Making sense of the experience of depression: general practitioners' and women's accounts of the management of depression in primary care

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Declaration

I declare that this thesis is entirely my own work and that it has been submitted only for the degree of PhD.

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Abstract

Despite UK general practitioners being responsible for helping people to manage most emotional distress and the majority of psychiatric problems very little is known about how they do this in their everyday clinical practice. There has been very little systematic research on general practitioners' views of their work and little critical reflection on the issues of 'problem definition'. In addition, whilst the perspectives of patients have been placed at the core of the development of health services, there has been relatively little research on the patient's perspective of depression and its management in primary care. This study explored the management of depression from both general practitioner and patient perspectives.

Using qualitative interviews, 37 women and 20 general practitioners were recruited from practices in four NHS Board areas of Scotland. Each participant was interviewed at the start of the study, and 30 women and 19 general practitioners were re-visited approximately 9-12 months later to review the process of care. The interviews explored how women made sense of their experiences, and their evaluations of their care; and how general practitioners made sense of the women's experiences and how they subsequently managed these women in the context of everyday practice.

In making sense of their depressive experience and its management the women drew upon a range of experiential, biographical and common-sense knowledge surrounding health, illness, emotions, depression, antidepressant medications and medication use in general. However, the generally negative views surrounding depression and antidepressants created a moral dilemma for the women in accepting the diagnosis and its treatment. The women did not passively accept their general practitioner's explanation and advice but evaluated this in relation to their own knowledge. They continually evaluated 'formal medical knowledge' and care in relation to their own understandings and as new knowledge (experiential and common-sense knowledge) emerged. General practitioners recognised that patients brought their own understandings to the consultation and their management involved eliciting patient beliefs and addressing the moral dilemmas that some of these beliefs created for the women. General practitioners had to negotiate care by addressing patients' concerns and sometimes acted strategically in order to persuade, or coerce, patients to accept their advice and treatment.

These findings are discussed in relation to the 'medicalisation' thesis through reflecting on patient and professional discourses concerning depression and its management, the doctor-patient relationship, and the doctor-patient interaction. I draw upon the later work of Foucault which affords patient agency through the 'technologies of the self' and also on the work of Habermas and the relationship between 'system' and 'lifeworld' as a theoretical basis for discussion of these findings. Finally, I consider the implications of the findings for recent policy developments which call for depression to be managed as a chronic disease and comment on the applicability of current guidelines for the management of depression to general practice. I conclude that the development of any management strategies should be based on a consideration of the 'patient's perspective' and acknowledge that 'formal medical knowledge' plays only a part in the management of depression in primary care.

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I dedicate this thesis to the memory of my mother, Helen Maxwell (nee Cunningham),
who encouraged me to start but never saw me finish.

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Chapter 1 Introduction

About How Many?

About one in six.
What kind of people?
People like us.
Who hasn't wanted
to scream the house down?
Felt there was no point
carrying on?
Sat day-dreaming
at place of employment?
Wouldn't be human
if you hadn't.
Why do five million
people per annum
visit their doctor?....
More working days lost
than flu and bad backs.
All walks of life –
executives, soldiers,
old-age pensioners
(hommes de letters?).
'Different'? 'Odd'?
Require reassurance.
Occupational
and industrial
therapy units
help, as can Fine Art,
Music and Drama.
Tolerance, patience,
talk freely to them,
build warm relaxed
relationships with them.

Peter Reading (b. 1946) in Beyond Bedlam (1997) Anvil Press Poetry.

The importance of depression as a national and international problem and the importance of primary care based support for the majority of people with depression is well recognised (World Health Organisation, 2003; Scottish Office Clinical Research and Audit Group (CRAG) 1993). However, it is also acknowledged that a large proportion of people with depression remain with their condition unrecognised and untreated. This has led to the development of strategies to improve the detection and management of depression within primary care, and particularly for general practitioner management of depression. Calls within the NHS for evidence based management and adherence to 'guidelines' have led to research that has focused on general practitioners' use of guidelines or identifying barriers or facilitators in implementing them.

This thesis concerns the management of depression in primary care. However, it takes the stance that doctors do not 'manage' depression alone. People themselves experience distress, symtoms and misery and seek to get by or 'manage' these experiences. In doing so they may seek help and advice from a doctor. Thus any attempt to understand and influence doctors' management of depression must include an understanding of patients' perspectives and the way they interact.

The impetus for the thesis came from an understanding that in order to develop and implement strategies to improve detection and treatment we must understand how doctors currently recognise and diagnose depression, and understand what influences their decisions in managing patients with depression.

Unlike epidemiological research, which informs our understanding of the prevalence of the illness, and research on the development and implementation of guidelines, the thesis recognises that because of the importance of interactions between doctors and patients it will be important to problematise the definition of depression.

In order to maximise the potential for discussing the role of the patient within general practitioner decision processes an approach was taken that would explore the decision making processes in general and in the management of specific patients. It was also recognised that decision making processes within general practice are often made over a period of time and with knowledge of the patient that extends beyond the detail elicited within a single consultation. To focus on a specific consultation would not take account of the historical relationship between the doctor and the patient and the biographical information that general practitioners may bring into play in making sense of patients' experiences. The approach taken in the study presented in this thesis was to interview both doctors and patients at two time points so that they could reflect on their experiences and decisions and what factors influenced these over time.

It was also recognised when embarking on this research that the experiences of patients with previous or long-term depression would be different from those experiencing new (or relatively new) and likely (as yet to be diagnosed) episodes of depression. Hence, the patient sample was chosen to reflect a broad spectrum of experiences in relation to depression. It was also recognised that the experiences of women may differ from men's experiences of depression. Given the higher levels of women being seen in general practice with depression, the in-depth nature of the research, and the limitations of the research funding on the size and timescale of the research, it was decided to focus specifically on women's experiences of the management of depression.

This thesis aims to investigate doctors' and womens' accounts of recognising, managing and treating depression. It does this to further understanding of the everyday context of depression in primary care and to contribute to improving the care provided. As such it is a very applied piece of work, but it seeks practical relevance also by drawing on sociological theories applied in the field of mental health.

Chapter 2 presents the the current approaches to research concerning depression and its management and relates these to the development of health service and professional policy on depression and its management. It emphasises the problem of the failure of research and policy to problematise the definition of depression and the failure of both research and policy to adopt a more patient-centred approach to the development of evidence based care. This chapter then discusses the need to acknowledge the historical and cultural relativity to the concept of depression and how this was taken on board in the empirical work undertaken for this thesis. As the study is based around the doctor-patient interaction and lay health behaviour and lay health beliefs in the context of depression, the chapter then outlines some of the main sociological writings on these topics before turning to a review of what is already known about lay experiences of depression and their evaluations of medical care. It ends by introducing the sociological understanding of mental health and illness that this thesis adopts and outlining some of the macro level theoretical debates that may further the understanding of the findings of the thesis.

Chapter 3 outlines the epistemological and methodological approaches that underpin this thesis and then provides details of the development, design, implementation and analysis of the study.

Chapters 4 to 7 report the findings of the study. This begins in chapter 4 with describing how the women in the study reported recognising that something was wrong, how they made sense of their experiences, and how they accounted for their decision to seek help. The women described several types of 'cues' that signalled to them that something was wrong, these were labelled as physical, behavioural, cognitive/emotional and communicative cues. Not all of these signs were experienced by all women but make up a general group of signs that were indicated by many women. It also explores how they attempted to make sense of these changes through making use of their existing knowledge on health and illness, their illness biographies, and common-sense knowledge of health and illness, emotions, and depression (including their understanding of the causal explanations for depression).The recognition of signs that indicated to these women that something was wrong was not enough in itself to make these women seek medical help. The remainder of this chapter focuses on the women's accounts of their decisions to seek help from their general practitioner.

Having explored the women's accounts of making sense of their experiences and their decisions to seek help, chapter 5 then explores the general practitioners' accounts of making sense of women's experiences of depression. General practitioners' accounts also revealed that they recognised something was wrong through various cues. These were labelled as symptom, behavioural and communicative cues. Their interpretation of these cues, or the 'diagnosis', was informed by several types of knowledge. These are described as (formal) medical knowledge, experiential and biographical knowledge. It was also found that general practitioners are involved in managing difficult lives, and in some cases it is not easy to define the depression. Nonetheless, general practitioners engaged in managing the patients' problems as best they could. The detection and diagnosis of depression in primary care is a complex process of doctors making use of different types of knowledge to detect and define the patients' problems.

Chapter 6 explores the women's accounts of the management of depression. It explores how the women's work in making sense of their experiences is brought to the interaction with their GP. When their own theories were accommodated, or when the doctor's explanation made sense to them, then the doctor's explanation was more likely to be accepted. When women perceived that their GP had not listened to them (when their own theories were not accommodated), they were more likely to question or reject the general practitioners explanation and advice. However, the process of making sense of experiences and accepting, questioning or rejecting explanations is an on-going process both within and across episodes of depression. The women continually evaluated new knowledge in relation to their depressive experiences which was then incorporated into their evaluations of the general practitioners advice and his/her care. The on-going relationship with their general practitioner was also brought in to their evaluations of care.

The second section of chapter 6 discusses the women's perceptions and attitudes towards anti-depressant medication (and other associated medications) and their use. It begins with a description of their beliefs and concerns surrounding medication use (there is a general dislike of taking any medication; when one feels better medication is no longer necessary, long-term use can lead to immunity; long-term use is associated with psychological dependency) and the types of knowledge they use to justify these concerns (cultural knowledge of these types of medications and personal experience either themselves or from knowledge of family and friends experiences). It also demonstrates how the use of antidepressants is morally ambiguous for the women in this study. It is apparent that there is an on-going, dynamic interaction between beliefs, attitudes and behaviour in relation to anti-depressant medication and its use.

The final data chapter of this thesis, chapter 7, deals with general practitioners' perceptions of the experience of managing depression and explores their descriptions of how they manage patients with depression. It begins by exploring their accounts of what makes depression easy or difficult to manage. From their experiences of managing depression they have come to perceive that when there is an additional complication (such as personality, lifestyle, life circumstances or external contributing factor) that these cases are more difficult to manage than those who are perceived as endogenous cases. For general practitioners, the experience of managing depression involves contemplating the boundaries of their professional role. In terms of how they manage depression, this chapter shows how engaging with the day-to-day problems of patients' lives is a valuable part of their work. Finally, this chapter describes how general practitioners use strategic action within the consultation in order to negotiate the explanation or diagnosis with patients (such as initiating tests to demonstrate they have taken patients concerns seriously). General practitioners were also willing to engage in negotiating care with patients and saw it as important that they provided an adequate explanation to patients of their illness and the need for medication. In some cases they were willing to allow patients to make decisions regarding their care. However, they could also seek to limit the negotiation and acted strategically in persuading a patient to accept their advice, but they explained this in terms of acting in the best interest of the patient.

Chapter 8 then summarises the main findings of the thesis and considers the contribution of a critical realist methodology to our understanding of lay and professional accounts of depression. It then considers these findings in relation to the macro level theoretical debates concerning the relationship between lay and professional medicine which considers whether this reflects medicalisation, or is more supportive of recent theoretical challenges to the medicalisation thesis namely: proletarianisation, de-professionalisation and lay re-skilling. It draws upon the later work of Foucault and the 'technologies of the self' and on Habermas's Theory of Communicative Action to contribute to the interpretation of these findings in relation to the medicalisation thesis. Finally the chapter considers the findings in relation to recent policies that call for depression to be managed as a chronic disease and makes some observations concerning the development of patient-centred guidelines to improve the detection and management of depression.

Chapter 2 Review of literature

> *"....the contemporary western medical notion of depression is confused, woolly and inadequate as a basis for formulating mental health problems."*
> (Pilgrim and Bentall, 1999: 271)

2.1 Introduction

This chapter provides an overview of the policy and theoretical contexts in which the research presented in this thesis was undertaken and outlines other empirical research in this area.

The chapter begins with an overview of the psychiatric epidemiological approach to the study of depression and highlights the problems associated with this approach, which essentially treats the definition of depression as unproblematic. Recognising the problems inherent in this essentially positivist approach, the chapter includes some recent epidemiological 'evidence' that has prompted professional, governmental, and even worldwide interest in depression. The chapter then provides an overview of both medical professional and governmental responses to the problem of depression. It first describes current medical approaches to the management of depression and how research has contributed to this field. In doing so it highlights the gaps in knowledge surrounding the management of depression that arise when essentially positivist research prevails and where the definition of depression remains unchallenged. Secondly, it provides some details of current UK government health policy relating to mental health and depression. Some brief conclusions are then drawn concerning professionally led policy and government led health policy by highlighting some of the differences between the two agendas.

Given the critical view of the way in which the definition of depression is seen as unproblematic within positivist/scientific approaches to research, and in the promotion of guidelines for the detection and diagnosis of depression, the chapter then includes a discussion of the historical and social construction of the 'definition of depression' and the implications of this for this thesis.

I conclude that neither professionally, nor government, led policy has been informed by an understanding of either general practitioners' or patients' conceptions of depression and its treatment or their experiences of the recognition and management of depression. This understanding is crucial for policy and practice to move towards taking account of the individual experience of depression, accepting doctors and patients as subjective beings for whom interactions can have a potentially major impact on the way a diagnosis of depression is negotiated and managed.

The field of medical sociology has already made a substantial contribution to the study of doctor-patient interaction, the 'illness experience', and 'illness behaviour'. Yet neither this literature, nor the methods generally advocated for research in this field, have been applied to the development of evidence based policy and evidence based management of depression. Given the relevance of these bodies of knowledge to this thesis, the chapter will include a review some of the influential writings in this field. This thesis is thus an attempt to bridge the gap between these bodies of research on the management of depression in UK general practice. It will explore the illness experience and the illness behaviour of patients' with depression, explore general practitioners' experiences of managing depression, and the doctor-patient interaction in the management of depression.

As a study of general practitioners' views of their work and of lay evaluations of health care and patient and professional relationships in the modern era, this study can also be used to contribute to macro level theoretical debates within medical sociology. Therefore, this chapter concludes by highlighting the main tenets of these macro level theoretical debates indicating their relevance to the study of general practitioner and patient perspectives on the management of depression.

2.2 Epidemiology of depression

Epidemiology is concerned with the occurrence, transmission and control of epidemic diseases (Oxford Dictionary) and studies health and its environment, in an attempt to map out the prevalence and incidence of disease and its potential causes. In measuring the occurrence of disease this branch of medicine and social science assumes that the disease ‘exists’ and can be identified by some means (for example, biological symptoms or a symptom checklist). Once the disease can be identified the epidemiologists set about identifying factors associated with its aetiology. In the case of depression medical epidemiologists and social scientists have indeed accepted that depression can be identified and measured within the population. They have identified ‘symptoms’ and developed criteria, such as the DSM-IV (American Psychiatric Association, 1994) or ICD-10 (World Health Organisation, 1992) which are regarded as the ‘gold standards for psychiatric classification’(Bowling, 1995), or questionnaires such as the HADS (Zigmond and Snaith, 1983) or GHQ (Goldberg, 1972). These types of measures are then used to establish prevalence or incidence of depression, usually in relation to various socio-demographic and socio-economic variables.

The most well known study was conducted by Brown and Harris (1978) in The Social Origins of Depression and as the title suggests made links between depression and various social causes. This model of social causation continues to dominate much of the epidemiological study of depression and variables such as age, gender and race have also been identified as having associations with the prevalence of the condition.

While this data is valuable in providing a general picture of the scale of the problem and for identifying patterns of illness and potential risk factors, there are also problems associated with this approach. The main problem is that the ‘definition’ of depression is seen as unproblematic, even although depression cannot currently be identified by any biological symptoms and its aetiology is not clearly established and remains a topic for debate (for example, whether there is a hereditary factor in depression that might be identified through new genetic research). I return to discussing the problem of definition below. Bearing these definitional problems in mind, I nonetheless outline some of the main epidemiological ‘evidence’ and other health related data that have prompted both UK government and medical professional responses to depression.

Depression is estimated to affect 121 million people across the globe. The World Health Organisation estimates that depression will become the second most important cause of disability in the world (second only to ischaemic heart disease) by 2020 (World Health Organisation, 2003). A recent survey of the British population by the Office of National Statistics estimates that the prevalence of any neurotic disorder among adults in the UK is 19% for females and 14% for males aged 16 to 74 (Office for National Statistics, 2000). In Scotland, the Scottish Health Survey found that 18% of women reported symptoms of psychological distress (as measured by the General Health Questionnaire) compared with 13% of men (Scottish Executive, 1998).

Depression is also recognised as one of the most common disorders presenting to general practitioners, and in 2002, was the most common condition recorded at general practice consultations in Scotland (NHS Scotland: Information and Statistics Division, 2003a). It is widely recognised that general practitioners and other members of the primary health care team come into contact with, and are responsible for, managing the bulk of emotional distress and psychiatric problems in the population (Goldberg and Huxley, 1992; Scottish Office, 1998). It is also estimated that ninety five percent of patients with clinical depression are dealt with in primary care (Wright, 1993). One study even reported that over half the patients attending general practice surgeries are depressed (Kessler et al, 1999).

The economic burden of depression in the UK in both direct and indirect costs has been estimated at £273m at 1985 costs (Stoudmire et al, 1986). More than 70 million working days are lost yearly in the UK as a result of depression; accounting for 17% of all sick leave.

The costs of treating depression are also rising. In Scotland, the current yearly costs of prescribing antidepressant medication are £44 million out of the total £60.6 million spent in total on mental health drugs (NHS Scotland: Information and Statistics Division, 2003b). The number of prescriptions for antidepressants has also risen during the period from 1992 to 2001 from 1.2 to 2.8 million per year (NHS Scotland:

Information and Statistics Division, 2003b). Although psychological therapies have been shown to be effective in the management of depression, the vast majority of patients are treated with antidepressant drugs alone. However, it is also estimated that up to 40% of depressed patients fail to respond to first line antidepressant drug treatment (Joffe and Sokolov, 1996), and only a proportion of these achieve full recovery (American Psychiatric Association, 1993).

Thus as a result of current epidemiological research, depression is viewed as a common illness of great relevance to primary care, the NHS and the UK economy.

2.3 Current approaches to the problem of depression

Given the perceived enormity of these problems many government and health profession led policies have attempted to address the mental health issue. This section will first describe current medical approaches to the management of depression and then outline the direction of recent government health policy relating to depression.

2.3.1 The medical professional approach to the management of depression

Given the prevalence of depression and other neurotic disorders, and the central role played by general practice in the management of depression, it is not surprising that the focus of primary care mental health research has been on the detection, diagnosis, prescribing of medication and referral to specialist services for symptoms of depression. In this section I do not intend to conduct a full review of all the available research literature on the management of depression. I merely wish to present a picture of the focus of this research and the problems that it leaves unsolved or not addressed.

It is estimated that a substantial amount of depression remains unrecognised by general practitioners (Freeling et al, 1985; Davenport, Goldberg, and Millar, 1987; Dowrick, 1992) and whilst some authors conclude that poor outcomes are associated with non-recognition (Marks, Goldberg, and Hillier, 1979; Freeling et al, 1985; Rost et al, 1998) others have shown the opposite, that poor outcome was not associated with non-recognition or that failure to recognise depression has serious adverse consequences (Dowrick and Buchan, 1995; Goldberg et al, 1998). Nonetheless, there has been a considerable amount of research focusing on improving general practitioners' identification of emotional distress, including depression. A range of factors have been considered in explaining the wide variations in detection rates, including general practitioners individual characteristics such as the nature and extent of their specialist training, their general orientation to medical practice and their attitude to depression, communication skills, and structural factors such as consultation length and surgery size (Millar and Goldberg, 1991; Kerr, Blizard, and Mann, 1995; Moore, 1997; Dowrick et al, 2000; Howie, Heaney, and Maxwell, 1999). Overall, the findings of these quantitative studies have only explained a small amount of variation and indicate that a broader understanding of general practitioners' beliefs, attitudes and skills may be required (Dowrick et al, 2000).

Attempts to improve detection and management have also fuelled approaches to develop guidelines and other educational and organisational interventions to improve the management and outcome of depression in primary care settings. By 1999 Littlejohns et al (1999) were able to review 45 clinical guidelines on detection and management of depression. Research has also identified that the diagnosis and treatment of depression in primary care may not be in line with current guidelines (Simon and Von Korff, 1995; Kessler et al, 1999) and reviews on guideline implementation suggest that educational interventions to improve detection have only made modest improvements (NHS Centre for Reviews and Dissemination, 2002; Gilbody et al, 2003).

Methodologically there has been little critical reflection on the issue of 'definition' which is at the core of research in this area (Goldberg, 1992). The measures used to detect depression are assumed to reflect an 'accurate' measure and the general practitioner either has the ability to get it right or not. The general practitioner's definition is not taken into account in these assessments.

Kendrick (2000) questioned the whole approach of guideline based educational initiatives in depression, the very basis of the guidelines themselves and their appropriateness in primary care. He suggested that the problem starts with diagnosis which is not always easy to make in primary care and general practitioners vary in the threshold at which they label patients with depression. Guidelines also promote the same treatment (for probably major depression) regardless of patients' demographic characteristics, their history of depression or whether their depression is perceived as endogenous or non-endogenous. Although guidelines recognise the contribution of psychological therapies, they are mostly recommended in conjunction with antidepressant drugs. Furthermore, these types of therapies are not widely available and the reality is that the majority of patients are managed with antidepressants alone. There have also been further criticisms from primary care concerning the emphasis being placed on detection and diagnosis of depression (Wight, 1994; Heath, 1999).

In response to general practitioners' claims of difficulties surrounding the diagnosis of depression within the primary care setting, psychiatrists have called for more rigorous assessment of patients, using diagnostic criteria such as ISD-10 and DSM-IV (Andrews, 2001; Llewellyn-Jones, 2000). Psychiatrists have also challenged general practitioners who contend that antidepressants should not be prescribed for social problems, arguing that the treatment of the condition should not be decided on the basis of aetiology (Llewellyn-Jones, 2000). Others argue that the failure of educational interventions promoting evidence based guidelines may be more to do with how we change practice or the model of implementation rather than the guidelines themselves (McCallagh, 2000). Hence neither the guidelines, nor the definitions upon which they are based, are questioned by psychiatrists and attempts by general practitioners to question their basis have been challenged.

These disagreements indicate that the conception of depression and its treatment varies even within the medical profession. In addition, these approaches to improve detection have not considered the role of the patient in influencing general practitioners' identification and diagnosis of depression.

Furthermore, most recent psychiatric led policy for the management of depression has called for depression to be managed within a chronic disease model (Andrews, 2001; Judd et al, 1998; Epping-Jordan et al, 2001). There are four components to the model for the management of chronic disease:

Practice re-organisation – establishing a register of cases and setting up proactive appointments which should be more frequent during acute phases
Patient education – booklets, video tapes and family consultations to educate them about signs and symptoms of depression and signs of relapse and about treatments including antidepressant drugs and psychological approaches

Expert systems – use of clinical practice guidelines for diagnosis and management of acute episodes, maintenance and relapse. Establish criteria for sharing care with psychologists and nurses

Computer support – record treatment and outcomes to flag poor progress

Evidence from a recent trial of "ongoing intervention" that used this model showed that it increased remission rates and was associated with improved indicators of emotional and physical functioning. The authors recommended that health services make a small but continuing investment in their depressed populations, matching the duration of the intervention to the chronicity of the condition (Rost et al, 2002).

Critics of this approach suggest that chronic disease management models manage the disease or illness in the individual and ignore or exclude addressing the potential underlying social causes or other factors in the social circumstances of patients that might affect relapse (Gilbert, 2001) despite research evidence of the importance of social factors in contributing to the persistence of depression, and recovery being associated with a reduction in social problems (Goldberg et al, 1990; Ronalds et al, 1997). Furthermore, managing depression within a chronic disease model would require patient acceptance of a relatively poor prognosis and the need for prolonged treatment(Gilbert, 2001; Fava, Ruini, and Mangelli, 2001). Indeed Andrews (2001) recognised that general practitioners' concerns, that telling people the true prognosis will cause their depression to worsen, does require to be researched.

However, the problem also remains that the 'expert systems' definition of depression (and their criteria for identifying depression) may not reflect general practitioners' definitions. Furthermore, the influence of psychiatric input into the development of

guidelines may result in imposing a definition of depression that may be more applicable to those seen in secondary care but does not reflect the range of disorders being seen in primary care.
Antidepressants are the most common treatment used for depression by general practitioners and the role of drug therapy in the management of depression in primary care constitutes a further major area of research in this field. In 'major' depression, trials conducted in primary care have shown that a range of tricyclic antidepressants are effective when used in recognised therapeutic doses (Blashki, Mowbray, and Daview, 1971; Thomson, Rankin, and Ashcroft, 1982; Hollyman, Freeling, and Paykel, 1988; Anderson, Nutt, and Deakin, 2000) and recent guidelines have outlined optimal doses (Scottish Office: Clinical Research and Audit Group (CRAG), 1993; Anderson, Nutt, and Deakin, 2000). It is also reported that the commonly available antidepressants have comparable efficacy in the majority of patients seen in primary care or outpatient psychiatric settings (Song et al, 1993; Geddes et al, 1999). It is generally accepted that newer antidepressants (SSRIs) are better tolerated than older tricyclic antidepressants (TCAs), are safer in overdose, and are more likely to be prescribed at recommended doses for an adequate period, but they are also more expensive than older drugs and current pharmaco-economic data do not favour initial treatment with an SSRI over older drugs (Anderson, Troein, and Lindberg, 2001).

However, the use of antidepressants in primary care is problematic. A recent Cochrane meta-analysis concluded that 'differences between antidepressants and active placebo are small' (Moncrieff, Wessely, and Hardy, 2002). In response to the release in September 2002 of the SSRI full data set (all previous 10 years trials, obligatory for drug manufacturers under FDA legislation) some researchers concluded that the difference between drug and placebo was not clinically significant (Kirsch and Antonuccio, 2002). This supports previous findings relating to antidepressants versus placebo in acute milder depressions (Anderson, Troein, and Lindberg, 2001; Paykel et al, 1988; Katon et al, 1996). There have also been concerns raised about the promotion of the long-term use of antidepressants: the potential for them to increase the likelihood of relapse; that they may worsen the course of depression through a sensitisation process; the paradoxical depression inducing effects of antidepressants switching and cycle acceleration in bipolar disorder; the occurrence of tolerance to their effects during long-term treatment; the onset of resistance upon re-using the same antidepressant drug; and withdrawal syndromes (Fava, Ruini, and Mangelli, 2001).

Analysis of drug prescribing in practice has resulted in criticism being levelled at general practitioners for prescribing sub-therapeutic treatments for presumed depression (Thompson and Thompson, 1989; Donoghue and Tylee, 1996; Kendrick, 1996; MacDonald et al, 1996; Simon and Von Korff, 1995; Wells et al, 1999). There are also wide variations in levels of prescribing of antidepressant medication (NHS Scotland: Information and Statistics Division, 2003).

General practitioners are also held partly responsible for problems of patient compliance with anti-depressive medication by their failure to be persuasive enough (Rifkin, 2000) or to adequately explain the need for antidepressants, their side effects, and the duration action of antidepressant medication (Carr, 1990; Priest et al, 1996). The increase in use of SSRIs, and general practitioners' prescribing of sub-therapeutic doses, has been hypothesised as general practitioners' attempts to reduce side effects for patients.

Both patients and professionals have questioned the idea that drugs are the answer to the underlying causes of depression (Kendrick, 2000; Moore, 1997; Scott and Freeman, 1992; Priest et al, 1996). Priest et al (1996) found in a general population survey that only one in six thought people suffering from depression should be offered antidepressants. There are also general concerns surrounding side effects and addiction (Priest et al, 1996).

The recognition and management of depression through the promotion of guidelines and evidence based medicine reflects the management of depression as a 'cognitive-rational enterprise' (Bensing, 2000). The relatively poor findings in relation to outcomes of educational interventions to promote guideline based management of depression have failed to take several factors on board. The first is that there has been a failure to recognise that conceptions of depression and its treatment may vary within the medical profession. Secondly, there has been a failure to take account of the patients' perceptions and experiences of depression (as patient-centred medicine would advocate) and to incorporate this into development of evidence based medicine. Thirdly, there has been a failure to recognise the influence of the doctor-patient interaction in recognising and managing depression, and to treat both general practitioners and patients as subjective beings. Current approaches to the management of depression reflect a separation of the worlds of evidence-based medicine and patient -centred medicine (Bensing, 2000).

2.3.2 UK health policy and depression

There have been a substantial number of policies relating to mental health in both Scotland and England in recent years, and mental health is now one of three top health priorities in Scotland. Table 1 summarises these policies in chronological order.

It can be seen that much recent policy focuses on the promotion of mental health and the prevention of mental illness. In Scotland there is an additional agenda to eliminate stigma and discrimination and to prevent suicide. The mechanisms for achieving improved mental health are: early intervention and access; delivering services to meet people's needs (in terms of social care, primary care and secondary care); and promoting and supporting recovery. In particular, depression is to be tackled through building increased capacity for self-help and increased capacity for psychological interventions and improved access to a range of services and supports within local communities by the creation and active management of networked pathways of care.

The importance of primary care in the management of mental health has increased with shifts in provision from specialised secondary care to primary care. The increasing role for primary care to engage in mental health promotion, prevention and recovery is highlighted in the various health improvement and mental health policy documents of the Scottish Executive. Primary care services are the first point of contact for most people who seek help for emotional distress and there have been recent changes in the provision of mental health services within primary care such as: the increasing use of counsellors, clinical psychologists, psychiatrists working in primary care; and the recent provision of specific Primary Care Mental Health Teams or Primary Care Mental Health workers[1]. Overall, improving the integration between primary and secondary care and developing capacity within existing healthcare professional roles is seen as an integral part of the response to the management of depression for both Scotland and England

The importance of patients' views in contributing to the development of health services has also emerged in recent years. The drive to establish quality improvements in services and promote clinical governance has included the measurement of satisfaction with services from the patient perspective. There has also been a perceived increase in 'consumerism' characterised by patient demands of services and to have their needs (rather than professionally defined needs) addressed (Bastian, 2003). Interestingly, there has been a corresponding response to develop approaches to help medical professionals manage this patient-led demand (Marinker, 1973; Bradley, 1994; Rogers, Entwistle, and Pencheon, 1998).

Within the focus on chronic disease management, there have also been moves to promote the recognition of the '*expert patient*', which supports patients as key decision makers in the treatment process (rather than mere recipients of care) and aims to empower patients to take some responsibility for the management of their condition and to work in partnership with their health and social care providers. The goal that '*self-management programmes can be specifically designed to reduce the severity of symptoms and improve confidence, resourcefulness and self-efficacy*' (Department of Health, 2001: 5) resonates with current plans in Scotland under the '*Doing well by people with depression*' campaign which also places the capacity to develop self-help and self management at the core of its agenda.

2.3.3 Summary of policy agenda

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[1] A specific example of this is the setting up of multi-disciplinary Primary Care Mental Health Teams in Glasgow to provide services to people with mild to moderate mental health problems and to focus local activity promoting positive mental health in their communities (Greater Glasgow Primary Care NHS Trust Newsletter, Issue 1 July 2002. Similar multi-disciplinary Primary Care Mental Health Projects have been established since the mid-late 1990's in England. The "NHS Plan" (England) to recruit 1000 new primary care mental health workers by 2004 is further evidence of this trend.

The medical professional response to the problem of depression has been to promote detection, diagnosis and management of depression through the use of guidelines, although this approach has been found to be largely ineffective. This approach assumes the criteria for detection are unproblematic. Attempts to understand general practitioners' recognition and management of depression have focused on measuring attitudes, skills or structural aspects of the surgery. What is required is a more in-depth exploration of general practitioners' constructions of depression and how they recognise, diagnose and manage depression.

The high rates of relapse of depression have prompted calls for depression to be managed as a chronic disease. However, this psychiatry-led policy has been challenged by general practitioners and has implications for people who come to be defined as depressed. In the backdrop to these developments is the increasing incorporation of patients' views in health service development and approaches to treatment that recognise the 'expert patient'. Government led health service policy aims to place greater emphasis on self help and in promoting alternatives or additional approaches to management. Despite this there has been no evidence of patient involvement in the development of approaches to improve the management of depression.

Dowrick et al (2000) call for doctors and patients' mutual understanding of problems and for an understanding of patients' preferences for treatment yet empirical work of this nature remains scarce. To enhance the detection and management of depression within primary care we need to problematise the concept of depression and explore general practitioner' and patients' conceptions of the condition and its treatment and we also need to place the patient experience, 'the patient as expert' at the forefront of research.

The research upon which this thesis is based attempts to address the gap between current approaches to the recognition and management of depression and to gain some understanding of how general practitioner and patient recognise the experience of depression and their perceptions and experiences of managing depression and being managed.

2.4 The definition of depression

Having raised the problem of pre-empirical and psychiatry-led conceptual notions of depression, it is worth elaborating on some of the writings that demonstrate the historical and social relativity of notions of depression. In this section, I do not attempt to give a complete account of the historical and social influences on notions and definitions of 'depression'. The purpose here is to make the point that depression is variably defined, even within the medical profession, and that its definition is indeed subject to historical and social relativity. In discussing the definition of depression, I also attend to the ways in which lay and professional definitions might differ.

Wolpert (2001), a research biologist with experience of depression has written a book 'to set down what is known' about depression but also to 'understand the nature of this dreadful affliction in scientific terms' (Wolpert, 2001: xvii). That aside, he provides some historical reflection on the concept of depression and its associated causal mechanisms and methods of management. It was not within the time or the scope of this research to conduct a detailed study and review of the literature relating to the historical development of depression and its management, therefore I relied on Wolpert's work to briefly summarise the emergence of the term depression and some of medicine's historical responses to its management. I acknowledge that Wolpert may have seen selective in presenting historical accounts that met his own purpose in this account. I also have not verified the historical accuracy of some of the 'evidence' he provides or the statements he makes. Wolpert makes use of Stanley Jackson's history of depression[2] among others to construct his brief historical account. However, in this thesis I merely wish to provide a view of the general historical context with which to compare current understandings of depression.

Although Wolpert cites use of the term depression in the 17th and 18th centuries, the term melancholia was more commonly used up until the early 20th century. Wolpert writes that 'melancholia as a distinct medical condition' was recognised in Greece in the 4th century BC in the Hippocratic writings. The leading authority on medical conditions in the second century, Galen, and his theory that sickness was due to an imbalance of the four humours – blood, yellow bile, black bile and phlegm – resulted in viewing melancholia as the result of an excess of black bile. In Burton's *Anatomy of Melancholy*(1621-51), humoral theory remained central, and pervaded medical thinking until the late 17th century when chemical and mechanical explanations gained prominence. Harvey's discovery of the circulation of the blood led to the development of theories of faulty circulation, although this did not radically alter the treatment from Galenic methods, for example, of bloodletting. It was not until the late 18th century that, according to Wolpert, mental disorders were seen as a disorder of the brain.

However, melancholia also covered a wide range of emotional states. It has also been associated with 'hypochondria' or 'the vapours'. Wolpert asserts that what we would now call a major depression would have been expressed in these terms up until the early 19th century. It was during the 19th century that the term depression emerged and it was used to describe a reduced emotional state. By the end of the 19th century depression was medically defined as 'a condition characterised by a sinking of the spirits, lack of courage, or initiative, and a tendency to gloomy thoughts'. Pilgrim and Bentall (1999) in a brief review of the historical roots of depression include three diagnoses with which the current psychiatric concept of depression has been associated: melancholia (which they describe as 'a form of lunacy'); neurasthenia (nervous exhaustion); and mopishness (a 19th century notion similar to melancholia but mostly attributed to the lower classes).

Emil Kraeplin, the German psychiatrist, is viewed as one of the main 20th century pioneers of the study of depression and in defining its clinical features. In his famous textbook Clinical Psychiatry he distinguished between manic depression and depression without mania. This distinction is still in use today and expressed in terms of unipolar and bipolar depression. Wolpert notes that at this time Kraeplin's advice for treatment 'offered little more than a rest cure'.

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[2] Jackson SW (1986) Melancholia and depression: from Hippocratic times to modern times. Yale University, New Haven.

The beginning of the 20th century saw much discussion and writing surrounding the diagnosis and classification of the various types of depression, including depression associated with mania. Paul Mobius's distinction of 'endogenous'(hereditary disposition) and 'exogenous' depression (a reaction to life events) developed in the 19th century was also influential at this time, and is also reflected in more recent terminology still in use in British general practice, distinguishing 'endogenous' (of biological origin) and 'reactive'(a reaction to life events) depressions.

Within Western medicine, diagnostic criteria have been refined throughout the 20th century and we now have sets of criteria or 'guidelines' for the classification of mental disorder that are generally agreed by the psychiatric profession and are used in clinical and research settings. The two major international classification systems that are used are the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), known as DSM-IV and the World Health Organisation's International Classification of Diseases, ICD-10. Although relatively similar, there are also some differences within these two sets of criteria that demonstrate that there is yet to be a universally agreed set of criteria for the diagnosis of depression and one that can adequately or unequivocally distinguish between severe and mild depression.

Pilgrim and Bentall (1999), in their exploration of professional representations of depression, identified a failure within some psychiatric and clinical psychology texts to offer a definition of depression and that others varied in their definitions of what constitutes depression. Depression can be defined in terms of 'mood disturbance' or as a more 'cognitive' experience of negative thoughts and feelings. It can also be defined as a syndrome requiring the presence of several symptoms. The DSM-IV and ICD-10 can be included within this latter categorisation. Pilgrim and Bentall refer to this as 'anything is possible' in diagnosing depression,

> ...there appears to be no consistent transcultural, transhistorical agreement about minimal necessary and sufficient pathognomic criteria for the phenomenon of interest (Pilgrim and Bentall, 1999: 263)

However, it is also (predominantly) Western Medicines' acceptance of the existence of emotional distress, such as depression, as having trans-cultural and trans-historical consistencies that has led to the creation and widespread application of diagnostic criteria. The fact that there is no consistency within current measures does not lead psychiatric professionals to question the validity of their assumptions. Yet, it is widely recognised that historical perceptions of emotional and psychological problems have changed, such as notions of demonic possession being replaced by medical explanations. As Pilgrim and Rogers comment,

> ...the caveat of social relativism has to be registered. Judgements about health and illness (physical as well as mental) are value-laden and reflect specific norms in time and place. (Pilgrim and Rogers, 1999: 11).

This historical and cultural relativism underpinned Armstrong's analysis reflecting on the disappearance of madness and the emergence of the neuroses as the focus of psychiatry and more recently as a focus for the general physician (Armstrong, 1980).

For Pilgrim and Bentall, this lack of consistency of definition leaves depression as a disjunctive concept whose diagnosis 'is based exclusively on symptoms and not signs' (Pilgrim and Bentall, 1999: 5). There is also ambiguity about what constitutes depression, how it differs from other psychological states. Pilgrim and Bentall point out many of the debates and contentions that arise from this lack of common definition such as: whether depression is a categorical concept or exists on a continuum of normal functioning; the relationship between depression and anxiety and whether they are co-existing conditions or a single pathological condition; the dividing line between depression and madness and how the various psychotic forms of depression might be classified; and the relationship between depression and physical disease.

Pilgrim and Bentall sum up the consequences of this lack of a coherent definition by quoting Seligman (1975) who described depression as '*The common cold of psychopathology at once familiar and mysterious*' (quoted in Pilgrim and Bentall, 1999: 265). This, say Pilgrim and Bentall '*acknowledges that the term belongs both to the technical vocabulary of the mental health professions and also, like the common cold, to ordinary language*' (p.265). It is, they say, essential to understand how professional and lay concepts of depression have emerged from their cultural contexts.

There are several ways in which professional and lay accounts of depression may differ, and there are also several reasons 'why' lay and professional accounts differ (Pilgrim and Bentall, 1999; Rogers and Pilgrim, 1993; Rogers and Pilgrim, 1997). Pilgrim and Bentall locate the professional lack of clarity surrounding the concept of depression as reflecting a tension between lay experiences of emotions and professional accounts. The main cause of this tension is that professional accounts of depression 'assume trans-historical and trans-cultural consistencies about mental illness whereas lay people express themselves about ordinary feelings and distress in a way which varies both across and within cultures' (Pilgrim and Bentall, 1999:268). Thus professional attempts to define, categorize and produce universal diagnostic tools will invariably be at odds with lay accounts of emotional experiences which may indeed have some trans-cultural features but which also involve biographically unique features.

Pilgrim and Rogers (1999) discuss the dominant features of psychiatry as reflecting a biological emphasis (diagnosis is a prime task, biological causes are given prominence and biological treatments are the 'cure'). However, they also acknowledge that such an illness framework can 'accommodate multiple aetiological factors' such as recognising the distress caused by adverse life circumstances as being the trigger for biochemical disturbances in the brain.

However, there is also a degree of co-construction of representations of distress that result in culturally specific representations. Pilgrim and Bentall comment that these culturally specific representations of distress are sustained by the interaction between the discourses of lay people and professional healers. Indeed lay access to professional knowledge and information has increased in recent decades (substantially so with the advent of the World Wide Web and internet technology) and this greater access to knowledge from the professional domain may serve to introduce professional discourses in to lay understandings of emotional distress. Pilgrim and Rogers (1999) recognise the overlap between lay and psychiatric notions of mental health and illness but also acknowledge differences, such as the way in which lay perspectives of mental abnormality and antisocial behaviour reflect contradictions within the lay discourse.

I describe in the next chapter that the philosophical approach taken in this thesis is 'critical realist'. Within this position due attention is given to the relationship between empirical methods and professional interests and social forces. It acknowledges the reality of the experience of depression for those suffering and acknowledges the value of empirical work that has explored its potential causal mechanisms. However, it is critical of blind adherence to current definitions of depression, and critical of research and management strategies which ignore the historical, social and professional influences on Western diagnostic criteria.

In adopting a critical realist position in undertaking the work for this thesis I therefore adopted an approach that did not seek to sample or define my patient subjects according to any diagnostic criteria. Pilgrim and Bentall's ideal for research is that:

> A more holistic understanding would attend to the social determinants of misery and would involve exploring the patients' individually attributed meanings. (Pilgrim and Bentall, 1999: 272)

2.5 The contribution of medical sociology to the study of lay and medical professional encounters

Whilst there is a relative paucity of research in the area of how general practitioners and patients construct depression and its management, much can be learnt from the medical sociological literature on illness behaviour, illness experiences, the doctor and patient interaction, and lay evaluation of health care. The theoretical and empirical work covering all of these areas is potentially vast, therefore this thesis will highlight some of the main contributors to these fields and work which has been particularly influential to this thesis.

This section begins with a discussion of general practice as a profession and the dominant discourses that shape the work of general practitioners. It then moves on to discuss what is known about lay perceptions of illness, help seeking and lay evaluations of health care in general, finally leading to a review of what is already known about lay accounts of the experience of depression.

It is important to say at the outset what I mean when I talk about lay accounts. Williams and Calnan (1996) go some way towards explaining this:

> "…"lay" can be defined as those members of society who despite being potential "experts" in other areas, lack any formal or orthodox medical knowledge, training, qualifications or expertise." (Williams and Calnan, 1996: 17)

They also recognise that there are differing levels of lay knowledge, experience and expertise. What must also be recognised is that there is no single common lay view, to hold such a position would be to deny the cultural and social differences that are at the heart of sociological investigation. Therefore when lay accounts or lay views are presented it must be noted that these are specific to the cultural and social groups from which they were derived.

2.5.1 The biopsychosocial model of general practice

General practice encourages a biopsychosocial model of health care which encompasses an understanding of the physical, psychological and social aspects of health and aims to give care to meet all these related needs. Balint (1957) is generally recognised as the first proponent of biopsychosocial care, and emphasized a psychodynamic understanding of the practice of medicine and the interaction between general practitioners and patients. The approach views patients as subjective beings rather than an objective body or biological entity; the patient's personality, concerns and social context are all seen as having relevance to diagnosis and treatment. In addition, the approach calls for medical practitioners to be reflective in their work and to have an awareness of how their own values, attitudes and personality might affect their practice. Balint saw the relationship between doctors and patients as therapeutic in its own right - the 'doctor as drug'- and therefore promoted the development of communication skills as being an essential element of general practitioner training.

Balint's approach is strongly apparent in the seminal text *The Future General Practitioner* (Royal College of General Practitioners, 1972) that underpinned most undergraduate and postgraduate teaching in and about general practice from the 1970's onwards. The term 'patient- centred' first appeared in the early pages of this document as an approach which encompasses 'the patient's total experience of illness' and this has come to represent the defining philosophy of general practice. At about the same time the academic discipline of general practice, in order to distinguish itself from other areas of medicine and to gain status in response to the increasing power of hospital based medicine (Osborne, 1994), set about establishing the criteria for an independent discipline. Among other criteria, a 'unique field of action' and 'its own skills' (McWhinney, 1966) and an 'identifiable philosophy' (Richardson, 1975) were called for. McWhinney (1984), in extending the logic of Kuhn's treatise on the Structure of Scientific Revolutions to medical practice argued that, for medicine, its 'paradigm shift' would be away from disease-centred biomedicine and into a more patient centred alternative. The whole person care approach or the 'patient-centred clinical approach' has come to be defined as the cornerstone of general practice.

As a result of this focus, the consultation and consulting styles has attracted a considerable amount of research attention. Byrne and Long (1976) developed a typology of consulting style as 'doctor-centred' or 'patient-centred'. A 'doctor-centred style' was characterised as being disease focused, using closed questions, having a paternalistic attitude and discouraging of patients' active involvement in their care. In contrast, a 'patient-centred style' was characterised as, exploring the illness in the context of the patient's life, using open questions, and encouraging patient participation in their care. It is the patient-centred approach that has come to epitomise the discipline of general practice whereby patient subjectivity and an understanding of the 'lifeworld' of the patient have been incorporated as core values of general practice.

The patient-centred approach was also advocated by Tuckett et al (1985) who saw the consultation as a 'meeting between experts'. This work is of particular relevance to this thesis as Tuckett et al recognised that patients' decisions to consult, and their attempts to make sense of consultation decisions and decisions to act on the advice received, all occur within the context of patients' own understandings of their health and illness, and the social context of their lives. Accordingly, the subjective patient and the multi-dimensional nature of patients' experience have to be acknowledged if an effective consultation is to take place.

Tuckett et al also suggested that patients need a 'reassuring' explanatory framework, so that the task for the general practitioner is to provide a framework for the patient to make sense of their illness experience. In order to provide an appropriate framework the general practitioner needs to understand the patient's perspective and to share information and provide reassurance to the patient. This, for them, would constitute a patient centred approach.

Another reason to adopt the patient centred approach is that Tuckett et al identified that patients make their own decisions about whether or not to accept their general practitioner's advice (particularly in medication use). If doctors are interested in adherence to their advice they will need greater understanding of the patient's agenda and the adoption of a shared approach in the management of the patient's illness experiences. In the late 1990's this idea has been widely adopted within the shift from 'compliance' to 'concordance' and I will return to this in more detail below. In general, Tuckett et al view the patient as active decision makers both within and outwith the consultation. For them, necessity of a patient centred approach, stems from the active role of the patient in their healthcare needs.

Armstrong (1979; 1982; 1984) traced the emergence of the notion of biopsychosocial medicine and represented this as an historical artefact. He suggested that the adoption of the biopsychosocial model by medical professionals was intended to increase the disciplinary power of medicine so that gaze of medicine could then encompass the physical, psychological and social, in relation to the individual. Armstrong viewed the development of a relationship with the patient as the means by which medical professionals could increase the potential surveillance of the patient. Accessing the patient's view merely increased the potential for surveillance of every domain of the patient's life. Within this view of the biopsychosocial model, patients are seen as passive in allowing the medical gaze to encompass all areas of their lives.

However, the 'rhetoric or reality' of the biopsychosocial model was explored by Dowrick et al. (1996) who found that general practitioners perceived that a bio(psycho) model was more appropriate in reflecting the boundaries of their work than a biopsychosocial model. A further quantitative study, which explored general practitioner and patient models of depression(UMDS MSC in General Practice Teaching Group, 1999), found that general practitioners favoured a medical model through their greater support for somatic symptoms, medical causes and medical treatments.

Adam (2003) in a qualitative study of the meaning of personal care for both doctors and patients, demonstrated that patients adopted a biopsychosocial approach to general practice medicine. This led her to question whether patient agency was at work in the way patients talked about personal care or whether it was evidence of patients 'being duped through a state of 'false consciousness' into adopting a dominant medical discourse on doctor's terms that serves to control them'. Adam concludes that patients were sophisticated and discriminating in understanding and engaging with the concept of personal care, of 'knowing' and 'being known'. Patients engaged with biopsychosocial medicine and were willing to accept its invasion into their personal sphere because it helped them to achieve their own objectives and to maximise their own and their families' health.

> 'In this sense, patient's engagement with the discourse of biopsychosocial medicine may also be a strategy by which they are liberated from uncertainty and any pain and distress they may suffer' (Adam, 2003: 332)

Adam also reported that patients placed greater value on personal care (including knowing their general practitioner and being known by their general practitioner) if problems of a psychological nature were involved. However, Adam's conducted this work among a group of women who were not necessarily consulting and did not focus specifically on women with psychological problems.

In relation to the general practitioners in her study, Adam showed how personal care was used by doctors to perform a dual function, one that is both liberating and controlling. The doctors reported engaging in getting to know patients in order to forge trust and as 'an investment for the future' when they might need to use this knowledge or to use the 'trusting' relationship that had been engendered. Within general practitioner accounts, personal care was seen as improving medical outcomes as it facilitated a more quick and accurate diagnosis and efficacious treatment (with fewer unnecessary tests). General practitioners, through 'knowing' a patient, could also live with a greater degree of uncertainty and had a higher threshold of risk and so could reduce the potential for medicalisation of symptoms. The provision of 'personal care' was also viewed by general practitioners as increasing their own satisfaction and as aiding patient compliance with advice and supporting doctors to manage problematic patients.

Adam considered to what extent general practitioners are constructed through and constrained by dominant medical discourse such as biopsychosocial medicine. Her data demonstrated that doctors did adopt the discourse and practice of biopsychosocial medicine and embraced the 'personal', but placed boundaries around and even resisted its use. The doctors also spoke of its value in empowering and liberating patients from ill-health, pain and distress, but they also used it to identify and exercise control over the problematic patient. Adam concluded, that doctors too exercised some autonomy in how they engage with and react to the dominant medical discourse (of biopsychosocial medicine) and are not merely passive purveyors of this governing strategy. In particular they resist this discourse when it is seen to draw too heavily upon their personal resources.

The majority of research focusing on general practitioners' detection and treatment patterns has been quantitative in nature. Some studies have related general practitioner attitudes to their role in the management of depression (Kerr, Blizard, and Mann, 1995; Lawrie et al, 1998; Ross et al, 1999; McCall, Clarke, and Rowley, 2002) and some has explored general practitioner and patient models of depression (UMDS MSc in General Practice Teaching Group, 1999). This latter work found that general practitioners and patients report different models of depression with general practitioners' favouring a medical model through their greater support for somatic symptoms, medical causes and medical treatments. Only very recently has any research focused on exploring general practitioners perceptions of managing depression using qualitative approaches (Pilgrim et al, 1997; Rogers, May, and Oliver, 2001) (the former focuses primarily on patient and general practitioner decision-making factors surrounding referral to psychological treatment). They conclude that general practitioners discourses surrounding psychological distress include elements of both lay and psychiatric discourses.

Rogers et al (2001) showed that general practitioners recognised the social causes of depression but treated it as a medical problem. They also noted that the active process of negotiation of care (that is currently how general practitioner and patient interactions are perceived) also takes place against a backdrop of routines and assumptions about the way in which primary care is organised, and that for general practitioners, the depressed are part of the normal everyday experience of family medicine. They noted that for general practitioners the central issue was recognising and dealing with the pathology that the patient presented with.

Doctors recognised the circumstances that led to the patient's presentation but the pathology of depression lay at the centre of their activities.

> "They appreciated the impact of these wider social and psychological factors on the experiences of sufferers. But in the short consultation of the general practitioner, it is the clinical synopsis the abbreviated account of signs and symptoms in which ontology and subjectivity recede into the distance that governs practice." (Rogers et al, 2001: 327)

Depression might be the product of the social and psychological experiences of the sufferer but general practitioners reasoned about depression as a medical problem and constituted sufferers as patients. General practitioners were pessimistic about their capacity to help the patient within structural and organisational constraints in which they worked.

Hence, whilst the biopsychosocial model reflects the dominant medical discourse in medical teaching in UK general practice there is no wholesale adoption of this model in the reality of practice and there are times when general practitioners exercise choice and preference in their models of care. Furthermore, as indicated earlier, the evidence based approach to the management of depression reflects a psychiatric-led, and disease oriented approach rather than a patient oriented approach in relation to detection and treatment. This may explain why such an approach to care has failed to be implemented by general practitioners if it conflicts with their biopsychosocial rhetorical approach to care. The 'rhetoric or reality' of the biospychosocial model in general practitioners' management of depression remains relatively unexplored. In addition, although one study has reported that patients also adopt a biopsychosocial approach to their care, the patient preference for models of care has not been explored within a sample of depressed patients.

2.5.2 Lay accounts of illness and help seeking

The study of how people perceive and respond to symptoms and experiences is known as 'illness of behaviour' (Mechanic, 1978), and more recently summarised by Mechanic (1995) as:

> "...the varying ways in individuals respond to symptoms or illness indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions, and utilise various sources of informal and formal care." (Mechanic, 1995:1208)

Understanding illness behaviour is important, says Mechanic, because it shapes how individual recognise illness, determines consulting behaviour and is influential in the course of illness, its treatment and adherence with medical advice.

