

Factors influencing self-management of depression in older adults: A qualitative study

ABSTRACT

Objectives: A considerable body of work addresses prevalence and treatment options for depression in older adults. However, less is known about their capacity to self-manage their depression. Effective self-management of depression has the potential to improve individuals' quality of life through information, empowerment and perceived control, while enabling more efficient health service utilisation. The aim of this paper was to identify the barriers and facilitators to self-management of depression in older adults.

Method: A qualitative study comprising in-depth, semi-structured interviews with 32 older adults with a diagnosis of moderate depression.

Results: Three over-arching themes captured the barriers and facilitators to participants' capacity to self-manage their depression. *Perspectives on age and depression* represented how views of older age and mental health influenced the approach to self-management. *Ability to access the health care system* concerned the ability to identify and engage with different services and support. *Individual capacity for self-management* reflected participants' views on and the resources required for effective self-management.

Conclusion: This study offers a better understanding of the factors that positively or negatively influence older adults' ability to self-manage their depression. Strategies to improve self-management should address misconceptions about age and depression, and older adults' interest in and capacity to embrace self-management practices.

Keywords: barriers; depression; facilitators; grounded theory; older adults; self-management

Introduction

Already the most common mental health disorder in adults aged 65 years and over (hereafter, older adults), the prevalence of depression is expected to increase with global population ageing (Sjöberg et al., 2017; World Health Organization, 2017). Although it is a serious condition at any age, depression is particularly complex in older adults (Dear et al., 2015; Pirkis et al., 2009). It often produces adverse effects such as physical illness, a decline in functioning and loss of independence, and greater self-neglect (Blackburn, Wilkins-Ho, & Wiese, 2017; Law, Laidlaw, & Peck, 2010). It frequently follows a more chronic course, with higher relapse rates, than depression earlier in life (Bruin, Comijs, Kok, Van der Mast, & Van den Berg, 2018; Mitchell, Rao, & Vaze, 2011) and is associated with greater risk of death by suicide (Draper, 2014; Webb, Cui, Titus, Fiske, & Nadorff, 2018). Globally, older adults with depression visit general practitioners (GP) and hospital emergency departments more frequently, use more medication, stay longer in hospital and incur higher outpatient charges (Arias et al., 2017; Vasiliadis et al., 2013). While timely diagnosis and treatment are critical, there is increasing interest in self-management as a way to empower individuals, while simultaneously promoting more efficient health service utilisation (Archer, 2017).

Self-management is a dynamic, interactive process by which individuals seek to meet their everyday social, emotional, psychological and physical needs (Chambers et al., 2015). Originally used to refer to active participation in treatment (Creer, Renne, & Christian, 1976), the term is used widely to describe how a person engages in the day-to-day management of a long-term condition (Lorig, Ritter, Pifer, & Werner, 2014). In theory, self-management reflects the individual's capacity to manage the symptoms, treatment, consequences and lifestyle issues associated with living with a chronic condition (Houle, Gascon-Depatie, Bélanger-Dumontier, & Cardinal, 2013). In practice,

it gives people more choice and control over treatment options, and a greater role in recovery and maintaining their health (Cramm et al., 2012). Often a life-long task, the fundamental skills for self-management include problem-solving, decision-making, resource utilisation and an effective patient-provider partnership (Lorig et al., 2014). By giving them more choice and control over their health, self-management may help older adults remain independent and healthier for longer, while moderating the risk of their depression worsening (Cramm et al., 2012). Consequently, effective self-management may also assist in ameliorating growing demands on limited health services (Fisher, Croxson, Ashdown, & Hobbs, 2017). This is clearly an important consideration, given that health systems across the world operate in an environment of limited resources (Cramm & Nieboer, 2015; Morgan, Jorm, & Mackinnon, 2012).

To facilitate effective self-management of depression, specific interventions that transfer relevant knowledge and skills to the person are required (Houle et al., 2013; Turner, Realpe, Wallace, & Kosmala-Anderson, 2015). A wide range of strategies identified by Van Grieken et al. (2013) to self-manage depression included taking a proactive attitude towards depression and treatment, explaining depression to others, remaining engaged in social activities and giving attention to oneself. In a study on a co-produced management program for people living with depression, Turner et al. (2015) reported that improved knowledge about depression and the use of appropriate self-management strategies resulted in significant improvements in health status and health-related quality of life. These findings align with the recovery approach in mental health, which involves people making sense of their experiences in a way that allows them to maintain a sense of personal efficacy or control (Chambers et al., 2015; Turner et al., 2015). In addition, each of these studies highlighted the need for health professionals to encourage individuals to take active roles in self-managing their mental

and physical health (Chambers et al., 2015; Turner et al., 2015; Van Grieken et al., 2013; Zimmermann et al., 2016). Thus, the process of managing depression typically commences with seeking a diagnosis (Atkins, Naismith, Luscombe, & Hickie, 2015).

