for this, influences over decisions to refer older patients with depression, decisions to seek out depression in older patients, changing skills with different patients and reasons for this, external influences over managing older people with depression e.g. services to refer patients to, influence of training. Some earlier topics were still included or came up in interviews without probing. Ideas explored to saturation were: attitudes and views of depression in later life, interest in mental health,

approach to depression, skills used in its management, challenges experienced, decisions faced managing older people with depression and influences over them, relationships with older people with depression and talking about depression with older people.

During later stages of analysis differences in the ways GPs who report using particular combinations of skills were grouped together and relationships between them were established. Differences between groups were also sought, and then differences within the groupings were explored to provide more depth and to challenge the explanations that had been developed. These lines of enquiry led to the identification of a number of different skills the groups of GPs report in managing older people with depression (presented in the next section, p.166 onwards) which contributed to the development of the GP typology (p.182).

There were certain factors that were considered by IG to be possible influences over the developing theory but were discounted during analysis as they were either not mentioned by GPs or not considered to be important by GPs when prompted. Ethnicity of GPs was considered as a potential influence over the development of theory. GP5 reports being Bangladeshi in her interview, however when prompted does not report it to be an influence over the way she perceives or manages depression in older people. Her views of managing depression seem to fit with those of other GPs who are not of ethnic origin. Ethnicity of GPs was therefore not explored further.

The GPs' position within the practice, e.g. whether they are employed as a Principle, salaried or locum GP, was recognised as a possible influence over developing ideas. However this is not raised by any GPs in their interviews as influential over the way they manage older people with depression, and because of this it was not a line of enquiry that was explored.

The patient list size of practices was also considered as a possible influence over the developing ideas in interviews GP1-GP14. However this is not mentioned by any GPs as a factor that influences the way they perceive or manage depression in older people. The number of GPs in the practice was mentioned by some GPs as influential over the way they manage depression in later life, for example GPs

from one larger practice report consulting their colleagues for advice and their reports suggest they are less isolated in the way they work than other GPs in the sample. This idea was explored further with other GPs from the larger practice as well as GPs from a smaller practice and it seemed that it was in fact the attitude of GPs at the larger practice about depression in older people rather than the size of the practice that explained this. The attitude to depression of GPs from the larger practice appears positive and these GPs report referring patients to each other according to their strengths and weaknesses in managing depression. In this way they work as a team more and GPs give an impression of being more confident in their style of managing depression.

Skills in managing older people with depression

In telling their stories of managing older people with depression GPs describe the skills they find to be successful and what works for them. This includes ways of recognising depression, starting a dialogue, changing patients' ways of thinking about depression, developing the doctor-patient relationship, sharing life experiences including those of mental ill health, seeking advice from colleagues and knowing when to refer older people on. However lack of time, distinguishing between depression and other problems of old age and housebound patients are factors GPs say they find challenging to its successful management.

Recognizing depression

GPs report using diagnostic tools to identify depression in older people particularly helpful in a number of situations. These include when they are pressured for time and need to determine a diagnosis of depression quickly, when there is uncertainty over symptoms and when they are not able to gather enough information from the older person.

“Blokes are disadvantaged because they don't show their feelings, nor do they come to the doctor ...so this idea of asking [screening questions] about depression annually is part of the contract but it's actually quite a good idea” (GP3, p11)

The diagnostic tools GPs report using are the NICE (2004, 2009b) recommended screening questions (for those at high risk of depression or those with chronic illness) and the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009), a

questionnaire to assess severity of depression, both of which are demanded by QOF.

Some GPs report their preference for using their clinical judgement as oppose to the screening questions (NICE, 2004) and PHQ9 as a means of identifying and assessing depression. Instead, these GPs tend to report finding it most useful to help patients come to terms with the idea of having depression as a form of evidence to “prove” it to them.

“There are a few patients that might say perhaps it [PHQ9] kind of legitimizes an illness that they might not otherwise have felt was acceptable” (GP9, p.5)

These GPs report asking patients these questions to “tick boxes” if their practice requires them to do so and may be GPs who report a greater interest in mental health.

Situational memo – first stages of analysis

GPs in the sample who seem to find diagnostic tools most helpful in their overall experiences of managing depression in older people tend to also report having a low or medium level of interest in mental health.

Other GPs prefer to rely on their clinical judgement to identify depression and use the assessment tools as back up in certain situations for example when they are short of time. These GPs feel that some signs of depression cannot be traced by the recommended questionnaires, and instead report looking for physical signs, including the patient complaining of long term pain or lack of sleep, as well as emotional or non verbal signs including tone of voice, the atmosphere in the room, facial expressions and body language.

“It's [PHQ9] probably not very informative to me because I ask all those questions anyway so it doesn't help me much... but you know it is never ever going to beat clinical judgment. It has some clinical use but all it is a tool to act to” (GP8, p.18)

These GPs more often describe responding to older people's stories of depression by listening to their explanations about what has happened to them and then reading between the lines to assess them using medical criteria.

Many GPs' reports suggest that they feel knowing the patient well is beneficial as they can see any changes brought about by depression without having to rely on patients' answers to screening questionnaires. This helps them use their clinical judgement to detect it. However they say there can be positives and negatives to knowing patients well in terms of identifying depression in later life: while GP9 prefers using clinical judgement she also indicates that being familiar with patients can allow small changes to be less obvious.

"You might recognize that someone is different to normal, but on the other hand your familiarity can sometimes blind you to things... there is always the risk if you've known someone for a long time you've got preconceived ideas, that you might miss something as well so it can be a double edge thing." (GP9, p.3)

Missing signs of depression because of familiarity with patients is mentioned by GPs in the sample as the only negative aspect of building a long term relationship with older patients.

Other GPs indicate they prefer a less structured approach and that they have more negative views of using screening methods, including the two screening questions recommended by QOF, developed by Whooley and colleagues (Whooley, et al., 1997). These two questions are used to identify the possibility of depression in any patients thought to be in high risk groups such as those with multiple or chronic health problems. GP14 reports being more inclined to use his clinical judgement and describes the QOF two screening questions (Whooley, et al., 1997) as *"ridiculously contrived"* (GP14, p.3) and suggests that this in itself may prevent patients opening up. Others who seem less strongly opposed to screening methods suggest that the questionnaire could be inaccurate and even unhelpful in recognising depression because of the risk of patients assessing themselves inaccurately. GP4 suggests that patients may give an inaccurate reflection of how severe their depression is or perceive their problems as less severe than they actually are and fill out the PHQ9 accordingly,

"...maybe someone who has filled it out as only being mildly depressed but actually when talking to them you get a sense that actually this is a much deeper problem" (GP4, p.12)

GP13 reports that despite using screening methods for chronic illness routinely, they had not picked up any depression in later life for her. She suggests that older people tend to cope with it better than younger people or not reveal it to GPs.

“Either older people just have better coping mechanisms and don’t have as much depression, or its much more poorly detected because they don’t self present ...I can’t think of a single incidence where I’ve been referred somebody where it’s been picked up” (GP13, p.2)

GPs’ stories of how they recognize depression in older people indicate that it usually involves seeking depression in older people rather than older people presenting it to them. Reading non verbal cues is another skill GPs describe using to establish older people’s depression. These cues are reported by some GPs to be equally as important as what is verbalized, particularly when looking for depression in older people. They refer to things such as body language, silences, hesitations, expressions and emotions as non verbal cues. Finding these cues for GPs appears to be about using their intuition and knowing when to pick things up from older people who do not reveal their full story.

“There is a human connection that I think we don’t understand... I think it probably is about reading all the clues and things.” (GP8, p.7)

As opposed to taking what is said at face value, GPs who seek out non-verbal cues tend to report a strong interest in mental health and that they automatically look for it. They also talk more often about creating opportunities for uncovering depression by finding alternative routes into talking about it with patients.

“...hopefully just looking for clues in body language and things or, just what people say or what they don’t say, or how they look.” (GP9, p.8)

There is a contrast between these GPs and those who do not report looking for such opportunities as often. GPs who tend to take what patients say at face value usually report a lower interest in mental health, and although they describe exploring issues when older people bring up depression seem more focused on dealing with physical problems.

From the data above, it appears that the range of methods GPs describe to recognize depression depend on the GPs’ preferences and circumstances at the time. When depression has been identified the next stage in managing it for GPs can be starting a dialogue with patients about their depression.

Starting a dialogue about depression

Starting a dialogue about depression is a skill that GPs with an interest in mental health seem to place importance on. It involves noticing signs that the patient wants to talk about depression or finding indirect means of identifying depression rather than directly questioning the patient.

“He was talking a bit about the grandchild...but I...I kind of thought when he was coming that he kind of wanted to talk about his loss really.” (GP2, p.5)

They report using different tactics to do this ranging from picking up on body language signals to using intuition or having a mutual understanding of their patients' individual cues for talking about depression. Other GPs report that identifying physical symptoms can be way of bringing depression up with older people, and likewise that older people may open a dialogue up about depression by speaking to them about physical symptoms.

“...you have to know older people better. To get it right. Which I hadn't necessarily realized. Coz I think you have to get to know them, and about them...to raise it” (GP2, p.4)

“[older] people will present with physical symptoms, and may not have realized that actually they're depressed. And, others might talk in terms of stress and life events, some talk about depression” (GP9, p.2)

“...just confronting them with it, I think you're depressed or do you think you could be depressed erm I think it does, it puts a little bit of a barrier in I think, you've got to be very careful about how you approach it ... it's perceived as a weakness on their part” (GP6, p.3)

The common ground between GPs who place importance on opening a dialogue is that they report actively seeking out depression in older people and wanting to explore it with them. GPs in the sample that report this sometimes describe their approach as holistic and believe mental and physical health problems are inseparable, and that talking in itself is a form of treatment.

When a dialogue about depression between GPs and patients has been established the next stage can be negotiating how to move forward with a management plan.

Changing ways of thinking

Changing an older person's way of thinking about depression is reported by GPs to be a helpful tool for them in managing it. They acknowledge that influences over patients' views of depression may have developed from stigmatized attitudes surrounding them, and report sometimes finding it useful to challenge any ingrained views as a way of opening up conversation and exploring a patients' understanding and acceptance of their own condition. This includes changing their views of taking medication, their views about depression itself, for example whether it is a legitimate illness, and changing other beliefs about their health for example taking responsibility for their mental health.

"I do think the greatest impacts are from changing thinking processes, from lifestyle changes and trying to challenge cultural attitudes...it's amazing how much you can change someone's thinking by just dropping in the right level of challenge." (GP8, p.5)

GP3 and GP8 report changing patients' perspectives to be a main tool in tackling depression in older people. These GPs also report a special interest in mental health being experienced in dealing with depression in later life. They also both seem to approach general practice with the view that talking with patients about their life and situations is just as important as tackling the health problem itself. Changing patients' attitudes to their health and illnesses appears to fit with this ethos.

"Your best chance of recovery is actually to do with change and situation." (GP4, p.3)

These GPs also report seeing the wider situation of the patient as important but would refer them to colleagues or secondary care if they felt they could not influence this kind of change themselves.

At other times GPs say that it is more appropriate for them to accept a patient's denial of depression or ingrained attitudes and manage their depression without referring to it as such. As GP7 states *"that's how some people cope, by being in denial"* and with this understanding GPs may either tackle it with medication or by simply talking to them on a regular basis, without the need for changing their views.

“I would say that even seeing someone and talking a bit in the GP surgery is a treatment in a sense although they might not think of it like that, they might just think it's a chat.” (GP9, p.3)

This suggests GPs feel it is important to recognize differences in what older people want from GPs, or that they may want different things at different times. This ability to judge what to do and when to do it appears to be an important factor for GPs in managing older people with depression.

GPs report that a challenging aspect of changing older people's views is their reluctance to try talking therapies such as counselling or Cognitive Behavioural Therapy (CBT). They give the reason that older people can find it difficult to open up about depression or because of an attitude that comes with age.

“I think there is a generational thing about talking therapies...they don't feel like it's a separate thing from just having a chat.” (GP10, p.1)

GPs say this is the case especially with older people who find it helpful talking to their own GP and do not want to open up with anyone new.

“If they feel like it's a helpful relationship [with the GP] they then don't want to necessarily go on and form a second therapeutic relationship.” (GP11, p.2)

This indicates that GPs may have to persuade older people to try counselling or CBT, but can spend too much time negotiating this, leaving them with not enough time to refer. This highlights a lack of time as an additional influence over what happens in consultations.

Developing the doctor-patient relationship

GPs describe components of the doctor patient relationship that they find to be important in the management of older people with depression and the type of relationship they feel works well. Many GPs in the sample share similar views on this.

Most GPs in the sample report having a long term relationship with older people to be helpful when managing their depression. They suggest it is important in building up trust and confidence if older people are to disclose their depression and be able to talk about it in consultations.

“If it's a patient you know, and you've got their confidence you can probably ask them how are you feeling, rather than start a little bit more like are you sleeping okay.” (GP6, p.1)

“I think what [a long term relationship] often means is a mutual respect and interest erm, and a personal knowledge of each other to a degree.” (GP8, p.13)

Some GPs also describe sharing life experiences with patients, and find this to be a way of building trust. They report it to help put patients at ease and give a higher likelihood of them disclosing depression. GP7 reports that a long term relationship can help with getting to know a patients' family situation and position in the community which is also important in piecing together a fuller picture of what is going on for them outside the consultation.

“It does give you a good perspective if you've been here for a while and you do have a relative stable population, a better perception of what's actually going on in the community with certain individuals and how they fit within the family situation.” (GP7, p.3)

Some GPs consider great value in managing older people with depression to come from a therapeutic alliance between themselves and the patient. This is when they use the therapeutic value of consultations and the supportive relationship which is built with their patients in place of using drugs or formal psychological therapies. This can include when patients have regular appointments with them in order to maintain their mental health in preference to taking medication.

“I would say that even seeing someone and talking a bit in the GP surgery is a treatment...although they might not think of it like that, they might just think it's a chat.” (GP9, p.3)

In the same way GP8 describes consultations as parts of a continual dialogue where she finds her patients prefer to talk rather than using other treatments for depression.

Sharing experiences

GPs who have experienced mental illness themselves can find that sharing these experiences with older patients helps them open up. This may be because they

have to demonstrate their understanding of what it is like. GP8 and GP11 both disclose having personal experience of mental health problems in their interviews. GP8 describes herself as an expert in mental health but also feeling depressed at the time of interview. Her views are that sharing this with patients who also have depression may be helpful for them in feeling they are not alone:

“I’m probably experiencing it [depression] now you know, and it’s horrible you know, it’s really awful and I just kind of, I suppose what I aim to do, is walk side by side with someone who is going through that.” (GP8, p.16)

GP11 also reveals that she had experienced mental health issues and says it influences her as it helps her pick up on mental health problems in patients. She also says that because of her own experiences she is more comfortable talking about depression with patients than other colleagues.

Other GPs (who do not reveal whether they have experienced depression) report sharing everyday experiences with patients as a way of helping them form a trusting relationship. They describe sharing stories about family, common experiences of living in a similar area, problematic situations they have both experienced and other everyday exchanges of information.

“You have to relate to them as individuals and as other human beings, and find some common ground and something you can be similar on.” (GP14, p.6)

Those who place a lot of emphasis on talking about such things are usually able to give more time in consultations to patients with depression, because of either having an arrangement with the practice for taking more time with such patients, or being able to adapt to different types of patients within the constraints of the job.

All GPs in the sample, regardless of the skills and strategies they describe using in managing older people with depression, appear to have their own boundaries for when to refer patients on to other primary care mental health services or secondary care mental health services. GPs’ perspectives around this are discussed next.

Referring older patients to mental health services

Factors relating to GPs’ different situations appear to influence the way they manage depression in older people. Those who report being able to easily access

specialist services seem to use them more regularly than other GPs in the sample, and their stories of managing it are more positive. These GPs all report working in the same locality.

Situational data – from IGs reflections noted during later stages of analysis

GPs who report being able to easily access specialist services seem confident their patients will receive expert help for their depression that they cannot provide. There is a notable difference between these GPs' in the way they talk about managing depression in older people – they seem freer to refer patients who need more time or expertise than they can offer, giving the impression that they are happier in general about managing older people with depression. This atmosphere of confidence contrasted to GPs who work in other localities where they report having too many patients for the available services and some of whom seem overwhelmed.

“If I am uncertain I often ask the advice of a specialist....where I work we have a really good service from an old age psychiatrist.” (GP14, p.3)

Although these GPs still experience the dilemmas and challenges that others mention, they say they find dealing with it easier because the choice to refer is there for them. GP10 says he finds that psycho geriatricians have more time to get the treatment right for older people and can prescribe a wider range of medications so GPs at her practice tend to refer older people earlier than younger people.

“We would refer on earlier [than with younger people] because we have got fantastic psycho geriatricians who give a really good service... also they are able to use this next tranche of antidepressants so we do use them, and we use the psychiatrists for younger people.” (GP10, p.3)

Having this back up may mean that these GPs' reports of managing depression in older people are more positive as they do not give the same sense of being powerless to help as other GPs convey. It also suggests that if they do not particularly like managing older people with depression they have the choice to refer and concentrate on other patients.

“You refer to this body, they seem to get seen, they seem to get sorted out and get medication to control behavioural issues, yes I think [mental health] services are good for elderly people.” (GP13, p.6)

In telling their stories of managing older people with depression and the skills they use, GPs also reveal some of the issues and challenges they face. These are discussed next.

Managing older patients with depression

GPs in the sample report common challenges in managing older people with depression. These include a lack of time and difficulties differentiating between depression in later life and other problems that come with old age. They also describe different ways they cope with challenges, such as achieving a balance between their personal and professional “selves” and seeking advice from colleagues. However situational data suggests that being interviewed by IG in their capacity as GPs may have affected what they disclose in interviews about challenges they face.

Situational data – from IGs observations of participants noted during interviews and from reflections noted after interviews

Many GPs appear uncomfortable when probed about what they find challenging. In interviews they tend to give non-specific answers and seem reluctant to reveal areas they struggled with. A possible reason for this is because they are being interviewed in their capacity as GPs, which may require them to find solutions and reassure people rather than focus on difficulties and challenges.

Challenges

Most GPs in the sample say that having enough time is important for them to be able to manage older people with depression effectively. However they also feel that having enough time is a great challenge and unattainable, commonly complaining of not having enough time to address the many complex issues surrounding depression in later life.

“In 10 minutes there is a lack of time as to what you can do with somebody ...sometimes you don’t get to the nitty gritty.” (GP5, p.4)

Many GPs reveal this in interviews whilst talking about other things, indicating that having too little time can affect all aspects of their work. GP13 reports finding this particularly problematic with older people who are housebound.

In contrast, some GPs in the sample say they are able to take the time they need in consultations with older patients. These GPs describe either having established a role within their practice to see particular types of patient, or their attitude is such that they refuse to see time pressures as a problematic. GP3 is such an example, and describes being known in the community and practice as the GP who sees older people including those with depression. He describes establishing this role within his practice team during the 20 years he had been there, and because of this understanding he is able to take longer for consultations if necessary and often visits patients at home. Likewise GP8 reports being able to specialize in mental health problems since she has come to an arrangement with her practice whereby she can take as long she needs for consultations.

“I’ve been quite lucky, I have only worked in two practices and they have allowed me my ethos.” (GP8, p.11)

GP14 also stands out because of his refusal to allow time constraints to be an issue, even though he does not describe making arrangements with his practice to take longer consultation times with certain patients. He describes seeing patients as many times as they need and having a good team of other GPs around him to compare notes to and discuss cases with. Unlike the other GPs who report being able to take enough time, he is a trainee GP and reports having additional support because of this. However other GPs working in the same practice report a similar attitude to the pressures of time in managing older people with depression, which indicates that the supportive team of GPs at the practice may also be influential over what happens in consultations.

Situational data – IGs reflections noted after interviews during later stages of analysis

GPs in the sample who feel less pressured for time were unusual in the sample but seemed more confident and positive about managing people with depression in later life. Possibly the additional support from colleagues influences this.

Many GPs report that they find differentiating between problems of later life and depression challenging. They say is usually due to the complex nature of depression in later life alongside other multiple situational and health problems people can encounter with old age. Problems which GPs report as particularly

challenging include distinguishing between depression and dementia, or between depression and someone with a depressive personality, or telling depression apart from a state of loneliness commonly experienced in old age.

“I think in the end I am deciding [the patient] isn’t depressed it’s just her personality as it were erm, to be angry I think, that is probably a part of her personality.” (GP4, p.9)

“He wasn’t depressed then he just said he had really had enough it was a bit boring being alive.... there is always this thing what do you call depression and are you right or not you just make your own judgement.” (GP9, p.19)

GPs can find it helpful if they have known patients for a longer period and know what they are normally like.

It [depression] is about...clarifying the difference between normal up and down sadness and this awful sort of contractible immoveable being that hangs around you (GP8, p.17)

When GPs are pushed for time and/or do not have a great interest in dealing with depression they tend to use the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009) to save time and to help them determine depression.

Balancing personal and professional “selves”

Some GPs in the sample report experiencing tensions between their internal perspectives and how they come across professionally. These GPs describe a separation between their professional and personal “selves” and can be torn in different directions between what their reaction as GPs “should” be and what they truly believe and feel.

“ I find myself kind of consciously trying to display the right kind of feelings of empathy and understanding but actually having little concept of what it must be like for this old person who has lost a partner.” (GP4, p.13)

“Sometimes it is difficult to be dispassionate about things and purely professional... a think it’s a strength of the job and its potential weakness for me as an individual, just got to try and hold that in my head and have 2 thoughts at the same time.” (GP7, p.9)

Their comments reveal that managing older people with depression can require an amount of personal investment for GPs even if they cannot communicate this because of being seen in their professional capacity.

Situational data – from IGs observations made during interviews

In interviews GPs do not often reveal their personal perspectives in interviews possibly because they do not see this side to their story as appropriate or necessary to talk about when being interviewed in their professional capacity. There also appear to be differences between GPs who are able to make this personal investment and those that are not.

Despite some GPs' reports of feeling challenged by finding the right balance of what to reveal and hold back on, they also recognize that their life experience can enhance their professional role when dealing with depression in older people.

“The professional “you” develops, the personal “you” develops at the same time coz you’re getting older and you’re having your own life experiences which is always quite valuable.” (GP3, p.9)

Their stories of this show that for GPs finding the right balance of their professional and personal selves with different patients and situations is a skill in managing older people with depression as well as in the wider role of being a GP.

Seeking advice from colleagues

Seeking advice from colleagues is reported by GPs to be helpful in managing challenging cases of depression in later life and as a means of gaining confidence, thereby minimising the need to refer patients with less severe depression. Having this type of support from colleagues appears to be a point of difference between GPs in the sample influencing the way they manage older people with depression.

Situational data - from a memo of IG's reflections during and after interviews with GP6 and GPs11-14

Working situations of GPs may influence the way they manage depression in older people. GPs who can seek support from colleagues are notably confident talking about managing depression even if they have a medium or low level of interest in mental health. GPs 11-14 stood apart as they report their practices' ethos as a team approach to managing depression in older people, and can easily seek advice from each other in a common room. None of the other practices had a GP common room where GPs could talk to each other, and working in this situation seems to increase their confidence. It also seems to influence their approach to managing challenging cases of depression in later life, as GPs who may be inclined to refer to specialist care report seeking advice from colleagues instead and refer patients to them if appropriate.

GP6 who is older and reports working for a long time in general practice describes telephoning colleagues in secondary care for advice in addition to referring patients when necessary. He says he finds the support of mental health consultants in the area helpful in tackling problems more quickly than patients having to wait for delays in the referral system. He says it also a way of dealing with his frustration about patients having to wait for help when he referred them on.

"I've got round a lot of that [delay] by actually getting to know even if it's only on the phone a lot of the local consultants, and I find this a useful tool as a was saying before, not just really for passing it by them in terms of what do." (GP6, p.8)

GP6 also says he finds this way of getting advice useful if patients are resistant to the idea of travelling somewhere else, seeing somebody else about their depression or going to a psychiatric hospital. He describes fears that he believes his older patients to have about being referred to secondary care, which he feels may arise from the stigma surrounding mental health problems.

"However unfounded there may be serious worries that they are going to be sectioned or kept in hospital or have their liberties and what not taken away and I think you have to win that confidence to say look it's not like that, all

we are expecting you to do is just go along and discuss the problem with the specialist.” (GP6, p.9)

GP6 reports having been able to build up a network of colleagues that he says he feels able to ring for advice. He says his previous experience of working in a psychiatric hospital during his GP training and working in the area has helped him build these contacts up and that he has maintained longstanding relationships with them. While seeking advice from colleagues appears to be a way of coping with challenging situations, it also highlights how isolated GPs can be in managing older people with depression as well as difficulties brought about by the gap between primary and secondary care mental health services.

Seeking advice from colleagues within the practice also appears to be a way of GPs finding support with more challenging cases. GP14 describes his practice's approach which emphasizes working as a team with other GPs at the practice. Here, GPs support each other by giving advice and consulting with each other around difficult decisions, sometimes directing patients to others within the team if they feel another GP can meet the patients' needs better.

“If you work in a good team as well, and I think I've had the benefit of doing that, then if you're getting stuck with somebody and you're not quite sure what's going on or you feel that there's lots of problems...you can always ask one of your colleagues to see them and you can compare notes.”
(GP14, p.3)

This seems to provide an additional strategy of coping with the challenges of managing older people with depression as well as counteracting the feelings of isolation that GPs can experience when managing complex cases alone. Consequently although the GPs interviewed from this practice (GP11, GP12, GP13, GP14) report having different strengths and weaknesses, they are all positive about managing older people with depression and appear to believe they can help patients in some way. It seems that this is due to having support from colleagues within their practice. These stories about seeking advice from colleagues draw attention to the importance of getting support from colleagues with difficult cases of depression in later life. It is a way of acknowledging and drawing on colleagues' strengths when needed thereby maximising GPs' skills and resources which are immediately available to them.

It appears from the findings presented so far in this chapter that GPs use different skills in different combinations and have a range of attitudes and strategies when managing people with depression in later life. This indicates different working styles when managing older people with depression which are explored in the next section of this chapter.

Section 2: Typology of GPs

This section presents a typology of groups of GPs identified during the analysis process, and is derived from analysis of what GPs say. It is a theoretical construct rather than a model of how they operate because consultations have not been observed and suggestions are based upon GPs' reports of what they say and do. The typology derives from the process informed by Adele Clarke (2005) on the development of different positions taken within the data. The positional map shown in Figure 5 (p. 188) shows the how the open and axial codes identified during analysis of interview data relate to each other to form the GP typology where the different positions taken by GPs that they reported are set out.

As with the older people study, the GP typology derives from a small sample of GPs who were interviewed on single occasions. While there may be drawbacks to using interview data as a basis for the typology rather than observing consultations (as discussed in the strengths and limitations of the study), it may be later used to corroborate information obtained from an observational study. Advantages may be that GPs may not get many opportunities to be heard in a confidential situation where they can talk freely and uninterrupted about positive or negative aspects of their work. As with older people, the interview situation gives GPs an opportunity to talk to the researcher in the knowledge that the interview is a single occasion and they will not have to see the researcher again, and they may find this beneficial. It may also be an opportunity for them to explore their own ideas out loud, which they may not have had time to do in a professional situation and an opportunity to talk about an area of their work that they enjoy or that interests them.

The typology derives from the GP interview data and is intended as a basis for further exploration in an observational study where consultations between older people and GPs could be observed.

From interview data to the GP typology

This section explains the process of analysis and interpretation of the GP interview data that led to the development of the GP typology.

Different skills that GPs use to manage depression in older people and the challenges they face are evident in the interview data and have been presented earlier in this chapter. This information derives from open codes identified in preliminary stages of analysis around which narrative was developed to describe GPs' stories. An extract from this list of open codes is below, where main lines of enquiry are highlighted in bold.

Early analysis: open codes relating to GPs' reports of skills used in managing older people with depression.

<p>Management What it means Role of older person Making choices Tensions in management choices Flexibility of GP</p> <p>Skills Adapting approach to diff patients Intuition, role of (relate to professionalism?) Barriers to management Diagnosis Identification Negotiating</p> <p>Talking about depression Language Appropriateness Bringing it up Impact of talking Usefulness Time Skills used for patients in care homes</p>

A full list of these codes can be seen in the list of codes provided in the Appendix (p.357).

Open codes identified in the GPs' interview data were explored in relation to one another which led to the development of axial categories that form the typology. IG

identified differences between GPs in the skills they reported using in managing older people with depression, the challenges they report facing, things they say works well for them and ways they report talking about depression. IG also noted her observations of the way they talk about the topic area in their interviews. These were all factors that shaped characteristics of each group identified in the GP typology. In this way a pathway through the data was developed, whereby relationships between codes were established and explanatory narrative was developed. Extracts from the next contextual data boxes illustrate an example of a pathway through the data, where IG noted some observations where ideas were forming about GPs with different levels of reported interest in mental health and the different skills they use managing older people with depression. These observations coupled with interview data led to groups of GPs emerging which were later to form the different styles of working set out in the GP typology.

From reflective memo made following interviews GP1-GP5

GPs with an interest in mental health appear to adopt a more psycho social approach to consultations for depression in older people. They tend to emphasize the importance of looking at individuals and their life contexts, and report being more confident talking about depression and exploring patients' stories of depression. How do these GPs see their role in managing depression in older people compared with other GPs? What are the challenges these GPs face? Why do some GPs have a high level of interest in depression in later life and others not?

Memo following discussion with supervisors following analysis of interviews GP6-10.

Explore whether some GPs have an agenda for consultations for depression in later life. If so, what is it and how do their agendas differ? Is it different for GPs reporting different levels of interest in mental health? This is to try and find out if GPs adopt particular combinations of skills, and if so what do they do. It is also to try and establish which GPs are able to adapt more easily than others to the needs of different patients.

From reflective memo following interviews GP11- 14

One GP with a strong interest in mental health purposefully gives more time for complex cases of late life depression; he reports this working well for him. How do other GPs in the practice cope with time pressures? Why is he able to do this – does he have strategies of coping with taking extra time with certain patients? Or are there certain allowances made by the practice?

Positional maps were also drawn up to map out the relationships established between lines of enquiry in the data. In doing these, IG noted differences between GPs in their attitudes towards managing older people with depression, what appears to influence the skills they report using in consultations and differences between what they say and do in response to different older people. The positional map shown in Figure 5 (p.188) sets out relationships IG identified between the open and axial codes around which narrative was developed to form categories of the typology. The main relationships identified showed groupings of GPs based around the skills they report using, their attitudes towards and perceptions of managing depression in older people, their work situations and their level of interest in mental health. Observational comments are included in the map which also illustrate how they talk about depression in their interviews. All of this data was used to develop each group included in the typology.

Many of the open codes in the GPs' interview data occur repeatedly, sometimes frequently, and some occur infrequently or once. Examples of those occurring infrequently or once include: intuition (GP8), reluctance seeking depression (GP13), modify approach (GP14). As with the older people's data, these codes occur infrequently but were important lines of enquiry that revealed differences between participants, complexities in the data and varying positions taken by GPs. They helped inform characteristics of groups in the GP typology by providing lines of enquiry that were used to ask questions of the data and explore relationships between codes already identified and participants that stood out in the sample.

As with the older people's data, IG carried out further interrogation of the data after interviews had stopped. This was to develop the GP typology further and to explore differences found in the data. An example of this was to examine whether GPs respond in different ways to patients with different ways of presenting their

depression, and what influences the ways they respond. Their descriptions of their contextual situations e.g. practice ethos, the location of the practice, external constraints were compared with the way they report responding to patients with depression. This led to a further development of the styles of working set out in the GP typology.

This interrogation of data also led to IG discounting lines of enquiry at this stage, which happened when the questions asked of the data did not lead to any relationships being identified or any explanations for the data being formed. An example of this was that initially the private and public stories some GPs shared about managing depression appeared to relate to exchanges with patients in consultations. This was apparent in interviews GP3, GP4 and GP13 and a link was found between their reports of their private and public “selves” and the ways they viewed their role in managing depression. However in later analysis this was not found to have a bearing on the help they offered different older patients with depression, the skills they reported using, or the way they adapted their skills in different situations. It was also found that GPs did not tend to disclose enough information about their personal stories/views/experiences to develop a detailed enough story, despite there being strong data indicating clear tensions between GPs balancing private and public perspectives and their influences over the decisions made in managing depression. IG therefore discounted this line of enquiry when she explored it against other transcripts.

Contextual data indicating differences in GPs’ situations and possible influences over what they were saying in interviews was considered in relation to all of the interviews and therefore became a strong line of enquiry. Contextual data included in the analysis consisted of IG’s observations and reflections after interviews alongside situational maps and social worlds/arenas maps. This contextual data gave indications of how participants came across in interviews such as how they appeared to speak, IG’s comments about the way they talked in their interview about managing depression e.g. if it flowed or was hesitant, and IG’s observations about their story e.g. was it consistent/contradictory etc. At this stage patterns became visible between the ways GPs report telling their stories, their reports of ways they manage depression and how they respond to older people in different situations.

By drawing these categories together and developing textual “stories” around them to explain their relationships to each other, typologies were formed detailing characteristics of the different positions GPs can take in consultations for depression. Open codes which were previously identified within their interviews, which have been grouped together: the way they conceptualize depression, their work situations, the skills they report using to manage older people with depression, what works and the challenges they face. Figure 5 (p.188) shows the way open codes were grouped with axial codes in the centre of each group, which formed the basis of the GP typology. After Figure 5 there is narrative to explain the relationships between codes and the groupings formed.