Mechanic also recognised how patients could have a stake in how illness and its causes are constructed by medicine: for reasons of legitimacy (to various entitlements such as insurance); to elicit sympathy; to avoid stigma; and to protect self-conceptions. These controversies he says '*play out on a personal as well as a societal level*'. Mechanic (1994) in exploring the way in which ideologies, attitudes and behaviour interact, conducted a study of the effects of how clients with schizophrenia defined their condition. This was conducted among patients from a group of families aligned to an advocacy group that vigorously promotes schizophrenia as a biological disease, and opposed to etiological explanations relating to family dynamics. Patients who conceived of their condition as more of an emotional or mental illness (and less of a biological/physical condition) reported a lower quality of life, which Mechanic related to diminishing self-esteem and an increasing sense of social stigma.

While Mechanic recognised the complex causes of illness behaviour (biological predispositions, the nature of symptomatology, learned patterns of response, attributional predispositions, situational influences, and the organisation and incentive characteristics of the healthcare system that affect access, responsiveness and the availability of secondary benefits (Mechanic, 1982) he also recognised that it is a longitudinal process '*involving interactions between personal history, social situations, and the opportunities and constraints of community institutions and social norms*'(Mechanic, 1995: 1213). Hence, studying the process that individuals go through as they make sense of their symptoms and decide on what actions to take '*requires strategies that offer views of different components of the process*' (Mechanic, 1995: 1213).

Mechanic's early work was an influential catalyst that has since led to a substantial body of research into illness behaviour such as comparing behaviours to consult with specific conditions(Lydeard and Jones, 1989; Ruston, Clayton, and Calnan, 1998; Richards, Reid, and Watt, 2002) and more generally on patient use of primary care services (Rogers, Hassell, and Nicolass, 1999; Hassell et al, 2001; Munro et al, 2000). However, this review focuses on two significant pieces of empirical work that have studied the 'process' of making sense of symptoms and deciding on what actions to take: the work of David Locker undertaken in the late 1970's (Locker, 1981) and of Gerry Stimson and Barbara Webb (1975).

David Locker published *Symptoms and Illness: the cognitive organization of disorder* in 1981, based on his PhD research. Locker argued that '*illness is a social phenomenon constituted by the meanings actors employ to make sense of observed or experienced events*' (p.i). He suggested that understanding the meanings that are applied to events are important for understanding how these events are subsequently managed. He drew upon the work of Schutz (1962) and ethnomethodology in seeing the relevance of everyday common-sense knowledge that actors use in interpreting, defining and thereby attributing meaning to events and experiences.

Locker interviewed six women who were mothers and wives, and as such were seen as and felt responsible for the families health care. He interviewed them several times each over a period of one year, and also collected information from health diaries completed by the women. He was interested in their own health experiences as well as those of their other family members or others known to them. Locker described how the participants 'made sense of problematic experiences' by interpreting them within a medical frame of reference.

> "Problematic experiences can be defined as events, situations, or states of affairs which disturb the taken-for-granted attitude towards the world and call for interpretive and explanatory activity…..Judgements of mental illness, for example, hinge entirely on behavioural 'abnormalities' such as disordered behaviour, perception or thought. These states of affairs may be viewed as problematic by the individual concerned or the others with whom he interacts." (Locker, 1981: 49)

Problematic experiences were perceived in the form of '*cues*' that disturb the taken-for-granted sense of order and call for interpretive and explanatory activity. Davis (Davis, 1963) in a study of the families of children with polio used the concept of a 'cue' to describe some of the interpretive processes employed in reaching a diagnosis. Locker used the concept of the 'cue' in an earlier stage of the process, '*the initial recognition of some departure from a state conceived of as normal, usual or routine*' (p 50). Locker determined that the women in his study described three types of cues: symptomatological, behavioural and communicative. Symptomatological cues involved changes in physical or psychological states that were either recognised by the individual or observed (in or by another) and these changes could be felt by the person or seen by their external appearance. Behavioural cues were observed changes in behaviour or conduct and communicative cues were the verbal claims of change made by one person to others or from others to an individual. As stated within the previous quote above, Locker suggested that mental illness is based on judgements of 'behavioural 'abnormalities' such as disordered behaviour, perception and thought whilst at the same time he included recognising changes in psychological states as a symptomatological cue.

Locker also described 'cue inventories' which were the typical ways in which specific disorders or disorders in general manifest themselves in different individuals. These inventories could be category specific (e.g. women or children) or person specific. Category specific inventories were derived from a socially given stock of knowledge whereas person specific inventories were derived from personal experience of the individuals involved.

In making sense of these problematic experiences Locker also recognised the importance of the context in which they occur, for example, in terms of the biography of the individual concerned or how they related to other events. In this way meaning and order surrounding these problematic experiences was established. Locker demonstrated that to achieve a sense of order people sought the answer to two questions: "what is wrong?" and "why has this happened?". Hence, meaning was given to events in explaining why they occurred or how they came about. Locker then described how the women in his study classified and explained their problematic experiences. He provided an account of how they decided that something was wrong and how they were able to make sense of this by locating the cause and determining the significance of the disorder. When an individual could not make sense of their experience in light of their available knowledge then the action taken by the individual had the purpose if identifying the nature of the problem as well as seeking help to manage the problem.

In his conclusions about the way women recognised, made sense of and acted upon problematic experiences Locker suggested that in interviews women were concerned to present themselves as 'moral actors, competent persons, and adequate performers in the social status they occupy' (Locker, 1981: x). Thus he located their accounts within the framework of everyday lives of wives and mothers in and within the context of help seeking such that they reflected 'responsible patienthood' (Locker, 1981: xi). He concluded that such accounts were constructed in ways that allowed them to be seen to conform to socially accepted criteria defining good performance in given social roles. They could thus define their behaviour as that of a 'moral actor'. In interviews the women also appeared to draw on a common stock of knowledge that was generally held within the society in which they operated, and it was this stock of knowledge that they employed in making sense of their problematic experiences. In this way they could return their experiences to their place within the normal order of things (p45).

> "These accounts are treated not as more or less accurate descriptions of what happened, but as reinterpretations of events designed to convey the rationality of their actions. Here, the women are able to show how their conduct *vis-à-vis* consulting the doctor conforms to the criteria which identify responsible patienthood." (Locker, 1981: xi.)

Locker's approach to understanding and analysing his data and the ways in which his interviewees made sense of and acted upon their experiences proved helpful in interpreting data gathered for this thesis as we shall see in Chapters 4, 5 and 6.

If Locker dealt with the process of making sense of symptoms and decisions to seek help, the second piece of empirical work that is of relevance to this thesis is the work of Stimson and Webb (1975) *Going to see the doctor.* In this book they write about the contact between patient and doctor from the point of view of the patient and they give an account of consulting behaviour.

Stimson and Webb were conducting their research in the early 1970's in the context of structural analyses of the doctor-patient relationship such as Parsons (1951) view of it as characterised by mutuality and reciprocity and Friedson's (1961) view of it as characterised by potential conflict. What was lacking for Stimson and Webb was an analysis at the level of the actual interaction.

Stimson and Webb divided the process of going to see the doctor into three stages: before the consultation, during the consultation and after the consultation. In addition, they considered the consultation in the context of the organisation of medical care in the UK and as a meeting of professionals and clients in general.

Like Locker, they supported the view that the social and cultural experiences of the participants must also be taken into account so that problems of doctor-patient communication were not seen as purely problems of the attributes of the two participants but were problems of contact between the lay and professional cultures from which each came.

In considering the consultation as a social process, they felt it was important to consider the interaction between the ill person and all of those around him (including the doctor) but also others in the social world. Previous studies undertaken from an interactionalist perspective (Davis, 1963; Roth, 1962) had shown interactions around illness to be characterised by bargaining and negotiation. As additional experience and information was accumulated new interpretations and definitions of the situation were required. Roth said:

> ...the treatment relationship may be conceived of as a conflict for control of the patient's behaviour, a conflict usually resolved by bargaining'. (Roth, 1962: 578)

In this way the relationship between the ill person and others is viewed as problematic in a way that structural approaches to illness behaviour do not take account of.

In taking account of these prior analyses Stimson and Webb recognised that in the context of the patient and their life, the consultation may be of little significance, hence the importance of looking at the wider process. However, on the grounds that they were interested in the interaction between patient and doctor (and clients and professionals in general) they placed the consultation at the centre of their research but included actions outside the face-to-face contact of patient and doctor that related to the actual interaction.

Stimson and Webb suggested that people came to consultations with three types of expectations: background expectations of what a consultation is generally like (and they found much subsequent criticism centred on behaviour at odds with these); interaction expectations about what would happen in the face-to-face consultation; and action expectations about the action the doctor would take (such as prescribing, referral).

In analysis of face to face interaction, Stimson and Webb were guided by two themes: strategies and negotiations. They suggested that both doctors and patients used strategies to attempt to control and direct the consultation to their own ends (for example, to persuade the other of their own ideas). However, they did this through on-going negotiation.

They recognised that any individual consultation had to be seen in the context of others and that negotiations were also structured by other factors such as: the organisation of medical care; the actors' perceptions of what is possible (for example in the time they have available for discussion); and 'areas of implicit agreement in interaction' or 'good manners'.

Like Locker, Stimson and Webb suggested that in perceiving symptoms patients had made some attempt to interpret symptoms and that in doing so he /she had defined, categorised and causally linked them to other factors. They used this interpretation to attempt to lead the doctor towards a particular diagnosis. However, doctors' and patients' interpretation of symptoms could be at odds.

Understanding illness behaviour and the complex influences on illness behaviour are important. In doing so, attention should be paid to the ideologies, attitudes and behaviour, and the meanings that are applied to events, and how these interact. It should also be recognised that patients can have a vested interest in how illnesses are constructed and that illnesses have meaning for patients. There is also value in explaining the relevance of everyday common-sense knowledge that people use in interpreting, defining and attributing meaning to events and experiences, to recognising the context in which problems occur, the biography of the individual concerned and how these are influential attempts to establish order. In understanding illness behaviour, an initial emphasis would be to explore how people come to decide that something is wrong and how they make sense of this prior to help seeking. The doctor-patient interaction must also be seen in relation to the wider social processes that take place outside of the doctor-patient interaction and which may also influence the interaction itself. Overall, the patient should be seen as active in constructing their own explanations of their problems and that these explanations are brought to the consultation and negotiated with the general practitioner with both parties making use of strategies to influence the negotiation. It is this type of approach that is required in exploring doctor and patient experiences of the recognition and management of depression. It is this type of research that is required to inform more patient-centred evidence-based approaches to the management of depression.

2.5.3 Lay evaluation of health care

Stimson and Webb's (1975) study of patients accounts of '*going to see the doctor*' raised the question as to why patients would take the trouble to consult a general practitioner and then choose not to use the doctor's treatment or advice. They drew upon Freidson's (1961) explanation of '*retrospective assessment of the consultation*' (p201) whereby patients will consult with non-professional or 'lay' members of their community, both before and after their consultation with their general practitioner. They found that patients evaluated the doctor and the consultation alongside their decisions regarding the use of the prescribed treatment and that this was an on-going process. Stimson and Webb also described the many elements that were brought in to play in the reappraisal of the consultation: the advice of others, particularly those with similar experiences; the interaction itself; and the action initiated by the general practitioner. The post-consultation evaluation would also include: reference to their prior expectations of the consultation; a comparison with the experiences of others; prior experiences of consultations in general practice; other illness experiences; and their experiences of medicines in general. They also suggested that patients evaluated what was accomplished in the interaction, and that patients assessed their own performance in terms of their prior expectations and in terms of appearing 'sensible'. Similarly the doctor's behaviour was also assessed and evaluated by the patient. they concluded:

> "Given that these processes – making sense of what happened, reappraisal, and evaluation – occur after the patient leaves the surgery, it becomes apparent that there is not necessarily any simple link between the doctor's action in prescribing a treatment, and whether or not, or in what way, that treatment is used by the patient. It is indeed difficult to divorce these processes from the patient's treatment decisions and actions." (Stimson and Webb, 1975: 80)

Stimson and Webb also made this further important observation from their data:

> "...if the doctor fails to persuade the patient to accept his perspective of the problem or fails to convince him that his orientation is the correct one, and the patient feels that the doctor has failed to grasp the problem as he perceives it, then it is possible that the patient may not follow the course of action prescribed by the doctor." (Stimson and Webb, 1975: 81)

As well as evaluating the consultation, Stimson and Webb demonstrated how patients evaluated treatments over time, bringing in their own personal experiences of using the medication as well as the experiences, knowledge and advice of others. In addition, patients' perceptions of medications and medication use in general are also seen to be brought in to play in their decisions regarding medication taking. So for Stimson and Webb, people draw upon many different sources of knowledge in their attempts to make sense of, and to evaluate, their encounter with their general practitioner and his advice and treatment.

Williams and Calnan (1996) set out to explore how lay people viewed modern medicine, the nature of their experiences of medical care and technology, and what criteria they drew upon and the factors that shaped and influenced their evaluations of modern medicine. In doing so they brought together a substantial body of empirical work on lay perspectives and experiences to conclude that *'people's views about modern medicine and the nature of their experiences of medical care and technology are complex, subtle and sophisticated'* (p256). They identified lay criticisms as focusing on medicines and drugs, the doctor-patient relationship, and the nature and quality of information in the medical encounter. They also identified six key factors (at both the micro and macro levels) which were likely to influence lay evaluations of modern medicine and medical care. These were: the socio-political values and professional ideologies upon which the health care system is based as these influence in a general way what lay people expect; the influence of the media in shaping lay views and in the profiling of risks; lay concepts of health and illness which structure their ideas about what constitutes health care and therefore their evaluation of it; lay concepts of health and illness which influence why an individual seeks help, as well as their perceptions of health problems and their responses to them; the nature of an individuals past experiences of care; and the influence of socio-demographic factors as mediatory elements that are likely to influence each of the previous factors.

Hence, previous literature in this field has identified that patients make decisions outwith the consultation with reference to many other sources of knowledge and experience as well as in relation to what happened within the consultation itself (their interaction with the general practitioner). Therefore, in exploring patients' behaviour surrounding their perceptions of their management one must be aware of the factors that are likely to have a bearing on their evaluations of care and adopt methods that are likely to capture patients' evaluations in this way.

2.6 Lay accounts of the experience of depression

Some accounts of the depression experience have become well known from biographical writings and these accounts continue to provide insight to enhance more systematic analyses of the experience of depression (see for example, (Wolpert, 2001; Plath, 1963; Styron, 1991; Wurtzel, 1995; Jamison, 1995)). In this section I review the empirical work that has been undertaken in exploring lay accounts of the experience of depression. I have restricted this review to qualitative studies that explore the 'experience of depression' (therefore excluding studies that have focused specifically on post-natal depression) and on work which has examined patients' experiences of medical care for the management of depression. What is evident from my attempts to find a substantial body of knowledge in this field (and is also commented on by those researchers who have contributed to this field), is that the subjective experience of living with and managing depression has received little research attention. There is also little understanding of how those experiencing depression understand and explain depression. Table 2 contains details of the relevant published papers that I discuss in this section and the following section in relation to lay experiences of antidepressants.

I summarise the main findings of these studies according to five main themes that generally reflect the depression illness career (as discussed in varying ways by (Rogers, May, and Oliver, 2001; Karp, 1994; Schreiber, 1996). In order to summarise the themes contained within this variety of empirical work I have labelled the main themes as: recognising that something is wrong; deciding to seek help; making sense of experiences and the meaning of diagnosis; evaluations of help seeking; and recovery. As Karp (1994) identified, it is important to acknowledge that individuals differed in the time they spent in each of these particular phases and he also recognised the importance of the onset (first experience) and the pattern of illness in shaping one's depression illness career.

2.6.1 Recognising that something is wrong

A unique feature of depression, as opposed to other types of illness, is that everyone will experience some degree of depressive type or emotional or psychological difficulty at some points in their lives. However, most people would not describe themselves as 'depressed' or perceive their problems required intervention. Whereas for some people, there will be a process whereby their problematic experiences come to be defined as abnormal and requiring explanation and help.

Karp (1994) traced the history of people's experience with depression from the first moment they realised that something was wrong to identify underlying patterns or commonalities in the way respondents described what it is like to live with depression. He recognised the social and structural features of people's lives that influenced their ability to 'recognise, to name, and to respond to their problem'. Both Karp and Rogers et al (2001) reported that respondents described a period of time when they had 'inchoate feelings' for which they had no vocabulary for naming their problem. Karp's respondents recognised that something was wrong but this was expressed in various ways such as 'feeling uncomfortable', 'marginal', 'scared' or 'in pain'. When he explored what it felt like when depressed, he found that respondents used very similar metaphors and similes such as 'drowning', 'suffocating', 'feeling empty' or 'being caught up in a storm'. Rogers et al. reported that the inchoate feelings people experienced were also described in relation to a general inability to cope with their everyday lives.

Karp also noted that those who had experienced bad feelings from an early age could not conclude that something was wrong because they had no baseline of normalcy against which they could compare their own experiences. Hence feeling bad was perceived as normal.

Despite their difficulties in naming their feelings Karp and Rogers et al's respondents eventually concluded that something was wrong. This transformation of the definition of the situation, from vague inchoate feelings to the recognition that something is wrong, occurs when the person feels sufficiently troubled to seek help.

2.6.2 Deciding to seek help

Karp and Rogers et al both identified that problem formulation and the conclusion that one needed help generally occurred over a long period of time. Rogers et al, suggested that there was a significant degree of confusion in their respondents formulation of the need to seek help which resulted in difficulties in deciding how to put this across to others. Karp associated delays in help seeking with a reluctance to 'go public' because this would have implications for their status and identity, related in part to the potential stigmatisation associated with mental health problems. This is also supported by Rogers et al who also identified that some patients felt (or anticipated) a degree of shame at presenting with a psychological problem or felt that the problem lacked legitimacy and that they had the 'wrong type of problem'. Rogers et al suggest that prior contact with services shapes patients' expectations and therefore patients would have knowledge of what professionals might constitute as legitimate illness. They reported that there were perceived negative or unwanted consequences of the consultation such as '*a reluctance to disclose a fragile sense of being able to cope*' (Rogers et al, 2001: 324). Furthermore, they found that respondents did not necessarily medicalise their problems, but general practitioner care was often perceived as the only source of available help, even although they also reported a pessimistic view concerning the general practitioners ability to help. Their reluctance to consult was also shaped by their perception that contact with services might result in more loss of control and '*disrupt an already fragile sense of self*'(p. 324). Schreiber (1996), found that the women in her study expressed difficulty in 'telling others' because of fears of being judged and misunderstood and having their complaints dismissed. As a result of this, when they did decide to talk to someone they controlled the information '*based on the woman's perception of how much honest information the other person could tolerate without causing repercussions to* *herself* (p.480). Thus in help seeking, controlling information was a way for the women to maintain their self-esteem. Schreiber's women were also reluctant to tell others because of the perceived stigmatisation from their inability to live up to perceived expectations of social roles. Kadam et al (2001) also found that patients had difficulty in communicating their emotional difficulties to their GP which is why only half of those whose problems were identified in the study via questionnaire had reported this to their GP. Respondent's also perceived other people as being generally unsympathetic and as a result their feelings were often invalidated or respondents were made to feel shameful or embarrassed by them.

It is worth noting some quantitative studies that have explored issues of reluctance to seek help. Meltzer et al (2000) in a national survey of psychiatric morbidity in Great Britain also found that people with neurotic disorders rarely present their symptoms to primary care. When they explored this further they found that the main determinants of reluctance were: symptom severity (more severe cases were more likely to report an episode of reluctance); ignorance of neurotic disorders; the perceived effectiveness of treatment and the perception that no-one could help them; and stigma. Cape and McCulloch (1999) reported similar findings in people who presented only somatic symptoms to their general practitioner. The reasons patients gave for not mentioning psychiatric problems to their general practitioners were the perceived lack of time from doctors and 'that there is nothing the doctor can do'.

An additional piece of empirical research that also contributes to this debate is by Prior et al (2003) who explored public attitudes towards disclosure of emotional problems using focus groups. They suggest that appeals to stigma are inadequate to explain the phenomenon and that it is more likely that lay views differ from health professionals as to what constitutes a mild to moderate psychiatric problem. Hence they say that it is more significant to explore the way in which lay people construct and recognise (psychiatric) illness. Prior et al also indicated that the lay community hold rational views about the extent to which their problem can be managed by their general practitioner.

Both Karp (1994) and Rogers et al (2001) identified a crisis stage which sufficiently troubled respondents and led them to conclude that something was wrong and that something had to be done. For Karp, the crisis stage involved a change in respondents' perceptions of the cause of their problems and a shift from perceiving their problems in relation to external causes to deciding that the problem was within themselves. He found that help seeking was also triggered by the recognition that the problem was now beyond their efforts to control.

2.6.3 A theoretical perspective of help-seeking behaviour related to depression

Thoits (1985) sought to account for help seeking behaviour for short episodes of psychological disturbance and distress and developed a theory of *self*-labelling based on the symbolic interactionist perspective that social control is largely a product of self-control, or that individuals imagine how they might appear to others in their actions. Hence, one can assess the meanings of one's actions with reference to how others might react. So even in the absence of others witnessing our behaviour we can still interpret our behaviour as deviant, and therefore engage in self-labelling.

> *Individuals can self-label because they are able to observe and classify their behaviours, thought and feelings from the perspective of the wider community* (Thoits, 1985:243)

For a label to be applied to the self by oneself, there must be some cultural understanding that one has engaged in rule breaking behaviour, but one must also be motivated to conform to the norm, and be bothered by the deviation, or anticipate some form of social sanctioning or loss of 'social reward' as a result of this behaviour. Thoits draws on Pugliesi (1981) and Hochschild (1983) in asserting that 'feeling norms and expression norms' exist, and that these emotion or feeling rules '*indicate the range, intensity, and duration of feelings that are appropriate in given situations*' (Thoits, 1985: p224).

Thoits argues that when an individual's experiences of emotion is understood to be out with the emotional norm then this results in "norm-state discrepancy". Thoits presents the processes by which norm-state discrepancy can be eliminated or reduced as 'emotion management processes' and offers some examples of emotion management techniques such as: leaving or avoiding a situation; ignoring it or engaging in distraction techniques; or by reinterpreting a situation to make it less problematic. Hochschild (1983) similarly talks about "expressive emotion work" through surface acting or deep acting (which can induce genuine feeling). Emotional management techniques thus 'enable individuals to transform discrepant feeling into normative ones' but it is when these discrepant feelings cannot be managed in this way that problems arise. Thoits identifies two conditions that are likely to result in failure of emotional management: (1) the persistence or recurrence of discrepancy-producing situations (here she includes multiple roles, role transitions and structural strains as examples); (2) lack of social support.

Support from others who have had similar experiences is important – this social support is seen as offering validation to one's emotional reactions in that others (who have experienced similar emotional reactions resulting from similar social circumstances) can testify to the objective bases of these feelings. They can also legitimise or normalise these feelings. This validation then reduces self-disapproval and improves self-esteem and may reduce 'self-condemnation for deviance' and reduce the likelihood of self attribution of mental illness. Conversely, a lack of social support would increase self-condemnation and self-attribution of mental illness. However, Thoits does acknowledge that social support can also increase the probability of self-labelling if the advice of others supports their own initial thoughts in relation to mental illness, and that informal labelling by others often precedes formal help seeking.

When emotion management attempts fail and there is a lack of social support then individuals are likely to conclude that their deviant feelings are symptoms of psychological difficulties and they will consequently be motivated to seek help. (subject to the social and economic factors that may also impact on seeking treatment). She also allows that because the symptoms of mental illness can have similarities to physical symptoms, that this explains the self-attribution of physical illness as often preceding thoughts of a psychological basis to problems.

Thoits concludes that mental health professionals help individuals to understand their feelings and provide the 'social support' that is missing from others. Psychotherapy, is therefore the purchase of social support whereby therapists validate and make sense of deviant feelings, they often help people to see these feelings or situations differently and reverse the self-attributions and self-condemnation. This study offers the opportunity to evaluate Thoits' theory in relation to women experiencing depression and their accounts of recognising that something is wrong and their help seeking behaviour.

2.6.4 Making sense of experiences and the meaning of diagnosis

As similarly described in the review of lay accounts of illness and help seeking above, in making sense of the experience of depression individuals are actively engaged in interpreting and making sense of their own experiences. Furthermore it is also recognised that the diagnosis itself has meaning for individuals.

> "How persons themselves understand a change in their state has implications for their behaviour, and this affects their apparent symptoms and how their problems are identified and classified. It also has implications for identifying appropriate treatments and for understanding the effects of communication about depression as part of the treatment process. The problem of depression may be identified through the diagnosis but the diagnosis itself has meaning" (Lewis, 1995: 370)

Lewis (1995) described how sufferers responses to diagnosis emphasised the search for meaning and the tension between individual and social explanations in the cause of depression.

Lewis suggested that the 'diagnosis was a key point at which an individual's problems were identified as depression' and described four types of reaction to the diagnosis: acceptance; acceptance but questioning; rejection; and the respondent's reaction to having a diagnosis denied. Lewis offered some explanations for these outcomes and recognised that receiving a diagnosis had variable meaning. The diagnosis could be perceived as legitimising and validating problems and bring relief from the confusion and worry that symptoms have generated. Lewis also notes that it can be rejected as inappropriate to the way someone actually feels and it can be stigmatising. A

clinician's denial of depression also had meaning and was seen as devaluing the person's suffering and the problems they were experiencing.
Lewis's work reports that there is often pressure for sufferers to explain their depression and therefore individuals try to find reasons for their depression. However, this can also lead to tension as sufferers try and make sense of individual and social explanations within their own experiences. Sometimes explanation is necessary for the acceptance of the diagnosis and Lewis also found that when patients had a previous understanding of the potential causes of depression, and their own experiences did not fit in with this explanation, then they were likely to reject the diagnosis. Individuals also explained their experiences of depression in multiple and contradictory ways, using individualised bio-medical models or social explanations. However, the adoption of a particular explanation was not always sufficient to fully explain their own experiences and patients often wrestled with this ambiguity. Either way, the adoption of either a bio-medical explanation (internalised) or a social explanation (externalised) could have negative consequences. In adopting the former explanation the individual is pathologised, whereas the latter explanation may imply that the individual is at fault for failing to cope in circumstances that do not cause depression in everyone.

> "It shifts the focus of explanation from the scientific discourse used in the biological model to a discourse of personal socio-moral inadequacy." (Lewis, 1995: 380)

Lewis found that the diagnosis of depression did not always fit with the patients' own explanations of their problems, and it was their own explanations that influenced their perceptions of the acceptability of medical treatments for their experiences.

Karp (1994) suggested that receipt of a diagnosis and treatment with medication resulted in respondents re-defining their past, present and future in illness terms. It is at this stage that patients are 'labelled' and they enter the therapeutic world. Entering into the therapeutic world required respondents to cope to grips with an illness identity which involved reconstructing and reinterpreting the past in relation to current experiences; searching for causes; constructing theories about the nature of depression; and establishing modes of coping behaviour. Like Lewis, he also found that the labelling of the illness experience could bring relief and explanation, as well

as feelings of stigmatisation and Karp's respondents differed in their willingness to define their condition as 'an illness'.
Karp also found that the adoption of a biochemical explanation had implications that whilst it might absolve them from feelings of personal failure would also lead to being perceived as a 'victim' and helpless. Karp's respondents all expressed reluctance towards taking medication for their problems, as this was seen as a further indication of their inability to control themselves.

Karp's (1994) respondents represented people with severe, enduring and chronic depression, many of whom traced feelings of emotional discomfort to very early childhood. Karp (1994) saw it as particularly salient, in terms of personal identity that the respondents' definitions of problems centred on the structural conditions of their lives, either of their past or in relation to their immediate life circumstances. Respondents reported feeling that if the structural conditions affecting their lives changed then their emotional problems would also disappear. Hence, when a perceived change in their structural conditions was not followed by a resolution of the problems, they were then confronted with the need to re-define 'what is wrong'. Karp says a decisive shift then occurs when persons come to see that the problem may be internal rather than situational.

Schreiber's (1996) study of the illness career through to recovery, identified a phase which she called 'seeking understanding and cluing in'. This reflected the women's attempts to make sense of their experiences through hypothesising, seeking additional knowledge, and making connections between how one is feeling and the things one has experienced. She identified 'seeking understanding' as having four subprocesses: making a provisional hypothesis, learning about my self; learning about my world; and learning about stigma.

Schreiber found that although the women were usually aware of the problems relating to psychosocial issues, they could simultaneously perceive their illness in biomedical terms, as biochemical changes in the brain. She reported that the women had an 'approach-avoidance attitude' about a biomedical component displayed in their approaches to medical care for help but general reluctance to actually engage with physician care.

Schreiber and Hartrick (2002) explored the explanatory models of women who experienced depression and who sought treatment. They reported that in order to 'keep it together' there were three supporting categories: taking up the biomedical explanation of depression (as a biochemical or genetic disorder); using the biomedical explanatory model to manage the stigma of depression (i.e. it is more acceptable to be chemically rather than mentally unbalanced); inadvertent consequences of using the biomedical explanatory model. Schreiber and Hartrick reported that all of the women, to a greater or lesser degree, explained their depression as a biochemical or a genetic phenomenon. When they explored this further they found that the women's physicians had provided them with this information and although for many of the women this explanation varied from their own, when presented with the biomedical explanation the women adapted their own understandings. Once the women had received this new knowledge they subsequently engaged in an on-going process of revision to accommodate the new information and all new experiences were evaluated in light of the biomedical explanation. However, Schreiber and Hartrick acknowledge that there may be cultural influences in their respondent's willingness to adopt the biomedical model such as the women's participation in a health care culture that is strongly shaped by a biomedical discourse.

Walters (1993) study of women's accounts of their health, reported that women explained their stress, anxiety and depression with reference to their daily experiences. The women's explanations of poor mental health were the heavy workload of women and the demands of family and work, the issues of identity and cultural pressures to assume gendered caring roles or body image, and their social legacy (the problems leading to or contributing to their current position e.g. as a single mother or survivor of sexual abuse). Hence, Walters' women emphasised a social aetiology of mental health, and although they did not consciously portray their own experiences with reference to class or gender structures they were aware of the impact of patriarchal structural forces on women's health. The impact of these social forces on mental health also led to increased physical health problems as a response to these stressful conditions. For Walters, her study revealed how women's models of health and illness were not based on a medical model, physical problems were not viewed in bio-medical terms and explanations for mental health problems rarely reflected a bio-medical model.

> "Their models had a strong social character and incorporated a recognition of distinctive gender roles and images of women. In this sense health problems were a source of gender consciousness, yet few women voiced a strong rejection of the structures of patriarchy." (Walters, 1993: 400)

Walters also reported that women normalised their mental health problems, they did not worry about them to the degree one might expect and if their experiences could be understood they were less likely to worry. For example, both Lewis (1995) and Walters (1993) have reported that some women attributed depressive experiences to aspects of female reproductive biology. However, Walters suggested that what is 'normal' is a socially constructed concept and women may feel pressured to ignore or normalise their problems, particularly if they felt was there is a lack of support or sympathy available.

2.6.5 Evaluations of help seeking and health care

Rogers et al (2001) sought to identify and elaborate the processes related to access and contact made with primary care. They found that general practice care reflected a relatively minor component of people's help seeking. However, their contact with primary care had implicit significance in shaping their experiences of depression and the parameters of their expectation of help from wider health care. They found that patient's were passively accepting of the clinician's treatment decisions (medication) but interpret this passivity with caution as some expressed reluctance to accept medication and a number of patients discontinued their use because of side effects or because it failed to deal with their perceived problems. Trust in their general practitioner and their general practitioners' willingness to talk and listen to them were the most highly valued aspects of care. When patients felt that clinicians were unwilling to give their time and engage with their problems there was dissatisfaction with care. Rogers et al suggested that patients had low expectations of the primary care system as a means of dealing with personal troubles; doctors were perceived to lack the personal knowledge of sufferer's circumstances that might create a basis for a confiding relationship and have a limited knowledge of depression. However, primary care was seen as better than having to attend secondary care services because of the increased stigma attached to psychiatric care and because the patients saw it as a further step from normalcy.

In Roger's et al's study, patient satisfaction was linked to expectations which were influenced by the experience of depression, the nature and perception of primary care provision and whether or not the nature of their problem was a legitimate one to be seen in primary care. Patients used knowledge of previous consultations in making judgements for the ways in which general practitioners handled depression. Primary care remained a marginal part of people's lives because it rarely addressed or even conceded the complex and intractable nature of problems.

> "While care in general practice has often been portrayed as an active process of negotiation between lay and professional knowledge, this takes place against the less obvious routines and assumptions about the way in which primary care is organised." (Rogers et al, 200: 331)

Kadam et al (2001) reported that patients' experiences were dominated by the struggle to control unwelcome and intrusive thoughts; living in a hostile and threatening world and searching for sources of help. All individual respondents located external sources for their difficulties and the challenge was not in dealing with the problems themselves but coping with the emotions they produced. Dealing with these emotions was portrayed as a battle or fight and coping strategies were developed to control or avoid focusing on their thoughts and emotions. Respondents' evaluations of help seeking related to 'someone to talk to', 'issues around access', and 'attitudes to medication'. Respondents were sceptical of the benefits of drug treatments while being open to complementary therapies and were unwilling to comply with interventions they perceived as unhelpful or irrelevant. They also reported that respondents were very active in seeking informal sources of help.

In exploring women's perception of help seeking, Schreiber (1996) found that women sought a 'sympathetic ear' and perceived the listener as an important potential source of validation of their illness and support. When support was not forthcoming and the women perceived they were misunderstood the women experienced additional distress and many of the women in Schreiber's study reported dissatisfaction with health care providers in this respect.

Finally, McNair et al (2002) sought to identify the major concerns of people with depression and their families. The key theme for respondents was the experience of stigma which was evident in healthcare settings as well as being a barrier to social participation. There was a perceived lack of access to high quality primary care and non-pharmacological care. Respondents' needs were reported as access to knowledge, support for self-care and the promotion of a broader model of recovery from illness than remission of symptoms.

2.6.6 Recovery

The final stage in the illness career (Karp, 1994) is structured around whether a person perceives they will always suffer from depression or whether they can or will recover fully from depression. However, new episodes of depression will call for new meaning to be attributed to experience and new theories about causation to be constructed. The experience of depression was a '*continuous process of construction, destruction, and reconstruction of selves in the face of repeated problems*' (p.26). Karp concludes that the experience of depression is an exercise in '*negotiating ambiguity and involves the evolution of an illness consciousness*' (p.26) and an on-going evaluation of the validity of the illness metaphor.

Schreiber (1996) examined the process of recovery in 21 women who had identified themselves as having recovered from depression. The basic social psychological process of recovery is described as "(re)defining my self" and consists of six phases – "my self before", "seeing the abyss", "telling my story", "seeking understanding", "cluing in" and "seeing with clarity". The first four of these are represented in the previous sections, therefore only the final stages of recovery are discussed here.

It was during the 'cluing in' phase, Schreiber said, that the women began to learn about themselves and reflect on the role of others in their lives. This was when the women evaluated the information they had received about their self and their world and made value judgements, and their subsequent decisions were informed by a wider understanding of their world. The women then began to re-invent themselves, and those who considered themselves most recovered spoke of 'owning the missing parts of the self', they accepted themselves and came to grips with their past experiences and even rid themselves of some aspects of their previous self (such as the 'good girl' who had lived up to perceived expectations)

In a more recent paper (Schreiber, 2001) Schreiber reflects on data from three grounded theory studies of women and depression. She suggested that women revealed an understanding of the social and cultural expectations of them and the moral judgements to which they would be subjected. Living up to these expectations is often in conflict with the woman's own sense of coherence. Recovery involved becoming aware of and challenging these expectations. Societal beliefs about what makes a 'good woman' limits the woman's potential or for her to realise her 'true self' and results in oppression and marginalisation. Women internalise these societal expectations uncritically and try to live up to these expectations and therefore unconsciously collude in their own oppression. When they then fail to live up to these expectations they feel inadequate. Schreiber also describes the symbolic losses that women feel (from difficult marriages, disappointing children, loss of innocent childhood) as losses of an imagined future. These losses could not be mourned in any socially sanctioned way and indeed the women had to be strong and not show vulnerability in the face of these losses. This essentially devalued and marginalised these women's experiences. Recovery meant challenging the understandings of the 'good woman' and attending to their internal dialogues and voicing their losses. Schreiber also reports on the role of violence in women's lives contributing to depression and which included emotional as well as physical violence. Schreiber's work presents depression as the result of unacknowledged and mourned losses that women experience throughout their lives.

2.6.7 Summary

Beyond the recognition of depression as an 'inchoate feeling' lacking understanding or explanation, there are few accounts which explore the recognition of problematic

experiences which come to be defined as depression. Although Lewis (1995) sets out to explore how individuals came to identify themselves as depressed he begins with the meaning of, or the reaction to the diagnosis and attempts to explain these reactions in terms of the validity of depression as a diagnosis in relation to patients own experiences and meanings. However, he fails to capture the process prior to the diagnosis whereby patients were making sense of 'problematic experiences' as yet undefined as depression. Hence, Lewis understands their experiences solely in relation to their meanings and understandings of depression and not within their wider understandings of health and changes of state. Therefore, he fails to capture the possibility that the patient has interpreted their problematic experience in an entirely different way and made an alternative diagnosis. Exploring patients' perceptions of symptoms and the process by which they interpret and make sense of them is a part of the process of how individuals come to identify themselves as depressed.
Given previous findings by Locker (1981) and Stimson and Webb (1975), it is worth exploring in more detail the recognition of problematic experiences and how people come to make sense of these prior to help seeking.

Whilst previous research has identified that people are generally reluctant to seek help because of fears of stigma, shame or legitimacy of illness, one recent qualitative study has suggested that lay constructions of depression also play a part in shaping decisions to disclose emotional problems (Prior et al, 2003). However this study was conducted among a community sample and therefore further research exploring constructions of depression among those experiencing depression and how this shapes their decisions to consult is required. Furthermore, the identification of a 'crisis' stage in influencing decisions to seek help may explain help seeking among those who perceive their problems as inchoate and confusing. However, it is also known that many people experience depression as physical symptoms and therefore rationalisations for help seeking may differ according to how symptoms are perceived.

The findings in relation to lay explanatory models for depression also differ with some studies reporting a social aetiology (Walters, 1993), others reporting the almost wholesale adoption of a biomedical explanatory model (Schreiber and Hartrick, 2002), and others reporting continuing ambiguity in relation to the adoption of a particular model (Karp, 1994, Lewis, 1995). However, attention must be paid to the different populations in these studies. For example, women in Walters' (1993) study were not necessarily 'patients' and may therefore be less likely to adopt a medical model when discussing stress and depression in the context of their daily lives. There was also some suggestion that the emphasis on a particular explanatory model changed according to the stage of illness career. Therefore, further exploration of lay concepts of depression should recognise the potential differences in perception among people at different stages in their illness career.

There have also been conflicting findings in relation to the acceptance of medical advice from suggestions of general passivity of patients (Rogers et al, 2001) to suggestions that patients are generally sceptical and reject orthodox care in favour of unorthodox approaches (Kadam, 2001). Hence, lay evaluation of medical care in the context of the management of depression requires further exploration.

Walters' (1993) research has indicated the potential influences of family structures and socio-economic status on women's depression. Hence, understanding the women's experiences of depression and the experience of its management within the context of the women's lives (their family and work circumstances) would therefore be important.

2.7 Lay use of medications and psychopharmacology

It is well recognised that patient medication taking behaviour influences health outcomes, health care utilisation and therefore health care costs (Chewning and Sleath, 1996). As noted above, patient adherence with antidepressants has been viewed as particularly problematic and much of the research on lay views of medications is primarily concerned with adherence. However, more recent research has called for the adoption of a 'client-centred approach' and 'shared decision making'(Marinker, 1997; Elwyn, Edwards, and Kinnersley, 1999; Chewning and Sleath, 1996; Elwyn, Edwards, and Britten, 2003). These approaches generally advocate a 'participatory model of medication management which acknowledges the decision-making responsibility and power of the client in partnership with health care providers' (Chewning and Sleath, 1996). Rogers et al (1998) in a study of the meaning and management of neuroleptic medication also called for the development of a collaborative patient centred model of medication management for patients.

2.7.1 Lay knowledge, attitudes and explanations of medication use

In order to promote the client centred approach there has been a number of studies that have explored the meaning, attitudes, and use of medications in general (Britten, 1996) and for patients with specific conditions such as epilepsy (Conrad, 1985) and asthma (Adams, Pill, and Jones, 1997). Other studies have reported lay beliefs that medications lose their effectiveness, or that one can become immune to them, if taken long-term (Donovan and Blake, 1992).

Britten (1996) categorised interviews with patients discussing medication use into orthodox (having medical legitimacy) and unorthodox accounts. Britten (1996) found that those giving orthodox accounts talked about medicines in a 'taken-for-granted fashion' and those with unorthodox accounts were mainly anti-medication (reference to "unnatural" and "damaging" properties was only made in unorthodox accounts). She suggests that patients may be expressing orthodox accounts within the consultation (being passive patients) and keeping unorthodox accounts to themselves, aware that they might lack medical legitimacy. The patients' unvoiced, unorthodox agenda may lead to 'conflict' in the encounter if their own views are suppressed and the medical view dominates. If negative views of medication and its use are not voiced in the consultation, then any advice or treatment offered by the doctor will not have taken the patients' agenda on board and the 'client-centred' approach will not be in operation. Britten reports that her respondents did not think their doctor knew their views on drugs and medicines (although a small number of unorthodox accounts had communicated their ideas to their doctor or had found a doctor sympathetic to their views). The inability to present their own views, or to challenge medical views in the consultation, may mean that challenge is more likely to occur outside of the consultation and to be displayed in non-adherence to prescribed medication. Britten also suggested that people evaluate doctors and medicines in conjunction thereby supporting the notion that 'medicine is a metonym for the doctor' (Van der Geest and Whyte, 1989).

Britten (1996) suggested that public accounts of medication and treatment are concerned with the moral status of illness and a medical diagnosis is proof of the reality of an illness. The prescription can then be seen as the visible proof of a diagnosis,

> 'To be given a prescription is to have won the moral argument about the reality of the illness' (Britten, 1996: 52)

However, this can also be a double edged sword as it then labels one as 'sick' and of poor health. From this, Britten reflects that private accounts might reveal some dislike of drug taking and influence non-adherence and concludes that patient behaviour is likely to be informed by their unorthodox (private) views and that

> "The "problem" of "non-compliance" is the failure of medicalisation to extend beyond the consulting room into the spheres of everyday life where people take their medicines. Hence the challenge to medical dominance may occur not in the public but in the private realm, in the guise of non-adherence to prescribed medication. (Britten, 1996: 71)

Conrad (1985) in a study of the experiences of people with epilepsy, explored issues of 'compliance' with drug regimens by focusing on the meanings of the medication in people's everyday lives in order to look at why people took their medication or not. Conrad suggested that to understand non-compliance one must account for several factors, including the notion that patients have their own ideas surrounding medications and their use, they have their own knowledge regarding illness and medication and they seek the advice of others in their evaluations. Conrad's findings lead him to conclude that the issue 'is more one of self-regulation than compliance'. Conrad was also able to establish the meanings of self-regulation for his respondents with epilepsy which included 'testing, controlling dependence, destigmatization and creating a practical practice'.

Dowell and Hudson (1997) in a qualitative study of medication-taking behaviour in primary care present a model of decision making as follows:

1) patients evaluate their own knowledge of disease and treatment alongside the recommendations of the GP. However, faith in the doctor is also important in determining whether patients decide to start treatment;
2) Most patients will test a medication before accepting it fully;
3) Three types of medicine user were identified
    Passive accepters of treatment advice
    Those who use medication as they decide is appropriate/necessary
    Those who reject medication;
4) accepting a treatment is linked to acceptance of illness;
5) practical problems only play a small part in the process.

Dowell and Hudson agree that understanding the symbolic role of medicines and how illness challenges an individual's identity are key. It is this understanding that has been missing from evidence based guideline development and implementation. However, it is also understood that lay experiences differ according to their experiences of different types of illness and different lay circumstances. Therefore similar research is warranted exploring the meaning and use of medications for those experiencing depression. This chapter will now review some of the studies that have explored lay perceptions of psychotropic and neuroleptic medications before reviewing empirical work which has focused on antidepressant medications.

2.7.2 Lay perceptions of psychotropic and neuroleptic medication

Concerns about the rising cost and widespread prescribing of psychotropic drugs like benzodiazepines in the late 1970's and early 1980's led to a small number of studies into the meaning of benzodiazepine use (Helman, 1981; Cooperstock and Lennard, 1979; Gabe and Lipshitz-Phillips, 1982; Gabe and Thorogood, 1986). Other studies have explored lay views of the meaning of neuroleptic medication (Rogers, Entwistle, and Pencheon, 1998), and other research which has explored lay views in general towards antidepressants (Priest et al, 1996).

Helman (1981), and Cooperstock and Lennard (1979) demonstrated how patients came to see taking benzodiazepines as acceptable in that they used these drugs either to enable themselves to sustain an idealised view of their social roles; or to enable them to manage being wives and mothers and maintain relationships with others; or that they viewed these drugs as 'fuel, food and tonic', often convincing themselves that they were in control of their use and not addicted and not taking real 'drugs'. Whereas Gabe and Lipshitz-Phillips (1984) found evidence of an *anti-drug culture* attitude characterised by a strong antipathy to using drugs of any kind and made explicit fears of becoming addicted or dependent on such drugs and associated these types of drugs with the potential to make them 'crazy' or more ill. In addition, the women in Gabe and Lipshitz-Phillips' study differentiated between medicines in general and medications that were for 'nerves' with the latter being perceived more negatively. Their accounts related stories of the negative experiences of others that they had seen using such medications and such stories were emphasised by 'non-users' to explain their rejection of such medications. They identified differences across the three groups they studied (non-users, high users and intermittent users). Non-users emphasised the 'unnatural' nature of pills and painkillers and developed their own coping routines. High users expressed hopelessness about the benefits of benzodiazepines and other medicines but conceded that these kinds of medications did help and also reported taking what the doctor prescribed. Intermittent users presented a mixed picture of both these viewpoints and seemed to use benzodiazepines more discriminately than high users.

Gabe and Lipshitz-Phillips findings also led them to assert that the women assessed their symptoms and treatment in moral terms as well as in terms of their needs and fears –'*The doubts they expressed about taking benzodiazepines in the light of the dangers of dependency seemed compounded by moral considerations'* (p. 205). They conclude that use (as opposed to non-use) of benzodiazepines 'seems to depend on successfully splitting feelings of need from fears of dependency or addiction'.

2.7.3 Lay perceptions of antidepressant medication

Given the current concerns about the rising cost and increasing prescribing of antidepressant there has surprisingly been little research into the meaning of antidepressant medication use.

Karp (1993; 1994) in his qualitative study of people 'living with depression' described a sub-career of medication use as potentially consisting of four phases: resistance, trial commitment, conversion and disenchantment. He described a 'drug socialisation' process where negative attitudes are replaced by acceptance within the right explanatory framework (such as the illness analogy). However, for others, their experiences of medications fostered increasing reluctance or downright rejection of their use. Karp recognised that healthcare treatment and use of medication was an important feature in the 'illness career' of depression and the impact this had on self identity.

It has only been more recently, that research has specifically focused on patients' perceptions of antidepressants and acknowledged the psychological and social meanings attached to antidepressant use.

Schreiber and Hartrick, (2002) reported that women whose understanding and explanatory models of depression included a biomedical component accepted medication and used it whilst those who rejected it also rejected medication. However, there were exceptions to this and women who attributed their condition as resulting from their life circumstances did not necessarily reject medication. Schreiber suggests that early use of medication to allow these women to function may have contributed to some being unable to critically reflect on their losses and pain that led to depression and so their course of action is to continue to 'seek the right medication' and prevent the necessary recovery (Schreiber, Stern, and Wilson, 1998; Schreiber, 1996). Some women recognised the limitations of medication and 'controlled' their own use of medication. Schreiber advocates the use of antidepressant therapy after women have undergone psychological therapies.

Gammell and Stoppard (1999), in reporting women's experiences of treatment, demonstrated how women often adopted a bio-medical explanation for their symptoms, drawing on bodily explanations such as hormonal fluctuations, and placing the meaning of medication use within this framework. In this way, older women who were receiving medical-psychiatric treatment attributed their experiences to the menopause.

Knudsen et al (2002) reported that young women with depression initially felt stigmatised for their inability to function 'normally' in their daily lives. On receiving the medication, the stigma was reclassified and it then became associated with taking the medication. This resulted in the young women hiding their medication use.

Even more recently, Garfield et al (2003) report similar findings from their study which interviewed patients beginning courses of antidepressant medication. Medication was seen as having a 'paradoxical role' in that it returned the respondents to normal functioning but their need for medication also reduced their sense of being normal. In order to manage the stigma, respondents reconciled their use of medications with their previous self-identity. They used the mechanism of 'passing as normal' and could control this (very much like Knudsen et al's respondents) by keeping their medication use secret; and they also compared themselves to others who were worse than themselves and disassociated their medication from the label of 'depression'. Respondents engaged in playing down or trivialising their own condition and the medication. They also found that respondents sought out others on similar medication and used them as a means of support and to 'normalise' the condition through its commonality. Garfield et al, conclude that there is a social stigma attached to depression and that antidepressant medication defines a person as suffering from depression and its use reduced respondents' sense of being normal. They call for healthcare professionals to be aware of the paradox of medication as helping symptoms but contributing to stigma and to help patients utilise their own mechanisms for coping with this stigma.

2.7.4 Summary

Research to date suggests an ambivalence towards psychotropic medication acceptance among some, to fears and rejection of their use by others, to a recognition of their limitation by others still. It is also suggested that their use is associated with moral considerations. The paradoxical role of antidepressants has been identified and how they contribute to stigma. However, research using the depression career model has also suggested that patients continually evaluate their use and that their experience of use also shapes their perceptions. Again, these few studies have been conducted among different populations with different levels of illness experience. Given the lack of research which has focused on lay perceptions of antidepressants in the UK, further knowledge is required to contribute to this field and to inform the development of patient-centred models of medication management within UK general practice.

What is also required in an approach to exploring the meaning and use of medications is to take a broad understanding of lay evaluations of health care, (such as the work of Stimson and Webb (1975) and Calnan and Williams (1996)) so that medication use is not seen in isolation but is also evaluated in terms of the re-appraisal of the consultation, lay concepts of health and illness and their perceptions of their health problems and their responses to them.

2.8 The sociology of mental health and illness

There are different sociological accounts of mental health and illness, such as: social causation theory (also known as the psychiatric epidemiological perspective) epitomised in the work of Brown and Harris (1978); labelling theory (Goffman, 1961) which focuses on how deviant behaviour is constructed; and critical theory (which emerged from the Frankfurt School and the work of Freud and focuses on the relationship between the individual and the psyche). However, the theoretical perspective most relevant to this thesis is that of social constructionism as it acknowledges the historical and social relativism (and therefore the social construction) of medical knowledge.

The social constructionist position asserts that all knowledge is socially contingent and therefore medical knowledge is socially constructed. It also contends that diseases and the body are not 'stable realities', instead they are 'created' within the prevailing social processes (of the wider society or of the scientific communities themselves). Modern Western medicine is associated with either a bio-medical model as the framework of knowledge, or more recently, and particularly within the discipline of general practice, a bio-psycho-social model. The bio-medical model is associated with treating the mind and body as distinct parts (mind-body dualism). The focus of bio-medicine is on achieving increasingly sophisticated technological interventions with which to manage the dysfunctioning body. This approach within medicine is seen as *reductionist* as it neglects any attention to social and psychological explanations for disease and illness. The framework of knowledge that underpins the bio-medical model is that the application of scientific method will lead to discovery of the truth about a disease. This is therefore in direct opposition to the social constructionist view that 'disease' is socially constructed. Social constructionists not only challenge medical knowledge, they also account for the emergence of medical dominance as resulting from socio-political struggles (rather than the outcome of scientific knowledge).

The most problematic challenge for social constructionism is the problem of *relativism* (Bury, 1986: 151). If all knowledge is socially relative, and therefore contingent, then so too is the knowledge derived from the social constructionists' gaze. The problem of relativism can be addressed within a realist approach (Bhaskar, 1979; Greenwood, 1994; Hammersley, 1992; Taylor and Ashworth, 1987; Pilgrim and Bentall, 1999; Pilgrim and Rogers, 1994). The realist view (whether described as 'subtle', 'scientific', 'critical' or 'sceptical') recognises the very real nature of disease and illness and that there can indeed be a 'biological reality' to the condition as well as socially and culturally relative constructs surrounding the disease or illness.

Thus medical, scientific and technological concepts can be examined within the social and historical conditions under which they emerged without the need to reduce all of these concepts as the product of discursive practices alone (Greenwood, 1994; Pilgrim and Bentall, 1999).

> In a critical realist account it is not *reality* which is deemed to be socially constructed (the axiomatic radical constructionist position), rather it is *our theories of reality*, and the methodological priorities we deploy to investigate it. (Pilgrim and Bentall, 1999: 262)

This is the approach that I have adopted in undertaking the work that I present in this thesis. It allows for the recognition that while disease and illness may be socially constructed there is also the potential for a biological reality. It is also a position that does not undermine the validity of people's experiences and the very real effects of biological, physical and social mechanisms that shape their illness experiences. The adoption of this stance also has implications for the methodological approach that underpins the empirical work upon which this thesis is based. Therefore, I return to the implications of the critical realist approach, particularly in relation to the status attributed to the qualitative interview data, in the next chapter on *Methodology and Methods.*

2.9 The doctor-patient encounter – micro and macro-perspectives

One of the current debates within medical sociology surrounding the doctor-patient encounter is the extent to which the medical encounter reflects or is shaped by macro-level social structures. Of particular relevance to this thesis is the charge that medical professionals offer biomedical or technical solutions for inherently social problems or the problems of everyday life. The social constructionists challenge to medical reductionism (that it ignores the social and psychological influences upon the body) then leaves medicine open to challenges of 'medicalisation' when it does seek to adopt a more bio-psycho-social approach and to bring the 'mind' and the 'body', and even the social, into the medical domain.