The ways in which depression is experienced and managed reflect a complex interplay of social, physical and economic factors. Formal help-seeking involves identifying and accessing suitable health professionals in order to receive a diagnosis and appropriate treatment (Atkins et al., 2015). Access, in this context, refers to the opportunity or ease with which individuals are able to engage with appropriate services that meet their specific needs (Levesque, Harris, & Russell, 2013). General practitioners (GPs) are the first point of access to care in most countries (Schäfer, Boerma, Schellevis, & Groenewegen, 2017; Stanners, Barton, Shakib, & Winefield, 2012). Hence, they are largely responsible for diagnosing and treating depression, as well as providing referrals to specialist services (Chew-Graham et al., 2012; Maust, Sirey, & Kales, 2017; Schäfer et al., 2017).

Help-seeking is also strongly influenced by mental health literacy, that is, beliefs and attitudes towards mental illness (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Kessler, Agines, & Bowen, 2015). High mental health literacy is associated with early help-seeking, and better recognition and understanding of mental health issues (Farrer et al., 2008; Kim, Rhee, Lee, Park, & Sharratt, 2017). It is essential to effective self-management of depression, as individuals seek to educate themselves about the symptoms, course, treatment options and lifestyle choices associated with their depression (Houle et al., 2013; Lorig et al., 2014). At a more fundamental level, mental health literacy helps to reduce the effect of negative attitudes towards depression, including the deleterious influence of stigma on help-seeking (Conner, McKinnon, Ward, Reynolds, & Brown, 2015).

Within the current context, one of the strongest influences on help-seeking and, in turn, self-management, is stigma (Corrigan, Bink, Fokuo, & Schmidt, 2015). Stigma is a common help-seeking barrier encountered by people with mental health conditions, including those with depression (Conner, McKinnon, Roker, Ward, & Brown, 2016). A significant outcome of stigma is that affected individuals may delay or avoid seeking help (Griffiths, Christensen, & Jorm, 2008). However, the narrative used by older adults when talking about ageing has also been associated with health, life satisfaction and quality of life (Carpentieri, Elliott, Brett, & Deary, 2017). Positive attitudes towards ageing are recognised as important drivers of healthy mental and physical ageing (Bryant et al., 2012; Carpentieri et al., 2017). Carpentieri et al. (2017) reported that older adults who engaged in high levels of constructive self-talk experienced higher well-being, despite low physical function. Conversely, negative views and expectations typically have a detrimental effect on the experience of ageing (Wurm & Benyamini, 2014). In addition, older adults who anticipate deterioration in physical and mental health—including increased expectation of depression—and loss of independence, may be unaware of the potential of seeking help and self-managing common physical or mental health problems in older age (Luck-Sikorski et al., 2017).

The erroneous view of depression as a normal part of ageing also serves as an obstacle to effective diagnosis and management (Ludvigsson, Milberg, Marcusson, & Wressle, 2015; Xiang, Danilovich, Tomasino, & Jordan, 2018). There is also a common belief that older adults are not motivated to or capable of learning new ways to look after themselves (Malta & Doyle, 2016; Ouchida & Lachs, 2015). Because much of the current research into depression in older age focuses on issues of prevalence, diagnosis and treatment, less is known about the personal experience of living with depression in older age (Ludvigsson et al., 2015). A deeper understanding of the self-management

strategies older adults used to optimise well-being is also warranted (Turner et al., 2015; Von Faber et al., 2016).

This study was nested within a larger grounded theory study on the self-management of depression in older adults. Overall, participants sought to enhance their well-being through the interlinked strategies of taking stock of their current circumstances, accessing support and reclaiming their sense of self-identity. In this paper, the aim was to identify the factors that positively or negatively influenced this process.

Method

Design

A qualitative approach was used to explore the factors that influenced the self-management of depression by older adults. This design is recommended when little is known about the subject, as it facilitates a rich and in-depth understanding of (Holloway & Galvin, 2016) participants' behaviour, feelings and experiences (Holloway & Galvin, 2016).