Figure 5: Positional map for GPs showing open and axial codes selected for the GP typology

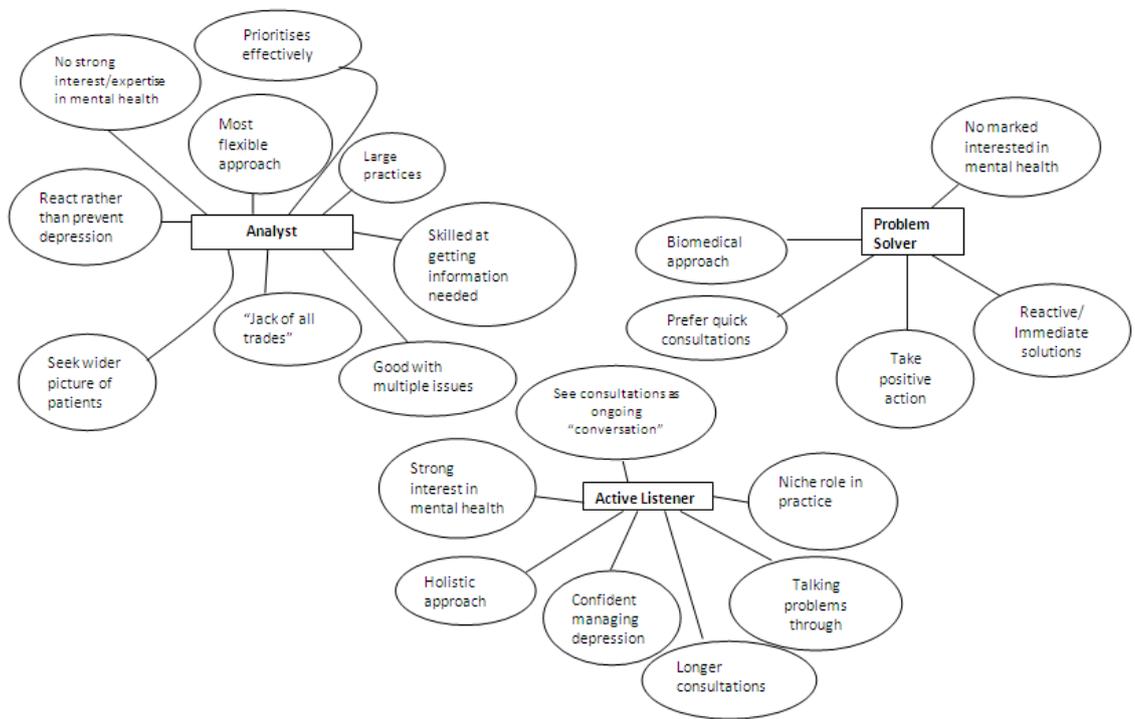


Figure 5 (p.188) illustrates how codes were grouped together during the development of the GP typology. It shows how ideas in analysis moved from describing the data (open codes) to interpreting it (axial codes). The oval boxes show the open codes identified in the GP interview data, which were selected and grouped together as relationships were found between them that explained the different skills GPs describe using to manage depression in their interviews. The square boxes show the axial codes, which are IG's interpretations of the groups of open codes. They are the basis for GP styles of working suggested in the GP typology, and describe the different positions GPs can take in consultations.

What stood out in the older people's data most prominently were the differences in the skills they report using in different situations. These factors seemed to influence how they report dealing with most aspects of managing older people with depression including how they move between working styles and provide different forms of help at different times. IG was able to build textual stories about this that related to many of the other categories identified. e.g. "holistic approach" and "talking problems through" became two linked categories that formed a characteristic of the Active Listener style of working.

Taking this pathway through the data led to the development of the GP typology and the suggestion that the way GPs report managing depression, particularly the skills they use and the challenges they face can indicate their style of working.

GP styles of working

The analysis process described above leads to the suggestion made in this typology that the different skills GPs describe using and the challenges they face indicates their different styles of working. They also report using different skills in different situations which indicates that they may adapt their skills and therefore move between styles of working. This highlights the changeable and fluid nature of their positions. Further explanation of way they move between stages and in which situations are given after the typology is presented (p. 204).

This typology sets out three styles of working, Active Listener, Analyst and Problem Solver styles. These groups are shaped by the skills GPs describe using to offer help to older people, what works well and the challenges they describe facing, the ways they talk with older people about depression and IG's

observations of the way they spoke about depression in interviews. Other contextual/situational factors GPs mention also shape the different styles of working, for example their reported work situation and life experiences.

Reports made by GPs in interviews suggest they can move between styles of working, despite many in the sample leaning towards one particular style. The styles of working are therefore presented as a continuum where at one end there are Active Listeners and at the other there are Problem Solver style GPs. GPs are also likely to change between working styles responding to different situations, patients or the point in time where they adapt their skills and move between positions on the continuum. GPs' different styles of working when managing older people with depression and factors characterizing them are presented below. Following this, examples of when GPs move between styles of working are discussed.

Active Listener

GPs with a predominantly Active Listener style include GP2, GP8, GP9, GP11 and GP14. Active Listener GPs typically establish long term and trusting relationships with their patients, have positive attitudes to mental health, value talking therapies and have an intuitive approach to consultations; this enables them to share personal experiences with patients.

These GPs see their role as listening and supporting older people when dealing with their depression rather than taking action immediately and working through problems relating to all areas of their lives by talking about them. Active listening is a central skill they use in dealing with depression in later life.

"It's about helping them make the link between their life situations and how that can be affecting their mental health...you have to understand the person and... the entire picture." (GP14, p.5)

Many describe themselves as being well known amongst their patients as providing a friendly ear when they need it, and often see consultations as an ongoing relationship rather than a single opportunity to bring about a change.

They describe having long term and trusting relationships with their older patients who have depression. They are interested in all aspects of their patients' lives and

often describe their approach as “holistic”. They see depression in older people as a long term commitment where separate consultations are a continuation of their relationship. They are able to establish a good rapport with patients and speak confidently about the trusting relationships they develop with their older patients with depression. A few in this group reported attracting patients with depression because of their style of working.

GPs in this group speak confidently, usually with a positive attitude, towards managing depression in older people and are optimistic about being able to help them. The positive attitude amongst this group may be because they are particularly interested in mental health and are dealing with it more frequently because they attract more patients. They also may not feel the pressures of time as much as other GPs if they are able to take longer consultations.

GPs that show strongest characteristics of this role type tend to purposefully focus on mental health issues and usually consider their patients’ mental health as part of maintaining their overall health. GP8 reports seeking mental ill health out before physical ill health and speaks of some of her patients having regular appointments to “maintain happiness” rather than manage depression. This highlights a less medicalized view of depression than other groups of GPs.

This group feel that talking is a particularly effective treatment for older people and some regard it as a kind of therapy they provide within the consultation rather than referring on.

“As long as he has permission to come in and off load every 2 or 3 weeks then actually that’s all he needs.” (GP4, p.7)

Others who feel that talking about depression is very important may also prescribe antidepressants alongside talking, however this depends on the GP and the patient. These GPs are not necessarily looking for quick solutions or hoping to provide definitive answers to patients’ problems in a single consultation.

Active Listener GPs place emphasis on listening and give the sense that they are more passive and neutral than GPs who adopt other styles of working. They place importance on talking together and sharing information, giving the impression they see consultations as a two way dialogue. Those who speak of sharing information

with their patients e.g. about life experiences feel this sometimes helps older people open up about their depression.

“Really all we do is exchange bits of stories or tales in the surgery. That’s a very non medical model sort of concept.” (GP9, p.13)

There were two GPs in the group who report their own experiences of mental health problems and say this had particularly helped them understand patients with depression, which was beneficial in managing patients’ depression.

“I personally have had experience of quite a lot of mental health stuff that I can pick up other bits that otherwise might get missed and sort of have a bit more understanding where they are coming from.” (GP11, p.7)

GP14 describes a particular case which illustrates how Active Listener style GPs typically respond to the stories older patients tell about their depression. He tells the story of an elderly man who had come to see him not knowing what was wrong. After a series of consultations where they talk through how he felt and what had happened to him recently, they had come to the decision together that he must be suffering from depression. GP14 says he felt that exploring the problem together had helped the patient come to terms with the diagnosis of depression and accepting treatment. Slowly the man had gained enough confidence to talk to his family and friends about his depression and had taken antidepressants which had been effective and helped his anxiety. He began to go out (where previously he was housebound) and his life dramatically changed for the better. This case shows the supportive role GP14 describes playing by seeing the patient regularly. Through talking about what had happened the patient’s confidence seemed to have increased and he had come to accept his diagnosis and treatment. GP14 says he had supported him by doing active listening and talking with him during the low points and had given him enough time to work through everything. GP14 reported finding this approach very rewarding as he was able to see the case through to its conclusion.

GP8 exemplifies the Active Listener style at one end of the continuum, describing her approach to managing people with depression in later life as “intuitive”. She appears completely dedicated to mental health and describes having an arrangement with her practice that she would mostly deal with patients who had

mental health problems. She says she believes that her style of working worked well for older people who normally wouldn't want to talk about it.

"An older gentleman who has quite a severe bipolar illness for all his life, and he came to see me for the first time and said you know it's the first time someone's talked to me like this" (GP8, p.2).

She says she sees her intuition as an integral part of her personality which indicates she naturally leans towards this style of working. Her attitude to tackling illness, including depression in later life, seems to be primarily about looking at people's emotional health:

"Most people actually come in with an emotion about what the problem is and I find if you tag into that fairly quickly the problem is a lot easier to deal with" (GP8, p.7)

GP8 and GP14 demonstrate that what GPs do and the skills they use can vary widely within the same style of working and between individual GPs.

The outcome of consultations with this group of GPs is usually to see patients regularly and as often as they need. They confidently describe their successful management of older people with depression and speak of having long term relationships with their patients. They also talk of attracting a certain type of patient, often with mental ill health.

The next GP style of working to be considered is that of the Analyst.

Analyst

GPs with a predominantly Analyst style are GP1, GP3, GP7 and GP10.

Analyst GPs see themselves as generalists and believe mental health is equally as important as physical health. They typically describe being able to find solutions within complex problems such as depression in later life navigate themselves and their patients through multiple issues and make decisions based on the wider picture. This seems to be due to their abilities to prioritize, consider the views of other people involved in the patients' situation and do what they feel is most appropriate at the time for patients.

“Sometimes you get very straight [answers] back, fine doctor, don’t talk to me about it...and sometimes people are much more reflective...the more difficult sub group are those who have long term mental health problems, often people with low self esteem depression, anxiety and may well have had pretty horrible experiences in the past...we spend a lot more time with people like that often just managing the condition and maintaining them.”
(GP7, p.3)

GPs in this group seem to be able to take complex problems such as depression in older people and find ways through to successful management. They report navigating their way through the many issues that older patients with depression may have, such as chronic illnesses and major life events, and describe identifying and managing people with depression in later life as if they were a detective where they have to piece together a jigsaw of information in order to make the right decisions.

“There is a kind of hidden agenda and you’ve got to try and tease out.”
(GP7, p.2)

They appear to make decisions based on the wider picture such as the input of other family members or carers to manage depression in later life. This differs from other groups of GPs who often talk about the patients (e.g. what they said about their situation and depression, their other health issues) rather than the input of others around them.

The advantage of being a GP...is having an idea of what the general background is like...and you are able to make more than a single snapshot judgement, you come to a decision over weeks, months potentially, even years “(GP7, p.2)

They typically describe taking a long term view of depression in later life, taking their time to make a diagnosis or decisions when they have all the necessary information.

These GPs report seeing themselves as generalists with no expertise in mental health problems including depression in older people. They typically report having a medium or low level of interest in mental health; some see this as an advantage because they are able to see the whole picture of a patients' health and circumstances.

“The thing about GPs...is that we are a jack of all trades and a master of none... mastering everything really... So I am not an expert or have an interest in depression especially in older people.” (GP1, p.8)

They tend to describe asking themselves questions as a way of coming to decisions, although they say many of these would remain unanswered. They also tend to talk about the uncertainties that come with depression in later life perhaps more than other groups of GPs. They also tend to reveal more about the challenges and tensions they face when seeing and managing depression in older people, possibly because they do not feel they are experts in the area. This group of GPs consequently demonstrate that they are particularly reflective and appear to constantly analyse what they were doing.

The practical help these GPs report providing in consultations varies and they do not tend to follow a particular formula in consultations. They seem resourceful and open minded about treatments, giving a strong impression of flexibility and tailoring their style to the individual. While this group do not appear to shy away from tackling depression in later life they speak of recognizing that their time is limited and often talk about having to prioritize. This may be due to the fact that they are seeing many patients with different problems and do not specifically attract patients with mental health issues.

Analyst GPs' attitude to depression in later life is generally that it is part of being a GP, and view mental health as equally important as physical health.

“A GP has to, to be effective has to realise that a significant part is psychological. And if you're not there you're not really functioning as a GP.” (GP1, p.3)

While they do not have a particular interest in mental health, they also do not appear to have many dislikes about managing it, speaking more of the pressures and challenges that come with it. These are to do with practicalities and the constraints of the job rather than dealing with depression in later life itself. Some GPs find it quite stressful because of time pressures and having to address multiple issues alongside the depression. Others see depression in later life as managing the patient as well as a number of associated people which they could find stressful. This may have partly been because they tend to consider the wider

picture and related issues including information given by others in the patient's situation.

These GPs are highly proactive with questioning patients about their lives and situations (as opposed to active listening or taking positive action) to seek out the information they need. Asking questions may give patients opportunities to reflect on and talk about what is happening to them. GP10 reports a long career as a GP so is likely to be highly experienced, and describes providing a wide range of help in consultations for depression in later life. She describes adapting her consultations by carrying out thorough physical examinations in order to help older people accept the idea of depression.

"I think it's incredibly important particularly for the elderly to have done a very sort of dramatic consultation, I mean in your face examination and a lot of screening...you do have to demonstrate their physical health before they will accept that there could be a psychological problem." (GP10, p.2)

Due to this she says her patients are willing to try a wider range of treatments and be more open to the idea of talking therapy or medication. GP10 describes having good access to other services and speaks of referring older people to talking therapies and psycho geriatricians. Other GPs in this group can see referral as a way they can help older people practically but do not usually have this choice due to demand on the services being too great.

Many Analyst GPs therefore describe feeling a tension where their role as a "jack of all trades" should enable them to deal with everything, but the constraints on their time and often complex presentations of older people result in them being unable to explore and manage depression as fully as they would like.

"You've got to pick a lot up from the relatives or from the staff so it's a little bit of a proxy." (GP3, p.3)

These GPs also feel that despite their focus on questioning and gathering information they might not always get the full picture of depression or the patients' situation. Analyst GPs can find making decisions without all of the information particularly frustrating, especially with so little time in consultations. GP10 acknowledges that this skill improves with experience and says she finds spending time with patients helpful as a solution, but also says she feels it is something GPs can learn to accept over time.

“They [older people] give us more information as we get to know them and as we get better...they just tell you what they need to tell you, and you only know exactly what people want you to know, and so you don’t know what’s going on really. Just a partial view of what’s happening.” (GP10 p.3)

This suggests that making decisions over the long term is beneficial for these GPs because when they are equipped with all of the information they need they feel empowered and confident to make informed choices. It also highlights a need amongst these GPs for long term relationships with their patients when dealing with depression in later life in a similar way to Active Listener GPs.

The outcome of consultations with Analyst GPs is that they are more likely to adapt their management style according to individual patients and situations than GPs who lean towards the other two role types. They are therefore more flexible in the ways they communicate as well as their style of management. Making decisions without all the information they need appears to be a particularly challenging aspect of managing people with depression in later life for these GPs.

The Problem Solver style of working will be discussed next.

Problem Solver

GPs with a predominantly Problem Solver style are GP4, GP5, GP6, GP12 and GP13.

Problem Solver GPs describe working in a structured scientific way, and at a quick pace. They say their interests lie in physical illness as opposed to mental health and they see depression as a biological illness which is treated medically as distinct episodes of disease. They appear to recognize their strengths and weaknesses, knowing when it is appropriate to refer older patients with depression onto experts or consult colleagues for advice. They also indicate that they prefer to take positive action in consultations which helps them feel in control of the situation, and in this way have a more traditional idea of the doctor-patient relationship.

“My key thing really is to establish a common agenda and priorities and goals and agree a management plan.” (GP6, p.7)

This group of GPs have strong convictions about their work and depression in later life; most were clear that they do not have a marked interest in depression in later life.

These GPs see themselves as leaning towards the bio medical approach to general practice, believing that depression is a biological illness which they treat as distinct episodes of disease. This differs to those in other groups who approach it more holistically and see managing depression as part of maintaining overall good health. They recognize that their style of working is not the ideal for managing people with depression in later life as they like to get things finished and move on to the next task. This leads them to refer quickly if they are not able to deal with the problem rather than spending time unravelling complex cases which they feel is the job of specialists such as psycho geriatricians.

“At the end of the day it’s a team game...there may be straight forward ones who where antidepressant is all that’s required, but I think involving other professionals gives the patient better outcomes and more options.” (GP6, p.9)

Although their attitude to treatments can be flexible they speak of prescribing antidepressants more themselves and referring on for other types of therapy such as counselling. They do not appear to view talking with their patients as a treatment in the same way other groups do.

“We are not counsellors and it’s not our role...we are not going to engage in the CBT or any therapy really, so...yeah supportive listening and then yes, drug therapy and review.” (GP12, p.5)

In this way they have clear ideas about their role as GPs and are able to help patients with depression in later life according to where their strengths lie.

These GPs do not hesitate to refer patients to secondary care if they need to. This may have contributed to their confidence in their ability to manage depression in later life even though it is not a special interest. GP13 illustrates this as although she reports feeling patients with depression in later life are “heart sink” when they have multiple, complex problems she appears confident there are good services to refer onto and she describes feeling supported when presented with depression in later life.

“Anyone you had real concerns about, you know their psychiatric status, you know those real heart sink ones, the oh my god where do we tease this out; like in GP you would do very little teasing and you would just refer on... it stops my heart sinking into my boots.” (GP13, p.6).

GP12 implies a similar attitude without being so direct, and says that patients like these generally did not come and see her. She says this may be to do with her personality, indicating that some GPs are simply not as suited to managing depression in older people as much as others.

“We are all different in consultations, the patient will know that and know where to go. I don’t think they are very dependant when they come back to me...I don’t think I have someone who never gets better... Some of us can cope with two weeks or three weeks [of consultations] so I think it depends on your personality.” (GP12, p.9 and p.11)

In practically helping patients these GPs prefer a measured, controlled approach to their work yet accept that this is not always possible with depression in later life. GP6 speaks of measuring the progress of the patient with the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009) questionnaire and a mood diary as well as having a planned agenda for consultations.

“I may sometimes get them to keep a mood or symptom diary, and perhaps do a PHQ9 to actually give them an objective score and then perhaps measure that later on after treatment.” (GP6, p.4)

This method also seems reassuring for GP4 who says this measured approach could also help patients come to terms with having depression. Problem Solver GPs also tend to see making decisions as positive and practical ways they can help, as it moves consultations forward. GP4 reports finding it helpful to make judgements about his own character and how it fits with the patient in order to progress and keep control over the problem in hand.

“Its wholly part of our job to try and make judgements about what kind of character you are and how you like to deal with problems and situations and the extent to which you want to control yours or someone else’s.” (GP4, p.7)

Other practical ways these GPs tend to describe helping include the use of assessment tools such as the PHQ9 (Depression in Primary Care PHQ9 Toolkit,

2009) questionnaire as a guide to deciding what action to take. This illustrates how Problem Solver GPs have a more scientific, less intuitive approach than other groups. This fits with the more structured pattern they prefer to take with their consultations, and they speak of doing this more than other GPs who follow their instincts as a first option.

“I’d much prefer to go down the medical line, like find out about the medical problem because that’s easy, whereas depression is difficult because it’s much more probing, its much less defined. You know, does someone have a urine infection, you get a urine specimen and check it, tick, that’s off the list, that’s not a problem, whereas depression it’s just not cut and dried like that.. I think you love it or you really hate it.” (GP13, p.6)

In this way Problem Solver GPs seem to aim to take a positive action in each consultation, which can range from prescribing medication to changing a patients’ view of something.

GP6 also talks of consulting experts for advice over the telephone or referring them on if necessary. These GPs possibly refer patients more quickly than those in other groups who are more inclined to try other things first, and suggest that looking at the complexities of depression in later life is the job of specialists. GP13 was clear that depression in later life was not her area of interest, and spoke openly about the fact she felt most GPs would prescribe antidepressants to elderly depressed people before considering other ways of helping.

“I would say with elderly people, particularly housebound ones, if there’s a suspicion of depression I would say with GPs in general there’s a much quicker [attitude] of just “let’s start antidepressants”. So if there’s any suspicion like if a relative or carer say oh they are depressed, you barely discuss it with them which is awful.” (GP13, p.2)

There seemed to be a sense that while she was saying this that she knew it was not really expected of her as a GP to verbalize this, but she stood out from the other GPs by talking about it so openly.

The ways in which this group of GPs describe interacting with their patients seems to be similar to a more traditional idea of doctor-patient interactions. This is where the doctor takes the lead in making decisions about what the complaint is and how to deal with it, and passing on knowledge to patients. GPs in this group tend to

report seeing educating their patients about the medical view of depression as important and speak of changing their patients' views in order to help them understand their illness.

"We may have a very medical model [of depression] but the patients' perception may be completely different and it's sometimes helpful to educate them on it." GP6, p.7

In addition GPs in this group seem to prefer going through consultations at a quicker pace as time is a main worry. This can sometimes present challenges to do with difficulties communicating with older people at the same fast pace. GP13 speaks of her experiences with this.

"you're thinking I've got 10 minutes but you don't want to be rude and you try and interject and they just ignore the cue totally and carry on with their own thing, so I think older GPs are probably better at...they are more skilled at managing their time" (GP13, p.5)

It appears that they feel taking control is helpful in consultations for depression in later life in getting quickly to the right information and recognize it as a skill to be able to do this if they are under pressure for time.

GP13 shows the strongest characteristics of GPs in the Problem Solver group. She reports being a GP for a relatively short time and working in a highly pressured inner city practice in a deprived area. She is the most forthright of the GPs interviewed and is open about the fact that managing people with depression in later life was not her preferred area. Her attitude is that *"proper, proper depression"* is mostly found in housebound older people with whom it was absolutely necessary to address their problems. Other than this she says she feels that older people have developed coping strategies for dealing with it on their own, which was why they prefer not to go to the GP about it. It may have been for this reason that she says she believes it is not a pressing issue to deal with unless the patient specifically brings it up.

"Unless somebody's specifically coming with that problem [depression], which you would then address, the thought of asking them to bring it up...I just think time constraints just don't allow it.

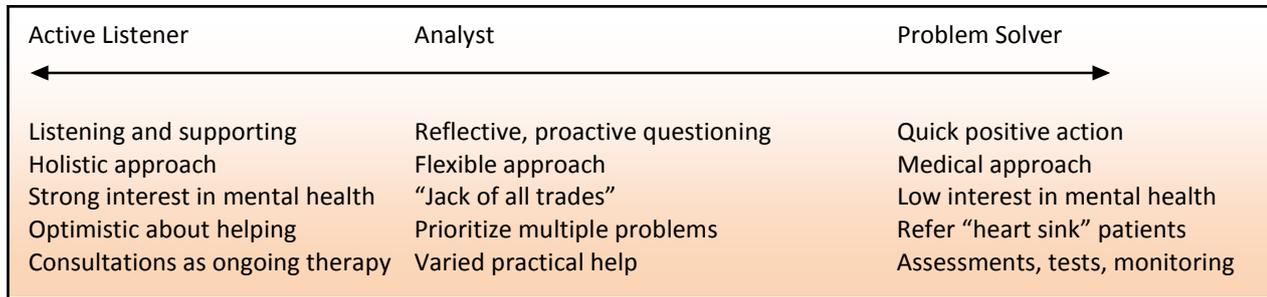
So GPs just don't want to go there? (IG)

Yeah, unless it's a specific aim of the patient's consultation" (GP13, p.5)

She was also one of only two GPs in the sample (GP8 being the other) who appeared inflexible in their style of working with depression in later life, and she suggests that it was the excellent referral services available to her allows her to work in this way.

While GPs employ different styles of working in managing people with depression in later life, most appear to be able to move between styles. Situations when they move between styles of working are therefore considered next.

Figure 6: GP typology of styles of working as a continuum showing characteristics of each style



Moving between styles of working

The GP typology shows that each style of working employs different skills. GPs can move between styles of working on a continuum to greater or lesser extents by adopting individual combinations of skills from different styles. Reasons for changing include what patients need at the time, and influences outside the consultations such as the GPs' situation at work and the resources available to them. The idea that these styles of working are positioned on a continuum is to illustrate their ability to move between styles. This continuum is shown in Figure 6.

The use of a continuum is a way of emphasising the “porous” boundaries (Clarke, 2005, p.111) that are likely to exist between groups of GPs in the typology. These boundaries are porous and changeable to recognize the possible influences of changing perspectives or situational and contextual circumstances. The continuum is intended to reflect the capacity for GPs' skills to change and their ability to move between styles of working and offer different forms of help at different times. They tend to move between positions as a result of seeing patients with differing needs, or as a result of their perspectives on depression or situation changing in some way (e.g. their practice agrees for them to take longer consultations) or influences over them changing (e.g. they experience depression). Some GPs appear not to move between working styles e.g. because they may have a low level of interest in mental health or they are not confident in their skills in managing depression. The findings do not account for whether GPs can move between all styles of working (and which GPs).

Most GPs speak of adapting their skills to different patients, and their different needs at the time.

“It’s whether the doctor suits the patient really” (GP14, p.6)

“They [OP] might not want tablets, they might not want to talk about their symptoms... if they feel ready to address it, that’s when you want to dive in, but sometimes it might be sort of like brushed aside and then you have to kind of be patient and sort of bring them back.” (GP5, p.5)

However GPs working in different styles describe adapting their skills differently. Others who appear to be positioned at the more extreme ends of the continuum of

styles of working describe being more static in the skills they use and not adapting to patients as often. GPs recognize that many older people prefer GPs who listen, share experiences and who have enough time, yet others do not want to talk about their depression and tend to prefer quick consultations and to find solutions quickly, and strive to adapt to their patients.

"...some patients, they don't want this or that, they don't want you to be interested in them I suppose, although I dispute it...some want to understand a bit about their problem and if they want to understand more then they want you to be interested" (GP2, p.8)

It is GPs who can adapt and move between styles of working to provide what patients with depression in later life want or need at different times that seem most confident and positive about managing it.

Active Listener GPs speak more than others about having enough time and following their intuition and clinical judgment to determine the best course of action for older people with depression. They tend to deal with depression in later life more frequently than others, possibly because they describe actively looking for it, which may lead to a self-perpetuating cycle where they grow in confidence as their approach works successfully with more patients. For these reasons, and since they find their way of working to be successful, they do not appear to move between styles as often as other GP groups.

"I am conscious that there is an expectation to do it [talk about depression] routinely. I would avoid doing that...because I think it would disengage me with the person." (GP2, p.3)

Instead of adapting their skills Active Listener GPs speak more of changing older people's understanding of their depression (thereby possibly encouraging a move between stages of depression for older people), or listening to their stories and helping the patient change in order to get better.

"...there's no other reason [to have a doctor patient relationship] than to help the patient change in whatever way they need to change to maintain health. (155) That might be taking antidepressants, it might be getting some fresh air, thinking about their relationship with their daughter a bit differently, whatever it is" (GP3, p.5)

“I do think the greatest impacts are from changing thinking processes, from lifestyle changes and trying to challenge cultural attitudes...it’s amazing how much you can change someone’s thinking by just dropping in the right level of challenge” (GP8, p.5)

They report that changing patients’ beliefs about depression may influence the help they accept, and that patients can become more involved or willing to engage in decision making. For example this may be where a patient feels their depression is a waste of the GPs’ time and the GP convinces them of its validity as an illness.

Analyst GPs are dynamic and able draw on a wide variety of skills. They feel that their remit as GPs is to be generalists and so they have boundaries between what they see as general and specialist. At this point they seem to become less confident with managing depression in older people and find it challenging to take on the complex situations they uncover in the time they have. Despite this they appear open to change and describe normally being able to adapt the practical help they offer according to the other situational and social factors they are encountering at the time.

“...it’s about time, it’s about reframing their thoughts, it’s about dealing with their physical illnesses adequately so you get this much relief from their arthritis or whatever you’re dealing with as much as you can. And as a say you’re doing all of this and can really feel you’re at your depth, and struggling with coping” (GP7, p.7)

“You could go down the physical route which is where we’re all trained to be but finding out what’s happening in their life and their mood, and whether there’s other biological symptoms of depression, erm, that’s quite a valuable thing. And you’ve got to pick up a lot from the relatives or from the [care home] staff...you’ve got to avail yourself with all the sources of information.” (GP1, p.3)

Some GPs in this sample suggest that the environment within which they work or the situation at the time can influence the extent to which they change between working styles. For example Active Listener GP8 appears able to remain more static in her style of working than other GPs interviewed, because of practice

allowances and the fact that she says patients choose to see her for the approach to mental health problems she takes with them.

"I've been quite lucky, I have only worked in two practices and they have allowed me my ethos" (GP8, p.11)

She reports that those with depression and mental health problems who prefer to talk through their problems would choose to see her, and would often see her regularly to "maintain happiness". This means that she does not need to adapt the way she works as her working environment allows her to maintain the "status quo".

Some Problem solver GPs also give the impression of being less flexible in adapting to patients with depression, by indicating they have a usual way of approaching consultations. They may also see themselves as less suited to managing depression in older people and because of this attitude they do not attempt to adapt as much.

"...my key thing really is to establish a common agenda and priorities and goals and agree a management plan" (GP6, p.7)

"...we are all different in terms of consultations. I don't have patients who never get better, and is just continuously coming back and making demands and coming back and it's not moving....so either by choice I am not providing that service, they probably need it, but by choice. Not that I'm asking them not to come back" (GP12, p.8)

The main way Problem solver GPs report adapting to their patients is through referring them to specialists when they feel unable to cope. Problem Solver GP13 reports being able to refer complex "heart sink" older patients to old age psychiatry relatively easily and gives the impression she believes specialists can do a better job.

"You can just refer anyone you had concerns about, like their psychiatric status as well as dementia...it's kind of a multidisciplinary arrangement I suppose, it's very good. It stops my heart sinking onto my boots" (GP13, p.6)

It seems that the advantage of working in a locality that is served well by appropriate mental health services for older people allows her to focus more on patients' physical illnesses, which she reports to be where her strengths lie.

A few GPs working in all three styles suggest their ability to adapt their skills to different patients can be restricted with the pressures of time. For example the skills GP5 describes using when managing patients with depression mostly fit with the Problem Solver style. However her reports suggest that she would prefer to use skills that fit more with the Active Listener style and this varies depending on how pressured for time she is and whether the patient has other physical problems to deal with.

“Unfortunately in 10 minutes there is a lack of time as to what you can do with somebody. If you’re homed in on the physical complaints you’re not going to get any further...but often they are not looking to you to find a solution it’s just basically someone to listen to them.” (GP5 p.5)

This impression of being pulled in opposite directions illustrates a dilemma that other GPs in the sample also report, and hints at a feeling of powerlessness where GPs may not be able to respond to patients in the way they find most acceptable.

“...you can’t solve everyone’s ills...you know, you can’t solve that woman’s loneliness” (GP14, p.8)

These reports underline the influence of GPs’ perceptions of depression in older people, the skills they can use and their environment and situation over the ways their working styles can change. It also indicates that the ways they manage older people with depression may be influenced by external influences which may be out of their control, for example availability of services to refer to, and this could either work well or be less appropriate to the style of working they naturally lean towards.

Key messages of GP findings

GPs’ stories of managing older people with depression reveal factors they find to be both successful and challenging. They also describe using different combinations of skills.

Their styles of working appear to be characterized by different combinations of skills that they describe using to varying degrees. Despite naturally leaning towards one style of working, GPs also describe adapting their skills and moving between styles of working. Factors that influence their style of working and the

extent to which they move between styles may include the patient, GPs' individual range of skills, the working environment and situation at the time as well as resources available to them.

Influences over GPs in which of their skills to use at different times, and the style of working they employ in response to older people's stories of depression are discussed in Chapter 6. Chapter 6 is the third findings chapter and considers areas of crossover found within the older people's and GPs' data.

Chapter 6: Crossover findings and theoretical interpretation of findings

Introduction

This chapter firstly presents new data on influences reported by older people and GPs over what they say and do in consultations. Following this a theoretical proposition is made about how older people and GPs are likely to respond to one another on the basis of all of the data given in their interviews. This theoretical proposition is an interpretation rather than a description of the data, resulting in IG's construction of a meaning or theory derived from what is reported by participants and recorded by IG as contextual data. It therefore moves from a descriptive level of analysis where categories found in the data are described (see chapters 4 and 5) to an interpretive level where an explanation of the data is offered.

This attention to ways older people and GPs might adapt and change highlights the "porous" and "flexible" nature of the position people can take (Clarke, 2005, p.111). This is further illustrated by the suggestion that older people and GPs can move between stages of understanding and styles of working respectively, and their ways of responding to one another can change accordingly. The project map (Figure 7, p.220) illustrates this interpretation of the data visually, representing the culmination of the study findings. It is included in order to "tell an analytic story" (Clarke, 2005) and draw the findings of the study together.

The structure of this chapter is as follows. The first section provides an account of how the theoretical interpretation derives from the interview data. It describes the journey from data to theory, explaining how the selective code was identified using analytical mapping to organize links made between interview and contextual data, and then how a "story" was constructed around this idea to form the theoretical interpretation. The position of the researcher and its possible impact on data

collection (i.e. what participants disclose in interviews) and analysis (i.e. the findings) is also discussed.

The second section of this chapter presents influences reported by older people at different stages of understanding and accepting their depression over telling their stories. It proposes what different groups of older people are likely to tell GPs and what influences this, and makes suggestions about the help they might need from GPs. This section is based on what older people report saying to GPs in their interviews and the typology of older people set out in the older people's findings (Chapter 4). The narrative is corroborated with interview and contextual data.

The third section of this chapter presents influences reported by GPs working in different styles over their responses to older people with depression. It proposes the help GPs working in different styles might offer different patients and what the influences over them might be when taking these actions. This section is based on reports given by GPs in their interviews of managing older people with depression and the typology of GPs' styles of working, as presented in the GP findings (Chapter 5). The narrative is illustrated with interview and contextual data.