Williams and Calnan (1996) and Scambler (2002) have provided a summary of some of the main contributors to this debate. The 'medicalisation' theory (a critique that has been adopted by political economy and feminist perspectives) views medicine as a powerful institution of social control and in order to achieve this control it seeks to take hold of areas of people's lives that would not necessarily be viewed as appropriate to the domain of medicine. The 'medicalisation' of childbirth is the most widely used example within this argument, whereby a natural life process is taken over by the medical profession and defined as a 'medical problem' and thence subject to continuous medical scrutiny and technological interventions (Findlay and Miller, 1994; Oakley, 1986).

According to Conrad and Schneider (1980), there are several ways in which medicalisation can occur: either conceptually (using medical vocabulary or jargon) to define a problem; institutionally (a problem or programme becomes part of the work of an institution and is this is legitimised by the medical profession); or interactionally, during the doctor-patient interaction when diagnosis and treatment take place. Conrad (1981) also sets out the conditions for medicalisation which include: the problem having at least some association with an 'organic cause'; that the medical profession accepts the problem as being relevant to its discipline; that the medical profession has some means for managing the problem. What opens the medical profession to criticism of medicalisation is the 'purpose' in applying these conditions to a problem. For some the purpose is medical dominance (Freidson, 1970; 1985) while for others the medical profession is merely responding to broader social processes of industrialisation and bureaucratisation by rendering the public as dependent (in all spheres of their life) (Illich, 1975). Others still, view the medical profession as contributing social control either for the benefit of the ruling capitalists (Navarro, 1986; Waitzkin, 1979) (with the creation of consumer dependence upon medicine) or for the benefit of various interest groups, for example institutions responsible for controlling deviance or the pharmaceutical industry (Conrad and Schneider, 1985; Conrad and Schneider, 1980; Gabe and Calnan, 1989).

Waitzkin (1991) refers to the management of discourse around 'personal troubles' within the consultation to demonstrate that medical professionals through their actions contribute:

> "....to social control by reinforcing individual accommodation to a generally unchanged context. With the technical help and emotional gratification that they have received, patients perhaps become better equipped to cope, as they continue their consent to the social conditions that troubled them in the first place." (Waitzkin, 1991: 232).

In short, according to this view, medical management reproduces mainstream ideology, governing appropriate behaviour and encouraging acquiescence to the social order. However, Waitzkin's theory covers some form of 'ideal type' of consultation and he too readily dismisses the 'humanistically inclined doctors' who do engage with personal troubles by saying *'the traditional format of the interview does not facilitate their expression'* (Waitzkin, 1991: 232).

Foucault examined the social function of medicine to conclude that medicine operates as a form of disciplinary power through the governance and regulation of the body. In his work *Madness and Civilization*, Foucault provides a historical study of the varying constructions of madness in Europe from the Renaissance to the lat 19th century (Foucault, 1967). In this work and in *Mental Illness and Psychology* (Foucault, 1976) the main intended argument is that

> "madness is not a self-evident behavioural or biological fact but is the product of various sociocultural practices. Madness has no presocial essence but acquires its density of being in relation to the needs and demands of a given culture" (McNay, 1994:18).

This is an argument that underpins the work of Armstrong who bases his account of the emergence into prominence of the neuroses on a Foucauldian perspective (Armstrong, 1980). In this work Armstrong suggests 'that during the 1920's and 1930's the main thrust for the incorporation of problems of mental instability (and of Freudian ideas) into medicine came not from asylum psychiatry but from general medicine'.

> "The mind in all its detail had become important – not the diseased mind of the mad and insane but the ordinary mind of everyone." (Armstrong, 1980: 297)

This, for Armstrong, signified the 'medicalisation of the mind and of certain problems of living' (Armstrong, 1980: 297) to the extent that, "general medicine's gaze extended beyond the surveillance and examination of the body to the mind of everyone."

Armstrong draws upon Foucault's idea of the 'panoptic vision' (Foucault, 1977), an invisible power (as opposed to the previously visible and crude power of the sovereign) that sought to create an efficient social organisation, as an explanation for the medicalisation of the mind. He explains:

> "Now,...the panoptic vision raised itself from the body to appear over the mind: not the mind of the mad but the mind of the sane. Insanity and neurasthenia had been afflictions of those constitutionally predisposed to them; neurosis was a potential problem for everyone." (Armstrong, 1980: 301)

Within this Foucauldian perspective, the neuroses were seen as a threat to everyone and consequently as a threat to the fabric of social order. Hence the panoptic view or the medical surveillance of the mind was required in order to maintain social order.

The medicalisation thesis would contend that when it comes to constructing the 'reality' of disease or illness it is the medical opinion which dominates, doctors define the conditions and their underlying symptoms. This is how medical professionals become charged with the potential for social regulation. In defining symptoms or behaviour as a medical matter they then take on the role of monitoring and managing people with these symptoms or behaviours. It is not difficult to see how the construction of mental illnesses could serve to gain control over people who display certain types of deviant behaviour and how, in doing so, medical professionals serve the function of social regulation.

Another tenet of the medicalisation thesis is that through the process of medicalisation people lose faith in their own knowledge and powers of judgement. Cornwell (1984) supports this theory with empirical data from an ethnographic study of working class people in London. She found that medical and lay concepts of health and illness were related but the medical view dominated and their common-sense beliefs reflected the influence of this view. This led to the development of two accounts that respondents portrayed: the 'public' and the 'private' account. The public account was one which reflected ideas and values that respondents perceived were likely to be 'publicly' acceptable and which generally reflected a medical point of view – this concerned moral aspects of illness such as acceptability and legitimacy of illness and the attribution of responsibility. Private accounts related to personal experience, the context of illness, their life circumstances and practical constraints.

Scambler (2002) sees Habermas as '*offering a more flexible frame for re-theorizing doctor-patient encounters in ways which integrate micro- and macro-perspectives*'(p121). Habermas suggests that there are two types of rationality that produces two types of world. One is 'communicative', or value, rationality and the other is 'purposive' rationality. Communicative rationality is associated with the 'lifeworld' and purposive rationality is associated with the 'system' and which represents technical interests and is expressed in the scientific attitude. Habermas sees the 'system' as promoting 'system rationalisation' or 'colonisation' of the lifeworld. Habermas's theories of 'communicative action' and 'strategic action' are based on the premise that people's narratives have a performative character – hence, communicative action is oriented to understanding and strategic action to success. Habermas recognises two forms of strategic action: 'open strategic action' in which the speaker 'openly' expresses the aim of influencing the hearer but with an orientation to success, rather than understanding; 'concealed strategic action' whereby the speaker intends to bring about something through acting in saying something but the hearer may not be aware of this intended effect. Furthermore concealed strategic action can involve either conscious or unconscious deception. Within conscious deception at least one of the participants acts with an orientation to success but effectively allows others to assume that they are engaging in communicative action. Within unconscious deception or systematically distorted communication neither party may be aware that strategic rather than communicative action is in play. This then allows for doctors to act with an orientation to success without perceiving that they are deceiving the patient for their own ends.

Applying this framework of communication to the doctor-patient encounter, and taking account of the medicalisation these presented above, it could be argued that we have moved from a style characterised by open strategic action where doctors adopted a paternalistic approach to patients and directed the patient to accepting their advice, to an approach that at least promotes communicative action as it strives towards patient-centred communication and concordance. Somewhere between these two opposites, Habermas's framework also accounts for the possibility of concealed strategic action with conscious deception or manipulation '*for example when doctors use technical jargon to subdue, browbeat or gain assent from a resistant patient*'

(Scambler, 2002: 122) as well as unconscious deception whereby the doctor may not be aware of his strategic intent.

Methodologically, it is difficult to see how empirical evidence of unconscious deception could be obtained. However, two pieces of work have drawn upon Habermas' theoretical concepts and applied them specifically to the world of medicine and the doctor patient encounter in particular.

Habermas' (1984) theory of Communicative Action was applied by Mishler (1984) to make sense of patterns of communication between doctors and their patients and also more recently by Barry et al (2001).

Mishler viewed the 'system' as the 'system of technological medicine' and that strategic action was used to maintain its dominance. As speech is the instrument of strategic action the 'voice of medicine' is used in distorted communication patterns (that may involve deception or manipulation) in order to achieve success. Like Friedson (1970), Mishler viewed the doctor-patient relationship as asymmetrical. Mishler (1984) categorised consultation dialogue as being conducted in '*the voice of medicine*' or the '*voice of the lifeworld*'. The voice of medicine is the means through which doctors' exercise power over the voice of the lifeworld and in doing so they suppress the meaningful accounts of patients. In this way the consultation is seen as based on conflict as the two voices compete and fragment the communication. If doctors were to use more 'ideal speech interactions' which would involve listening, asking open-ended questions, translating technical language into the voice of the lifeworld and negotiating a sharing of power, then care would become more 'humane and effective' (Mishler, 1984). Mishler analysed 25 interactions between doctors and patients and identified a typical pattern of communication that he labelled the '*Unremarkable Interview*'. In these interviews the voice of the lifeworld was either not heard or silenced and the interview was conducted through the use of technical questions. For Mishler, the 'voice of medicine' relied exclusively on the biomedical model.

Barry et al (2001) set out to investigate and critique Mishler's premise that consultations conducted in the voice of medicine which suppressed and fragmented patients' contextualised, meaningful, accounts resulted in '*inhumane and ineffective*' medical care. They interviewed patients before and after a general practice consultation as well as recording the consultation itself. They analysed 35 case studies and identified four communication patterns within consultations and related these to patients' evaluations of the encounters. The four communication patterns were: strictly medicine; mutual lifeworld; lifeworld ignored; and lifeworld blocked.

The consultations conducted within a 'strictly medicine' dialogue were mainly for single acute physical problems and in general this communication pattern seemed to work for both doctor and patient. Consultations for more chronic health problems were the ones in which the lifeworld was likely to be raised by patients but was also likely to be ignored or blocked by doctors. These consultations were rated in the poorest outcome categories. When the consultation had a psychological component they found that the voice of the lifeworld was more likely to be used by doctors and encouraged in patients. These consultations were rated as having some of the best outcomes. They explained this finding through claiming that psychological conditions are more rooted in the lifeworld and that whilst there is a voice of medicine discourse about causation, psychological conditions are defined by (and success of treatment is measured by) lifeworld terms of reference and that items used in depression inventories or scales relate to lifeworld activities. They say that it may be through employing such scales that doctors are required to enter a lifeworld discourse to some degree. However they also acknowledge that insights from tools alone are not enough to understand and treat the whole person. The doctors need to know what contextual factors are operating in the person's relationships and working life. This requires natural communication and life skills.

Scambler (2002) discusses Mishler's and Barry et al's work in which doctors are presented as generally operating within a framework of strategic action and patients as agents of communicative action. He makes the point that medical paternalism is *responsive to certain vital system imperatives*, and contends:

> "In so far as doctors respond to these system imperatives (that is, in so far as these needs inform medical paternalism), they are agents of strategic action, and not just of open strategic action and conscious deception, but also, and this

> to the extent to which they remain unaware of system imperatives, unconscious deception." (Scambler, 2002: 125)

However, Scambler also recognises that doctors engage in communicative action, that patients engage in strategic action and that doctor-patient encounters '*represent a dynamic and negotiated 'mix' of communicative and strategic action*'(Scambler, 2002: 125). Scambler also reminds us that lay and professional knowledge is not mutually exclusive. Patient narratives can, and do, include medical models of disease and doctors' also have an awareness of common-sense knowledge from the lifeworld. Hence it should be recognised that the doctor-patient encounter is both dynamic, negotiated, and structured.

Scambler also considers the wider societal changes that have an impact on the doctor-patient encounter, namely: consumerism, clientalisation and increasing interest in alternative sources of help; political assaults on welfare state-ism (leading to reforms of the NHS); and a decline in the status of the medical profession. These, he suggests, offer a challenge to medicalisation theorists.

The medicalisation thesis does not generally allow for the recipients of medical care to be credited with any degree of freedom: they are constructed as passive and uncritical. As Scambler points out the counter arguments point to the lay populace as being ever increasingly informed about health issues and medical technologies and to people being less deferential to the professions in general which in turn has had an effect on the doctor-patient relationship (Gabe, Kelleher, and Williams, 1994; Elston, 1991). Some authors have asserted that there is a process of 'demedicalisation' within society (Fox, 1977). This could be supported by the general discontent among the lay populace with modern medicine, a rise in medical complaints (of either malpractice or more generally in the quality of care) and increasing support for alternative or complementary therapies and self-help strategies for managing health and illness. However Lowenberg and Davis (1994) argue that the growth in the 'holistic health movement' could support both medicalisation and de-medicalisation theories by suggesting that holistic health care results in an increasing number of areas of everyday life come under medical scrutiny due to its emphasis upon lifestyle modification and the attention it focuses on the mind-body as a whole. Additionally, it remains to be seen whether these alternative therapists replace orthodox medical professionals, there is still an ever increasing demand upon formal medical services.

As well as a process of de-medicalization, it is also claimed that medicine is going through the process of "deprofessionalization" (Haug, 1973; 1988) and of "proletarianization"(McKinlay and Arches, 1985). Deprofessionalization is seen as a reduction in the knowledge gap between the public and medical professionals a decline in patients' trust in medical expertise and their willingness to accept that other 'providers' may also have something to offer. Proletarianization is seen as the de-skilling of the medical profession, their loss of economic independence and having to work under 'managers' within bureaucratically organised institutions. The de-skilling of medical professionals and the imputation of agency to medical subjects has also led to support for the notion of lay 're-skilling' where technical knowledge is re-acquired or re-appropriated by lay persons and routinely applied in the course of their day-to-day activities (Williams and Calnan, 1996). Therefore more recent theoretical perspectives challenge the medicalisation thesis.

Foucault's early writings have been criticised for leaving aside the notion of patient agency, as Lupton says:

> "One major problem is the tendency of Foucault and those using his work to neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated and transformed by members of the lay population in their quest to maximise their health status and avoid physical distress and pain." (Lupton, 1997a: 94-95)

Lupton (1997a) comments that the concept of the 'docile body' of the patient caught in 'the clinical gaze' has resulted in Foucauldian accounts of medical practice being concerned with surveillance and medical domination and which do not afford the patient the ability to return the medical gaze: they illuminate the repressive nature of power. Lupton points to the concentration, by Foucauldian scholars, upon Foucault's earlier writings such as *The Birth of the Clinic* (1975), *Madness and Civilisation* (1967) and *Discipline and Punish* (1977), with their focus of the ill, the mad and the criminal, as engendering this view and fuelling the medicalisation these presented earlier. Whereas, Foucault saw the possibility for a 'productive' nature of power and also emphasised that where there is power there is also resistance. Furthermore, the existence of strategies of power do not necessarily imply that power will be successfully exerted, hence, disciplinary strategies may fail. Lupton acknowledges that the concept of resistance was never fully explained in Foucault's work but nonetheless there is a disjuncture between his concept of the 'docile body' and the recognition of resistance. Lupton argues that there has been little discussion of the 'phenomenological body' or how people respond to the external discourses and strategies that attempt to discipline them (p103).

Foucault in Volume 3 of *The History of Sexuality* (1986) does attend to issues of 'personhood' or 'the technology or practices of the self'. Although still relatively undeveloped, this was approaching a phenomenology of everyday life which allowed for subjectivity in individuals and for the patient to resist being passive. Foucault was thus interested in 'subjugated knowledges' that are hidden by dominant or 'scientific' or 'expert' knowledges. Lupton (1997a) drew upon Foucault's practices of the self in analysing data from a study she conducted involving 60 lay and 20 doctor accounts of medical encounters and the doctor-patient relationship, she says:

> "The doctor-patient relationship is a central site at which subjugated knowledges and the practices of the self play a major role in the interrelation of institutional and localised power." (Lupton, 1997a: 105)

Lupton's patients constituted themselves as "ideal type consumers" (as autonomous, reflexive individuals rather than as accepting a passive, orthodox patient role) and/or as someone who follows doctors' orders and presents themselves as "a good patient". She maintained that the patient engaged in presenting themselves as a certain type of person "*engaged in 'rational' and 'civilised behaviour' consonant with her or his social or embodied position at the time*" (Lupton, 1997a: 105). She further contends that patients who appear to accept medical advice need not be seen in terms of a 'passive' patient, or a docile body passively accepting of the medical gaze, but rather they:

> "...could be seen as engaging in practices of the self that they consider are vital to their own well-being and freedom from discomfort and pain." (Lupton, 1997a: 105)

Whilst seeing value in Foucault's later work in the 'technologies of the self', Lupton also takes issue with this new 'subjectivity' as it assumes that a person is constantly in a state of reflexive evaluation and that now the notion of the rational autonomous subject is privileged, while no account is taken of the "*cultural, psychodynamic and affective processes in an individual's life choices, decisions and actions*" (Lupton, 1997b: 374). She argues for a notion of subjectivity that is dynamic and contextual rather than static and a concept of the self that is fragmented, contradictory and "*pulled between a number of desires emerging from both the unconscious and the conscious*" (Lupton, 1997a: 106). She summarises:

> "This concept of the self recognises the emotional investments people make in their relations with others, the ways in which different sources of the self intertwine, and become important at different times for the same person." (Lupton, 1997a: 106)

It is through this notion of subjectivity that we may explain how people can be both complicit with medical power as well as engaging in challenging medical power. For Lupton, the relationship between medical professionals and patients is much more ambivalent and contingent. Patients need to trust health professionals at certain times and to surrender to their authority, while at other times the relationship involves a negotiation of power.

Williams and Calnan were concerned, at a broader level, to explore what lay accounts might reveal about the relationship between modern medicine and the lay populace and how these views '*might shed light in the macro-focused theoretical debates*' (William and Calnan, 1996: ix). They found evidence of continuing faith in doctors and that people still look to medicine for '*a "solution" to their ills*' and suggest that instead of complementary medicines replacing orthodox medicine, there is "dual usage" of both types of medicine. They also suggest that the media play an important role in influencing lay perspectives and shaping their experiences of modern medicine. Furthermore, lay views must also be seen in terms of whether the lay person is talking about modern medicine in general or in personal terms because when talking about medical care in general people tend to be more sceptical. From their review of current evidence about the relationship between modern medicine and the lay populace, like Lupton, they rejected the notion of "blanket dependence" on modern medicine and the construction of "docile bodies" and asserted that there has been an "overdrawn" view of medical power, dominance and control and that indeed a "critical distance" is being established by the lay populace in relation to modern medicine, characterised by ambivalence and scepticism. They see this as reflecting a broader set of changes sweeping through contemporary western societies, which Giddens refers to as late modernity (Giddens, 1991). Within late modernity sources of authority are frequently contested but are also subject to "active" forms of trust (whereby trust has to be continually won and retained in the face of doubt and uncertainty) and "radical" forms of doubt. This is how Williams and Calnan characterised the relationship between modern medicine and the lay populace "*increasingly built around a reflexively organised dialectic of trust and doubt*" (p262).

Their findings also supported the notion of lay "*re-skilling*" where technical knowledge is re-acquired or re-appropriated by lay persons and routinely applied in the course of their day-to-day activities (Giddens, 1991) and the growth of the "*life political agenda*" (reflected in the growth of the self-help movement, environmental health movements and anti-vivisectionist activity (Kelleher, 1994; Elston, 1994; Williams and Popay, 1994). However, lay re-skilling can either be seen as an attempt to de-medicalise society with a return to natural rather than technical forms of healing (and non-compliance with medical treatment and the growth of complementary therapies could used to support this view); or it can be seen as lay re-appropriation whereby individuals use medical technology for their own ends and is thus seen as a means of 'liberation' than oppression. In supporting the notion that medical power and dominance is undergoing a period of critical reconfiguration, Williams and Calnan summarise their reflections as follows

> "....lay "ambivalence" towards modern medicine may fruitfully be located within the broader contours and existential parameters of life in late modernity; a reflexive social order in which active forms of trust intersect with radical forms of doubt in a dialectical interplay, and processes of "lay re-skilling" and the emergence of "life political agenda" come to the fore as a response to the expropriating effects of modern abstract systems." (Williams and Calnan, 1996: 263)

In this respect the lay public are not simply passive and dependent upon modern medicine, nor are they necessarily duped by medical ideology and technology.

In relation to the role of the general practitioner, Foucault's work would suggest that doctors are not figures of domination but are "*links in a set of power relations*", "*people through whom power passe[s] or who are important in the field of power relations.*"(cited in Lupton, 1997a: 99). Thus more recent Foucauldian scholars have portrayed medical professionals as serving to regulate and maintain social order as well as promoting good health and productivity (unlike the orthodox medicalisation critique which portrays doctors as seeking to gain power and status and limiting the power of others).
Medical professionals are charged with medicalising misery by offering biomedical solutions for inherently social problems and at the same time are open to charges of medicalisation when they adopt a biopsychosocial model of health care. New perspectives have emerged which challenge theories of medicalisation and medical dominance and advocate that the changing nature of the relationship between the lay populace and modern medicine points to a de-professionalisation or proletarianisation of the medical profession and towards consumerism and lay re-skilling. Within these approaches the patient has come to be recognised as autonomous, reflective and active in their care (Lupton (1997a) and Adam (2003) have provided empirical evidence to support this thesis). However, there are also suggestions that the challenge to medical dominance occurs in the private realm and that in the medical encounter itself patients still remain relatively passive.

Whilst a single piece of empirical research would not be able to resolve these macro theoretical debates there is value in applying these theoretical positions to empirical findings and to contribute in small ways to their advancement. This study, as an exploration of patient and doctor encounters in the management of depression will attempt to contribute to these on-going debates.

2.10 Summary

The impetus for this study stems from the recognition of the importance of depression within primary care, and general practice in particular, and from the recognition that the definition of depression has not been problematised in current approaches to the management of depression and to research in this field. Furthermore, there appears to be a separation of the evidence-based approach from the patient-centred approach to care. This thesis acknowledges the contribution of medical sociology to the study of the doctor and patient encounter, to lay and professional views of medical care, and to lay views of health and illness. It is therefore also concerned with applying this knowledge to the study of the management of depression in general practice.

In the backdrop to this study have been the criticisms that have been levelled at general practitioners in their management of depression: that there is variation in their identification of emotional distress, including depression; and that even when depression is identified general practitioners will often prescribe at sub-therapeutic levels; that general practitioners even question the notion that drugs are the answer to the underlying causes of depression; and that general practitioners do not adhere to clinical guidelines for the management of depression. Research on general practitioners management of patients with depression has focused on issues of clinical management such as detection, diagnosis, prescribing medication and referral to specialist agencies (Moore, 1997). This research has failed to problematise the definition of depression. There have been no attempts to understand general practitioners conceptions of depression, how they recognise and diagnose depression, and how they experience managing depression.

Whilst there are implicit suggestions and anecdotal evidence that the management of depression involves work which is 'hidden' in formal clinical accounts of the process, such as development of trust, the management of stigma, resistance of labels, or taking account of the patients' views and experiences, there has been little empirical research on general practitioners views of their work. An understanding of their views, of the practical context in which they work and the potentially conflicting motives, priorities and reasoning that define their approach, is needed to explain why formal clinical knowledge is not always implemented in practice (Dowrick, 1995; Howe, 1996). Hence the purpose of this study was also to explore general practitioners experiences of managing depression in the practical context in which they work.

In addition to this, there has been little research within general practice on the patient's perspective on the management of depression despite the perspectives of patients currently being given a greater voice within health service development. Much of the research on general practitioners management of depression implicitly presents a passive and unidimensional view of the patient, not as a person whose views and experiences may have to be taken into account in the process of medical management. Where an active role for patients is implied this is often a negative role of 'non-compliance' (Moore, 1997). There is evidence that patients are reluctant to take antidepressant medication and this may be due to a 'lack of understanding' of the difference between antidepressants and tranquillisers (Scott and Freeman, 1992) or related to wider concerns about the role of medications in managing illness and distress (Williams and Calnan, 1996).

Medical sociology points to the importance of research which considers the process of care in general practice as an active process of negotiation between 'lay' and 'professional' knowledge, experience and motivation and between doctors and patients as individuals (Tylee, Freeling, and Kerry, 1993). What is crucial in order to further better detection and 'concordant' management (where any form of management is based on understanding and incorporating patient as well as professional agendas) is to understand the patient experience of depression and their perceptions of its management; as well as understanding of the context of everyday clinical practice in managing depression from the general practitioners perspective.

The empirical work upon which this thesis is based sought to explore general practitioners' and women's experiences of the management of depression, to explore how they recognised that something was wrong and made sense of this and their subsequent experiences of the management of depression using interpretive and inductive methods. Through this understanding of the context of everyday clinical practice it should be possible to identify where 'evidence based practice' or 'clinical guidelines' do not reflect this everyday practice and the problems in managing depression, as they are defined from the patients' and general practitioners' perspectives. It is only through greater understanding of the patient and general practitioner perspectives and how they interact in negotiating care that we can develop guidelines that are applicable to the general practice context of managing depression.

Chapter 3 Methodology and Methods

> *Like theories, methodologies cannot be true or false, only more or less useful* (Silverman, 2001: 4)

3.1 Introduction

This research was undertaken from the broad philosophical stance of interpretivism. The chapter begins with a description of this general philosophical tradition and the methodological approach therefore adopted within this research study. I then provide some detail on the background of the study, as this had some bearing on the design and conduct of the research. Finally, I provide a detailed account of the methods I employed in conducting the research including: sampling and accessing respondents; constructing and conducting the research interviews; and the analysis of the study data including the systematic categorisation of the data and constantly comparing analytical findings across the data. The aim of this chapter then, is to provide an account of the theoretical framework that underpins the research and to describe in detail the development, design, implementation and analysis of the study.

3.2 The philosophical position

There are essentially two main competing paradigms (or world views) within which one can view the nature of knowledge concerning the social world – positivism and interpretivism. These two distinct philosophical perspectives differ in their view of the nature of reality and what counts as evidence in relation to this. Sociology enters these philosophical debates but with the purpose of exploring social phenomena, theorising or explaining these phenomena, and explaining or justifying the means by which we conduct this exploration.

Max Weber (1948: 88) defines sociology as:

> A science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects…..Action is social in so far as, by virtue of the subjective meaning attached to it by the acting individual (or individuals), it takes account of the behaviour of others, and is thereby oriented in its course. (Weber,1948: 88)

The Sociology of Knowledge[3] concerns 'what is real' and 'how do we know' or what can we accept as evidence of reality. As a sociologist, I understand that everything in the social world is socially relative (what exists within one culture does not necessarily exist within another) and therefore questions of 'reality' and 'knowledge' must also be viewed as being socially relative. Berger and Luckman also considered the interest of sociology in ontological debates:

> Sociological interest in questions of 'reality' and 'knowledge' is thus initially justified by the fact of their social relativity….It follows that specific agglomerations of 'reality' and 'knowledge' pertain to specific social contexts, and that these relationships will have to be included in an adequate sociological analysis of these contexts. (Berger and Luckmann, 1966: 15)

I offer a simplistic account of these two main (and opposing) perspectives and the epistemological stances associated with these traditions simply because I want to locate the epistemological position that generally underpins my own thinking in relation to this study.

At one extreme is the positivist position, which regards the social world as 'out there' and real and available to discovery; there is an objective reality. The positivist tradition holds that scientific theories can be subject to empirical evaluation. This perspective can also be described as 'scientism' and is generally the approach adopted within the natural sciences using quantitative methods to test hypotheses. For those who hold a wholly positivist view, the nature of the social world can be understood and presented in 'facts'. The social world can be reduced to variables that can be systematically collected and used to prove or disprove theoretical hypotheses.

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[3] The Sociology of Knowledge is the focus of Berger and Luckman's work in *The Social Construction of Reality* (Berger and Luckman, 1966) and within this work they attribute the term 'sociology of knowledge' to Max Scheler in Die Wissensformen und die Gesellschaft (Bern:Francke, 1960)

When applied to the study of behaviours and attitudes these behaviours and attitudes are reduced to variables that can be identified and reported as facts or beliefs.

The task for the researcher who works within a positivist tradition is to identify ways in which these facts can be identified and measured in a way that reduces bias and attempts to be objective and precise. What remains open to question is the reliability of the technique for systematically collecting and measuring or identifying these facts. Hence these researchers attempt to reduce unreliability or bias in their methods and research design. The data or facts gathered within this process should not be dependent upon the research setting or the researcher.

The other main philosophical tradition that relates to understanding the social world, and the one that underpins this thesis, is that of interpretivism. Interpretivism (also described as phenomenological inquiry) is concerned with meaning and action within the social world. Here I rely on an understanding of the work of Schutz (as interpreted by (Heritage, 1984)), who has been a key figure in the development of interpretivism, in my attempt to explain an interpretivist approach to social theory. However, the philosophical tradition of interpretivism underpins many schools of thought within sociological theory such as symbolic interactionism, ethnomethodology and social constructionism. Each of these methodological perspectives may differ in their pursuit of understanding and in the nature of what constitutes evidence of this understanding and I return to this subject later in this section. However, for the purposes of a broad description of the tradition and its general approach to interpreting the social world I rely on the work of Schutz.

For Schutz, the natural sciences, their field of study and their methodological approaches were fundamentally different from that of the social sciences. This justified the need for a different methodological approach in order to study 'the meaningful nature of the social world' (Heritage, 1984: 46)

> The world of nature, as explored by the natural scientist, does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist - social reality – has a specific meaning and relevance structure for the human beings living, acting and thinking within it. By a series of common-sense constructs they have pre-selected and pre-interpreted this

> world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their behaviour by motivating it. (Schutz, 1962: 59 quoted in Heritage, 1984: 46)

Interpretivism can also be described as an approach to 'understanding' and therefore places the social actor's point of view at the centre of attempts to understand the social world and their actions within it. Heritage comments of Schutz,

> Schutz insisted that the social world is, in the first instance, experientially interpreted by its members as meaningful and intelligible in terms of social categories and constructs. This did not imply for Schutz that the social world cannot be studied scientifically, but it did indicate the special subject matter and constraints with which a scientific understanding of the social world must come to terms. (Heritage, 1984: 45)

Interpretivism holds that science itself is not objective or based on established 'fact' but is also subject to social and political influences. In this way science is also subject to meaning and intention on the part of the scientist.

The pursuit of understanding as the basis of interpretivism goes beyond the scientific limitations of observing behaviours and characteristics towards 'the interpretation of such behaviours as actions by the imputation of goals, motives, intents, etc.' (Heritage, 1984: 48).

An interpretivist view of society is that it is created by its members. For example, the social constructionist view within the interpretivist paradigm is that people construct the social world between them, through daily interactions in the social world and the sharing of 'versions of knowledge' (Burr, 1995: 4) and through this interaction and sharing our version of how the social world 'is' become constructed.

> Our current accepted ways of understanding the world, is a product not of direct observation of the world, but of the social processes and interactions in which people are constantly engaged with each other. (Burr, 1995: 4).

The social constructionist view, states Burr, is "in opposition to what are referred to as positivism and empiricism in traditional science – the assumption that the nature of the world can be revealed by observation, and that what exists is what we perceive to exist" (Burr, 1995: 3). Burr, like the French Philosopher Foucault (1972; 1976; 1979) also holds the view that knowledge (the way in which we understand the world) is historically and culturally specific.

> The particular forms of knowledge that abound in any culture are therefore artefacts of it, and we should not assume that our ways of understanding are necessarily any better (in terms of being any nearer the truth) than any other ways. (Burr, 1995: 4).

A consequence of this social construction of the world is that the interactions and sharing of versions of knowledge are 'negotiated' between the social actors. It is therefore possible to have numerous outcomes in terms of how the social world has been constructed. This in turn will have consequences for subsequent social action in relation to this social construction. For example, how we view or construct 'mental illness' will have consequences for how we might propose to manage this 'illness'.

My starting point in this research was that 'beliefs, experiences, opinions and perception' form part of the 'reality' of the social world. I also recognised that women with depression may experience their reality differently to their general practitioners and their interpretation and meaning of symptoms may differ according to their common-sense knowledge and beliefs. These in turn might influence their understanding of the management of their experiences and their actions and reactions to the proposed management of their experiences. Hence, understanding the influences surrounding, and the meanings attached to, the experience of depression and its management was the main focus of the patient interviews in this study.

I also understood that general practitioners (within the discipline of general practice) are taught to take account of patients' ideas, concerns and meanings in their management of patients (as part of the 'patient-centred' approach). General practitioners interact with patients in the role of 'medical professional' with specialist knowledge, but also as a person who lives within a similar (although not necessarily the same) social world and who therefore shares much of the same common-sense knowledge as their patients. My purpose was to understand how general practitioners managed these women's experiences (within the context of their own ideas, concerns and meanings) within the context of everyday practice. Thus I was concerned with understanding meaning and its influence on reported action (or reaction or inaction).

3.3 Methodology

The various schools of thought that lie within the interpretivist tradition do not necessarily specify any particular methodology for exploring understanding and meaning of action within the social context. However, the methodological approach should at least be consistent with the world view concerning understanding the nature of the social world (Mason, 1996).

If I were to hold a positivist epistemological perspective and adopt an empiricist approach to the research topic, I might have sought to objectively match or quantify patients views or beliefs to management outcomes, or likewise to have studied (measured) doctors characteristics, doctors perceptions of patients, or practice organisation variables, that influenced their decision making processes. This approach would also have to assume the epistemological position that views, beliefs, characteristics and perceptions can be objectively measured, and that these are static and not context specific. Likewise, this position would have implications for the definition of depression: that it exists as a reality and is not subject to different interpretations or is to be understood in terms of historical or cultural relativism.

However, within the broad ontological position of interpretivism, a methodological approach which seeks to understand how people make sense of their world was seen as appropriate for exploring women's experiences of depression (including the meaning of depression) and their perceptions of its management, and general practitioners' perceptions of depression and their experiences of managing depression. Hence, an approach that would allow these concepts to be explored in a way that allowed the research participants to express their own accounts was required and a qualitative, analytically inductive approach chosen.

In order to explore general practitioners' and patients' interactions in the management of depression two methods could be considered: direct observation; or interviews to elicit personal accounts of meaning and perceptions.

The advantages and disadvantages of the two methods were considered. From direct observation of the interaction between doctors and patients one could study the process within the consultation of how patients presented and how general practitioners responded to this; the explanations that general practitioners offered to patients and how patients reacted to this. Hence it would be possible to see the potential negotiation unfolding and to see each party's response, how agreement was reached and how disagreement was addressed or resolved. However, this method would not allow for insight into the doctors' or patients' perceptions of the process (i.e. what they were thinking in order to act the way they did) and how their previous experiences might influence their actions.

In addition, observation would have practical difficulties. Directly observing consultations (or video recording consultations for indirect observation) would involve attending consecutive surgeries in the hope that patients meeting the selection criteria would attend and at the same time give consent to have their consultation observed. It would be practically impossible to directly observe consultations with new/likely cases of depressive illness unless they disclosed their intention to consult with depressive symptoms in an interview prior to the consultation. Indeed, many patients present in primary care with somatic symptoms and would not associate these symptoms with a depressive illness. Recruiting patients with the aim of observing/recording their next consultation would mean assuming that the consultation is to include a discussion of their depressive illness (rather than attending for a prescription for the contraceptive pill for example or have their blood pressure taken) and may influence the interaction between the doctor and the patient. It is understood within general practice that diagnosing and managing illness often takes place over a series of consultations. In order to capture the whole process one would have to directly observe each interaction. Logistically this would be extremely difficult, time consuming and costly.

It may be argued that this method of direct observation would be more 'objective' in presenting an account of the doctor-patient interaction. However, the 'objectiveness' of direct observation can also be called into question. The consultation itself is still an encounter that is conducted within a social, cultural and historical context. This may lead to participants acting in a way which was 'constructed' in order to present a 'self' that was acceptable to the other. The additional imposition of an observer or a camera may heighten the need to present a self that gives a certain impression to the observer, so the actual observed behaviour is not 'normal' behaviour. Observing or video-recording entire surgeries may reduce the impact on behaviour over time as the GP becomes accustomed to the intervention. However, this would not be the case for the individual patient.

The method of direct observation is not infallible and cannot claim to capture all of 'what actually happened'. In a natural setting, it is difficult to set up a camera in a way that captures the facial expressions and non-verbal behaviour of both participants. Tape recording of consultations would equally miss out on accessing the body language or non-verbal behaviour of participants.

Interacting with individuals through one-to-one interviews to elicit their accounts of the process of care was seen as the preferred method. Whilst this would not afford the opportunity to observe the process in action, it would allow for both doctor and patient to comment on their perception of the process and place this within the context of their own views, beliefs, and family and social circumstances. It would also make it possible to track both doctors' and patients' perceptions of the process of the management of depression over a series of consultations and to follow the patient experience of depression over time.

The same criticisms of validity could be levelled at the data obtained from interviews. Respondents may reveal partial information to create an impression, they may knowingly misrepresent, or block some of the information they could include in their accounts. I have no doubt that in presenting an account of oneself, what one chooses to reveal can be selective. The participants in this study were informed that both doctor and patient accounts were being sought, which may have alerted participants to possible verification of at least some of their accounts. We also conducted follow-up interviews, which would highlight consistency or contradictions within accounts. But beyond these methods I accept that the accounts presented to me represent data which should be seen '*not…simply as true or false reports on reality….[but] as displays of perspectives and moral forms*'(Silverman, 1993). However, the importance of this issue of the status of interview data requires further consideration within this thesis.

3.3.1 The status of interview accounts

The underlying epistemological approach adopted has implications for the way evidence is treated, or the status that we attribute to our evidence.
From a positivist perspective, interview data would be treated as 'fact' or as revealing the truth about the social world. The account would either be true or untrue. From an interpretivist perspective the data are not facts but are 'ways of knowing' that have been constructed within a specific social setting and a specific interaction. Hence the data must be interpreted with close attention to the situation in which they were created. That is not to say that the data do not exist out with the context of the interview. The data are still viewed as reflecting the 'reality' of the experiences of interviewees but the way in which that reality is portrayed will be influenced by the setting and interaction within the research interview. However, even within the interpretivist paradigm, there are challenges to this position and a radical constructionist view would be that there is no reality beyond the interview, and that the data do not reflect the social world. For ethnomethodologists the data that are generated within the interview remain situated narratives. These debates surrounding the epistemological status of interview data must at least be acknowledged within this thesis.

It is possible to take 'the middle route' which 'would suggest that an empirical or 'real world' does exist independently, but that it can only be known and understood interpretively' (Mason, 1996: 140). A similar appeal to the middle ground is made by Hammersley (1992) in promoting 'subtle realism', by Altheide and Johnson (1994) with 'analytic realism', by Bhaskar (1989) with 'critical realism', and by Greenwood (1994) with 'scientific realism'. Seale writes

> The researcher treading this middle way is continually aware of the constructed nature of research, but avoids the wholesale application of constructivism to his or her own practise, which would result in a descent into nihilism (Seale, 1999: 26)

Seale also concludes that 'subtle realism provides a pragmatic philosophical rationale for researchers locating their practice within a constructively self-critical research community' (Seale, 1999: 31).

The critical realist view has been applied to the study of depression and psychological distress by Pilgrim and Bentall (Pilgrim and Bentall, 1999). They argue that the two main epistemological positions relating to psychological distress - medical naturalism ('there exists a real and invariant external world of natural disease entities'. Pilgrim and Bentall reference the work of Hoff (1995) on Kraeplin for this description) and social constructionism (mental illness is socially constituted, it is a product of the work of the mental health professionals) – are unhelpful in offering practical solutions to the conceptual incoherence of current notions of depression. Adopting a critical realist approach 'ensures a proper caution about historical and cultural relativism, without degenerating into the unending relativism and nihilism attending social constructionism' (Pilgrim and Bentall, 1999: 271)

> In a critical realist account it is not *reality* which is deemed to be socially constructed (the axiomatic radical constructionist position), rather it is *our theories of reality* , and the methodological priorities we deploy to investigate it. (Pilgrim and Bentall, 1999: 262)

Some additional perspectives also support the view that the concepts of mental disorder and psychological distress are better understood when we allow for both the existence of a disease entity and for its construction. Lilienfeld and Marino (1995) in their critique of Wakefield's (Wakefield 1992, 1993) "harmful dysfunction" analysis argue that Wakefield's definition of dysfunction as 'the failure of a system to function as designed by natural selection' is flawed on the basis that many important mental and physical systems were not designed directly by evolution to perform a given function and also begs the question as to how the evolutionary response is to be defined? Lilienfeld and Marino see that, because for many systems the range of responses is distributed within the population there tends to be no clear-cut demarcation or threshold which separates abnormal functioning from normal functioning and that Wakefield's definition of dysfunction implies that the diagnostic threshold would be different for different individuals. They conclude that the concept of disorder, including mental disorder, lacks any clear-cut natural counterpart and by extension there is no natural or scientific basis for disorder.

Instead, Lilienfeld and Marino (1995) argue that we should view mental disorder as a Roschian concept (Rosch, 1973). Roschian concepts are 'mental constructions that are typically used to categorise entities in the natural environment', they are characterised by unclear boundaries and an absence of defining features. They are based on an ideal mental prototype that contains all of the features constituting the category. They contain both clear-cut (prototypical) as well as more marginal examples. So schizophrenia and major depression are seen as relatively prototypical examples for most people but other conditions such as personality disorder are relatively marginal examples for most individuals). The controversy as to whether some conditions are disorders or not is not so much the failure to define the disorder but that some conditions lie within the marginal examples or the 'fuzzy boundaries of most individuals' Roschian concepts of disorder. Lilienfeld and Marino conclude that it is impossible to define mental disorder since it is a mental construction with no clearly defined attributes that are amenable to scientific measurement.

> *"From this perspective, controversies regarding the inclusion or exclusion of specific conditions in the DSM result not from a failure to adequately define mental disorder... but rather from a failure to recognise that the question of whether a given condition constitutes a mental disorder cannot be answered by means of scientific criteria."* (Lilienfeld and Marino, 1995:417)

They use the Roschian concept as a way of explaining the persistent debates concering what constitutes a mental disorder. That certain conditions reflect prototypical examples may increase consensus among researchers regarding such conditions and increase the view that a 'real entity' called mental disorder exists. Conversley, the fact that some conditions represent marginal examples may fuel arguments concerning whether they do or do not represent disorder. They suggest that researchers refrain from placing their energies in continuing these debates and instead focus on more scientifically relevant tasks such as the aetiology, assessment, treatment and prevention of psychopathological syndromes.

Hacking (1999) also considers the opposing arguments of those who would view mental disorder as a biochemical, neurological or genetic disorder (a scientific perspective) to those who contend that it is socially constructed. Hacking offers a way in which both sides of the argument can be developed. He introduces the concept of '*an interactive kind*' which arise from the notion that the 'kinds' interact with the classification as they become self-aware of being 'of a kind' and so experience themselves in that way (as opposed to *indifferent kinds* whereby the classification or label makes no difference to the 'kind' e.g. the nuclear physicists 'quark' is indifferent in the sense that calling it a quark makes no difference to it, or the way it behaves). Hacking points out that he is interested in the interaction that occurs in the larger matrix of institutions and practices surrounding the classification rather than individual reactions to classification. Hacking describes the 'looping effect' of human kinds, that a kind becomes aware of how they are classified and the knowledge basis surrounding their classification, and this in turn changes the way they behave which then loops back to force changes in the classification and knowledge about them. Hence, the classifications 'schizophrenic' or 'autistic' and the knowledge of what constitutes such classification becomes known to those so classified which in turn affects their behaviour leading to changes in the classification and knowledge base itself. Hacking offers the example of the changing level of prominence that hallucinations have been given over time in the classification of schizophrenia in demonstrating that they reflect the medical and social attitude of a particular era. He suggests that the behaviours associated with many conditions shift, and sometimes as a result of the behaviours of those so classified. However, this classificatory looping is to be distinguished from biolooping (an analogy with biofeedback) where how one responds to illness or interacts with it can affect the outcome of the condition itself.

Hacking sees the constructionist argument as too much of a 'one-way street' (society constructs the disorder, so it does not really exist and would not exist if society had not constructed or described it) and his notion of an 'interactive kind' reflects that it is 'a two-way street'. He also argues that many kinds of mental illness are both interactive kinds and indifferent kinds (indifferent in the sense that the biological or genetic kind remains unaffected by what we know about it) but in the looping effect the interactive kind may be affected by the knowledge or classification resulting from the indifferent kind. Hacking sees the dynamics of classification as being more significant than the semantics.

In conclusion, while Lilienfeld and Marino argue that the question of what constitutes a mental disorder cannot be answered by scientific criteria and we should view it as a Roschian concept, Hacking theorises that what constitutes a mental disorder is not so much the scientific criteria themselves (and that to some point these can be useful tools) but the interactions that 'kinds' (those so classified) have with what is classified and how the classification itself can be modified and replaced. I do not attempt to favour either of these positions for this thesis but to merely extend the argument that the social constructionist one-way street limits our potential understanding of mental disorder and from conducting much needed research to reduce the harm and suffering that the symptoms of mental disorders create for those who experience them.

Within an interpretivist view it is also acknowledged that we cannot access another individuals 'real' experiences. Rather, we all share 'learned common-sense constructs to actions, events and their contexts' (Heritage on Schutz (Heritage, 1984: 49). Schutz recognised that although we cannot share the real experiences and the meanings that others ascribe to their actions that 'in spite of all these inadequacies, common-sense knowledge of everyday life is sufficient for coming to terms with fellow-men, cultural objects, social institutions – in brief, with social reality' (Schutz, 1962: 55, quoted in Heritage, 1984: 49).

Hence, the data that have been generated within this study are presented as reflecting the reality of these women's lives and the general practitioners everyday experiences in managing depression as they perceived them at that time. This is similar to Schreiber's view (Schreiber, 1996) on the matter. Schreiber interviewed women who had identified themselves as having recovered from depression and used interview data to understand the depression experience. Acknowledging that these were retrospective accounts she refutes that this invalidates her data as reflecting the 'depression experience' and states

> there is merit in hearing women's understandings of the people they were at the time (Schreiber, 1996: 474)

However, I also recognise that these data are also the product of the interview itself and that these accounts have been constructed to present a version of the truth for me, the interviewer. In this respect a realist approach

> ...maintains a view of language both as constructing new worlds and as referring to a world outside the text, a means of communicating past experiences as well as imagining new experiences (Seale, 1999: 15)

3.3.2 The case for methodological pluralism

I do not intend to make the point that my preferred methodological approach to this subject is the only way to conduct research in this field. Indeed it can be unproductive to remain locked into one paradigmatic or epistemological view and many others have recognised this and called for more flexible and pragmatic approaches (Seale, 1999; Patton, 1990) and methodological pluralism (Williams, 2000; Roth and Rohatyn, 1991; Johnson, Long, and White, 2001).

> Routine ways of thinking and paradigmatic blinders constrain methodological flexibility and creativity by locking researchers into unconscious patterns of perception and behaviour that disguise the biased, predetermined nature of their methods "decisions".(Patton, 1990: 38)

Patton emphasises the importance of understanding alternative research paradigms as it will,

> Sensitize researchers and evaluators to the ways in which their methodological prejudices, derived from their disciplinary socialisation experiences, may reduce their methodological flexibility and adaptability (Patton, 1990: 38)

Patten advocates pragmatism and for a paradigm of choices which 'rejects methodological orthodoxy in favour of methodological appropriateness as the primary criterion for judging methodological quality' (Patton, 1990: 39). Within this perspective, in order to explore women's and doctor's experiences, understanding and perceptions, a qualitative approach was seen as being methodologically appropriate.

In addition to debates surrounding the choice of methodologies and their compatibility with philosophical traditions there are also challenges to the way in which methodologies are applied. Mixing methods or 'method slurring' (Baker, Wuest, and Stern, 1992) will result in research that is not rigorous and is even claimed as 'sloppy' by others (Morse and Johnson, 1991). These criticisms are also levelled at research which does not strictly adhere to the methodology they claim to utilise (Baker, Wuest, and Stern, 1992). However, Johnson et al (2001) in their call for pluralism in research methods reject the claims that any method is ever applied in a 'pure' sense – 'There are no pure qualitative methods'. They call for greater reflexivity and a critical attitude, drawing upon Pierre Bourdieu's interpretation of reflexivity when they state 'the methods and theory of both oneself and one's colleagues should be subjected to constructive criticism' (Johnson, Long and White, 2001: 248).

> Fundamental to this position is the view, to us self evident from any interpretive, interactionist, social constructionist or hermeneutic perspective, that there are no 'real' natural laws concerning socially derived knowledge and therefore no possibility for a 'pure' method for the social or interpersonal sciences' (Johnson, Long and White, 2001: 249).

The context within which I embarked on the qualitative study (upon which this thesis is based) restricted, to some extent, my ability to adhere to any form of methodological purism. In applying for funding issues of sampling and design had to be set out in advance and the adherence to a timeframe restricted the ability of the project to conduct, for example, theoretical sampling. Responsibilities to the funding body also led to a more structured approach to data collection than is perhaps desirable in qualitative research. Within these constraints I have had to be pragmatic and flexible in my approach. Nonetheless, I have also endeavoured to be reflexive, and rigorous in my approach to data collection and analysis.

In order to access the women's and GPs experiences, understandings and perceptions I chose to conduct semi-structured in-depth interviews using open ended questions. The development and use of interview schedules and topic guides are described later in this chapter.

3.4 The background and aims of the main study

The empirical research on which this thesis is based was funded by the Chief Scientist Office of the Scottish Executive Health Department. The rationale for the study was summarised as follows:

> Some 5% of the population suffer from major depression, a further 5% experience milder symptoms and an additional 10% experience some depressive symptoms. The majority of people who receive professional help are managed in primary care. Quantitative research on the management of depression has focussed on general practitioners' management in clinical areas of detection, prescription of medications and referral. Questions remain about why clinical knowledge is not implemented in practice. The patients' perspective on general practitioner care and the patients' active contribution to the negotiation of care have been neglected. The current project aims to explore in-depth both patients' and general practitioners' perceptions of the management of depression and the process of negotiation.

The development of a funding application requires the proposed research to be specific in its focus and its aims as well as its size and time-scale. This has had implications for the methods that have had to be employed in conducting and analysing this piece of empirical work. I shall comment on these in turn in the forthcoming sections.

The stated aims of the funded study determined the focus for the data to be collected. These aims were as follows:

> ***Overall***
>
> To investigate general practitioners' and patients' perceptions of the management of depression and how these are negotiated in practice.
>
> ***Specific aims***
>
> - to explore general practitioners' views on the definition and detection of depression and their negotiation of this with patients

- to explore general practitioners' perceptions of problems in the management of depression and their therapeutic decisions
- to explore general practitioners' views and experiences of the process of managing depression in general and in relation to specific patients
- to explore the patients' experience of depression and the negotiation of the illness label
- to explore the patients' views and experiences of the management of their illness and relate this in the wider context of their views on mental health and the context of their daily lives
- to directly compare patients' accounts of their care with those of their general practitioner in order to explore similarities and differences in meaning and interpretation of the process
- to detail aspects of the organisational context of general practice which influence patient care

To this end we sought to recruit 20 general practitioners and to recruit 2 of the female patients of each of these general practitioners. Within the sample of women we wanted to include a range of depression experience and also wanted to capture the process of initially deciding that something was wrong and deciding to seek help. Therefore the two women to be sampled from each general practitioner were to include: one patient with previous experience of depression; and one patient with new/likely depression (newly experienced within the last three months).

Two interviews were conducted with both general practitioners and patients. Patients were interviewed at the point of recruitment and approximately 9-12 months later. General practitioners were interviewed as soon as could be arranged after both patient interviews had been conducted. The second round of interviews were included to allow for follow-up of the care experience from both general practitioner and patient perspectives.

At the time of applying for this research grant, recent research within my own department had made extensive use of practices in the immediate environ. In order to reduce the burden on inner-city practices surrounding academic departments of general practice and to increase the likelihood of recruiting practices from less research active areas we decided to recruit within non-inner city urban areas with medium to high levels of deprivation. This would still afford a high degree of applicability of the research findings to urban areas across Scotland where the majority of the population are to be found. We recognised that the experiences of women living in rural areas might be markedly different from the urban experience (because of cultural and lifestyle differences and differences in access to healthcare services) and decided that it was not within the scope of this project (and its size) to address this population. This work should be undertaken within additional research projects.

Similarly, we did not attempt to include the experiences of women from different minority ethnic backgrounds within this study. Again, we believe that this requires detailed research in its own right to do justice to the experiences of these women. We did not want include a few 'token' interviews and claim to have included the views of ethnic minorities in our study. However, neither did we use ethnicity as a criterion for exclusion. We gave general practitioners no instructions in relation to which women to recruit other than the minimum criteria detailed below. We did not in the end recruit any women of minority ethnic origin. This would justify our initial thoughts that any studies seeking access to ethnic minority populations would require to develop specific methods of recruitment in Scotland.

This study also focused on women because men's experience of depression was also thought to be potentially markedly different from that of women. There were also practical reasons for not including men within this study sample. Evidence suggested that women present more frequently in general practice with mental disorders, including depression, than men[4].

Random sampling would have produced a sample containing male and female patients in their 'natural' proportions and would reflect the workload of general practitioners. Taking this approach, meaningful analysis of gender differences would not have been possible as the number of male patients would be very low. To adopt a stratified random sampling approach in order to recruit equal numbers of male and female patients would have allowed gender comparisons but would have raised practical difficulties because of the length of time it would take to recruit male patients. It would also not be compatible with the natural pattern of general practitioners work. To base the study on a gender comparison of the experience of depression and its management would also have shifted the focus of the study itself. It would not have been possible within the limitations of funding to pursue exploring the experiences of both men and women representing a broad range of depression experiences. We felt that men's experiences of depression in the context of primary care required to be researched in its own right.