Ethical approval

Ethical approval to conduct the study was obtained from *** [to be inserted after blind peer review] Human Research Ethics Committee (Approval no.: HRE15-280). Written consent was obtained before data collection commenced, and participants were informed of their right to withdraw from the study at any time (none withdrew).

Participants and recruitment

Purposive and theoretical sampling are used in a grounded theory study. Criterion-based

purposive sampling was used initially to recruit participants (Corbin & Strauss, 2015), mainly through senior citizens' groups, community centres, and sports and social clubs. The study was also promoted through moderated online forums and email networks. Inclusion criteria were: (a) men and women, aged 65 years and over; (b) living in their own home; (c) not in full-time paid employment; (d) diagnosis of moderate depression for which treatment and/or support was being received; (e) a score of at least 25 (indicating moderate psychological distress) on the Kessler Psychological Distress Scale (K10) (Kessler et al., 2002); and (f) ability to converse in English. Exclusion criteria were: (a) currently undergoing inpatient treatment for an acute episode of depression, and (b) suicide intent or attempt within the past week. Participants' mean score on the K10 was 26.6, with a range of 22 to 31. Theoretical sampling commenced as soon as the first set of data had been analysed. This enabled the process of collecting data for comparative analysis in order to generate a theory (Birks & Mills, 2015).

Procedure

Simultaneous data collection and analysis took place from January to September 2016. Depending on their preferences, individual, semi-structured, audio-recorded interviews took place in participants' homes, various public settings, or by telephone, each lasting approximately one hour. A flexible interview schedule (Table 1) allowed the researcher to commence with broad questions, before moving onto more specific questioning. Answers were probed and examined further by the researcher. The researcher summarised participants' responses at the end of each section of the interview, to ensure that their views were understood correctly. This verification activity increased the credibility of the study (Holloway & Galvin, 2016).

** Place Table 1 about here **

Data analysis

Data collection and analysis were guided by Corbin and Strauss' (2015) approach to grounded theory. Interview data were transcribed verbatim and initially coded manually (that is, by hand), before being entered into NVivo (Version 10; QSR International, Victoria, Australia). Through three levels of coding—open, axial and selective—raw data were broken down into discrete parts and concepts identified. Links and relationships between concepts were refined and a core category identified, until theoretical saturation was achieved (Corbin & Strauss, 2015). At this point, no new concepts or themes are identified, and the links between concepts can be clearly explicated and validated (McCann & Clark, 2003). Although theoretical saturation is a goal that largely determines sample size in a grounded theory study, the quality of the data is more important than the frequency with which it occurs (McCann & Clark, 2003).

Data analysis was undertaken by ** [to be inserted after blind peer review]. This was followed by independent review of the data collection and analysis process by ** and ** [to be inserted after blind peer review]. Any differences in coding and theme identification were overcome through discussion. This process improved the rigour of the study (Holloway & Galvin, 2016).

Results

A total of 32 older adults participated in the study, comprising 19 females and 13 males. Participants' mean age was 71.3 years, ranging from 65 to 82 years. The mean age at which the first formal diagnosis of depression was received was 50.6 years (range 16 to 81 years). Most lived alone (n=20), although 12 lived with a partner. Half of the participants had a tertiary qualification, while 13 had completed high school and two

had obtained a trade qualification. One participant had completed primary school only. Participants' level of post-school education is consistent with national data for this age group in Australia (Australian Bureau of Statistics, 2006).

Three themes were abstracted from the data, reflecting the major influences on participants' capacity to self-manage their depression. *Perspectives on age and depression* reflected views about the ways in which views of older age and mental health influenced individual help-seeking and self-management efforts. *Ability to access the health care system* concerned the individual's ability to identify and access different services and support. *Individual capacity for self-management* reflected participants' views on self-management and the resources required for effective self-management.

Perspectives on age and depression

Participants' efforts towards effective self-management depended on timely and effective help-seeking. This process was influenced by their individual perspectives on age and depression. Although the inclusion criteria for the study required participants to be receiving formal treatment for depression, they were asked to recall the extent to which their views on age and depression influenced their help-seeking, if at all.

Regarding the experience of ageing and being a certain age—in this case, over 65—participants questioned the seemingly arbitrary definition of “old”. They accepted that health policies were often based on formal definitions of different age categories but rejected the notion that they should feel or behave a certain way because of their chronological age.