The final section "Interactions between older people and GPs" proposes theory about what may happen when different combinations of older people and GPs meet. This theoretical proposition sets out the selective code or "thick analyses" (Clarke, 2005) developed during data analysis to offer an explanation for what older people and GPs report saying and doing in consultations for depression. It proposes how different types of older people and GPs are likely to respond to each other in consultations for depression, and is based on the different groups identified in the older people's and GPs' typologies and the influences they report over what they say and say they do. Consideration of their fluid and changing positions has led to theory being developed on how what they say and do might change when different combinations of older people and GP meet under different circumstances, and how their responses to each other might impact on the way depression is managed. Acknowledging situations which may cause change or which are changing at the time is an aspect of Clarke's (2005) "thick analyses" that sets it apart from the production of theory in more traditional versions of grounded theory.

The journey from interview data to theory

This section explains the move to explore influences that older people and GPs report over what they say and do in consultations for depression. It discusses how this emerged as the central category in both data sets, where the starting points were within both data sets, and how interrelationships were located across the two data sets which led to the development of the theoretical interpretation. There is also discussion of the role of the researcher in data collection and analysis and the impact this may have had on the theoretical proposition made later in this chapter.

The starting point for the decision to explore “influences” was the identification of research previously carried out in a review of the literature. Using the literature to inform the research process is promoted as a valuable way of generating “theoretically informed and knowledgeable research” in *Situational Analysis* (Clarke, 2005 p.13 and 75). The literature was therefore the starting point to inform the data collection and was revisited during analysis to help identify areas that needed addressing. This recognition of prior knowledge informing the research process differs from traditional versions of grounded theory where preconceived ideas are not used as a basis for research.

Evidence suggests there are certain influences over older people and GPs in the broader management of depression. For both older people (e.g. Peters et al., 2008; Burroughs et al., 2006; Givens et al., 2006) and GPs (e.g. Rijswijk et al., 2009; Oopik et al., 2006; Baik et al., 2005; Chew-Graham et al., 2000) the way they perceive depression seems to be at the forefront of the well evidenced problems and barriers there can be to the successful management of depression in later life. However there seems to be little understanding of how this translates into practice, for example what is helping or preventing older people telling GPs about depression and why GPs are likely to respond to them in certain ways. This shows a need for further understanding of the influences over what older people and GPs say and do in the management of depression, to give a more detailed picture of reasons for the problems both groups face and what happens in consultations.

The analysis process and journey from data to theory is now explained separately for both sets of data.

Older people's interviews to theory

The way older people perceive depression has been identified in the literature as an important influence over ways they seek help for depression and how it is managed in primary care (Peters et al., 2008; Burroughs et al., 2006; Givens et al., 2006). Exploration of influences over what older people tell GPs about their depression appear to be lacking in research and this is needed in order to explain why they do not always seek help or why there may be different reasons for them holding back certain information from GPs. These areas were therefore included in the older people's topic guide as prompts, exploring influences over participants' views of depression and influences over their decisions in its management (see Appendix for initial topic guide). Use of these prompts encouraged some older people to report influences over the way they told their stories of depression, whereas others spoke of these matters without the need for prompting. Some older people spoke of influences over the way they told their story when talking about other things.

During analysis of OP1-5 IG found that older people frequently spoke of influences over how they told their stories of depression. They tended to focus on how their attitudes and beliefs about depression influenced the ways they talked about it, and observations tended to be about their agendas of what they were prepared to talk about or not, which seemed to relate to how they viewed their own depression. Observational memos tended to note how their reports of life experiences influenced their depression, and the level of detail they were prepared to go into. In addition contextual influences over what they said and IG's observations of the interview situation that may have affected them were noted. In early stages of analysis influences therefore remained an important area that needed detailed exploration in the following stage of interviews.

During interviews OP5-10 the ways participants viewed their own depression and how this influenced their storytelling was explored further. In addition the limits of what different types of older people were prepared to talk about were explored. For example in this stage of interviewing there were older people who describe traumatic events in their lives and the differences in the way they do this were focused on in IG's observational memos and then in analysis. In order to find out more about the different components of their stories that older people share and

hold back on, and the influences over what they discuss with GPs in consultations and how they respond to each other, final topic guides included prompts about older people's expectations of GPs in consultations for depression, their needs at different times, how they ask for help and what works best for them.

These factors were explored by IG in final interviews OP10-16, together with what older people brought up themselves regarding influences over them. They talk about influences over ways they told their story, as well as influences over other ways they operate in consultations for depression (e.g. taking medication, treatment options). Some older people speak of this without the need for prompting and with others prompts were used by IG.

Influences over what older people tell and hold back about their depression was explored in relation to interview data of all participants, and led to explanations being developed relating it to many of the other codes and categories identified. Because of its relationship to so many other areas of the data it was noted as a possible selective code to be explored in relation to the GP data. The most prominent influence over the way older people tell their story of depression continued to be whether they tell or hold back certain components of their story of depression. This was noticeable because all participants interviewed this far report reasons for them either telling or holding back in different ways or in different situations.

Contextual data – reflective memo after OP1-OP16 noting possible relationships between older people telling their stories of depression and what may influence them

Within the sample, those who do not like talking about their depression seem to be female participants who say they worry a lot, especially about family and put their depression down to nerves. They also do not seem to like talking about it under the label of depression. Indeed they even prefer not to actually talk about talking about depression. They sometimes also have long term physical pain.

The following questions could be raised to explore by revisiting the data:

Is it a possibility that those who have had longer term depression particularly do not like talking about it to GPs? Why? Are they passive, or tired of talking/thinking about it?

Is it necessary for GPs to talk about depression with an older person to get an insight into their views and experiences of depression? Why is it important for some older people not to label it as depression?

Following this, IG explored links in the data between older people's reports of influences over telling their stories and other factors they report about their experiences of depression and its management. In relation to this, observational

and reflective memos were produced during and after interviews and analytical maps linking influences over older people's storytelling to other categories identified in the data. Explanations for these influences were then developed in theoretical memos.

Theoretical memos offer explanations for differences between types of older people set out in the older people's typology. Data from the typologies was placed alongside the theoretical memos by comparing these explanations which were then developed for the differences between what they report. IG's interpretation of this was that there are different influences over the ways older people tell their stories in consultations and this is central to the way depression is managed. These influences are discussed in the following section of this chapter entitled "Influences over what older people report saying".

GPs interview data to theory

Influences over the ways GPs manage older people with depression have been identified in the research. These include the ways they conceptualize it (Chew-Graham et al., 2000, 2002; May et al., 2004) their perceptions of their roles and responsibilities (Murray et al., 2006; Burroughs et al., 2006; Nolan et al., 2003), skills gained both from personal experience and aspects of their relationships with patients (Nolan et al., 2003; Andersson et al., 2002; Oopik et al., 2006), their work circumstances (Baik et al., 2005) and the way older people perceive depression and their struggle to talk to GPs about it (e.g. Lawrence et al., 2006b; Burroughs et al., 2006; Dowrick, 2009; Lafrance, 2007; Kaddam et al., 2001). However there are still unanswered questions about how these factors influence what actually happens in consultations and why GPs respond to older people with depression in different ways. This information could be used to help GPs identify ways of helping different older people with depression that also fits with their perspectives and working situations.

These areas were therefore included in the topic guides for GP interviews as prompts to facilitate their exploration with GPs, e.g. how GPs' views of what depression is affects choices made in its management (See Appendix p.356 for initial topic guide). Use of these prompts encouraged some GPs to report influences over the way they manage depression, whereas others report these

matters without the need for prompting. Some GPs speak of influences over the way they manage depression when talking about other things.

New ideas were introduced by GPs during interviews and these were followed up in subsequent interviews when they were found to relate to developing ideas. This introduction and exploration of new ideas during the course of interviews with GPs is in line with the iterative nature of the methodology. For example the category “decision making” emerged in the first ten minutes of interview GP1 and occurred frequently in all of the other GP interviews in a variety of ways. It was found to relate to many of the other aspects of managing depression that GPs had reported in previous interviews and became an important line of enquiry. Later topic guides therefore included exploration of GPs’ ideas around how they made decisions, e.g. decisions for the use of certain language or management strategies.

During later stages of analysis “decision making” was thought to be the selective code within the GP data as it related to all aspects of GPs reports of managing and responding to older people. However with further interrogation of the data and revisiting the analysis after some time, it later emerged that the factors that influence their decisions explain what they do more fully and how they respond to older people in consultations for depression. It was found that GPs talk about how they make decisions and factors that influence this, even though they are not always asked about this directly. “Influences” over what GPs say and do was therefore explored in relation to the other codes previously identified and it was found that explanations for most of the ideas identified in the GP data related to this code. For this reason “influences” became the selective code within the GP data. Narrative was developed around “influences” and a detailed story was built up about the influences reported by GPs over how they respond to older people.

IG finally developed explanations for differences between types of GPs set out in the GPs’ typology. Data from the typologies were placed alongside the theoretical memos, and explanations were developed for the differences between what they report. IGs interpretation of the GP data (formed from the process of analysis described) is that there are different influences over the ways GPs respond to older people in consultations and this is a central factor in the way they manage

depression. These influences are discussed in the third section of this chapter entitled “Influences reported by GPs over ways they respond to older people”.

Crossover themes to theory

Finally the code “influences” was located as the most important area of crossover across the two data sets.

Areas of crossover were found by comparing similar codes existing in both the older people’s and GPs’ data and developing new codes to describe messages conveyed by the combined data. This process was carried out during data collection and after data collection had finished. Firstly, interrelationships across the older people’s and GPs’ data were located by comparison of observational and reflective memos made during and immediately after interviews were carried out. These codes were about what older people and GPs said about each other in their respective interviews. These areas of “crossover” were added to topic guides to investigate these ideas with both sets of participants who were subsequently interviewed. As interviews progressed, analytical maps were drawn up linking the emerging “crossover themes” together and to identify possible avenues of enquiry.

Crossover codes appearing to be prominent included: relationship between GP/patient, talking about depression, older people preferences/help provided by GPs (see list of crossover codes in Appendix, p.366). Narrative was developed around how the all of the crossover codes described the older people and GPs data, and how the codes related to each other. As with the older people’s and GPs separate data, the code “influences” appeared to be relevant to all of the other codes and a story was generated to give a detailed explanation of the data.

As a result IG used prompts about what older people and GPs report to be influences over what they say and do in consultations for depression. Interviews with both sets of participants then explored what they report to be influences over them in relation to other issues that appear important in their experiences of having and managing depression (e.g. what influences them minimizing depression, what influences them recognizing depression). In later stages of analysis after the older people’s and GPs’ typologies were developed, narrative about how different types of older people and GPs might respond to each other

was built up, with consideration of the contextual data and analytical maps developed.

In this way the theoretical proposition was developed about interactions between older people and GPs. This is presented in the fourth section of this chapter entitled “Interactions between older people and GPs” and set out visually in the Project Map, Figure 7 (p.220).

Project Map

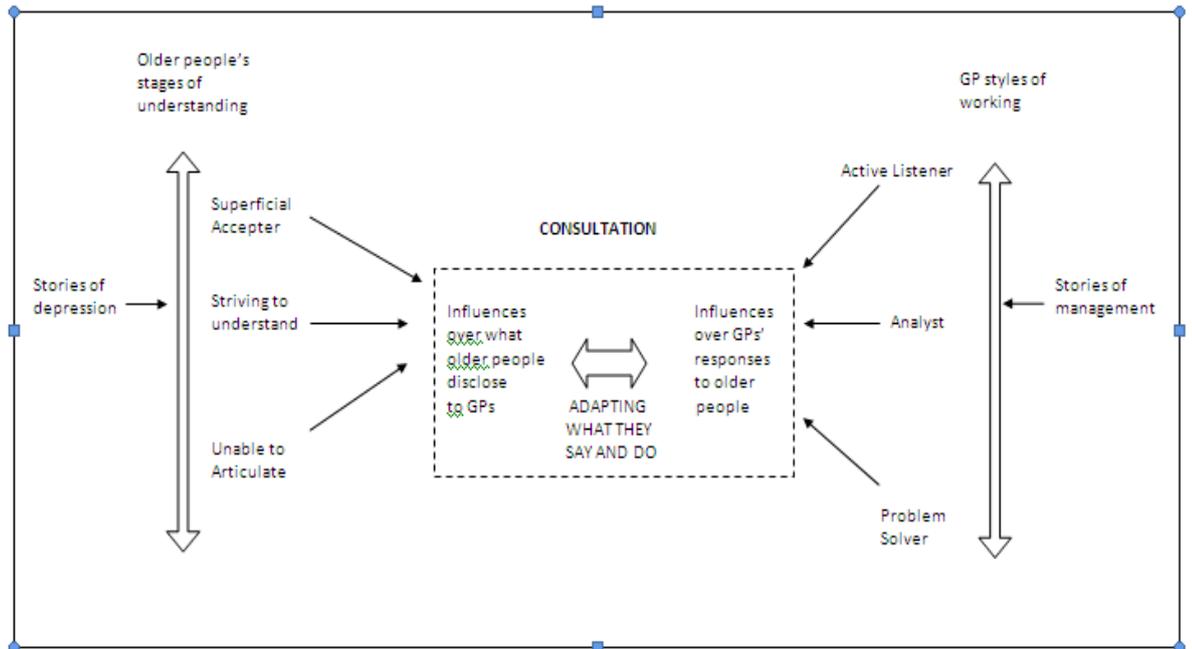
The project map Figure 7 (p. 220) illustrates how the older people’s and GPs’ findings have been drawn together to represent the theoretical proposition made in this chapter. On either side of the map the different positions older people and GPs may take are shown, which are described in the older people’s and GPs’ typologies. Older people’s stories of depression guide the position they take, and for GPs it is their stories of managing depression, so these are located at the far edges of the map with arrows towards the continuums. The blocked arrows running from top to bottom represent the continuums older people and GPs can be positioned on, and are intended to emphasize the “porous” and “flexible” boundaries (Clarke, 2005, p.111) between the different positions, and people’s ability to move between them.

The dotted line around the box labelled “consultation” illustrates the porous boundary of the consultation situation and represents the possibility of it taking different forms and being influenced by different things. Clarke’s “porous boundaries” (Clarke, 2005, p.111) have informed this aspect of the findings of the study, giving the findings “flexibility” and “capacity to take change into account” (p.111). The dotted lines in Figure 7 represent the flexibility of the changing situations and perspectives that older people and GPs report bringing into consultations, and experiences and perspectives they report taking away from them. This porous boundary also signifies that consultations can be changing situations influenced by multiple factors dependant on not only older people and GPs but also factors that are external to consultation. This flexibility and changeability is evidenced in the older people’s and GPs data where they report bringing different and changing perspectives to consultations for depression, and

different influences over what they say and do with regard to having and managing depression.

The block arrow inside the consultation box represents exchanges between older people and GPs in consultations for depression. In particular it represents ways they adapt their responses to each other, which may vary depending on the combination of types of older people and GPs in the consultation. The double ended arrow represents the two way nature of their exchange.

Figure 7: Project map showing a visual representation of study findings



Influences reported by older people over telling their story

The older people's findings presented in Chapter 4 show different ways older people tell their stories of depression. This includes their stories of what depression feels like, explanations of its cause, how older people minimize their depression, internal and external stories and ways they tell their stories to GPs. A continuum of stages of understanding and accepting depression shows that older people belong to different groups according to the different ways they tell their stories. The groups identified are Superficial Accepters, Striving to Understand and Unable to Articulate.

The influences they report over telling their stories include how to define, explain and label their depression; how to balance private and public components of their story and which parts to tell and hold back on with others, including GPs. This section therefore focuses on influences they report over what they tell and hold back in consultations at different stages of their depression. This may be useful for understanding more about why older people do not always seek help for their depression from GPs, or why there may be different reasons for them holding back certain information from GPs.

Influences over ways older people define, explain and label depression

Older people's reports suggest there may be different influences over ways they define, explain and label their depression, for example whether to use the word depression, use other labels or give indirect suggestions of their depression. Their definitions of depression sometimes appear to be influenced by their beliefs of what it is, which may or may not be fully established.

"I think it's a word that should be confined to a state where you're really at the bottom, not just going through a period of a depressed day" (OP5, p.18)

The way they explain depression in interviews often includes their reasoning behind why they have it and the way they present their depression to others. Many seem to regard the label they use as sending out an impression of themselves to others, and the different labels they use may give clues about their attitude to depression and their stage of understanding and accepting it. These are factors that GPs might take into account when hearing their story of depression in consultations.

Older people from the Superficial Acceptor group appear to separate their public image which they project to others from the private components of their story of depression. They describe what influences them in how to label, define and explain their depression to fit the image they want to project. The choices of the label they use for their depression are about whether to avoid any mention of the word depression and call it something like “sleeplessness” (OP3), or whether to call it “clinical depression” which emphasizes its medical legitimacy therefore making it seem more acceptable to themselves and others. Superficial Acceptors’ explanations are likely to follow this pattern when speaking to most people and if they choose to reveal their depression they have a definite agenda ensuring their explanations for having depression are included.

“I never called it as depression I just felt awful, you know, you feel sad, I think sad is the word that I’ve always used” (OP15, p.10)

Situations where they reveal their depression include when they are at crisis point and feel their lives or depression are out of control, or are at a point where their views of depression are changing and they want to explore this further. However they are likely not to use the label depression because of the stigma attached to it.

People in the Striving to Understand group alternate between the labels they use since they are still establishing their ideas about depression. They may not know the reason behind why they have depression and could be hesitant in how they refer to it because they are testing their story out. OP13 describes how he told his GP about his depression initially by talking about his physical symptoms, and in a similar way did this in his interview.

“I didn’t tell him [the GP] the details I just said, it started off with me feet and then I got a rash up me back and even in my face” (OP13, p.2)

By the end of the interview OP13 was calling it depression and it seemed he was more comfortable talking about it as an emotional problem by practicing his story. For these older people, hearing themselves out loud may help confirm some of their ideas about their depression and influence ways they tell their story in future.

People in the Unable to Articulate group have relatively fixed views on the reason for their depression which they have often held for a long time (e.g. their personality) indicating they have accepted the idea of having it but are also less

likely to change their position of understanding. Their explanations are minimal and they are unlikely to use the label depression, instead deferring responsibility of depression from themselves by using labels such as “*heartbreak*” (OP12) or “*my back*” (OP1). Their story is likely to be the same whoever they talk to including GPs and friends.

The different ways older people have of defining, explaining and labelling their depression can therefore show the influences that their attitudes about depression can have and where they are in terms of understanding and accepting it. These clues can be suggestive of the kind of help they expect or need from GPs.

Balancing private and public components of stories

Older people can have differing views on which components of their story should be private or shared with others. Many are not prepared to go beyond a certain level of depth and this boundary seems to be where their public story becomes private. This appears to be partially influenced by an attitude that comes with age, where they believe it is inappropriate to talk with anybody about their innermost feelings or it is self indulgent to dwell on something unjustifiable like depression.

“Was your sister someone you could talk to about how you felt about things? (IG)

Well I dare say but you don't like to talk about that do you, you know not really” (OP15, p.7)

Factors that may influence the balance of their stories may therefore differ between types of older people on the continuum of understanding and acceptance and is considered next.

Superficial Accepters appear to be strongly influenced by the public image they want to convey and their wish to be seen by others as unaffected by depression. This suggests that they would mainly tell the practiced components of their story which are reserved for other people in order to communicate their previously chosen agenda.

“People don't want to listen to you, or worry about your illness, that's how I feel” (OP4, p.7)

“No, nobody knows that I've got depression, just don't tell anybody.

Does your family know? (IG)

The family know but apart from that I wouldn't tell friends or strangers, you wouldn't would you? It's kind of erm, I don't know, people think that you're mad, you know” (OP14, p.16)

Because of this they are likely to need GPs to be sensitive to their wish to maintain this public image whilst undergoing treatment, and give them help without labelling it as such.

Those Striving to Understand do not appear to have finalized the private and public components of their story. In talking they appear to switch between what is private and public since they are practicing their stories since they may not have established what they feel comfortable sharing. The process of establishing which information they are comfortable sharing seems to help maintain some kind of control which they may feel they have lost through having depression.

“If I needed to ask them for their support they would be absolutely furious that I hadn't done it, but my feeling was, I've got to cope with it... It's just silly, but if I told my son that he would have said mum, for heaven's sake...”
(OP10, p.6)

Their confidence usually grows during the interview process and telling their story indicating that they find it empowering to confirm their story. However people in this group may need help making decisions regarding how their depression is managed if they remain unsure of what their views are and what they are willing to accept. GPs may need to distinguish between which of their views and feelings are concrete and which are not yet fully established, in order to help them make decisions about how their depression is managed.

Those who are Unable to Articulate their depression are likely to see most of their story as private since they tend to reveal little more than the basic facts about their depression. This may be because they want to block out trauma and be disconnected from their depression. OP11 talks about significant life events that have triggered her sadness, yet she does not go into details of the event or how she feels.

“...she [her mother] just collapsed one day and died. I wasn't there, like, I was married like and our (name) was there, and she just collapsed and

died. I say it was a shock at the time but I think it's better that way than her suffering for years (OP11, p.12)

Those in the Unable to Articulate group typically do not reveal their inner feelings or perspectives or the extent of any trauma they have experienced in their interviews, and if this is also the case in consultations it seems likely that this would impact on how their depression is managed. For example, if these patients do not share information about how medication is making them feel or their views on the way their depression is being managed, GPs may have very little to base management decisions on. Instead they may have to follow their intuition in managing it, relying on other clues such as body language and reading between the lines which could be challenging with patients who do not give much information at face value. To open up with private components of their story may depend on whether they are ready to revisit these experiences.

The way different types of older people make decisions on what to tell and hold back from others, including their GP, is considered next.

Influences over what to tell and hold back on

Older people share and hold back certain components of their story about depression and are influenced by different things. Reasons include wanting to conceal their depression from others and a fear of stigma. Considered here are influences over how they tell their stories which appear to be common amongst older people from all groups.

Across the continuum of groups of older people there seems to be a desire to escape from illness and depression, which may influence them in holding back components of their story. Some seem to use contact with others as an escape from themselves, possibly avoiding the details of their depression so as not to bring the mood down. These older people appear to prefer not to dwell upon illness and often assume older people should not talk about depression as others are not interested. This suggests that as well as for escapism, holding back for the sake of the listener is common amongst older people whatever stage of understanding and acceptance they are at.

Older people across groups can also be concerned about being a burden on other people and this influences their decisions to hold back. Their reasoning behind this is usually formed through comparing themselves to others and assuming their depression is not as bad.

“With some doctors you hold back, you don’t want to feel as if you’re moaning on...there is people worse off than me so you don’t want to waste his time...” (OP16, p.9)

When older people hold back for this reason they either tend not to talk about their depression at all or prefer to find quick solutions without exploring the impact of it too deeply, even though this may not be the most appropriate course of action. GPs that can identify this may be able to address it by challenging their views of what depression is and exploring why they feel unable to talk to GPs about it. Influences over older people in what to share are considered next, and are specific to their stages of understanding.

Superficial Accepters are influenced by portraying what they perceive as an acceptable image of themselves to others. In interviews they are prepared to share their experiences of what depression feels like and their explanations about why they have it since they like to be seen as experts, making them appear at ease with talking about their depression and sharing their story. However at the same time they may report minimizing their depression.

“Well don’t think the family are aware...I certainly don’t act in a depressive manner when they are here. I am a good little actor, I hide it quite well” (OP9, p.12)

Minimizing their depression can also involve comparisons of themselves with others who were in their view truly depressed or using negative views of care they have received to suggest their diagnosis of depression is wrong. Information about the impact their depression has had on their working “selves” is usually volunteered by Superficial Accepters as they want to explain the full picture on their terms. The topic of their career and success achieved may therefore be a good route for GPs into starting exploration around depression with Superficial Accepters who find it difficult to open up about their depression.

Superficial Accepters are most likely to tell their public and more practised story to their GP because this is likely to be what they feel safe with. An important

influence over the way they tell even the more public side of their story seems to be for GPs to accept their explanation for depression and how they make sense of it, making them feel like an expert who is taken at face value.

*“I expect them [doctors] to understand that I know what am talking about... doesn't make much difference to them but makes a difference to me”
(OP14, p.15)*

They tend to hold back with GPs on how depression makes them feel which indicates they are not comfortable with confronting this verbally. To reveal the more private components of their story it is likely that they would need to feel on a level with their GP as a person rather than a patient, which involves the GP recognizing their achievements, knowledge and life experiences e.g. their career or knowledge about depression. Unless there is a change which triggers their wish to explore it further (e.g. becoming unable to cope with keeping depression a secret) they are likely to prefer to live with a partial acceptance and discussion about it with the GP on their terms. GPs need to be alert to clues of this kind which signal their readiness to further explore and move forward with their understanding and acceptance of depression. Active Listener GPs are well suited to doing this and adapting but some Analyst and Problem Solver GPs may need to be particularly mindful of when Superficial Accepters' needs are changing.

A pivotal influence over people in the Striving to Understand group when talking about depression seems to be choosing the right time to share information. They seem to share more components of their stories than any of the other groups if it is the right time and situation for them to open up.

“I intend to come clean today because when the family ring me up I'm always alright, even when I'm not...but I don't want to be a burden...I've tended up to now to put the bright side on it....you are the first person, I've talked to (name) about my problems” (OP13, p.1 and 3)

They tend to do this when they have reached their limits in some way, such as being unable to continue hiding it or needing to confront their depression in order to move forward with its treatment or recovery. Once they are able to explore their depression further they are freer to talk without holding back, and through this may come to an increased understanding and acceptance of it. When opening up, they tend to share insightful information about what depression feels like and the whole

experience of depression from the beginning to the present moment which is not volunteered as readily with other groups. Whilst talking, they also tend to experiment with what is acceptable for them to share and so are in the process of deciding what they can share and hold back. They may also be influenced in the way they tell their story by how the story sounds out loud.

For those in the Striving to Understand group their need to talk about it seems to outweigh the value they place on having a trusting and long term relationship with their GP. This means that they may not be so much influenced by the relationship with their GP as other groups and are likely to talk to whoever they are seeing at the time, if they have decided it is the right time. GPs may need to recognize this is happening particularly if it is a patient they have not seen often, and give them the time and space to talk while supporting them in testing out their story. This may be challenging for Analyst or Problem Solver GPs who feel pressured to stick to appointment times and who also may not have time to listen to the story when it is the right time for the older person.

Those in the Unable to Articulate group appear to have no motivation to tell their story and this influences them in tending to hold back. This may be because they have little hope of getting better or want to forget their experiences of having severe depression.

It's when you're really gone that you cannot say what you want, can you.

And do you feel that you can say what you want now? (IG)

No I don't, I don't really.

You don't really, you keep it bottled up. (IG)

Well at the moment I'm just living the way I've lived for years, you know and just accept it. (OP11, p.10)

Instead they are likely to benefit from talking about their day to day business or everyday matters which can reveal more about their stories of depression than what appears on the surface. This indicates they may need GPs who are skilled at reading between the lines of what people are saying, such as Active Listener GPs who use their intuition to do this.

People in this group are likely to hold back and share similar things regardless of who they are talking to. They reveal little verbal information about their

depression, and talk about physical symptoms to communicate their psychological distress rather than engaging with the idea of depression. They describe being in pain and when their spirits are low their physical problems become worse. The way they do this suggests they are so accustomed to revealing their physical symptoms in preference to engaging with the idea of depression that the process of telling their story in this way has become automatic.

People who are Unable to Articulate seem less likely to move between stages of understanding than other groups since they remain closed to sharing their stories of depression. However being given the opportunity to talk can be helpful if they are ready or if the right person triggers a change in their perspectives or desire to talk. Their typical reliance on healthcare workers to make decisions for them in the management of their depression can leave GPs responsible to decide whether to look for clues that they are willing to talk. Active Listener and Analyst GPs are likely to be most skilled at this but they may need to adapt to a different “mode” if they find the older person is not ready to talk.

The factors discussed above suggest that depression is a topic that older people commonly struggle with when talking to GPs about some aspects of their stories. Active Listener GPs who are typically able to develop long term relationships with their patients and share experiences so that they establish a mutual understanding are in an ideal position to help older people explore these attitudes to depression and why they prevent them from opening up. Many older people may also need help with selecting the information to share with GPs that leads them to getting the type of help they want. Analyst GPs are often skilled at drawing out the right information so could be well suited to helping them with this aspect of talking about their depression.

The following two sections focus on influences over older people in the types of help they prefer from GPs. Influences over them in accepting medication for depression or not are considered next.

Influences over accepting medication

Older people make different choices about the way their depression is managed such as whether to accept medication or not. A main influence over this can be the

way they perceive depression and in turn their stage of understanding and acceptance of their depression.

Older people's acceptance of taking antidepressants can be influenced by their fears of losing and regaining control and the stigma attached to taking them. This includes those mainly belonging to the Superficial Acceptor and Striving to Understand groups rather than from the Unable to Articulate group who may not engage with their ability to be part of the decision making process. An important factor is the lack of control that some report feeling when taking antidepressants, especially with those in the Striving to Understand group.

"The sooner I can stop taking it the better...I don't like the fact that some blob that I swallowed is taking over my life" (OP10, p.14)

Superficial Accepters tend to be reluctant to trying antidepressants due to their non acceptance of having depression and the stigma surrounding it alongside their conviction that they know what is best.

"I would rather have had something different to a load of tablets 'cos they do spoil your life...'cos you're here but you're not here...things is happening but they're not happening" (OP14, p.18)

They may need GPs to help them change their views of antidepressants or other treatments, or accept these views whilst meeting their needs. This can work when they are persuaded that depression is comparable to other physical illnesses and therefore justifiable.

While many older people are not keen on taking antidepressants, the thought that they are better than taking nothing seems to influence their decisions to stay on them. Those who are Unable to Articulate their depression have usually taken antidepressants long term and project a sense of resignation about taking them.

"I don't think anything has helped me very much you know, a just continue with it [medication]" (OP1, p.10)

Many Superficial Accepters have a negative opinion of antidepressants and do not believe they are helpful. This could be influenced by their fear of the stigma associated with antidepressants and their limited acceptance of their depression. They are also more likely to focus on negative sensations which they attribute to medication rather than the symptoms of depression.

“She prescribed Prozac. And, that’s just a short of knee jerk reaction from the doctors, miserable Prozac, miserable Prozac, not what I needed at all, what would have been much better off if she had given me a couple of sleeping pills” (OP3, p.2)

Older people in this sample seem to report taking antidepressants more willingly when they have had previous positive experiences of them, have been surprised by their beneficial effects, or when their GP has been able to help them view antidepressants differently.

“[Antidepressants] help me stay calm and let things go over my head... I never realized that a medicine could change my life so much” (OP5, p.3, 5)

“He [the GP] solved the problem for me by saying...this is not for your heart it’s for your brain, it was a good way he put and I sort of accepted it a bit better” (OP6, p.12)

This change is most likely to happen with Superficial Accepters who tend to have low expectations of them helping and are averse to taking them initially, but whose views can change after the initial decision to take them.

Reports given by the Striving to Understand group suggest they are more open to experimenting with antidepressants than other groups because they are experiencing a period of transition in their previous views and attitudes to depression. This includes being more likely to try them initially and testing what happens if they stop taking them.

They both advised that I keep on taking the tablets. I’d love to give them up which I did once... but I thought I was getting better so I stopped taking them, but I realized that I should have kept on taking them (OP6, p.2)

It seems that GPs are more likely to persuade older people in this group than others to take them by explaining how they work or challenging their attitudes towards them.

These factors suggest that the majority of older people who struggle with the idea of taking antidepressants link them with their fears of stigma, losing control and dependency. Superficial Accepters or those Striving to Understand may be more readily influenced by GPs who can challenge and explore these attitudes with them at the time of making decisions about treatment. Those who are Unable to

Articulate may benefit from GPs increasing their awareness of the choices of treatment available to them which may help them feel more empowered and influence them in moving forward.

Older people's decisions about trying talking therapies such as CBT (Cognitive Behavioural Therapy) or counselling are considered next.

Influences over views of talking therapies

Influences over whether older people are likely to try talking therapies such as counselling or CBT (cognitive behavioural therapy) give an insight into what influences them in trying it or not as a form of treatment. In some cases their negative expectations of the treatment can influence them in trying it, as can their stage of understanding and acceptance of depression. It is most likely that dilemmas about whether to try counselling or CBT can arise for older people who have conflicting views on talking about depression.

"It's difficult, you know, talking about how you feel, I always feel it's like I don't want to, that depresses me. ... but I think sometimes talking about it can help you know." (OP15, p.3)

This can particularly be the case with Superficial Accepters or with people between stages of understanding and accepting their depression. For those Unable to Articulate there is a need for GPs to recognize times of change in their attitudes to depression and treatment, and adapt to their needs accordingly.

Older people in the Striving to Understand group seem most open to trying counselling or CBT as an alternative to medication, but appear to attach conditions to this. At the same time they are likely to choose home visits and building a relationship with a counselor in order to be in a situation or environment where they can talk freely. OP8 felt that the home visits from mental health nurses and home visits to psychologists were more helpful as support for his wife than for him as he did not feel any benefit from talking therapies.

I don't know how psychology operates...it [talking therapy] didn't do any harm and eventually I got better, but I think it was more of a satisfying situation feeling secure for [name of wife] (OP8, p.6)

Some older people in the Unable to Articulate group with severe or long term depression seem to be more comfortable taking medication than dwelling on their depression by talking about it. They come across in interviews as indifferent to talking therapies and may report trying them but not feel any benefit from them.

I don't need counselling you know ...I've been through that much I think I can handle it myself now (OP16, p.4)

Their expectations of talking therapies working can be very low, since they appear to view their depression as being too deeply ingrained within them to be able to change by talking about it. These expectations further underline the lack of benefit talking therapies could have for them, particularly if it is the wrong time.

Although it seems most pertinent for the Unable to Articulate group, the timing of talking therapies can be important for all groups of older people for different reasons. Their decisions not to try CBT or counselling may be influenced by the stage at which they have previously experienced counselling as well as what triggers the depression. This can happen if they have had counselling at the wrong time, such as when they were previously too distressed to talk during a crisis point.