One further point of note is that we did not set out to define depression for use in this study. This would have been to adopt a positivist or scientific or medical naturalist position that depression could be defined and measured and that we were only interested in the experiences of depression that fitted with our criteria. As commented by Stoppard:

> One consequence of this methodological stance, however, is that the phenomenon being studied, in this case depression, is assumed to be adequately represented by the way it is measured. In a sense, the measure itself becomes the phenomenon (Stoppard, 2000: 15)

Following our critical realist perspective we held that we did not want to rely on a medical definition of the condition (which may also limit the naturalistic approach of detection and diagnosis from general practitioners) nor did we want to deny the very real nature of depressive illnesses. Therefore we adopted a 'naturalistic' approach that reflected the real world of the general practitioner in defining and detecting depression.

The research team consisted of three grant applicants (including myself, a professor of general practice and another social scientist). I was the only grant applicant employed on the project but was aided by another part-time researcher who conducted approximately half of the first round of interviews. This researcher left the project at the beginning of the second round of interviews and was replaced by another part-

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[4] At the time this study was being proposed the available data in support of this statement came from

time researcher who completed the second round of these interviews. I completed both the first and second round of interviews for half of the women in this study.

3.4.1 Recruitment of participants

Pilot study

An initial pilot study was carried out to determine the suitability and feasibility of the methods for recruiting patients (July- August and November-December 1998). Three general practitioners and 3 patients were recruited in Lothian, and 2 general practitioners and 2 patients from Glasgow. General practitioners were recruited using personal contacts and they were asked to approach one female patient with either previous experience of depression or new or likely experience of depression (presenting within the last three months). Patients were recruited within one to two weeks of the request. Three patients represented those with new/likely experience of depression and two had previous experience of depression. In Lothian, the general practitioners interviewed were: an honorary member of the Department who worked in an area of high deprivation; a general practitioner who was a personal friend of another of the grant holders; and a general practitioner who had previously been interviewed by myself in relation to patients with mental health problems and was therefore known to have an interest in mental health in primary care. The two general practitioners in Glasgow were also known by the researcher from their previous role as a social worker and as a researcher in the area. The interviews were conducted using a pilot version of the interview schedule being developed for the main study (its development is described more fully below). The broad aims of the interviews were: to explore patients' experiences of depressive illness, from the point of them initially realising that something was wrong through to their decision to seek help; their perceptions of the process of care from their general practitioner; their perceptions of the role of the general practitioner; and their perceptions of their relationship with their general practitioner. General practitioners interviews focused on how they identified depression in patients, the problems in managing depression, their general approaches to the management of depression and their management of the specific patient they recruited to the pilot study.

Morbidity Statistics for General Practice 4th national Study 1991-1992. OPCS Series MB5 No.3.

Recruitment to the main study

On the basis of the feasibility study and on experience of previous research projects, it was initially anticipated that six practices would require to be recruited to achieve the sample of 20 general practitioners and 40 patients (each participating general practitioner recruiting two patients). The criteria for sampling practices were that they be non-inner city urban practices with medium to high levels of deprivation[5]. It was originally intended to base the study within one Health Board region (Fife).

There were considerable problems and delays in the recruitment of general practitioners and patients. An initial letter of introduction, including the research protocol, was sent to each of 10 main partners in practices that had been sampled for recruitment to the study. This letter indicated that the researcher would call soon to discuss any potential interest in participating in the research and also suggested that this could involve a visit to the practice to discuss the research more broadly among colleagues at a regular practice meeting. Two practices immediately wrote back declining to participate.

From an initial approach to 10 eligible practices in Fife (October 1998) only two practices and eight general practitioners agreed to participate. A further 6 eligible practices in Fife were approached but only one agreed to participate. Two general practitioners were recruited from this practice. As a result of this poor response and recognition that the remaining practices in Fife, which met the sampling criteria, were unlikely to yield sufficient numbers of participants, it was decided to extend the fieldwork. The area (Argyll and Clyde) was chosen as it contained towns similar in size to those in Fife. It was also more practical for the other researcher to operate fieldwork on the West Coast of Scotland closer to her home. After an initial approach to eligible practices in Argyll and Clyde, the poor response prompted further extensions of the fieldwork sites to include Lanarkshire and West Lothian. The

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[5] Those practices who received high deprivation payments for more than 2% of their patients were categorised as high deprivation practices; those who received medium deprivation payments for more than 2% of their patients and who did not have more than 2% of their patients in the highly deprived category were placed in the medium deprivation category; and those practices who received low deprivation payments for more than 2% of their patients but did not have more than 2% receiving high deprivation payments or medium deprivation payments were classified in the low deprivation category.

extension of the study to different Health Board areas required ethical approval to be obtained in all study areas, leading to further delays in the research. Table 3. summarises the numbers of participants recruited from each area.

Table 3.Recruitment of participants

Health board area	Practices approached	Practices recruited	General practitioners recruited	General practitioners interviewed	Patients recruited	Patients Interviewed	Follow-up GP Interviews	Follow-up patient interviews
Fife	16	3	10	6	11	10	6	8
West Lothian	4	3	6	3	6	5	3	4
Argyll and Clyde	13	3	7	7	14	14	7	11
Lanarkshire	22	2	4	4	8	8	3	7
Total	55	11	27	20	38	37	19	30

During the recruitment phase most practices in Scotland were involved in implementing organisational changes taking place within primary care, namely, the development of Primary Care Trusts (PCTs) and Local Health Care Cooperatives (LHCCs). Three of the practices who had declined to participate directly reported to us that the additional burden of preparing for these changes was the main reason for their reluctance to commit to any research during this time. In the latter stages of recruitment a range of strategies to encourage participation in the study were used: including networking through contacts in Public Health and General Practice; attendance at LHCC meetings; seeking the advice of practices who had agreed to participate about other potential participants; and the advice of general practitioner colleagues.

3.4.2 The general practitioner sample

The General Practitioner interviews were conducted within their surgery premises (with the exception of one first round interview). The first round interviews lasted approximately one hour and the second round interviews were more varied from approximately half an hour to one hour. The interviewers were generally more sensitive to time pressures when conducting interviews with general practitioners than with patients and were anxious not to exceed the negotiated time allocation.

The sample of general practitioners contained equal numbers of male and female GPs with 7 (35%) aged between 30-40 years, 10 (50%) aged between 40-50, and 3(15%) aged 50-60 years. Two general practitioners reported having a specific interest in depression, and one of these had participated in developing local guidelines for the management of depression. Two general practitioners reported that they were interested in stress/anxiety management, both having recently attended a short introductory training course. One GP reported having a certificate in Counselling but was specifically interested in psychosexual counselling and was undertaking training in this. One general practitioner was active in post-graduate teaching, which included some psychiatry. One GP had spent a year as a Registrar in Psychiatry. For the remainder of general practitioners, their experience of psychiatric medicine was mainly limited to 6 months as a registrar or they did not specify any prior training in psychiatric medicine. Two general practitioners reported personal experience of depression (one of whom had reported a special interest in depression).

It is not known whether this sample is representative of the general practitioner population. The age and sex mix of the general practitioners ensured a reasonable sample to be able to comment if any age/sex trends emerged from the analysis. There is a strong possibility that the general practitioners, that volunteered to participate in this study, were generally more interested in mental health (or depression) issues or felt more confident in their management of depression. However, only two reported having a special interest in depression and only five (including the post-graduate teacher) reported having any specific knowledge or training beyond the standard six months as a registrar. Whilst the majority of patients in this study presented their general practitioner as 'listening' to their problems and generally attributed a therapeutic role to their GP, it is not known whether these GPs represented a more patient-centred or holistic group of doctors.

There were no age or sex differences identified in relation to general practitioners' perceptions of depression or their perceptions of the management of depression in this dataset. This finding might be explained as a factor of the homogeneity of the volunteer general practitioners – that they were indeed relatively similar in their interest in depression and their therapeutic/patient-centred consulting style.

3.4.3 The patient sample

The GPs recruited to the study were given a start date from which to commence the recruitment of two patients. From this start date, the first two patients that the general practitioner identified as having depression or deemed likely to have depression and whom they were or intended to manage as depression were to be approached and introduced to the study. This method would avoid any GP selection of 'suitable' candidates and provide a 'random' selection of recruits within each of the two main patient groups. The term 'random' is being used in the sense that they happened by chance to be the first patient that the general practitioner had seen who fulfilled the selection criteria. The exclusion criteria that general practitioners were given applied to women with: psychotic illness; serious current problems of alcohol or drug abuse; or known to be at risk of serious suicidal intent. Patients who declined to take part were to be replaced by other eligible female patients approached in sequential order until one female patient from each group had been recruited.

General practitioners were asked to introduce the women to the study and to request their permission to pass on contact details to the researcher. General practitioners were supplied with copies of letters that introduced the researcher and the research project and explained that the general practitioner was taking part in a study into how general practitioners manage patients with a range of problems. In recognition that the diagnosis may still be under sensitive negotiation between the general practitioner and the female patient we sought to ensure that communication about the study (whether verbal or written) did not give or confirm a diagnosis of depression to patients, nor commit general practitioners to a diagnosis. The study was thus presented to general practitioners as being about depression or 'likely' depression as indicated by the experience of emotional distress and symptoms of low mood. It was presented to the women as a study about how general practitioners manage patients who present with a range of symptoms including: low mood or feeling down; emotional difficulties; problems with sleeping or concentration; problems of tiredness; or generally finding it difficult to cope with their symptoms or other problems. The women then initially consented to having their contact details passed on to the researcher, but also received a pre-paid envelope and a tear off slip if they wanted to subsequently decline to participate without having to inform their general practitioner of this decision. This was important for patients who may not wish to take part but did not want to express this wish to their general practitioner. General practitioners then forwarded patient contact details to the researcher. The researcher then contacted the patient approximately 5-7 days later, normally via telephone. This delay was to allow for receipt of tear off slips indicating that patients wished to decline to participate. No patients subsequently used the tear off slips to decline to participate.

The researcher briefly explained the purpose and the methods of the study to the patient over the phone and asked if the patient would be willing to agree to participate in an initial and follow-up interview. Suitable dates and times for interview were then arranged. Of the patients who had been recruited by their GPs, only one subsequently declined to participate when initially contacted by the researcher.

The recruitment of patients to the study was problematic and led to substantial delays in conducting the fieldwork. It took up to nine months for some general practitioners to recruit patients and some general practitioners subsequently withdrew from the study because they had not engaged in recruiting any patients.

Given the evidence on the prevalence of depressive symptoms, particularly among women, and the evidence that it is one of the most common presentations in general practice, it was easy to see why we did not anticipate that finding patient recruits would be a problem. We attempted to discuss the problems of recruiting patients with the participating general practitioners. For the most part general practitioners reported that they 'just forgotten' to recruit patients (despite several reminders). In the day-to-day running of their surgeries GPs did not always keep the information about the study to hand and they often forgot to recruit suitable patients.

In other instances it became clear that many doctors found it uncomfortable to approach patients about the study and were 'ruling out' many potential candidates. One general practitioner offered an explanation during their interview. This was based upon the importance of 'knowing' the patient and having established a relationship with the patient that made approaching the subject of recruitment easier.

> "…and I thought that, the kind of person she was, she would be quite receptive to taking part in something like this. And I also knew her fairly well then, because I'd seen her a lot, so it was easy to sort of say, you know "We're doing this, do you feel that you would want to take part?"….I think that's why it's difficult to pick up new people, because we don't have much of a relationship with them." (F03)

In order to remove some of the burden of approaching and explaining the study to potential candidates, we produced a leaflet explaining the study and asking patients to contact the researchers if they were willing to participate. This meant that general practitioners could have the option of letting the leaflet 'do the talking' for them. By this stage we were several months into the project, and the production of leaflets did not seem to impact upon those GPs who were unable or reluctant to recruit patients. Most GPs reported that they did not give them out to potential candidates but handed one to the patient that they had already decided was suitable as extra information. No patients ever contacted the researchers of their own accord after receiving this leaflet.

In order to address the problems of recruitment the study expanded to other potential areas until sufficient numbers of general practitioners and patients had been recruited. The study also received additional funding to extend the length of the study period to cover the loss of time incurred in recruiting respondents.

We have no way of knowing how 'selective' GPs were in their recruitment of patients, despite our attempts to make this process 'unbiased'. We also have no idea how many patients declined to participate in the first instance (i.e. declined to have their contact details released to the researcher). When asked about problems with recruitment, GPs described their own difficulties in approaching patients rather than reporting patients declining to participate as the problem.

The patient sample

Patients' ages ranged from 19 to 72 years (mean age of 40 years). Seven patients (19%) were single, 22 (59%) were married or cohabiting, 6 (16%) were divorced or separated, and 2 (6%) were widowed. Just over half the sample (54%) were employed either full-time or part-time. There were 5 cases in this study who presented with depressive symptoms post-natally. However, the diagnosis of 'post-natal' depression was not always confirmed by the GP and was sometimes contested by the patient. A brief summary of each of the women who took part in this study is provided in Appendix A.

3.5 Ethical considerations

Did patients feel pressured into participating? I can only rely on my own impressions of the patients' willingness to participate and what they told me during the interview. The majority of the women appeared very keen to speak to me, and I have considered some explanations for this. Although they had received written information on the study and it had been explained over the telephone that this was a research study and that I was not a medical professional, some women were still under the impression that talking to me was going to do them some good. I would doubt whether their GP had intentionally given them this impression but some patients had taken the doctor's 'suggestion that they speak to me' as indicative of some kind of therapeutic value. I was always quick to clarify my position as 'just a researcher'. In most instances, I think the women valued the chance to 'tell their story'. This might have been because it was a 'new' and perhaps confusing experience to them. For women with previous or long-term experience it was a chance to talk about their experiences of their illness and its care. Some women mentioned that they had agreed to take part because of their relationship with their GP whereby they felt that it was doing the GP a favour to agree. They did not say to me that a refusal would jeopardise the relationship.

At the end of each interview I thanked the women for their valuable help and for the time they had given to me. Many women reported that they had found the interview experience enjoyable and a few even said they found it helpful as it had made them 'think about things'. There were three women for whom I did not obtain a follow-up interview. One directly declined when I called her, saying that her circumstances had changed, she had a new partner and a new life and it would not be convenient to have me visit. Her GP, unprompted, later confirmed this information. Two others could not be contacted via their previous telephone numbers, which were unobtainable. Nowadays, many people have resorted to only having a mobile telephone and practice records are not always updated with this information. This explanation was offered by these women's GPs. The practice verified that they did not have notification of a change of address. However, these women did not respond to a follow-up letter requesting that they contact me to discuss a second interview. The general practitioner of one of these two women also reported that the woman had met a new partner, was off medication and had not discussed her depressive illness with her GP for several months. In the second case, the GP reported that the patient had seemed very keen to speak to me again and could offer no explanation as to why she had not contacted me. Given that two patients had likely been lost to follow-up because of their changing personal circumstances and a desire to mark an end to their depressive episode, I decided it was best not to pursue the third patient with a further follow-up letter. The GP follow-up interviews still discussed each of these cases.

The women in this study were given at least three opportunities to decline to participate in this study: with their general practitioner, using the tear off slip; during the first telephone contact with the researcher and before commencing the interview. At each contact with the researcher the purpose of the research was explained and the opportunity to ask questions or have further explanation provided was given. Verbal consent was obtained to having the interview tape recorded, transcribed and analysed for the purposes of the research. It was explained to the women that they did not have to answer questions they did not want to or speak about things they did not want to and that at any point they could terminate the interview or have the tape recorder switched off. If a woman became upset during the interview the offer to stop the interview at this point was repeated usually saying "We can stop if you like or we can have a break or we can come back to this at a later date". No interviews were terminated by the women. Some women did become upset and cried but all indicated that they were alright to continue with the interview (sometimes this was after a short break to make a cup of tea or to have a cigarette).

The procedures for confidentiality and anonymity in handling their interview tapes and transcripts was explained to the women. Each tape was allocated an individual code number and this was applied to the transcript. Only the interviewer was able to link the code to the individual. The other part-time interviewers (one in round one and one in round two) were only able to link their own interviews to the codes. I was the only researcher to have access to all codes and patient data. The tapes and transcripts have been kept in a secure office. The women's names and addresses have also been kept secure in a password protected database. All reporting of the data has either used the anonymised code or, as presented in this thesis, using first names that have been changed from the original.

I describe below in the section on 'the interview as a product of social interaction' (3.7.1) how I felt it important to develop a degree of rapport with these women in order to access emotional accounts. In this sense I have to acknowledge my own strategic behaviour in seeking to develop 'a relationship' (albeit brief) with these women in order that I could gain access to private issues. During the interviews I also had to consider whether I was letting them tell me things I didn't need to know. It was difficult in these circumstances to draw the line since I was interested in hearing about the problems that they attributed to their illness, however far back in their past. However, there were times when patients hinted at problems or family issues and unless they were willing to disclose the nature of these to me I did not probe (it was sufficient that they had conveyed that there were issues within the home or family that were causing them some degree of stress or worry).

If in the course of conducting these interviews, we came across something which concerned us or we were sufficiently concerned for the safety of the woman or other family members, then we had approval from the local ethics committees to do something about this. We carried consent forms that could be signed by the women to allow us to approach someone on their behalf (e.g. their general practitioner, a CPN, social worker etc.). We also had approval from the ethics committee to report our concerns to their general practitioner even if we did not have consent. This would have been for use in extreme circumstances and these measures were never employed.

3.6 Development of interview schedules

The format of the interviews was to allow patients to describe their experience of: recognising that something was wrong; deciding to seek help; their expectations and perceptions of their management (particularly of medication and referrals); their relationship with and the role of their GP; and their expectations of outcome. The term 'depression' was only used in interviews if patients described their condition in this way. Other terms such as 'emotional problems', 'difficulty sleeping', 'stress and anxiety' were used as the interviewers remained sensitive to the possible on-going 'negotiation' of the diagnosis between the patient and their general practitioner. General practitioner interviews were also conducted in a format that allowed them to describe their experiences of managing depression, how they recognised that something was wrong and made sense of this as depression and how they managed depression (in general and in the two female patients sampled). Semi-structured interview guides using open-ended questions were developed (see Appendix B) but in the end these only served as checklists or prompts to ensure coverage of topics. All interviews were audio-taped and transcribed verbatim.

The initial interview schedules for use in the pilot study were drafted by myself using knowledge from having previously interviewed patients with a range of mental health problems (including depression) and from a previous study exploring GPs' and patients' perceptions of the management of chronic pain (which one of the other co-grantholders had conducted). The aims of the research were also adhered to in order that the data obtained would be able to meet the requirements of the funded project. The interview schedules were further refined in discussions with the research team and after pilot interviews had been conducted. The schedules were intended as guides with prompts and were also seen as a tool that could be available in the event that several interviewers might be involved in data collection. This would provide them with a clear idea of the topics to pursue. In the end only one other interviewer and my self were involved in conducting the first round of interviews. After some initial interviews, we felt confident that we knew the broad areas to pursue, and subsequently we both used brief topic guides (see Appendix C).

In conducting the second round of interviews, only very brief topic guides were drawn up (see Appendix D). The purpose of the patient interviews was to follow the women's experience of the depressive episode and their experience of its management (to fill in the story as to what had happened to the patient in the intervening 9-12 months); to explore their subsequent views on their problems; to explore their subsequent views on antidepressant medication and elicit details and explanations of their medication use; to discuss any insight they may have gained on their problems and how they managed their problems. The purpose of the second interviews with general practitioners was to follow-up the general practitioners' experiences of managing these women and the decisions they had made regarding their management, any further insights they may have gained in relation to their patients, any problems or difficulties they had experienced in managing the women, and their on-going relationship with these women.

All interview transcripts were read, just prior to conducting the second interview, so that the interviewer would be familiar with what respondents had previously said (their circumstances, concerns, ideas and explanations) and would therefore be more aware of any significant changes.

3.7 Conduct of Interviews

In reality, both GP and patient interviews were semi-structured. However, the GP interviews were relatively more consistent in the ordering of the discussion because time was more limited and it was easier to ensure that all the topics were covered if the interviewer kept the discussions more focussed and directed. Doctors were initially informed that interviews would last approximately 45 minutes to one hour. This is a fairly large portion of a doctor's time, which was being given freely, and it was seen as important not to exceed this time limit, particularly since we were seeking a follow-up interview. Within the patient interviews, the patient was encouraged to tell their story. Hence, questions could not always be asked in a standard manner or in the same order since the patient directed the flow of the discussion. Both I and the other interviewers talked about having to adapt our approach. However, these regular discussions of conducting the interviews, and what and how avenues could or should be explored, increased the likelihood that the coverage of topics of interest to the research field was consistent. Occasionally, the interviewer had to re-direct the discussion in order to ensure that the main topics were covered in a reasonable amount of time. Most patient interviews lasted about one to two hours. In some instances I took more control over the interview in order to keep to a reasonable time. This would occur if the interviewee had a small child to look after or if the interviewee had indicated that they had other engagements.

Interviews were tape-recorded in all instances. This method was seen as the best way of being able to accurately record the stories and perceptions of both doctors and patients. Indeed, the initial 'microanalysis' that Strauss and Corbin suggest 'is necessary at the beginning of a project to generate initial categories' (Strauss and Corbin, 1998: 57) or the development of Seale's 'low inference descriptors' (Seale, 1999: 148) is better served if the researcher has access to the language used by the interviewee. This I believe, will reduce (although it cannot entirely remove) the effect of 'the interplay that takes place between data and researcher in both gathering and analyzing data'(Strauss and Corbin, 1998: 58). To take notes during the interview would have undoubtedly resulted in selecting some statements for inclusion at the expense of others. It would have disrupted the flow of the interview and I believe would have made interviewees more aware that their statements were being noted. If breaks in note taking were observed, they might perceive that we were more interested in some aspects of their story more than others. This might either result in unwittingly directing the focus of their talk, or more seriously, in their eyes belittling issues which they perceived to be important.

Before each first interview commenced interviewers were instructed to explain how we would ensure confidentiality and the procedure for handling tapes. No participant refused to allow their interviews to be tape-recorded. It was also stressed that the general practitioner would not have access to any of the information obtained during the interview and that data used in any reports or papers would be presented anonymously.

The majority of patient interviews were conducted in their homes with a few exceptions being conducted in a private room provided by the practice. Although it was seen as preferable to conduct interviews in the homes of patients to allow them to feel more comfortable 'on their own territory', it was also seen as important to offer an alternative in case other family members were unaware of the patient's condition or family circumstances would make it difficult for them to openly discuss their perceptions of problems.

I had to conduct two interviews with other family members present. In one case, a very supportive spouse was present (to help look after a very young baby). I believe the presence of the husband did not have a detrimental effect on the information I obtained, and may indeed have enhanced it. In the other case, a mother (who also suffered from mental health problems) was present with her daughter and was quite disruptive to the interview. The mother wanted her daughter to focus on a particular family bereavement, and kept telling the daughter to tell me all about it. The mother was also keen that I heard about her own problems and experiences. This interview was the longest one that I conducted (over two hours). I continually tried to re-focus the interview upon the daughter and the issues within the topic guide with only some degree of success. This young woman did not respond to my letter to request a second interview, despite indicating to her general practitioner that she was keen to speak to me again. The other interviewers did not report any other's being present during interviews beyond pre-school children.

3.7.1 The interview as a product of social interaction.

It is inevitable that the information obtained during the interviews will itself be a product of the social interaction between the researcher and the interviewee and respondents will provide an account of themselves that they think the interviewer ought to hear. There may be attempts to justify their position and offer rationales for behaviour. An account of the researcher as an active participant in the generation of data must be given. I was, I think, fortunate not to have been medically qualified since this helped patients to see me as a 'lay person' and to put them in the position of holding 'expert' knowledge. When the women expressed that they felt unsure if what they were telling me was relevant or 'of use' I reassured them that what they had to say was 'really helpful' or 'interesting' to someone in my position and that it was their experiences which counted.

Preparing for qualitative interviewing involves 'preparing for the social interaction' and 'intellectual preparation' (Mason, 1996: 47). Therefore how an interviewer presents themselves and how they will respond to issues arising in the interview (to encourage the interviewee to 'tell their story' whilst maintaining the relevance of the discussion to the interview topics) should be thought out in advance. Whilst it is important to appear impartial to statements and to maintain some degree of objectiveness within the interview, I believe there also has to be the development of rapport with the interviewee. I was not comfortable with remaining distant and aloof whilst I expected the women to reveal intimate details of their lives and to witness, at times, the emotional impact that their current situation was having upon them. Here I adopted a position that closely relates to the 'emotionalist' perspective (Silverman, 2001:90). An emotionalist interviewer is concerned with the 'lived experience' of the interviewees and recognise their 'emotions' as central to this experience in gaining an 'authentic' account of their experiences. Emotionalists would encourage emotional involvement with respondents and for interviewers to convey their own feelings to respondents and readers. There are varying opinions as to the extent to which an emotionalist portrays themselves as a 'peer' or 'companion' (Reason and Rowan, 1981: 205) to the interviewee. I did not fool myself into thinking I was either a peer or companion to these women in the brief amount of time that I spent with them. Our interactional roles could not be 'equal' however much we found we had in common. There would also be a degree of self presentation in the interview on both sides. I have already discussed the interpretivist debates concerning the status of interview accounts and therefore within a general emotionalist approach it must also be recognised that we may not entirely access the authentic reality of interviewees lives, particularly when attempting to access private and emotional accounts or when discussing sensitive issues.

However, I believed that in order to increase the possibility of accessing the emotional experiences of these women it was important to develop a degree of trust with the respondents before commencing the interview. If people are being asked to disclose personal information about themselves, I believe they will feel more comfortable doing so with someone they feel they have something in common with. It was therefore important for me to give a little personal information about myself. For example, commenting that I had a young child myself, when the interviewee had their own child present, or if they mentioned or had lots of photographs around of grandchildren. A brief chat about motherhood was a great way to establish rapport with most women. Indeed, when conducting many of the second round interviews I was pregnant with my second child and it immediately became a focus for friendly discussion. In two other cases, I found out quite quickly that they were attempting studies and I could chat briefly about what they were doing and empathise with them. There was always some focus for discussion, even if some were more personally oriented than others (e.g. discussing my journey and my attempt to find their home). I am sure this approach helped to convey on myself a 'non-professional' role and to remove the potential to be seen as conducting medical surveillance.

It has been suggested that people can produce both 'public and 'private' accounts of themselves (Cornwell, 1984: 11-17) and that it can be difficult to ascertain which type of account has been given. Britten (1996) discussed Cornwell's theory in relation to a qualitative study involving one-off interviews (as opposed to conducting months of ethnographic work which may have enabled Cornwell to develop a relationship with respondents that facilitated discussion of their 'private' lives) and concludes:

> It was not possible to determine whether each interview did in fact have both a public and private account, nor to conclude that one or the other type of account came closer to what people "really" believed. It therefore seemed appropriate to use a different terminology that did not imply that there were layers of reality such that behind each public account lay a private account" (Britten, 1996)

Britten labelled her accounts as "orthodox" and "unorthodox" primarily on the basis of the content of the interviews but the interview process could also be included. Orthodox accounts were established mainly on the basis of the presence of 'medical legitimation' (medical opinion justified all or most of their actions and beliefs) and the absence of 'self-legitimation' (statements such as 'I believe', or including their own opinions, beliefs or philosophy. Unorthodox accounts were described as reflecting the opposite of, so an absence of medical legitimation and accounts that included self-legitimation. The women's accounts in my own data reflected a high degree of self-legitimation and an absence of medical legitimation in many, although not all respects.

I can only assume that from the degree of intimacy with which patients' divulged personal information and the real emotions with which they were sometimes overcome during the interview process that there was a large degree of their 'private' self being exposed within the interview. Within an interpretivist approach I take the view that there are different accounts and the way to understand these is to explore why the respondent is telling me this now, rather than view the data as representing 'layers of reality'. For example, during the first interview one woman gave an account of the cause of her depression as emphatically due to her husband and his family's treatment of her. At the second interview, this was barely mentioned and the cause was rationalised as menstrual/hormonal and that her problems had been solved by her recent hysterectomy. I do not believe that it was just for my benefit that she had re-constructed her account of her illness, I believe that for her, at that point in time, that it represented the 'truth'.

The purpose of the study was explained to GPs as seeking to explore the problems that GPs faced in the day-to-day management of depression and we emphasised that whilst we were interested in decision-making processes, we were not investigating their clinical knowledge and clinical behaviour. General practitioners were often very frank about their perceptions of patients. One general practitioner even joked about being so honest about his perceptions of patients whilst being tape-recorded. Again, I believe that my position as a social scientist and not a clinician helped to steer GPs away from thinking that their skills were being assessed. General practitioners' accounts also revealed the use of 'self-legitimation' and referred to their personal experience rather than formal medical teaching in accounts of their decisions. There were also appeals to unorthodox legitimation (that not all their decisions were justified by formal medical opinion). In the way I presented myself to both general practitioners and the women, my intention was make them feel comfortable with expressing their own opinions. I nodded, as if in agreement with their statements and to show that what they had to say was interesting and valid and endeavoured not to express surprise or concern at something they were saying unless this was an appropriate response (such as showing concern when a woman told me her uncle had just died that week).

In addition, the experience of having conducted the interviews provides the researcher with more than just the paper transcript of a conversation to contribute to the analysis. I had seen part of the social circumstances of the patient, and had conversations outwith the formal research interview. I also observed their behaviour and body language. There is little doubt that I formed opinions of these women and their lives. In interpreting their accounts and 'what they said' I was also influenced by my memory of the women and their circumstances in trying to understand why they might say such a thing. However, I also acknowledge that this additional knowledge was only available to me in relation to half the patient sample (those with whom I conducted interviews). Qualitative researchers are often conscious of stripping the data from its context. I wrote up brief notes immediately after each interview but it was my memories of my encounters with these women that were called upon when examining their transcripts. This knowledge did not necessarily contribute to the analysis but neither could I strip this contextual knowledge from my mind when re-reading the transcripts of these interviews. Even to this day I think about the women I interviewed and can remember their faces and voices, their smiles, their sadness and tears, their homes, their children, and their problems. Perhaps it is for this reason that the notes the other interviewers provided never managed to convey the same knowledge of context that I had for the women I interviewed.

In presenting the data extracts that exemplify the analytic points being made within the following data chapters of this thesis, I have used first names (although changed to protect anonymity) for the women and surnames for general practitioners. This reflects the relationship and rapport that was established with each group. The women and I used first name terms with each other and, as I have previously commented, I emphasised my non-clinical and non-professional role within the interviews. The interviews with general practitioners, although reasonably friendly, were more formal (and were conducted within the clinical setting). It was also important for me to be perceived 'as a professional' in my academic role so that the general practitioners would take the research study seriously and consent to giving up valuable time for two interviews. At the end of the study I was not on 'first name terms' with all general practitioners.

3.8 Analytical approach

Immediately after each interview, field notes were written up, detailing the conduct of the interview and any difficulties encountered as well as a brief summary of the interview and details of the respondent. All interviews were tape-recorded and transcribed verbatim, within a day or two of the interview, by two transcribers experienced in the production of transcripts for qualitative data analysis. Transcripts were then read by the interviewer and corrections made, or gaps filled in where possible (when the transcribers had difficulty making out what was said). Reading of the transcripts at this stage also resulted in the compilation of interview summaries that noted, for example: summaries of patient details (age, whether single/married etc., any children, employment status); current problems in their day to day lives that impacted on the way they were feeling; their 'history' of depression or emotional problems; their history of medication use; general acceptance/attitudes towards their general practitioners explanation or understanding of their problems; general acceptance or attitudes towards medications; and the woman's own explanation for their problems.

There is always a degree of conceptualisation of data during the data collection phase. For myself, this began with data that I had collected in a previous research project that resulted in conducting a small number of interviews with women with depressive illness about their experiences of primary care. It raised questions for me such as: how can some doctors 'get it right' and some 'get it wrong' in the eyes of the patients; and given the strong opposition to antidepressant medication why do so many women appear to use antidepressants. I was also not in an intellectual vacuum in reading the data. I have spent several years as a researcher in general practice and therefore I had a degree of knowledge of some of the literature surrounding the doctor/patient encounter and the doctor/patient relationship to inform my thinking of potential theoretical explanations. However, this did not mean that I had formulated a particular theory or answer prior to examining the data.

Methodological purists might criticise the development of ideas (or theory) that have not been grounded in the data themselves. However, even Glaser and Strauss (1967) recognised that prior interests, experiences or knowledge could contribute to the development of theory. They also acknowledged how they themselves had been 'sensitized' to a particular research topic. Mason (1996) also comments:

> It is certainly debatable whether 'pure' forms of, for example, inductive, deductive, abductive, or retroductive reasoning are ever actually practices. Certainly, the idea that theory can ever come last has been much criticised, since in its most naïve form this appears to assume that research can be begun and undertaken in a theoretical vacuum...(Mason, 1996: 142)

During each round of data collection, I came together with the second interviewer to discuss the interview process as well as compare patients' stories and experiences. This was important, particularly during the first interview phase, in obtaining an overall picture of the sample that we had interviewed. It was also useful for comparing similarities and differences in experiences and we often offered tentative suggestions as to why some phenomena had occurred. Before the second interview with a patient, transcripts were re-read in order to familiarise ourselves with the patients account. The same process of writing up field notes after the interview and of reading over and amending transcribed interviews was followed.

At the outset of this study, it was anticipated that we would use the qualitative analysis package of NUD.ist to facilitate data management. However, the other researcher was not comfortable with this technology and I myself was inexperienced in its use. This resulted in making minimal use of this technology. It was used as a means of data filing and data retrieval only. The data was initially coded into broad categories which merely reflected the broad topics of interest within the project, for example: women's perceptions of depression women's perceptions of medications and their use; women's perceptions of their general practitioner; women's perceptions of referral. Grouping the respondents' data within these broad topics helped me to see what women were saying about these topics. This was very much like reading all the transcripts together on a single issue and was helpful in developing the next stage of analysis, the conceptual coding. This was carried out using more traditional paper based methods.

It was during the stage of broadly categorising the data (and before the second round of interviews was underway) that the second researcher left the project. The third researcher was only involved in conducting second round interviews. Therefore all subsequent coding and analysis of the data was conducted by myself. The description I have given in this thesis about 'how' the study was conducted has been very much focused on how I conducted myself and there has been little account of the other researchers in this process. I only have my memory of conversations with them, some notes of project meetings, their brief interview notes and their transcripts to go by. The second interviewer had a background in social work and the third interviewer was a semi-retired free-lance researcher. As I have described, there was a detailed questionnaire that made the topic areas to be covered very explicit, therefore there was consistency in relation to this within the project. However, our interview styles were very different. A glance at the transcripts conducted by the other interviewers revealed less free dialogue on the women's behalf. The second interviewer was also more likely to comment on the women's statements. Perhaps this reflects her background as a social worker. It may also be relevant that the third researcher was asking the women to discuss their personal lives with another stranger. I believe that my second visit to the women was more relaxed through familiarity and that we were picking up where we left off. My familiarity with the data which I had been responsible for collecting and my confidence in the way this data had been generated, that I had indeed allowed the women to tell their stories in their own words, resulted in the decision to use my own interview transcripts with which to conduct the main analysis and to generate the findings. I then used the remaining data to verify or contradict the emerging analysis. Throughout the data chapters I present data from the whole set of interviews by way of demonstrating that my own findings were confirmed in the remaining data or to reflect any contradictory findings in the remaining data.

The approach to the analysis that I adopted is based on the constant comparison method (a systematic tool for developing and refining theoretical categories and their properties) (Seale, 1999; Mason, 1996; Silverman, 1993). Using the general principles set out by Glaser and Strauss (Glaser and Strauss, 1967; Strauss and Corbin, 1990) in their 'grounded theory' methodology, I developed a coding system for the data. The data itself reflected the broad themes that the funded project had set out to address (for example, women's perceptions of medication or their medication use).However, labelling extracts that merely reflect prior topics of interest is not a 'conceptual analysis' of the data. In examining the data some 'in vivo' codes (categories used by the respondents themselves) emerged, such as the descriptions that general practitioners offered of patient types ('chronic and unhappy women'). However, the properties of these patients and what constituted such a type were inductively generated from analysing general practitioners accounts of why some patients were difficult to manage. As a further example of this process, a category that emerged from the women's accounts was that of 'being listened to'. However, to present this as a data category only serves to present a description of the data within their accounts. It was through the process of questioning this data and comparing it across respondents' accounts that the analytical value of understanding why being listened to was important (such as being taken seriously; having their own ideas acknowledged) that the conceptual categories emerged. The next stage then involved exploring the integration of categories and their properties; how the properties interacted. So for example, a conceptual category within the doctor's data was the 'doctor and patient relationship' in which there was a sub-category of 'trust' and the properties within this category were the existence of 'inherent' trust and the development of trust on the basis of 'experience' of the doctor's care. The findings could therefore include a discussion of the importance of trust in the doctor-patient relationship and to account for the existence of 'trust' when no previous relationship had been established. As a further example, within the women's accounts in relation to their perceptions of medications I identified that their accounts were based on 'experiential' and/or 'common-sense' knowledge. Experiential knowledge could also come from personal experience or from the experiences of others using medications. Both these types of knowledge contributed to their 'fears surrounding antidepressant medication' which were identified as the 'fear of addiction' and 'fear of change in their personal state'.

Crucial to this second stage in constructing explanations (or developing theory) from the data is the search for deviant cases or negative instances (Green, 1998; Silverman, 1993).

> The key to developing rigorous and valid theory using the constant comparative method is the search for deviant cases. (Green, 1998)

When I thought of a relationship between categories I verified this by looking at this in relation to all cases. When cases emerged that appeared to contradict my original thinking, it prompted me consider this further and to refine my original explanation in order to account for these deviant cases. As an example of this, my explanation in relation to women's acceptance of medication could not account for why some women who appeared to have accepted medication would suddenly stop taking this. It is only when we understand the constant or on-going evaluation that the women engage in, in relation to explanations for their problems and their need for medication, that we can understand this behaviour. In relation to the example of 'trust' that I described above, it was only through identifying cases where there appeared to be no prior relationship with the general practitioner that I identified examples of 'inherent' trust' thereby allowing me to refine my discussion.

I also attempted to make use of another approach to data management and analysis known as 'framework analysis' (Ritchie and Spencer, 1994). This approach is particularly useful in applied research where particular research questions require to be addressed. I initially used this tool in the very early stages of trying to makes sense of the seemingly complex data sets. There are five stages to the process involved:

Familiarisation
Identifying a thematic framework
Indexing
Charting
Mapping and interpretation

The first three stages of this process are similar to, and were therefore covered by, the initial thematic coding of the data. The charting process involves creating charts for key subject areas (such as 'medication use'). Then, for each individual case, characteristics or dimensions related to that subject area can be mapped out (for example, medication taking behaviour, perceptions of medications, previous experience of medications). A whole set of key subject areas can then be easily reviewed for each individual case. Charting involves abstraction and synthesis of the indexed data i.e. the respondent's view or experience in a particular area is summarised by the analyst and entered on the chart and the original text is referenced so that the source can then be traced for data retrieval or verification purposes.

I did not attempt to index and chart all the data in this study (unlike the systematic coding of data using the methods described above, which attempted to account for the majority of issued raised within the transcripts). I saw this method as a way of seeing all patient or general practitioner data relating to a particular topic area but broken down by thematic areas. This method did not add anything to the substantial analysis conducted in identifying categories and their properties, exploring the integration of properties within categories, and the interaction of different categories. However, it was a useful tool in the process of constantly checking proposed associations. The charting of patient details and summarising patients' views or experiences in relation to key subject areas often allowed quick access to data relating to all patients (particularly useful when I felt I did not have the same degree of familiarity with one half of my transcripts), provided of course, that the associations I was checking out were charted.

The design of this study matched two patients to each participating general practitioner. It was initially intended to directly compare women's accounts of their care with those of their general practitioner in order to explore similarities and differences in meaning and interpretation of the process. However, the women's and the general practitioners' accounts have been analysed separately. This is because the interview process and the content of the interviews were sufficiently different that a constant comparative process across patient and general practitioner interviews would not be appropriate. The theoretical basis for this decision can also be explained by Schutz's theory of relevance – what is relevant to one group can be fundamentally different from another. Returning to Heritage's commentary on Schutz

> Schutz's discussion of common-sense knowledge of the world is one which repeatedly stresses its pragmatic character. Common-sense knowledge is built up ad hoc, as a product of practical, 'interested' engagement with the world. (Heritage, 1984: 61)

GPs have different 'practical interests' therefore what they talked about in the interviews and what they were 'doing' in the interviews (giving an account of their management) was different from the patients interests of making sense of problematic experiences and evaluating their general practitioner's explanations and advice. Although, I do attempt to draw comparisons where appropriate between the general practitioners' and the women's accounts where I have specifically identified differences in meaning or where general practitioners accounts of their actions have shown similarities with women's accounts of their needs.

3.9 The limitations of this study

It is inevitable that practical decisions are taken when conducting research that limit the scope of the work and have implications for the broader generalisability of findings. I have already drawn attention to the limitations of my sample in representing the views of women within a particularly homogenous cultural, social and ethnic background. The sample of women in this study were drawn from practices in areas of medium to high deprivation, and whilst no attempt was made to establish their social class position, their occupations and housing conditions reflected a sample of 'working class women'. A sample that was perhaps stratified according to social class in order to achieve a broader mix of social class composition may have yielded interesting social class differences in relation to the experience of depression and its care (for example, in relation to the causal factors for their depression or in their ability to purchase other forms of help). The findings of this study are therefore reflective of the experiences of working class women.

There is still further scope for similar work which can focus more specifically on issues of social class, gender, ethnicity and rurality, and indeed to explore the perceptions and experiences of : men; men and women from different ethnic and cultural backgrounds; and men and women living in remote or rural areas.

The design and scope of this study was specified and set out in detail in advance in order to meet the requirements of the funding application. This meant that a methodology of 'pure grounded theory' could not be adhered to, particularly in relation to theoretical sampling. The sample we worked with had all been issued with a prescription for antidepressant medication and although not everyone subsequently took antidepressant medication (or took it for a very short time), these were in the minority within the sample. It would have been more ideal had we been able to sample more people who did not comply with medication use. However, the constant comparative method need not be limited to within an individual study,

> Constant comparison does not stop with the researcher's own data set. Theoretical insight and comparative material comes from other research, perhaps outside the substantive field of interest (Green, 1998: 1065)

Therefore there is scope to compare further additional evidence, particularly to accommodate further understanding of these 'deviant cases' without rendering the work undertaken within this thesis as 'flawed' because it did not generate sufficient data for a particular sub-set of patients.

The following four data chapters will now present the findings from the empirical work undertaken for this thesis. I begin with the women's story of how they came to perceive that something was wrong and how they made sense of their experiences and what influenced their decisions to seek help. I then turn to the general practitioners' data and give an account of how general practitioners made sense of the women's experiences and how they decided that the problem was psychological in nature. The third data chapter deals with the women's experiences of being managed: how they made sense of the general practitioners explanation for their experiences and their general practitioners advice (that they try antidepressant medication). Finally, the fourth data chapter presents the general practitioners' accounts of the experience of managing depression in women in general and in relation to their female patients recruited to this study. In this way the women's and the general practitioners' accounts of 'making sense' are presented before both of their accounts of their perceptions of the management of depression.

Chapter 4 Women's accounts of perceiving and making sense of symptoms.

> *"The elementary but important principle.... is that human illness occurs, of necessity, within a particular culture that fundamentally shapes and influences the way illness is experienced.... Illness beliefs shape the responses to symptoms by the sufferer.... "* (Fitzpatrick and Hinton, 1984: 254)

4.1 Introduction

The purpose of this chapter is to provide an account of how respondents said they came to recognise that something was wrong, how they accounted for their decisions to seek formal medical help from their general practitioner, and how they made sense of their experiences and the types of knowledge they used in this process.

In presenting the women's accounts, it is important to acknowledge that in the interview process they were making sense of their *current experiences*. The women did not necessarily distinguish between their explanations prior to consulting and the explanations as they were perceived at the time of the interview. They were easily able to talk to the interviewers about the early part of their story of how they came to recognise that something was wrong and about their decisions to seek formal help for their experiences (and indeed this was still particularly salient for women with new/likely experience of depression). However, because their accounts were constructed retrospectively they were drawing subsequently on knowledge gained through their interactions with their general practitioner. As I outlined in chapter 3, it would have required a very different, and practically impossible, research design to capture 'real time' decisions. With this in mind, the chapter first provides a description of the women's retrospective accounts of the early part of their story and of their decisions to consult, then gives an account of how the women made sense of their experiences and the types of knowledge that they utilised in this process.

In understanding the processes by which the women came to define 'problematic experiences' and attempted to 'make sense of symptoms', I draw heavily upon the work of Locker (1981) (as described more fully in chapter 2) to inform my analytical interpretation of these data. As a reminder, Locker (1981) refers to 'problematic experiences that give rise to and are ordered by the interpretive activity as cues' (Locker, 1981: 50) whereby the concept of the cue is used to describe some of the interpretive processes that can lead to a diagnosis. In his own work Locker uses the notion of the cue as 'the initial recognition of some departure from a state conceived of as normal, usual, or routine'. Locker conducted qualitative interviews with six families at several time points over a period of 12 months to discuss, mainly with the mothers, their experiences of everyday illness in themselves and their family. He described how the women in his study perceived "symptomatological", "behavioural" or "communicative" cues in the process of recognising that something was wrong. Locker's analysis proved a useful framework for understanding the way my respondents described their awareness that something was wrong, and how they made sense of their symptoms.

In examining the women's accounts of help seeking I will demonstrate how this was perceived as a moral decision, which supports previous findings that have identified help seeking as a social process in which the justification for formal help seeking is constructed as a moral decision (Rogers et al, 1999; Adam, 2003).

Describing the process of how they recognised something was wrong, their decisions to seek help, their initial encounters with general practitioners and attempts to make sense of their experiences were more central to the discussions with patients with new experience of depression than those with more long-term experience. These experiences must have been more salient to them at the time of interview than to those with more long-term experience. As a result, the chapter draws more heavily on the accounts of women with relatively new experience in describing these processes.

4.2 How women perceived that something was wrong and defined their experience as problematic.

I have explained in chapter 3, in conducting the interviews we avoided using the term 'depression' in the questions we posed. We explained that we were interested in the experiences of women who had been experiencing emotional or anxiety problems, trouble sleeping or having difficulties in coping. Women were asked to focus on 'these types of difficulties' or 'problems' they had been experiencing and that had recently led them to visit their general practitioner. We also explained that we were interested in how they were 'feeling' about these difficulties or problems. They were asked to talk about when they first experienced difficulty and how they felt and thought about it. Women with previous experience were asked if they had experienced these kinds of difficulties or problems before and what they had felt and thought at the time. This approach provided a focus for discussion without being too prescriptive. The intention was to steer respondents towards describing their experiences in relation to their depressive symptoms rather than any other illnesses or experiences that may have also resulted in a recent consultation with their general practitioner. Women's accounts of how they felt and thought about the difficulties they were experiencing included detailed accounts of how they recognised 'something was wrong'. This may have been because we had expressed interest in their decisions to consult and what happened subsequently, and respondents may have thought it was important or necessary within the interview context to give an account that justified their subsequent help seeking. As I have mentioned, previous research has also shown that decisions to consult have been framed as moral decisions.

Like the women in Locker's study, respondents in this study also described perceiving 'signs' that something was wrong. The signs were how they recognised a change in their personal state. Locker used the term '*cues*' to describe something which '*disturbs the taken-for-granted sense of order and the unnoticed everyday functioning of the body and the person*'(Locker, 1981: 50). Cues therefore refer to '*the initial recognition of some departure from a state conceived of as normal, usual or routine*' (Locker, 1981: 50). This definition of a 'cue' seemed fitting with my own analytical interpretations of the interview data. Locker preferred to use the term cues because 'they are only constituted as signs and symptoms when they are interpreted as the indicators of an underlying organic or psychological problem' (p50). However, some of the women in this study did use terms such as 'signs' and 'symptoms' (although 'symptoms' was used more specifically when describing perceived changes in their physical health) in their descriptions of how they recognised that something was wrong and so I also use these terms when talking about the process of recognition in general.

The three main cues which women described in their identification that something was wrong were 'physical', 'behavioural' and 'cognitive/emotional' cues, with a fourth category, 'communicative' cues, serving as an additional rather than an initial indication of something being wrong. These differ from Locker's cues which were 'symptomatological', 'behavioural' and 'communicative'. This difference is probably because the nature of the problems being discussed by respondents in the two studies were not the same. Respondents in my study were all talking about a personal experience and an experience that involved their emotions to a large degree, whereas in Locker's study the women were describing recognition of both their own and their families' health problems. Locker's definition of a symptomatological cue is '*one that involves changes in physical or psychological states, they involve some change in the way one feels or some change in external appearance*' (p.50). Within the accounts of the women in my study the recognition of a change in their psychological state was less definitive and more inchoate than the recognition of physical symptoms, and the emphasis placed on each of these cues was influential in the women's attempts to make sense of their experiences. For this reason I have separated Locker's symptomatological cues into physical and cognitive/emotional cues. Locker's behavioural cues also refer to observed changes in behaviour 'on the part of another', whereas the women in my study were observing changes in their own behaviour.
In the context in which Locker conducted his study (among caring wives and mothers whose role was perceived as having a responsibility to recognise and manage disorder within the family) communicative cues were an important mechanism by which the women came to recognise disorder in others. For example, when a child or partner told them they felt unwell or reported specific symptoms or an injury. This type of communication is not relevant to this study. However, there were descriptions of communication by others to the woman that they had perceived a change in the woman's state. In most cases this communicative sign served as an additional indicator to the woman that something was wrong since they had already perceived signs of change within themselves.

In the following paragraphs I offer a brief description of these physical, behavioural, cognitive/emotional and communicative cues that indicated to the women that something was wrong. In determining that 'what is wrong' was also problematic, the women placed their experience within the broader perspective that involved evaluating their problematic experiences and the impact that their experiences were having on their day-to-day lives.

4.2.1 Perceiving change: physical cues

Physical cues that something was wrong involved physical changes that could be gauged against understanding of their normal state of health. These physical cues could also be described in terms of 'symptoms'. They were most likely to be described by patients with new experience of depression, and included changes in sleep patterns and feeling tired or a lack of energy. In a general question about what types of things could affect her health, Janet (who was experiencing depression for the first time) discussed how she recognised something was wrong.

> "...because I knew how I was feeling and I told [husband's name] and my health visitor and the doctor I was feeling worn out and low......one or two days when things did get bad, I didn't feel like getting up in the morning and that's not like me." (Janet)

Janet perceived a physical cue of 'feeling worn out and low', and defined this as problematic because it affected her ability to function. She emphasised the experience by highlighting this as 'not normal' for her. Jill's description of initial recognition of a problem also included physical cues and their impact on her life.

> "I was very tearful, very tired and I had aches and pains. My arms and my legs were really painful all the time. I felt I couldn't lift things up and I just started to realise there's something not right here." (Jill)

Jill's physical symptoms also affected her ability to do things. It was the perceived effects of these physical cues that defined them as problematic.

Even women with more long-term experience perceived physical signs that something was wrong. In describing how she felt leading up to a recent episode of depression, Maeve exlained:

> "Tiredness, just such tiredness, I can't describe how tired I was." (Maeve)

In some cases the symptoms perceived by patients were more specific and sometimes multiple. Linda, in response to being asked at the very start of her interview to describe her general health, responded:

> Interviewee " ...And what I'm learning as I go along, I'm relating it back to how I was feeling maybe before Christmas and I'm beginning to understand maybe it was farther back that I started getting signs."
>
> Interviewer (A) "I don't know anything about what's been going on or what sort of illnesses you've had. So maybe you want to start from the beginning?"
>
> Interviewee "Well first of all, as I said, I was getting checked for high blood pressure and that was picked up because I had went for my pill....but em I was suffering from getting a cold....my four days off I was starting to get over it but I was going back into my work and I was feeling dreadful straight away and I was getting sore backs , a lot of sore heads. I used to do Tai Quondo, I do horse riding and I was gradually not going to these things because I didn't feel I could do them....I was getting symptoms of the cold. My face was breaking out. I was getting a lot of rashes and itchiness round about my eye, my eye it was all drying up. My lips were all drying up, em I was just generally feeling like I was run down." (Linda)

Although Linda reported that, in retrospect, she had perceived 'signs' that she was experiencing a change in her personal state, and in this case physical changes, she also emphasised their seriousness and how problematic they were by stating that they resulted in her inability to undertake certain activities that she had previously enjoyed.

In some cases it was the severity of symptoms that resulted in them being perceived as problematic.

> Interviewer (A) "But why did you decide to go and see a doctor this time?"
>
> Interviewee "I didn't actually. It was just I was at the doctor's anyway. I go like once a month for blood pressure, things like that. Oh no, it was my hair was falling out, lost an awful lot of hair and that was why I was down [at the

> doctors] and I just said I didn't feel very well. But I can't remember, I took like flu symptoms. It was for all the world like flu only I didn't have the runny nose for that ...but the symptoms, I was flat on my back in my bed, it was just too much. My feet and legs were burning hot, unbearable...and my stomach was going, heart thumping, splitting headaches really." (Sarah)

These physical cues were sometimes enough in their own right to encourage patients to seek help from their general practitioner, particularly where there were multiple symptoms or when they were perceived as persistent or severe and having an effect on their day to day functioning.

4.2.2 Perceiving change: behavioural cues

Behavioural cues involved departures from their normal behaviour or conduct. For some patients it was a change in their behaviour that was perceived as the first indication that something had changed. While for others, as in the example of Linda above, the departure from normal activity (Linda's Tai Quondo and horse riding) was seen as coinciding with other perceived changes.

The most commonly reported perceived change in behaviour was described as inexplicable and uncontrollable crying.