I actually feel hardly any different internally than I did in my 30s. I mean, I look different, I know that when I look in the mirror, but I don't feel any different (Participant 32, female, 66 years).

However, some participants expressed negative views about the experience of ageing, which led to a sense of futility about their efforts to maintain their physical and mental health. These views gave rise to the risk that they may not engage in the day-to-day management of their health, which is a requirement of effective self-management.

As far as I'm concerned, there's nothing to look forward to, really. Just life getting harder, rather than easier (Participant 28, female, 69 years).

In addition to their personal views of age, self-management was undermined when GPs treated them differently because of their older age. Numerous examples were given of GPs patronising participants, listening less to their views and cutting short the clinical consultation time spent with them. Thus, several felt that their age was a barrier to receiving a timely diagnosis and treatment for depression.

I went to see somebody else at the clinic, but she was a lot younger ... I just felt it was a battle to get her to acknowledge [my symptoms]. She just didn't want to listen to me... Oh, it was a battle (Participant 20, female, 67 years).

Participants' perspectives on depression related mainly to stigma. Although they had overcome public stigma to seek help, several were still grappling with self-stigma. Hence, their fundamental views and knowledge of depression determined how a diagnosis was sought initially.

I do have a sense of stigma about depression, I do really, yeah (Participant 6, female, 77 years).

Where stigma had resulted in delayed help-seeking, participants had taken longer to identify and implement self-management strategies that met their individual needs. However, for those whose quality of life was being compromised by their undiagnosed depression, the search for a diagnosis and treatment became more important than any experience or fear of stigma.

I think people don't understand and are scared of it [depression], but I think mental health should be regarded the same as physical health ... it's exactly the

same sort of thing – it's just affecting a different part of your body (Participant 30, female, 67 years).

By associating positive views with improved help-seeking and self-management, participants tried to be constructive in how they responded to their diagnosis.

You know there's something not right and that's when you either decide you're going to do something about it, or you're not (Participant 9, male, 69 years).

Ability to access the health care system

Understanding and accessing the health care system are essential components of self-management. Thus, the second influence on self-management concerned individuals' ability to access the health care system. This depended on their understanding of their symptoms and being able to access appropriate and timely information and formal support.

I didn't know what depression was. I just felt terrible. I didn't really know what was wrong. I just knew I was unhappy (Participant 19, female, 71 years).

Participants' capacity for access was strongly associated with their level of mental health literacy.

In my experience, the information is all out there, you just have to pick it up and deal with it. It isn't going to come and knock on your door (Participant 32, female, 66 years).

I read a lot of self-help books, yes. The new books are better than the old ones, you know, and they sort of work with you (Participant 4, male, 82 years).

The informal support provided by significant others—partners, family members or close friends—also facilitated access to the health care system. Participants described how significant others had encouraged them to seek a diagnosis, engage in treatment and adopt strategies that allowed them to self-manage their depression.

[My wife] would be very encouraging of anything that I thought I should do and she's been very proactive in terms of getting things, or even things from the

library, little articles or, you know books or whatever (Participant 17, male, 66 years).

However, some relied on their health professional, usually a GP, to guide them through the health care system.

I had a recent doubt, if you will, on something which doesn't seem to be working terribly well in my case ... I was thinking of just packing it in [stopping it], but I asked my GP and he gave me advice which I followed (Participant 2, male, 76 years).

Access to the health care system was also constrained by a range of instrumental barriers, such as a lack of appropriate services, financial costs restricting access, problems with transport and long waiting lists.

I'm traveling an area of probably over 100 kilometres between various clinics, trying to find someone that will stop for five minutes and listen to me (Participant 31, male, 67 years).

For some [private services], I have had to wait until I might have been able to put money together (Participant 27, male, 66 years).

Other factors included the quality of their relationship with their preferred health professional. Positive relationships between participants and their GPs, particularly, facilitated their efforts to self-manage their depression. Conversely, self-management was impeded by the absence of a mutually beneficial patient-doctor relationship.

I think that [my GP], for all his faults, is a very good general GP. He's just working within the system that he's in. I know myself well enough now to know that if he can't give me what I need and I want, I will search somewhere else (Participant 27, male, 66 years).

I'm sure there are some very good people out there, but I don't really feel that I've kind of clicked into anyone [established an effective relationship] that's given me the help that I need (Participant 16, female, 67 years).