I found it [counselling] very difficult... she was probing a bit deep into my life as it was, if you follow, what had happened over 32 years, married and you know like, questions I didn't like, a bit personal you know... (OP6, p.2-3)

If you are in the middle of your depression and you talk to one of these [talking therapists] and I can say they're all the same, they always leave you in a sort of feeling down on your early life (OP3, p.10)

This illustrates how older people can need different things at different times and may not always be able to articulate what they need.

Influences over older people in the way they tell their stories have now been considered. The next section of this chapter considers influences over GPs in the ways they respond to the stories older people tell them.

Influences reported by GPs over responding to older people's stories of depression

This section looks at influences reported by GPs over how they say they respond to older people.

There appear to be a number of influences over GPs when managing older people with depression when they respond to the stories they tell them. The majority of the time the help they offer appears to be influenced by their different styles of working and skills they draw on, as well as contextual and situational factors such as medical guidance and issues specific to their workplace. Influences include whether to tackle mental or physical health first, those over identifying, diagnosing and labelling depression in later life, those over whether they dig deeper or leave depression well alone, and those over the course of action they take and the choice of skills to draw on for different patients. When taking these actions GPs also face different dilemmas depending on their style of working. The influences they report over them and dilemmas they report facing in response to older people's stories of depression are discussed next.

Influences over addressing physical or mental health first in consultations

Tensions appear to exist for GPs in choosing whether to tackle physical or mental health first in consultations. They report that what patients choose to tell and hold back in consultations can influence them in this, alongside situational factors such as resources and the practice they work in.

Active Listener GPs say they primarily tackle mental health problems by being aware of their possibility in everyone, even when patients are presenting with something else. When they describe dilemmas over tackling physical or mental health first it seems to be mostly with older people who have multiple physical or mental health problems.

"I'm sure I under-recognize it in the elderly because we get side tracked with other physical illness but if you look at the literature people with chronic illness are very likely to be depressed anyway and it's hard to know which comes first" (GP9, p.10)

These could be patients across the continuum of understanding and accepting their depression. However some Active Listeners say they mainly see patients who go to them specifically for mental health problems, so it seems this dilemma may not be as likely to arise as often for them as for GPs working in other styles. However they may need to adapt their skills with Unable to Articulate patients who need quick solutions to physical manifestations of depression and who struggle with communicating their depression. Active Listeners could do this by changing their working style towards that of a Problem Solver GP and treat physical problems as a way of tackling the depression.

Analyst GPs express concerns about whether they have gathered all the necessary information about patients' health problems to make the right choice about tackling mental or physical health first.

“Occasionally I fool myself into thinking I know what is going on and then something will happen and I think people just tell you....so you don't know what's going on really, just a partial view” (GP10, p.3)

This might happen with older people in the Superficial Acceptor or Unable to Articulate groups who have a definite agenda of what they want to present. In these situations it seems Analyst GPs need to be skilled in obtaining a full picture of the patients' health whilst adapting their skills and using their intuition to prioritize.

Problem Solver GPs say they are more comfortable working with physical illness but prioritize mental health problems in patients when necessary. While they typically appear more concerned with overlooking physical illnesses than depression in older people, they seem to use their skills in judging the right time to adopt different approaches and judge what sort of consultation it is going to be.

You have to be a little bit more sort of open to the fact that the patient with one problem... [may not be] the sum total of what that consultation is going to be about, and you know to adopt a more holistic approach...that's very important I think (GP5, p.5)

Challenges may arise for Problem Solver GPs with Striving to Understand patients who need time to talk about their depression. These GPs indicate they may not have enough time or confidence in their suitability to talk about emotional issues

and react by referring to colleagues or counsellors who they see as well placed to provide this help.

“Maybe we should be more direct and ask them [about depression]. I mean we should be asking, but how far? Sometimes you don’t...” (OP12, p. 8-9)

Other challenges can arise with Unable to Articulate or Superficial Acceptor patients who do not reveal their depression. If Problem Solver GPs suspect depression in these patients they are likely to use assessment tools such as the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009) to decide on whether it is a mental or physical health consultation. Alternatively they may refer on if they feel the patient needs help they cannot offer or if they feel the older person is not coping. It is likely that Problem Solver GPs are best placed to respond effectively to Superficial Acceptor patients who prefer having scientific evidence to support a diagnosis of depression as well as Unable to Articulate patients who seem to prefer quick solutions such as changing medications and who may not be in a position to explore their ideas around depression further.

For GPs across the continuum of working styles there are conflicting influences over them in deciding whether to tackle mental or physical health first with patients who have multiple health problems and/or who are Unable to Articulate their depression. This can produce tensions particularly with Problem Solver GPs and some Analysts where on the one hand they believe it is wrong to overlook depression in older people but that they also recognize they may be less alert to it because of their tendency to focus on physical illnesses.

“A lot of doctors get bogged down in the physical things and they don’t think about the psychological...you are talking about often hidden agendas, deeper problems, problems that you need to go to a little bit of effort to detect they are going to get missed (GP6, p.6)

“I don’t think you can just get away as a GP with just treating a physical problem... you do have to dig” (GP5, p.5)

GPs may also give the impression they can also feel powerless if what they are able offer the patient is different to what they feel is best. In these situations they might focus on physical problems to make a difference in whatever way they can instead of the depression. They say this is likely to happen with patients who have multiple and closely entwined physical and mental health problems and whose

situations or lives have been particularly traumatic. It is likely that this can include patients from across the continuum of groups in the older people's typology and are described by GPs as "heart sink" patients.

Influences over GPs in whether to tackle mental or physical health problems first highlight a need for patients with more ambiguous or multiple health problems to be able to express their preferences to GPs clearly. It also points towards a need for some GPs to build their confidence in dealing with depression in later life with these patients.

Alongside these influences there are related factors considered by GPs about whether to dig deeper for patients' fuller stories of depression or to take their stories at face value. This is discussed next.

Influences over taking stories at face value or digging deeper

When GPs have established depression in older people, they describe considering factors that influence them in whether to take patients' stories at face value or dig deeper to uncover more information about individuals' circumstances. It is likely that their style of working is a main influence over what they do, particularly on the basis of whether or not they can offer the type of help patients need. Other influences appear to be how confident they report themselves to be in managing older people with depression and whether they report having time to unravel complex situations.

Problem Solver and Analyst GPs who have little interest in mental health or are less confident dealing with it sometimes liken uncovering depression in later life to "opening a can of worms".

"...I think if there's any possibility of any other problem you wouldn't go there, well I wouldn't..." (GP13, p.11)

This suggests that for those GPs uncovering it can reveal numerous additional problems relating to the patient's health and situation which they find overwhelming when working within the limits of 10 minute consultations. These GPs say that an important consideration is whether to address what the patient says at face value as most important, or whether to dig deeper and look beyond what is said, in order to seek out depression. It seems that GPs mostly face this

dilemma when pressurized for time and when it would be quicker to take what is said at face value, but also when their instinct can be to actually dig deeper for depression.

The more radical Problem Solver GPs do not appear to see it as their responsibility to seek out depression in older people and imply they believe the decision to present with depression should rest with the patient. This approach may not be ideal for patients who need encouragement or support in disclosing their depression. This

includes some Superficial Accepters whose view can be that depression is a sign of weakness and prevents them from revealing it to GPs.

In contrast, the more radical Active Listener GPs say they believe it is a priority to dig deeply for mental health problems in most patients possibly because it is a special interest of theirs and many patients come to them specifically with mental health problems. They tend to regard addressing older people's mental health as the first step towards maintaining good overall health and often a key factor in tackling physical health complaints. Patients who are Unable to Articulate their depression may need more encouragement in teasing their story out, and if they are experiencing a crisis and are unable to cope they may need this support. Active Listener GPs who can intuitively see when they need this extra support would be ideal at these times, but they would also need to recognize when these patients need quick positive action and can adapt their skills accordingly.

This section suggests that GPs who are less likely to dig deeper to uncover more information include some Problem Solver GPs with more radical and inflexible working styles. It may also include those who work in different styles that also have less interest in depression in later life.

Influences over GPs in the process of identifying depression in later life are considered next.

Influences over identifying depression in older people

GPs report using different methods of identifying depression in older people, and make choices about which is the most appropriate to use at the time. Influences include the style of working they employ and how the patient defines, explains and labels their depression when telling their story in consultations.

Assessment tools for identifying and measuring the severity of depression are seen as valuable by GPs across the continuum of working styles for different reasons. With Unable to Articulate patients who do not open up many GPs say they feel that using assessment tools such as the PHQ9 (Depression in Primary Care PHQ9 Toolkit, 2009) or the QOF questions are a good way of opening a conversation about depression. This is likely to be the case with patients who are Superficial Accepters who need “evidence” of their depression to help them accept it.

Problem Solver GPs say they typically use assessment tools in preference to active listening and exploring patients’ ideas around depression. Patients who are Unable to Articulate their depression and hold back on their stories are likely to prefer this approach as it fits with the way they tell their stories. This is also the case with some Superficial Accepters who are not ready to move forward with their ideas about depression and its impact on themselves. However GPs could be mindful that this could cause a situation where patients and GPs become stuck in a cycle of not finding the right treatment and recovery for the patients’ depression, as neither are adapting to each other or changing the way they tell their stories or use their skills in managing it.

Active Listener and some Analyst GPs particularly appear to feel their intuition is an important tool in identifying depression in older people. They generally speak of using this in preference to assessment tools if they have a special interest in mental health or are led by their intuition in their style of working. They feel that these tools do not capture the frequent changes and depth of patients’ experiences.

Tensions can be found when GPs’ intuition challenges information they find in patient records. This can sway their decisions to use assessment tools and go

against their intuition especially if pushed for time or feel less confident with particular patients.

“I suppose in the end there is a kind of gut feeling that you get as a GP. Maybe actually we probably ignore our gut feelings and go along with what is on the screen” (GP4, p.12)

“When pushed for time you want to ignore your intuition” (GP10, p. 8)

This approach to identifying and diagnosing depression is likely to work well with older people who do not speak of their depression openly, such as those in the Unable to Articulate group. These people may need their GP to spot clues in their demeanor or read between the lines of what they say. Active Listener and some Analyst GPs may also need to change their natural intuitive approach to identifying depression in later life when they encounter Superficial Acceptor patients, who need concrete evidence of their depression to be able to accept it and move forward with the way it is managed.

Analyst GPs are likely to need as much information as possible and because of this can become frustrated when trying to identify and diagnose depression in older people. This is especially likely with patients who are Unable to Articulate their story or with those whose carers or relatives are involved in their healthcare and speak for them.

“One of the most difficult things with people who perhaps lack capacity or have other co morbidity such as dementia is that how do you know they are depressed? Is it the carer conveying this information to us? Do we take the carer’s word?...Are we treating the carer and the carer’s perceptions or the older person?” (GP1, p.1)

This frustration exemplifies a common challenge amongst Analyst GPs when they describe striving to get enough information, and illustrates how it is not always possible for them to do this when one patient has many different carers e.g. in a nursing home. Analyst GPs may be able to address these concerns by moving towards a more intuitive style in identifying depression in older people and placing confidence in their own judgements where they feel information is missing.

The timing of using assessment tools in identifying depression in older people also appears to be an important influence. This requires GPs to be skilled at accurately

judging when assessment tools are appropriate and which patients need other approaches to identifying it at different times.

The next section focuses on influences that GPs report over [their decisions around] diagnosing and labelling depression in response to older people's differing stories.

Influences over diagnosing and labelling

Influences GPs report in diagnosing and labelling depression in older people generally centre on how patients communicate their story. Making a formal diagnosis is seen as beneficial for some older people and less so for others due to their range of attitudes towards a diagnosis of depression and the impact it could have on their recovery. GPs can therefore face decisions with some patients about whether it is more suitable to avoid a formal diagnosis and find a less medicalized "language" for it, and with others what they would find to be the most suitable term for depression.

"...we do use the word depression in a very varied way really, people will say I'm depressed, and they're not depressed they're just fed up... but then if you ask people if they are depressed then usually they are depressed"
(GP9, p.5)

"It's not so much the way it affects them, it's the stigma attached to it, the unfair stigma, I think the fact that they often will feel uncomfortable about either calling it that or acknowledging that it's that and I try to rephrase it or frame it differently" (GP6, p.3)

It can be challenging to pre-empt this decision and achieve the right balance between formally acknowledging depression and mutually recognizing it without using the term. In addition GPs make these decisions whilst establishing the patient's perspective on their depression and assessing what they can do to help.

Many GPs across the continuum of working styles also report feeling that making a formal diagnosis and labelling depression is helpful with patients who fit the characteristics of Striving to Understand or Superficial Acceptor patients. They report doing this to help them explore their perceptions of what it is or accept they

have depression. They report finding it helpful to use the term “clinical depression” when patients struggle with the idea of it being a legitimate illness.

“I’ll often say “well I think you’re clinically depressed”, when they’re depressed. And they’re more likely to accept that and internalize that I feel than “you’re depressed”... There’s something in that word that’s....that’s slightly incontrovertible. You know. They’ve been given this “clinical” diagnosis” (GP3, p.5)

It is likely this would usually be with Superficial Acceptor patients who have a stoical attitude to depression and see depression as a weakness of character. Alternatively for all types of GPs, normalizing it and avoiding the term depression can be reassuring for patients who they describe as fitting with the Superficial Acceptor group, who minimize their depression by reducing their worry about stigma.

It is likely that for Problem Solver GPs, using the patients’ chosen term for depression is a way of saving time in consultations rather than challenging and exploring their ideas by using medical terms.

“To reflect back at them their own language and their own description is a very good idea, I find that quite useful in consultation because that’s helping them to understand what they’ve got so it’s kind of try and empathize” (GP5, p.7)

It could also be beneficial when the patient is at a crisis point and needs to accept diagnosis and treatment for their depression quickly. At a later stage it may be appropriate for these GPs to refer onto somebody who they can talk their experiences through with if they need to. Recognizing this changing need is an important skill for Problem Solver GPs. A disadvantage of this is that it could form a repetitive cycle where opportunities to improve may not be taken by either the patient or GP if they are both comfortable working this way. A strength of these GPs is being able to recognize when patients require help outside their capabilities and respond by referring to colleagues or mental health services.

Another consideration for GPs is whether they report feeling it more appropriate to give a formal diagnosis of depression or leave the patient to label it themselves, whilst still addressing the depression through treatment and management. Active

Listener GPs usually do this when they feel the patient will struggle with accepting the idea of having depression such as with some Superficial Acceptor or Unable to Articulate patients. They appear confident they can make a positive difference with most patients when they are able to approach depression holistically and explore wider issues in the patients' situation. Most Active Listeners seem confident to take this line of action with all three groups of patients if they are in a position to change in their understanding/acceptance of depression or their willingness to talk. However even though they prefer this approach with decisions around formally diagnosing and labelling depression Active Listeners are able to adapt to most older people telling their story by using their intuition to gauge patients' boundaries.

This section proposes that an important factor for GPs whatever their working style is to understand how patients conceptualize depression. Having this understanding is the basis for influences over GPs' in which of their skills to draw on for individual patients, and is considered in the next section.

GPs' reports of adapting their skills

This section focuses on how GPs report adapting their skills to different patients, and what appears to influence them adapting. As with the rest of this chapter, the suggestions made here of what is likely to happen in consultations are made on the basis of interviews with a small sample, and could be used as a starting point in an observational study. It is also recognized that GPs' reports may differ in interviews with a researcher than in other situations e.g. talking to a GP colleague. Suggestions of how different GPs and patients might respond to one another derive from comparing older people's and GPs' reports of what they say and do in consultations for depression and theorizing about what is likely to happen.

In telling their stories of managing depression, GPs report drawing on combinations of skills that vary depending on the patient they are seeing. This indicates they are likely to adapt their skills to different patients. GPs in the sample report adapting their styles of working to various degrees with different patients at different times. It also seems that adapting may be necessary at different stages of the management process from establishing the type of consultation it will be, to

identifying depression, deciding on the most appropriate course of action for individual patients and selecting the skills they need to use at different times.

Main influences over GPs in how they adapt their skills appear to be their working style and the stories older people tell. In their interviews they describe different situations where they use different skills and when they might change their usual style. The stories told by Active Listeners suggest that they adapt their skills by relying on their intuition to ascertain the type of help to offer patients. They also describe taking a lead from patients' on what they think needs to be done.

"It's about forming an alliance, that allows them to explore possibilities and to make their own choices with a body of information and with support to make some leaps that may be a little bit harder" (GP8, p.3)

In adapting their skills Active Listener GPs describe facing decisions about when to rely on assessments and guidance rather than intuition and clinical judgement, and when to lead the direction of consultations rather than taking a lead from patients.

"I'd put assessments aside and say what is really important is response to the difficulty, and adverse life events, what impact that's having and...and how vulnerable that's making them" (GP2, p.4)

This approach could be challenging with Unable to Articulate patients who indicate they are not accustomed to expressing their preferences in consultations.

"he was one of the care people and seemed to know when I was ready to talk and that was a relief, like...up until then I wouldn't talk to the doctors...I wouldn't explain what was wrong cos I didn't know" (OP11, p.4)

It is also possible that adapting their skills towards that of a Problem Solver GP could be helpful in situations when patients need GPs to take decisions out of their hands at certain times e.g. when they are at rock bottom with depression.

From their reports of being able to draw together a broad range of information, it seems that Analyst GPs may be skilled at finding solutions to complex jigsaws of patients' stories. However they sometimes indicate their frustration of not having enough time to get the full story which could suggest a need to adapt their skills towards those of the Problem Solver style.

"If you find yourself really stucka hear myself saying things like, am not going to insult you by saying I can sort this out in 10 minutes so let's set

aside some special time that we can go through this and I can actually try and work through some of the issues and problems that we've talked about... And I think people really appreciate that sort of approach, and does get you out of a bit of hole at that particular day.” (GP7, p.7)

Adapting towards a more Problem Solver style might involve becoming more focused on taking action around single health problems and making these decisions by recognizing when they feel “stuck”. From their reports of managing complex cases, it seems that GPs are likely to feel stuck if they have come to an impasse with the patient where they are caught in a cycle of being unable to find a solution that works.

Problem Solver style GPs seem confident when they describe monitoring and assessing patients, and are possibly more solution focused than patients who prefer other styles. It would therefore appear that their strengths lie in dealing with Unable to Articulate patients who are likely to prefer this approach and Superficial Accepters who need long term care, as well as patients who need quick medical intervention at crisis points. However they seem less comfortable offering their skills in talking about depression as a main form of help in consultations.

“If someone presents with physical problems that you are not getting to the bottom of and its almost impeding your consultations....in that case you would almost be pushed into asking...” (GP13, p.3)

Because of this these GPs may need to be particularly alert to when patients need to discuss their experiences or understanding of their depression.

Problem solver GPs appear to ascertain what has caused the patients' depression before deciding on how to adapt their skills and what help to offer.

“I would tend to make that decision, that offering depending on what's actually caused the depression” (GP4, p.3)

If patients have been depressed over the long term it may lead to gradual exploration of ideas in short consultations with Problem Solver GPs; with patients whose depression has been brought on by bereavement they are likely to refer to a counsellor. This could include those Striving to Understand who are past their crisis point and want to explore their depression further. The most extreme Problem Solver GPs are least likely to adapt their skills to patients with depression in older people and more likely to refer on if their skills do not match the situation.

A lesser degree of adapting seems likely with GPs who are positioned towards the ends of the continuum of working styles. This is because they report being more extreme in their convictions about what depression in later life is and how it should be managed. A combination of GPs like these who are less likely to adapt and older

people who prefer a more rigid approach could create a repetitive cycle of them only responding to each other in certain ways. This may be the case especially if the GPs' working environment accommodates their style of working, such as where there is an agreement with the practice to work this way. It seems that GPs in these situations would need to be mindful of this happening to prevent patients who have the potential to move forward positively from remaining static.

It therefore appears that a key factor in managing older people with depression is for GPs to adapt their skills appropriately to achieve the right balance at the right times. The most adaptable GPs can draw on skills and characteristics of a variety of styles to meet patients' individual needs. GPs who can adapt like this may be best suited to managing older people with depression.

Interactions between older people and GPs

This section is a theoretical proposition and presentation of the "crossover themes" identified in both sets of data. It proposes what is likely to happen in consultations for depression in older people between different types of older people and GPs. How groups of older people and GPs may interact is at the heart of this theoretical proposition since it takes the earlier findings chapters of this study, which are presented as a descriptive analysis of data, to an interpretive level of analysis where propositions of what may happen on the basis of the earlier findings are made. Quotes from the data are minimal in this section since it comprises the researcher's constructions developed from the data given by participants, who do not directly speak of the different types set out in the typologies and how these they interact. In this way generating these ideas involved IG taking analysis beyond the "knowing subject" (Foucault 1973, cited in Clarke, 2005, p.126) to

make suggestions about what might happen and is presented at an interpretive level.

The suggestions here derive from the different types of older people and GPs identified in the typologies found in the earlier findings chapters, and their reports of influences over what they say and say they do in consultations for depression. Crossovers identified in the data of what happens in different situations are also considered. The section starts by proposing what older people's preferences in GPs are likely to be given the ways they tell their stories, which may be helpful in predicting GPs they are likely to respond best to. This was the starting point for building theory around how older people and GPs are likely to respond to each other. Different combinations of older people and GPs are then considered, including those that may work well in practice. The purpose of this is to provide a starting point that could inform observations of consultations to see what would help older people and GPs interact together more effectively. This responds to evidence showing that there are problems in the way older people and GPs talk about depression to each other in consultations (e.g. Coventry et al., 2011). Alternatively this information could be used as a basis for checking what happens in consultations between older people and GPs, and identifying what works well for them and what does not.

Influences over older people's preferences in GPs

Superficial Accepters' stories indicate they prefer to see GPs who take a lead from them and accept their denial of depression whilst at the same time helping them recover. Analyst GPs are able to use a wide array of skills at one time to accommodate Superficial Accepters' needs, such as talking around the depression with patients but not as the focus of consultations, being flexible in the help they offer and asking lots of questions which may prompt further reflection in patients. However there may be tensions when Superficial Accepters have a definite agenda which does not fit with Analysts' GPs questioning style but this could be resolved by Analysts asserting their professional expertise. Further, making the patient feel listened to seems to be important for Superficial Accepters but they suggest this has to be on their own terms since their reports indicate a separation between the story they are prepared to share with others and talking about their true thoughts and feelings about their depression and its impact on their lives.

Therefore Active Listener GPs' skills are likely to work well for them if they are able to adapt and draw on some of the skills from the Analyst style of working which help them progress their acceptance and understanding of their depression.

Older people who are Striving to Understand their depression may typically prefer GPs who lean towards the Active Listener style. This is because they need to work out their ideas about depression and practice their story. Active Listener GPs are skilled at facilitating this and guiding the patient through the process of verbalizing their depression and consolidating their story. They are also able to spend the necessary time with patients to do this and talk about other areas of the person's life as well as the depression in order to help them work out what has happened to them. Those Striving to Understand describe these GPs fondly and consider the trusting nature of their relationship to be important as it allows them to open up. However people from this group may not be able to express their story in the way they want to and require support from GPs in doing this. Therefore GPs may not only need to dig deeper to uncover depression but also may not have time to listen to the story. In less ideal situations where these patients cannot choose their GP (e.g. if their preferred GP was unavailable) they may not take the step of opening up with a stranger and instead revert to a previous stage of presenting with physical problems or minimizing their depression.

Older people who were Unable to Articulate their depression generally do not speak of their choices regarding which GP to see. They are passive about this and speak of being given medication and going for review appointments or checkups but do not give many details about how they interact with their GP during consultations about their depression. This indicates that GPs working in the Problem Solver style are best suited to their preferences of not wanting to talk about their depression and taking actions such as trying different medications and assessing and monitoring their progress with these. However Analyst GPs who are skilled at showing empathy and can use their skills in putting together a jigsaw of information may be the most appropriate GPs for these older people. For the relationship to work these GPs would have to be skilled at building a trusting relationship and become familiar with their story from the glimpses of information given. Analyst GPs developing long term relationships with these patients are

likely to be helpful with getting to know their stories as far as possible and through this finding out about their individual needs and preferences.

Older people who are between stages of understanding may be best suited to GPs who use skills leaning towards the Active Listener style of working. These skills include making the patient feel as if there is enough time to talk through their problems, being able to listen effectively and helping them establish their position in relation to their depression. These skills are about GPs making patients feel that their needs are being individually met, and then being able to adapt to what patients need or recognize the need to refer on afterwards.

Older people can therefore have different needs and preferences depending on the stage they are at. What is likely to happen when different types of older people see different GPs is considered next.

Different combinations of older people and GPs

The stories told by older people and GPs about what happens in consultations seem to suggest that different combinations of GPs and older people are likely to have typical ways of interacting in consultations. The interpretations that follow have been developed by comparing the interviews of different types of older people (set out in the older people's typology) with those of different types of GPs (set out in the GP typology), where ideas developed from this comparison have been built around the data. For example what Superficial Accepters tend to say about what they tell GPs and how Analyst GPs report responding to different types of patient. This is an attempt to bring the two sets of data together and make suggestions about how older people and GPs might respond to each other. Consideration is also given to the help different types of older people may need from different GPs and how different GPs may respond. These suggestions may be useful as a starting point for developing a model that GPs could use to quickly ascertain the most appropriate help for different older people from the stories they tell about their depression.

Superficial Acceptor and GPs with different styles

The stories of Superficial Acceptor patients suggest they may need to come to an acceptance of their depression, and that while they appear happy to talk about it

they often report minimizing or hiding it from other people. Active Listener GPs describe listening to patients about their depression and helping them by facilitating their storytelling. This suggests that they may be well suited to helping patients who either need to explore their ideas about depression verbally as a means of helping them move forward, or who need encouragement to talk. These factors suggest it is likely that this style of GP would work well managing Superficial Acceptor patients.

“...at the best end you’ll have very thoughtful caring doctors who will see the patient again who will enquire further will strive [to help with depression], and at the other end you’ve have people “well here’s a pill” ...well first of all they might not spot it [laughter] or secondly there might be “a pill for every ill philosophy” without too much support” (GP3, p.12)

Superficial Accepters patients also tend to say that feeling understood is important to them, and Active Listener GPs describe using their skills in active listening and showing that they are hearing and understanding what is being said. It is likely that this approach would support Superficial Accepters’ in their story telling agenda and help them explore their story of depression over the long term, in order to help them accept it more. It seems that if these patients feel their depression is understood by their GP it may help calm the frustrations they describe feeling towards the healthcare they receive for depression

Most Active Listener GPs describe using their intuition to determine how patients are feeling and whether to encourage patients to talk more about their depression. This suggests that these GPs may be ideally suited to assessing whether Superficial Accepters are between stages of understanding and accepting depression and whether it is the right time for them to begin exploring their ideas further about depression.

Problem Solver GPs describe themselves as being less likely to dig deeper to explore patients’ ideas beyond what they say at face value about their depression.

“I am trying to wrack my brains to think of [conversations about depression] that I’ve initiated recently...very few come in and say ‘I’m down in the dumps’ ” (GP12, p.1)

This may be ideal for Superficial Accepters whose stories indicate they have a definite agenda of the information they are willing to share with other people and who

are not at a point of change in their perspectives of depression. However it seems likely that problems may arise if Superficial Accepters do not reveal their depression to these GPs or minimize it because of their fear of stigma or wasting the GPs' time. This could happen with the more extreme Problem Solver GPs who say they believe it is the patients' responsibility to come to them with depression rather than for them to seek it out.

"If they want to tell you something they will crack on and tell you." (GP13, p.4)

Also due to their reports of preferring to take positive action in consultations and using assessment and monitoring tools, it seems that Problem Solver GPs are likely to be skilled at providing help quickly in the short term. This approach may also provide Superficial Acceptor patients with the medical evidence they seem to prefer to convince them of their depression or to try certain therapies. However Problem Solver GPs give the impression they address visible physical symptoms as a priority, which could mean that if these patients are minimizing their depression there may be a delay in the GP uncovering it.

Striving to Understand and GPs with different styles

When Striving to Understand patients tell their stories of depression they often try to put events into chronological order as if to make sense of what has happened to them and feel more control of their depression. They can also appear overwhelmed by the multiple issues that come to the forefront when they tell their story for the first time.

Since Analyst GPs describe confidently dealing with wide ranging information and complex patients, they may be well suited to helping Striving to Understand patients. They could be skilled at helping them tell their stories by defining choices for them and focusing on what is important in their recovery, as well as helping them see a way through their stories amidst the mass of information that can surface during their storytelling.

"Sometimes people are much more reflective...the more difficult sub group are those who have long term mental health problems, often people with

low self esteem depression, anxiety and may well have had pretty horrible experiences in the past...we spend a lot more time with people like that” (GP7, p.3)

Some Analyst and many Problem Solver GPs report their concerns about time limited consultations. Because of this they may not be able to give the time required to listen to the stories of Striving to Understand patients for as long as they need to feel fully unburdened. In contrast Active Listener GPs may be best at this aspect of consultations with Striving to Understand patients as they describe listening to patients’ stories of depression and helping uncover their concerns about it, without feeling as pressured for time.

“Everyone knows time is a problem, how can you be this perfect holistic doctor in a 10 minute appointment? You’ve got to use the resources available to you, and that’s bringing people back. You have the luxury of being able to see them again” (GP14, p.4)

Taking more time is likely to help these patients establish their own ideas about depression which they may find reassuring, and help restore a sense of control which these patients particularly express struggling with. Active Listener GPs also report relying on their intuition to make judgments about when it is the right time to explore certain ideas about depression with patients, which suggests that they would be good at judging when it these patients are ready to open up or when they are at a point of transition between stages of understanding.

Unable to Articulate and GPs with different styles

Interviews with Unable to Articulate patients suggest that they tend to give minimal information when telling their stories of depression. Active Listener GPs indicate they are confident reading between the lines of what patients are saying, and because of this may be skilled at uncovering clues about these patients’ depression when they hold back information. These GPs report using their intuition and clinical judgement to ascertain the patient’s non verbal cues and possible references to their state of mind embedded in what they are saying.

These GPs’ reports of exploring patients’ stories of depression indicate they are more likely than other working styles to help the patients explore their longstanding

views about why they have depression and its impact on themselves, and by doing this

possibly challenge and change patients' views. This may be what Unable to Articulate patients need to move forward in their treatment, providing this happens at a time when they are ready to talk. Active Listener GPs talk of using their intuition to ascertain the right time for patients to open up, so may intuitively see when Unable to Articulate patients need extra support in times of crisis.

Analyst GPs report using a wide range of management strategies for depression and because of this may be likely to provide Unable to Articulate patients with ideas for trying new forms of help for their depression.

"It's making a balanced judgment of what are the risks of using for example a drug that may have side effects and cause more problems versus doing nothing." (GP1, p.4)

Due to their reported skills in navigating their way through complex problems, these GPs may also be able to help guide these patients through choices that are available to them. Since these patients tend to project a more passive mindset in interviews, this could help empower them and possibly encourage them to take a more active role in consultations.

Due to their reports of preferring to take some form of action consultations, it seems likely that Problem Solver GPs would take control and make decisions about management without it being necessary for these patients to open up. They often report using assessment tools and seem confident monitoring patients' depression, which may also minimize the need to talk about the impact of the depression on the patients' sense of self. Their reports infer that these GPs are most comfortable tackling physical manifestations of depression, but that they may not explore the patients' understanding of why they have depression. Unable to Articulate patients tend to hold back in telling personal components of their story and it is possible that they may be telling these GPs what they think they want to hear. In doing this they would be sharing what they perceive to be problem that is "legitimate" to take to GPs rather than wasting their time.

In considering what is likely to happen between different combinations of older people and GPs, it seems that different types of GPs could offer valuable skills for each type of older person. In addition there may be common needs that the majority of older people have, such as a desire to escape from illness, not wanting to burden the listener with stories of depression and finding it difficult to open up for different reasons. There are also common challenges for GPs such as deciding whether to tackle mental or physical health first, taking in hand multiple health and situational problems and a lack of time. These factors suggest a need for GPs to adapt between styles of working appropriately for different types of patient and it seems likely that GPs who do this would be most successful at managing older people with depression.

Key theoretical interpretations

The findings from this chapter provide a model that is not empirical but theoretical, which would need to be tested using other methods to see if it has relevance. However it does suggest influences over the different ways older people and GPs operate in consultations for depression, and how different combinations are likely to respond to each other. It may be seen as a starting point to determine what influences older people in what they say and do in consultations for depression in later life, and may complement data obtained in an observational study of consultations between older people and GPs.

Analysis of older people's and GPs' interview and contextual data has led to the development of theory about influences over what older people and GPs say and do in consultations for depression. This includes possible influences over the different ways older people tell their stories to GPs and possible influences over how GPs respond.

Older people report being influenced by different factors in telling their story of depression and this is guided by their stage of understanding their depression. However depression also appears to be a topic older people commonly struggle with when talking to GPs with some aspects of their stories. GPs report being influenced by different factors in the management of older people with depression

and this is guided by their style of working and the skills they draw on when offering help.

Older people need GPs to adapt to their differing and changing needs to provide the most appropriate help in managing their depression.

All combinations of older people and GPs are likely to have benefits and disadvantages. However Active Listener GPs seem most suited to addressing the needs of most groups of older people with depression identified in the older people's typology.

The findings presented in Chapters 4, 5 and 6 and their implications are discussed in the next chapter.

Chapter 7: Discussion

Introduction

This chapter summarizes the key findings of this study and critically discusses them in light of the literature presented in Chapter 1. It highlights what is new and how the study contributes to previous research. It also discusses its strengths and limitations with close regard to the methods and methodology used. Implications for older people, GPs, policy and research are discussed at the end of the chapter together with the conclusion.

Summary of findings

This study provides insight to the perspectives of both older people and GPs about their experiences of the management of older people with depression in primary care. The main form of data is from interviews with older people and GPs, alongside contextual data consisting of observations made by the researcher during the research process. The findings present evidence of the stories told and by older people and GPs of having and managing depression, and suggest why there may be differences in the ways they operate in consultations. It is proposed that these differences can be explained by the different and changing positions they take; where older people move around on a continuum of stages of understanding and accepting their depression and where GPs move between styles of working and employ different combinations of skills in response to older people's stories. It also appears that there are multiple situational factors (e.g. social context, life history, workplace) which may influence the positions both older people and GPs take and as a result how they respond to each other in consultations. Figure 7 (p. 220) summarizes the study findings.