> "I used to burst out greeting [crying] for no reason at all. There was one day, I was washing the dishes, and the next thing, I just burst out crying and that, I'm not actually thinking about certain things, I just burst out greeting. I go to my bed, lie in my bed, and then I burst out greeting, and I couldn't understand why I was doing that all the time. At the shops, standing in the queue waiting to get served and I felt my eyes watering up, and I thought I'm going to start greeting here, I dropped my basket and walked out, because I knew I was going, for no reason at all, I just, and I thought, no I can't keep on [like this]."(Carrie)

For Carrie, the changes in her behaviour were seen within the context of the apparent lack of reason for the behaviour, the lack of control that she perceived in relation to this behaviour, and in the persistence of this behaviour. Carrie emphasised her behaviour as problematic by drawing attention to the fact that in some circumstances crying could be perceived as rational behaviour whereby 'thinking about certain things' could offer a rationale for suddenly crying. However, in the absence of such an explanation this same behaviour is described as irrational and problematic. Other examples of behaviour change included becoming irritable or losing their temper.

Patients with previous experience of depression also described changes in their behaviour that they came to associate with their depressive experiences.

> "You go into yourself and you just don't want to know anybody which is why I shut the world out." (Ailsa)

4.2.3 Perceiving change: cognitive/emotional cues

As I have already noted, Locker included changes in psychological state within his category of 'symptomatological cues' and I have chosen to categorise psychological cues separately, because for the women in this study, the process of recognising a change in psychological state was often less definitive, and more inchoate, than the recognition of 'physical' signs and symptoms. In these data, there was cognition ['knowing, perceiving, or conceiving as an act or faculty distinct from emotion and volition', Oxford Dictionary definition] that something was different, even if it could not be understood or described. In addition, the women's descriptions of perceived change also made reference to emotions ['strong instinctive feelings', Oxford Dictionary definition] such as 'fear', 'anger' or 'guilt'. Hence, cognitive/emotional cues refer to descriptions of recognition of a change in state that could not be understood within their existing knowledge of physical signs or defined and understood as a behavioural change. The cognitive/emotional cues were most likely to be described metaphorically as this was the language through which they could be expressed. The cognitive/emotional cues were also coupled with a sense of helplessness in not being able to react to or manage the perceived change of state.

> "I just felt like I had this cloud and I couldn't get rid of it." (Janet)
>
> "I was falling right down and right down, and I didn't know how to pick myself back up again." (Carrie)

Many of the descriptions of these cognitive experiences were very similar in nature such as 'black clouds', 'black holes', 'a dark pit' or a 'weight' upon them.

> "For me it was like a black hole, deep black hole"(Ailsa)

For those with previous experience of depression, these cognitive cues formed a major part of the recognition process and were often enough in their own right, irrespective of additional physical or behavioural cues, to indicate that their depression had returned.

> "I felt like I was starting to go back down that slope again, maybe just getting a bit irate, just generally feeling low down." (Sandy)

> "There's a sort of fear, when you're feeling maybe upset or depressed or whatever, you're sort of feeling out of control." (Ann)

4.2.4 Perceiving change: communicative cues

In general, women described being told by others that they thought something was different or wrong as confirmation of their own perceptions. For example, Maeve described a recurrence of her illness

> "....and I left it far too late this time because I was really on the breaking line on Boxing Day and I thought I'm just going to die, I'm going to do it this time, I want to die. And my friend phoned me, she said "Oh I just thought I'd see how your Christmas was" and she picked up right away she said " You're no well Maeve are you?". I said "Oh I'm okay". But she went off the phone, she never told me she was coming to visit me, but she did...she said "I knew I couldn't leave you because I just knew in your voice that there was something really badly wrong you". And she came in and she spoke with me and that's when she said: "Right, I'll take these tablets away from you", and she phoned the doctor." (Maeve)

Talking to others at their own instigation also had the function of seeking confirmation that others too had perceived that something was wrong, and it often acted as the first form of help seeking by the patient.

> "I spoke to my brother-in-law's girlfriend and she said that I should go because of my attitude...but I'd actually em, phoned the health visitor the next day..she says even if I was to wait till the next morning, because the doctor's

> was shut at that time, but to get in touch and definitely phone because there was obviously like a problem as such." (Amanda)

There were also a few cases among those with possible post-natal depression who described encounters with their health visitor that confirmed there was a problem but only after they had started to disclose their feeling to the health visitor.

> "So [husband] persuaded me to talk to her first...so we phoned her and she came out to see me, and I told her how I'd been feeling, and I felt quite easy to tell her that because as I say, I could just talk away to her as normal. Once I'd told her, she told me I'd have to go and tell the doctor." (Janet)

There was one woman (Jeanie) who described being 'diagnosed' by her health visitor as having post-natal depression, and how she rejected this 'communicative' cue. However, she later acknowledged perceiving cognitive/emotional and behavioural cues and acted upon these at a later date (see below within section on 'Help seeking behaviour'). This might indicate that a communicative cue by others to the depressed person would not be sufficient for the person to recognise a problem in themselves. They would also have to be personally aware of changes in themself before recognition takes place. However, there were not enough examples of communication by others preceding personal recognition of a problem to be able to confirm this finding.

4.2.5 Perceiving change: a combination of cues

Although there were examples of how each of these cues were indicative that 'something was wrong', women often described an accumulation of cues as important.

> "I genuinely felt so down in the dumps at times and just at the stage I felt so run down, I just felt I couldn't cope and I thought, no. But it was just like stupid things I would be in tears for ages and I couldn't understand why at times. Just silly things like the place being in a mess, obviously with their toys and everything but you just felt everything was just getting on top of you and just really, really hard to go through each day I would say. Just cope day to day." (Sandy)

Sandy perceived a cognitive/emotional sign that something had changed ('feeling down in the dumps'). She also perceived physical changes of being 'run down', and perceived a change in her normal behaviour that she could not comprehend (being 'in tears for ages' or over reacting to normal everyday situations). The combination of cognitive/emotional, physical, and behavioural signs, was presented as cumulative problems that contributed to difficulties in coping with everyday life.

Similarly, patients with long-term experience reported perceiving a combination of signs in recognising that something was wrong.

> "I just felt like, well what can I say, just felt like everything had built up and I was just ready to explode. That's why I thought right, see Dr[ ]. I wasn't sleeping. I mean I was eating an' that, I just wasn't sleeping. I knew I wasn't right at that. I was going into myself again...awful bad time...and so I just phoned Dr[ ]." (Ailsa)

However, some women perceived cues as exclusively physical or placed more emphasis on their physical symptoms as 'the problem', as was the case with Linda and Sarah shown above. Whilst for others the recognition that something was wrong was primarily described in behavioural and cognitive/emotional cues. The emphasis given to perceived cues (or the absence of some types of cues) played an important role in how women perceived their signs and symptoms could be explained and how they should be managed, and I explore this further in Chapter 6. Understanding how women perceived that something was wrong is relevant to understanding their subsequent behaviour in relation to its explanation and management (particularly by their general practitioner). It was their experience of perceiving signs and symptoms for which they subsequently sought explanation.

4.3 Help seeking behaviour

Locker argued that in making sense of illness experiences, the women in his study consulted formal medical services to either confirm, refute, or to provide an explanation for their problematic experiences. The women in this study engaged in their own attempts to make sense of their experiences. Sometimes they entered the consultation with an idea or explanation for their problems, and sometimes their own knowledge could not offer an adequate explanation and they sought help from their general practitioner in seeking answers to what is it and/or why has this happened.

> Interviewer (B) "So what made you go to see Dr[ ] 3 months later then?"
> Interviewee "What made me go is because I realised it wasn't going away. And there wasn't a big major crisis in my life where I could say right this is how [why] I feel down. I couldn't label it. I just – no matter what I did, I'd have one day I was alright and I'd have one day I was really down and I wasn't taking an interest in my house, which isn't me at all." (Jeanie)

This patient had previously been alerted by her health visitor that she may be experiencing post-natal depression but had refused help at that time because she did not agree with the diagnosis. However, three months later she re-assessed her situation and decided to seek help. There were several factors that she brought into consideration in making her decision: the persistence of her signs and symptoms beyond a reasonable time frame, the perceived lack of a causal explanation for her symptoms, and her inability to establish recognisable symptoms against which she could apply common-sense knowledge.

However, these types of reasons were not the only explanations women gave in accounting for their help seeking. The women's perceptions of their ability to function within their social roles played a large part in their accounts of help seeking. Women's accounts of help seeking were often portrayed as help seeking out of a sense of duty.

> "And I thought, especially when it started to come between me and [husband], because we just weren't getting on and I knew then, because we do communicate we're good at talking things out,. And all I wanted to do was just lie in bed….and then I was so guilty because I thought maybe, what if this is something I'm letting go and its affecting [her son]. So I went to the doctor." (Jeanie)

> "I feel terrible for what I've put him through, I mean that's what made me go and get help really, in the end, because I seen what it was doing to him, and I thought "No, this isn't right, there's something wrong, I'll need to get something done about this". And that's when I approached the doctor." (Amy)

The women perceived that their own emotional states were affecting the functioning of the family and relationships within the family. It was also perceived that it was up to them to take action. In the first quote the woman perceives that her inaction might lead to further problems for her son and so she decides she must take steps to prevent this. Their decisions to act were based on a sense of duty towards other family members and to preserve relationships.

> "So it was more for em, the kids sake as well. I thought, I felt I couldn't be a good mother sort of if you're snapping at them all the time and getting on to them for no apparent reason. I thought well if it's only something that's going to be short term then obviously it's worth getting the help and then sort your problems out and see how things go after that more or less."(Sandy)

The women also revealed how their decisions to seek help were based on their need to fulfil their expected roles, in this example that of the 'good mother'.
The following patient also reveals how her concerns about her ability to fulfil her work role caused her to seek help.

> "Well the reason why was at work I couldn't cope, simply. I'm a primary school teacher and it got to the stage that the children, I was calling them all the wrong names and putting the wrong dates on the boards…and I felt that I was snapping at them an awful lot. I wasn't my usual self. I was doing the same at home too, snapping at my own children. I was very tearful, very tired, I had aches and pains…and I just started to realise there's something not right…." (Jill)

Jill's concern was for the children at school and her own children. However, she also had a conflicting sense of duty to keep performing her working role even though she perceived that she was not coping as well as she used to.

> "I didn't want to go off work, in fact so much so I did go back to work the next day and eh, I realised that having spoken to her, I realised that she was right, that I wasn't coping." (Jill)

She only felt able to relinquish this duty when her general practitioner stated that she was 'not fit to be working'. Jill sought help and acted on the doctor's advice to give up her work out of a sense of duty. Her behaviour, and the behaviour of the women above, can be seen in terms of 'moral actions'.

Help seeking was portrayed as a moral action by the women in the sense that it was undertaken for the sake of others. In the next data chapter relating to the women's accounts (chapter 6), I return to this theme of 'moral actions' in describing women's accounts of accepting the advice (mainly for treatment with antidepressants) of their general practitioner, and how this was also portrayed as actions taken to, either enable the women to maintain their roles (for example, as 'the good mother'), or to relinquish their roles when they were perceived as not being able to fulfil this role.

The context of help seeking for the women in this study did not only involve their perception of cues. The cues they perceived were more likely to be defined as problematic when they were also perceived as affecting their ability to function within their social roles. The women's accounts revealed that they perceived there were expectations and values placed around the performance of certain social roles, and their help seeking was portrayed as a moral act in taking action that would enable them to function more appropriately within their role, or to relinquish this role for the sake of others. Help seeking, particularly in the context of depression, was linked to the women's sense of self. It is also within this context that they enter into the consultation with their general practitioner.

4.4 Making sense of experiences and seeking explanation

In making sense of problematic experiences people need to be able to construct explanations to account for them. Locker wrote

> Symptomatological, behavioural and communicative cues both point to and are explained by a definition of disorder. Achieving a sense of order also requires that the disorder itself is explained. (Locker, 1981: 62)

Locker described how seeking explanation involved seeking answers to the questions 'what is it?' and 'why has this happened?' and that the women in his study used knowledge about health and illness per se and also knowledge about the context of the problematic experiences to construct hypotheses about 'what it is' and 'why' it may have occurred. Causal theorising was described as 'ubiquitous' in the process of seeking to understand illness. It involved determining a 'cause' and a 'reason' for illness experience and in this process the women made use of existing knowledge of health and illness and the context of the illness experience. This causal theorising thus helped them to construct a diagnosis. Similarly, a diagnosis could also be evaluated with reference to a potential cause and a reason and through making use of existing knowledge of illness and the context of the illness.

In the remainder of this chapter the task is to describe the women's accounts of making sense of their experiences and the different types of knowledge they used in this process, including their personal experiences of depression in themselves and others, their personal knowledge of their previous illness experiences, knowledge of their personal biographies and previous emotional experiences and common-sense knowledge of illness, emotional experience and depression, and common-sense understandings of the causes of depression.

Locker described the process of developing cue inventories that might be thought of as 'recipes' in how to respond to problematic experiences. He described 'person-specific' cue inventories and 'category-specific' cue inventories. Person-specific cue inventories draw upon knowledge of how a person 'normally' is, as well as knowledge of the person's illness biography and how they normally exhibit or react to ill-health, whereas more general types of knowledge concerning symptoms and illness such as: how illnesses typically manifest; and under what circumstances; and even which groups of people they are more likely to manifest in, were category-specific. These types of knowledge and how they are applied in the process of making sense of symptoms provided a useful sensitising approach to my own data and its analytic understanding. I describe the types of knowledge that the women drew upon to make sense of their experiences as 'experiential knowledge' and 'common-sense knowledge'. Experiential knowledge is knowledge gained from personal experience or from observation of others' experiences. Common-sense knowledge reflects the 'common-sense knowledge of everyday life' to which Schutz (1962) refers to as knowledge which is shared and in various ways socialised (Heritage, 1984: 49). Schutz's analysis of mundane knowledge also asserts that actors draw upon type constructs to organise their mundane experiences. In this sense, Locker's 'cue inventories' could be seen to reflect the development of 'type constructs' in making sense of health and illness experiences.

4.4.1 Experiential knowledge of depression

Women with previous experience of depression could draw upon the knowledge they had acquired during this experience to make sense of their current experiences. They could describe signs that were typical of the way depression manifested itself in them.

> "It's when I get to the stage when I don't want to go out the house and I don't want to meet anybody or really speak, because then they'll know and then you want to die, because what's the point in living any more, it's just a struggle, it's so difficult to pull yourself up every morning. That's the really deep side, the deep depression, you know." (Maeve)

The women used their experiential knowledge to construct their own ideas about 'what depression is' and they then used this knowledge to assess their current experiences and to recognise it in themselves. They had developed a body of knowledge about how they are likely to experience depression. Locker described person-specific knowledge being used in assessing whether or not perceived cues were identified as problematic. In this study, the women with on-going and long-term experience had developed sensitivity in this regard and to the extent that the perceived cues could also help them to define their depression, for example, as 'really bad' or 'the deep depression'.

> "Em, there is different stages of feeling down, you know there are some stages when you are down and all you can do is just stay in bed all day and that would be fine. But then there's other days, that's when it's really bad, I would just lock myself in the room and stay there and hope and pray that this will all, this big black thing will just lift away and I'll be fine, and deep down inside I know it probably will but I have to give it a week or a fortnight to go."(Maeve)

The nature of depression and the sign systems involved in evaluating its presence also meant that, even with personal experience, it could not always be recognised nor its severity accurately determined.

> "Because I wasn't as far down the pit as I had been before, I thought I wasn't depressed until I took the anti-depressants. And then it's, it's something that you live with and you don't have to but you live with it, [but] because you don't, even when you know, you don't always recognise it." (Vicky)

Vicky's cognitive recognition of depression was metaphorically described as a pit. How far down into this pit she perceived herself to be was her way of recognising the severity of her condition. However, on a day-to-day level she lived with a degree of depression, and this made it difficult to recognise when it had significantly progressed to a stage where she should seek help.

In women for whom the experience was new, or relatively new, they did not have or had not developed a body of knowledge as to how depression would manifest itself in them. They did not have a 'personal cue inventory' for depression. However, some accounts revealed how they made use of experiential knowledge of depression in others in evaluating their own experiences. For example, Amanda described watching a television programme about depression and how the experiences of others made her re-think how 'normal' her own day-to-day experiences actually were.

> Interviewee "Because it was a schoolgirl that was on it and she was going through like the depression and it was because she had no self confidence or anything like that, and it was everything she said that I really thought "That's how I am, I ken how she feels….."
> Interviewer (A) "And over the years when you were going to see a doctor for something else, did you ever think to mention how you were feeling to anyone?"
> Interviewee "Nothing at all, no, because I didnae know it wasnae, I suppose the normal as such."(Amanda)

Amanda had incorporated her lack of self-confidence and other perceived symptoms into her personal inventory to such an extent that these signs did not operate as cues. Her stock of knowledge regarding her self and her limited knowledge of depression had led her to perceive her symptoms as 'normal'. It was the receipt of 'external' knowledge of other people's personal experiences of depression, and the fact that these experiences made sense to her, that led her to re-evaluate her own biographical knowledge.

4.4.2 Knowledge of personal biography, previous illness and emotional experience.

Although women with relatively new experience of depression did not have knowledge of personal experience of depression from which they could make sense of their current experiences, they had knowledge concerning their 'normal' self and knowledge of previous illness and emotional experiences. They often made references to their 'normal' self, particularly in relation to recognising behavioural signs whereby they commented 'that wasn't like me' (Tricia). Hence, it was with reference to this 'normal' self that the women perceived a change in their personal state through the recognition of symptoms. I have already described this and provided some examples of this (for example, Janet's account in section 4.2.1 of this chapter and Jeanie's account at the beginning of section 4.3).

Women also described using their illness biographies in their constructions of explanations. In the first example below, Evelyn had suffered an episode of Bells Palsy 14 years previously.

> "......but there are parts of my head still don't have any feeling. And when I went to the doctor I initially thought it was all to do with that." (Evelyn)

It was through making reference to her previous illness that Evelyn made the decision to seek medical help. She went on to experience a second episode of depression, and the quote below reveals how she also had other theories regarding her problems and their cause, and discussed these with her general practitioner.

> "....when I came back and I said to him, I said "Look, I don't know what it is but I'm not as bad as I was", I said, "But I am weepy". But he also put that down to what had happened with my parents. He had actually said that was a trauma anyway....and then I was having problems with my monthly periods. Well I have had problems with them for years and that was another thing that I used to think was the problem. You know, that could be part of the way I was feeling, you know the weepiness and everything." (Evelyn)

Evelyn had gained some knowledge from her first experience of depression to be able to make a judgement of her current experience as 'not as bad' as it had been previously, and to recognise her 'weepy' behaviour as one of her personal cues for recognising depression. Her general practitioner offered her an explanation for her recurrent episode. However, that is portrayed as *his* explanation. Evelyn introduced menstrual problems as another potential explanation, and revealed how this explanation was one that she had thought of before when making sense of her signs and symptoms in relation to the way she was 'feeling'. This also reveals her common-sense knowledge concerning menstrual problems and its association with emotional problems. It is this common-sense knowledge to which she turned to make sense of her signs and symptoms.

In another example, Rebecca described how a previous illness experience had made her feel.

> "I dinnae feel, ken when this feeling's on me it's really on me. I dinnae want to do very much at all. Em, I hav'nae been feeling very great the noo at all anyway. I've had this pain and at the back of your mind you think is this the cancer coming back? Cos that's how I felt when I was no well. And it's all right saying one thing but I would reckon the first six months after having my treatment life wasn't even worth the living with me. I didnae even feel good for me because I had nae energy, I had nothing." (Rebecca)

Following her experience of cancer, Rebecca perceived that 'life was not worth living'. She had also experienced physical symptoms, such as 'a lack of energy'. Her current experiences of symptoms were perceived as being similar to those she had experienced during her episode of cancer and she was concerned that this might also indicate a return of her cancer. Hence, Rebecca used her previous illness biography and its similarities with her current experience of signs and symptoms in making sense of her experiences and in seeking an explanation for her experiences.

> "I think it all stems back fi' when I was diagnosed with cancer. I think I lost all my self-confidence." (Rebecca)

The women also had a sense of their emotional biography, about how they usually reacted to situations and how they would generally describe their emotional personality.

> "And I'm a worrier, I worry about things. Unnecessarily probably. But it's just the way I am. And I'm quite an emotional person as well which doesnae help me at times....and I cry at everything you know." (Fiona)

This understanding of their emotional biography gave them a sense of what is normal emotional behaviour for them. They would have to perceive a change from their 'normal' behaviour, or to perceive that their emotional behaviour was impacting on their ability to function, or be unable to identify a cause for their emotional behaviour, for it to be perceived as problematic.

4.4.3 Common-sense knowledge of emotions

The women also used common-sense knowledge of emotions to assess their own experiences. For example, obviously talking in retrospect, Susan said:

> Interviewee "I think that maybe I needed to go along before I did, you know. I think I was putting it off."
> Interviewer (B) "What was that about do you think, why do you think you put it off?"
> Interviewee "Well after the dog died and what I was saying I was grieving for her but I think I was also maybe, I don't know if depressed or if I was just grieving. So I just kept putting it off and I'd say to myself if I don't feel any better in say in a month's time I'll maybe do something you know." (Susan)

Susan recognised an emotional problem and assessed it in relation to her common-sense knowledge of grieving for a loss. Her common-sense knowledge was that grieving was a normal process following bereavement, and in view of her limited knowledge of knowledge of depression, she relied on further common-sense knowledge in relation to bereavement: that it should diminish after a certain amount of time. In her assessment, persistent grieving beyond an acceptable length of time would indicate that some form of action was required.

4.4.4 Common-sense knowledge of depression

At the time of the interviews, the women had consulted with their general practitioner (sometimes several times) and were therefore drawing upon the knowledge they had received during these interactions in making sense of their experiences. This had introduced the women to the possibility that they may be experiencing depression, or in some cases had confirmed their experiences as depression. Therefore, in making sense of their experiences the women's accounts revealed how they then incorporated the use of common-sense knowledge concerning depression. This involved drawing upon knowledge of the types of behaviour that people with depression might exhibit or engage in, and revealed common-sense or everyday beliefs surrounding the construction of people who are depressed (e.g. 'as people who cannot cope with life').

In drawing upon this knowledge, the women then made sense of their own experiences by re-defining their notion of 'what depression is'.

> "I'm not going to hold my hands up and say I'm depressed. I've not got depression. I don't think I have. I have in some respects but haven't to the extent that it felt like....life threatening. You always think of depression as 'slit your wrists'. That's the way I look at it because I've never had any dealings with it." (Linda)
>
> "The way I used to think about it was "Oh no that's somebody that canny cope with life" and I thought as well when you had post natal depression it meant that you were'nae wanting your baby. But obviously it's not like that and it was'nae like that in my case." (Janet)

In the first extract, Linda revealed her belief that depression is 'life threatening', and hence those who are depressed will engage in life threatening or suicidal behaviour. The second extract revealed how Janet perceived depression as an inability to cope with life. She also revealed more specific detail as to what she perceived postnatal depression to be and the typical behaviour that she attributed to someone with postnatal depression, which involved rejection of the baby. In order to accommodate the explanation of depression in relation to their own problems, the women had to re-define or re-think their understanding of 'what depression is' and the type of person who gets depressed.

As well as having knowledge gained through the personal experience of depression, patients with previous experience of depression also held general beliefs about depression which they used in defining and assessing their own experiences.

> "I have been depressed, but then again you think to yourself well you've not really. You know, although you've been on tablets, but when I think of somebody depressed and I still do, I think of somebody who is more

> suicidal....that to me is depression, in its worst form and it must be terrible." (Evelyn)

Evelyn described a depressed person as one who exhibits suicidal behaviour. Hence, in order to incorporate her own personal experiences within this framework she developed an understanding that depression has different forms, some more 'terrible' than others. She compared the extreme behaviours of 'depressed people' to her own personal experience to conclude that she had not experienced the same form of depression.

The women used their knowledge of 'what depression is' to construct themselves as 'not depressed', or to play down their own experiences as 'not as bad' as others. This may reflect attempts to construct their illness experiences more positively in order to reduce being stigmatised or judged negatively by others, including the interviewers.

There was also recognition by the women in this study that people use the term 'depression' in everyday life. In retrospect, their experience and knowledge allows them to understand that in the everyday context its meaning differs from depression 'as an illness'.

> "I don't think the public at large think of it as an illness because a lot of people say "Oh I'm depressed" just if they feel a wee bit fed up. They don't actually know what depression is. But when you get to the point that you are going to go out the front door and you can't put one foot out – that's not just being fed up.[patient in tears]" (Norma)
>
> Interviewer (B) "Well you have distinguished between having your fed up days and the way you felt, what would you say the difference was?"
> Interviewee "Well if somebody had to sit with me and describe, if they were saying I'm taking dizzy turns and I've got panic attacks, taking palpitations and when I try and go my shopping I'm feeling paranoid."
> Interviewer (B) "You would say that was too extreme?"
> Interviewee "That sounds too much like depression- that sounds more than a bit down." (Katie)

I have stated previously, that the women's accounts revealed generally held beliefs concerning what could be considered 'normal' emotional experience. Feeling 'fed up' and 'a bit down' were considered part of this normal experience. However, Norma and Katie could now, through their own personal experience, re-define depression and distinguish this from the everyday use of the term. They could then make sense of their own experiences 'as depression' by re-defining it in this way.

The final example I present in this section exemplifies how the women held quite a complex range of knowledge concerning mental ill health and the behaviours associated with it. It demonstrates how Tricia made use of various types of common-sense knowledge in making sense of her own experiences.

> "I just found that I was so tired, so chronically tired and every morning I got up, I felt worse than the night before, and I would cry for nothing, I'd been taking like, wee panic attacks but em, I knew what was happening so I was able to breathe myself out of it, and I just ignored it, it was silly, I just thought, "Oh well it's that situation and I know what it is, so I'll be Ok".... I'd sleep, but I'd be wakening up quite regularly throughout the night, and get back to sleep again, but it was never a very good sleep. Moments of real sort of high, but where I knew it wasn't natural if you know what I mean, I'd feel "Huh" (sharp intake of breath kind of sound) and looking back now, I think it was like a stress build up, but I'd be high, on a right high and then really really low, but then the low got more frequent than the high. I felt that em, in the house and things like that, I'd get upstairs and I'd forget what I was up for, come back down and remember and then go upstairs again, really demented, it used to infuriate me, but I couldn't remember. I started having to write things down, what I was going upstairs for. And sort of compulsive behaviour, always having to be wiping something down, things like that, that were just creeping in. And I thought "I feel as if I've got that attention deficit thing", I don't know, whatever they call it, because I just couldn't concentrate on anything for very long, at all and that wasn't like me either." (Tricia)

Tricia initially perceived both physical and behavioural cues in recognising that something was wrong. In addition, she lacked an adequate explanation for her experiences. However, she revealed that some symptoms could be made sense of in relation to previous illness experiences, which she classified as 'panic attacks'. She therefore had a vocabulary or terminology to classify these symptoms. Using this knowledge she made her own diagnosis. In addition, her stock of knowledge extended to having developed her own coping mechanism for these symptoms and to making a rational decision based on this knowledge that these symptoms did not require further action. However, the persistent sleep problems, experiencing an emotional 'high' that she did not perceive to be 'natural', and further behavioural signs led Tricia to re-assess her original evaluation. She described her behaviour as 'demented', 'compulsive behaviour' and as an 'attention deficit', and she sought to explain her various behaviours with reference to these 'psychological' diagnoses. Tricia had a general understanding of these psychological diagnoses and the typical behaviours that she associated with each of these.

4.5 Causal theorising

As well as having knowledge of 'what depression is', the women in this study also revealed their understanding of the potential causes of depression. It is important to understand these causal explanations, as they are relevant to how the women made sense of their own experiences, and for understanding their subsequent evaluations of the explanations offered to them by their general practitioner.

Locker credits Beales (Beales, 1976) for the introduction of the concept of 'causal theorising' in lay talk. Locker refers to the women's accounts of locating causes and reasons in his study as '*ubiquitous causal theorising*' (p.62) in order to reflect the pervasive and on-going nature of the activity. Various causal mechanisms may be identified and then new evidence might be obtained which can lead to further decision making in relation to alternative explanations. Furthermore, 'licensed problem solvers' such as medical professionals might be brought in to either provide an explanation or confirm their own theory on the matter. Similarly, these new explanations might be rejected in favour of their own hypotheses.

Explanations are also subject to 'cultural' influences. For example, some societies or cultures may include explanations of a spiritual, or voodoo, nature. Locker claims '*a culture will not only recognise certain phenomena as causal agents while rejecting others, it also specifies sets of causal nexus in which objects and events are linked together as cause and effect*' (p65). An example of this from my own data, and previously presented in this thesis, would be the common-sense understanding within Western female culture that menstrual problems effect our emotions or even cause emotional difficulties.

In relation to depression, the women's accounts revealed that there were two broad categories of causal explanation which I refer to as 'extrinsic causal factors' and 'intrinsic causal factors'. In the following sections I provide some examples in relation to these causal categories, and describe the properties that were generally ascribed to these causal explanations.

Extrinsic causal factors

Women described environmental and biographical (or life) circumstances within their explanations for depression.

> "But as I said there's a lot more people got depression. I think it's a way of life now, it's just a rat race. Nobody's got time for each other, sit down, talk, you know who's got the best house, money, work and that."(Ailsa)
>
> "Well in general I would say, getting hit with things unexpectedly you can get into depression. If some people overspend and then get all worried because they can't pay the bills.......Bereavement can cause it. A particular lifestyle like living with alcoholism, or a man who beats you, all different things. It's like a physical or mental attack to the system, not a one off, a constant bombardment would normally bring it on." (Norma)

These extrinsic factors were portrayed in two ways: as affecting society and our 'way of life' generally; and as factors that are experienced and impact on us personally. The women in this study also spoke of the work environment as contributing to stress and depression in themselves and others. On a personal level, money problems, experience of bereavement and insecure or unsafe living environment were offered as potential extrinsic causal factors that would make an individual susceptible to depression.

These explanations of depression, as endemic to our society because of the social pressures and social circumstances that we live with, makes it plausible for these women that anyone can experience depression. To explain the increasing numbers of people experiencing depression, the rationale of an external cause that can affect everyone within our society, serves as an adequate explanation. The understanding and acceptance of the association of depression with environmental and biographical factors can also lead to assumptions about the likelihood of the emergence of depression when social pressures and social circumstances are present.

Women described both 'immediate causal factors', happening within the present and sometimes unexpectedly, and 'long-term causal factors' such as those resulting from experiences in childhood. These long-term extrinsic causal factors may not be the direct cause of the current emergence of depression, but they were seen as contributing to a person's susceptibility. One further point that was made by the women in this study, was that although individual causes could result in depression, it was more likely to be the result of multiple causes. For example, Evelyn described multiple causal factors:

> "Well I couldn't see how, em, how could I be depressed because I always associated depression with unhappy, an unhappy family life, em, money worries, you know if you didn't get on with your partner, your husband, if you didn't love them, you know worries there. But everything appeared to be normal, you know I just didn't know what I had to be worried about or depressed about or anxious about." (Evelyn)

In Evelyn's case it was the absence of any perceived external causal factors that made it difficult for her to accept that she herself was experiencing depression. This demonstrates how causal theorising was incorporated into the women's attempts to make sense and seek explanation for their own experiences.

When these external causal explanations were perceived as being absent, it was difficult to associate their own experiences with depression, and also, as in the case of Amanda, resulted in problems for others in understanding the person's experience as depression.

> "My dad had depression but his was like different because he had an accident at work so he suffered. But they canny understand why I've got this sort of thing. And they tell you to pick up and get on with it. Because obviously when my mum was growing up there wasnae really such depression, it was mair or less you just get on wi' it and didnae have the time to sort of stop and think." (Amanda)

Carrie described her attempt to find a causal explanation for her own experiences:

> "When the Doctor said it was depression, stress and anxiety, all in the one, I thought but how did it happen, for the three things, to come together. There's

> been too many things in my life, and I'm still not happy yet, I don't think I ever will be, it's just one of those things....
> .....and then with my Mum, I thought "But how's my Mum got depression, she's got nothing to be depressed about", but then, when you think about it, when my Dad was killed and all different things that's been happening in her life, folk deal with it a different way." (Carrie)

After receiving a diagnosis from her general practitioner, Carrie asked the question 'how did it happen'. She offered a potential explanation based on extrinsic factors: 'too many things in my life'. Although things in Carrie's life were changing she could offer no explanation as to why she felt that she would never be happy. To account for this she used what Locker termed an 'esoteric' explanation: 'it's just one of those things'. It is interesting to note that esoteric explanations were only used when describing personal explanations for the occurrence of depression, when patients could not provide an explanation for themselves or when faced with contradictory explanations. Carrie also asked 'why?' in relation to her mother's episode of depression. She could not determine any recent factors that could explain its emergence but further reflection into her family's past (her father was killed) did offer a potential explanation.

Intrinsic causal factors

In addition to extrinsic explanations, the women's accounts also suggested causal factors intrinsic to the self as explanations for depression. Intrinsic causal factors are to do with 'the way a person is', whether these inherent traits be biological (including genetic), psychological or personality type.

> "I do believe there are different types of depression. Like there is reactive depression to something terrible happening, or like postnatal depression. And I think really that it's a combination of biological, your biological make up and your psychological make up. And I think that my em, what's the best way to put this – my grandmother suffered from depression...so I do think there are cases where you do have a genetic disposition to it. I mean I didn't know she suffered from it until long after I had suffered from it, so it wasn't as if I knew that and kind of thought I'm going down that road...there must be something in your genetics that makes you kind of more prone to reacting more strongly to things and then there's your own personality and psyche that comes into it....I am just more genetically inclined to suffer from depression.....I think I'm physically more inclined, you know chemical imbalance or whatever, that can affect mood, and personality wise I'm maybe kind of quite affected by things more than other people." (Ann)

Ann's account revealed that she had knowledge of both extrinsic and intrinsic causal factors for depression. She also acknowledged that more than one intrinsic factor may have been at play. Ann's explanation for her own condition lay within an intrinsic causal explanatory framework.

For some women, the causal explanation of 'personality type' was more central to their thinking as it was often used in relation to their descriptions of their self.

> "I believe that you are a negative person, you're born with the genes and it just comes out in the type of the situation [you are in]. So I've actually grown up with feeling self pity...I always thought I was just the type of person that felt sorry for myself. I believe it's in you and even if you grew up in a so-called normal family it would still come out....It's just negative thinking. That's really what I think my problem is negative thinking. You know I see the glass as half empty, I don't see it half full." (Jeanie)
>
> Interviewee "When I was younger...I was always afraid when everything was going well that something was going to happen to spoil it and that's definitely a throwback to my childhood....."
> Interviewer (C) "And do you think depression is an illness?"
> Interviewee "Yes, yes I do."
> Interviewer (C) "And how do you think that fits in with what happened to you?"
> Interviewee "I think that I would've been depressed even if I hadn't been sexually abused because it's there and I see it in my children." (Vicky)

Both of these women described being aware that they engaged in 'negative thinking', and that this had been an element of their persona that they had observed since childhood. Although both of these women had experienced traumatic childhood circumstances (living with alcoholic parents and being sexually abused), they associated their personality type as having more relevance than these serious life events in the emergence of their depression. Nevertheless, they acknowledged that such events could be seen as causal explanations. Vicky's exert demonstrated her belief that this personality trait was familial (hereditary) because she could see it in her children who (to her current knowledge) had not been subjected to the sexual abuse that she suffered.

The following account is an example of how one of the women attempted to seek explanation for her experiences and how she drew upon both extrinsic and intrinsic factors in this process.

> Interviewee "I don't know what caused mine, I think it was a build up of stress. I think that does it. Anyone feeling a failure."
> Interviewer (B) "Did you ever feel a failure?"
> Interviewee "No. My father died when I was three, although I accepted that years ago, I wonder if that played a part because you don't really have a normal childhood. It could be just some people are more prone to it. Maybe sensitive people who are normally anxious anyway. I am pretty sensitive – normal is two parents. I was the only daughter." (Susan)

Susan perceived that recent extrinsic factors (a build up of stress from external sources)[6] may have been a potential causal factor for her current condition. She also considered that factors affecting the psychological state of a person could be a causal factor, although she did not apply this to her self. However, she then revealed that she had considered the possibility of a life-long familial explanation for her own condition but was unsure of the causal nature of this. She also hypothesised that intrinsic factors may be at play, such as personality type or 'sensitive people who are normally anxious'. This explanation could then be incorporated into her own causal framework because she recognised this personality trait within herself. This personality trait could also account for her sensitivity to feeling a sense of loss (loss of a normal childhood) from not having had both parents throughout their childhood. Susan considered several different causal explanations for her own condition, and ruled out ones that did not fit in with her biographical experience or her perception of herself.

Causal explanation: an on-going process

The search for a cause is also one that patient's engaged in with each individual episode of depression. Although the women may have a general explanation for their own experiences that is rooted in either extrinsic or intrinsic causal frameworks, they also still engaged in searching for a reason for individual episodes.

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[6] Susan had also previously described how two recent bereavements had affected her. "...and then I had an uncle that died that we were close to....his wife didn't have anybody else to help her out so she was kind of relying on me a lot. So that happened and then about 5 month after that I lost my dog...so

> "Sometimes it's reactive because of the pressures in your life. But the hardest kind of depression for me to deal with is the [pause]I can't get the word. It's not insiduous, it's a word like that [endogenous] which means there's no actual cause, you're just depressed...but I don't seem to have that anymore, or there's so much crisis going on in my life that I don't need to, you know, it...there's always some reason for it."(Vicky)

> "There are some of the periods that I've had that , you know, there is an obvious cause beforehand that you've been ill or you've been stressed or ,you know, sometimes you can sort of feel yourself struggling a wee bit, but there are other times when I've become depressed for no reason apparently whatsoever. Em, so I really don't know. I wish I did know." (Ann)

Vicky's account revealed how she had previously experienced depression that was explained as 'endogenous'. However, this explanation was perceived as meaning 'no actual cause' and this was problematic for Vicky. Her current life circumstances now offered her several extrinsic causal explanations that she could draw upon to help her make sense of her experiences.

Although Ann generally made sense of her depression through intrinsic causal explanations (as shown above), she still searched for an 'obvious cause' for her individual episodes. It was the extrinsic causal explanations (of illness and stress) that she drew upon when seeking an 'obvious cause'.

One final point to make concerning causal explanations is that not all women shared the same knowledge in relation to potential causal factors. Some women revealed a broader range of knowledge than others (or referred to several causal factors that included both extrinsic and intrinsic factors). Patients with new and previous experience of depression displayed knowledge of both extrinsic and intrinsic factors in their causal theorising. However, their own experience often influenced the priority they gave to certain causal explanations over others. There was a general tendency for new patients to focus on external causes such as environmental and biographical factors, and for patients with more long-term experience of depression to focus on intrinsic explanatory frameworks such as biological, psychological and personality type explanations. However, the lifelong personal experiences of some new patients

it was, I felt okay then obviously I was grieving but I was still getting on with my life then it was about shaped their perceptions of the importance of intrinsic explanations within their own explanatory frameworks for depression; and the causal association of extrinsic factors preceding episodes of depression for some patients with previous experience of depression also shaped their understandings of depression. Although not exclusively so, women with new experience of depression were generally more likely to describe extrinsic causal explanations, and women with previous and particularly long-term experience of depression were more likely to present knowledge of both extrinsic and intrinsic causal explanations.

4.6 Some reflections on Locker's "Cognitive organisations of disorder"

The women's accounts identified four types of 'cue' that indicated to them that something was wrong. These were physical, behavioural, cognitive/emotional and communicative. As previously described, these differed from Locker's three cues of symptomatological, behavioural and communicative. This can be explained through the context of Locker's study which was interviewing women as caring wives and mothers, and their descriptions which focused mainly on recognising and managing disorder in others. Within these accounts, depression or mental health problems were only reflected upon in detail in one account. In the present study, the focus on depression type problems contributed to the development of a different set of cues for the recognition of such problems.

Locker suggested that what he called cues and cue inventories could act as both indicators of disorder as well as leading to an explanation of a disorder. He suggested that in making sense of problematic experiences, the onset of the disorder had to be explained. This explanation could then facilitate the construction of a diagnosis, or facilitate the process of choosing between different potential diagnoses. In some cases, it was after a diagnosis had been given that the search for an explanation began. Within the pre-diagnostic phase the search for explanation mainly concerned the nature of the condition: it concerned seeking an answer to 'what is it?' Within the

six months after the dog died, I don't know what happened, I just felt I couldnae go on" (Susan) post-diagnostic phase, Locker suggested that the answers to two questions are sought, 'what is it?' and 'why has this happened?'[7].

Women's accounts from this study concur with those of Locker's that the search for an explanation can occur both in the pre-and post-diagnostic phases. In a post-diagnostic phase the women may have to re-evaluate their previous perceptions of 'what is it?' as well as re-evaluate or begin to search for an explanation. It is important to note that by the time these women were interviewed they had already gained new knowledge (from their interaction with their GP, and also possibly in discussing their encounter with their GP with friends and family) that may have contributed an explanation for their experiences. In reflecting on how they recognised something was wrong and made sense of this they may consciously or unconsciously have used this knowledge in providing me with a rational account of how they made sense of their symptoms and for their subsequent help seeking behaviour.

Nonetheless, the women provided a retrospective account of their early experiences and this reflects, to some extent, what they were thinking 'at that time' when they were making sense of cues and in their decisions to consult. Their accounts of making sense of their experiences are more reflective of their attempts to make sense of their current experiences, and this is demonstrated in their engagement with the possibility that their experiences could be depression. Making sense of, and seeking explanation for, depressive experiences involves making use of various types of knowledge -

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[7] Other studies identified by Locker raised a third question which was 'why has this happened to me' and Locker cited the relatively trivial nature of the problems arising in his respondents' accounts for the lack of interest in this question. Such questions, says Locker, also presuppose a world view that might not be commonly held among all subjects. For example 'why has this happened to me?' indicates that the subject may hold a world view that there is an answer to this question and that it is not a random event. However, previous findings reviewed by Locker in relation to the identification of this question among research subjects, indicate that such explanations are sought when serious, life-threatening or chronic illnesses are involved. This question was also relevant within my data in the sense that some women asked 'why me-why now?'. This question was raised after a diagnosis or an explanation of depression or stress was presented to them. It was posed by women who generally perceived themselves to be generally good at coping with life circumstances, and it reflected their search for an explanation for their (sudden) loss of ability to cope.

including experiential knowledge of depression or other illness experiences and also experiential knowledge of their illness biographies and common-sense knowledge of depression and 'what depression is' and 'what causes it' - to evaluate their own experiences and to define their experiences.

Locker identified seven causal explanations that the women in his study used to explain the emergence of symptoms. These were: environmental; noxious agent; biographical; person type; psychological states; familial; and esoteric. A brief description of these causal factors is as follows:

> Environmental: elements within their physical environment that might cause or exacerbate a condition (e.g. certain weather conditions, driving position)
> Biographical: life situations, life events or life stages (e.g. childhood, adolescence, menopause, old-age)
> Noxious agent: something caught or ingested
> Person type: how a person might respond to events or situations, internal tendencies
> Psychological states: tension, stress, depression, being nervous, as causing other conditions
> Familial: the product of relationships within the family or the product of inherited tendencies
> Esoteric: things that happen for no apparent reason, 'just one of those things'

The explanations that the women in this present study used to account for the emergence of depression could also be located within most of Locker's groups. The one exception was the use of the 'noxious agent' explanation. This reveals that the women in this study operated within a range of culturally acceptable explanations for a condition such as depression, and that the notion that it is somehow 'catching' or directly caused by viral infections is not part of their common understanding within the set of potential explanations. There were two further causal categories identified within this study, which were 'physical illness' and 'biological' causes. Within the causal explanation of 'physical illness' – viral infections, physical illnesses, chronic conditions and disability could be seen to contribute to the emergence of depression, although not as a direct causal agent. It was mainly through the process of being 'run-down' by their illness that depression could occur. Within the causal explanation of 'biological' causes, the women recognised that depression could be caused by a chemical disturbance in the brain. Not all women in this study identified all of the potential causal explanations. Most women did identify several causal explanations and there was enough commonality across the whole sample to support their inclusion in the analysis.

4.7 Chapter Summary

This chapter has demonstrated that in recognising the problematic experience of depression, the women in this study perceived physical, behavioural, cognitive/emotional, and communicative cues. The recognition also involved additional (cognitive/emotional) cues as indicating that something was wrong. Not all women perceived all of these cues but they make up a general classificatory system of cues that were reported by the women in this study. Many women perceived more than one type of cue that indicated to them that something was wrong.

The women also engaged in attempts to make sense of these signs and symptoms using several different types of knowledge. Women with previous experience of depression could draw upon their experiential knowledge to make sense of their current symptoms. Women with relatively new experience of depression did not have this knowledge of personal experience, but could draw upon experiential knowledge of others' experiences of depression. All women had knowledge of their illness biographies and general knowledge concerning health and illness. They held general and personal knowledge concerning emotional behaviour and what may be perceived as normal in general and normal for themselves. They also held knowledge and beliefs concerning the nature and causal explanations for depression (and for some other psychological conditions). They used these knowledge systems to help them to make sense of their experiences in seeking answers to 'what is it?' and 'why has this happened?'.

Locker's suggestion that the women in his study sought answers to the questions 'what is it?' and 'why has this happened?' is upheld by the data in this study of women with depression. This process is also one that the women engaged in prior to the consultation with their general practitioner. It is within this context that they present and interact with their general practitioner. Their subsequent evaluation of the general practitioner's explanation for their signs and symptoms, and their evaluation of the proposed treatment, will be influenced by their own previous deliberations of making sense and seeking explanation. In Chapter 6, I will explore the women's perceptions of the management of the condition by their general practitioner.

Locker argued, that in making sense of illness experiences the women in his study consulted formal medical services to either confirm, refute or to provide an explanation for the problematic experiences. I have shown how the women in this study engaged in their own attempts to make sense of their experiences. Sometimes the women had determined a working explanation for their experiences, and other times their current knowledge could not offer an adequate explanation. Understanding the women's own attempts to make sense of their experiences can help in understanding their subsequent behaviour in relation to their encounter with their general practitioner and their acceptance of the general practitioner's explanation and advice.

In the next data chapter relating to the women's interviews, I focus on how the women's perception of certain types of cues, their own understanding and knowledge and their attempts to make sense of their experiences contributed to their evaluation of their general practitioners explanation of their experiences and also to their evaluation of the advice for treatment.

Prior to this, the following chapter deals with the general practitioners' accounts of the process of recognising that something is wrong, and how they identified the problem as psychological (rather than physical) in nature, and the types of knowledge that general practitioners used in this process.

Chapter 5 General Practitioners' accounts of detecting and diagnosing depression.

> *I am not surprised when details that I imagine about a patient turn out to be true. There is, after all, a deep spring of knowledge about our patients that is only slightly tapped in our conscious work. We know more about our patients than we think we do. This intuition is the basis for diagnosis as well as well as for interpersonal aspects of patient care. As scientists and as artists, and I submit that we are always both when we act as doctors, we rely on hints, guesses and connections that are made not so much by our minds as by our imaginations.* (Charon, 1989: 532)

5.1 Introduction

The majority of research into general practitioners' management of depression has focused on identifying depression and optimising management (as discussed in chapter 2). However, understanding how general practitioners detect and manage depression requires more basic investigation to describe their perceptions of their work. This chapter present general practitioners' accounts of detecting and diagnosing depression. The focus of the analysis presented in this chapter will be upon: how general practitioners perceived that something was wrong in the patients presenting to them; how they perceived that what was wrong was 'psychological' rather than 'physical' in nature; and how they determined that the patient presenting to them was depressed.

At all stages the study avoided imposing a 'definition' of depression upon general practitioners. In recruiting patients to the study we asked that if the general practitioners thought the patient had a depressive condition, and were managing the patient as if they were suffering from what the general practitioner perceived to be a depressive illness, then they could be included as potential recruits. In interviews, general practitioners were not asked to define depression, they were generally asked how they picked up or identified that someone may be presenting with depression before moving on to asking them to describe this process in the two specific patients recruited to the study.

In making sense of these data consideration was given to whether the analytical framework used relating to the cues that signalled to the women that something was wrong (Locker, 1981), might also apply to general practitioners' descriptions of recognising that something was wrong in their patients. The women in Locker's study had also been engaged in recognising and making sense of illness *in others* and their 'lay' role could be viewed as similar to the professional role of detecting and diagnosing (albeit that their diagnosis was sometimes tentative and they may subsequently have consulted a professional opinion when their own knowledge was perceived as inconclusive). This framework was indeed useful in the analytical interpretation of the data and facilitated the construction of a profile of the types of cues that general practitioners described as indicating to them that something was wrong and that the nature of the problem was psychological rather than physical.

As I described in the last chapter, Locker had demonstrated how symptomatological, behavioural and communicative cues were perceived by the women in his study as indications that something was wrong either in themselves or in other members of their family. The data in this thesis showed that because women were discussing their own health, compared to others health in this study the cues they perceived were different in some respects to Locker's cues. In particular they used physical, behavioural, cognitive/emotional and communicative cues. An analysis of general practitioners' discussions of recognising the problematic experience of depression using this framework also suggests they perceive several types of cues. These have been labelled as: behavioural; symptom; and communicative cues.

The chapter will begin by describing the range of cues that were identified within general practitioners accounts, demonstrating how they recognised these cues, and how they led the general practitioner towards making sense of these signs as 'psychological' in nature.

The second section of the chapter addresses how general practitioners described making sense of these problems as 'depression'. Like the women, general practitioners described making sense of the patients' presentation by drawing upon different types of knowledge that ebabled them to come to a diagnosis, or working approach and understanding of the patients' problems.

5.2 Recognising patients' problems as psychological in nature.

The previous chapter showed how women perceived a range of cues to identify their experiences as problematic, requiring interpretation and explanation. General practitioners, by the nature of their work, see patients in whom there has been a departure from a 'normal' state or who are having a 'problematic experience' whatever its nature. It is seen as their job to detect and diagnose problems.

So, how then do general practitioners come to define problematic experiences brought to them and confirm that there is indeed a change in a patient's states of affairs? Analysis of the general practitioners' discussions suggests that they perceived one or more different types of cues in deciding that patients had problems that might be psychological and might be depression. These cues have been labelled as: behavioural; symptom; and communicative cues. Although Locker did not specify any ordering or prioritising of one type of cue over another, the general practitioners' descriptions generally mentioned behavioural signs as the first indication that something was wrong, before they had elicited any information from the patient regarding symptoms. It is for this reason that this cue is described first.

The following sections include some examples of the types of statements that were used to label each of these different types of cue. However, it was mostly through the perception of more than one of these cues that led the general practitioner towards identifying a psychological problem, and to make sense of these cues as 'depression'. Different types of cues were used accumulatively to elaborate each other and to construct the evidence which led general practitioners towards a psychological diagnosis.

5.2.1 Detecting a problem: Behavioural cues

General practitioners used terms such as 'intuition', 'feeling' and 'sixth-sense' in describing how they initially picked up that a person may be depressed. However, the general practitioners accounts also went on to present a rationale for these 'intuitions' by suggesting that perhaps they picked up these cues from patient behaviour or styles of communication, for example:

> "They could present with headaches or anything and the diagnosis just appears. There is a sixth sense element to that, this person looks depressed. I suppose the thing they all come with, they all know there is something wrong, they know they are not right. "(Dr Murphy)
>
> "Yes it's sometimes one of these gut feelings, but I suppose, its in the way that people respond to questioning. Sometimes if their responses are very short and their poor eye contact, that's sometimes a trigger for me to say "I wonder what's going on here", em, and their demeanour as they come in the door, just sometimes how they walk, and how they look, their personal appearance." (Dr Shaw)

Some general practitioners' described their own 'feelings' and 'emotive reactions' to patients as triggering their thinking towards a diagnosis of depression.

> Interviewer (A) "What would you say are the sort of indicators to you that someone might be depressed?"
>
> GP "Right , well I think that the way they look, em, quite often people have got quite a flat affect and they often have tears in their eyes. You know, you are talking to them and you can see tears in their eyes, and the way they make me feel speaking to them. Because someone who is depressed makes you feel depressed, just as when somebody is anxious you know. Em, I think obviously the content of the things that they say to you in terms of the symptomatology they come up with. But a lot of it goes on the way they make you feel and the way they look. The way they sit down, whether they sigh, because a lot of it is non-verbal, you know, without a doubt and you just get this feeling from them from the moment they walk through the door." (Dr Purves)

Dr Purves emphasised that 'the way they make you feel' is indeed recognised as a cue in itself, and that this feeling could be perceived instantaneously, and prior to any verbal communication by the patient regarding the reason for presentation. This cue is then elaborated and confirmed by more observable signs such as 'the way they look', and then subsequently by the presenting 'symptomology'.

As demonstrated already in some of the data extracts above, there were a variety of behavioural cues that general practitioners' described as triggering a suspicion of depression. The following examples give a flavour of the variety of behavioural cues described by general practitioners.

> "You get a clue from the patient's general demeanour...sometimes they appear to be excessively worried or they just look miserable" (Dr Blair)
>
> "I'm very suspicious of situations where there seems to be a huge amount of anxiety about an illness for example. I would be looking at the demeanour of the patient as well. What's the eye contact like? (Dr Green)
>
> "Interviewer (A) "How else would you pick up on the fact that a patient might be depressed?"
> GP "If they're presenting with their child, if they come along with the child and the child is well, or it's a behavioural problem with the child....the number of consultations with children about behavioural problems, you know, I always think, well how's mum feeling really" (Dr Moore)

Behavioural signs included patients' non-verbal communication of their state such as their demeanour and level of eye contact. They also included a list of behaviours that the general practitioners' judged as being unusual and in some cases inappropriate : an unusual amount of anxiety about an illness; repeated consultations for minor things; and parents expressing disproportionate concern with their children's health. These were the types of behaviour that could trigger a general practitioner's suspicion that there was an additional problem to the one presenting. In this example, additional intuitive signs would elaborate these suspicions and lead the general practitioners towards making sense of these behavioural signs as depression.

It is also clear that general practitioners build a stock of knowledge concerning usual or appropriate behaviour. Patients acting contrary to their beliefs of what is appropriate may then trigger them to seek an explanation for this behaviour. Their source of knowledge, based on their previous experience of other patients presenting in similar ways, directs them towards thinking along the lines of a depressive diagnosis. It is this experiential knowledge that appears to provide them with the checklist of behavioural cues that trigger the notion that the presentation may portend something other than it first appears.