Individual capacity for self-management

The third factor that influenced participants' capacity to self-manage their depression

concerned their ability to overcome barriers, improve mental health literacy, access formal support and optimise informal support. It also related to their finances, environment and social support.

The self-stuff is that I'm identifying what the issues might be and then using strategies to manage that. When I go to a psychologist, I don't go to talk about grief ... I am there to learn some strategies to deal with my depression (Participant 16, female, 67 years).

It became apparent early in the process of concurrent data collection and analysis that participants had a strong interest in and commitment to self-determination and self-management, although they did not necessarily use those exact terms.

I haven't thought of that term, self-management. Self-care, I have. I think it's being kind to yourself, really, and not judging yourself (Participant 29, female, 70 years).

I think self-management is looking after yourself to the very best of your ability. It's looking after your health problems, it's trying to be good to other people. It's being good to yourself. To me, that's self-management (Participant 7, female, 77 years).

Facilitators of self-management included a proactive attitude towards age and depression, the establishment of short- and long-term strategies, remaining socially engaged and maintaining physical health.

My approach is looking at myself and asking, "What is it that I can change in my behaviour to improve what's getting in the way?" Just making those assessments that are going to be meaningful for me (Participant 20, female, 67 years).

To optimise well-being, participants drew on the resources available to them to facilitate effective self-management. Identification of and engagement with these resources depended largely on each person's mental health literacy. A strong sense of personal autonomy was also associated with self-management capacity.

You determine what you're going to do with yourself and how others deal with you (Participant 30, female, 67 years).

I don't want a miserable life. I want to do the best I can. So, if you're going to look after your health, you might as well, really, do it the best you can (Participant 21, female, 68 years).

Conversely, the absence of these attributes, coupled with as a sense of futility or hopelessness about ageing with depression, would adversely affect self-management. Those with the personal capacity for self-management drew on the resources available to them.

I've looked at sites like beyondblue [an Australia depression website] and I think they're tremendous for anyone who's feeling depression. It's a great resource to help find your way through some of the rubbish (Participant 11, male, 75 years).

By educating themselves about the symptoms, course, treatment options and lifestyle choices associated with their depression, participants developed their mental health literacy in ways that enabled them to self-manage.

If I'm really self-managing, it's turning up at the doctors, it's taking the tablets, and it should be eating the right foods and all that sort of thing. Taking responsibility, I suppose (Participant 28, female, 69 years).

Discussion

Through this exploratory study, we gained an in-depth understanding of the factors that positively or negatively influence the self-management of depression in older adults. Participants' capacity to self-manage their depression was influenced by their perspectives on age and depression, ability to access the healthcare system, and individual capacity for self-management.

Perspectives on age and depression

Timely help-seeking for a diagnosis and treatment is integral to the self-management of depression (Atkins et al., 2015; Von Faber et al., 2016). Positive perspectives on older age and depression are strongly associated with help-seeking

(Kessler et al., 2015). Conversely, negative perspectives and low expectations of ageing have a detrimental effect on help-seeking (Ouchida & Lachs, 2015). While participants in the current study described how their views had influenced their help-seeking and, consequently, their self-management of depression, they also had to contend with preconceptions of age and depression held by GPs, and with public and self-stigma.

GPs are often slow to recognise and treat depression in older adults (Kessler et al., 2015; Ludvigsson et al., 2015). In the current study, it was common for the symptoms of depression to be attributed to ageing, or to remain undistinguished from normal ageing. Improved screening for symptoms of depression in older adults is needed (Mitchell et al., 2011; Xiang et al., 2018), while the erroneous view by older adults and GPs that depression is a normal part of ageing should be addressed (Haralambous et al., 2009; Ludvigsson et al., 2015). There is also a prevailing attitude by GPs that older adults are less functional or capable of actively participating in optimising their health and quality of life (Blancato & Ponder, 2015; Malta & Doyle, 2016), both of which are requirements of effective self-management. A consequence of these views is that older adults are frequently not offered the information or support that is relevant to their actual needs, and to facilitate the self-management of depression (Cramm et al., 2012; Holm, Lyberg, Lassenius, Severinsson, & Berggren, 2013).

From a broader perspective, current health service models and structures often make collaborative care difficult, as GPs generally lack the time and information needed to facilitate knowledge-sharing and decision-making practices associated with effective self-management (Ellis et al., 2017; Lawn, Delany, Sweet, Battersby, & Skinner, 2013). Frequently, GPs only have time to listen to the patient to obtain information that helps them to make a diagnosis (Karp, 2017). Current systems of care also frequently lead to the disempowerment of patients, rather than facilitating better engagement and health

outcomes (Lawn et al., 2013). Hence, the adoption of programs that support self-management requires change at the policy level.