Doctor-patient interactions are complex and the findings of this study suggest that older people need different things at different times. Therefore it is likely that the

GPs' ability to adapt his or her skills appropriately to these needs is essential in managing older people with depression. This study suggests a provisional model for tackling depression in older people, offering suggestions of different skills GPs could use with different older people according to the way they tell their story. The model consists of typologies illustrating the different positions that different groups of older people and GPs may take in consultations for depression, also a theoretical proposition is made about what is likely to influence older people in what they say, GPs in how they respond to older people and how they are likely to respond to each other in consultations for depression. The theoretical proposition is included in order to give an explanation for the different ways they operate. The model proposed may be seen as a flexible and practical approach that could be used in conjunction with the current medical guidance for depression. A "one size fits all" approach is currently advocated in NICE guidelines for depression (NICE, 2004 and 2009a) and government health strategies such as the NSFs for Older People (Department of Health, 2001) and Mental Health (Department of Health, 1999) where the same range of help is offered across the lifespan. The model suggested here provides more information about the different ways older people may tell their stories of depression to GPs, and how this may indicate the help they may need at particular stages of their depression. It also offers suggestions about how GPs working in different styles might adapt to their different types of older patient.

Previous research identifies factors from both the perspectives of older people and GP perspectives that influence and impede the management of depression in older people. This study contributes to the evidence by proposing how GPs working in different styles might help older people based on the different ways they tell their stories. Other studies exploring the dual perspectives of older patients and GPs on depression have looked at interactions between patients and GPs and the influences over what they say and do in consultations for depression, however few have suggested the different positions they take in relation to each other and influences over how they respond to each other in consultations.

The first section of this chapter is a comparison of the literature to the key messages from the findings and the theoretical proposition. Following this there is discussion of the strengths and limitations of the study including the methodology

and methods used. Finally the implications of the study for practice are discussed, followed by the conclusion.

Comparison of findings to existing literature

The older people's findings suggest that there are a number of different components to older people's stories of depression, which they tell in different combinations. The components of their stories, and the combinations of which they choose to tell and hold back from GPs, can indicate their stage of understanding and acceptance of their depression and what help they need at different times. These findings are discussed in light of the current evidence base.

Different ways older people conceptualize depression

Older people have different ways of conceptualizing their depression which diverge from the medical framework that guides general practice (Burroughs et al., 2006; Murray et al., 2006; Lawrence et al., 2006a). Research shows this can lead to challenges in its management, for example some do not see it as a medical problem in its own right and tend not to regard it as needing treatment (Pill, Prior and Wood, 2003; Reynolds and Charney, 2002; Rabins, 1996) however few solutions have been proposed. This study uses the different ways older people conceptualize their depression and the consequent stories they tell (in the older people's typology) as a basis for suggesting ways in which GPs can help them. Other studies have explored how patients construct their thoughts of depression. Those that have focused on older people's conceptualizations of depression have also highlighted the complexities and situational influences over their views but have not proposed practical solutions for GPs to tackle problems in managing it.

In a mixed methods qualitative study Barg et al. (2006) suggest that older people base their ideas of what depression is on loneliness and acknowledge different stages of loneliness which contribute to their depression. They propose that older people's acceptance of a diagnosis of depression and its treatment may be hindered by their beliefs that depression is normal in old age. In comparison this study suggests that older people's stages of understanding and accepting depression steer their storytelling which in turn influences how their depression is

managed. This study challenges the notion that Barg and colleagues (2006) put forward, that older people conceptualize depression in terms of degrees of loneliness and instead proposes that reasons for differences in older peoples' viewpoints are based on their position in understanding and accepting it. It also recognizes situational influences over their views including past experiences of treatment, traumatic life events, a fear of stigma which may hamper their acceptance of having it and their willingness to accept treatment. This acknowledges a wide sphere of influence over their perspectives and provides a typology of older people which can be used by GPs to determine how they conceptualize their depression and the impact this is likely to have over their choices in its management.

In a qualitative study Cornford, Hill and Reilly (2007) also explore the way patients with depression see their condition. Unlike Barg et al. (2006) the study is not specific to older people but they highlight a divergence between the social and medical constructs of depression by showing that patients can have difficulty separating depression from understandable reactions to life events. To address this Cornford and colleagues (2007) suggest a move away from the medical model of depression where it is defined as an illness, towards an approach which acknowledges the patient's experiences of feeling a loss of control and self identity. They suggest that the whole context of a persons' life should be considered in the help given and emphasize the individual nature of understandings of depression. They propose that the NICE (2004) guidance, which recommends that patients use self management tools as part of the stepped care model, could focus more on patients' individual strengths to help them recover rather than using similar self help tools for all patients.

The model put forward in the current study is based around older people's individual constructs of depression, which also include feelings of losing control and identity. In this way similarities can be seen between the present study and the Cornford, Hill and Reilly (2007) study in the way people conceptualize depression across the lifespan. However, the focus of this study is on older people and ways GPs can recognize their individual needs through the stories they tell. In considering the whole context of older people's experiences and situations, the findings of this study suggest that older people perceive depression differently

from each other and the way they construct depression is framed by their stage of understanding and accepting it. Like Cornford and colleagues (2007) this study addresses differences between the medical and social models of depression by considering the perspectives of both older people and GPs, and also suggests that GPs can help older people individually by adapting their style of working according to the stage of understanding the older person is at. This study also promotes an individual approach to managing older people with depression, by suggesting the importance of GPs considering their situations and influences over them in the way they tell their stories. This is supported by NICE (NICE, 2004 and 2009a) which recommends that interventions for the management of depression in all adults are flexible and patient-centred, for example that their psychological, social and physical characteristics are assessed as well as the impact of their environments.

The findings of this study about the different ways older people conceptualize their depression and the challenges they face in accepting it suggest that some older people may need support in preparing for later life and being able to recognize when they need help. The findings imply this as many older people indicate they have some difficulties telling their story of depression and report struggling to ask GPs for what they need. For example, some Superficial Accepters report both the detrimental impact that retirement has had on them and minimizing their mental struggle with GPs, preventing them from talking openly about their depression. Other Superficial Accepters do not recognize they have depression and report denying it altogether and not seeking help from GPs. Older people from the Unable to Articulate group seem to deal with having depression by blocking it out or appearing to block it out by not talking about it directly, or by expressing it through physical symptoms. A common perception reported by older people from all of the groups identified in the typology is that depression is normal in later life and they suggest this contributes to them holding back different parts of their stories from GPs. One way older people could prepare for later life might be to get past this way of conceptualizing depression by knowing more about it and in doing so being able to see it as a more acceptable condition to have.

There is literature to suggest that older people need support in preparing for significant changes in later life. For example older people report that being forced

to retire against one's will has a very negative effect on their mental health and sense of well being (Age Concern and The Mental Health Foundation, 2006) and their identity can be lost at times they retire or when their family responsibilities diminish (Crosland and Wallace, 2011). It has been suggested that participating in meaningful activities can "provide a sense of purpose and identity" (Age Concern and The Mental Health Foundation, 2006) and attending pre-retirement courses that provide support with planning for having time, signpost to activities and practical advice about pensions (Crosland and Wallace, 2011). Challenging and reducing the stigma associated with old age and mental health problems has also been pinpointed as a priority issue in mental health and later life across the European Union (Jané-Llopis and Gabilondon, 2008). This would challenge the public narrative that aligns "mental health" to "madness", and "old age" to a "drain on resources" as well as the misconception that old age and loneliness are to be expected in old age (Keady and Watts, 2011b).

Different ways older people tell stories of depression

Older people have different ways of communicating their stories of depression. This study identifies different components of their stories which is supported by other work.

Barg et al. (2006) found that older people tell their story of depression by describing it in terms of loneliness, rather than using standard clinical definitions. The study highlights this as a possible influence over the way depression is handled in primary care consultations, where if older people see their depression as age related loneliness, they may not view medication as an appropriate form of help or may not bring it up with GPs. Also if they describe their problems in terms of loneliness GPs need to be alert to this and be able to link it to the clinical symptoms of depression where necessary. This aspect of the Barg (2006) study supports the suggestion made in this study that older people need to be able to express their depression in a way that allows them to get what they need out of GP consultations. In addition to identifying different components to older people's stories of depression this study suggests that a reason for their multiple stories centres on what they are comfortable sharing with other people and what they prefer to keep private.

Older people's concerns about externalizing their story of depression are also highlighted by this study. The findings indicate that many older people hold back components of their stories of depression because of concerns they have about how others see their depression. This includes holding back on their experiences and feelings regarding their depression and not giving the level of depth which reveals an uninhibited side to their story. Obtaining this missing information may assist GPs in offering them appropriate help. It therefore seems that support in learning to externalize their depression, and telling their stories of depression to GPs more effectively, may assist older people in getting the help they need in consultations. This includes learning to recognize and talk about components of their stories which they struggle with accepting, selecting their stories to get what they want out of consultations with GPs, and understanding how they can get appropriate help by telling their stories more effectively.

Older people's changing needs

This study conveys that as older people move between stages of understanding, their depression and needs regarding its management change, alongside their perspectives of it. GPs can influence change in patients' understanding and acceptance of depression in order to help them but this is dependent upon whether it is the right time for the older person and whether they are open to changing their perspectives.

The findings of Cape et al. (2010) support the notion conveyed in this study that older people's stage of understanding and accepting depression may be changed by the way GPs respond to their stories. Cape et al. (2010) report on the way adults understand their mental health problems by how they describe them in tape recorded consultations and in interviews afterwards using tape assisted recall. They suggest that for adults there is a process of coming to an understanding of their mental health which is predominantly patient led and facilitated by GPs. This can happen when patients talk through their own explanations of their mental health problems and GPs guide them without additional input or refining and shaping their accounts. They also suggest that the role GPs play in this is to facilitate, validate, focus and shape patients' understanding, all of which encourage patients to talk. They do this through the questions they ask and what they reflect back to patients, as well as making choices around what patients

summarize and elaborate on. Cape and colleagues (2010) conclude that this way of helping patients tell their story is beneficial for patients with mental health problems. The present study adds to Cape et al. (2010) by focusing on older people rather than patients of all ages, and makes suggestions about what their specific needs from GPs might be and differences between the ways they talk about depression in consultations. The present study also focuses solely on depression rather than mental health problems in general. However the present study is based on reports given by older people and GPs' in interviews, so the information provided could be regarded as a starting point for a similar observational study to Cape et al. (2010) where consultations are also recorded.

The approach of GPs in the Cape (2010) study resonate with the skills used by Active Listener GPs who take a lead in what the patient is saying, placing value on anything the patient brings up which relates to their situation, and exploring their ideas with a view to helping their depression. However this study also recognizes that some types of older people are less inclined to initiate exploration of their ideas and need GPs to take more of a lead. For example, this includes GPs challenging their longstanding ideas about depression and its management, at appropriate times, in order to encourage them to accept different forms of treatment. In this way it confirms that older people need different things at different times and that GPs need to recognize this. In addition older people can remain static for long periods and this is when they may need GPs to instigate change or take control of the direction of the consultation.

The GP findings suggest that in managing older people with depression GPs draw on different combinations of skills to greater and lesser degrees. This determines their position on the continuum of different working styles where they can move around depending on the skills they draw on. This is set out in the GP typology that shows different combinations of skills GPs draw on that determine their styles of working.

GP perspectives on managing older people with depression

GPs' perspectives on managing older people with depression have been characterized by negativity and a lack of confidence in their expertise in mental health in the literature, where they tend to focus on problems and barriers to

managing it successfully (e.g. Collins, Katona and Orrell, 1995; Montano, 1999; Rothera, et al., 2002; Murray et al., 2006; Burroughs et al., 2006). One reason for this could be because there is little practical guidance on managing the complex needs of older people with depression that considers the demands of working in general practice.

There is a view amongst some GPs that it is not within their remit to manage mental health problems, which has generated negative attitudes and a lack of confidence in managing it. It has been found that many GPs (who are within easy access of specialist mental healthcare) prefer psychiatrists to remain clinically responsible for patients with long term mental illnesses, with their role being to manage any associated physical problems (Kendrick et al., 1991). There is also “therapeutic pessimism” about the chances of improving these patients’ lives (Gask et al., 2005) and a feeling of powerlessness and it being a burden amongst GPs working in deprived inner city areas (Chew-Graham et al., 2000). More recently similar attitudes have been found amongst GPs with an interest in mental health regarding the management of older people with depression, where they report feeling pessimistic about their ability to help with the complex needs of these patients (Burroughs et al., 2006). This negative atmosphere may be reflected in the lack of impetus behind the development of further definition of GPs’ roles in its management. The present study takes GPs’ stories of managing older people with depression into account, particularly why they work in different ways and use different combinations of skills. The GP typology provides further definition around GPs’ approaches to managing people with depression in later life and the theoretical interpretation of the findings offers suggestions as to how different GPs are likely to practically help patients with complex and differing needs.

Comparable studies have identified different approaches taken by GPs in managing depression which are based around the skills they employ (Wittink et al., 2006) and their conceptualizations of depression in later life (Murray et al., 2006, Butcher and McGonigal-Kenney, 2005). Influences over GPs work with depressed adults have also been explored (Andersson et al., 2002).

Parallels can be drawn between GP approaches to managing older people with depression identified by Wittink et al. (2006) and those identified in the GP typology of this study. Wittink et al. (2006) identify GPs who actively look for depression, relying on their intuition to “just pick it up” without patients presenting it themselves. Patients report feeling that these GPs “understood” them and although they had discussed their feelings in the past they were reliant on these GPs to uncover their depression without them expressing their mood symptoms. Parallels could be drawn between this type of GP and the Active Listener style of working identified in this study, who typically look for depression and talk through wide ranging problems with patients. Furthermore the present study indicates that certain types of older people may not bring up or explore their depression with GPs if they feel there is a mutual understanding between them that depression exists but neither want to address it. This is especially the case with Superficial Acceptors who minimize their depression or those who are Unable to Articulate who prefer little or no discussion of their depression. At times such as a crisis or between stages of understanding these patients may need GPs to help them talk through and construct a concrete “story” of their depression.

Wittink et al. (2006) also identify GPs who only deal with physical illness and who patients perceive as seeing mental health problems to be inappropriate for a medical consultation. This reinforces patients’ assumptions that their role is to deal with only physical problems and leads them only to bring up physical problems in consultations. Wittink et al. (2006) identify a further category of GPs who despite recognizing and diagnosing depression typically refer patients on to a psychiatrist and do not directly address any emotional issues themselves. Although Wittink et al. (2006) is a U.S. study (which may explain why doctors are able to refer to psychiatrists more readily) characteristics of GPs identified in these two approaches may be recognized in the Problem Solver style of working identified in the present study. These GPs’ strengths appear to lie in managing physical illnesses and they report being more likely to respond to depression in older people either by monitoring it and prescribing medication themselves, or referring onto psycho geriatricians or other professionals they consider better equipped to help. The stories told by Unable to Articulate patients indicate they are likely to prefer the approach of GPs who respond more to their physical manifestations of depression and who they feel “just understand” them, since they

may not have fully accepted their depression and prefer not to explore their ideas around it.

The GP types identified by Wittink and colleagues (2006) are based on older patients' accounts alone, and although represent their perspectives of consultations for depression in later life they do not consider GPs' perspectives. In addition many GPs are perceived to shy away from addressing depression in patients by either referring on to psychiatrists or avoiding it altogether. Their study gives an insight into why many older patients do not reveal their depression to GPs, but only focuses on views and expectations older people have of their GPs and not other factors which may influence their reluctance (or willingness) to talk about it. Wittink et al. (2006) also give little attention to GPs who do address depression in later life and why their approaches work. The present study addresses these gaps by exploring in depth different ways of working GPs can employ in consultations for depression in later life alongside older patients' stories of their experiences. Different styles of working are identified, and theory on influences over how GPs respond to different patients' stories of depression has been developed, with explanations about how they operate differently (i.e. different influences over them). The present study also builds on the findings of Wittink et al. (2006) by suggesting how GPs working in different styles may respond to different types of patients. It also shows that older people's needs vary depending on the point in time and their stage of understanding and accepting depression, highlighting the need for GPs to recognize that different skills may be needed by patients at different times.

A study by Andersson et al., (2002) explores influences over GPs work with depressed patients. They provide evidence of personal and professional influences that shape GPs' work, where personal influences are particularly pertinent with depressed patients. GPs found that because of the importance of attitudes and experiences when dealing with depression they had a high degree of personal commitment to patients with depression, which they recognize as making it more difficult to set boundaries between the private and public. The Andersson et al. (2002) study shows that working with depressed patients for many GPs involves a higher degree of personal judgements and skills in communicating, as

opposed to learnt knowledge, and the influence of their education which cannot teach these personal qualities.

The findings of the present study resonate with these findings of Andersson et al. (2002), as they suggest that the best GPs are those who can adapt to their patients and provide what is needed at the time of the consultation. Adapting and the influences over GPs in doing this also requires GPs to use their personal qualities and judgements, such as their instincts, sharing life experiences or having an interest in mental health. GPs in this study also report that balancing their personal and professional “selves” can be a challenge because of the nature of depression in older people and they are aware that sharing information with older patients may be beneficial to the doctor-patient relationship by building the patients’ trust. Some GPs acknowledge that being able to adapt their style of working and draw on these skills was a personal quality which defines their style of working when managing older people with depression. While these skills may be part of the GPs’ personality rather than knowledge that can be taught, this study offers a typology of older people which could be used by GPs to help them quickly determine the form of help different older people may need at the time. They might use it to recognize the different stories told by patients and from this identify their stage of understanding and acceptance which would indicate the help they need. This may assist GPs in adapting to different patients, where they would be able to quickly determine which of their skills would be most helpful for different types of older people.

Other research highlights the conflict between medical and social perspectives on depression in later life and how this impacts on practice. Murray et al. (2006) highlight that these conflicting perspectives can lead to minimal action being taken to address depression either by older people or GPs. They argue that this happens with GPs who do not see depression in later life as an illness and also perceive older people to regard symptoms of depression as being normal signs of aging. These GPs can be reluctant to offer medication for something they see as a non-medical problem and may feel it is inappropriate to bring up non-physical problems in a medical consultation. This can be the case with many GPs including those who see themselves as adopting a psychosocial approach with managing older people with depression.

This way of approaching depression in later life found by Murray et al. (2006) is comparable to the attitudes of the Problem Solver style of working identified in this study, who see their role as managing physical illnesses. It is particularly resonant with the more extreme Problem Solver style GPs who say they consider it the patients' responsibility to bring up depression if they want it to be addressed in consultations and who prefer to manage physical illnesses instead. This study builds on Murray and colleagues' (2006) work by offering more detailed evidence of different types of GPs who are able to adapt their responses to patients rather than remaining static in their views and approaches to helping. It also presents a range of perspectives of GPs within the medical framework of depression and considers contextual influences over them in the ways they respond to older people's stories.

GPs' role in managing older people with depression

The role of GPs' in managing common mental health problems was largely unrecognized until Kendrick's work in the 1990s (Kendrick, 1991; Kendrick et al., 1994) after Goldberg and Huxley highlighted GPs as the main point of contact for patients with common mental health problems like depression (Goldberg and Huxley, 1980). Before the 1990s prominent work relating to the doctor patient relationship and its centrality to general practice was carried out by psychoanalyst Michael Balint (1890-1970). Some of his ideas can be considered in relation to understanding of the GPs' role in managing mental health problems such as depression.

The Active Listener style GP identified in this study can be compared to aspects of Balint's 1950s work. He introduced the concept of patient centred care (Balint, 1955; Balint, 1957) as an alternative to medicine being centred on the illness. There is little agreement on its meaning but a more recent definition suggested by Mead (2000) is that patient centred care requires five components consisting of the bio psychosocial perspective, understanding the "patient as person", sharing power and responsibility, the therapeutic alliance and the doctors' self awareness known as the "doctor as person" (Lewin et al., 2009) . The Active Listener style of working corresponds with these aspects of patient centred care, because of its

emphasis on the patient leading the discussion and GPs maintaining their mental health by listening rather than other treatments.

Balint's proposition of the "doctor is the drug" also resonates with the skill of active listening which is central to the Active Listener style of working, where some older people report this to be a way of coping with depression, and where some GPs report being able to "maintain (their patients') happiness" by doing this. However this study also suggests that while older people's relationship with their GP can be influential in the way their depression is managed, some may not regard talking therapies as valuable in helping them recover from depression and report preferring not to talk about their depression to people they do not know. Older people who talk positively in their interviews about building long term and trusting relationships with their GP tend to report being more open about their depression with them. In addition to supporting the importance of the GPs' role in managing older people with depression, this finding indicates that therapies for depression such as CBT which have recently been prioritized in health provision through initiatives such as IAPT (NICE, 2006) may not be the most appropriate form of help for older people who are a large and growing sector of the population who need help for depression.

Older people and GPs: Adapting to depression in later life

Older people making decisions about what to share and hold back with GPs

This study suggests that there are a number of influences over older people in what to tell and hold back on with GPs, and that the way they tell their story and information they share in consultations with GPs can determine their stage of understanding and acceptance of depression. This can be seen as a circular argument where their stage of understanding and acceptance of depression guides the way they tell their stories. Seeing it this way may be useful to GPs if they wish to look for cues in older people's stories that indicate the type of help they need for the stage they are at, or changes in the way they perceive their depression that may require them to work in a different style.

In looking at older people's perspectives on their interactions with GPs about depression, Wittink et al. (2006) highlight a decision making process of "giving and taking" that happens for older patients with depression. This is where patients go

into consultations with expectations of what will happen (some of which are based on past experiences), that can influence what they are willing to disclose to doctors and what they prefer to hold back because of the impact this may have on the way doctors perceive them. The present study develops this concept further by giving specific information about what “give and take” is (i.e. how much of their stories they are willing to share and hold back on) and what the influences over them are, as well as why different types of older people tell their story in different ways. The idea that there are different components of their stories is also developed in this study, and provides a detailed insight into the type of information patients “give and take” as well as which groups of older people tell which parts of their story to GPs and why.

Others have also highlighted patients’ reasoning for holding back and sharing certain information with their GP. Older people may withhold their depression from GPs if they believe it is not a justifiable illness and is normal in old age (Burroughs et al., 2006) and may also hold back as they take personal responsibility for it (Switzer et al., 2006). In non age specific studies This includes patients wishing to protect their GP from being burdened with their depression (Malpass et al., 2011), the “inner struggle” patients face in dealing with their depression and the barrier it can create in seeking help (Kadam et al., 2001) and patients’ internal reasoning when explaining their depression to others (Lewis, 1995). This evidence supports the findings of the present study which suggest that older people have different components of their story of depression including those which they believe should be kept private and those which can be shared with GPs. Having more support from their GPs in telling their story to get the most appropriate help may for some (e.g. Unable to Articulate) be empowering and for others (e.g. Striving to Understand) help to regain control over the way their depression is managed. This indicates that GPs need to determine which actions to take with different patients and which skills to draw on in these different situations. They may also need to dig deeper rather than take patients’ stories at face value, and in doing this recognize the multiple stories that older people tell. The GP just asking is not enough for some older people and may mean they do not reveal enough for GPs to make informed judgements.

The best combinations of skills

The findings suggest that Active Listener GPs are likely to adopt a combination of skills which allow them to identify and manage older people with depression most successfully. Other research has identified GP skills which work well in managing people with depression, where parallels can be drawn to the Active Listener working style. Using data from audio taped consultations and tape assisted recall, Cape et al. (2010) identify GPs' skills in helping patients understand their mental health problems, which include facilitating and focusing patients' stories by questioning, listening, validating and elaborating aspects they consider important. In contrast to Cape et al. (2010), the present study is based on interview data and not a direct observation of consultations but also suggests that similar GP skills are likely to work well in managing older people with depression, where Active Listeners describe offering similar forms of help in consultations. This study builds on Cape et al. (2010) since both older people and GPs report their insight into the changing nature of depression and the differences between the way older patients tell their story and the ways GPs respond. It places emphasis on the need for GPs to adapt their skills to older people by recognizing the differences between ways they tell their story and their changing needs. In addition a theoretical proposition is made about how GPs working in different styles are likely to respond to the stories of different types of older people, and adapt their skills to older people who are at different stages of their depression.

Influences over GPs' responses to older people

GPs report using different combinations of skills when seeing different patients and situations, leading them to move around on the continuum of GP working styles to greater and lesser degrees. This study identifies that many Active Listeners and some Analysts are likely to be more flexible in adapting their skills, whereas Problem Solvers are likely to be less flexible.

An Australian study by Baik et al. (2005) explores how GPs manage depression in patients across the age spectrum and presents three processes by which they do this and three conditions which influence them. They put forward a preliminary model showing this, and parallels can be drawn between this and the GP typology presented in the findings of this study. The processes suggested by the Baik (2005) model are ruling out, opening the door and recognizing the person, all of

which are ways clinicians use to uncover depression. Parallels can be drawn between what GPs say they do in consultations in the present study and the processes of opening the door and ruling out identified by Baik et al. (2005). GPs in the present study describe either digging deeper for depression or leaving well alone and focusing on other health problems in different ways, depending on the style of working they lean towards. Further, processes identified by Baik et al. (2005) may be compared to the styles of working identified in the GP typology of this study as they provide evidence of the way clinicians work practically, and suggest GPs' different responses leading to different outcomes to consultations.

An example identified in the Baik (2005) study is the "opening the door" process where the patient is given permission to talk. While asking open questions is likely to be an important aspect of all GPs work, Active Listener GPs in this study appear to prioritize it, since they report actively looking for depression and encouraging patients to talk more than other GPs in the sample. However this is what they report to a researcher and it is possible that other GPs in the sample may be doing this but not something they prioritize talking about in interviews. The conditions Baik and colleagues (2005) identify for this to happen are that the clinician has more experience and enough time but that they may not be familiar with the patient. In the same way many Active Listener GPs in the present study also report taking more time in consultations, report being experienced in managing older people with depression and talk more than other GPs in the sample about their skills in helping patients disclose the information they need to detect depression. The present study builds on the Baik (2005) study by providing further insight into having and managing depression from the perspectives of older people and GPs, whereas the Baik (2005) study focuses on the identification stage in the process of managing depression. The present study proposes that the way GPs choose to tackle depression in older people at different stages can be pivotal in its successful management. Also identified in the present study are factors that older people report to influence how they tell their stories at different stages of their depression, such as influences over what they reveal and hold back with GPs and the impact this is likely to have in the way their depression is managed. The way older people's stages of understanding guide their needs at different times highlights older people's changing positions that GPs need to remain alert to.

Particular GP behaviours or skills are found to be influential over patients revealing mental health problems in consultations. In a study looking at the abilities of trainee GPs in identifying psychological distress amongst their patients Goldberg et al. (1993) identify medical behaviours or skills in GPs that work best in encouraging patients to reveal mental disorders by talking or “releasing cues”. These behaviours include GPs being empathic, allowing the patient to lead the consultation interview, and asking psychological questions appropriately to the individual. GPs’ behaviours linked with patients not displaying evidence of their mental disorders during consultations were interrupting the patient, asking many questions derived from theory or closed ended questions concerning physical symptoms. Though the study is not recent, Goldberg and colleagues (1993) suggest a variety of GP skills that are effective in uncovering mental health problems and highlight the influence of GPs’ combinations of skills on what patients are prepared to reveal to them. These factors can be compared to skills used by Active Listener GPs identified in the present study, which instead of applying to psychological disorders generally focuses on depression in later life which is an area in need of research that has been recognized more recently. More recently Goldberg (2009) has suggested that lack of detection of depression (including in those with chronic physical health problems) is not just about GP factors, but patient factors and circumstances of the consultation are also influential over whether the patient discloses depression (Goldberg, 2009; Meader et al., 2011). This supports the exploration of wider influences carried out in this study over what patients and GPs say and do in consultations for depression.

Theories of behaviours between older people and GPs

Studies which compare both the views of doctors and patients can give evidence of how interactions between them impact on their behaviours in consultations for depression. Few studies have involved both older people with depression and GPs, however the findings of this study can be mapped onto other research which has produced comparable evidence.

Tensions between the social and medical models of depression are commonly known to cause problems in doctor-patient interactions in the management of depression (e.g. Cornford, Hill and Reilly, 2007; Lawrence et al., 2006a; Pill, Prior and Wood, 2001). This can be due to GPs diagnosing and treating it as an illness

and lay people normalizing it by finding a common sense explanation or linking it to social circumstances (Lafrance, 2007). In exploring the processes and interactions underlying the way patients with depression are responded to by GPs, Rogers, May and Oliver (2001) argue that this mismatch is due to patients' perceptions of help available for depression in primary care and whether their problem is perceived to be legitimate by both patients and GPs. Their findings suggest that although patients' encounters with GPs are important to them in assessing and identifying their depression, they perceive their contact with primary care to be of minor importance compared to the experience of having depression and the problems and circumstances they face in their lives. Patients' contact with primary care is also found to shape their experiences of depression because of the expectations of the help they could get.

A study by Rogers, May and Oliver (2001) examines influences that shape the way both patients and doctors perceive depression and its management. They found that patients' expectations of GPs' help and their satisfaction with the care provided is shaped by their experience of depression, the nature and perception of care available to them and whether they see their problem as legitimate for primary care. Those shaping GPs' work are both their individual agendas and the wider influences and constraints over them, which include their treatment decisions, medical knowledge and practice, political organization of resources and professional interactions in primary care. They report that for GPs, depression can be influenced by many social and personal difficulties, and they find it challenging to identify and manage these problems due to the constraints and conditions imposed on them professionally. Like the present study, Rogers, May and Oliver (2001) reveal tensions between the medical perspective of depression where GPs are trained to deal with clinical signs and symptoms of depression, and the social perspective which many patients bring to consultations. In response, GPs may view patients' reactions as "normal" given their circumstances, or that feel they are seeking clinical help for a personal problem and end up treating it as such. GPs may also feel that if constraints on them are less pressing they may respond differently. A main point of difference between the present study and the Rogers, May and Oliver (2001) study is the focus on older people and how their conceptualizations of depression can impact on ways they tell their stories and how their depression is managed. The specific information about different types of

older people that this study adds may be used to develop ways to help GPs identify depression in older people from the ways they tell their stories, and respond by offering the most appropriate form of help depending on their stage of depression.

Similarities and differences in contextual factors influencing the management of depression can be seen between the present study and the Rogers, May and Oliver (2001) study. For example the present study recognizes patients' experiences of depression and external professional constraints over GPs. For older people these can also include their social situation, their constructions and experiences of depression and its treatment, which like the Rogers (2001) study are subjective influences. In contrast to the Rogers study, the present study focuses on how older people and GPs respond to each other by giving detailed information on components of stories they tell and influences over what they report saying and doing in consultations showing how they meet in the middle, whereas the Rogers, May and Oliver (2001) study shows them to be in "separate worlds". The present study proposes practical ways GPs can adapt their skills to help patients at different stages of depression, however it echoes Rogers' et al. (2001) by suggesting that for both older people and GPs depression in later life is a multi factorial and complex problem to manage, where the situations of both need to be considered on an individual basis.

Like the present study, Rogers, May and Oliver (2001) reveal patients' low expectations of the help they could receive in primary care which influences them in seeking help or coping with depression themselves. This is despite the differences in age groups between the Rogers and present studies as well as the gap of 11 years between when the studies were carried out. This underlines similarities between patients with depression across the lifespan in the ways they conceptualize and seek help, serving as a reminder that depression in later life extends into older age rather than it being a different condition in later life than it is in younger age groups. Similarities in the way patients are reluctant to seek help for depression also underline that however much the help available to patients with depression in primary care might change, patients' experiences and conceptualizations of depression and influences over them in seeking help can remain similar. This indicates that as well as more information about the help

available to them, patients may need support in understanding reasons for their views of depression and decisions in seeking help, and the impact this can have on them.

Others have also carried out work that focuses on how patients and GPs interact in consultations for depression, and points towards a need for depression to be normalized and addressed as a social problem. In a qualitative interview study, Burroughs et al. (2006) explores how older people and primary care health professionals (including GPs) conceptualize depression including the causes and its management. They suggest that many older people do not see depression as a “justifiable” illness worthy of taking to their GP since they rationalize it in terms of social rather than medical problems. This underlines tensions between the way depression in older people is perceived either as a medical problem or a problem of living, and suggests that the biomedical perspective does not fit with most older people’s and some GPs’ views. In this way, Burroughs and colleagues (2006) recognize the disparity between the medical and social models of depression and that older people’s beliefs about it can impact on their health seeking behaviours. It also shows that both older people and GPs can have multi faceted perspectives on depression in later life which influence the way it is managed.

The present study builds on this by offering new insights into how older people and GPs interact in consultations for depression. It recognizes the different positions older people and GPs can take, and builds on the findings of the Burroughs (2006) study by suggesting influences over the way they tell their stories and respond to each other and what happens in consultations as a result. It shows that a central factor in the management of depression in older people is the way they tell their stories of depression and influences over them in what they reveal and hold back on with GPs, whereas for GPs it is the skills they use and influences over them in ways they respond to different stories older people tell. This information is used to offer practical suggestions for GPs taking account of their different styles of working.

Other comparable work explores existing barriers to talking about depression between health professionals (mostly from primary care) and patients with long term conditions (Coventry et al., 2011). It suggests that barriers exist when both

patients and GPs believe depression is a normal and understandable response to the losses relating to long term physical conditions. This can lead to patients and GPs together creating a relationship where they believe depression is normal and therefore do not talk about it, recognize or address it through treatment. It is argued that whilst continuity can be positive it can also be the basis for a “dysfunctional relationship”. The present study acknowledges the likelihood of this component of the doctor-patient relationship in some combinations of older people and GPs, where older people prefer not to talk about their depression and GPs focus on physical illnesses instead. This study offers a model which suggests how GPs can recognize these situations and adapt their skills appropriately to what the older person needs at the time.