5.2.2 Detecting a problem: Symptom cues

There were also certain types of symptoms that general practitioners perceived as indicating that something was wrong, and that the problem may be psychological in nature. A common symptom cue that general practitioners included in their descriptions of detecting a problem were those that could be perceived as vague or ill-defined.

> "A number of people with depression don't actually present with saying "I'm depressed" or "I think I've got depression". They come in to say they think they're feeling unwell and they think they've got some obscure disease or something like that and it can take a bit of convincing them that it is a depression that they've got." (Dr Blair)

> "...I get a lot of presentations of sort of tired all the time, that's quite a common thing. Em, so probably exploring with them. Sometimes, people that are coming with sort of recurrent complaints, very small complaints, you will gradually get through that, if you ask them, if they've come back a second time with something you know they wouldn't normally come with, then you would probably go on and ask them how they're feeling and that kind of thing." (Dr Reid)

Hence, vague complaints or persistent complaints that general practitioners perceived to be trivial, were described as a trigger to probe patients further.

Recognising a depressive illness when people present with physical illness was not always easy, as explained by Dr Blair below. However, some specific symptoms were described as having an association with 'stress-related' conditions.

> "People presenting with physical ailments is slightly more difficult because em, the way doctors are always taught is that they deal with the supposed physical thing first. So you often finish up either examining them, sometimes even investigating them in sort of going on a bit of a wild goose chase before the penny drops that they're depressed. I think you can pick it up sometimes by the nature of the symptoms. You know they usually, people with depression who are presenting with physical symptoms are either relatively obviously stress-related, for example irritable bowel syndrome type symptoms or tension-type chest pains is another one that you sometimes see with eh, and it's quite clear that it's not related to exertion. It just, you know, gets gradually worse as the day goes on so there are some clues in the history and coupled with the fact usually you don't find too much wrong in examining them. We

> usually examine them largely to reassure them that they haven't – we're not ignoring the symptoms. And you get a clue from the patient's general demeanour. You know I think if someone is, it's understandable anyone with symptoms is going to be a little worried but sometimes they appear to be excessively worried or they just look miserable and depressed and you might just get a hint from the fact the symptoms are not particularly typical of a physical disease and may start asking about depressive symptoms and discover that they have a few of them.." (Dr Blair)

Dr Blair acknowledged that formal application of the clinical method steers them towards managing problems within a biomedical framework. It is the general practitioner's experiential knowledge that helps to define which types of physical symptoms might be indicative of depression, but behavioural and other cues often provided additional information to trigger the investigation of a depressive rather than a physical condition.

It is also interesting that although the general practitioners are talking about symptoms that might indicate depression, they generally do not mention the physical symptoms of depression, as indicated in DSM-IV criteria for example, such as weight loss, reduced appetite, sleep disturbance.

5.2.3 Detecting a problem: Communicative cues

General practitioners described that there were some patients who presented their depression up-front, who would actually come into the consultation and say "I'm depressed". However this communication was, for the most part, only perceived as another potential cue for general practitioners because they would still have to determine whether this cue did indeed lead to a diagnosis of depression.

> Interviewer (B) " So we'll start by talking about how you manage depressive illness generally before you move on to the specific cases that you referred to me. How do you usually identify it?"
> GP "I mean sometimes it's very easy, they either come in and say "I am depressed", which they identify, and sometimes they are and sometimes it means they're a wee bit fed-up that week, but it isn't something I would call depression in medical terms." (Dr Morris)

The communicative statement could be interpreted at face value, that the patient is indeed depressed, or the communication could be interpreted as reflecting a more everyday common use of the term of being 'fed-up'. The general practitioner was aware of the potential for the patients definition to be ambiguous, and that their own 'medical' definition might differ from that of the patient.

> Interviewer (B) "How would you say you usually identify a depressed patient?"
> GP " Well it varies a lot. Some people come in and tell me they're depressed as their opening statement. That makes it slightly easier. Some people you know present with physical illnesses when you then manage to winkle out of them that actually they are suffering from depression. Some people come in with one thing and then as they're going out the door they happen to mention how low they're feeling. It's a question of being aware I think of the possibilities. The other side of things is the way that people make you feel. If somebody comes in and makes you feel depressed then it's worth thinking about whether they are." (Dr Gray)

This example also demonstrates that sometimes there are no perceived behavioural cues and that the first indication is a communicative cue, in this case appearing at the end of the consultation. This brings the general practitioner to comment that general practitioners have to remain 'aware' in order to be receptive to potential cues.

5.2.4 Detecting a problem: combining cues to make sense of patients' presentations.

The majority of the data extracts presented in describing the different types of cue, demonstrate that it was usually the presence of more than one perceived cue that would lead a general practitioner to consider that the patient's presentation involved a psychological or depressive problem. The cues were described as accumulating and they elaborated each other to suggest a potential psychological problem, although the types of cue and the emphasis placed on cues may differ for each individual patient. Below is an example of how doctors described drawing on a variety of behavioural, symptom and communicative cues in informing their recognition that the patient may be presenting with depression.

> Interviewer (B) "So let's move on to the sort or general management of patients with depressive illness, or potential depressive illness. How would you usually pick it up?"

> GP "Em, I'm very suspicious of situations where there seems to be a huge amount of anxiety about an illness for example. I would be looking at the demeanour of the patient as well. What's the eye contact like, are they prepared to be forthcoming. I would look you know, em unreasonable requests, I would wonder. Things where there might be a hidden agenda...repeated consultations for minor things would raise my suspicions or the parent presenting the child with problems that seem to be out of proportion to what's going on. Sometimes you can tell from the atmosphere between the patients when they come in together, say if they come in as a couple....I mean sometimes they come and tell me they're depressed you know, but that is quite unusual really. Well they say they're not feeling well, they're tired all the time, something like that. Yeah, what else? ....and the other thing is how the patient makes me feel. And certainly if a patient comes in and I immediately feel really low or depressed or I feel low or depressed afterwards, I highlight that in my own mind and think, "Right I must think about that next time I see the patient", you know whether there could be depressive illness here." (Dr Green)

The following example demonstrates this process in one of the women involved in the study.

> "[Patient's name] came to see me a few times beforehand and she was one of those women that gave me that sinking feeling, kind of as soon as I met her, and it did make me wonder about depressive illness. She was very pre-occupied with her physical well-being and she actually presented initially with some physical symptoms which she found very difficult to acknowledge might have a sort of anxiety undertone to them." (Dr Green)

Intuitive signs were triggered by the woman's previous and current behaviour patterns relating to her pre-occupation with her physical health and these were elaborated with the notion that the physical symptoms were indicative to the general practitioner of anxiety based symptoms.

5.2.5 Perceiving cues and acting upon them

One final point which I wish to make concerning the perception of cues by general practitioners, is that it was acknowledged by the general practitioners in this study that some general practitioners are more aware or receptive to signs than others, particularly the intuitive and non-verbal behavioural signs. It was also acknowledged that even when general practitioners had perceived signs that triggered their thinking towards an emotional or psychological problem they sometimes chose not to respond to these signs and sometimes deferred acting on them.

> "So it's not always easy. I think different doctors have different approaches to this. I tend to be sort of quite alert to, I try and pick these up. But I know for many years it was fairly traditional to actually just pat them on the back, reassure them, treat the physical diseases, sort of send them off for an x-ray and pat them on the back and say yes you're fine, and off you go. I think if you actually look for the depression type symptoms they are there and it can be quite rewarding to treat them." (F06)]
>
> "I think you've got to be able to either find the time or give the impression that you want to find the time. Now sometimes it's just not feasible, it's a matter of " I can see that you are really upset but I'm sorry today's not a good time, can you come back?". Sometimes yeah, I mean if the surgery is running late and somebody else comes in you think I'm just not going to pick up, whatever cues you throw at me I'm just not going to go for them. And you get some people who do that all the time unconsciously or not. And other people are absolutely hopeless at it and can never tell anyone to come back and most of us probably somewhere in the middle." (A3)

Hence 'intuition', 'awareness' and skills that detect behavioural changes in patients are skills that some general practitioners are perceived as being better at than others. It is also implied that medical practice in relation to the detection of depression has changed and that managing non-physical symptoms is now more recognised as part of the role of the general practitioner. However, it is also implied that some general practitioners are more reticent in picking up on signs and in managing emotional/psychological problems than others. General practitioners' descriptions demonstrated that they were sometimes limited by the organisational constraints within which they worked and they had to ignore the cues that they received from patients. However, the structure of general practice care also allowed them to take this risk as it was seen as deferring the problem to more suitable time rather than ignoring it. The general practitioners' accounts demonstrated the degree of freedom which they had in acting upon their recognition of depressive signs.

Although perceiving a cue that something was wrong precedes the diagnosis, it was also evident that the general practitioners could reach a diagnosis on the basis of these cues. These cues formed part of their knowledge for diagnosing depression. However, as will be demonstrated below, the general practitioners in this study also used other forms of knowledge in order interpret these cues and to diagnose and define the depression. The following section describes the process by which these cues were interpreted and the diagnosis was made. It is within this process that GPs constructions of definitions of depression emerge.

5.3 Making a diagnosis

As we have seen, in the process of recognising that something was wrong, general practitioners seemed to describe a range of cues that indicated to them that the patient was likely to be presenting with a psychological problem, and from these cues they may even have made a preliminary diagnosis of depression. However, the overall diagnostic process could be described as general practitioners making sense of these signs in combination with other types of knowledge. The signs were described as being interpreted against a background of knowledge from a range of sources.

We have also seen that general practitioners described how they did not necessarily find the experience of detecting and diagnosing depression straightforward. It was in discussing the problem of making a diagnosis that they revealed further types of knowledge that they used in their assessments. In this section I will describe these types of knowledge that general practitioners appeared to draw on. The analysis distinguished a range of 'types' of knowledge: medical (formal medical knowledge, clinical guidelines); experiential (the development of their own knowledge based on experience as a general practitioner and includes category specific knowledge); and biographical (in relation to the patient's history, family background, social circumstances). In analysis of these data, it is possible to ascertain how respondents thought about the underlying causes of depression.

The general practitioner accounts of the process of making a diagnosis described below, in combination with the set of cues described above, offer a general model of the elements involved in this process of making sense of problems as depression. That is to say, although not every general practitioner described each of these elements or placed the same emphasis on elements, each element was substantially represented within the data to justify its inclusion within the process of making a diagnosis.

5.3.1 Making a diagnosis: Medical knowledge

General practitioners had a body of medical knowledge, or medical reference points, against which they could compare the signs and symptoms of the patients presenting to them.

> GP "You find that em, in the early stages they maybe don't have the true depression, they maybe just feel a bit anxious or vaguely out of sorts, nothing that you can really put your finger on without the classical depression symptoms like you know sleep disturbance, loss of appetite. So sometimes in the early stages its difficult to pick up. And you know maybe a month later it's perfectly obvious that's what they've got but you can't always do that." (Dr Blair)

The previous section indicated how vague presentations or observed anxious behaviour might trigger a general practitioner to consider that there might be a depressive element to a patient's presentation. However, these same cues could also be perceived as problematic for determining a diagnosis of depression. The absence of 'classical depression symptoms' may lead the general practitioner to question the validity or the 'true' nature of the depression. This suggests that general practitioners feel they have knowledge of what a 'true' depression might represent and that this is related to a range of 'classical' symptoms. The absence of these classical symptoms is explained by the presentation of the condition 'in the early stages' with an indication that in time more obvious symptoms will emerge.

All doctors expressed in some way, the notion that there was a difference between a 'true' depression and some of the other depressive symptoms presenting to them in general practice. This 'true' depression was associated with 'classical', 'clinical', 'endogenous', 'biological' or 'medical' depression. General practitioners' accounts suggested that the types of depressive symptoms that general practitioners reported dealing with and how patients present to them only fit the clinical or 'classical' definitions of symptoms of depression in very few instances, and was occasionally problematic, as these two examples show:

> Interviewer (A) "What would be your ideal case scenario of managing someone?"
> GP "...I suppose somebody who comes in who, who has classical symptoms, biological symptoms...you know the sort of not sleeping, no concentration and all these sort of things. But it is usually not that straightforward, actually coming to a diagnosis." (Dr Cook)

> GP "As I say, the depressed patient who's lying in his bed, "hasn't eaten for 3 days doctor, he's expressing suicidal thoughts and we've found the loaded shotgun" – they're easy. But the whole point is where does low mood and difficulty coping with life appropriately start, and where does true depression, or where does it end? Where does depression start? And again, is this a depression with anxiety or agitation or is this a true anxiety based illness that's causing sleep [problems]? Or is there a depressive element to it as well? I find these things incredibly difficult and I've never found them in a book, I've never found the answer in a book." (Dr White)

Thus whilst general practitioner respondents did recognise and use their medical knowledge, this was not always enough. One explanation that was suggested for this is that there is a spectrum of depressive symptoms or presentations, with some being more obviously at the severe end and others within a borderline area that might constitute 'true' depression. However, the demarcation lines for determining the diagnosis are not clear for them.

The application of medical knowledge in the diagnostic process was also recognised as fallible.

> Interviewer (A) "Could you describe to me your general approach to the management of patients with depressive illness?"
> GP "First of all you make the diagnosis, that is the most important thing, because they are often presenting with other things in other ways...."
> Interviewer "Do you have any particular techniques that are used?"
> GP "If it feels like depression, then I ask them depression questions. They may have loss of appetite and energy, weakness and irritability – they are the standard ones and I just run through them. Once you have that then they are either depressed or not. It is a clinical diagnosis and sometimes you get it wrong. But that is as good as it gets to me." (Dr Murphy)

In discussing their use of a body of medical knowledge (in their reference to 'classical depression') general practitioners seemed to make distinctions between two main types of depression: 'reactive' and 'endogenous' depression. For example, in describing the thought processes he went through Dr White asked himself,

> "....is this a reaction to some life event or is it a true endogenous depression" (Dr White)

Dr Purves went on:

> Interviewer (A) "Do you have different categories of patients, do you categorise patients?
> GP "Sort of, but you see I've got a very pragmatic attitude to this you know and it's probably based on treatment rather than anything else and you do get, the two major groups of people that I see are people that have reactive depression and that's far and away the commonest sort of thing. It's an old fashioned expression perhaps. But people who have probably become depressed as a result of their circumstances. Em, there is a smaller group of people that I see that you've picked up over the years who have definitely a genetic pre-disposition or some form of em pre-disposition as a result of events in childhood or in later life that have left them vulnerable to depression and you see that group as well. You never lose them, do you know what I mean? Once they start coming to you, you are seeing them regularly for years....The commonest by far are the people who are there because you know, their marriage is awful, they have problems at work, their children are drug addicts, you know these sorts of things." (Dr Purves)

The medical reference points of 'reactive' and 'endogenous' types of depression are intrinsically associated with external and internal causal explanations[8]. The medical reference point of 'reactive depression' describes those that 'have probably become depressed as a result of their circumstances'. The 'endogenous' category applies to those who have a pre-disposition to depression. This pre-disposition can be genetic or the result of some traumatic event in life that has led to a vulnerable personality.

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[8] I have previously discussed the problem of defining and classifying depression in Chapter 2. Paul Mobius in the 19th century is credited with the notion of endogenous and exogenous disorders: the former consisting of a hereditary disposition and the latter being associated with life events. Wolpert (Wolpert, 1999) describes the endogenous and reactive categories as based on Mobius's terminology with endogenous being associated with a biological origin and reactive with life events with a negative psychological consequence. The main point is that it is within the medical literature and medical classificatory systems that these terms have emerged and although the terms 'reactive' and 'endogenous' may have disappeared from current classificatory or diagnostic systems they are still used in everyday general medical practice. It is also interesting to note that the women in this study, although using different terms, also used similar concepts in their causal explanatory frameworks.

Another general practitioner on being asked about whether they perceived different categories or types of patients with depressive illness commented:

> "You've got to sort of tell them "but it's", explain about chemicals in their brain and that kind of thing. And a lot of them find that very hard to accept. They understand that if somebody dies they should feel sad, but they don't understand why if everything's going well in their lives...why they should suddenly be feeling down, now....So I think the sort of endogenous ones, the ones that haven't got a reactive reason, can be quite hard." (Dr Reid)

Depressions that could not be associated with 'a reactive reason' were categorised as endogenous. In defining the type of depression general practitioners appeared to rely on the ability to determine an external causal explanation.

However, regardless of the categorisation of the causes of depression in the first instance, general practitioners did describe how 'chemicals in their brain' were implicated in causing even reactive depression. General practitioners pathologised the route by which external causal explanations (social problems or life events such as marriage problems, problems with work and difficulties with children as expressed by Dr Purves above) resulted in an illness, by suggesting to patients that their response to external factors caused 'a biochemical disturbance in the brain'.

> "I believe depression to be a biochemical disturbance in the brain, so it is a genuine illness that they've got. If you explain that and how it causes the symptoms they have, they're often a bit more receptive...But a surprisingly common comment is that eh, people will not actually feel depressed in the conventional sense of the word. You know they feel unwell, maybe have headaches, aches and pains, they don't sleep. But it's surprising how infrequently they actually mention the word depressed."(Dr Blair)

The application of medical knowledge that depression is to be understood as 'a biochemical disturbance in the brain' enabled general practitioners to define depression as 'a genuine illness'.

5.3.2 Making a diagnosis: Experiential knowledge

As I indicated above, general practitioners described using experiential knowledge in the recognition of depression, which helped them to identify depression in ways that are not reflected in formal medical knowledge (in clinical criteria such as DSM-IV). This experiential knowledge was used to differentiate different types and different stages of depression. General practitioners made it clear that this experiential knowledge differed from formal medical knowledge.

> Interviewer (A) "Do you personally have any sort of categories of patients with depressive illness?"
> GP "My three categories are anxiety, stress and depression. Which is totally non-clinical I guess and I won't imagine you'll find that in the ICD [ICD10 Classification System] or whatever configuration of depression.....So I probably don't make a conscious different diagnosis with them all, I tend to put them down with either stress or depression. I guess just based on how much is going on in life, around what the background and the context of the patient is." (Dr Cook)

General practitioners' used the terms 'anxiety' and 'stress' as reflecting both 'causes' and 'symptoms' of depression in addition to being conditions they also associated with depression. Dr Cook's perception, that her classifications were 'non-clinical' and would not be found within text-book classificatory systems, was similarly expressed by other general practitioners in this study. For example, in the exert from Dr White above (under the sub-section 5.3.1 on medical knowledge) where the general practitioner remarks that, for the types of decisions that he has to make on the basis of presentations in primary care, he says 'I've never found them in a book'.

General practitioners were explicit about their use of experiential knowledge.

> Interviewer (B) "What about the way you manage patients with depressive illness generally, before we home in on the two specific patients. Do you have, I mean how do you usually identify it, what usually triggers it for you? Are there specific things you look for?"
>
> GP "Well they tend to be female. I think that's the first thing. I think it's something they have a high awareness of. And there are many, many ways of discovering whether patients are depressed. They come in with something non-specific, like a common one is being tired all the time. I mean, how many times have we heard that? And once you let them talk it becomes clear that there is a background to this, of depression. I think that's the most common one. Or else they will actually come and say they're feeling low or they're feeling irritable, they're not coping. So either it's a sort of vague "I'm tired all the time" and they, either they don't know why or they don't want to talk about it initially. Or else it's the specific complaint. And sometimes it's the

> psychosomatic illness of course, the irritable bowel or the palpitations, these are the common ones I think we see nowadays." (Dr Cassidy)

The general practitioner holds a stock of knowledge that depressed patients tend to be female. This knowledge could be both experiential and/or derived from epidemiological or more formal knowledge. Dr Cassidy then talks about other types of knowledge that they use. The repeated presentation of 'being tired all the time' has also been incorporated into the general practitioners' knowledge as being indicative of a depressive condition. When these symptoms (or behaviours) are then observed in patients presenting to them, their experiential knowledge is used in making judgements concerning these symptoms. Hence the diagnostic process is one whereby general practitioners make sense of the signs they perceive in combination with general types of knowledge they hold – in this case experiential knowledge. As we have seen, they also hold experiential knowledge about the way a person looks when depressed that is used to inform their intuitive perception of signs and also their perception of behavioural signs.

General practitioners' accounts also revealed that they have knowledge of what they would consider to be normal emotional reactions.

> GP "I think she would certainly blame the death of her granny as the cause of her symptoms. And I think it may have been the trigger but it would be very unusual for someone that age for this to go on without other underlying problems." (Dr Purves)

In this example, the general practitioner recognises the potential for the bereavement to act as a causal mechanism for depression. However, it also shows that the general practitioner has a perception of what would be a normal or an 'unusual' reaction to a bereavement. In his stock of knowledge, this general practitioner does not associate someone of her age as normally reacting to a bereavement to such a degree. This leads him to suspect that there are other underlying problems.

Experiential knowledge was also mentioned in relation to the causal explanations for depression.

> "….But a lot of folk in this area do have pretty stressful lives for one reason or another – with financial problems and not particularly enjoying their work and kids that go on drugs as soon as they've got the money to go and spend on it. And a lot of people, whether or not they have that kind of [problem] – whether or not they might have had a tendency to depression in the first place, have so many adverse life events going on that something kicks it off, or a series of events just one on top of the other. And then they come in and start telling us about it." (Dr Morris)

The general practitioners experiential knowledge also indicated that some causal factor would be established, even if over time.

> "You just need to find out if everything is fine, with work with home, no debts or other things. And yet you think that there's something that's not ringing true here. And sometimes you just have to accept that's the way it is and hope that in time whatever it is will come to the surface." (Dr Cook)

5.3.3 Making a diagnosis: Biographical knowledge of the patient

All general practitioners described how their ability to detect depression was influenced by the degree to which they had prior knowledge of a patient. Knowing a patient provided the background knowledge against which they could assess whether the patient's behaviour was perceived as 'normal' or expected.

> "If it's somebody you've known for some time and then you notice that their personal appearance, that they haven't taken as much care as you would normally expect. You know, somebody who is usually made up and today there's no make-up, or there's, they're not as clean as you would normally expect to see them, things like that. Sometimes also people who are, not exactly aggressive but they may be a bit short, who you know are normally reasonably placid and they come in and a bit bad tempered because they've had to wait a little while, little things like that sometimes trigger in your mind maybe there's an underlying problem here." (Dr Shaw)

General practitioners also perceived that patients have different abilities in 'coping' and their assessment of patients in this respect also formed part of the detection and diagnostic process.

> " I think after 14 or 15 years you come to a consultation forearmed with the way that people have presented before….you build up a picture of how they

> cope over the years...you begin to realise just when something isn't quite right with a patient." (Dr White)

Most general practitioners accounts revealed how the process of *detecting* depression in patients involved an assessment of 'what is normal' for this patient. This was expressed in relation to what is normal or abnormal behaviour in the individual patient.

Defining the depression also involved assessing the severity of the condition. Whilst this could include the severity of behavioural and symptom cues observed, it was also expressed by the general practitioners in this study as including an evaluation of the impact the condition was having on the patient's day to day life. When asked about how they usually pick up that a patient is depressed this doctor described appraising the impact of symptoms on patients' lives.

> GP "Um well, their history and their symptoms eh.."
> Interviewer (B) "What do you particularly look for I mean."
> GP "Well eh, the severity of their symptoms, how much it's disrupting their day to day life."
> Interviewer "Right"
> GP "The effect that it's having on their personality, their ability to function on a day to day basis. Really whether that to carry on their work or maintain their role in their domestic situation." (Dr Smith)

Thus the general practitioners discussed explicitly gaining biographical knowledge and knowledge of the social context of the patient in order to define the severity of the symptoms.

5.3.4 Making a diagnosis: a subjective experience

Overall, the experience of diagnosing 'mild' depression was reflected in the general practitioners' accounts as a subjective process where even the application of medical, experiential and biographical knowledge could not always result in a clear cut diagnostic decision.

> GP "But I think you also get to the stage where you sort of wonder what is actually normal, the mildly depressed ones are quite difficult because em you

> know, you sort of think what is normal and what is not normal. And certainly I mean I find that post-natal depression ones, we give them a questionnaire, and the health Visitors are coming back with an awful lot of patients that they say"
>
> Interviewer (Aine) "All new mothers are suffering from PND (laughing)"
>
> GP "I know, and I mean really everybody sort of has low phases after they have had a baby you know. It's deciding at what point these women are actually genuinely depressed. I mean it may just have been sort of the mood they were in when they filled in the form." (Dr Swift)

This expressed the general level of ambiguity that general practitioners experienced when assessing what they considered to be a 'mild' depression. In this example the findings of a standard diagnostic questionnaire were brought into question and even experiential knowledge can not always be used to determine what is to be perceived as 'normal'.

5.4 Chapter summary

In this Chapter I have presented an analysis of how general practitioners recognise that patients are presenting with a problem and how they make sense of this problem as psychological in nature (that it is something other than a physical presentation or that the physical presentation has an underlying emotional/psychological background). Within this process, general practitioners described three types of cues that alerted and triggered their thinking towards an emotional/psychological or depressive problem: behavioural; symptom; and communicative cues. Although the perception of cues themselves could indicate to the general practitioner that a diagnosis of depression was likely, these signs were usually interpreted and made sense of with reference to further sources of knowledge held by the general practitioners. I have described this knowledge as consisting of three types: medical; experiential and biographical. The process of diagnosing and defining patients involves making use of these sources of knowledge. The general practitioners medical knowledge provided a backdrop of symptoms and criterion that they could use. However, these classical signs and symptoms were not always enough on which to base a diagnosis, particularly when such 'classical' symptoms were not evident in the patient's presentation (and in their experience people were often 'presenting with other things in other ways'). General practitioners made distinctions between reactive and endogenous depressions and therefore in defining the type of depression they relied on the ability to determine an external causal explanation. This led them to seek further biographical knowledge of the patient's circumstances. The general practitioners also made use of their experiential knowledge in establishing a range of: patient types; normal and abnormal reactions; presentations and symptoms; and causal explanations, that they developed into a 'recipe' for identification of depression. Their biographical knowledge of the patient would act as a trigger for suspecting depression and in defining the severity of the condition or the threshold for normality in any given patient. The combination and interaction of these types of knowledge helped the general practitioners to make a diagnosis and to define the depression. However, the subjective nature of the diagnosis of depression was exemplified in the general practitioners accounts of the difficulty and the fallibility in applying their knowledge. Experiential and biographical knowledge were particularly influential in raising general practitioners awareness of the types of signs that could indicate an underlying problem of depression, and particularly in relation to individual patients.

Although the diagnosis of depression was rarely made reference to formal medical knowledge, it was the application of medical knowledge that general practitioners used in order to define depression 'as an illness' and to pathologise the effects of the patients' social problems.

General practitioners' accounts of managing depression must also be seen within the context in which they take place: within busy general practice surgeries; over a series of consultations (not all related to the management of depression); with general practitioners having substantial knowledge of the patient and their family; and within an established or newly establishing relationship. These contextual issues have implications for the management of patients. I will return to exploring the general practitioners' accounts of managing depression in chapter 7.

The following chapter now returns to exploring the women's accounts of the management of depression and describes how the women evaluated their doctor's explanations and advice in relation to their problems.

Chapter 6 Women's perceptions of the management of depression

> *"Attitudes of trust, as well as more pragmatic acceptance, scepticism, rejection and withdrawal, uneasily co-exist in the social space linking individual activities and expert systems. Lay attitudes towards science, technology and other esoteric forms of expertise, in the age of high modernity, express the same mixture of attitudes of reverence and reserve, approval and disquiet, enthusiasm and antipathy... "* (Giddens, 1991: 7)

6.1 Introduction

In presenting an analysis of the women's data in this thesis, I am presenting an epistemology of the women's experiences, which takes account of how they make sense of depression and of antidepressant medications: how they derive their knowledge. Chapter 4 described how women talked about recognising a problem. This involved the perception of one or more signs that were categorised as physical, behavioural, cognitive/emotional, and (to a lesser extent) communicative. It also showed how women made sense of these signs and symptoms with reference to different types of knowledge. It also demonstrated how decisions to consult a general practitioner were presented as seeking further answers to the questions 'what is it?' and 'why has this happened?', and how help seeking was presented as a moral act, as 'a last resort', and for the benefit of others.

I have previously stated that in order to understand patient behaviour in relation to the management of depression it is important to understand their perception of the problem. When the women in this study presented their problematic experiences in the consultation, they had already engaged in some attempt to make sense of their experiences with reference to their own existing knowledge. They entered the consultation to seek further help with understanding 'what is it?' and 'why has this happened?', or to confirm their own 'diagnosis', and also to do something about the problem. The first section of this chapter explores the women's accounts of making sense of their problematic experiences having consulted their general practitioner. It demonstrates how patients evaluated their general practitioners' explanations of their problems in relation to their own perceptions and explanations for their problems. It describes how the women accounts of the general practitioners' explanation (and in some cases a diagnosis), was understood and was largely accepted: when the women perceived their own theories had been recognised and accommodated; or when the general practitioner's explanation/diagnosis made sense to them within their existing knowledge; or when the general practitioner's explanation/diagnosis made sense of their inchoate feelings and/or was acceptable to them because it addressed their needs at that stage of their experience. The data also demonstrate how the women's perceptions of the interaction with their general practitioner also played a crucial role in their evaluation of the consultation and the explanations or advice offered. The data also lend additional support to the view that the process of evaluating explanations and making sense of their experiences is an on-going process where the general practitioners' (medical) knowledge is evaluated in light of the women's existing knowledge.

The second section of this chapter explores the women's accounts of being offered antidepressants and their experiences of using anti-depressant medication. It describes the meanings the women attributed to antidepressant medications, and their evaluations of anti-depressant medications for the management of their problems, as they perceived them. I have chosen to focus on the women's perceptions of antidepressants and their use, rather than other aspects of their management (e.g. a referral), because antidepressant therapy was the main treatment offered to the women in this study, and it was offered to all women. Compliance with medication was also one of the main themes of interest to the study as presented in the funding application.

Since some of our interviewees had relatively new experience of depression, and some (but not all) had received a diagnosis, they were able to recount the experience of presenting their symptoms to their general practitioner, and of receiving an explanation or 'diagnosis' in detail. Women with more long-term experience of depression were likely to have received an explanation or diagnosis in the, sometimes distant, past and therefore their accounts were less focused on this event. Therefore, in the first section of this chapter, which examines the women's perceptions of their general practitioner's explanations of their problem, there is more of a focus on the accounts of those with relatively new/likely depression. Nevertheless, throughout this chapter, some similarities and differences across the two groups of women are also highlighted.

6.2 Women's perceptions of their general practitioners' explanations of their problems.

Lewis (1995) has previously shown how patients had different reactions to a diagnosis because it held different meanings for them.

> "How persons themselves understand a change in their state has implications for their behaviour, and this affects their apparent symptoms and how their problems are identified and classified. It also has implications for identifying appropriate treatments and for understanding the effects of communication about depression as part of the treatment process. The problem of depression may be identified through the diagnosis but the diagnosis itself has meaning." (Lewis, 1995: 370)

Lewis' sample (unlike the present study's) had all received a definitive diagnosis of depression and/or defined themselves as depressed. Lewis suggested that "*The diagnosis was a key point at which an individual's problems were identified as depression*"(p370) and described four potential outcomes on receiving a diagnosis: acceptance of diagnosis; acceptance but also questioning the diagnosis; rejecting the diagnosis; and having a diagnosis denied. The analysis presented here builds on this by attempting to explain how different outcomes are likely to be achieved.

6.2.1 Explanation: own theories accommodated

Women's accounts suggest that general practitioners' explanations were understood and were largely accepted when the women's own theories were perceived to have been taken on board. It was important for the women to have felt that they had been listened to, and that their general practitioner had been sympathetic towards their experiences. When the women perceived that they had been listened to, and to have had their own theories accommodated, they were more likely to accept or accommodate the general practitioners' explanation and to be satisfied with the outcome of their interaction with their general practitioner. This is implicit in the tenor of their accounts, but is also supported by an overall understanding of their interview accounts as a whole.

> "I had made an appointment for Dr[] the following Monday and she said "We'll run that one again [blood test] because it's not terribly high, but just to eliminate any other physical thing". And she chatted to me, and asked me how I felt, and had I been sleeping em, how had I been feeling, what did I do at work, how were things at home and before I knew where I was I had just opened up and I was in tears and she sat and she listened to me and she was very sympathetic, not through actually saying anything, but you could see, just by her demeanour that she was listening to me, and really listening to what I was saying, because at that point I really did think it was something physical, I didn't think it was any emotional thing that had made me ill, or that way. I thought it's something wrong that we just can't see yet. And I said to her "I really feel as though I'm going off my head" because there were times where I'd be ranting and raving, I'd get really quite up-tight with what was going on, and I thought "I'm going to explode"....I was so relieved when she told me there actually was something wrong....she said "Look given what you've told me just now" and she must have been watching me the whole time, she said "You're very up-tight, very stressed and", she listened to what had happened and she definitely felt that it had been a build up, but precipitated at that point by the pressures of work, em she said "You're not off your head, you're not going mad, you're stressed" and she said "I think you're depressed as well" ". (Tricia)

Tricia constructed two accounts of her symptoms. In one account her understanding of symptoms and common-sense knowledge indicated to her that there could be something physically wrong. However, this account would not serve to explain her behaviour, which she perceived to be irrational. The two possibilities that Tricia considered were: that there was a physical explanation that had yet to be detected; or, she was 'going off her head'. The general practitioner's explanation brought relief because it meant that she could put aside her own fears and concerns of 'going mad'. The general practitioner's explanation also included a reason for the stress and depression, namely her working environment (this was an explanation that Tricia could identify with, and one that she subsequently adopted and used herself to account for her condition). The general practitioner had also attended to Tricia's other potential explanation by conducting the relevant tests to eliminate this causal explanation. The general practitioner had not trivialised or ignored Tricia's own personal theory, but had accommodated this when pursuing their own explanation. Tricia perceived she had been listened to and had had her experiences acknowledged.

It was important for the women to feel that their opinions had been taken seriously. For example, Linda described how her general practitioner had not dismissed her own ideas. She also recognised that her general practitioner had not readily imposed his own ideas upon her.

> "I feel that he [GP] has been brilliant with me, it's like he has not dismissed anything I've said......But I feel that the first week when I went to him I had a wee bit of a weep and I was strange with him...but he didn't say "Right, I think you've got this that and the other", he didn't kind of like judge what I had and say that's it cheerio, take the medicine, away you go. It was like he sat back, he would help out if I was struggling [to explain]." (Linda)

Linda's general practitioner had taken her own opinions seriously and had not rejected them without consideration. She perceived her own contribution to the diagnostic process to have been valued. Linda also described her general practitioner's explanations for depression and how he accounted for her own symptoms within this framework.

> "...the way he explained it was, part of your brain, like people with maybe arthritis, if they are constantly living with pain in their arms or legs or whatever, part of their brain gets run down because they are having to deal with this and it was a type of depression that they get. Or if somebody split up like my mum. And in my case it was where I had the flu so much and my body was running itself down and my brain was really going into neutral in certain ways, that it wasn't giving like the motivation and kind of injection to get up and do things, my brain wasn't stimulating enough, it was run down, and I don't know if this is right." (Linda)

Linda's own understanding of her symptoms was that she had a post-viral condition. Her general practitioner's subsequent explanation for the depression accommodated her own theory that she was 'run down'. Her general practitioner's description also included other potential explanations for depression that did not apply to Linda but provided her with examples of both physical and social causal mechanisms for depression. Her general practitioner produced a causal framework that made sense in relation to her own post-viral theory. To Linda, this explanation seemed plausible and therefore was not rejected. However, she revealed that she did not fully understand how physical illness impacted on the functioning of the brain and therefore the doctor's explanation was still open to further evaluation.

To further elaborate the importance that the women attributed to having their own theories sufficiently taken on board, I will present some examples from the data whereby the women perceived that their general practitioner had not sufficiently accommodated their own theories. In this first example, Maria recently consulted her general practitioner because she was on steroids and wanted to come off them because of her weight. Her doctor diagnosed depression, but Maria insisted on going to hospital for (thyroid) tests again.

> "I went to the doctor about 6 month ago and maybe 9 month ago because I was feeling very, very tired and I've got pituitary gland problems.... He said it was depression but I would insist on going [to hospital] because I've been in and out – I first took these symptoms about 10 years ago....eh tiredness and I couldnae concentrate....so I went up [to the GP] to see about the weight and the steroids and could I come off them. And I was feeling miserable and down and tired so he gave me an examination, and it took a fortnight for the results to come through and he said it wasnae that. I don't believe him." (Maria)

Maria was unconvinced of the general practitioner's diagnosis of depression because she saw her symptoms as a consequence of her physical health problems. Maria perceived physical symptoms of 'tiredness and not being able to do things', and made sense of these signs and symptoms in relation to her pituitary gland problems. Maria had used her knowledge of her illness biography and her previous illness experiences to make sense of her current experiences. Maria reports that, she had to 'insist' on being referred to hospital. This reveals that her general practitioner was reluctant to accommodate her own ideas and theories concerning her illness. In the end, the results of a medical test did not carry enough weight for Maria to reject her own hypothesis and accept her general practitioner's explanation.

Maria had previously been ill following the death of her husband and was treated for depression as an in-patient. Her own explanation for this was "I wore myself out wi' looking after him" and viewed her psychiatric care as a result of the medical profession's inability to diagnosis her problem. "So they couldnae diagnose me and they sent me into a mental hospital right". It was around this same time that she was subsequently found to have pituitary gland problems. Maria also explained another episode of depression as a reaction to 'an anti-bacterial' that she had been given for a UTI. Therefore, Maria also made use of her previous experiences of medical encounters, and her knowledge of the potential for the medical profession to mis-diagnosis illness, in evaluating her general practitioner's explanation and advice.

Whereas Maria's own theories contested her general practitioner's (and other doctors') explanations of depression, other examples from this study show how some women's self-diagnosis of depression was not taken on seriously by their doctors.

> Interviewer B "So you did go to your original doctor and what happened?"
> Interviewee "He told me to pull myself together. I was a young woman with two healthy children at home and my husband worked, [he said] "What do you have to be depressed about?"(Vicky)
>
> "I was really, really ill with post natal depression and the doctor down South he said "Oh why can't you cope with a baby?" and ...."Oh don't be silly, how can't you cope with a baby of six months" and things like this, but I didn't cope with her. And that was basically the start of the problems that I did have with depression." (Louise)

Both of these women's problematic experiences were effectively denied in these medical encounters; at best, both doctors' reactions served to trivialise their problematic experiences. The general practitioners used the women's family circumstances as reason to indicate that they should not be depressed. Vicky and Louise reported having had depression for many years and the comments above relate to their early experiences of attending a general practitioner. These experiences contrast with their current experiences of their interactions with their general practitioners:

> "He's very good. He listens and he never hurries you. So I think in that respect I'm lucky I've got a good doctor. Because I think a lot of folk maybe with depression and that just put it off, it's not important, it's your own fault type of thing, but he's not like that at all. So I've been lucky." (Louise)

Sometimes the women had to persist in having their own theories accommodated and to have their experiences acknowledged. The following example shows how Carrie had to make different approaches to her general practitioner in order to have her experiences acknowledged.

> "....then I thought, there has been a lot of things, between my divorce and family and things like that, there has to be a reason why I was greeting like that, and as I was saying when I went to the Doctors, it was like he didn't want to listen to me to begin with, and that's what I'm saying, I was trying to get through to him, there's something wrong with me, I'm greeting all the time, I need help.
> ....The second time, it was more my anxiety, my anxiety was getting worse, he knew about the way I was feeling but the second time it was my anxiety, that I couldn't breathe, I felt that I was choking, and it was like, "There's nothing I'm going to give you for it, you're just going to have to learn to relax", and I thought, but I've tried that, I can't relax, I just, this feeling in my throat, I couldn't breathe and I actually got the Doctor to check my throat, just to check if there was any obstruction, or anything in my throat that was making me, I thought it was like my airway, something was blocking my airways, that I couldn't breathe properly, and he felt round my throat and he felt my glands and that, and he said, no there's nothing obstructing your airways or anything, you're just going to have to learn to relax."(Carrie)

Carrie presented up-front with emotional problems but did not receive the response she expected from her general practitioner. Therefore, when consulting for a second time she presented with more physical symptoms, and even asked for a physical examination in an attempt to have her symptoms taken more seriously. It was only at her third consultation, when she presented with difficulties sleeping, that Carrie eventually received a diagnosis of anxiety and depression. It is interesting that Carrie tried different approaches to get the response she wanted.

In all of the examples presented above, the women had attended their general practitioner with some notion or theory that might explain their experiences.

6.2.2 Explanation: makes sense to the women in relation to their own experiences and knowledge

The accounts from the women in this study also suggest that the general practitioner's explanation was likely to be acceptable when it made sense to them in relation to their experiences and in relation to their existing knowledge, or when it provided them with new knowledge that could be accommodated into their current understandings of illness and emotional experiences.

> "He just he understood straight away, he said "Well you have had a lot of problems with [baby's name]...and he said it was understandable that I was feeling like that, that I was feeling low and obviously I would be feeling worn out....and the times that I had to feed her every hour for 24 hours and he said "Obviously you're going to feel worn out, not everybody's supersonic, not everybody can live like that", and he told me, he said to me that the important thing as well, was not to feel guilty about the way I was feeling, that it's not a bad thing, that a lot of people go through it."(Janet)

The general practitioner's explanation made sense to Janet because it reflected her own experiences back to her. His descriptions of her condition as 'feeling low' and 'feeling worn out' were also terms used by Janet to describe her symptoms. In this way the diagnosis of depression was not made explicit but was presented to her in a way that fitted with her own experience of symptoms; and the causal explanation given (problems with the baby) also reflected her own explanations for her symptoms. In chapter 4, I showed how Janet's understanding of post-natal depression was "*not wanting your baby*". Her general practitioner's explanation presented her with new knowledge that enabled her to redefine what she perceived post-natal depression to be like, and for her to conclude "*but obviously it's not like that, and it wasn'ae like that in my case*". The general practitioner's explanation also informed Janet that this was a common experience, which served to normalise the experience for her and address any potential feelings of guilt that she may have been experiencing (I address this issue further in the sub-section below).

An example of when a woman perceived that the general practitioner's explanation did not make sense further makes this point:

> "I took gingivitis when I was pregnant which is bleeding gums....so I went to the hospital, been twice and they took blood tests to check for vitamin deficiency. That's what actually made me go to the doctors, because I was tired all the time...the doctor must have picked that up. That's when she suggested to me I was possibly depressed and I was like that, "No". And I actually left the surgery thinking "God sake I went up there for I thought it was lack of iron and she's trying to say I'm depressed. I'm no depressed"." (Jeanie)

In this case, the general practitioner's diagnosis and explanation was so far removed from Jeanie's own theories about her symptoms that it actually made her angry and led her to reject the general practitioner's explanation.

By the second interview Jeanie had new evidence that confirmed her own explanation. Her account also suggests that she continued to search for explanations for her experiences and continued to evaluate her general practitioner's explanation.

> Interviewee "And the blood tests came back that I was anaemic, so I am now on iron tablets, which I'm not very good at taking. But that would explain how I feel the tiredness all the time, which was my initial visit to the doctor. I am, what I have also mentioned to the doctor, see I didn't think anything of it. I actually thought it was quite normal every month just to get down in the dumps and get tired and eat a lot. And it was actually the health visitor, she said, "Have you ever mentioned to the doctor about PMT" and I said no, I just thought it was something that you put up with. I'm beginning to see now that that's..."
> Interviewer (B) "Related?"
> Interviewee "I think that's what it is. I think see for that week before my period my mood just goes right down and I think that now I've got awareness of it I'm accepting it more and thinking well this isn't going to be forever. I'm not putting that down to an excuse but I think maybe, was it depression? Or was it that was the times I was going to the doctor when I was really, really feeling low like that. Because I used to say that when he kept diagnosing me as post-natal depression I am saying no, it wasn't anything to do with my baby, I didn't really feel that. I had a lot of stresses round about me, the pressure of my mother-in-law. And a lot of it I feel as if it is just my mood swings that I take, PMT and also the baggage, all that baggage I carried about with me as well." (Jeanie)

Jeanie's 'baggage' involved being brought up by alcoholic parents but this did not make sense to her as causal factor for post-natal depression.

However, her account suggests that she began to incorporate her general practitioner's suggestions into her explanations. She went on:

> "I think I suffer from very, very mild depression. See my problem with this PMT but, is it depression or is it an effect from living with alcoholism, because part of me sometimes I feel that living with alcoholism is a world of self-pity that somebody listening to you would think it was depression, is it the same thing, I really honestly don't know." (Jeanie)

It is clear that Jeanie remained equivocal about the explanations for her experiences at least partly because her general practitioner did not incorporate her own theories.

6.2.3 Explanation brought relief

General practitioners' explanations were more likely to be acceptable to the women when they brought feelings of relief or when they normalised or legitimised their perceived symptoms. The general practitioners' explanations were also more likely to be acceptable when they helped to make sense of inchoate feelings that the women had been unable to make sense of within their existing knowledge. In a sense, the general practitioners' explanations were acceptable when they met a 'need' for these women.

> Interviewer (B) "So that consultation with Dr[], did you think it was helpful?" Interviewee "Well, I came out thinking to myself that I wasn't the only person that was feeling down. I didn't feel so much embarrassed about coming in because she explained to me that a lot of people, she said she sees a lot of people that have got the same symptoms and that there is medicines that can help and she says to me "You're not going mad"....So, I did come out feeling better." (Ruth)

For Ruth, the general practitioner had acknowledged her experience and confirmed that her experience of 'feeling down' was a legitimate reason for consulting. The general practitioner's explanation also normalised her experience in portraying it as common, thereby addressing her concerns about 'going mad'.

In other circumstances, the general practitioner's explanation was acceptable because the explanation, or its meaning, had consequences that met other needs as perceived by the women. In the following example, it is the need to take time out from work, whereas other examples included the need to have their behaviour legitimised for others (such as family members).

> "...I'd had flu at Christmas and I said to her "I think this might be post-viral"....but she discussed it with me in greater depth and she felt it was anxiety...and at that point she said "You're not fit to be working.....
> ....I wouldn't have [stopped] I needed the doctor to tell me that, I needed someone to do that." (Jill)

The general practitioner's alternative explanation had implications for Jill's ability to work. Having previously recognised that she was not functioning as well as she used to at work, but unable to detach herself from her responsibilities, the general practitioner's explanation offered a legitimate reason to stop working. Jill readily accepted this explanation over her own initial attempt to make sense of her symptoms as post-viral.

In contrast, when the women perceived that they had not been listened to, and the general practitioner's explanation was perceived as inadequate or was not perceived to have brought relief (or legitimacy), they were more likely to express unhappiness or dissatisfaction with their general practitioner's explanation.

> "So I went to the doctor and explained what I was going through and he said I was very stressed and I had a very stressful life and being totally stressed that's why I was feeling depressed....Em, I felt as if when I came home, I felt at the end of the day he wasn't really taking in why I was so ill. But at the end of the day I was still left with the burden on the shoulders. I just couldn't cope.....Went back four times...It's just the obvious [he says] I'm stressed out, [he says] "do something, go away on holiday or have a break somewhere and that would be fine", but it's not easy." (Pat)

Pat did not challenge the general practitioner's explanation as such, but the general practitioner's explanation was something she already knew, and in her account this was not an adequate explanation as to 'why' she should be depressed, and, in effect, receiving a diagnosis was of no help to her. Pat's interaction with her general practitioner had not met her perceived needs.

> "At the end of the day I should have had someone to talk to...he didn't sit down and talk to me, just "There's some tablets for you to take out". And you walk out and think "He didn't want to know what I was saying, he just didn't listen to what I was saying." (Pat)

Receiving a diagnosis without an adequate explanation was also perceived by the women as adding to distress rather than bringing relief.

> Interviewer A "Can you think of anything that might have been handled differently in your situation over the years?"
> Patient "Well, I suppose when my, five years after my father died when I went to the doctor's and he just said here's Valium....I didn't know what depression

> was, I'd never experienced anything like this....even my husband didn't know what it was. The doctor said "Well its depression", he [husband] says "What's depression" and that was it...because I didn't know what depression was. Horrible, horrible experience. Oh [gasps]." (Ailsa)

In this encounter with a general practitioner Ailsa did not receive an explanation for her condition, only a diagnosis which she did not understand or have any knowledge of at that time. The general practitioner's explanation did not meet her needs, which were to understand her experiences. This description contrasts with her current encounters with her general practitioner, where she perceives that her general practitioner has insight into the potential causal factors for her recurrent episodes, and that these explanations make sense in terms of her own perceptions of the factors that are likely to trigger a depressive episode.

6.2.4 Value of the relationship

The women were all asked directly about how they would describe their relationship with their general practitioner. The women's accounts showed how the development of a 'trusting' relationship was important for their care.

> "I'm more trustworthy of my GP now, I'll continue to go back if possible...to try and see the same doctor as much as I can. Because when you're seeing various doctors they don't know you that well. They've got your notes and that's it. But when you've been seeing a doctor regularly, they get to know your personality. And that's how I feel with Dr[], because I've seen him a few times, he knows me and I trust him, and I do trust doctors, but I trust him more, because he's listened to me and he understands and so it has changed the way I think about GPs. Some of them don't listen, some so...and I'll go back to the same one now that I have found one that I could trust, and that I feel able to talk to and relax with." Janet
>
> "But she [general practitioner] was sort of new and it's like everything else. It's like breaking in a pair of shoes, you walk carefully at first so you don't get blisters on your heels. But yes I think I could go in and speak to her now and fel alright about it because I've got to know her." (Rebecca)

Janet describes having a general degree of trust in doctors but also of having 'developed' trust through her encounters with her general practitioner. Whereas Rebecca was more cautious in trusting her general practitioner and it was through her experiences of her interaction with her general practitioner that the trust would develop. The women's accounts also contained stories of encounters with general practitioners where they perceived that they had not listened and how they had subsequently lost 'faith' or 'trust' in the doctor.

The women also spoke of having a relationship or valuing a relationship that went beyond the 'traditional' doctor-patient relationship.

> ...It's not a kind of doctor-patient relationship, it's like a kind of relationship where you have got two people talking about things and discussing them, discussing how you feel, discussing what treatment should be of help, discussing if I need a prescription for something." (Linda)
>
> "He'll maybe say "I'm going on holiday" [I'll say] "Oh where are you going" or "How are your children" Which I think is an extra thing. A lot of doctor's you couldn't do that with...It can't always be just a one way thing you know."(Louise)
>
> Interviewer(A) "How well do you feel he understands what is going on in your life?"
> Interviewee "Oh he knows everything, even any wee things. You tell him and he deals with it...he's always got time for you....I do what that man tells me...he's one for the few people that I trust." (Peggy)

Reciprocity in the relationship was important and having encounters that were more of an equal partnership. The latter two examples also reflect the value that the women placed on 'being known' by their general practitioners and 'knowing' their general practitioners. However, there were some women in this study who did not place the same value on the benefits of 'being known' by their general practitioner. In one example, a woman was happier to speak to a general practitioner she did not know because she did not want her usual general practitioner, who had seen her throughout her pregnancy, to judge her, particularly in relation to her new status as a mother. In another example the woman was reluctant to speak to her general practitioner because she perceived him to be a 'friend of the family'. In both these examples the women were concerned about their emotional problems affecting the way they were 'currently known' by their general practitioner.

There were also some women whose accounts did not emphasise the importance of the relationship as much as the majority of women did. These examples generally reflected a lack of an established relationship and a degree of disagreement surrounding the diagnosis and its management. For example, Gwen perceived that her problems were the result of an accident she had suffered and she had been taking pain killers for a long time (almost two years). There was a general reluctance to consult her general practitioner and she reported that he restricted the type of painkillers she could access. She had twice taken an overdose (of painkillers) and did not want to accept antidepressant medication saying:

> "Because I don't think they helped me the last time, so I didn't see any point going, listening to him, forcing me to take something I didn't want to take." (Gwen)

Gwen said she found it difficult to 'volunteer information' about herself and that her general practitioner did not have an understanding of her life in general.

6.2.5 Summary

In this section I have shown how in evaluating their general practitioner's explanation for their problem women made use of their own knowledge and experiences. The women were more likely to take on board their general practitioner's explanation if they perceived that their own theories had been accommodated and adequately explored. When general practitioners were perceived to have taken patients' concerns for their physical health seriously and conducted tests or examinations, the patients were more likely to perceive that their general practitioner had listened to them and taken them seriously (as a person). Patients were less likely to feel that their problems had been trivialised. It was also important for the women to perceive that their general practitioner had acknowledged, and not denied, their experiences. 'Being listened to' was an important aspect when first presenting with depressive symptoms.

The general practitioner's explanation was also more likely to have been taken on board by the women if it made sense to them in relation to their own knowledge and their own deliberations on making sense of their experiences, or when the general practitioner's explanation helped the women to make sense of inchoate feelings and brought them relief, legitimised their behaviour, helped to address their feelings of guilt or fulfilled some other need for these women. The guilt that these women experienced through their behaviour, their loss of ability to cope, and their inability to perform expected social roles was partly alleviated or sanctioned through the receipt of the explanation (or 'diagnosis').

The women placed great value on their relationship with their general practitioner. There was some degree of 'inherent' trust in general practitioners. However, their interactions with their general practitioners were important in the development of trust. Trust in a general practitioner was engendered by 'being listened to' and also through a degree of reciprocity in the relationship. The women generally valued encounters where they perceived there was mutual understanding and a sharing of knowledge.

Finally, it is clear that the process of making sense of their problems and evaluating their general practitioner's explanations is an on-going process – whereby new evidence is assimilated and evaluated in light of previous knowledge and experience. This new evidence can add to their existing theories (and help to confirm these further), or it can be rejected, or it can remain open to further evaluation when more new evidence becomes available.