From the individual's perspective, approaching ageing as a process of adaptation and change may maximise coping processes that support well-being, foster personal control and increase confidence in self-management (Troutman-Jordan, 2015).

However, this requires that the dominant biomedical approach to treating depression be moderated by improved understanding of the personal, social and environmental factors that influence the personal experience of depression and individual capacity for self-management.

Most participants had experienced stigma at some point, which made them cautious about sharing their experience of depression. Initially, this had a detrimental effect on their self-management efforts, as they balanced the risk of stigma with the desire to access resources and support. Overall, however, they were more affected by ageism. Consistent with the literature, participants reported that it was in the interaction between health professionals and older patients that ageism most frequently occurred (Blancato & Ponder, 2015; São José, Amado, Ilinca, Buttigieg, & Taghizadeh Larsson, 2017; Schroyen et al., 2018). Health professionals are known to patronise older patients, allow less time for the clinical interview and listen less to their views (Blancato & Ponder, 2015; Chrisler, Barney, & Palatino, 2016; Makris et al., 2015; Schroyen et al., 2018; Wilson et al., 2017). By attributing symptoms of depression to older age, there is also a danger of over- or under-treatment of mental and physical conditions in older adults (Ouchida & Lachs, 2015; Schroyen et al., 2018). These problems, however, presuppose that the individual can access the health care system in the first place. Access to formal and informal support is crucial to the self-management of depression.

Ability to access the healthcare system

The multifaceted concept of access is strongly associated with help-seeking and self-management capacity. Older adults with higher mental health literacy were more likely to succeed in their efforts to access the health care system, as they recognised their symptoms, informed themselves of treatment options and sought to maximise their self-management capacity (Farrer et al., 2008). However, the ability of participants to access the health care system was affected by a lack of GPs who specialised in depression in older adults, a general dearth of appropriate services for older adults with depression, and failure of GPs to refer older adults to existing services (Clement et al., 2015).

Individual capacity for self-management

Contrary to the common view that older adults are not motivated to, or capable of, learning new ways to look after themselves (Malta & Doyle, 2016; Ouchida & Lachs, 2015), participants in the current study were actively engaged in their treatment and described individual strategies they had developed to self-manage their depression. However, they reported that their discussions with their GPs had not focused on self-management, or self-management education. Without tailored self-management support, they were left to develop their own overall management plans, as they combined information and support from different sources. Hence, a proactive attitude was integral to effective depression self-management. Participants demonstrated several known facilitators of self-management, including a proactive attitude towards age and depression, the establishment of short- and long-term strategies, remaining social engaged and maintaining physical health (Van Grieken et al., 2013). Thus, they demonstrated a shift from a narrow biomedical discourse of depression in older age to a broader experiential focus as experts for managing their depression.

Limitations

This study has several limitations. As a qualitative study, the findings cannot be generalised to other settings or cohorts. However, the concepts can be verified (Corbin & Strauss, 2015) and are applicable to older adults with a diagnosis of depression in similar contexts. Another limitation concerns participant recruitment. Data were collected from participants who were sufficiently motivated and informed to access services and support for depression, respond to the researcher's recruitment efforts and contact the researcher directly to discuss participation. Thus, the findings may not reflect the experiences of those who were not coping well with depression, or those with less education. A final potential limitation concerns the lack of cultural diversity among participants. Only one of the 32 identified as coming from a culturally and linguistically diverse background. Future studies may consider using more expansive recruitment methods to achieve a more diverse sample of participants.

Conclusions

Our findings indicate that older adults with depression are committed to self-managing their illness. However, their capacity for self-management was influenced by their perspectives on age and depression, ability to access the health care system, and individual capacity for self-management. Measures are needed to encourage early help-seeking for a diagnosis and treatment, and to improve screening of depression in older adults. At a fundamental level, this requires that individuals and GPs challenge prevailing (mis)preconceptions about age and depression. There is a clear need to improve the mental health literacy of GPs, older adults and their significant others in relation to depression in older age. A deeper understanding of the complexities of ageing with depression could facilitate diagnosis, treatment and self-management, with

a view to supporting older adults to become experts in their own care. From a broader perspective, healthcare systems could increase their focus on providing education or support to facilitate effective self-management.

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