Others have shown that older people and GPs conceptualize depression as normal in later life, not a legitimate illness to take to GPs, and that nothing can be done to help (Burroughs et al., 2006; Murray et al., 2006; Lawrence et al., 2006a; Coventry et al., 2011). The present study suggests these characteristics can be found in older people who are Unable to Articulate and Superficial Accepters as well as GPs who work in the Problem Solver style. In addition this study builds on the previous work by recognizing different types of older people and GPs that may explain their differing beliefs about depression, and suggests that some combinations are likely to be more acceptable and appropriate for both than other combinations. It also offers explanations as to why they take these different positions, proposing different influences over them. As well as showing combinations of older people and GPs that are likely to have problems in identifying and managing older people with depression (such as Superficial Accepters and those Unable to Articulate with Problem Solver GPs), this study also suggests that other combinations of GP and older people work well, such as GPs who are Active Listeners combined with Striving to Understand or Superficial Acceptor patients. What happens with other combinations of older people and GPs could be developed further in future research to provide GPs with a more specific tool for identifying how to help different older people in different situations.

GPs adapting their skills

New evidence offered by this study is that central to the management of depression in older people is the need for GPs to adapt their skills to meet older

patients' differing needs at the right times. GPs such as Active Listeners who can adapt in this way, depending on the situation and the older person's needs, could be best suited to managing older people with depression.

A study by Malpass et al. (2011) pinpoints a mismatch between patients' and GPs' perceptions of each other's role in managing depression. This has been called "inverted paternalism" which is where GPs assume patients want to take a lead especially in making decisions in the way their depression is managed, whereas patients with depression often look to their GP to take decisions out of their hands, particularly when a symptom of depression can be indecisiveness. Malpass et al. (2011) suggest GPs need to find out how much patients wish to be involved in the decision making process and differentiate between passivity as a preference and passivity as a symptom. Further, Schofield et al. (2011) highlight the importance of decision making at different stages of depression, and suggest that during the early stages patients (regardless of age) are most likely to need doctors to take initiative in decision making as they have often reached their lowest point before seeking help and at this time are least able to make decisions. These factors resonate with the present study which highlights the importance of GPs needing to adapt their skills to patients and to determine when older people need them to take control over consultations and when to involve them in decision making. For example it suggests that older people at the Unable to Articulate stage can prefer their GP to take a lead and when this expectation is not met they can take this to mean that the doctor is too inexperienced or does not "understand" them. Therefore it is likely that GPs need to establish older patients' expectations (including those about their respective roles) in order to build trust when dealing with depression in later life, thereby creating opportunities for older people to open up with their stories of depression.

Others have identified models for tackling depression in later life successfully within the primary care setting that involve receiving care from other health professionals. Qualities identified in the Active Listener style of working (including listening and supporting, a trusting relationship with shared life experiences, and talking through issues that are important to the patient) are similar to the qualities older patients valued in a collaborative care model for depression in later life that has been found to be acceptable and feasible for use in primary care (Chew-

Graham et al., 2007). This collaborative care model was used in a primary care setting with a facilitated self-help intervention. The intervention was delivered by community practice nurses (CPNs) who coordinated the management of depression in liaison with primary healthcare professionals, and included education about depression, advice about antidepressant medication, a manualized, facilitated self-help intervention (SHADE) and sign-posting to other services. While Chew-Graham et al. (2007) suggest their collaborative care model is more effective than usual GP care for depression and show that it is successful with older people, the present study findings suggest that older people prefer their GP to manage their depression, especially if they have a long term and trusting relationship and their GP uses skills of the Active Listener style. This suggests that certain GPs could be selected for collaborative care models for managing depression in older people, for example Active Listeners could be selected over Problem solvers within a practice.

Questions also remain about how it is possible for non Active Listener GPs to adapt their skills to those of Active Listeners and whether educational interventions for GPs to help them do this would be appropriate. It seems that if GPs could adapt their skills in managing older people with depression this would also be acceptable to patients and their depression could be tackled with GPs rather than having to be referred to other healthcare professionals where they would need to establish new relationships as well as tackling their depression.

Building on the current one size fits all guidance

The typologies of older people and GPs suggest that older people need different help according to their stage of depression and that GPs use different combinations of skills in response. It therefore provides additional information about older people and their specific needs, thereby building on the current NICE guidelines on managing depression which recommends the same range of treatments for adults of all ages. The model proposed in this study could be used by all GPs as a quick route into recognizing different types of older people by the stories they tell and which skills they could employ to help them at different stages of their depression. It recognizes the value of GPs' subjective skills such as intuition and clinical judgement in combination with objective clinical skills such as monitoring and assessment, and the importance of the changing nature of patient,

GP and situational factors. This study proposes that this model could be used for the identification and management of depression in older people alongside the more rigid assessment-based stepped care model for depression (NICE, 2004), including the QOF screening questionnaires (British Medical Association and NHS Employers, 2011) which are currently the gold standard in primary care.

A patient centred approach (Mead, 2000) to mental health problems in later life is also promoted in both medical policy and guidance. The NSF for Older People states that:

“mental health services should be able to respond effectively to individual needs and take into account the social and cultural factors affecting recovery and support” (Department of Health, 2001, Standard Seven, p.91)

Despite this there is nothing recommending the consideration of individual need in primary care management of depression in older people. In addition no guidance is offered to clinicians on how an individual approach might be carried out in managing older people with depression, such as deciding on which help is the most appropriate for different types of older person or how they can meet these different needs. The NICE guidelines for depression offer a one size fits all framework that offers no specific recommendations for older people with depression. It states:

“Offer the same range of treatments to older people as to younger people” (Step 2, Clinical guideline 23, NICE, 2004)

This is despite their claim that the stepped care model considers individual needs:

“draws attention to the different needs that depressed people have – depending on the characteristics of their depression and their personal and social circumstances – and the responses required from services” (NICE 2004, guideline 23, p.57)

A prime example of the universal approach of the NICE guidelines is the use of two screening questions, developed by Whooley and colleagues (Whooley, et al., 1997), which were introduced by NICE depression guideline (2004) and highlighted in the updated QOF (British Medical Association and NHS Employers, 2011)

In contrast this study argues that the NICE one size fits all approach may not address many of the complex multi-faceted issues that are commonly entwined

with depression in older people. It presents evidence that shows older people require different help at different stages of understanding and accepting their depression. It suggests an approach to the management of depression in older people that recognizes the differing ways they tell their story of depression and their changing needs, where GPs adapt their skills to meet the needs of patients at different stages of understanding their depression. It sets out different combinations of skills that GPs draw on when they adopt different styles of working in response to older people's stories. The model presented in this study could therefore be used in addition to the NICE guidance to help GPs identify traits in different older people from the stories they tell in consultations and help them target their skills more appropriately.

Unlike current guidance, the typologies presented in this study offer quick routes for GPs to identify where older people are in their stage of understanding and accepting depression and the skills they can use to help them. The typologies suggest that both older people and GPs are on a continuum where they can move between positions depending on the influences over them at the time, and suggest that GPs can adapt their skills to the patient and situation by taking on skills from different styles of working when needed. For example when older people need Active Listener GPs to take control of decisions they could employ skills leaning towards those of Problem Solvers, and both typologies would help them quickly determine particular skills to employ. However GPs may need to learn how they can change their consultation styles in order to offer different types of help. This could be the basis of an educational intervention for GPs in managing older people with depression which uses the information on how different combinations of older people and GPs are likely to respond to each other. It could be an alternative to previous interventions such as those included in The Hampshire Depression Project. This was a large scale educational intervention focusing on educating primary care teams, including GPs, to use the hospital and anxiety depression (HAD) scale to identify and improve clinical outcomes for depression, however it was not found to deliver improvements in recognition or recovery from depression (Thomson et al., 2000). This supports the argument that a different, less structured and more individualized approach focusing on social rather than clinical factors may address areas that these other methods do not.

This approach suggests a more complex way of training GPs where they learn about which of their skills to use at different times according to different patients' needs, rather than what to do with different severities of depressive symptoms (e.g. watchful waiting, antidepressants etc), which is the NICE guidance one size fits all solution. This new approach is more complex because it has a number of different positions patients and GPs can take, and we need to understand further about the interaction between them. However these findings suggest that if GPs could recognize older people's different positions from the stories they tell, they could quickly find the right solutions by knowing which of their skills they could adapt.

It is unclear from the present study findings whether achieving the right balance of skills for individual patients is something that can be taught to GPs or whether it is a natural, intrinsic ability. This has implications for further research and raises questions for GP education interventions, or those who train GPs, who may be able to teach GPs how to adapt their skills to different types of older people using the typologies proposed in the present study.

Strengths and limitations of the study

This study provides evidence about different ways older people tell their stories of depression and different components of their stories that they may tell and hold back on with GPs. It offers insight into older people's reports of influences over them in what they tell and hold back on with GPs concerning their depression. The study also provides evidence of different styles of working that GPs can employ when managing older people with depression and how they report responding to the different stories older people tell. A key message is the importance of GPs being able to adapt to the needs of different older people at different stages of their depression rather than adopting a one size fits all approach. It suggests a model that GPs could use to identify and provide appropriate help for different older people in response to the stories they tell about their depression.

Methodology and methods

Processes of change and the dynamic of the way humans understand the world is recognized in symbolic interactionism and grounded theory (Hildenbrand, 2004). Similarly, in doing *Situational Analysis* (Clarke, 2005) which recognizes the changing nature of ideas and the importance of this in the analysis process. Recognizing the changing nature of ideas has been influential over the research process and the findings of this study, where participants' changing situations, social worlds, perceptions and beliefs are a focus of analysis. Exploring when changes in older people's and GPs' perspectives on depression in later life can happen and how this affects its management in primary care has led to the older people's and GPs' typologies being developed. This can be seen where both older people and GPs are positioned on continuums where older people can change their understanding and acceptance of their depression, and where GPs can adapt to patients by changing between styles of working and adopting different combinations of skills. This aspect of the findings means that this study recognizes the changing nature of depression and the different circumstances that both patients and GPs experience. It also recognizes the need for change in the help GPs can provide patients at different times and in different situations, which appears to fit with the social model of depression that evidence suggests is more appropriate to addressing depression in older people.

Situational Analysis (Clarke, 2005) requires the consideration of multiple perspectives relating to the field of enquiry such as historical, geographical and biographical. The use of situational, social and positional maps facilitates seeing the data and interrogating it from a variety of angles, which encourages richer analysis of the data. This multi dimensional approach to analysis is more appropriate to the field of enquiry of this study than the two dimensional route of enquiry (i.e. the researcher and researched) traditionally employed in grounded theory. This is because of the complex nature of depression in later life and the many situational factors that come into play for both older people and GPs.

A strength of the study is that the methodological approach has enabled comparison of the older people's and GPs' data. These two sets of complex data from diverse groups have been translated into typologies through the analysis process, and have been united in a theoretical model. The methods employed to

produce situational, social and positional maps enabled the systematic consideration of numerous influences over the data relating to individuals in different positions, and brought a practical way of accounting for interrelating aspects between them. In this way using *Situational Analysis* (Clarke, 2005) assisted consideration of the stories brought by older people and GPs including their similarities and differences, what guided these and the identification of areas which interrelated to produce the thick analyses presented in Chapter 5. The social worlds/arenas maps component of the methods reflects the symbolic interactionism element to the methodology by enabling exploration of how participants' experiences of their social worlds influenced their behaviour and contributed to their perspectives.

The use of secondary data (Clarke, 2005), which in this study consists of observations of the interview situation and use of memos, brings an additional objective angle to the analysis of data, in contrast to traditional versions of grounded theory which channel interpretation of interview/observed data through the researcher (e.g. Glaser and Strauss, 1967). The findings of this study show that a topic of investigation such as depression benefits from the use of secondary data to support the interview/observed data. This is because opportunities for increased understanding are provided by the secondary data where there are uncertain areas (e.g. participant cannot verbalize) or wide variations of complex subjective experiences (e.g. understandings of depression are different) in the primary data.

Situating the data is a key premise of Clarke's *Situational Analysis* (Clarke, 2005), where consideration of multiple influences over the field of enquiry is encouraged. The central ideas proposed in this study centre on influences over older people and GPs in what they report saying and doing in consultations for depression, so it could be argued that the findings serve as a way of situating the data gathered in this study amidst the complex field it is embedded within.

The thick analyses of the data provided in the third findings chapter is equivalent to the final goal of producing a selective theory in traditional approaches to grounded theory. The flexible concept of thick analyses fits with the continually evolving ways of accepting and understanding depression that older people have

and the developing nature of medicine and GPs' approaches to managing depression. The study therefore captures older people's and GPs' views at a particular point in time and acknowledges the possibility that these may change over time.

Grounded theory approaches also allow for participants to express their views on their terms, for example during semi structured interviews where the researcher explores issues raised by participants. In this way participants steer the outcomes of the research and arguably have more influence than a study which builds theories around a preconceived theoretical framework. This is appropriate for mental health research, especially exploratory research looking at patient views, as it could be seen as giving more power and control to the participants over the outcomes of the research. On a practical level, it may also be empowering for participants to lead the discussion in interviews because it gives them the choice of controlling what they talk about. Using a methodological approach which allows participants to guide theory is particularly appropriate to experiences of mental health problems which can only be described by the individual and cannot be objectively measured.

Was a true theoretical sample achieved?

The use of theoretical sampling may limit the selection criteria of participants and therefore limit the more open philosophical perspective promoted by grounded theory. In this study theoretical sampling was carried out, yet only minimal sampling criteria could be applied as there were few that met the needs of the study that could be accessed within the health research and governance framework (as set out by NHS Research Ethics Service). This meant that in reality the sample was relatively open, and by chance included a variety of criteria that allowed for many of the developing ideas to be explored to saturation during the progression of data collection and analysis. Therefore by being limited in the possibilities of carrying out true theoretical sampling, the openness of the sample in fact allowed for a less limited field of participants from which to collect data. Ideas introduced by participants may therefore have captured a wider perspective on the field than otherwise, and the ideas introduced also came directly from participants rather than being preconceived by the researcher, a requirement of traditional grounded theory. Further, participants would ideally have been selected

according to information that could not be obtained beforehand, such as the severity and duration of patients' depression. In addition this would have ensured participants who could have informed many of the lines of enquiry were included in the sample. However keeping the sample more open with less selection criteria may have meant that the size of the sample was larger, with more opportunities to explore developing ideas. These factors indicate that the use of the theoretical sampling method in this study can be seen as both a strength and a limitation.

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In this study the sample consists of 16 older people and 14 GP participants. Other studies using theoretical sampling such as Baik et al. (2005) and Kumar, Little and Britten (2003) show that a sample of approximately this size allows for data saturation to be achieved and the investigation of disconfirming cases if

necessary. However as should be the case with all sampling techniques, the sample of this study was determined according the needs of the study and not external criteria (Morse, 1998), and in this way the iterative cycle of sampling, data collection and analysis meant that initial data analysis shaped later sampling and collection of data. This is in keeping with Glaser and Strauss' (1967) "constant comparison" method, which is included in Clarke's *Situational Analysis* (2005), where identified concepts are continually compared with each other throughout the research process. Each concept can be compared to the others to find further commonalities or differences and in turn form even broader or new cases. Although theoretical sampling and constant comparison proceeded in this study, the criteria for sampling were very limited due to research and governance constraints.

In designing the study the theoretical sampling method was chosen to enhance the findings by developing a theory that was directly grounded in the data. In reality it was found that the criteria for sampling in this way were very limited, and recruiting participants who could inform many of the developing ideas within the data was not possible when carrying out research with NHS patients. This is due to the confidential nature of information about participants on medical records that cannot be obtained before recruitment is carried out by researchers. In light of this a theoretical sample was achieved with both older people and GPs where criteria were based on publicly available information, for example level of deprivation of general practices and practices' expression of interest in mental health. A theoretical sample was achieved with participants who were selected according to these criteria as they informed the related lines of enquiry to the point of saturation and were able to provide the information needed. Examples of these lines of enquiry include exploration of the relationship between older people's beliefs/attitudes about depression and level of deprivation of the area they lived in, and the relationship between the level of GPs' interest in mental health and their style of working with older people who had depression.

However some aspects of the sampling process were modified and cannot be thought of as true theoretical sampling. One such aspect was that selection of patients to send recruitment material to was subject to the discretion of GPs with certain criteria which emerged as the data collection and analysis progressed.

GPs recruiting patients to the study were aware of the need for particular groups of participants as the stages of recruitment progressed (e.g. the need for views of participants over 90) and were able to access additional information about them from medical records before sending recruitment material. This included age, severity and duration of depression, living circumstances, the duration of the relationship with the GP and the impact of stressful life experiences such as bereavement on patients' depression. This meant that part of the sampling process was in the hands of GPs who were helping recruit patients rather than the researcher, and happened when GPs prioritized sending out material to these groups if they were able. While it was not in the power of the researcher to select participants this approach increased the likelihood that there would be participants in the sample who could inform other ideas developing. This way of adapting the true method of theoretical sampling was a way of sampling participants within the requirements of the research and governance framework, which also met the needs of the study. It was fortunate that most of the participants met these sampling criteria and that it was possible to explore strong ideas emerging in analysis to saturation.

Recruitment

A good sized theoretical sample was achieved and no problems were encountered in recruiting willing participants. However the recruitment process of the study means that older people and GP groups are self selecting, and because of their respective motivations to take part in the study a full range of views from both groups may not have been captured.

Older people in the sample are those who have experienced depression previously or who reported experiencing milder forms of depression at the time of interviews. No older people reported experiencing severe depression at the time of interviewing, and are likely not to have volunteered due to symptoms associated with depression such as feeling unmotivated or unsociable. In addition no older people in the sample had both dementia and depression since the recruitment process allowed only those with competence to consent to take part. This meant that a large group of older people who present a common challenge for GPs of differentiating between the two illnesses were not included, and only GPs' views on this were obtained.

GPs with no special interest in mental health were needed as part of theoretical sampling. However it is likely that GPs who volunteered to take part in the study had some interest in mental health even if they reported it to be low, but this cannot be assumed. Letters were sent out to all GP practices across the 5 PCTs specified in Tyne and Wear, and through this GPs with other motivations to take part in the study may also have volunteered. Only GPs were sampled and the views of other primary healthcare professionals were not sought.

All of the participants in the study are white British and nobody from ethnic groups volunteered to take part in the study. This means that the views of these groups are not represented in the findings. In addition, the views of both groups are related to the particular experiences that they encountered in their geographical area and may not reflect the views of all older people and GPs.

Interviews

The use of qualitative research techniques such as semi structured interviewing enables understanding and exploration of the experience of illness and the organization of primary care (Kinmouth, 1995). In this study it has allowed for the exploration of older people's and GPs experiences of having and managing depression, capturing their perspectives on complex and interrelated factors that influence their positions in relation to each other and how this impacts on the way they respond to each other in consultations.

Interviews with both older people and GPs were carried out on a single occasion. It is possible that if they had been interviewed on more than one occasion changes or consistencies in their reports may have been evidenced. It is also possible that participants' reports may have been influenced by the factors specific to the day of the interview, such as how they felt on the day, or their reports may have been different if they had been interviewed at another time. An aspect of *Situational Analysis* (Clarke, 2005) drawn on in this study is the recognition of change and factors that influence change over the topic of enquiry. This has allowed for consideration of possible factors during analysis that may have influenced both changes in older people's and GPs' views over time or situations where their views remain static. Although interviews were carried out on a single occasion this

consideration of change has brought flexibility to the findings, where they suggest that older people and GPs move around on continuums depending on their situations and influences over them at the time of the interview.

Interviews with older people and GPs include their reports of what happens in consultations for depression. Since the typology is based on interview data rather than observed consultations, it is also recognized that what older people and GPs report in interviews may be different to what they actually do (Corden and Sainsbury, 2006; Richards and Emslie, 2000). The typologies are intended as a basis for further exploration for example in an observational study where consultations between older people and GPs could be observed. Findings are based on interviews with small samples of older people and GPs. Assumptions made are on the basis of groups of five or six participants (as grouped in the typologies). Therefore claims are not being made about why they report certain things in interviews, rather suggestions are being made about why this is likely. This is a first step in finding answers to why older people and GPs say and do particular things in consultations for depression, however it is based on their reports and the value of this is that it is based a version of their truth rather than the researchers' interpretations of what is observed without the explanation of those being observed. This indicates that it would be beneficial to consider both types of data alongside each other, and therefore an observational study of consultations for depression between older people and GPs may support and help verify or discount suggestions made in this study.

Both older people and GP participants opened up in interviews and were able to talk about their experiences. A slight disadvantage may have been that IG is not a GP, and GPs interviewed did not reveal some of their more personal stories as older people did. This was possibly due to the fact they were being interviewed in their professional capacity as GPs, which could have meant they focused on aspects of their story that relate to their roles as GPs rather than their subjective experiences and opinions. In support of this, a study exploring the views of GP respondents (from two qualitative studies) on how they conceptualize the GP as qualitative researcher (Chew-Graham, May & Perry, 2002) suggests that the professional identity of the researcher can influence data obtained from participants. For example it shows that GPs tend to be more formal when they

assume the interviewer is a researcher, not revealing their feelings or attitudes to consultations and giving the impression they feel under scrutiny. In contrast when the interviewing GP is known to the GP respondent, they tend to open up more and treat the interviewer less like a researcher, talking about the benefits of having a “shared language” with the interviewer and feeling more understood by a peer. A similar sense of formality is also found by Rogers, May and Oliver (2001) in their interviews with GPs about their experiences managing depression, where GPs use a “language of work”.

An advantage of GPs being interviewed by a researcher in this study is that during interviews GPs appear to be in GP “mode” (rather than peer mode), which is needed for the context of the study in order to gain insight into what happens in consultations and how GPs are likely to be with patients in their professional role. Also having a shared understanding with the interviewer may have been problematic in this study if both were GPs. This is because a GP interviewer may not have explored or interrogated some of these shared or taken for granted understandings, which may underpin the management of depression and help explain some of the problems between older people and GPs.

In primary care research, respondents’ perceptions of the professional background of researchers can impact on the data collected. Richards and Emslie (2000) found that GP researchers can be associated with formality and social status thereby overshadowing personal qualities which are an important influence over information volunteered by respondents. With sociologist researchers (such as IG in the present study) they found that age and gender appeared to be more important defining characteristics to respondents, and as a result they tended to volunteer broader, less health related information that they tended to talk about with to the doctor interviewer. This supports the type of information volunteered by both older people and GP respondents in this study and may go some way to explaining why both older people and GPs talk about the wider influences over them in the ways they respond to each other in consultations for depression.

Validity

The limitations of this study mean that it cannot claim to give a complete picture of the influences over older people and GPs ways they tell their stories and respond

to each other in consultations for depression. However the iterative approach of theoretical sampling, interviewing and developing the topic guide with triangulation via discussion of interpretations with supervisors and colleagues means that the study has validity and is comprehensive. The use of the literature to inform data collection and analysis of data is also considered to be important to accountability in research (Clarke, 2005, p.75).

Personal Reflections and influence of the researcher

The impact of the researcher, IG, and how this may have affected data collection and analysis is a factor that has been considered throughout the research process of this study. IG's input in analysis and role in constructing ideas deriving from the data is also a key component of constructivist versions of grounded theory, including Adele Clarke's *Situational Analysis* (Clarke, 2005), and can lead to the production of an interpretation or theory about the data (such as is presented in this chapter). This is partly because what participants report in interviews when speaking to researchers may be different to what they actually do or say.

Therefore in this study what older people disclose in interviews may be different to what they disclose to GPs, and likewise what GPs report doing in interviews may be different to what they do in consultations.

The role of the researcher can also be influential over the data that is gathered, as well as how it is analyzed. The use of memos where the researcher writes down observations of participants during interviews and reflections on what may be influencing the information given by participants in interviews can help build a fuller picture of how the researcher has influenced what has been said. In this study reflective information has been considered as part of analysis and examples which are relevant to the lines of enquiry followed are presented as contextual data boxes, so that it can be seen where IG has influenced suggestions made.

The theoretical interpretation presents IG's constructions of the data and ideas about what may happen which can derive from what participants report doing and saying. Writing up the findings can also be part of the theorizing process and gives additional perspective on the data. In this study IGs perspectives were developed

further by writing theoretical memos which contributed to the narrative in the findings. This is inspired by a central aspect of the situational analysis approach which leans towards constructionism and involves an active role on the part of the researcher in constructing meaning from the data.

The background of the researcher (IG) in this study was influential over the research process in a number of ways. Previous experience as a qualitative researcher in the field of primary care as well as having academic background in philosophical studies provided the IG with a broad perspective on the topic of study. This was particularly helpful in understanding the philosophical orientation of the methodology and ways of processing large amounts of qualitative data. It was also advantageous when analyzing a field of data which crossed multiple discourses.

Richard and Emslie (2000) found that sociologist researchers can retain a distance from the medical profession thereby addressing a wider range of issues in interviews, and respondents can be unsure of what to expect. They also found that contextual details of the interview can influence the interview process, such as the gender and age of the interviewer and where the interview takes place, differences in social class and the respondents' knowledge that the researcher is not medically qualified can evoke unprompted, unfavorable comments about their doctors or views of health professionals. In the present study, IG's background as a non health professional may have had both positive and negative aspects when interviewing and analyzing the GP data. Working outside the health arena meant that an "outsiders" perspective was brought to the research process, and whilst giving distance from the field of enquiry may have allowed for the observation of things which may otherwise have been taken for granted. One such example is the possibility of IG interpreting GPs' views without the taken for granted knowledge that may come with working as a GP. This shared understanding has been highlighted as potentially problematic when GPs interview other GPs, as they may not interrogate respondents effectively due to a shared understanding of the profession (Chew-Graham, May and Perry, 2002). IG's position as a non GP may have also meant that in interviews GPs explained and clarified their statements more than they would if they were being interviewed by a fellow GP (Richards and Emslie (2000).

During interviews it seemed that some participants assumed IG was a health professional, even though the researcher's position was clarified on information sheets prior to research starting. Participants tended to ask IG questions about her career after the interview, so this was often the first opportunity they revealed this, and for IG to remind them of her position now. This may have meant that some older people told their story in the same way as they would to a health professional and some GPs may have spoken in the interview as if to a GP colleague. In contrast other older people and GPs appeared to feel at ease and spoke very freely in the knowledge that the researcher was not a GP. Not being a GP had the advantage of being in a distanced position when asking questions of both sets of participants which may not have been asked otherwise and when interrogating data during analysis.

No personal experience of depression may have been a limitation for IG in understanding what it was like for older people with depression but may have also given the distance that was useful for maintaining objectivity.

The time limitations of the study meant that several theoretical sampling possibilities were not explored. Had the sample size been larger the typology groups in both the older people's and GPs data could have been further developed and tested. In the older people's typology the Unable to Articulate group may have been explored further to capture more detailed views about making decisions and their reasons for these, and how they preferred their depression to be managed. This may have also provided more data on what they preferred in a GP. Nevertheless, this information may not have been gathered because of the characteristics of people belonging to this group in the typology. Furthermore, older people's views of mental health services available to them may have been explored further to capture how they felt about accessing services and whether their perceptions of them influenced presenting depression to their GP.

Implications for Clinical Practice

This study offers a unique and flexible model suggesting ways that GPs could identify depression in different older people from the way they tell their stories in consultations. It also suggests skills GPs could draw on to provide the most appropriate help in response to their stories. The model proposed could be used by GPs as additional information alongside the NICE guidance (NICE, 2004; NICE 2009a) which provides recommendations for the management of people with depression across the lifespan and for those with depression and chronic illness (NICE 2009b), but with little focus on older people who have depression and how GPs could meet their specific needs.

The model proposed in the findings of this study considers the stories older people are telling about their depression, which relate to their perspectives on depression and their stage of understanding and acceptance. It also takes into account the influences over the way older people tell their stories in consultations for depression, including their individual situations and changing needs. The factors the model of this study is based on lean more towards a social model of depression that is thought to fit more closely with older peoples' perspectives on depression (Burroughs et al., 2006; Murray et al., 2006) as opposed to the NICE guidance which leans towards the medical model by focusing on screening, identification of clinical symptoms and treatments (NICE, 2004). The model proposed here may therefore be useful if clinical symptoms are not quickly or easily identifiable for GPs, and could be used as an alternative route into identifying depression in older people.

The findings suggest that the combination of skills used by Active Listener GPs are likely to be most successful in managing older people with depression and providing appropriate help for them. Practices may wish to recognize which of their GPs lean towards the Active Listener most and direct older people to them.

The older people's typology could help GPs determine the patients' stage of understanding and the help they need from the way they are telling their stories. The GP typology provides a way that GPs could identify help they can offer different types of patient in response to their stories, by adapting their skills

towards other styles of working. A visual representation of these typologies may help GPs quickly identify depression in older people from the ways they are telling their story and which skills they could draw on to provide patients with the help they need at the time.

The findings of this study also suggest that approaches to managing depression need to straddle the multiple discourses brought to consultations for depression by older people and GPs. The need for GPs to adapt their skills and make judgements about the best help to offer patients at different times suggests that managing older people with depression involves bringing medical knowledge, practical skills and personal qualities together to manage a condition which is viewed both as a normal state of being and an illness. The diverse range of views about depression reported by older people and GPs also points towards a need for wider approaches to identifying and managing it, in addition to the medical model of depression that dominates the approach taken in primary care. The model proposed in this study takes these factors into account, and could be seen as a step towards a more formal and detailed recognition of older people's storytelling in the approach to depression taken in primary care and as a key part of managing older people with depression.

It appears timely to build upon the current one size fits all approach to the management of depression, towards a more individual approach to helping older people adjust to the changing situations that happen in later life. This is due to the traditional retirement age of 65 years recently being abolished (The Employment Equality Regulations, 2011) and calls in health policy to address increasingly common problems such as depression in later life that are occurring due to an aging population (Age UK, 2010).

Longer consultation times could be given for patients with multiple health problems including both mental and physical health problems. This may allow patients time to build trusting relationships with GPs where they would feel listened to, be more likely to disclose their depression, establish an understanding and acceptance of their illness and have time to express their preferences to GPs. It would also allow GPs more time to have a better understanding of the patients' depression, navigate their way through complex cases and dig deeper into patients' stories

where necessary to uncover depression. The need for longer consultation times has been recognized by the RCGP (RCGP, 2010). They argue that longer consultation times are associated with GPs recognizing more psycho social problems, prescribe less and offer more advice on lifestyles and health promotion activities (Hill and Freeman, 2011) This may be considered in policy for primary care provision about how consultations can be adapted to the UK's aging population

Implications for education and training

The findings of this study suggest that helping older people understand the way they perceive depression and introducing ways they could identify depression in themselves and could be useful in helping them identify when and how they would ask GPs for help. This would challenge the assumption that mental health problems are an inevitable part of aging and also recognize vulnerabilities that exist for older people in this phase of their lives (Crosland and Wallace, 2011).

Some older people in this study found that they need support in telling their story of depression, in order to clearly express their needs to GPs in time limited consultations. The stories they tell about having depression and their experiences of its management in primary care reveal that they move around on a continuum of stages of understanding and acceptance of their depression. The position they take is guided by components of their stories that they decide to tell and hold back on, as well as other contextual factors such as how they perceive depression and the attitudes they grew up with. Coventry et al. (2011) show that people with long term conditions and their GPs can together normalize depression which hinders its recognition and treatment. They suggest that coming to a shared understanding of what depression is and how it is labeled may help overcome this. Thus, Coventry et al. (2011) and the present study findings indicate that improving doctor-patient interactions is necessary. If older people could recognize their depression and communicate what their needs are to GPs this may help improve its recognition and successful management.

Older people who are Striving to Understand appear to struggle with explaining how they feel, what has happened to them and what they need from GPs. If these

older people were able to recognize these characteristics in themselves as something that may happen to them with depression, they may be able to ask for the help they need from GPs. Having access to information about depression in later life and the different stages of understanding and accepting depression may help them with this. Support from GPs could include giving older people this information in leaflets about depression developed specifically for them. This could include information on what depression is and the treatments available, suggestions of how to revisit their experiences of depression and make sense of their story with somebody they trust, suggestions of how to establish the kind of help they would find most acceptable. This may mean discussions in consultations are more focused on what they need which could reduce the amount of time they need to talk to GPs. Having clear information about what depression is and treatments available may also help some older people accept treatments they are offered more readily.

Older people who are Unable to Articulate their depression appear to particularly struggle in verbalizing their story to GPs and tend to rely on others to take the lead in how their depression is managed. They may not have identified a trigger for their depression and some appear to have blocked it out to the extent that they have never come to terms with it or its impact on themselves. These older people may benefit from support from GPs in finding ways of telling their story of depression and communicating their preferences for how it is managed. This would empower them and build their confidence. They may also need help from talking therapists to revisit their past experiences of depression to build on their understanding of what happened to them. This may help them accept their depression in order to communicate their stories clearly and further to get what they need in consultations.

In the older people's findings, Superficial Accepters speak of minimizing their depression and being in denial of it, saying they do not believe they have proper depression or that they do not feel they need help from GPs. They say this prevents them from telling their GPs about their depression as well as talking about how they feel to other people, suggesting that they could have received help earlier had they been able to. They identify triggers to their depression as boredom, overactive mind, and retirement, indicating that they could benefit from

having information before retirement about what depression is, what triggers it, how it manifests itself and how common it is. This may help them see it as less stigmatized and accept that it can happen in later life. Age UK suggest that people may be helped to age well and prevent depression from occurring in later life by making certain lifestyle choices which would ease the transition from a busy working life to an active retirement (Age UK, 2011a). As part of preparing for retirement older people from the Superficial Acceptor group could be supported in exploring their beliefs about what later life means and be helped to make lifestyle choices that might intercept feelings they associate with depression e.g. engaging in social activities to combat loneliness or starting voluntary work to combat boredom triggered by retirement.