Lewis emphasised 'the diagnosis' as the key point at which problems are identified as depression. However, chapter 4 showed that this is not the same as the point at which an individual identifies a problem and begins the process of making sense of their experience. For Lewis, acceptance or rejection of the diagnosis was based on an individual's understanding of depression and its potential causes. But, in examining the whole process of the patients' experience of recognising and making sense of symptoms, this study has shown that patients' evaluations of the explanation or 'diagnosis' are not simply made on their understanding of depression and its causes. Patients use a broader and more complex assimilation of knowledge of signs and symptoms and personal inventories of behaviour and illness experience. In addition, I have found that the interaction between the patient and the practitioner itself may influence the patient's evaluation of the doctor's explanation. Therefore my own account goes beyond Lewis', which only acknowledged the 'contradictory relationship with the medical authorities', in discussing a patient who had a diagnosis denied by her general practitioner.

The women's evaluations of their general practitioners' explanations of their problematic experiences also had implications for their acceptance of the therapeutic management proposed by their general practitioner. In the second section of this chapter, I explore the women's accounts of their perceptions of the management of their symptoms with antidepressant medication. I present this as the women's evaluations of antidepressants for the management of their problems as they perceived and made sense of them.

6.3 Section 2: Patients' perceptions of medication

In order to shed light on the women's acceptance and use of antidepressant medications, this section explores the way they talked about and seemed to perceive these medications. Whilst it does not describe the outcomes for each of the women in relation to medication use, it does attempt to explain what influenced their decisions regarding medication use and to explain how different outcomes are likely to emerge.

The analysis in this section suggests that the acceptance and use of anti-depressant medication was influenced by one or more of the following: the women's own perceptions of their problem (based on their use of experiential and common-sense knowledge), their evaluations of their general practitioner's explanations and their evaluations of their interactions with their general practitioner; the women's common-sense knowledge and personal experience of antidepressant (and similar) medications; and the women's common-sense knowledge concerning medication taking in general. I will demonstrate how the women perceived medication use as a moral dilemma and how they subsequently accounted for their medication use as a moral act and/or because their general practitioner's explanation of medication had addressed their concerns, thus alleviating the moral dilemma. The accounts of medication taking by the women in this study showed how medication use was subject to on-going evaluation so that they both accepted and rejected medication at many different points in their illness careers. Thus the women could not be classified as either 'accepting' or 'rejecting' medication. In considering taking antidepressants they reflected on whether this made sense, as well as evaluating the decision in terms of other knowledge regarding medication and medication use.

In the accounts of women with relatively new/likely depression, their thoughts and feelings concerning the suggestion that they take antidepressant medication for their problems, and their personal accounts of their decisions regarding the use antidepressants, were more at the forefront of their discussions. Hence their accounts of being presented with antidepressants, and the meaning this had for them, were more detailed than for the women who had previous experience of depression and had already experienced using antidepressants. For women with previous experience of depression I will offer some insight into their on-going evaluation of medication use, in order to explain their behaviour in relation to medication use.

6.3.1 Evaluating antidepressants in relation to available explanations

The women's accounts revealed how their previous evaluations of their general practitioners' explanations (evaluated in relation to their own attempts at making sense of their experiences with reference to their own knowledge systems), and the degree to which the general practitioners' explanations were taken on board by the women, were also influential in their evaluations of antidepressant medication for the subsequent management of their problems. In order to provide some continuity in describing this process I have used data from many of the same women whose accounts I presented in chapter 4 and the previous section of this chapter. This helps to build a picture of how the women's own attempts at making sense of their experiences and their general practitioners' explanations were brought into play in evaluating antidepressants and their use.

For example, Linda had perceived her problems as the result of post-viral fatigue. She accepted that she might have depression '*in some respects*' (see chapter 4, section 4.3.4), but that "*it's a depression that is related to physical and mental side rather than maybe my granny passing away or my husband getting paid off*". Her general practitioner's explanation of her condition had accommodated her own theory, as did his explanation in relation to her need to take antidepressants.

> "He let me speak about whatever I wanted to speak about and then he would suggest something to me and we would talk about it and this was what he was doing with the antidepressants. So he kind of explained to me that's what had happened that my brain was run down to a way that I couldn't get motivated and my body couldn't get stimulated enough to boost myself back up, to getting back to normal after the cold. So that was fine, I was quite happy [to take medication]." (Linda)

Linda's general practitioner had accommodated her own theory in his explanation of her problems (see previous section) and also used this explanation when presenting to her the need for antidepressant medication. Linda also felt that she had been listened to and that she had been allowed to discuss issues together with her general practitioner. Her general practitioner's approach, as well as his explanation, was acceptable to her.

However, when the general practitioner's explanation was questioned it was more likely that the acceptance of medication was also questioned. In the previous section I presented Jeanie's perceptions of her condition and her reaction to her diagnosis, whereby she was equivocal about the general practitioner's explanation.

> "I was diagnosed as having the post-natal but I refused medicine. I didn't want anything for it because I didn't really believe I was post-natally depressed….I just believe it's a depression which is part of living with alcoholism." (Jeanie)

Jeanie did eventually try anti-depressant medication, and, at first, she felt it was helping her, but as shown above in her on-going evaluation of her condition, she also received new knowledge (from a health visitor) that made sense to her within her experiential knowledge, and she re-framed her explanation of her problems as 'PMT'. This was influential in her decision to not take any more antidepressants.

> "I've actually come off the tablets, I've not been on the tablets for a long time either. I was only on them for six months and I asked to come off them. And then again in another month I was back up to go back on them but I never ever got the prescription [dispensed]. Because that was when I became aware. I had only had a mood like that for about a week and then it went away, I started to get uplifted again. And that was when I thought that's what's up with me

> [PMT]. You know I used to say the tablets don't make any difference, for me they just made me feel slowed down and out of it really to be quite honest with you. I didn't feel as if anything was being solved." (Jeanie)

Women with more long-term experience also evaluated their use of medication in relation to their understandings and explanations of their condition.

> "I think I'm physically more inclined, you know chemical imbalance or whatever that can affect mood. And personality wise I'm maybe quite affected by things more than other people....I could probably go into lots of different theories about it but I think it's probably the combination of the two and I think that it's good that you're also treated like that. Your treatment is medication that can help that side of things [chemical imbalance], and then to have something like psychotherapy...one should go and has to go hand in hand with the other for my type of depression anyway. So I have probably now accepted that this is the way I am, and I'm going to be like this for the rest of my life...and it means that you're just going to have to live with it the same as other people live with diabetes or whatever and its just part of who I am." (Ann)

Ann used her experiential knowledge to conclude that her 'type of depression' is the result of both chemical imbalances and her 'personality'. From this she perceived that two different forms of treatment were required and the treatment had to be appropriate to the causal mechanism. Ann used her experience and her understanding of her problems to conclude that depression was likely to remain a problem for her for the rest of her life and she accepted that taking medication may also be a long-term prospect. However, as I will demonstrate below, this did not mean that Ann stopped evaluating medications and their use.

6.3.2 Evaluating the prescription as a reflection of their interaction with their general practitioner.

In addition to evaluating medication use in light of their own and their general practitioners' explanations of their problems, the accounts of the women in this study also revealed how their perception of their interactions with their general practitioner were important in shaping their reactions to medication use.

> "It's very important for me to get that eye contact and for somebody to listen to what I say and make no judgements and not be too ready to get the

> prescription out…I would feel fobbed off with that. And I've got to say Dr[] took her time about that, which I was really happy about…I know some people would probably love medication, some people think it's the only way to get better, I don't. But in this case it has helped me. But I was very pleased she didn't get the wee pad out right away." Tricia

Tricia reports how important it is for her to perceive that she has been listened to. She also sets herself apart from those who resort to using medication all the time, a point that I will return to further on in this section. Although she does not say directly that she would refuse the prescription, she does indicate she would look upon the prescription in a negative light, as having been 'fobbed off'.

This contrasts with Pat's account, which should also be viewed in the context of her previous comments about how she recognised her own stress but was not satisfied with the way in which her general practitioner had responded to her needs.

> " [quoting a GP] "Sorry, just take an anti-depressant and in a couple of days you'll be fine". But they don't really want to talk, or want to know anything about it eh, because they've got somebody else to see….And then when you go back and you're still the same, "go and see a psychiatrist or something", and it's all wrong. It's not because you're off your head things aren't going right, and doctors dinnae realise that." (Pat)

Both antidepressants and a referral to psychiatry were perceived as inappropriate because these were perceived as treatments for someone who is "off your head". Pat did not equate her 'stress' with a mental health problem. She perceived that if the general practitioner had listened to her he would have understood her better and reacted differently in terms of managing her needs. When asked what she did with the prescription she received she responded,

> "What did I do with it? Oh I came home ripped it up and threw it in the bucket, but still at the end of the day I was still desperate to speak to somebody…" (Pat)

In this sub-section I have demonstrated how the women's own understandings of their experiences were used in their evaluation of antidepressants and their use, and how the women's degree of acceptance of their general practitioner's explanation was clearly associated with their acceptance of antidepressant medication (at least in the short-term). I demonstrated how their evaluation of the interaction with their general practitioner, and whether they perceived that their own concerns had been listened to, also shaped their overall positive or negative attitudes towards their prescription. I have also introduced some examples of how the women's evaluation of antidepressants and their use was an on-going process, whereby new knowledge contributed to evaluating whether their use still made sense to them (I return to the issue of the process of on-going evaluation below).

However, there were also other concerns raised by the women in relation to their acceptance of antidepressant medication which stemmed from their common-sense and experiential knowledge of these types of medication. I will now describe these types of knowledge.

6.3.3 Common-sense knowledge of antidepressant medication

The accounts of the women in this study revealed that they held common-sense knowledge concerning antidepressants and similar medications,[9] and how they drew upon this knowledge in evaluating their own use of antidepressant medication. In addition to common-sense knowledge surrounding 'the image' of antidepressants and similar medications, there were also perceptions concerning the effects that they might have on you, and particularly the addictive nature of antidepressant and similar medication, which also reflected common-sense knowledge. The women also held views surrounding the appropriateness of antidepressant medication in relation to some causal explanations for depression.

The common perception or the 'image' of antidepressants, and particularly Prozac, was generally negative. The following data extracts provide some examples of the ways in which the women referred to this cultural image or common-sense knowledge.

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[9] The women in this study also included tranquillisers 'and the like' in their talk of medications and antidepressants. The two types of medication were often seen as similar or indeed the same. There is no doubt that they were associated with each other, at least until new knowledge was received to indicate otherwise.

> "She [the doctor] was just telling me that these help people and not to listen to the stories." (Frances)
>
> "I mean I was always under the impression that people who took Prozac were loonies…I think it's just the sort of interpretation you get off, when you hear it sort of like maybe on television. I always thought people who took Prozac were people who were ready to go to [names local psychiatric hospital] basically. So when I actually did get prescribed Prozac with the doctor, because when I got the prescription it said Flux something [Fluoxetine], I can't remember the name of it, but I didn't think it was Prozac. And then when I got it from the chemist I looked at it and went home and cried my eyes out. Because I thought "Oh God, you're losing it", do you know what I mean, "You're totally, this is it, you're going mad"." (Ruth)
>
> "Now apparently half America is on this drug and their dogs and there was this woman at work and I don't really know what was wrong with her but she was over-exuberant, not a maniac, but you know everything would be, if it was funny it would be absolutely hilarious, if it was sad it would be devastating. And somebody said to me "Oh well you see she's on Prozac"…although I wanted to be better I didn't want to lose my, you know I didn't want my character to change. I didn't want to be so falsely happy or sad." (Lily)
>
> "I knew a lot about people who had been given Prozac and it being 'the happy pill' and people always saying it would change your life…and I just don't really believe it you know…and I felt funny kind of telling people about it because it's got sort of a high profile name and I just kinda thought I'm not sure about this at all." (Barbara)

Frances refered to the existence of 'stories' surrounding antidepressants whereas Ruth, Lily and Barbara were more specific in exemplifying some of the reputation that is accorded to antidepressants, in this case Prozac. Antidepressants were associated with a change in personal status: such as being ready to go into psychiatric care or 'going mad'. They were also associated with changing one's character or 'changing your life'. Hence taking antidepressants would have had a significant meaning for these women. The emphasis on Prozac might be explained because of its 'high profile name' and that people were more familiar with this brand, or it may reflect the fact that many general practitioners used Prozac as their front-line treatment for depression. However, it is clear that there was a shared common-sense knowledge surrounding antidepressants and that the women used this knowledge in evaluating their potential use of antidepressants.

There were also common-sense perceptions concerning the effects that antidepressants might have on you. Some of this is shown in Lily and Barbara's accounts above. They perceived that the antidepressants might affect their personality in some way and result in unnatural happiness. Another common term used in relation to antidepressants and tranquillisers were that they would make one feel like 'a zombie'.

> "Because everybody says, my mum says, that'll [in this case Prozac] make you out to be a zombie." (Ruth)
>
> "I mean, if it was tranquillisers, I'd have second thoughts, because there's no way I would like to walk about like a zombie." (Amy)

Antidepressants were associated with a change in the women's personality or their way of 'being'. In addition to the potential effects on 'the person', there were also generally held views concerning the addictive nature of antidepressants and similar medications.

> "But em, go back twenty odd years ago it was all Valium. They used to prescribe Valium "Oh here take Valium be alright". Then again they didn't know. I mean Valium is an anti-depressant, they didn't know it was addictive. And folk I've spoke to trying to come off it – terrible. But eh, I like to know what's going into my body. I do, I like to know." (Ailsa)
>
> "So I went to the doctor and we had a chat and she says that I sounded depressed and she recommended medication but I was still again hesitant. I didn't want to take the medication and she asked me to consider it and have a think about it. She was reassuring, telling me that they're not addictive. I suppose I got to the stage then that I thought well you'll need to give this a try. But I was just, I'm still, got a wee bit fearful. I think what if a year down the line I can't come off these, I won't be able to cope without them. I think that's the biggest main thing. Do I need this to be happy? It's weird needing something." (Jeanie)
>
> "I used to always think they were addictive but they're not, they're not addictive. A lot of folk think antidepressants are addictive, a few people I've spoke to. I says they're not. Some maybe are but a lot of them aren't." (Ailsa)

The legacy of Valium and the behaviour of the medical profession in prescribing addictive medication had become part of the common-sense knowledge held by the women in this study. Ailsa described how it was generally acknowledged that antidepressants are addictive but also makes a point of showing how she held different (experiential) knowledge. However, even within her own knowledge she still perceived that some antidepressants were addictive.

In the second exert above, despite reassurances from her general practitioner, Jeanie's reluctance to take antidepressants was evaluated in relation to her understanding of their addictive properties. However, it was a psychological dependency that underpinned Jeanie's concerns, not physical dependency. Jeanie's beliefs concerning difficulties in being able to come off medication still persisted despite the doctor's advice because this advice did not address the psychological dependency that underpinned Jeanie's beliefs. Psychological dependency and fears of coming off medication were a concern for women with both new and long-term depression in this study.

> "I thought, "Well, when I go off these tablets, am I going to be the same, like now, or am I going to go right back to the way I was?"."(Carrie)
>
> "But the thing I worry about it, what happens if I become better and they take me off the tablets, I'm now relying on the tablets, I feel I need them."(Beth)
>
> ".....but then you think to yourself "Well how am I going to know when I don't need to take these anymore?" If I stop taking them, is it going to be just the same? And I think that's what worries you as well, the fact of how long are you going to have to take them, or if you stop will you need to go back on them."(Karen)

One further commonly held belief was that medication is not an appropriate response in relation to certain causal explanations.

> Interviewer (A) "So when he first suggested that he was going to give you an anti-depressant, what did you think of that at the time?
> Interviewee "I wasn't keen. Like I say, I used to say that the answer to things wouldn't come out of a bottle. I knew I was reluctant to take them, at night I used to sit looking at them thinking "Nut [No], this is only sort of temporarily helping the problem, it's no really getting to the root of it." (Sandy)

As shown in Ann's account above (Section 6.3.1), medication was acceptable when a biochemical explanation was proposed, but other intrinsic causal explanations (personality) required different approaches. In Sandy's case, where the cause of her problems was perceived as extrinsic (family problems), the appropriateness of medication was also questioned.

Overall, the common-sense knowledge of antidepressants and similar medications was generally negative and raised many concerns for the women in this study.

6.3.4 Experiential knowledge of antidepressant medication

The women in this study also evaluated their use of antidepressants by drawing upon their experiential knowledge of these types of medications. These ideas and notions are based on knowledge gained from the experiences of others or from previous personal experience with antidepressants (for those women with previous experience of depression).

a) Experiential knowledge of antidepressant use in others

The knowledge gained from personal experience of antidepressant use in others confirmed their common-sense beliefs that they are addictive.

> "I was quite against taking anything, because my mum, many moons ago, ended up addicted to Valium. And of course, I was still thinking along the lines of Valium and things like that....my mum ended up on Valium until the day she died, she was just hooked." (Tricia)

> "I didn't want medication because I had a fear of being addicted to them. And my mum was also on depressants as well and she'd overdosed, which I'd seen on about four occasions, which I just associated with – I know that one time she was on Prozac and because she came off them herself em, she tried to commit suicide and I just associated anti-depressants with that." (Jeanie)

> "I had an uncle who had a drug problem as well, and he was taking tablets. And I sort of, I didn't like that and it just sort of made me think "Oh I never want to have to rely on tablets". And then also seeing one of my friends taking the Prozac and taking all different tablets, and letting it rule her life basically. Well I didn't want it to be like that for me, so as I say when I went to the doctor I was wary about tablets and what he was going to give me. And when he said that they weren't addictive, because I don't want to be on tablets long-term, I want to be able to feel good because I feel good and not because a tablet makes me feel good." (Janet)

Both Tricia and Jeanie used common-sense knowledge as well as personal experience of witnessing antidepressant use in others in order to elaborate and explain their own attitudes and beliefs towards antidepressants. There is a common-sense understanding that drug misuse can result in addicts 'overdosing', albeit accidentally. In order to clarify her meaning surrounding the link between overdose and addiction, Jeanie provides a more specific account of her mother's behaviour - it is '*because she came off them herself*' that this resulted in suicidal behaviour. Jeanie's knowledge was that there would be a problem in coming off medication, that it could affect one's behaviour to the extent that it could encourage suicide attempts. If one had a problem coming off medication, then her logical reasoning was that you were then 'addicted' to the medication. This is not the same as the addict's physical dependency on medication, but implies a psychological dependency, as I alluded to earlier.

Janet also described her personal knowledge in relation to two people as being instrumental in shaping her perception that taking 'tablets' would result in dependency ('relying on them') and a loss of control ('letting them rule your life'). Janet also associated long-term use with addiction. Her general practitioner had to sufficiently reassure her about these concerns.

However, not all personal knowledge of antidepressant use in others was negative.

> "I know that with my mum having depression and her having the tablets, I know they were doing my mum an awful lot of good. I notice the changes in my mum taking these tablets. I thought well obviously the tablets are helping, but obviously I would have to try them myself to see if, tablets will not solve anything, they'll maybe help deal with anything at the time." (Carrie)

Carrie had a positive experience of antidepressant use to draw upon. However, she also made use of common-sense knowledge – that the medication would not solve her problems- in her evaluation of the medication. Carrie had presented to her general practitioner with the hope of receiving antidepressants, and was actually disappointed when it took her several visits before she obtained a prescription.

b) Experiential knowledge from previous personal use

The women in this study with previous personal experience of depression and antidepressant medication used this knowledge to evaluate their own (or other's) use of antidepressants.

> "Amitriptyline, as I say, they just took me down too far, you didn't want to talk, just shut the door, just shut the blinds and just leave me. I've actually got a niece that suffers, the one that's mum died, and I can tell whenever I see her she's doped up with them, because when she's talking her voice is awful slow, she can hardly get words out. And I just think "Oh [niece's name] go back to the doctor and try and get on something else. They slow you down an awful lot and I wouldn't go out." (Peggy)

> "Tried them for a month and had to stop them. Eh, I was on Prozac. She made me promise faithfully to take them for a month and I did. I couldn'ae stand the pains in my head. The headaches that I got and feeling sick and I only took one a day. And I was never so glad to see the month up on the Prozac. There's no point in giving me a repeat prescription for them." (Rebecca)

Peggy used her own experiential knowledge to make judgements concerning her niece's use of medication and Rebecca indicates that she would use her experiential knowledge as a basis for rejecting medication if she was presented with another prescription for Prozac.

Experiential knowledge was also used to evaluate how they might use their medications.

> "But now, you know, I accept that once I'm feeling well that you can still you know, you can maybe bring your medication down gradually. But you would still maybe want to stay on a very low dosage when you're someone like me who has suffered continuous bouts throughout the last fifteen years."

This experiential knowledge forms part of the knowledge used by those with previous experience of depression in their on-going evaluation of medication use, which I discuss below.

6.3.5 Common-sense perceptions of medication use

Within the women's accounts, it was generally reported that they disliked taking medication and were reluctant to do so.

> "As I said before I'm not one for taking tablets, I never have been. It'll even take me a while to take a painkiller if I've got a headache." (Janet)
>
> "And I'm a bit dubious about taking anything. I mean I'd rather just get over it myself, let my body deal with it. Because I feel your system isn't as good if you go to the doctor's too much, it's just my old fashioned way. It's just the way I am, I only go if I need to go." (Linda)
>
> "I wasn't keen, like I say, I used to say that the answer to things wouldn't come out of a bottle. I knew I was reluctant to take them." Sandy
>
> "Personally, I always think there must be some way that I can learn to deal with it without having to pop a pill for it." (Ann)

The women in this study were keen to portray themselves as the type of people who do not resort to medication use, or who would rather not have to resort to medication use if they could help it. This could reflect a cultural perception that resorting to medication use is indicative of weakness and should only be used as a last resort. Indeed help seeking in general was often portrayed as 'giving in' (see Chapter 4), and medication use was also perceived as a sign of failure.

> "...here I am again having just put my medication up, and although I know that it's okay, there is still a part of you that thinks, you feel like kind of you've failed a wee bit yourself." (Ann)

In portraying themselves to me as the type of person who does not normally take medications, the women reflected a need to be seen as not weak or not the type of person to give in to illness.

> "He said he knew that I hadn't been at the doctors often and I never really took tablets or anything like that, so I wasn't wanting to go on anti-depressants. So he put me on tablets just to give me a sleep [Dothiepin]. But he says that they're non-addictive and they weren't anything heavy or that. And he says "Once you get a good sleep, you should be able to cope better during the day"." (Janet)

Frequent consulting and resorting to medication use is not the type of behaviour that Janet wanted to be associated with. The general practitioner confirmed for her that he saw her as a certain type of patient. Janet accounts for her medication taking by placing the responsibility for this onto her general practitioner - 'he put me on tablets'. This maintains her position as someone who is reluctant to take medications. In effect, the general practitioner played down the purpose of the medication to the extent that it was not entirely clear to Janet that her medication was an anti-depressant, and the general practitioner also gave her the impression that it was milder medication than some other types –'they weren't anything heavy'.

Another generally held, or common-sense belief concerning medication use, was that long-term use could lead to immunity to the effects of drugs, to the extent that they were no longer effective.

> "I'd been on it for such a long time and I thought if I reduced it and didnae have so much of it in my system for a while and then come off it, it might start to work again. Well, I thought I'd feel good, or still be alright but then I wasnae, so I waited a wee while and then I'll try taking them again. But I think if you've been on a tablet for so long, I don't think it always has the same effect on you. Maybe I'm wrong, I'm only a patient looking at it from my side." (Rebecca)

> "But as I said to you, I hope I never become immune to it, but some people do become immune to anti-biotics and things....but Dr[], she said "No" she said "You are worrying needlessly about that" (Maeve)

Developing immunity to medication was an issue for women with long-term experience of depression and antidepressant medication. The data exert from Rebecca's account helps us to understand her medication taking behaviour. Rebecca's idea that her medications had become ineffectual because she had developed resistance to their effects explains why she self-titrated and stopped taking her medication of her own accord. Rebecca acknowledged that her own beliefs may not be correct and that her knowledge might differ from formal medical knowledge. Nonetheless, she perceived her own knowledge to be sufficiently true that she acted upon it – without consulting a medical opinion as to its veracity.

Whereas Rebecca had perceived that she had become immune to her medication, this was only a concern of Maeve's at this stage. She invoked her common-sense knowledge concerning other types of medications to conclude that it was possible for antidepressants to operate in the same way. Her general practitioner's advice reassured her that this would not happen.

The accounts of some women who had experienced depression more long-term indicated that medication regimens that had previously 'worked' were perceived to be ineffectual at times. The women were often placed on higher doses or received a change of medication. The explanation that the women had for this loss of effect with medications was that they had become immune to these effects.

6.3.6 Explaining medication use

Dowell and Hudson's study (described in chapter 2) was concerned with exploring patients' accounts of their behaviour and the reasons they *did not* take the doctor's advice (i.e. medication), particularly after having sought the doctor's advice. Stimson and Webb (1975), in their study of patients' accounts of 'going to see the doctor', also raised the question as to why patients would take the trouble to consult a general practitioner and then choose not to use the doctor's treatment or advice.

Although the women in this study were also 'help seeking', the majority of patients began their accounts of medication taking by stating their reluctance to accept medication. Given the general portrayal of their dislike for taking medication and their need to portray themselves as the type of people who do not resort to medication use, as well as their more specific concerns regarding anti-depressant (and other similar) medications, the women in this study felt the need to give an account of their own reasons *for accepting* medication, to justify medication taking.

I have previously described in chapter 4 how the women accounted for their help seeking as a moral act in that they were 'doing it for the sake of others'. Similarly when women with relatively new/likely depression discussed their acceptance of medication they also framed this as an act for the sake of others.

> " I felt I would have taken anything if it helped me because I didnae like the way I was and I had nae patience, even with the older one. He couldnae speak to me but I was shouting at him. If they'd given me Valium I would have taken it. I would have taken anything just to be over it. I didnae like the way I was." (Katie)

> "But em, when you think about them [points to 3 year old child] , I thought well if it's going to help me be a better mother and sort of cope, just generally have an easier time day to day then maybe anything would be worth it after feeling so down and so horrible, so I thought well give it a try and see how it helps." (Sandy)

Both Katie and Sandy expressed concern for their behaviour towards their children and framed their acceptance of medication as seeking help for this behaviour. Katie invoked the cultural perceptions of Valium (with its attendant fears surrounding addiction and being like 'a zombie') in order to stress the lengths she would have been willing to go to get help for the sake of her children. This reveals sense of self-sacrifice in the women's willingness to accept help.

Some women with previous or more-long term experience also reflected back on their willingness to accept the consequences of care in order to get help for themselves.

> "Earlier on I was so desperate I wouldn't have cared what they'd done with me. And as I say I knew I risked my child getting taken into care and probably I could have been taken into care but I was so desperate I didn't care."(Vicky)

The following data quote from Sandy further exemplifies the moral dilemma that the women perceived in relation to taking antidepressant medication. Sandy's explanation for her subsequent use of medication is fairly typical of the women in this study.

> "I would say em, that being one of these people who said the answer to my problems never came out a bottle, they don't, they don't. It doesn't. It doesn't solve your problems but it helps you feel better about yourself, become better in a sense, then whatever your problems are you can approach them probably in a different way whereas I felt before, I would just go in guns blazing whereas now I would probably go in a bit more reasonable…..Basically dinnae feel bad about yourself because you've had to do it. At the end of the day, well in my case I'm thinking of it as temporary and if it's no going to be long term, if it helps you sort of cope better day to day then it's, I feel it's obviously going to be worth it."(Sandy)

Sandy portrayed herself as a certain type in relation to medication use – one who would not rely on medications to solve problems. She distanced herself from those who might use medication for such purposes. In the face of having accepted the use of anti-depressant medication she re-affirmed herself as still holding the same beliefs as those who do not resort to medications to solve problems. She explained her own medication taking behaviour as having a different 'purpose', and justified her continuing use by offering evidence that the medication had impacted positively on her in making her behaviour 'more reasonable'. This provided her with new knowledge on the purpose and potential of anti-depressant medications.

Sandy's account further exemplifies the potential for the women to feel a sense of failure in accepting anti-depressant medication. Sandy used her own personal experience as advice to others, perhaps revealing a common understanding that other women are likely to have a similar perception.

Accepting medication could also be perceived as either a duty of the 'responsible patient' or an act to preserve the doctor and patient relationship.

> Interviewer (B) And were you able to be honest about your reservations about Prozac when she prescribed it?
> Interviewee "No I never said anything actually. I just kind of thought well, because you always feel when the doctor says that's what you need, you feel they know best type of thing. I know that's not true but I never really said anything to them…I thought well I'll give it a try because I think at that point I felt, well I really did feel miserable."(Karen)

Karen explained her acceptance of medication as partly through a deferential acquiescence to the general practitioner and partly because of her symptoms. She revealed a general belief that 'the doctor knows best', and although she did not actually believe this herself, she did not communicate her own knowledge and beliefs to her general practitioner, and therefore did not challenge this assumption about the role of the general practitioner.

Other accounts from the women in explaining their acceptance of antidepressants (when this clearly contradicted their wishes or their own perceived needs) gave the explanation that they did this for the sake of their general practitioner. I have previously described how Maria did not perceive that she was depressed, she perceived that her problems were related to her pituitary gland problems. When subsequently asked why she accepted antidepressant medication, and did not tell her general practitioner that she disagreed with the diagnosis of depression, she said:

> "I didn't like to. He was daein' his best, I dinnae like to dampen his spirit, so I would put it like that." (Maria)

Mary did not want to offend her general practitioner or make him feel ineffectual by revealing that she perceived he was wrong as regards the diagnosis. She therefore pretended to concede to the knowledge of her GP by accepting the medication offered.

It is also worth reminding ourselves of Rebecca's account shown above (see sub-section on 'knowledge of personal experience'), where Rebecca persists in taking Prozac, despite experiencing extreme discomfort from the perceived side effects, because her general practitioner has extracted a promise from her that she would do so. Despite her own discomfort Rebecca upheld her promise and acted as a 'responsible patient'.

The women in this study expressed general reluctance to use antidepressant medication. Their general acceptance or reluctance to accept medications was shaped by their understanding of their problems and their ability to accept their general practitioners' explanation, as well as additional common-sense and personal knowledge of antidepressants (and similar medications) and their common-sense beliefs surrounding medication taking. Given their perceptions of common-sense expectations regarding medical help seeking and medication use and their fears of antidepressants, the women faced a moral dilemma in accepting antidepressant medication. In order to account for their medication use the women framed this as a moral act for the sake of others – for example, their family or for the sake of their relationship with their general practitioner- or as a last resort, an act of desperation. However, the women often included the proviso that medication use would only be acceptable to them in the short-term. I explain this in more detail below.

6.3.7 Explaining medication use – provisional use

Although accepting medication for the sake of others was offered as a rationale for accepting medication, it was also important that the women perceived that their main concerns (of addiction, and the perceived 'changes' that these might have on their personality or way of 'being'), were addressed. Their general practitioners' explanation of medication was crucial in addressing these fears because their removal helped to alleviate the women's concerns that they would be addicted or somehow change their personality (for example, become a 'zombie'). It was important for the women to perceive that acceptance of its use was on a short-term basis.

> Interviewer (A) "Did you explain [how you felt about medication] to him? Interviewee "Mmmm hmmm, I told him when he said to me "How do you feel about tablets?" and I said exactly just what I've said to you...and he said "Well I'll give you these because they will help you sleep" he says " They'll just make you feel slightly drowsy", he says "They're non-addictive, they're not strong, they're not Valium, don't feel bad about having to take them. And I said "Right I'll try them. And he didn't put me under any pressure either. He said that if after a while, if I still didn't feel any better that he wouldn't make me take them if they weren't helping me. So I felt well, because as I said when he first spoke to me about the tablets, he said "I want you to be on them for a minimum of six weeks". Which made me think "Well at least he's not saying 'for three months' " or whatever. I knew that if in six weeks I felt better, he might either half the dosage or maybe take me off them altogether. Because then it wasn't making me think "Right I'm going to be on these tablets long-term". So I explained to him, and then he explained to me about the tablets and I felt at ease with that." (Janet)
>
> "I plucked up the courage more or less to go and see her, and she put me on anti-depressants. I didn't feel so bad about being on them, because I didn't think they're so addictive, em, I definitely didn't want anything long-term, if it could possibly be helped." (Amy)

Janet's general practitioner encouraged her to talk about her concerns surrounding antidepressants and then addressed these concerns until she felt 'at ease' with accepting them. He made the decision to make them more acceptable to her by reducing the concerns and anxieties, thereby reducing the moral dilemma, which these concerns raised. He also made her feel that she had a choice in making the decision and that she could re-evaluate her decision at a later date.

The data also showed that the general practitioner's advice contributed to the perception that anti-depressant use would be short term and that short-term use was an indication of a less serious condition.

> "I mean I get the impression from him that it's not sort of serious….I think he's got every faith in me that it is only going to be a short term thing…he's always given me the impression that he doesn't think it'll be a long term thing and I'm happy with that because em, I don't want it to be either. I mean I want to be able to be how I was before, without the help of taking tablets." (Sandy)

Sandy associated her short-term use with good behaviour, as the type of behaviour that her general practitioner expected of her. Her statement 'he's got every faith in me' revealed that short-term medication use was an expectation that she felt she had to live up to.

The accounts in this section may also reflect the women's need to have 'hope' in their recovery and that these experiences are a "short-term setback" in their lives. They also reflect the women's portrayal of their depression as 'not serious', which also emerged in chapter 4 in how they accounted for their own depressive experiences as being less severe than common-sense descriptions of someone who is depressed.

As I have already explained, the dilemma of accepting medication was more prominent in the accounts of women with relatively new/likely depression. Women with previous experience of depression and antidepressants were more concerned with evaluating their on-going use. Women with more long-term experience of depression who made sense of their depression through intrinsic causal mechanisms were more likely to accept medication use as a long-term prospect.

I will now move on to describe the process of on-going evaluation of medication use by the women in this study.

6.3.8 Evaluating medication and its use – an on-going process

The negotiation of the acceptance of medication was not something that was confined to the consultation with their general practitioner. The women in this study also consulted others or received opinions from others concerning their use of antidepressants.

> "And I also felt at that point that I didn't need medication you know, I felt all I needed was a rest. I felt I was worn out....but eh, after that point when I went home and I spoke to members of my family and a few other people and, they'd said if you go on anti-depressants you, well Dr[] had explained all this as well, you don't become dependent upon them and that sometimes you've got to take a short dose of medication just to get you back...So eh, the next time I went to see Dr[] I agreed to go on medication."(Jill)

Jill had her own perceptions regarding her needs when she went to see her general practitioner. Within her own understanding, medication was not perceived as an appropriate response to these needs. However, in making her decision regarding their potential use, Jill consulted the opinions of others. Their advice confirmed that of her general practitioner - that they were non-addictive and would only be required for a short period of time. Jill did not receive any negative feedback concerning their use and therefore the moral dilemma (of having to take medication that has a negative image and meaning for these women) was reduced.

In other instances, seeking the advice of others resulted in questioning or rejecting the use of antidepressants.

> Interviewer (C) "How long did you take it for?"
> Interviewee "About three weeks."
> Interviewer (C) "Did you talk to the doctor about stopping?"
> Interviewee "No"
> Interviewer (C) "Did you go back to her at all?"
> Interviewee "No"
> Interviewer (C) "What made you stop taking it?"
> Interviewee "I just heard a lot of stories about it. Em, and my boyfriend's mum she was an auxiliary nurse and she didn't think I should be taking it."
> Interviewer (C) "Do you know why she said that?"
> Interviewee "She just said that she had seen so many people, what they've been through taking it. She just thought I was too young to start taking tablets like that." (Frances)

> "....but I tried, I spoke to my mum...and I told her and the first thing she said was "Oh give me those tablets till I take them up the road, you're not taking them"...and I said to her "Look mum you can't take them off me because I'm 24". But she's like that "That's ridiculous, you shouldn't be taking them", I mean my mum makes me feel worse because she's like that "That's for people

> who have got serious, serious problems and all the rest of it, just take the multi-vitamins that I got you and you'll be fine"." (Ruth)

The women's perceptions of antidepressant medication were reinforced or learned through interaction with others. Even though Frances had made the decision to begin using antidepressants she was persuaded to discontinue their use. There was a sense that Frances attributed a certain status to the advice given to her in that the woman was an 'auxiliary nurse' and had experiential knowledge of the use of antidepressants in others. This advice overruled that of her general practitioner.

In the second example, Ruth's moral dilemma (of having to take something that had a negative image and meaning for these women) was made even more difficult by the contribution of others' knowledge. Her own decision was called into question when common-sense beliefs surrounding antidepressant medications, and people who use them, were raised. In both these examples, and in contrast to Jill above, the opinions of others increased rather than reduced the women's moral dilemma, by implying that if they took these medications then this would infer a new identity on them and/or result in a change in their personality or the way they behaved (such as becoming a 'zombie').

The women would also evaluate their use of antidepressants in relation to their understanding of the causal factors for depression. Hence, as I have shown above, when intrinsic causal factors were used by the women to explain their depression then their continuing use of antidepressant medication was also more likely to be understood. When extrinsic causal factors were understood by the women as a factor in their depression, then their on-going evaluation of medication also included some evaluation of the persistence or absence of these causal factors.

> "I'm glad they are helping me, but I'm no somebody that's going to be quite happy to pop them for the rest of my life. I'm sort of like fine six months, em like he did the first time. Obviously if things in my life are more settled then I dinnae see the need why I should still have to be on them any longer. So finger crossed, six months should see her [daughter] at play school." (Sandy)

Sandy re-iterates her dislike for taking medication but that she will accept their use in the short term. She indicates that she will re-evaluate their use when circumstances in her life change.

The on-going process of evaluation of the use of antidepressants is also one that incorporates experiential knowledge from taking antidepressants. When the women's experiences of taking antidepressants were positive then they were more likely to be willing to continue their use. It was also important that their general practitioner's (or other's) advice, mainly that the medication was non-addictive, was not brought into question through their experiential use.

> Interviewee "He didn't say how long I would be on them, he just said for a minimum of six weeks."
> Interviewer (A) "So how do you feel about that yourself"
> Interviewee "Alright because I know that, when he explained they weren't addictive, I don't feel so bad about taking them. I mean there's been times when I've forgotten to take them and it doesn't put me up nor down.....so I know within myself that I don't need the tablets. But I'll keep on taking the tablets because I think it's the tablets that are maybe helping me. But I know that I don't have to rely on them, so it doesn't bother me about how long I'll have to be on them." (Janet)

Janet's experiential knowledge of taking her medication -that she did not experience adverse effects when not taking it – confirmed for her that she did not have to rely on the medication. This knowledge encouraged her continuing use of the medication.

Alison, on the other hand, used her experiential knowledge to determine that she should stop taking one type of medication and return to a previous medication.

> "I was on Prozac and I stopped taking it because I was going into that zombie state, and I had some Amitriptyline left over from before...So anyway these [Amitriptyline] were lying, and I thought they're doing me no good, the Prozac. So, I stopped taking them and I started taking [Amitriptyline], ...I was a bit wary of saying "Doctor I've stopped taking those Prozac because it wasn't working but I'm taking Amitriptyline". He said "That's all right"....And it was 50 [milligrams] he gave me..but I started taking one and a half of those [75mg].."That's alright" he says "take two 50's"...and I'll be truthful there was a day there I was very, in fact I had to phone my sister... I took the half of a [another] 50 [milligrams] but that was the only time I've taken more than the 100 because I still feel a bit uptight sometimes." (Alison)

Alison used her experiential knowledge to both change her medication and to self-titrate on several occasions in order to manage her symptoms. This self-management was common among the women in this study, particularly among those with previous experience of antidepressant medication.

The women's accounts also demonstrated how they evaluated their medication use in light of new knowledge.

> Interviewee "I've tried about three or four times since then, cutting it down and then the last time…I stopped and I lasted twelve days and I just felt I can't, I can't cope any more, I'll need to start taking them again"
> Interviewer (B) "So has it taken a year for your doctor to suggest you changing to a new tablet or did she ever suggest it earlier?" [This issue was raised at the first interview]
> Interviewee "No she had suggested it earlier, she did. But I just felt I was used to the Seroxat, I knew the side effects, I mean I didn't have any side effects and I was a bit apprehensive about trying something else in case I had side effects. But I've been on the Internet quite a lot myself looking it up and there's a lot of people out there having problems coming off it, so I just thought, well, enough's enough. I mean to me they don't know enough about it so I want off it." (Amy)

Amy had been relying on her experiential knowledge as the basis of her decisions regarding her medication use. However, she independently continued to seek new knowledge about antidepressants and re-evaluated her use in light of this new knowledge to conclude 'enough's enough'. Her new knowledge also led her to question the validity of all other knowledge relating to her medication – 'they don't know enough about it'.

Experiential knowledge could also lead some women to re-evaluate their use of antidepressants and to accept this as a long-term prospect. This finding relates to women who had been experiencing depression for many years and who had also adopted an intrinsic causal explanation for their problems (mainly a biochemical imbalance and sometimes with additional 'personality' traits).

> "Yes, I think the medication has got a lot to do with it. I wouldn't, I don't think I'll come off it. I really feel I'm too frightened to come off it…because I did that before…it was about October I started coming off it and by Christmas I was really, I had got myself into an awful state but I knew it was happening, I knew I was going down when I came off the medication. Not immediately but I felt the changes in me. I thought no, this is stupid, this is silly, for goodness sake fight it,

> you know just fight against all these fears…but em, by December I couldn't fight anymore because I was back down feeling really, really low, feeling suicidal again…..So I'll keep on the medication." (Maeve)

Maeve's negative experience of stopping medication made her re-evaluate her use of medication and to conclude 'I don't think I'll come off it'. Maeve made several references throughout her two interviews to this episode and her recent acceptance that she needed to continue to take medication in the long-term. This experience had been a turning point in forming Maeve's evaluation of her medication use as a long-term prospect.

The women's accounts also demonstrated how they would continue to evaluate new knowledge as it emerged.

> "In my experience taking a tablet in the short term helps it, but it didn't solve the underlying issues that were causing it in the first place. But true if they done more research into it, it could be a chemical thing, as well. But I don't think it's all chemical." (Jeanie)
>
> "I'm sceptical about antidepressants but I hope that maybe when there's an improvement, there's maybe more choice. But I often wonder how much choice people actually have about what they're prescribed. And it is trial and error, and often you don't know. You have to actually physically take it and go through all the time it takes to go into your system and them come out of your system, before you know whether this is the right one for you or whether it's going to work or not." (Ann)

Jeanie had questioned the validity of using medication beyond the short-term because she did not perceive the medication was an appropriate solution in relation to her causal understanding. She perceived that new knowledge could emerge that might give her new insight into causal mechanisms, but also indicated that this would not entirely replace her existing understanding of the causal mechanisms.

Sometimes, the women just perceived that they had had enough of taking medications and re-evaluated their continuing use.

> "I just decided last week that to me they weren't doing anything for me, and I thought maybe after all these years being on them, I don't really know what I'm like."(Peggy)

> Interviewer (B) "So you didn't have any difficulty coming off?"
> "No, I just made up my mind one day. I just thought, I just feel better, I just feel much better and I don't think I need that in order to make me feel better any more, um, and so I just stopped." (Barbara)
> "It's really a lot down to yourself. People are going to help you so far and then you've got to do it yourself. Trying to convince your mind isn't it. Mind over matter really isn't it, it really is. But no I just dinnae like taking antidepressants, I've had enough of them." (Ailsa)

In these circumstances the women had ceased to have a good enough reason to continue their use. They did not perceive the medication was having any beneficial effect, and in some instances that it was down to them to help themselves in some other way.

In this section I have shown how the women engaged in on-going evaluation of their medication use. Lay (common-sense and experiential) knowledge and knowledge received from medical professionals and other sources of knowledge (such as books or the internet) were presented in their accounts of this process. Knowledge which alleviated the women's moral dilemma or addressed their fears or concerns could be used to shape their decisions to accept medication; whereas knowledge which served to increase their moral dilemma or added to their concerns and fears surrounding the medication was more likely to lead to continued reluctance to accept medication or to their decisions to discontinue its use. The women's experiential knowledge of taking antidepressants was also a factor in shaping their continuing use. Experiences that increased their concerns about addiction, or whereby the women perceived they were acting out of character ('like a zombie'), were likely to lead to the women stopping, self-titrating or changing their medication. Experiences that were positive and whereby the women perceived that they were not relying on medication (at least where this was a concern for them) were more likely to result in the women expressing a willingness to continue taking medication – at least in the short-term. For some women, it was their experiential knowledge of stopping medication and the effects on their psychological well-being that made them re-evaluate their medication use, and to conclude that medication was a long-term prospect. For other women, in evaluating their on-going use of medication they had ceased to have a sufficient reason to maintain its use. However, the emergence of a new episode of depression would then begin a new process of re-evaluation of this decision.

6.3.9 Summary

In this section of this chapter I have attempted to give an account of the women's decisions to use antidepressant medication and to explain how different outcomes were likely to emerge. I have also attempted to offer some general explanations for the medication taking behaviour of these women. I have shown how the women's acceptance and use of antidepressants was explained by them with reference to: their own perceptions of their problem and their evaluations of their general practitioners' explanations for their problems; their evaluation of the interaction with their general practitioner (in promoting a positive or negative attitude towards the general practitioners' advice regarding medication use); their common-sense and experiential knowledge of antidepressant (and similar) medications; and cultural knowledge of medication taking. The women's common-sense and experiential knowledge of medication use by others and their common-sense knowledge of medication taking, created a moral dilemma for the women in accepting and using antidepressants. The negative meaning and associations which antidepressant medication had for these women and their understanding of the change in their personality or way of 'being' that might accompany their use, generally made their use unacceptable. Their acceptance would therefore have implications for their 'moral' status. The women therefore accounted for their subsequent use of antidepressants as a moral act of 'doing it for the sake of others'. However, fears about addiction to antidepressant medication also had to be sufficiently addressed before they were willing to accept medication use. When knowledge and advice from others (including both lay and professional sources) helped to allay their fears of addiction or a change in their persona, this reduced their moral dilemma and the medication use was more acceptable to the women. However, medication use was subject to on-going evaluation by the women. The application of new knowledge, and particularly experiential knowledge, was evident in their descriptions of their on-going evaluation of medication and how they used medications. Common-sense perceptions of medication use, such as the ability to become immune to medications, were also evident in their explanations of their medication taking behaviour. This might explain some of their behaviour such as self-cessation and self-titration. The women in this study engaged in on-going evaluation and self-regulation of their medication, whereby they continually tested their medication and its effects on them.

6.4 Chapter summary

In this chapter I have described the women's perceptions of the management of their problems and have shown how the women came to the consultation with some understanding of their problems and how they evaluated their general practitioners explanations for their problems with reference to various sources of common-sense, experiential and biographical knowledge. Their evaluation of the interaction with their general practitioner was also influential in shaping their perceptions of the general practitioners' explanations. The women placed value on their relationship with their general practitioner and their ability to trust him/her. The women generally valued 'being known' and 'knowing' their general practitioner. I have also shown how the women held common-sense and experiential knowledge of antidepressants and medication use in general, and that the acceptance of antidepressant medication created a moral dilemma for these women.

How did general practitioners manage these women when they presented with their own theories and understandings of their problems and when their common-sense and experiential knowledge of antidepressants influenced their reactions to the treatment being offered? I will now address the issue of general practitioners' perceptions of the management of depression in the following chapter.

Chapter 7 General practitioners' perceptions of managing depression.

> *Negotiation is a process. That patient and doctor both use strategies to influence each other does not mean that one or other is going to be successful. But the concept of negotiation means that we see the outcome as the result of their interaction and the strategies they have each adopted, rather than as determined solely by the facts that are brought and the application of the skills that the doctor has.* (Stimson and Webb, 1975: 38)

Chapter 5, presented an account of how general practitioners made sense of patients' presentations (as depression) by drawing upon different types of knowledge to enable the general practitioner reach a 'diagnosis' of depression or develop a working approach and understanding of the type of depression that was presenting to them. Chapter 6, described how the women evaluated the general practitioner's explanations for their problems and the general practitioner's advice regarding their potential need for, or for their ability to benefit from, antidepressant medication. This demonstrated how the women drew upon different types of knowledge in their evaluations and how common-sense, experiential and biographical knowledge were described in relation to their understanding of their problems, and how common-sense and experiential knowledge was invoked in their accounts of antidepressant medication and medication use. It also demonstrated the importance, for these women, of the interaction with their general practitioner in shaping their evaluations of the general practitioners' explanations (involving the importance of perceiving that their own theories had been accommodated and their own opinions had been valued and feeling that they had been listened to) as well as in promoting a positive outlook on the presentation of a prescription for antidepressants. In addition, the data have shown that seeking help was accounted for by the women as a moral act (chapter 4) and that using medication, and particularly antidepressants, presented a moral dilemma for the women (and particularly for those presenting with relatively new/likely depression as this was their first experience of having to confront its use). So how then did general practitioners in this study manage these women within the context of the women's own understanding of their problems and within the context of their moral dilemma over medication use?

This study attempted to explore some of these issues using methods that would capture the experience and perceptions of general practitioners and acknowledge their understanding of the practical context in which they worked. The study, in accessing both patients' and doctors' accounts of the processes involved in the experience of depression in the primary care setting, allowed for the possibility that the patient may be active rather than passive in shaping the care that they received, and that for general practitioners there may be a degree of work that is hidden in formal clinical accounts of the process.

This chapter presents an account of the general practitioners' perceptions of the experience of managing depression (in general and in the female participants in the study). It begin with a description of the general problems of managing depression from the general practitioners' perspective and move on to describe how managing depression involved them contemplating the boundaries of their professional role. It then describes the general practitioners experiences of managing depression, and general practitioners' accounts of the negotiation of the explanation for their patient's problems and the negotiation of the use of antidepressant medication. Within these accounts general practitioners reported how they attended to: recognising and addressing the patient's moral dilemma; taking account of patients' understandings of their problems, acknowledging the patients' experience and accommodating the patients' own theories. General practitioners accounts of managing depression also emphasised the importance of the doctor/patient relationship and 'knowing' the patient and involved the general practitioners in dealing with the problems and issues arising in patients' day to day lives: their engagement in 'lifework'. In presenting these accounts of managing depression, it will also be shown how managing patients (in the context of the patient's common-sense and experiential knowledge of depression) involved strategic acts on the part of the general practitioner to facilitate and influence the negotiation of acceptance (of the general practitioner's explanation and advice) among patients.

7.1 The problems of managing depression

General practitioners were asked what were the main difficulties in managing patients with depressive illness? ; how did they feel working with patients who are depressed? ; how would they describe their role in working with patients who are depressed?; whether they identified any particular categories of patient? ; and whether they perceived any factors that influenced their ability to manage patients with depression? They were also asked to describe the best-case scenario (or ideal process) of care and the worst-case scenario in managing patients with depression. Perhaps this is why the general practitioners simultaneously offered two accounts of the management of depression: that it could be relatively straightforward to manage and that it could also be difficult. However, the purpose of the questioning was to explore their explanations of what makes people with depression easy or difficult to manage. They were also asked to describe the main problems in managing depression and how they subsequently managed these difficulties and problems. The responses to these questions constitute much of the data presented in the following sections of this chapter.

Several factors were reported as making a patient fairly easy to manage: those who presented up-front with depression or emotional difficulties (communicatively) or who presented with fairly classical or 'glaringly obvious' symptoms; the most severely or acutely ill; and those who accepted the diagnosis and complied with its treatment and who subsequently responded well to treatment.

> "Sometimes treating someone with endogenous depression is dead easy, you know it really is. Here's the synopsis: we've talked, this is the problem, it has come from within your self. And if you're not getting better with talking and the antidepressants, maybe the CPN becoming involved, sending you to see one of the psychiatrists....They're often the easiest ones, the glaringly obvious. But patients don't present like that." (Dr White)

> "The best-case scenario, em, I don't know. I suppose somebody who comes in who has classical symptoms, biological symptoms, you know the sort of not sleeping, no concentration and all these sort of things...It is usually not that straightforward actually coming to a diagnosis. But somebody who is fairly straightforward who accepts that they have a problem, who sees it themselves as the problem of depression and who respond to treatment and who are very grateful thereafter [laughing]" (Dr Cook)

It was also perceived to be 'easier' when there was a clear 'medical model' of management such as when symptoms were 'classical' and 'biological' and there was a clear pathway as to how to proceed, what to do and when. Easier diagnosis and subsequent management was mostly associated with those perceived to have endogenous, severe or acute illnesses (as opposed to exogenous and chronic).

From their experience of managing depression the general practitioners have come to perceive that patients whose depression involves an additional complication (such as 'personality', 'lifestyle', 'reactive' to some situation in their life, 'contributing factors'), as opposed to the more 'straightforward' forms of the illness are more difficult to manage.

> "I find it a very difficult condition to treat, I think a lot of what makes it difficult are the surrounding personality or lifestyle issues or whatever. For straightforward depression they generally get better with the treatment." (Dr Murphy)

When exogenous or extrinsic causal factors were involved and these causal factors were perceived as being beyond either their own or their patient's ability to address, then it was more difficult to manage and to effectively 'treat' patients.

> "There are people where it's very much a reactive depression....if it's a reason you can change... it's easier for them to see it and change it. But if they're depressed because of a situation they can't get out of, then it can be very difficult to treat." (Dr Reid)

General practitioners recognised that the way in which patients presented often reflected some degree of the patient's own understanding of their problem. They described how this could be problematic for themselves.

> "I suppose if they are presenting with a strongly physical symptom, then that could be harder to convince them. Whereas, if they present with more emotional symptoms, if they are already into that mode of thinking, they may have something in their life that they need to sort out. Indeed that may play an important part in their recovery. At least they are into thinking in that way." (Dr Murphy)

General practitioners' accounts showed that they were aware that patients present in the consultation with their own understanding of their symptoms. They also demonstrated knowledge of patients' common-sense beliefs surrounding physical symptoms and depression.