The Striving to Understand group and Unable to Articulate groups identified in the older people's typology may also benefit from establishing and confronting their own views about depression before later life occurs, in order to improve their help-seeking for depression it. This could include being helped to explore their perspectives on what depression is in order to challenge any stigma they may have about depression, and information on life events that people can experience in later life which can trigger their depression, such as bereavement, caring responsibilities, isolation and chronic health problems. This may help them recognize when they are experiencing depression and decide to seek help when they need it rather than viewing it as a burden on others or blocking it out. In support of this Help the Aged has highlighted that in order to sustain and enhance well-being over the aging process, a clearer understanding of the aging process that older people are trying to make sense of is needed as it happens to them (Help the Aged, 2004).

The typology of older people's different stages of understanding and acceptance of depression also presents implications for training GPs about depression in later life. GPs could be taught about different components of older people's stories of depression in order to identify their depression and what their needs are, and to increase their insight into factors underlying older people's stories.

Educational interventions for GPs in managing depression that have focused on teaching appropriate clinical skills have not improved care for patients because of

GPs' lack of belief that they can help, suggesting that GPs' attitudes to helping patients with depression needs to be addressed early in medical training (Gask et al., 2005). Other interventions teaching GPs "micro skills" (or complex clinical skills broken down into components) with particular focus on GPs' interviewing skills, combined with providing feedback to GPs have been recommended (Goldberg and Gask, 2002). The model proposed by this study may help GPs recognize skills they already have in managing depression or those they are able to adapt to particular patients. This may help build their confidence by focusing on patients who will benefit from their style of working, and assist them in recognizing when they need to refer patients to colleagues.

It seems that training GPs may be more appropriate to help older people with depression than involving new people. Older people in this study have pinpointed the role of their own GP as important in helping them with their depression in preference to starting a form of talking therapy with someone new. Older people in this study could not or would not access CBT as they preferred to see their own GP and build a long term and trusting relationship with them before they disclosed and accepted help for depression. They also reported that simply talking with their GP, sharing life experiences and exploring issues that are important to them at the time can be just as helpful as medication. For example the older people who were Striving to Understand their depression found it beneficial to recall events relating to their depression in order to establish their own understanding of what had happened to them and confirm their perceptions of depression.

It may not always be realistic for GPs to take on this workload in time limited consultations, and instead older people may need to develop trusting relationships with other primary healthcare professionals. Therapies such as CBT offer patients with depression an opportunity to learn ways of breaking patterns in their behaviour that trigger symptoms of their depression (NICE, 2006), and is usually accessed by GPs through referral to a new practitioner. The findings here suggest that older people's needs and preferences fit with counselling rather than CBT. This is supported by other work that shows their preferences are for counselling (Gum et al., 2006) and indicates that the governments' investments in CBT through IAPT in recent years are not addressing the needs of older people, despite their aim to deliver a "life course approach" (Department of Health, 2011).

Implications for future research

Further exploration of when and how older people change their understanding and acceptance of depression could be carried out amongst a larger sample of older people and GPs. This could be valuable in providing more detailed guidance for GPs about appropriate times to intervene with different forms of help for older people at different stages.

Further research could also explore older people's views of the current retirement model and how health improvement policy could be altered to improve the transition into later life.

The Active Listener style is the best developed group in the GP typology proposed in this study, and this is possibly due to the sample of GPs being self selecting where many are interested in mental health or specifically late life depression. Further development of the Analyst and Problem Solver styles of working may be carried out in future research as these two groups are likely to have wider applicability for GPs without a special interest in mental health. GPs that lean towards the Problem Solver and Analyst working styles are likely to have a greater need to build their skills in managing older people with depression, since they report having less experience of dealing with it and seem less interested in it than Active Listener GPs.

The model proposed in this study proposes practical and flexible ways that GPs could help older people with depression by identifying their individual needs through the ways they tell their stories of depression and adapting their skills accordingly. Helping GPs learn how they could adapt their skills could be done by changing the ways they make decisions in the management of depression to help older people. This needs further research to develop ideas of how GPs can learn to adapt to skills belonging to styles of working they are not inclined towards, for example through an educational or training intervention.

The identification of skills GPs could use to help different types of patient has a practical application in helping them adapt their skills to patients' needs, and this could be developed further. A visual model could be developed as a quick

reference to be used by GPs, which sets out the skills GPs could use in response to the stories older people tell when they are at different stages of depression.

Exploration of the views of GPs who are not interested in mental health could be carried out in order to capture a wider range of GPs' views on the theoretical model proposed in this study. This could be done with the intention of developing the model further to inform a training or educational intervention for GPs in managing older people with depression, based on the stories older people tell and their stage of understanding and accepting depression, as opposed to their clinical and psychological symptoms.

Further exploration of the interactions between different groups of older people and GPs could be carried out, using the findings of this study as a starting point. Consultations between older people with depression and GPs could be observed to see how they respond to each other and to test out the suggestions made about this in the present study. The older people and GP typologies developed in this study could be used as a template for further exploration into what works best in managing people with depression in later life. This could be carried out with different combinations of older people and GPs, particularly with GPs who have no special interest in mental health problems. This would build on work that suggests the disparity between the social and medical models of depression (e.g. Rogers, May and Oliver, 2001) which can result in a mismatch between older people's and GPs perspectives on depression in consultations, that can lead to the under reporting of symptoms by older people (Burroughs et al., 2006; Murray et al., 2006; Lyness et al., 1995).

Conclusion

This study highlights the multi faceted, changing and individual nature of depression in later life. It emphasizes the importance of considering differences in the ways older people and GPs perceive having and managing depression, and the influences they report over the ways they respond to each other in consultations.

The aim of this study has been to explore how older people's and GPs' different positions and situations influence the ways they perceive depression. It has done this by drawing on methodological elements of *Situational Analysis* (Clarke, 2005) to explore the stories told by older people and GPs in interviews about their experiences of having and managing depression. Particular focus is on influences reported by older people over ways they talk about depression and influences reported by GPs over ways they respond.

The contribution made by this research is that older people need different forms of help at different times and it is the GPs' ability to adapt his or her skills appropriately to these needs that is essential to managing late life depression. The study considers the multiple influences of the conceptual, social, policy driven and medicalized landscape that surrounds the management of depression in later life, and the different positions and situations of older people and GPs who operate within this. It proposes that differences in the ways older people report telling their stories and GPs report responding in consultations for depression can be explained by the different and changing positions they take. These are set out in the typologies found in the older people's and GPs' findings. It also suggests a model that GPs could use to identify and provide appropriate help for different older people in response to the stories they tell at different stages of their depression.

The theoretical model which has been developed by drawing on elements of *Situational Analysis* (Clarke, 2005) proposes an explanation for the different ways older people and GPs operate in consultations, suggesting what influences both older people in telling their stories of depression and GPs in how they respond. It proposes ways that GPs can quickly identify depression in older people based on the stories they tell, and how they can respond by adapting their skills to provide them with the most appropriate help. This is an attempt to find ways to tackle the struggle many older people have in disclosing their depression to GPs and challenges faced by GPs in the identification and management of depression in older people.

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Appendix

Letter to GP practices



Isabel Gordon
Room C13 Preistman Building
School of Health, Natural and Social Sciences
University of Sunderland
Green Terrace
Sunderland
SR1 7PZ
0191 515 2847

1 May 2008

Dear Practice Manager,

Project title: Depression in older people seen in primary care: an exploration of older people's and GPs views of depression

I am a PhD student looking at older people's and GP's views of the management of depression in primary care. The project aims to inform management of depression in older people seen in primary care. I am contacting you to see if GPs at your practice would be interested in participating in the research.

Evidence shows that although most older people with depression are seen in primary care, it is still under recognized and under treated. It has been suggested that developing new ways of managing late life depression in primary care has been neglected possibly because of the stigma associated with it. This project seeks to explore the views of older people and GPs to provide information about their views of depression, barriers to treatment and what can be done to improve the services offered to older people in primary care.

The research will be conducted by myself and supported by a supervisory team at Sunderland and Newcastle Universities.

Participation in the research would involve GPs at your practice being interviewed about their views of depression in older people.

Enclosed is the research proposal outlining details of the project. Also enclosed are information sheets and reply slips for GPs and I would be very grateful if you could pass them onto the GPs at your practice. GPs who are interested to participate in interviews will also be sent information about recruiting patients if requested on the reply slip.

If you are interested in taking part or have any questions, please contact me on 0191 515 2847 or you can email me on Isabel.Gordon@sunderland.ac.uk. I am more than happy to come along to the practice to discuss this further if you wish.

Yours sincerely,

Isabel Gordon
PhD student at Sunderland University

Information sheet



PROJECT INFORMATION SHEET FOR GPs WHO ARE BEING INTERVIEWED

Project Title: Depression in older people seen in primary care: an exploration of older people's and GP's views of depression

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what will happen. Please take time to read this information carefully and talk to others about it if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This is a PhD research study looking at older people's and GP's views of depression. Primary care is mostly where older people with depression are seen. However it can sometimes be difficult to tell depression apart from other health problems that may exist in older age, and many older people have depression which is not recognised or treated. GPs mostly provide care for older people with depression, but there is little information about what it is like receiving and providing primary care for both older people and GPs. This project is to find out more about this.

Why have I been chosen?

GP practices across five PCTs in the region have been approached. GPs within these practices are being asked if they would like to take part in an interview.

Do I have to take part?

It is your choice whether or not to take part. If you choose to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be asked to take part in an interview. Interviews will be arranged for a suitable time and place, and will last between 30 minutes and one hour. During the interview you will be asked about:

- Your overall views of working with older people who have depression
- Choices in the management of older people with depression
- What it is like talking to older people about depression
- What works and does not work in managing depression in older people in primary care
- Ideas for future management of depression in primary care

If you agree, the interview will be tape recorded. All tapes will be erased after transcription, and transcripts will be securely stored in the university. All information about you will be kept strictly confidential. If you wish to stop the interview at any time you will be able to do so.

At the end of the interview Isabel will ask you if you would like a summary of interview data sent to you and a telephone call for your verbal consent to use this anonymised information. This is to make sure Isabel's understanding of what you have discussed is correct. If there is anything you do not agree with it will not be included.

What do I have to do?

If you decide to take part in the research, please return the reply slip in the pre-paid envelope (enclosed with this sheet). Isabel Gordon, the researcher, will get in touch with you to arrange the interview. Isabel can also answer any questions you have about the project at this time, or you can contact her beforehand using the contact details below.

If you are also willing to identify and recruit patients please indicate on the reply slip and further information about this will be sent to you.

What are the benefits of taking part?

There are no direct benefits to you taking part. The research may give information to help improve our understanding of how older people and GPs view depression and the way it is dealt with in primary care. This may be of benefit to others.

It is also a chance for your views to be heard. Your views may influence the way depression in older people is dealt with in primary care.

What will happen to the results of the research study?

The information will be looked at to see how older people's and GPs views compare and what the most important things are for older people and GPs in the way depression is dealt with in primary care. This may inform management within primary care.

The results will be included in a PhD thesis which you will be able to access in Sunderland University Library. The results may also be printed in healthcare journals. This information will be made available to you, Sunderland University and any other interested bodies. You will also be asked at the interview if you would like a summary of the results sent out to you.

Will my taking part in the study be kept confidential?

Yes. All information collected will be strictly confidential to Isabel Gordon and the supervisory team. Interview tapes will be erased after transcription, and interview transcripts will be kept in a locked filing cabinet within Sunderland University until they are destroyed. You will not be identified in any of the results.

Who is organising and funding the research?

This project is being carried out by Isabel Gordon at Sunderland University. Supervision is being provided by Professor Ann Crosland and Professor Greg

Rubin at Sunderland University, and Dr Louise Robinson at Newcastle University. The research is being funded by the School of Health, Natural and Social Sciences at Sunderland University.

Contact for further information

If you need any further information please contact:

Isabel Gordon

Room C13 Priestman Building

School of Health, Natural and Social Sciences,

University of Sunderland,

Green Terrace,

Sunderland,

SR1 7PZ

0191 515 2847

email: Isabel.Gordon@sunderland.ac.uk

If there is anything about the research you are not satisfied with you can also contact Professor Ann Crosland at Sunderland University on 0191 515 2736

To obtain this information sheet in another language please contact the above.

You will be given a copy of this Information Sheet and a signed consent form to keep.

Reply slips for GPs being interviewed



**REPLY SLIP FOR GPs
WHO ARE BEING INTERVIEWED**

Project title: Depression in older people seen in primary care: an exploration of older people's and GP's views of depression

I agree to be contacted by Isabel Gordon (the researcher) about the above research project.

I agree to being sent information about identifying and recruiting patients (please tick box if applicable)

Name.....

Address of practice.....

.....

.....

.....

.....

Telephone number.....

I confirm that I have read and understand the information sheet. I confirm that I am interested in taking part in the research project .

Signed.....Date.....

Letter for GPs who are interested in identifying patients



[Practice manager's name]
[Address]

[Date]

Dear [name of practice manager]

Project title: Depression in older people seen in primary care: an exploration of older people's and GPs views of depression

I am conducting a PhD study looking at older people's and GP's views of depression within a primary care context. The project aims to inform management of depression in older people seen in primary care. I am contacting you to see if GPs at your practice would be interested in participating in the research.

Evidence shows that although most older people with depression are seen in primary care, it is still under recognised and under treated. It has been suggested that developing new ways of managing late life depression in primary care has been neglected possibly because of the stigma associated with it. This project seeks to explore the views of older people and GPs to provide information about their views of depression and what can be done to improve management of older people with depression in primary care.

The research will be conducted by myself and supported by a supervisory team at Sunderland and Newcastle Universities.

Participation in the research would involve sending an information pack with template letters from GPs to patients who fit the research criteria. GPs would assess the patients' capacity to consent to the study before these were sent. Information packs and letters would be prepared by me and I would give additional assistance wherever possible. Postage and expenses would also be paid. Work for practice staff would be kept to an absolute minimum.

Enclosed is the research proposal outlining details of the project. Also enclosed are information sheets and reply slips for GPs. I would be very grateful if you could pass these onto the GPs at your practice. If you are interested in taking part or have any questions, please contact me on 0191 515 2847 or you can email me on Isabel.Gordon@sunderland.ac.uk. I am more than happy to come along to the practice to discuss this further if you wish.

Yours sincerely,

Isabel Gordon
PhD student at Sunderland University

Proposal



Depression in older people seen in primary care: an exploration of older people's and GP's views of depression

Isabel Gordon

INTRODUCTION

This PhD study seeks to explore the views of older people and GPs on the management of depression in older people seen in primary care.

BACKGROUND AND LITERATURE

A literature review was carried out between November 2006 and July 2007. This will be reviewed and updated in a similar way during the course of the study, and so is regarded as an ongoing process. Literature searches were carried out on electronic databases including Medline, CINAHL, Ovid, SwetsWise, Cochrane Library, Department of Health, Database of Abstracts of Reviews of Effects, National Library for Health, World Health Organisation and the National Health Services Research Register. Search terms included depression, older people, primary care, management, qualitative, patient views, GP views.

There is some debate about what depression actually "is" from the perspectives of GPs and patients and how their different interpretations can make an impact upon choices in its management in primary care (Rogers et al 2001; Pilgrim & Bentall 1999). This is because the word "depression" carries a spectrum of meaningful implications for both patients and GPs and there are question marks over its usefulness as a label for symptoms of mental ill health. Consequently tensions can arise for GPs between choosing to diagnose "depression" or alternatively acknowledging "depressive symptoms" because of how patients may interpret the meaning of depression (Karp 1996; Lewis 1995). It has been suggested that it is more appropriate to manage a patient's depressive symptoms and avoid the implications of using the label of depression, and instead assist the patient in finding some meaning from their distress (Dowrick 2004). The use of language and the way GPs and patients talk about depression has been highlighted as especially important with older patients (Murray et al 2006; Burroughs et al 2006; Lawrence et al 2006; Butcher & McGonigal-Kenney 2005). It is therefore important to acknowledge the complexity of the experience of depression and recognise different viewpoints about how depression is defined, plus the implications these different views may have in the management of depression in older people in primary care. These different interpretations and tensions are recognised in this study and the complexities of language and different models will be explored in greater detail as the study progresses. However, for purposes of clarity and convention the term depression is used throughout this proposal.

Research shows that depression is the most frequent cause of emotional suffering in older adults (those over 65), and can significantly decrease their quality of life (Blazer 2003; Chew-Graham et al 2004). It can become a chronic or recurrent problem for up to 50% of affected older people particularly those in poor physical health (Unutzer 2002, Beekman et al 1999). It is associated with serious morbidity and mortality including malnutrition, physical decline, poor medical outcomes and suicide (Montano 1999). For older people there is an increasing risk of major life events associated with depression such as loss of employment, bereavement, changing social environments (e.g. retirement or a move), increased risk of social isolation and changes in health status (NICE 2004). These risks are more likely to affect older people than those who are younger. As demographic

changes signal an increase in the elderly population over the next decades alongside rising rates of depression (Appleby 2007) action around tackling depression in older people needs to be taken (MHILLI 2006).

Despite the huge problem of mental ill health in later life, the Department of Health policy documents show that older people's mental health has been low on the agenda in the past. This lack of recognition includes the needs of older people with depression, and has meant that the needs of older people and mental health problems have been treated separately in the National Service Frameworks (NSFs) for Older People (2001) and Mental Health (1999). There is also a lack of evidence about the efficacy of different treatment options in older people. For example, clinical guidelines show only sufficient evidence for people over 65 for psychological interventions combined with antidepressants but insufficient evidence about other forms of management (NICE 2004). More focus on mental ill health in older people has begun recently. Mental health services for older people including those in primary care are to be "age inclusive" so that all ages are considered in improvements (Department of Health 2006). A recent report by the National Director for Mental Health highlights the need to break down barriers in the way services are delivered so that they are more closely aligned to the needs of all patients (Appleby 2007). However there is clearly little guidance or policy specifically relating to older people with depression and how primary care can be improved for them. This indicates a need for stronger evidence and better understanding of this area.

Within primary care, depression in older people is still under recognised and under treated (Barg et al 2006; Murray et al 2006; Lawrence 2006). This is despite the fact that major depression affects 5-10% of older adults who visit a primary care provider (Gum et al 2006; Unutzer 2002). Most older people with symptoms of depression present to their GP first, and the majority continue to be cared for and managed in primary care by GPs. Therefore GPs are uniquely placed to provide valuable information about their views of depression in older people, and opportunities to improve recognition and management of depression in primary care.

Barriers for GPs in the recognition of depression in older people have been identified in the research. There are differences in the presentation of symptoms between older and younger people because of aging, physical illness or both. (Butcher & McGonigal-Kenney 2005; Reynolds 2002; Rabins 1996). In older people symptoms such as slowing of thought and activity are more pronounced than in younger people. This makes it difficult to distinguish between depression and co-existent health problems in older age such as dementia. (Murray 2006; Godfrey & Townsend 2005; Noel et al 2004; Charlson & Peterson 2002). In addition older people may not have sufficient symptoms to meet the threshold for mood disorder, and two thirds of older people with serious depression do not have symptoms that fit current classifications of mood disorders (Beekman et al 1999; Chew-Graham 2004). Symptoms of depression in older people can also have similarities with early symptoms of dementia (NICE, 2004) which may cause confusion for GPs diagnosing it. Barriers for GPs in recognising depression therefore tend to relate to individuals' symptoms, and this approach suggests little leeway for consideration of people's views about illnesses and any social influences (Rogers et al 2001). This includes consideration of GPs' own views from personal experiences of working with older people who are depressed (Feely et al 2007, Burroughs 2006). Information about these considerations may provide opportunities to tackle existing barriers for GPs in recognising depression.

There is limited evidence of GPs' views of working with older people who have depression. It suggests that GPs' attitudes to late life depression are underpinned by a lack of confidence in their knowledge and consultation skills to diagnose and manage the problem. When they are not confident about how older patients will react to their approach to depression they tend to deal with other medical problems instead (Burroughs 2006; Chew-Graham 2004) or they may be wary of opening a "Pandora's Box" in consultations

which are limited in time (Montano 1999). GPs have also reported concern about medicalising “understandable” distress due to problems such as isolation and bereavement (Murray et al 2006, Nolan et al 2003). This highlights tensions in decision making for GPs between diagnosing problems of living or a psychiatric condition. Finding out more about how older people think approaches to depression in primary care could be adapted to meet their needs and their role in decision making may provide GPs with more confidence in this area.

A few small scale studies have recently focused on older people’s attitudes to depression and treatment (Gum et al 2006; Barg et al 2006; Lawrence et al 2006; Givens et al 2006; Burroughs et al 2006; James et al 1999). It is clear that stigma and lack of knowledge about depression may affect older people’s perception of its severity and the need to seek treatment (Lawrence et al 2006; Givens et al 2005) which can lead to adverse prognosis (Kessing, 2005). Older people tend to see depression as a normal, inevitable part of aging (Butcher & McGonigal-Kenny 2005; Unutzer 2002; WHO 2001;) and can be reluctant to go to the doctor about it as they feel they should be able to handle it themselves or do not recognise it as an illness in its own right needing treatment (Reynolds & Charney 2002; Rabins 1996). Research of this kind highlights the importance of considering how attitudes of older people towards depression can have an impact on treatment choices and getting help, as well as why they make these decisions.

It has been shown that experiences in primary care can influence people’s views of depression. Nolan (2005) reports that patients who felt listened to and reassured by their GP decided to do everything they could to recover, thereby having a positive influence over their views. Wittnik et al (2006) showed that the way a GP communicates with older patients about depression can influence how they see depression, and consequently what they come to expect when presenting their symptoms to their GP. It is therefore important to understand these influences in order to make positive changes and continue with what patients find helpful. Older people’s attitudes about depression have been pinpointed as a barrier to them deciding to seek help in primary care for depression, so it seems that further exploration about what can be done to positively influence their views in primary care is needed. When carrying out research of this kind consideration might be given to differences in people’s accounts at the time of being depressed and when they are not.

GPs’ attitudes towards late life depression have been shown to echo some of the attitudes older people have reported about depression, where both have a misperception that depression is normal in later life (Burroughs 2006; Montano 1999). The Burroughs et al (2006) suggest that older patients’ passivity to their treatment, alongside the way health professionals perceive older people’s attitudes to depression, gives health professionals unspoken permission to overlook depression and concentrate on other health problems. The Burroughs study was part of a larger feasibility study of an intervention for late life depression in primary care. A more detailed, patient-centred (Stewart 2001) exploration of the strengths as well as the weaknesses in current management of late life depression within primary care would build on the evidence given in this study.

It has been suggested that developing new ways of managing late life depression in primary care have been neglected because of the stigma associated with it from both sides (Chew-Graham 2004). One way of finding out how management of late life depression might change in primary care is to identify further similarities and differences in the views of GPs and older people about depression, as well as where mismatches in their views lie (Murray et al 2006). A focus group study by Lester et al (2005) looked at the views of GPs and patients with serious mental illness. It showed that the way mental health is managed in primary care does not always fit in with what patients with serious mental illness want. Givens et al (2006) only looks at patient views but also highlights this mismatch by revealing older people’s dislike of taking antidepressants despite them being the most common treatment of major depression for older people in primary care. Burroughs et al (2006) also showed that neither GPs’ nor older patients’ views fit in with

services provided in primary care and highlights a need for provision of primary care that addresses the needs of older people including their attitudes towards depression. Furthermore, Murray et al (2006) shows that the framework adopted in practice within primary care does not take into account wider issues in older people's lives and co-existent health problems as well as their attitude to what depression is. Looking at dual views has therefore provided valuable evidence about where lay and professional views meet and whether differences and similarities are problematic and need to be addressed in practice. However the limited evidence base offers few solutions about what can be done in future to address the mismatch between older people's and GP views about depression. The next step would be to explore how these views may actually be applied in practice for example in the way decisions are made on both sides. More work also needs to be done around understanding influences on both older people and GPs views of the management of depression to get to the core of why barriers exist and how they can be tackled.

Therefore this proposal seeks to explore the views of older people and GPs about the management of depression in older people seen in primary care. The study will explore how older people's experiences of having depression and being treated in primary care have influenced the way they view the management of depression, their role in decision making and their views of what can be done in future. It will also explore how GPs' experiences of working with older people with depression have influenced their views about its management and decisions relating to its management as well as what can be done in future. The study will respond to the lack of evidence documenting both older people's and GPs' experiences and views on the management of depression in older people seen in primary care, and what they would like to see in future. It will provide information to inform strategies for the management of depression within primary care.

AIM

The aim of this proposal is to explore the views of older people and GPs on the management of depression in older people seen in primary care.

METHODOLOGY

Theoretical framework

Methodological approaches used in this study will draw on some of the principles of grounded theory outlined by Glaser and Strauss (1967). Grounded theory is suitable for exploratory research into people's experiences over time which may have brought about change in their views of the world (Morse 1998).

Grounded theory approaches have been used in other qualitative studies looking at subjective experiences of illness. A study by Feely et al 2007 used grounded theory to explore people's perceptions of living with or caring for people with depression, focussing on experiences before diagnosis. The approach in this study allowed for identification of key factors in people's experiences, providing valuable information for those caring for them. It shows that grounded theory is suitable for exploring people's personal experiences and what has shaped their views. Using a methodological approach which allows participants to guide theory is particularly appropriate to experiences of mental illnesses which can only be described by the individual and cannot be objectively measured. Therefore use of some of the principles of grounded theory will be appropriate for exploring the views of older people and GPs on the management of depression in older people seen in primary care.

Grounded theory derives from symbolic interactionism which focuses on how individuals choose to make sense of the world through their experiences of social interaction (Denzin, 2004). In a similar way to symbolic interactionism, grounded theory also focuses on how people choose to see the world, and how their views have been influenced by their experiences (Hildenbrand 2004). They both promote the avoidance of preconceptions being made before data collection starts. However symbolic interactionism is a theoretical

discourse which grounded theory adds to by incorporating a number of practical procedures intended to help develop theory and avoid preconceptions (Bohm 2004). Therefore a major difference between symbolic interactionism and grounded theory is the inclusion of practical procedures carried out during the research process (Strauss & Corbin 1998). These procedures are carried out in stages including theoretical sampling and three types of coding to aid analysis. They are carried out in parallel, continuing throughout the research process so that concepts identified in early data collection can guide the next stages of data collection (Strauss & Corbin 1998).

Theoretical sampling is one principle of grounded theory that will be used in this study to develop theory during the analysis of interview data. This technique was developed by Glaser & Strauss (1967). A first set of participants are identified randomly and then interviewed using an initial topic guide. Researchers then analyse these first interviews to identify important concepts brought up by participants. The topic guide is modified to focus on what needs to be explored next. Further participants are then deliberately selected with the intention of exploring these concepts further. This process is repeated until "data saturation" is reached. Data saturation is where no new concepts are being found in the data (Glaser & Strauss 1967). Finally disconfirming cases are sought in the same way to challenge theories developed in the previous interviews, and this also proceeds until saturation of data is achieved. The theoretical sampling technique ensures that few assumptions are made by researchers before data is collected, and participants directly influence the theory that results from the research. This is necessary because following this approach ideas are vague at the beginning and only materialise during the course of the investigation (Merken, 2004).

Analysis of data in this study will also draw on principles of grounded theory. The three stages of coding will be used to compare data: open, axial and selective coding (Bohm, 2004). Firstly categories in the interview data are identified by "open coding". Open coding is where data are broken down analytically, and concepts are developed which may be built on later. At the second stage, concepts are grouped together by "axial coding". Axial coding is when concepts are refined and differences are identified between them to form groups of concepts, or categories. In doing this one category is located at the centre and a network of relationships is developed around it to form theory. The third stage of analysis is "selective coding". Selective coding is when central or core categories are identified and theory is confirmed.

In comparing data through the use of coding, similarities and differences between what participants say can be identified and theories can then be developed.

The methodological procedures described here are taken from grounded theory to form the approach used in this study. This approach will be used to illuminate personal experiences of older people who have depression and their views on how it is managed in primary care. It will allow for exploration of their role in decision making in the management of depression, as well as their views about what they would like to see in the future. This approach will also allow for exploration of GP's experiences of working with older people who have depression and influences over decisions GPs make in the management of older people with depression.

METHODS

Recruitment and interviewing of GPs

The first stage of interviews will be carried out with three or four GPs using an initial topic guide (below). These interviews will be analysed to identify what appear to be the most important emergent concepts. The topic guide will then be adapted accordingly.

Theoretical sampling will be carried out next to identify further participants for interview who may be able to illuminate these concepts further. It is envisaged that there will be a maximum of 25 GPs in the sample. Other studies using theoretical sampling such as Murphy et al (2003) and Kumar et al (2003) show that a sample of approximately this size allows for data saturation to be achieved and the investigation of disconfirming cases.

Interviews will be used to explore GPs views of depression and how it is managed in primary care, including how their experiences have shaped the choices they have made and their role in decision making. Initial topics will include:

- Overall views of working with older people who have depression (prompts: How depression is recognised in older people /how common in older people/differences in older people compared to younger people; whether GPs' views about depression have been influenced by experiences of working with them)
- Explore views about what depression is, different ways of looking at the problem and the impact different interpretations may have on its management (prompts: views on role of diagnosis, how views of what depression is affects choices made in its management, views on whether meaning is different when dealing with older people)
- Choices in the management of older people with depression (prompts: GPs views of the choices available in managing older people with depression; how GPs make decisions around management; what influences these choices - personal/professional/political; views of older people's role in making choices)
- Communication about depression (prompts: Language used in talking with older people about their depression; reasons for GPs' choices about language)
- Opportunities and barriers to optimum management of depression in older people within primary care (prompts: GPs' views of optimum management of depression in older people; GPs' experiences of things working well/any problems in managing older people with depression; opportunities and barriers to making choices)
- Ideas for future management of depression in primary care (prompt: GPs' views of changes that could be made in future and reasons for their views; GPs future role in decision making; how GPs' experiences have guided their views about what should happen in future)

Face to face interviews will be carried out by Isabel Gordon at the GPs place of work. Interviews are expected to take about one hour, will be audio-taped with consent and transcribed verbatim.

Recruitment and interviewing of patients

Up to 5 GP practices will be involved in the identification and recruitment of patients. Information will be sent via Northern and Yorkshire Research Network (NyReN) to GP practices who have expressed an interest in mental health research. GPs who are willing to identify patients will send reply slips back to the Isabel Gordon at Sunderland University. They will be asked to only approach older people who they assess as having capacity to consent to the research study. GPs will send letters and information about the study to identified patients. GPs who are interested to participate in interviews will also be sent information about recruiting patients.

Criteria for inclusion will be for patients to be over 65 years old, and to have had treatment for depression since they were 65. Older people who have a diagnosis of dementia will be excluded from the study due to the possibility of fluctuating capacity. GPs will be informed of patients who agree to take part in the study.

Reply slips will be returned by older people who wish to take part. The researcher will then contact them to answer any questions they may have about the study. Interviews will be

carried out once, within one month of receipt of the reply slip or as soon as possible thereafter. Written consent will be sought from all participants prior to data collection.

The first stage of interviews will be carried out with three or four older people using an initial topic guide (below). These interviews will be analysed to identify what appear to be the most important emergent concepts. The topic guide will then be adapted accordingly. Theoretical sampling will be carried out next to identify further participants for interview who may be able to illuminate these concepts further. It is envisaged that data saturation will be achieved with between 15 and 25 participants. There will be up to a maximum of 25 older people in the sample. As with the sample of GPs, this size will allow for data saturation to be achieved and the investigation of disconfirming cases (Murphy et al 2003; Kumar & Gantley 1999).

Interviews will be used to explore older people's views of depression and how it is managed in primary care. This will include exploration of how older people's experiences have shaped choices they make relating to the management of their depression and their role in decision making. Initial topics will include:

- Overall views of depression
(prompts: experiences of depression/views of what depression is/ whether this has changed over the years; what has influenced their views about depression; are views different when depressed)
- Explore views about what depression is, whether they have encountered different views and perspectives on depression and how different perspectives may impact on its management
(prompts: views on role of diagnosis, how views of what depression is affects choices made in its management; whether views on its meaning has changed over the years)
- Experiences of depression being managed in primary care
(prompts: What it is like being treated for depression in primary care; recent experiences of seeing the GP about depression -what has been good /bad/what could be improved; how do older people feel about their role in decision making; whether experiences of primary care have influenced the they think about depression)
- Communication about depression
(prompts: Conversations with GPs about depression – what has been good/bad; how depression was first brought up/ appropriate language; choices about how older people would talk to their GP about depression/reasons for these choices; would this be different if feeling depressed)
- Ideas of what works well and what could be changed
(prompt: Views of any changes that could be made in primary care in the future/ reasons for these views; any changes to older people's role in the management of their depression e.g. in decision making)

Interviews will be conducted by Isabel Gordon in the patients' homes or if requested either at the GP surgery or in a university room. Interviews are expected to last about one hour, will be audio-taped and transcribed verbatim. Interview transcripts will form the material for analysis.

Analysis

Analysis will proceed in three stages where open, axial and selective coding is used (as described before). Between each stage of analysis the researcher will have discussions with the supervisory team to confirm ways of moving forward in data collection.

Interpretation of data will be undertaken by Isabel Gordon and the interpretation will be discussed with Ann Crosland, Greg Rubin and Louise Robinson at regular intervals. It is necessary to maintain awareness that the nature of grounded theory relies on both the interpretation of participants as well as researchers during analysis. This means that researchers must be especially mindful of their own interpretations becoming incorporated onto the theories developed (Strauss & Corbin 1998). At the end of each interview Isabel Gordon will ask participants if they would like a summary of multiple interview transcripts (including their own) sent to them and a follow up telephone call for their verbal consent to use this information provided it is anonymised. This will ensure that the interpretation of data is trustworthy and faithful to what participants report in interviews (Strauss & Corbin 1998). This is one way of ensuring rigour in qualitative research as participants will be able to confirm the accuracy and validity of the study, and possibly offer additional stories to confirm any theory further (Morse 1998).

Issues around maintaining rigour in data collection and analysis will be explored further as part of the PhD study. Issues to be addressed will include credibility, transferability as well as discussion around how rigour is understood within qualitative research as detailed by Lincoln & Guba (1985) and this will be included in the PhD thesis.

ETHICAL CONSIDERATIONS

The research in this study will be carried out with people who may be vulnerable on a number of levels including those with mental ill health, old age, possible disability and those who may have a number of co-existent illnesses. Guidelines on research with vulnerable people require that researchers have CRB disclosures to ensure that they do not have a history that will make them unsuitable for working with vulnerable groups. In addition every effort should be made to secure informed consent from participants, and that informed consent is properly defined (ESRC 2006).

A key ethical consideration is that it may be distressing for patients to talk about their depression and it may also bring about some painful memories. Therefore the researcher must be aware of this and be able to recognise somebody showing signs of distress during the interview. If this is the case the research must stop immediately. If a participant asks for advice during the interview the researcher must not give any personal opinions, but be able to recognise when someone is asking for help or advice and signpost them to their GP.

Another ethical consideration arising from this study centres on participants being fully informed about what is involved prior to consenting and taking part in the research. This will be addressed through a stepped approach that will allow participants time to consider the written information provided and to ask any questions to the researcher prior to agreeing to participate. Detailed written information sheets will be used to inform older people and GPs what will be involved in the research. The information sheets will clearly state that if participants show any signs of harming themselves or others during the research the researcher will discuss with the participant the need to inform their GP.

Participants may have concerns about commenting on the care they have received, for example they may feel anxious about criticising their GP or primary care services, or be anxious not to. There is therefore a need to stress to participants that data will be kept anonymous during the collection and analysis processes. They will also be reassured that their usual care will not be affected by taking part in the research and that they can withdraw at any time.

A risk associated with carrying out research with older people is the possibility of them having memory problems or dementia. To minimise this risk an exclusion criteria for the study is a diagnosis of dementia. The researcher is aware that alongside the possibility of other health conditions in older patients, this may affect the research, such as when and if people can take part. Therefore GPs will be asked only to invite people to take part who

they consider competent to consent and well enough to take part. The possibility of memory problems will be addressed whereby consent will be an ongoing negotiation during the research process. Patients may also not be able to take part in the research at various times because of their condition worsening, or another illness preventing them to participate at various points during the research.

TIMESCALE

June - Sept 2007	Peer approval and submission to ethics for approval
Sept 2007 – March 2008	Recruitment process
Nov 2007 – June 2008	Interviews
Nov 2007- Apr 2009	Analysis of data during and after interviews
Aug 2007 – Nov 2009	Continuous literature review and writing up of PhD thesis

PROJECT MANAGEMENT

The principal investigator of the project will be Isabel Gordon, a PhD student at Sunderland University. Isabel will be responsible for ensuring milestones in the research process are met and for the writing up of the PhD thesis at the end of the study. Data collection for this study will also be carried out by Isabel Gordon.

Supervision for the PhD study is provided by Professor Ann Crosland, Professor of Nursing at Sunderland University. Co-supervision is provided by Professor Greg Rubin, Professor of Primary Care at Sunderland University, and Dr Louise Robinson Senior Lecturer at Newcastle University and General Practitioner specialising in dementia at an inner city practice in Newcastle. Supervisory meetings will be held formally on monthly basis with Professor Crosland and Isabel Gordon, and group supervision will be on a tri-monthly basis with all supervisors present. The university has in place an annual reviewing system to provide further guidance about the progress of the research.

COSTS

Postage costs
 Travel and mileage
 Printing letters, information, reply slips and consent forms
 Binding and dissemination

DISSEMINATION

Research findings will be disseminated to inform future practice and research. The following report and papers will be produced:

- A PhD thesis with findings from the study.
- Participants will be asked if they would like a summary of the findings section of the thesis sent to them on completion of the PhD.
- A journal paper on the findings to be submitted for publication in an academic journal.

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Initial topic guide for older people

- Overall views of depression
(prompts: experiences of depression/views of what depression is/ whether or how this has changed over the years; what has influenced their views about depression; are their views different when depressed)
- Explore views about what depression is, whether they have encountered different perspectives on depression in different situations and how these may impact on its management in primary care
(prompts: views on diagnosis, how views of what depression is affects the decisions made in its management; whether their views on its meaning has changed over the years)
- Experiences of depression being managed in primary care
(prompts: What it is like being treated for depression in primary care; recent experiences of seeing their GP about depression -what has been good /bad/what could be improved; how do they feel about their role in decision making; whether their experiences in primary care have influenced the way they view depression)
- Communication about depression
(prompts: Conversations with GPs about depression – what has been good/bad; how depression was first brought up/ appropriate language; decisions about how they talk to their GP about depression/reasons for these decisions; would this be different if feeling depressed)
- Ideas of what works well and what could be changed
(prompt: Views of any changes that could be made in primary care in the future/ reasons for these views; any changes to older people's role in the management of their depression e.g. in decision making)

List of codes identified from sensitizing the older people's data with possible lines of enquiry in bold

Talking about depression	Identity and depression
Rehearsed story	Long v short term depression
Unrehearsed story	Self compared to others with depression
Agenda unshakeable	Comparison of self with well-respected famous figures
Chronology	Image of self
Selective information giving	Happy and not old
Just wanting company	Being a burden
Mantras	Denial of depression
Monologues	
Minimising depression	Perceived "type" of depression
Need bolstering	OCD
Question and answer	Overactive mind
Internalising story	Nerves
Boundaries	"Something ingrained in me"
Conditions attached to talking	Depression and masculinity
Preferences of who to talk to	
Private and public stories	Attitude to depression
Selective information giving	What makes it acceptable
Not telling people	Being treated differently
Being a burden	Stigma (how others see them)
Different stories for different people	Change in attitudes
	Passivity (rela to long/short term?)
Relief in talking	Older old/young old
Bringing it up	
What depression means	Preferences in telling story to GPs
Language	Preferred qualities in GP
Euphemisms	GP as "friend"
Used by GP	Know life context
Preferences	GP approach/style
	Holistic
Explanations for depression	No talking just medication
Overactive mind	Trust in GP
Bereavement	Long relationship with GP
Lack of routine	Older GP
How depression relates to age	Shared experiences
Isolation, impact of	Empathy/understanding
Nerves	GP as stranger
Abuse	
Family problems	Needs at crisis point
Suicide of family member	Changing needs
Suicidal thoughts	How select GP
	Coping
What depression feels like	
Comparing self to others	Power/control
Justifying as normal	

Situational map developed during/after OP3 Interview

Participant:

Male, 68 years

Rural community

Middle class, appeared reasonably well off

Well educated, described self as "high achiever", very successful and busy career – attached a lot of importance to this

Active, regularly exercised, did not report any other health problems

3 episodes of severe depression over last 14 years – one episode needed hospitalisation, two episodes managed in primary care

Observations/setting:

In conservatory at home, undisturbed

Key areas:

Self-Identity

Sees self as healthy – first thing he mentioned that he had no health problems before the depression

"High achiever" very proud of education and career, "high intellectual activity", prides self-education

Depression is total exhaustion,

Likens self to Einstein, Winston Churchill – calls his depression Churchill "Black Dog" like Churchill – is this a way of coping?

Does not perceive self to have depression

Speaks of other people who are depressed as "iller".

Wanted to help other depressed patients in hospital, *did not see self as having "proper depression"*

At first did not understand reasons for depression - over time and with hindsight and research has formed own views to explain why it happened to him

Explains depression because of his "busy mind"

"went into overdrive" and "freaked out" because of this

Nervous breakdown, "overactive mind"

episodes were "5 weeks in 14 years" had three episodes

Experience "Plunge", "Bleakness" no sleep "Whirring" in his head

Coping strategies

Holidays and hobbies, Exercise – has always been a big part of life

"Level headed wife", Not moping, Refusing to be "ill" – denial of depression?

Medication

On Prozac – did not like it, makes him drowsy.

Feels that docs put patients on it as a "knee jerk reaction" – he was first prescribed this by GP on first contact

Associates Prozac with misery – which he did not feel he had – as if he thought Prozac was completely inappropriate – has stigma influenced this view?

Cont....situational map developed during/after OP3 Interview

Seems expert on depression

Long relationship with GP

Mutual understanding of how to talk about depression –uses “black dog”

would have liked things to have been handled differently at beginning - would have preferred sleeping pills to Prozac. *Importance of negotiation? Needs at crisis?*

Important aspects of treatment and management

Familiarity to doctors and knowledge about treatment

No talking not helpful

Being valued by doctors that he is a “high achiever”

Situational map written after OP6 Interview

No opening question or prompt needed – started talking when he came outside to meet me, could not get tape recorder on fast enough – with prompting he revisited what had said before
Good info given in interview

Was very upset during interview –cried. Talked of considering suicide recently but that did not feel like that now.

Is it right to probe further when someone is this upset?

I decided not to interrupt to stop interview and he continued with what he wanted to talk about. My position as a researcher constructing the story with him is exemplified here because I made a decision not to interrupt. Would it have affected his story otherwise? Would he have gone into as much depth after this point if I had interrupted or did he have his own agenda that would have stayed the same whatever had happened? *My hunch is that he had his own agenda and this would not have changed if I had done something – observe this in later interviews.*

He became brighter – left him much happier at end of interview. Should I have offered to stop interview?

Consider ways of bringing someone back from when lost in thoughts – this time we talked about his relatives and seeing them now which seemed to cheer him up and brought him back to present.

Theoretical Memo: Talking about depression – older people

Talking about depression

Older people talk about depression in different ways. Their ways of talking about depression can indicate a wide range of their views about depression, including their explanations about depression, the type of language they prefer to use and how they cope with having depression. The way older people talk about depression can also give an insight into their social attitude to depression (e.g. stigma) as well as how they view their identity and how it may have changed their self-image. Moreover the way older people express their views about depression can also have a significant impact on how it is managed in primary care, through the way they communicate about it with health professionals.

During analysis the overall theme of talking about depression was identified and a number of categories relating to this became apparent. Characteristics of these categories are described below, including how participants within the groups are similar and different, plus any individual cases within the groups that are exceptions. This led to identification of sub-categories which attempt to explain these similarities and differences. Relationships between categories are also described as part of this second stage of analysis, in order to find out where information is missing and what needs to be followed up in final interviews to develop a final theory.

Interview Styles

Distinctive interview styles (or ways of talking) were identified amongst participants during interviews. This was important because their interview style often revealed how participants expressed themselves when asked about depression, how they went about describing their experiences of depression, whether they seemed comfortable or not talking about depression and how much depth they were prepared to go into. Characteristics like this indicated participants' views of depression and also gave an insight into what was *not* said. With some older people what was left unsaid sometimes seemed to be just as important as what was actually said, and is perhaps a generational characteristic [explore further?].

There were participants who seemed more at ease than others being in an interview situation even though it was conducted like an informal conversation. Participants who were very forthcoming and talked readily during interviews were either male and described themselves as having had successful careers, or females who described having a strong support group of close friends or family. These participants may have been more used to talking because of these factors or were the type of personalities that were sociable. The differences were that not all of these participants would talk freely about depression itself, for example by limiting the amount of depth they would go into about their experiences of depression. This is an example of how sub-categories were identified, in an attempt to explain the differences within groups.

Some interview styles are interrelated and there were participants who displayed a combination of interview styles.

Repeating mantras

Repetition of mantras was characteristic in some of the interviews. Participants would repeat phrases or mantras describing beliefs about their depression such as why they had it, how their depression affected them, or something relating to their identity. They would repeat the same phrase as if to reinforce it to themselves as well as who they were talking to. They were often strong personalities who came across as quite positive when they spoke and would often be participants who were willing to talk freely even if they held back on the subject of depression. Participants who repeated mantras tended to be

different to other participants because they seemed practised at telling their stories, more confident and open, and reported finding it helpful to talk to others about their depression. [Do people who use mantras like talking about their depression?]

Examples of mantras are:

“I have an overactive mind” (OP6?)

“I am different to most people with depression”(OP14)

“I only make one friend at a time, I never bother with anybody else”(OP12)

“I’ve been a worrier, all my life a was worrier” (OP7)

A few participants in this group sought reassurance during the interview that what they were saying was useful to me, relevant and that they were not wasting my time. It was as if they were seeking permission to continue talking. This overlaps with another sub-category of interview style characterized by participants who needed frequent “bolstering” throughout the interview.

Repeating mantras seemed to also relate to ways participants cope with depression. It seemed to help some participants rationalise their depression and even accept it by explaining why they had it or to reinforce the type of person they are - as if having depression diluted their identity in some way. For some, repeating mantras also appeared to be a tool for expressing themselves to other people and “externalising”* their views.

Repetition of mantras also relates to some participants’ self image. This is because the mantras could be used describe the type of person they saw themselves as (in relation to their depression or not), and were often positive affirmations of who they were – or possibly how they would like to be seen by others [explore further?*

“I am normally a happy person” (OP10)

“I have no other illnesses” (OP9)

“I’m always manic, not depressed” (OP5)

“I am an active person” (OP4)

Idea of *external and internal views of depression* should be followed up as another (overriding) theme. (Different “stories” to different people, private and public explanations)

Older people have internal and external stories about their depression. Internal stories are their own version of their depression and what has happened to them, it represents their own understanding and reasoning behind their depression. Some people give only glimpses of this internal story in interviews whereas others are more open about it.

External stories are what older people are prepared to tell other people, this could be by way of a rehearsed or unrehearsed story, but it relates to the image of themselves that they want to project publicly and what they want people to know about their depression. It seems that there could be different types of external story adapted to who they are telling. It may be the case that they tell health professionals their story in a different way to friends or in an interview situation.

This needs to be unpicked

[Explore in future interviews which stories are told to which types of people e.g. what do they tell health professionals and how is this different to what older people tell friends?]

Practicing story (Rehearsed/Unrehearsed story)

Some participants told rehearsed stories whilst others told unrehearsed stories. Those who told rehearsed stories seem to have an unshakeable agenda (they continue with their story regardless of what questions are asked), and the stories are often told in chronological order. An importance placed on giving details such as dates, names of health professionals, places where treated and medication given and not so much on the

experience of being depressed. Often the participant would start off by explaining their perceived cause of their depression, indicating that it is of primary importance to them to make sure other people know why they have it. The unshakeable agenda is quite telling of the participants' attitude to depression and how they relate to other people about it.

Amongst those who told unrehearsed stories some participants seemed to be getting the story straight in their heads by ordering and trying to understand what had happened to them as they went along. They would sometimes say that they had never told anybody their story about having depression and reported using the interview as a means of practicing their story about depression. Some participants said they had never told anybody about their depression before and were using this as an opportunity to "come clean" (OP13). Others would appear to be ordering the story in their own heads as they were telling it, as if they had not practiced the story before - for example by putting dates in order, remembering names of doctors, where they were treated, names of medication etc. as they went along. Amongst those who were practicing their story there was one participant who was preparing to tell relatives and reported that this was the main reason for taking part in the interview. [Quote (OP13)].

There were others within this group who said that they took part in the interview only because they wanted company. These people were not interested in giving information about their depression. They were very selective in what they were prepared to disclose and talked about other aspects of their life, rather than the depression itself. However giving a context about their lives often revealed some of their views about depression in an indirect way.

With these people it came across that they were not used to telling their story (and it was therefore unrehearsed) as they were often quite vague in the details and seemed to have trouble recalling how they felt and what the experience of being depressed was like. It may have been the case that they did not want to recall these things – possibly that it was too painful or that it was just something they did not talk about. In these cases what was not said was just as important as what was said because for some reason they were not willing to talk about their depression. [Reasons for this needs to be explored further in interviews]

Participants who were practicing their story sometimes described their reasons for not talking about it before, such as their attitude to depression (not wanting to be a burden, seeing depression as invalid, stigma etc) their past life experiences (being abused, suicide of close relatives) or lack of opportunity (no close relationship with GP, no t knowing anyone else with depression who would understand). Other similarities were that they were often male, had not told their friends or family what was happening to them, had had a career helping others (e.g. headmaster, counsellor) and described their external persona as being extrovert - "jack the lad" (OP8) or the type of person who others did not expect to be depressed. These participants often described not wanting to be a "burden" (OP13) and felt that if others knew about their depression they would be treated differently (OP8)

Differences within the group....

Holding back

Only prepared to talk about their depression up to a certain point and then hold back. *Superficial level*, not talking about how they feel, more descriptive and unattached.

Relate to power/control?

Culture

Coping

Some older people explained that talking about it got them depressed and could even "push them over the edge again" (OP1). Happy to talk about it on a superficial level but when actually describing feelings and views of depression, and more in depth questions

this would upset them too much to continue talking thin this way. Mostly women, did not like to be reminded of the bad times. Described their way of coping as not talking or thinking about it too much.

Being old

Long term – some participants who held back had lifetime depression, were on a lot of medication, may account for the emotional detachment

Need bolstering

Question and answer

- Language

Different ways of describing depression

Participants would name their depression differently, some referring to it as depression or clinical depression and others referring to it using other words describing the way it felt or a nickname for it.

Those who described it as clinical depression often seemed to be using the medical term as if it gave them more permission to have depression (and not to take responsibility for it themselves). Those who referred to it as how they felt e.g. nerves or worry were often people who held back and did not talk about their views of depression in great depth.

Those who described it with a nickname tended to deny they actually had depression at all, and seemed not to have accepted it as something that had happened to them but that happened to other people.

“black dog” – using other words to describe it which are unrelated to the depression; maybe humorous, diverting attention away from depression, often people who did not acknowledge having depression

“clinical depression” – medical terminology making it more acceptable or justifiable. Some people find a formal diagnosis, passing on responsibility to something that is not in their control. Also helps because like any other illness has no be

“nerves”, “worry” – prefer to use words describing how they feel or symptoms rather than using the word depression

The way participants describe their depression relates to ways they present to their GP. How GP approaches depression – GPs report using same language and taking the lead from patients.

Ways that categories relate:

- Power/control

Talking about depression relates to how participants can control what they tell people. Some were willing to be interviewed and were happy to talk about their depression however were not open when asked questions. Participants like this would hold back to a certain extent

Also control over how others perceive them,

What they tell their GP can have a bearing over what treatment they negotiate

- The way older people talk about depression can affect the way it is managed by GPs.

Quotes

Similar people/diff people

- OP have different ways of talking to their GPs about depression and this has a bearing on the way they present their depression in consultation, whether it is verbally or through a physical complaint (somatisation).

Types of presentation / exceptions to the rule

Some OP give an insight into how they view themselves and their identity through talking about their depression.

- The way older people talk about depression can have a bearing on their choice of GP. For example OP who find it helpful to talk about their depression and how they are feeling may select their GP on the basis that they are given enough time in consultations to talk.

Quote

Other older people may not feel comfortable talking about their depression until a level of trust is built up. This can be over a long time and even to the point where they consider the GP as a “friend” before they will talk freely about their depression.

Quote/example

Those who talked about their GP being a “friend” were mainly from rural communities where the GP had been there a long time.

Some older people expressed a preference for or did not mind seeing GPs who ran shorter consultations. These older people did not necessarily have to have known them for a long time to feel comfortable talking to them about their depression. Often these OP would have longer term depression and would be used to having a review or changing their medication. They were perhaps also more used to talking to health professionals about their depression. [check out further in follow ups?]

Crossover categories

For both GPs and older people talking about depression is one of the most important elements of a consultation and affects how the patient presents to the GP, how the GP interprets the patients' symptoms and wishes, and consequently how the depression is managed. The way both GPs and older people talk about depression to each other is important as it can influence the GPs perception of what depression is like for older people and the GPs approach to depression and way of talking about it can affect older people's experience of depression as a whole.

Similarities between groups
Differences between groups
Quotes
Individual cases

Hunches/areas to follow up

Describe what they are and how to follow them up in future interviews.

What is empowering in treatment? What is disempowering?

What helps us understand depression?

What does well feel like, what does feeling ill feel like? Is it disempowering to put a label onto depression?

Why do people open up when doing interviews?

Differences between those who are used to talking and those who are not

Is acceptance of depression to do with having it long term?

Is there something about long term treatment and losing control/becoming passive

Is describing depression important? Why/why not?

Initial topics for GPs

- Overall views of working with older people who have depression
(prompts: How depression is recognized in older people /how common in older people/differences in older people compared to younger people; whether GPs' views about depression have been influenced by experiences of working with them)
- Explore views about what depression is, different ways of looking at the problem and the impact different interpretations may have on its management
(prompts: views on role of diagnosis, how views of what depression is affects choices made in its management, views on whether meaning is different when dealing with older people)
- Choices in the management of older people with depression
(prompts: GPs views of the choices available in managing older people with depression; how GPs make decisions around management; what influences these choices - personal/professional/political; views of older people's role in making choices)
- Communication about depression
(prompts: Language used in talking with older people about their depression; reasons for GPs' choices about language)
- Opportunities and barriers to optimum management of depression in older people within primary care
(prompts: GPs' views of optimum management of depression in older people; GPs' experiences of things working well/any problems in managing older people with depression; opportunities and barriers to making choices)
- Ideas for future management of depression in primary care
(prompt: GPs' views of changes that could be made in future and reasons for their views; GPs future role in decision making; how GPs' experiences have guided their views about what should happen in future)

List of codes identified from sensitizing the GPs' data with possible lines of enquiry in bold

<u>July 2008</u>	
Interest in mental health	Decisions
Attitude to depression	coping with uncertainty
Expectations of GP	time constraints/problems
Optimism/pessimism	Decisions about time
Needs of patient	
Not interested?	Attitude to medication/therapies
Approach	Negotiation
Job satisfaction and depression	Asking patient preferences
Qualities in GP	relationship with patient
Role – what it “should” be	influencing patient’s attitudes
Experience, importance of	
“Professionalism” v Friendship	Power/control over management
Attitude to depression	
Selection of GP	Agenda in consultations
Shared experiences, importance of	Personal views
	External influences
Explanations for depression	Confidence
Overall health	Professional boundaries
Age	
Life context	
GPs approach	
Different types of presentation	
Types of older people	
Somatisation	
Talking about depression	
Language	
Appropriateness	
Bringing it up	
Impact of talking	
Usefulness	
Time	
Management	
What it means	Diagnosis
Role of older person	Identification
Making choices	Care homes
Tensions in management choices	Others involved in management
Flexibility of GP	Urban vs Rural issues
Skills	
Adapting approach to diff patients	
Intuition, role of (relate to professionalism?)	
Barrier	

Situational map developed during/after GP8 Interview

General:

3 year psychiatry diploma
Special interest – big influence
Female, deprived area
MH reason became GP

Setting

Meeting room in practice – private
Large room with big table and lots of chairs, sat side by side and slightly facing towards each other – may have given her the opportunity to look away while she was talking and therefore get lost in her own narrative

Key issues:

Diagnosis not important - *work is about changing attitudes* and challenging cultural attitudes
– more of a challenge with OP
View of depression – reject labels, spectrum of mental ill-health and easy for GPs to ignore
Regional culture – expectations of ill-health derived from the mining community

OP prefer to talk when there is a shared understanding - *this GP disclosed own depression*
Felt tackling depression in OP was about intuition, emotion, going under the surface

Views 10 minute consultation as the beginning of a long conversation
“maintaining happiness”

Lifelong causes, attitudes embedded about illness and getting on with things; how older people “should be” when old age starts; influence of mining community and working class; role of carers – strong sense of duty to family “greatest cause of depression” because of guilt

GP role

Making a human connection, Intuition, Persuading people
Changing the way people think (similar to GP3)
Negotiating with patient
Works in a way patient wants to “be” – suggests flexible role [however her attitude seems so strong is this possible?]
Can only get people as good as the wish to be
Sees MH as affecting phys health not other way round – different to the other GPs
Believes in forming a long term relationship with patients which allows them to explore possibilities and make choices
Holistic approach

Special interest in MH

Because of this gets referrals of depression from practice
Mental health was reason became a GP- deals mostly with mental health problems, has developed own role as mental health GP within practice team

Situational map written during/after GP10 Interview

Reflections on interviewee

Seemed hassled, in middle of busy day

Hurried – only had 30 minutes and it was during lunch break – maybe distracted

Slightly nervy – felt put on spot? Perhaps had no time to think before interview

Short answers to questions – not terribly comfortable being interviewed

Definitely holding back. Sensed possibly something about PCT/external influences

Gave few of her own views, said “we” rather than “I” – not personal answers, highlights more removed professional “self”

Was she worried about revealing weaknesses in management of depression? What was motivation for interview? Worried about research going to press? Senior partner special interest in mental health – reputation for being expert in mental health issues. Feel need to follow suit and not say anything too controversial. Want to be supportive of partner.

Sense of holding back: possibly because in an open space where colleagues could hear interview

Three GPs are trainers – may want to show good side?

Reflections of self

Have I missed some things that worry them? Do I need to rephrase questions to get answers I need

Are questions too direct?

More time would have been better to set more relaxed pace – possibly need to address important topics fast – but how does this balance with rapport and GP getting into interview “zone”

Thoughts on GPs “holding back”:

I don’t know if I can do anything to prevent this – it is perhaps an interesting finding in itself? Building a rapport in half an hour is hard but the nature of interviewing GPs and gaining their trust perhaps involves all of these dilemmas. Is it because they are being interviewed in GP mode? Will we ever get totally unaffected answers from GPs in this kind of situation, especially as interviewing them in their capacity as GPs rather than personal lives?

Theoretical Memo: GPs internal and external stories

Internal/external personas - quotes to build story

the professional "you" develops, the personal "you" develops at the same time coz you're getting older and you're having your own life experiences which is always quite valuable (GP3, p.9)

If they're coming in to see a new doctor or if they're coming in to see a GP registrar, you haven't got access to that inner most brain, whereas most of the time people sitting there, they know they're going to get it absolutely straight (GP3, p.9)

if they see we are really running late that they will kind of tailor, you know alter what they were planning to do that day (GP9, p.8)

it's difficult to say what's experience and what's you... you have things you've missed and things you wished you done differently so you get that experience but whether that's better or worse sometimes than a fresh face I don't know (GP9, p.9)

what "supposed" to do v following gut instinct

there is various techniques for doing it, one is to try and get the person at the beginning of the consultation to say what all the things were that they wanted to say that day... then you are supposed to ask which is the most important...but [you] don't always do that [and] hopefully just looking for clues in body language and things or, just what people say or what they don't say, or how they look (GP9, p.8)

the guidance is your supposed to wait until they've had it a certain length, but if you've had problems before and they know that they are getting low I reckon they probably know themselves, so I would be unlikely that I would refuse to give anything and I offer them an alternative but you know if that's what they wanted (GP9, p.10)

when you have friends who were patients...you do need to be careful 'cos you get things from different sources of information...I used to have some elderly neighbours in my previous house who were patients, but people just tend to be absolutely fine (GP9, p.17)

people like me your ordinary Joe GP, it's a think it's more about being if you like just being alert to it...you always feel better and more confident in the areas that you know well... and if you're a GP with special interests... then great you know that's your area of if you like expertise and we all have areas that we do better in than other but that's where really sharing it within the practice is useful (GP6, p.14)

in talking to you now I am realizing...that I think you have to know older people better. To get it right. Which I hadn't necessarily realized. Coz I think you have to get to know them, and about them, ...to raise it (GP2, p.4)

I think what's very influential is the number of relationships involved with the management of depression. I don't think I've ever given that as much thought, I've never actually quantified each individual that I've managed in saying that this is a scenario that I'm dealing with six relationship problems, or five or four or tree or two or one. I've never done that (GP1, p.2)

I am not an expert or have an interest in depression especially in older people, so you are talking to a very generalist GP in terms of this (GP1, p.8)

often it's a case of managing as I said before rather than curing, so again it can be sort of soul destroying (GP1, p.8)

Personal position: The GPs' internal Story

GPs internal story was made up of unvoiced attitudes, experiences and feelings which they did not see as appropriate to bring into their professional role, as well as taken for granted knowledge, their personality, intuition and their own life experiences. It was also to do with their body language, "giveaways" about their core beliefs not just about late life depression but also about other values they had as a person.

The mood of the GP could also be part of their internal story and could be influenced by how their day was going, how pressured they felt, the combination of patients they had seen etc

Internal story not as evident in this data – seemed as if much of what was said had been verbalized before or even thought about, only a few glimpses of internal story came through [*how?*]

Professional (external) story

A number of GPs described or indicated a separation between their professional and personal "selves", or the position they viewed things from, which had an impact on how they managed depression in later life. These professional and personal positions referred to different aspects of GPs that came into play according to the situation or what was happening around them. GPs' professional position was generally about how they projected themselves in consultations for depression in later life (and also extended to their wider professional identity as a GP). This included the use of "formal", professionally recognized methods of dealing with patients, language used in consultations e.g. questionnaires, diagnosis, prescribing medication, negotiation etc, as well as how they talked about depression with patients and their style of working. Their personal position was about private rationalizations of depression and beliefs about it which were formed from life experiences as well as through their professional role (e.g. GP3 described experiences with his father's depression), how they viewed their professional role and how their experiences formed their beliefs. These personal perspectives were not revealed by GPs as often in these interviews possibly because of the fact they were interviewed in their professional capacity as GPs and mostly at their place of work.

It was apparent that GPs sometimes made conscious choices about what information to tell patients and the right balance of professional and personal to share with patients. This happened for example when GPs felt they should do or say something because of their professional position which was actually not the same as what they personally thought. GP9 reported believing that depression was caused by something different to what she actually told some patients in order to help them come to terms with their depression. GP4 reported negotiating treatment by making choices about what information to tell patients and held back on his personal thoughts (his internal story) that he did not find depression in later life particularly interesting to manage.

...if you think about it [depression] being a chemical sort of thing, rather than self induced then to see whether people can live with that, a don't think I would believe it but that's how I would introduce it (GP9, p.6)

sometimes there is a bit of a dilemma about whether or not to try and persuade someone to take antidepressants as an atypical painkiller...when actually you're true motive is because you think that the chronic pain is mixed in with depression and that the patient may not accept that (GP4, p.5)

I find myself kind of consciously trying to display the right kind of feelings of empathy and understanding but actually having little concept of what it must be like for this old person who has lost a partner (GP4, p.13)

That will be across a range of different conditions where the, you know, “why should I bother and put myself out?”....might come into it. It has to be resisted professionally – you’ve got to resist that. But we all have little demons in our heads that say these sorts of things all the time.... (GP1, p.3)

there are connections that are there and sometimes it is difficult to be dispassionate about things and purely professional... a think it's a strength of the job and its potential weakness for me as an individual, just got to try and hold that in my head and have 2 thoughts at the same time (GP7, p.9)

Tensions for GPs between the personal and professional positions were articulated occasionally by GPs especially in relation to constraints outside their control such as time constraints.

“When pushed for time you want to ignore your intuition” (GP10, p.7)

In saying this GP10 suggests that if she followed her intuition by looking for depression when time is short she may not be able to deal with the complexities of what could be discovered. This also shows how GPs can be torn in different directions between what their internal views are telling them and what their external reaction “should” be (in this case keeping to the time constraints of a 10 minute consultation).

The tensions between internal instincts and external pressures

the professional “you“ develops, the personal “you” develops at the same time coz you’re getting older and you’re having your own life experiences which is always quite valuable (GP3, p.9)

it's difficult to say what's experience and what's you...you have things you've missed and things you wished you done differently (GP9, p.9)

I suppose in the end there is a kind of gut feeling that you get as a GP. Maybe actually we probably ignoring our gut feelings and go along with what on the screen (GP4, p.12)

sometimes it is difficult to be dispassionate about things and purely professional... a think it's a strength of the job and its potential weakness for me as an individual, just got to try and hold that in my head and have 2 thoughts at the same time (GP7, p.9)

If they want to tell you something they will crack on and tell you (GP13, p.5)

Decision not to pursue this theme as a theoretical interpretation

Decision was made that this line of enquiry is not going to be followed up any further. This is because GPs are being interviewed in their professional capacity, and do not tend to give away enough about their personal stories/views/experiences to develop a detailed enough story. This is despite there being some strong data about clear tensions between private/personal perspectives influencing decisions made as GPs over how to manage depression.

Possibilities were explored to use this as an overriding category for “crossover themes” but it did not “fit” with older people’s data. This is because there were weak relationships between codes for both older people and GPs, and not enough of a storyline to develop about the two things. Older people did not talk about GPs private and public sides, but

GPs did mention older people's private and public stories although it was not clear how they responded.

The older people's data on internal/external stories, had plenty of evidence on private and public stories which interconnect with more categories in the data set.

List of open codes identified as crossover themes

Relationship between GP/patient
Importance of trust
Approach
Age
Experience
Friendship
Shared experiences
Length of relationship
Respective roles in management

GPs and older people describe the type of relationship they prefer with each other. Patients in this study who have been the most satisfied tend to describe their GP as a “friend” but use similar terms when asked to explain what this meant to them. GPs also say that older people tend to disclose more about their depression when they have built up trust over time and where they know the patient’s background, medical history and are familiar with them.

Patient selecting GP / GP niche area of expertise

Qualities of GP
Expectations of GP/patient
Professionalism, expectations of both
GP Approach

Reasons/explanations for depression

How relates to age
Life context and events
Physical symptoms (somatisation)
Overall health – how depression relates

Talking about depression

Bringing it up
Language
 What is appropriate
 Difficulties
 Labelling/diagnosis, importance of
Different presentation styles
Appropriateness (treatment, management, talking about, positioning of roles)
Attitudes to talking

Management

Needs at crisis point v available resources
Tensions
Influences over
Role of family

Views of medication
Decision making
Individual patients
Sharing views

Ideal world primary care
Changing attitude
What works best

Attitude to depression

What depression "is"

Importance of explanations

Interest in mental health/not

How depression is identified

"Types" of depression

Optimism/ realism /minimizing/normalizing depression

Symptoms v life events (rela. to approach...)

Medical v social model

Older people preferences / help provided by GP

List of crossover themes identified from sensitizing older people and GP data with possible lines of enquiry in bold

September 2009

What depression is/attitudes to depression

Types of depression

Qualities older people prefer in GPs

Most important factors in managing depression

Talking as therapy

How GP approach to depression influences older people's perspectives

Different "types" of older people with depression

Information exchanged with GPs in consultations

Relationship with GP

Private and public "selves"

What is appropriate when talking about depression

Do older people's experiences of depression influence help they accept

Role of both older people and GPs in making decisions about management

Needs of older people at crisis point

Is GPs' experience/age important

Is flexibility of GP important

Expectations of older people