> "Well I think a lot of the ones who come in and they have either had a lot of em relatively trivial complaints , or the ones who say, for example, they are tired all the time, they quite often are unwilling to accept that the diagnosis might actually be depression. I think those are the ones who are more likely to feel that there is a stigma attached to a diagnosis of depression and are probably going to be less willing to start taking any sort of anti-depressants, either because they feel it is still something else, it's still something physical that is making them feel the way they are, or just because they won't accept they could possibly be depressed, which I think is more sort of lack of education and that they don't know much about depression, in you know, as an illness." (Dr Swift)

General practitioners were also aware of patient held beliefs surrounding addiction to antidepressants.

> "...and compliance with medication, a lot of people are worried about becoming addicted to an antidepressant. And I'm often quite surprised looking back on records, how often people have been prescribed something and then it turns out that they didn't take it, or they stopped it early because they're afraid that they were going to never be able to come off it." (Dr Shaw)

General practitioners acknowledged that patients held their own explanations for their condition and that depression and antidepressants also held meaning for patients. They also acknowledged that patient's beliefs were influential in shaping their subsequent behaviour in relation to the acceptance of the explanation of depression and the acceptance of antidepressant medication. Managing depression involved addressing patient held knowledge and beliefs.

7.2 Contemplating the boundaries of their professional role

General practitioners acknowledged the contribution of the social circumstances of their patients' lives to their patients' emotional well-being. Although they could not be expected to manage the everyday lives of their patients, they believed they were still able to offer something to counteract the effects of these social circumstances.

> Interviewer (A) “I was going to ask you, how you personally feel about working with patients with depressive illness?”
> GP “…I just see the problems of so many of my patients being insoluble. You know, or em, requiring huge change on their part which they are not able to entertain, they don’t have the self-confidence to do it. And it’s difficult to see how they can get out of it. But having said that I don’t resent the time I spend with them.” (Dr Purves)
>
> “I think with patients who chronically present with low mood, I find it difficult. Are they just miserable, are they depressed now. And I find it difficult to refuse them. Because patients with low mood, who have a miserable life but are not doing anything about it, do get better with anti-depressants too. And sometimes when they’re in that situation, you can’t force them to change, or they can’t see that they should change their life, I think it can sometime be unethical to not give them something, which at least maybe helps them cope a bit better.” (Dr White)

Spending time with patients listening to their problems and even prescribing medication to ‘help them cope better’ was seen as legitimate work in managing the effects of patients’ social circumstances. General practitioners’ also believed that it was a legitimate task to do *something* with these women, even when the diagnosis of depression was thought to be unclear or problematic.

However, there was also recognition that in some circumstances the role of the general practitioner had limited impact on the patient’s emotional state.

> Interviewer (A) “Overall, how do you feel about working with patients who are depressed or seem to be depressed?"
> GP “It’s very rewarding to treat depression and see it improve. But the flip side of that coin is there are many people who are unhappy. They may be mildly depressed, they are not seriously depressed, but they are chronic and they have been for twenty years and they’re coming up with the same problems. And it’s just trying to crack that cycle. But there are some people you will never help, they are just unhappy, and that’s very sad and it’s frustrating that you can’t help them. But a lot of the problems that they have, the contributing factors, are beyond my limit.” (Dr Moore)

General practitioners’ experiential knowledge has led them to define the experience of managing depression as both ‘rewarding’ and ‘frustrating’. They are also aware that, when persistent external causal factors are involved, the ability of the general practitioner to make a difference to the patient’s mental state is limited.

General practitioners were also concerned about their role in 'medicalising' the effects of problems associated with everyday living.

> Interviewer (B) "And how well placed do you think GPs are to help with that?"
> GP "I think what we do is very minimal and think we could do better than that....and I think there's a great – I mean it worries me that there seems to be a tendency to medicalise it all. Go there if you've got itchy ears and find out people are depressed and stick them on anti-depressants. And in theory it might fiddle with their brain chemistry and give them the motivation to go and change things in their lives but it doesn't work out that way. I think we're making things into medical problems that are not. They are social problems or political problems or financial problems and all the rest of it." (Dr Morris)

They also expressed concern that engaging with emotional problems associated with life circumstances or life events could lead to over identification of depression.

> "The only worry is that you see depression in everybody. I've had surgeries where almost everyone is on anti-depressants or I'm thinking of putting them on them and you really start to panic under these circumstances...but you've got to remember the sort of people I'm seeing." (Dr Purves)

General practitioners acknowledged the social causation factors but questioned whether the effects of these social problems should be medicalised and treated with anti-depressants. Managing depression involved contemplating the boundaries of their professional role and their contribution to the social construction of depression.

General practitioners' accounts revealed their own dilemma concerning whether they should prescribe medication for essentially social problems.

> "Well she accepts that it helps her sleep and keeps her calm. I think she has also got enough insight to know that she is really taking pills to help with a difficult domestic situation rather than a more purely organic depressive illness....she knows and I know that she is taking pills to help with a difficult domestic situation...So it's a kind of impractical situation here." (Dr Black)

> "You wonder, whether this person is really unhappy and not so much depressed as just a bit fed up with life and has difficulties that you can't overcome. It's an awful lot easier to write a prescription for an anti-depressant." (Dr Purves)

There was also a concern among general practitioners that their intervention in managing the effects of patients' social problems could lead to patients becoming dependent upon medical intervention and lead to a lack of ability to self-help.

> Interviewer (Maureen) "So how would you describe your response to this patient?"
> GP "I think I'm there more as a support, in a supportive role. Because I think a lot of her problems are...she is not able or willing to do quite a lot towards trying to solve some of her own problems. I think she's, she's using the various sort of health professionals to try and solve all her problems for her and she's not really trying terribly hard to do anything about it herself. I mean the depression may well be some of that. She describes herself as being in a rut, and she can't get out of the rut. And she's, her skin gets her down and then her weight. She goes and eats for comfort and then she puts on more weight. So it's sort of a vicious circle that she's in and it just goes on and on from there." (Dr Swift)

7.3 General practitioners' experiences of managing women with depression

General practitioners described how they provided explanations to patients concerning their problems and sought to encourage an acceptance of this explanation and compliance with the suggested treatment. This section describes what general practitioners said were important in negotiating 'the explanation' and in negotiating the use of antidepressant medication. Factors described by general practitioners as important were: recognising and addressing the patient's dilemmas surrounding acceptance of the explanation of depression and the use of antidepressant medication; taking account of patients' understandings and accommodating their theories; and the doctor/patient relationship and knowing the patient. One final aspect of general practitioners' accounts of the experience of managing depression that is described, were their descriptions of engaging with the problems of the day to day lives of their patients.

These data emerged in two ways. First, during discussions when general practitioners were asked to describe their general approach to the management of depression; second, when the general practitioners were asked: what they thought the issues were (in relation to depression) from the patients' point of view; how they perceived the two women recruited to the study viewed their problems; and what they perceived were patients' views on medication (in general and in relation to the two women recruited to this study). It is from these discussions that an account of how general practitioners managed women with depression in the context of their common-sense, experiential and biographical lives, has been constructed.

7.3.1 Recognising and addressing the patient's dilemma

General practitioners recognised that women were reluctant to seek help because of the implications that this held for them in being seen as 'weak' in character.

> "There's an awful lot of women think that "I'll beat it". They will come in and they will say "I've tried to beat this". They've got this idea that it is a weakness, or its poor character to have depression and its trying to educate them that it's an illness like any other, that we can help, although I am aware that medication has its limitations too." (Dr Moore)

The approach by general practitioners in these circumstances was to 'educate' the women and provide them with new knowledge that allowed the women to understand their problem as 'an illness like any other'. 'Medicalising' the problem would enable the women to more readily accept the help being offered. In this, and in most cases, the help being offered was medication. Although the quote above does acknowledge that defining symptoms as an illness does not imply there is always an effective treatment.

General practitioners also recognised that taking medication may be symbolic of their 'inability to cope' for some women.

> "I think they're maybe scared that these tablets will somehow affect them, that somehow they are a sign that they are not coping" (Dr White)

General practitioners were aware of the negative perceptions of antidepressant medication that contributed to the women's reluctance to take them. They were also aware of common-sense perceptions surrounding newer medications, and Prozac in particular.

> Interviewer (A) "On the whole what do you think patients' views on medication are like?"
> GP "On large, I think my patients' views are really negative to antidepressants, not to medication in general but to antidepressants. I think in particular there's a perception of drugs being addictive and "Once I get on them I'll never get off them". And that's always the first question they ask you. Em, I think the newer, there's a sort of little bit of mystery behind Prozac as well isn't there, in popular magazine's sort of stuff as well. Em, which is both positive and negative." (Dr Cook)

In order to counteract the feelings the women had towards the explanation of depression and the dilemma they faced in accepting antidepressant medication, general practitioners attempted to normalise the condition for women by framing it as an illness like any other. Dr Moore (above) and Dr Murphy (below) spoke about dealing with feeling of guilt, weakness and poor character in this way.

> GP "A lot of my approach is getting people to think of it as a straightforward illness. Because it involves emotions and affect the way people think then it is interpreted as being something different from diabetes or Crohns disease or whatever. If you can just get them to think of it as an illness they will deal with it better"
> Interviewer (A) "So how would you go about trying to convince people and convey that it is an illness?"
> GP "To say something like, "There is often a guilt about taking antidepressants, you wouldn't feel guilty about taking insulin if you had diabetes". To convey it that sort of way." (Dr Murphy)

General practitioners also challenged the women's beliefs that they should be able to manage their depression by themselves.

> "Em, I usually say to them, you know that they think "Oh I should be able to get over this myself" and all this sort of stuff, and I just say "If you had broken your leg or had high blood pressure , you know you wouldn't be sitting in the chair saying to me I think I should manage this myself." (Dr Purves)

General practitioners also saw a role for themselves in validating the women's experiences through acknowledgement of it. The general practitioner must somehow convey to the patient that he/she believes the patient.

> "I think one of the most important things about going to see a general practitioner is the sense of validation in the way you are feeling. And I just have a sense that a lot of my patients must have that "this guy has seen a lot of people like me before". It kind of normalises things, sort of saying, you're not the only one in the world…just that process is actually very healing in a way" (Dr Walker)

It is implicit in this account that the general practitioner somehow conveys to the patient that they have experience of seeing people with similar problems. Their intention in doing so is to 'normalise' the patient's experiences, perhaps in order to address the stigma that general practitioners recognised as a consequence of cultural beliefs surrounding depression. Indeed the general practitioner acknowledged that this 'act' can be a therapeutic act.

Thus general practitioners recognised the dilemmas that the women faced in accepting a diagnosis of depression and they engaged in strategic acts in order to address the implications for their patients. These strategic acts involve 'educating' the women that their problem should be perceived as 'an illness' like any other and 'validating' and 'normalising' their experiences as real but not uncommon. Further strategic acts for addressing the women's dilemmas, concerning acceptance of a diagnosis of depression and antidepressant medication, included presenting the non-acceptance of help as irrational and demonstrating to the patient that they recognise them as responsible and according the patient a 'status'.

7.3.2 Taking account of patients understanding and accommodating patient's theories

The general practitioners were aware that it was only when the women perceived that their own theories, 'ideas and concerns and expectations' have been adequately taken on board, would they be open to considering alternative explanations.

> "I think I might have gone down the road of investigating this a little bit further because that does tend to be my sort of way, that I'll go along with some of the patients ideas and concerns and expectations because I think that's a good way of getting the patient to realise that she's being taken seriously and also giving the patient some space to start thinking about "Well if it's not this what else could it be?"(Dr Green)

> "....even going through the motions of doing a physical examination and investigation, because sometimes part of the management is actually getting people to come round to seeing, accepting the diagnosis of depression....and that sometimes takes time...and you can't [get them to accept the diagnosis of depression] without working through their hypotheses, their idea of what's going on. So unless you check out the tiredness etc., then its very difficult to come back and be confident so far as the patient is concerned that there's something else going on." (Dr Cook)

The advantage in being aware of the patient's perspective is that general practitioners can work with this knowledge in their strategic management of the patient. In these examples the general practitioners already knew that the test/investigation were unnecessary but the real purpose of the tests was to provide evidence to discount the patient's ideas/theories about their problem and re-direct them towards thinking about alternative explanation. The general practitioners described how this act has the additional advantage of signalling to the patient that their own experience and knowledge are being taken seriously.

In the many descriptions of getting the patient to come around to thinking that their problem may be psychological in nature or depression, one general practitioner described the process as 'selling' the idea to patients.

> Interviewer (M) "I'm just trying to get a feel for the issues that you might have to take into consideration in dealing with the patient."
> GP "Well again I suppose it is selling them the diagnosis, it's where they are coming from and that sort of issue, they can be very wary of mental illness and accepting that they could have that. Or again they could be convinced that they have some sort of medical illness, you are asking them to come a bit along the road with you....again it comes back to selling the idea." (Dr Murphy)

Taking on board this analogy, the general practitioner could be perceived as a salesman who employs a set of sales techniques at his/her disposal in order to persuade the client to accept their advice. I discuss some of the mechanisms that general practitioners reported using to negotiate with patients further below.

General practitioners were also aware that they had to take account of patients' understandings of medications and to address patients' concerns and to provide the patient with an adequate explanation for adopting their use.

> "I think one of the most important things is that you have to have full agreement of the patient, you know what you are going to prescribe is going to be of benefit and is necessary. A lot of patients don't like the idea of being put onto anti-depressants because they associate them with addiction, and you know, long-term treatment. And em, I think it needs to be talked through at quite a bit of length you know to try and eh, so the patient knows what is going on and, you know, why they need treatment and how the treatment is going to work. And I usually spend quite a bit of time trying to explain how SSRI's work and, you know, why people get depressed." (Dr Swift)

The following examples show how general practitioners were aware of some of the influences on patients' attitudes and decisions regarding medication but they were also aware of the need to elicit individual patient's concerns.

> Interviewer (A) "What do you think patients' views on medication are?"
> GP "(Laughing) I don't know em, they're probably a bit less expectant of a prescription every time, than they used to be. With publicity about resistance to antibiotics and things like that, I think people are beginning to learn that you don't have to have a prescription every time you come to see the doctor....I'm surprised sometimes at those who actually take a prescription and then some weeks later I discover that they haven't had it dispensed, I think "What did I do wrong there?" (laughing) and that is sometimes because they haven't, well I haven't sussed out just how resistant they are to taking medication. But some people do get medication, then read the leaflet inside from the drug company and see all the possible side effects and say "Well there's a list that long, I'm not going to even try it" so that happens." (Dr Shaw).
>
> "I felt that she is listening to quite a lot to other people's concerns about it...It's the same thing with Depo-Provera. You can recommend it and say it's just one of the best forms of contraception. "Oh my friend had it and she gained six stones in weight". And that's it, there's nothing you can do about it. And that's fair enough, I mean, you know, people learn from other people's experiences."(Dr Green)

General practitioners were aware of the on-going evaluation by patients and that even addressing concerns within the consultation could not prevent the evaluation of new knowledge influencing their subsequent decisions. The general practitioner's advice was recognised as only one source upon which decisions were evaluated.

General practitioners' accounts revealed some of the mechanisms they employed to address patients concerns and to negotiate acceptance of antidepressant medication by patients. In the following example, Dr Green describes how they addressed their patient's concerns regarding antidepressant medication.

> Interviewer (B) "So how did you deal with her negative attitude to medication?"
> GP "Well I let her talk. I said to her what are your concerns about anti-depressants. And she said "Well I've read that they're addictive". And I said "Well that's quite surprising, I'm not aware that they're addictive". And then I spoke to her about the withdrawal effect and how certainly if you withdraw them abruptly you can have quite horrible nasty side effects and that's why it's important to continue the medication and then withdraw them slowly. So I kind of tried to acknowledge that yes there was, I understood where the addictive bit came from but this was the reason for it. And then I tried to explain what the anti-depressants did, that they weren't mind takeovers, or mood sort of changers or whatever. I mean I tried to explore what her concerns were and then tried to answer them sort of with simple scientific fact. And I did say to her that ultimately there was no point in starting on anti-depressants if she did not feel confident about taking them because compliance was going to be really necessary. And then she said well she felt so awful she'd be prepared to try anything so she said she would start the prozac."(Dr Green)

Dr Green established the nature of the patient's concerns and was aware that the patient may attach a certain status to their knowledge because they had 'read' this. Dr Green had to counteract the patient's knowledge and did so in a way that did not discredit the patient or their knowledge by acknowledging that there was some logic to the patient held theory in relation to 'the withdrawal effect'. [It is interesting to note that the Dr Green's explanation revolves around the 'withdrawal effect', assuming that this might be the issue to which the patient's knowledge refers. However, as was shown in chapter 6, the patients' ideas concerning addiction are not entirely focused on physical addiction or dependency but also include fears of psychological dependency.] Dr Green provides the patient with further knowledge concerning antidepressants using non-medical terms ('mind takeovers' and 'mood sort of changers') to describe what they do not do, although she views her own knowledge as representing 'scientific fact'.

The purpose in exploring the patient's beliefs or knowledge was to counteract these beliefs/knowledge with (what the general practitioner believed to be) scientific or formal knowledge. The general practitioner then allows the patient to evaluate the new knowledge they have provided as part of the process of negotiating their use.

However, the general practitioner's accounts also revealed that there were some circumstances when the general practitioners were less willing to 'negotiate' with patients.

> "...if you get someone who is really very depressed and who is saying "No, I don't want to take any medication", you are definitely putting the pressure on, you are sitting there pulling out the big guns, everything you can do to try and persuade this person to take medication....general practitioners only negotiate with patients when they know they are going to agree with them. But if you have got a seriously ill patient, you will find there is still negotiation going on but you are laying it on very thick." (Dr Purves)
>
> "I would have more come and go in negotiation perhaps with [patent1] who in my perception is not the type of patent that [patient2] is. [Patient2] is a more at risk depressive and therefore I think I would be slightly more coercive or persuasive about being managed than I might be with [patient1]" (Dr Cook)

In these circumstances general practitioners are less concerned with taking account of patients' understandings and accommodating patients' own theories. Patients perceived to have less serious depression are given more opportunity to evaluate the general practitioners' explanations and advice and to make informed decisions. When patients are perceived to have more serious depression, general practitioners are more strategic in using their knowledge and other mechanisms to 'coerce', 'persuade' and 'put pressure' on patients.

7.3.3 Doctor/patient relationship and knowing the patient

I have previously shown how 'knowing' a patient could facilitate the general practitioners' recognition that something was wrong with their patient. General practitioners' accounts demonstrated the importance that they attached to their relationship with the patient and how this was perceived as being influential in getting patients to accept their explanation and advice. General practitioners spoke of how knowing the patient over time had contributed to the development of their relationship and also the development of a degree of trust. The women in this study also placed value on their relationship with their general practitioner, and 'knowing' their general practitioner and also 'being known' by their general practitioner. I have already shown in chapter 6 how the women's perception of their relationship and their interactions with their general practitioner promoted a positive or negative outlook towards the general practitioner's explanation and advice.

General practitioners' perceived that the development of trust within a good relationship was sufficient to influence the patients' evaluation in favour of the general practitioners' advice.

> "We had a good relationship...I think there is an amount of trust there. I think she would trust me to do the right thing or to give her advice that she would be happy with. And the advice is based on my knowledge of what [kind of] person she is." (Dr Murphy)

General practitioners could also use the relationship to enter into agreements with patients.

> "Where it helps I think, if you know someone quite well, you know. If you have seen them a lot, you can say look, I would like you to make an agreement with me that we will just try this for a month and if at the end of the month you aren't any better we will stop these tablets and we will forget we ever spoke about them." (Dr Purves)

In this example the patient is being asked to put their evaluation of their knowledge on hold and to delay making their decision, and to enter into a trial of the general practitioner's advice. On the basis that people normally only enter into contracts/agreements when there is a degree of trust, I assume that a degree of trust would have to exist between the doctor and the patient. The general practitioner acknowledges that this strategy would not work unless there had been previous interactions with the patient and it is implicit that these interactions would have been favourable enough to develop a degree of trust by the patient. However, in other accounts, general practitioners discussed managing patients with whom they did not have a long-standing relationship as was the case with Dr Murphy's second patient.

> Interviewer (M) "So how would you describe your relationship with her?"
> GP " Certainly it is different if you don't know the patient....The relationship is getting better. Obviously initially I was asking her to trust me and take the right decision and you will get better. If they have no experience with me before, there wasn't much to base that trust on. So I think the relationship is getting better as different issues come up. I am sure we can deal with those

> and to think of positive ways to get the patient through it. And then the relationship improves. (Dr Murphy)

Dr Murphy worked with the patient on the basis of a 'trust' that had not been established through the formation of a relationship. As the relationship progressed and the patient gained positive experience of being managed by Dr Murphy then it was implicit that the basis of the patient's trust would be established from this on-going relationship. Dr Smith also described how the patient's positive experience of being managed could affect their subsequent relationship.

> "I don't have a particularly strong relationship with her simply because I haven't seen her a lot over the years...so I wouldn't say that I really know what she's like when she's well....and I hope that now that her treatment is working that she's starting to realise that she can get better and I hope also that it makes her slightly more confident both in the diagnosis and the treatment that I've given her also, um so it might help her to trust me a wee bit more and therefore we can start looking at getting her through it." (Dr Smith)

Hence, for general practitioners there are practical advantages in knowing the patient and developing a relationship with a patient but this 'trusting relationship' is also dependant on positive experiences of care. As well as 'trust' being conceptualised as something that is established through doctor and patient interaction, it is also something that general practitioners could rely on in the absence of an established relationship. This could be taken as '*inherent*' trust that is accorded by patients or the public in general to the profession of medicine.

7.4 Engaging with the day to day problems of patients' lives

General practitioners were involved in managing the day to day problems in patients' lives. They understood the impact of these problems on their patients' well-being. In response to questioning about their role in managing depression, and what aspect of their role was perceived as being of most value to patients, it was often their involvement in helping patients to cope with their day to day problems that was seen as being of most value. The following exert is an example of a general practitioner account of this work taking place within the consultation.

> Interviewer (B) "So what do you think is the most valuable thing you are doing for [patient]?
> GP "I think that she knows that I know what her home life is like. That she has got these two boys who just don't sleep and we have spent quite some time just talking about what we can do to try and get these two boys to sleep better. And em, not the last time but the time before when I saw her she was speaking about putting the younger one, who I think is still only about less than a year old, she was speaking about taking him out of the cot and onto a mattress on the floor. Which is apparently what solved the sleeping problem with the older one at the same sort of age. And then of course, they both went and got croup and diarrhoea and vomiting so that all had to be put on hold. And I haven't seen her since then but this is what she was going to do...but she gets very worried about the boys waking the neighbours at night and it must be an absolute nightmare." (Dr Swift)

Dr Swift acknowledges her 'supportive' role and accounts for her involvement in the patient's day to day problems– because it is a source of worry for the patient.

General practitioners explored the day to day problems of patients in order to allow patients to share their experiences and have these experiences acknowledged- they allowed patients to feel listened to.

> "I try and give them time with a little bit of prompting to just explain what the problems in their life are. Often it's things like relationship problems, problems with family, problems with their job. Sometimes after some time to talk things through, and sometimes with, even some time off work just to give themselves a little bit of space just to see and to have a look at their lives, they can manage without medication." (Dr Shaw)

Within general practitioners' accounts, as exemplified by Dr Shaw above, exploring the day to day problems was viewed as a therapeutic act. The lack of time to talk to their patients was seen by general practitioners as the main organisational constraint on their ability to manage depression more effectively and appropriately. As Dr Shaw continues,

> "So often you feel that if we had a little bit more time to allow them to talk a bit more and express themselves, but I do often feel I'm pushing on, being aware of having a ten minute slot only." (Dr Shaw)

General practitioners involvement in sharing and empathising with patients' day to day problems also helped to develop a relationship with the patient and to build trust in the doctor/patient relationship. As I have demonstrated in the previous section, a trusting relationship could be helpful in negotiating patient acceptance of the general practitioners explanation and advice. Engaging with the day to day problems of patients' lives could also be therapeutic in meeting the deeper needs of patients. In the following example the general practitioner became involved in a domestic disagreement surrounding the sympathy cards that she had been sent on the death of her father.

> Interviewer (B) "What made you think that she was abnormally grieving? Why were you so concerned about her?"
> GP "I clearly felt greatly relieved that she could talk about her feelings. I think that was her main problem and also, I mean, she was, I think she was relieved to have someone who could understand and I told her she could leave the cards up. I remember she made a great thing about this disagreement with her boyfriend or her partner who wanted the cards down. "Och" I said "Just leave your cards up that's fine". That's what she said the last time, she had decided she was going to take the cards down at New Year. And I thought well that's interesting. I hadn't told her to take the cards down but she had. So I think it was allowing her to express what she really was feeling and to say that that was normal, I think she found quite helpful." (Dr Thomas)

Dr Thomas' willingness to engage with and understand the patient's need to keep the bereavement cards up indicated to the patient that their behaviour could be viewed as 'normal' and appropriate (as opposed to her partner's view). Dr Thomas felt his approach conveyed to the patient that they understood the patient and that this enabled the patient to 'express what she was really feeling'. This description of work *in the consultation* contrasts with Dr Thomas' subsequent account of the patient and his perception of her partner's viewpoint.

> "I don't usually use ant-depressants before three plus months of bereavement because I think it is natural to be very depressed and I think people need to talk that through. But I thought she did need something quite quickly because her bereavement reaction was abnormal to me. Em ,it was so intense and I could see why [partner's name] was struggling with her, and told her how to manage that, because I thought he was having rather a bad time with her and he sounded quite a nice guy, I had never met him." (Dr Thomas)

Managing the depression had involved managing a relationship problem between the patient and her partner. Dr Thomas really viewed the patient's behaviour as abnormal and empathised with the patient's partner. However, in the consultation Dr Thomas ignored or acted against his perceptions in order to manage the patient. Dr Thomas was engaged in some form of strategic acting with the patient, strategic in the sense that the he engaged in this acting (or pretence) for a purpose – in this case to allow the patient to feel that she could express her feelings without fear that these feelings would be viewed as abnormal. In dealing with patient's day to day concerns, the general practitioner's work could be seen as symbolic in meeting the deeper needs of the patient.

General practitioners accounts of their roles also included being engaged in the role of 'arbiter' in family relations or disputes. Patients' accounts of engaging the opinion of their general practitioner regarding their day to day problems and relationships showed that patients believed their general practitioner to have taken their side and to have validated their own opinions or actions. In this way the behaviour of others was portrayed as unreasonable and the behaviour of patients as reasonable.

7.5 Summary

In this chapter I have shown how general practitioners perceived that some categories of depression were easier to manage than others. Patients' recognised as having 'endogenous' depression , or when the presenting symptoms were perceived to represent 'classical' features of depression were seen as easier to manage than cases where extrinsic causal factors were involved or when the patient presented with physical or vague symptoms. The way patients presented was recognised by general practitioners as providing knowledge of the patient's own understanding of the problem and the likelihood of whether the patient would readily accept the general practitioners explanation or require to have the patient's own understanding explored further and to manage the patient in a way that they accommodated or accounted for the patient's own theories.

If one looks at their definitions of depression from chapter 5, it could be assumed that the 'straightforward' depressions are the endogenous types, that is, those that do not appear to have any additional complicating factors or external causes. General practitioners are most comfortable when dealing with depressions of a bio-medical nature. Managing cases of depression that involve engaging with or managing the social circumstances of the patient are problematic. They are problematic for two reasons: one is their inability to change situations that even the patients are perceived as unable (or in some cases this was put as 'unwilling') to change; and two, is the issue of whether general practitioners should be responsible or engage in managing these contributing factors. General practitioners expressed concern with their role and whether, or to what extent, they should engage in addressing the social problems or events surrounding the women's lives.

General practitioners perceived that it was a legitimate task to do something to help alleviate the effects of these problems in the women's lives. General practitioners believed that medications could help these women to cope better and therefore they perceived a professional duty to offer this help. However, general practitioners also recognised the subjective nature of deciding when the effects of these social problems came to be defined as a medical problem and they raised concerns surrounding their role in 'medicalising' the effects of social problems and the potential impact that medical intervention might have in preventing the development of other coping or self-help strategies to enable the women to address their problems, particularly persistent problems that negated any potential benefit that medication might have.

Although general practitioners expressed concerns about applying medical interventions for essentially social problems, they also saw engaging in the day to day problems of patients' lives as legitimate work in the consultation. This work achieved several purposes: it allowed patients to share their experiences and to feel understood and listened to; it allowed general practitioner to help patients to discuss solutions and coping strategies for their problems; it was of therapeutic benefit for the patients. General practitioners perceived this work to be of such importance in the management of depression that they expressed a need to have more time within the consultation to engage in this work.

Sharing and empathising with the patients' day to day problems was also instrumental in developing a relationship with the patient and to the development of a trusting relationship with the general practitioner. General practitioners could be strategic in portraying empathy and understanding with the patient and their day to day problems in order to allow patients' to express their concerns and feelings.

It has also been shown in this chapter how general practitioners managed women with depression in relation to negotiating the explanation of a psychological problem or depression and in relation to negotiating their use of antidepressants. I have demonstrated how general practitioners had a general understanding of the patients' dilemmas surrounding acceptance of an explanation that involved a psychological problem and the use of antidepressant medication and also of the sources of some of these concerns. General practitioners were aware of the common-sense knowledge that surrounded depression and antidepressant medication and thus the potential meaning that a diagnosis of depression and antidepressant medication might have for patients. The general practitioners attended to the patients' dilemmas by framing the problem 'as an illness' and de-personalising the problem thereby attending to the feelings of 'guilt' that they perceived the women to be experiencing. The use of the 'illness analogy' also had the purpose of presenting to the women the alternative dilemma -that it would be irrational not to accept help, which in all cases represented antidepressant medication.

General practitioners also attempted to 'normalise' the experience for women rather than have their experience perceived as abnormal. Their intention was to reduce the stigma that general practitioners perceived the women associated with psychological problems including depression.

I have also shown how general practitioners engaged in understanding the patients' perspective and the patients concerns, theories and beliefs about 'what is wrong'. The general practitioners engaged in strategic acts to demonstrate to the patient that their own theories had been taken seriously. The general practitioners also determined the nature of patients' concerns surrounding antidepressants and, if necessary, counteracted these theories and concerns by providing the patient with new or additional knowledge. However general practitioners' accounts also revealed that in some circumstances they attempted to limit patient negotiation and evaluation and they adopted more persuasive strategies in order to get patients to accept medication.

Finally, I demonstrated how general practitioners perceived that their relationship with the patient could be used to facilitate patient acceptance of the general practitioners explanation and advice. The necessity of a trusting relationship was implicit in the general practitioner accounts. The relationship could be of value in itself in that the existence of a positive relationship could be enough to influence the patient's acceptance or the relationship could be used in a strategic way by the general practitioner to influence the negotiation. However, in the absence of an existing relationship, general practitioners could also rely on a degree of 'inherent' trust in them, a trust that is accorded to their status as doctors by patients the first instance. This 'inherent' trust would subsequently be replaced or strengthened by the patients' experiences of being managed and the trust that arose from these experiences.

Chapter 8 Discussion

> *"What needs to be emphasised here is that doctor-patient encounters are at one and the same time dynamic and negotiated…… and structured…… As Bhaskar reminds us, it is neither necessary nor credible to choose between agency and structure."* (Scambler, 2002:125)

8.1 Introduction

The main impetus for this thesis was the perceived failure of the majority of research on the management of depression to problematise the definition of depression. It was suggested that the starting point for developing strategies to improve recognition and management should be to understand how general practitioners recognise and manage depression. There was also a perceived failure to link previous sociological understandings and methodological approaches from research on the doctor-patient encounter, lay health behaviour, and illness experiences, to research and guidelines for the management of depression. This literature recognises the active role of the patient and the nature of the doctor-patient interaction as a negotiation. It is this type of research that is associated with the development of patient-centred approaches to care. Hence, this thesis derived from the need for research into the management of depression that could bridge the gap between patient-centred and evidence-based approaches to care.

The overall aim of the thesis was to explore general practitioners' and women's experiences of the management of depression in primary care. More specifically, it investigated how women recognised that something was wrong, their accounts of decisions to consult, how they made sense of their experiences, and what they thought and felt about their experiences of the care they received. At the same time, it investigated how general practitioners recognised and made sense of the women's problems, their experiences of managing depression, and how they subsequently cared for the women and their problems in the context of everyday practice. Framed another way, this thesis has essentially been an exploration of accounts of both lay and professional knowledge in relation to the recognition and management of depression. It has also been an exploration of the doctor-patient relationship in accounts of managing depression and an evaluation of doctor-patient encounters from both lay and professional perspectives. As such, this thesis has made a contribution to both micro and macro focused theoretical debates.

In interpreting the findings I have drawn upon the later work of Foucault as interpreted and applied in the empirical work of Lupton (Lupton, 1997a, 1997b) and on Habermas's Theory of Communicative Action (Habermas, 1987; Scambler, 2002) as discussed in chapter 2. However, I do this to enhance the practical and applied relevance of the data to primary care rather than to contribute to a debate about the relative contributions or relevance of these philosophers at the level of social theory.

Other writers (Jones, 2001; McCarthy, 1994) have also suggested that there is value in considering the contribution of both Foucault and Habermas to the medicalisation debates. They have suggested that social constructionist and critical theories (or Foucault and the Frankfurt School) are more closely related than the debates within these disciplines would suggest. Therefore:

> "...rather than choosing between them we should strive to 'combine them in constructing theoretically informed and practically interested histories of the present' (McCarthy, 1994:273)". (Jones, 2001:164).

I have also found value in drawing on more than one perspective. Foucault recognised the existence of strategies of power and that their existence did not necessarily result in the successful exertion of power (Lupton, 1997a) but since Foucault neglected the ways in which medical practitioners and lay people practice and experience medicine he offered no framework for exploring these strategies of power and how and when they might be used. This is where the work of Habermas has more applicability in exploring the doctor-patient interaction at the micro level and his writing provides a way of explaining the relationship between lay and expert knowledge and to account for *how* doctors negotiate their explanations and advice in the management of depression.

I have presented the main findings in relation to the study aims in the four data chapters. By way of a reminder, this chapter begins with a summary of the main points made in each of the data chapters. The discussion then turns to summarising how a critical realist methodology contributed to our understanding of lay and professional accounts of depression and its management, before moving on to discuss the findings in relation to broader theoretical debates concerning the relationship between the lay populace and modern medicine within the medicalisation thesis. The discussion ends with attending to the relevance of the findings and theoretical insights of critical realism to policy developments that call for health care professionals to manage depression as a chronic disease, and to the applicability of current guidelines for the management of depression.

8.2 Summary of previous data chapters

Chapter 4 described the women's accounts of how they reported recognising that something was wrong, how they accounted for their decisions to seek help, how they made sense of their problematic experiences and the types of knowledge they used in this process. The women in this study described how they recognised cues that something had changed in their personal state and 'that something was wrong'. These cues were labelled as physical, behavioural, cognitive/emotional, and communicative. The problematic nature of these cues was often defined in relation to their impact upon an ability to function. In making sense of their experiences (which involved seeking answers to the questions 'what is it?' and 'why has this happened?') the women made reference to different sources of knowledge, which were categorised as experiential (knowledge gained through personal experience or the personal experience of others), common-sense (everyday knowledge) and biographical knowledge. In making sense of their experiences 'as depression' the women referred to their common-sense knowledge of depression and its causal mechanisms and engaged in causal theorising in relation to their own experiences. It was also demonstrated how women described their accounts of help seeking as a last resort and as 'doing it for others'. The women expressed concern about their social behaviour and their failure to perform their perceived social roles. In this way their help seeking was portrayed as a 'moral act'.

Chapter 5 turned to the general practitioners' accounts of how they recognised what was wrong when the women consulted, how they identified the problem as psychological rather than physical in nature, how they came to define the problem as depression, and the types of knowledge that they used in this process. It was considered whether Locker's (1981) framework, which had been derived from lay accounts of recognising and making sense of signs and symptoms, could be applied to general practitioners' accounts of detecting and diagnosing depression in others. This framework facilitated the construction of the types of 'cues' that general practitioners described as indicating to them that something was wrong and that the problem was likely to be psychological rather than physical.

From general practitioners' accounts of this process, three types of cues that would trigger their thinking towards a psychological or emotional problem were identified. These were labelled as *behavioural* (including intuitive recognition of types of behaviour), *symptom* and *communicative* cues. It was through the recognition of a combination of cues, with cue elaborating each other, that general practitioners were able to identify the nature of the problem as psychological, or as depression itself. However, in diagnosing depression, these cues were usually interpreted and made sense of with reference to additional sources of knowledge. Their descriptions contained three types of knowledge: medical, experiential and biographical. General practitioners' definitions of depression were inextricably linked to their causal explanations which in turn caused them to seek further knowledge of the biographical context of the patient.

Chapter 6 addressed women's perceptions of the management of depression and demonstrated how they evaluated their general practitioners' explanations for their problems and how they made use of their own understanding in relation to 'what is it?' and 'why has this happened?'. It was shown how the general practitioners' explanations (in some cases the diagnoses) were understood and largely accepted: when the women's own theories were acknowledged and accommodated; or when the general practitioners' explanations made sense to the women within their existing knowledge; or when the general practitioners' explanations made sense of their inchoate feelings and/or were acceptable to them because they addressed their needs at that stage of their experience. In addition to 'making sense' to them, the women also spoke of the importance of their interaction with their general practitioner. It was implicit in these accounts that a positive interaction (characterised by being listened to and having their own theories taken on board) was more likely to facilitate the development of trust in, and an enhanced relationship with, the general practitioner. This in turn was likely to encourage a more positive outlook or acceptance (at least in the short-term) of the general practitioner's explanation and advice. Overall, this chapter demonstrated how the process of making sense of depression experiences and evaluating explanations was an on-going process, whereby new evidence was assimilated and evaluated in light of previous knowledge and experience. Women also sought out the views of others beyond the medical encounter and evaluated this advice in their decisions regarding their care.

The second part of chapter 6 addressed women's perceptions of medication for the management of their problems. The women evaluated antidepressant medication and its use in relation to whether it made sense within their own perceptions of their problems and also in relation to their evaluation of their general practitioners' explanation and advice. The women's perceptions of their interactions with their general practitioner were also important in their evaluation of his/her advice to use antidepressants. It was important for the women to feel that they had been listened to and that they were not being 'fobbed off'. The issuing of a prescription had to be seen as a carefully considered decision and not one made on the basis of a routine response or through a lack of interest. In addition, the women also demonstrated the range of knowledge that they held surrounding antidepressant (and similar) medications. I labelled these different types of knowledge as 'experiential and 'common-sense' knowledge. Experiential knowledge included personal experience of using antidepressants and/or experience of seeing others using these types of medications. Common-sense knowledge reflected more general ways in which antidepressants were known by these women and also included common-sense perceptions surrounding medication use. Common-sense perceptions of antidepressants and medication taking were generally negative. Experiential knowledge of seeing antidepressant use in others was also generally negative (although there were some positive accounts). The negative images included the fear of addiction and the notion that medication use would result in a change in the women's personality or their way of 'being' (for example, becoming a 'zombie'). Therefore, the acceptance of medication in light of these negative attributes created a moral dilemma for the women. In order to manage this moral dilemma the women described their use as 'doing it for the sake of others' or to control their behaviour and enable them to function within their social roles, particularly as a 'good mother'; medication use was also therefore portrayed as 'a moral act'. However, the women's concerns surrounding addiction or the potential change in their mental state also had to be adequately addressed if they were to consider taking antidepressants. The women explained their acceptance (at least in the short-term) in terms of how the general practitioner had reassured them about these concerns. In addition, the women also sought the advice of others as to whether they should use antidepressants. When this 'lay' advice addressed the women's concerns they were generally more positive about using the medication. Addressing the women's concerns (whether by the general practitioner or by others) reduced the moral dilemma women faced surrounding taking medication. Medication use was also subject to on-going evaluation. New knowledge, particularly experiential knowledge, was described in their explanation of their decisions to continue to use medication. Women also engaged in self-titration in their use of medications according to their own perceived needs at the time. Common-sense knowledge surrounding medication use (for example that they become ineffective with long-term use) was also brought into play in their descriptions of explaining their own medication use.

The final data chapter (chapter 7) dealt with the issue of general practitioners' perceptions of the management of depression (both in general and in the women in this study) and how they managed patients in the context of everyday practice. I described some of the problems that were prominent in general practitioners' accounts of managing depression. Problems arose when patients presented with physical symptoms or did not present with 'classical' depression symptoms (defined as biological signs such as not sleeping, lack of concentration). Patients perceived as having 'endogenous', severe or acute illness were also reported as being less problematic than patients with 'exogenous' or chronic depression, and particularly when additional 'contributing' or extrinsic causal factors were involved. General practitioners were aware that patients had their own ideas or understanding of their experiences and that they had to take these understandings on board. General practitioners were also aware of their patients' common-sense knowledge of illness, depression and medications (including antidepressant medication) and therefore managing depression also involved addressing patient held knowledge and beliefs.

For general practitioners, the experience of managing depression involved contemplating the boundaries of their professional role as they engaged in managing emotional problems that stemmed from the patients' life circumstances. They were aware of the subjective nature of decisions and when the effects of social problems came to be defined as a medical problem. They also described their own dilemmas in determining whether medication use was appropriate in these circumstances while at the same time feeling that they had the ability, and even a duty, to do something for their patients. General practitioners engaged with the day-to-day problems of their patients' lives and felt this was justified because these problems were seen as either causing or exacerbating the patient's depression. Engaging with patients' day-to-day problems was also strategic in making patients feel that the general practitioner had listened and taken their concerns on board, it fostered a (trusting) relationship with the patient and was also portrayed as 'therapeutic' in itself. This in turn brought benefits to the general practitioner when negotiating the acceptance of a psychological problem or the diagnosis of depression and also in negotiating the use of antidepressants.

From the general practitioners' accounts, the factors that were identified as important in negotiating 'the explanation' and the use of antidepressant were: recognising and addressing the patients' dilemmas about the acceptance of the explanation (of depression) and about the use of antidepressants and the meaning (or stigma) that this would have for the patient; taking account of patients' own understandings and accommodating their theories; and the relationship with. and knowledge of, the patient. They described the value of developing a 'trusting' relationship with patients. In the absence of an established relationship, general practitioners were still able to proceed with negotiating acceptance of their advice on the basis of inherent trust but were aware that the patient's subsequent experiences of care would determine whether this trust was maintained. Overall, the data in this chapter also showed that general practitioners were aware of common-sense understandings of depression and antidepressant medication and of their need to attend to these common-sense beliefs in managing their patients. They shared similar knowledge to patients of the causal explanatory frameworks for depression although their explanations focused on explaining how extrinsic causal factors would result in biological reactions. Their accounts also demonstrated that they could either reject the biopsychosocial model or engage with this depending on their personal and professional resources. The general practitioners engaged in strategic acts to demonstrate to the patient that their own theories had been taken seriously (such as initiating tests). Determining the nature of patients' concerns was also strategic as it then allowed them to challenge or counteract these beliefs and concerns. They also described how they sometimes adopted more persuasive strategies and sought to limit patient negotiation of medication use when this was perceived as being for the benefit of the patient.

8.3 The contribution of a critical realist approach to understanding lay and professional constructions of depression

It was argued at the start of this thesis that a critical realist methodological approach would offer a more practical solution to the current conceptual incoherence within current notions of depression (as provided by either the medical view or the social constructionist view). Within this view, the 'biological reality' of disease and illness is recognised alongside the socially and culturally relative constructs that surround disease and illness. It recognised that the construction of depression in the primary care consultation is influenced by the nature of the interaction between the doctor and the patient, but that this is also bounded by social and cultural constructs of the illness. This approach provided a useful theoretical model for exploring the construction of depression in primary care. This thesis adds knowledge of some of the components within this theoretical model.

Chapter 4 described the various cues through which the women identified a problem (physical, behavioural, cognitive/emotional and communicative). They entered the consultation having already made some attempt at understanding the nature and the potential cause of their problems. Women used different types of knowledge in making sense of their experiences. There was knowledge at a personal level (their illness biography, emotional biography, and experiential knowledge of depression in themselves or in others, their previous illness experiences and experiences of medication use), and knowledge at a social/cultural level (common-sense knowledge of depression and mental illness, common-sense knowledge of emotions, and common-sense knowledge of health and illness and medication use, common-sense knowledge of expectations of social roles). This common-sense knowledge can also consist of formal medical knowledge that the lay populace have access to (through various forms of media).

General practitioners also described the cues through which they recognised psychological problems (behavioural, symptom and communicative cues) and the type of knowledge they drew upon in making sense of the patients' presentation as depression (medical knowledge, experiential knowledge, and biographical knowledge of the patient). They shared common-sense knowledge of depression and emotions, and were aware of media influences in the construction of this knowledge. They understood that the negotiation of the illness and its treatment involved attending to patients' understandings and constructs of the illness.

It is in the context of this knowledge that general practitioners and their patients engage in negotiating and understanding the problem. The interaction itself resulted in a sharing of knowledge; whereby medical knowledge was relayed to patients, which they evaluated in relation to their existing knowledge. The experience of the interaction was also important in influencing the exchange and evaluation of knowledge. General practitioners had take on board patients' understandings in order to know how to proceed in negotiating other explanations; and patients had to feel that their own understandings had been taken on board, or the general practitioner's explanation had to make sense to them within their current knowledge and understanding, or to bring relief in some way. The interaction was also influenced by structural aspects of the surgery, such as the time available for the consultation, which could affect the potential for symptoms to be identified as depression (or to be managed as a physical presentation).

What is evident from this study, is that the majority of patients' symptoms do not fit exactly with diagnostic criteria. Patients are diverse in the way they experience symptoms and in how they evaluate and cope with these symptoms. It is also evident that general practitioners incorporate different types of knowledge, of which formal medical knowledge is only one part, in recognising and managing depression. Doctors also have to negotiate their explanations with patients and they have to make sense to patients. The rational application of evidence based guidelines does not fit in with this patient-centred approach that general practitioners engage with in managing depression. To improve the recognition and management of depression, what is required is an approach that facilitates the negotiation of the illness, in terms of both diagnosis, explanation and treatment.

8.4 Medicalisation or proletarianisation, de-professionalisation and lay re-skilling?

The discussion of the medicalisation thesis in chapter 2 suggested that there were several ways of theorising about the relationship between the lay populace and modern medicine and that instead of medicalisation there could be de-professionalisation, proletarianisation and lay-re-skilling. Each of these potential arguments will now be considered in turn, in relation to the data.

8.4.1 Medicalisation

At the beginning of the thesis (in chapter 2), work was reviewed which suggested that medical interest in, and management, of depression could be seen as evidence of 'medicalisation'. I also discussed some of the more recent writings that challenge the medicalisation theory and assert that the dominance of medical professionals may be under threat or being undermined. I also took the view, and this was reflected in the epistemological approach, that patient agency may also play a part in the recognition and management of their problems.

The 'medicalisation' thesis involves two aspects. Firstly, that detection of depression in women is the result of medical professionals attempts to increase surveillance over women's lives (Armstrong, 1980) or to increase the domains and power of the profession (Freidson, 1970). Secondly, that patients' problems (that were once perceived as problems of everyday life) become medicalised, that patients are passive to this, and that their own knowledge is replaced by the 'superior' knowledge of medicine.

Thus, in relation to the management of depression there are two possibilities about medicalisation: the first is that problems that are largely the product of social circumstances are managed within a bio-medical model of care where biology and biochemical explanations lead to treatment with pharmacological products; or second, is the possibility that through the adoption of a biopsychosocial discourse, general practitioners act as the instrument of power that seeks to increase surveillance and 'medicalise' the problems of everyday life in order to increase the opportunities for surveillance and control.

In relation to patients, it is suggested that they are in effect, 'duped' into accepting a discourse that ultimately serves to control them. Thus, it would be assumed that patients were either passive recipients of care, or, that in making sense of depression and evaluating its management lay views will reflect medical discourses surrounding depression. Additionally, if lay views are to become medicalised, then they will adopt and reflect either a bio-medical discourse of depression or a biopsychosocial discourse (depending on which discourse predominates in the management of depression in primary care).

However, general practitioners' accounts analysed here, revealed that they were aware of the social causes surrounding many of their patients presentations of distress and that they often pathologised the effects of these social problems to explain the appropriateness of medication. However, they also expressed concern about medicalising social problems and sometimes deferred 'medicalising' the problems or engaged in managing the problems in other ways, such as talking through the problems causing distress. When general practitioners were aware that they had prescribed medication for essentially social causes they explained this in terms of feeling compelled to do something to alleviate the distress of their patients. There was often a received lack of other forms of help for the women. They were also aware of the limitations of medications in their ability to help some patients. The consultation often included work whereby they engaged in helping patients to mange the problems of their day-to-day lives. This was seen as meeting the needs of their patients and showing empathy for their patients' problems. Engaging in this type of work sometimes removed the need to prescribe medication. However, at a more abstract level, they also expressed concerns about whether this should be part of their professional activities.

Foucault reflected on the nature of medical professionals as 'links in a set of power relations' or 'people through whom power passes' (Lupton 1997a:99). This view assumes that general practitioners exercise power (on behalf of others) and display no agency in doing so. If this were the case then general practitioners would promote care that reflected the dominant medical model. (It was suggested at the start of this thesis that there may indeed be different views between medical disciplines regarding the appropriateness of current and proposed models of care for the management of depression). What is evident from this data is that general practitioners adopted different models of care at different times depending on their personal and professional needs, and in response to the structural constraints in which they worked.

General practitioners displayed 'agency' in their ability to reject the biopsychosocial model of care when this was seen as drawing too heavily upon either their own personal or organisational resources. The general practitioners placed boundaries around their role and did not always manage within a biopsychosocial model of care. General practitioners portrayed themselves as having a choice as to whether they would enter into a biopsychosocial discourse with their patients, or leave this to some other time when they felt they had either the personal or organisational resources to implement this model of care. In some case general practitioners indicated that they would restrict the consultation to the patient's physical presentation and manage within a bio-medical model. They also perceived that some general practitioners were better working within the biopsychosocial model than others and some were better at being able to restrict themselves to the biomedical approach. When their resources were stretched (either personally or due to limited time within the surgery) they could fall back to defining their role in biomedical terms. These findings mirror Adam's (2003) conclusions surrounding general practitioners' abilities to act with agency in relation to the dominant biopsychosocial discourse.

Furthermore, general practitioners concerns of medicalising social problems and their explanations of this as the alleviation of patients' distress could be seen as doctors engaging in a form of 'practices of the technologies of the self' (Lupton, 1997a) on behalf of patients to alleviate suffering and distress.

Other research into general practitioners views of working with depressed patients has shown similar findings although these are more focused on the negative aspects of managing depression that are coupled in this thesis with more rewarding and beneficient views. Chew-Graham et al (2000) conducted a qualitative study of general practitioners views of their work with depressed patients. They reported that general practitioners conceptualised depression as an everyday problem of practice rather than as an objective diagnostic category. They also reported 3 views of depression : (1) as the medicalisation of problems associated with socio-economic disadvantage; (2) that the diagnosis offers a degree of secondary gain to both patients and doctors; (3) and that general practitioners experienced depressed people as 'an intractable interactional problem' that placed demands on their time and was also viewed as unrewarding and frustrating work. The general practitioners in their study displayed negative attributions concerning depression through their recognition that they were responding to the despair created by social and economic disadvantage and that rather than recognise their limitations for care they focused on the difficulties that patients caused for them. Chew-Graham at al comment that this may result in a reluctance to recognise and respond to patients because of the wider social and structural factors involved. The data in this thesis also reflected similar 'problems' associated with the management of depression but also found that general practitioners were both reluctant to medicalise problems but felt morally bound to do something. Chew-Graham et al had a similar sample of GPs in that they worked in areas of social and economic disadvantage, however, they asked GPs to discuss the management of depression in general, whereas this study also focused on the management of two specific patients. Chew-Graham's findings thus reflect the cycle of negative attributions as constructing a pessimistic view of depression and its outcomes. The general practitioners in the study reported in this thesis spoke of wanting to be able to spend more time with patients and of their beliefs that medications could help alleviate suffering from adverse circumstances and that the management of depression was as rewarding as it was frustrating.

This thesis suggests that while there is evidence of general practitioners medicalising social problems and bringing everyday problems into the realm of the medical consultation, they do so for the benefit of their patients. There was also some resistance to the medicalisation of social problems but with little availability of other resources (including time to talk things through) then general practitioners had limited options for care and felt compelled to 'do something' by dealing with symptoms with medication.

In relation to patients, the consideration is whether they are indeed duped into acquiescing to the medicalisation of their problems; or whether patients do show agency in their use and acceptance of medical discourses and advice.

The women had their own discourses concerning their problems, based on experiential and common-sense knowledge and when 'formal' medical knowledge was introduced they evaluated this in relation to their own knowledge. The women demonstrated that they held their own knowledge as 'expert' in that they expected their general practitioner to take their knowledge and beliefs seriously. The doctor's explanation had to make sense to them and was not passively accepted. Therefore this thesis does not support the notion that patients are either passive in their acceptance of medical explanations or that their own common-sense knowledge is replaced by expert knowledge. Rather, they incorporate medical knowledge in to their own systems of causal theorising.

The women's accounts showed the range of knowledge women held concerning depression and its potential causes. They were aware of both intrinsic and extrinsic causal mechanisms. They had knowledge of bio-medical explanations (biology, genetics, and biochemistry) and psychosocial explanations. However, there were also some subtle distinctions in their explanation of their own problems. Women with relatively new experience were more likely to explain their problems in relation to extrinsic causal mechanisms and some women with long-term experience explained their problems in terms of intrinsic causal mechanisms. Hence, women with more long term experience could be said to adopt bio-medical or bio-psychological explanations. However, this did not mean that they rejected the biopsychosocial model as this was still seen as an appropriate explanation for depression in others, and sometimes was used to explain individual episodes of depression in themselves. Other women with long-term experience did not adopt an intrinsic explanatory model but continued to seek extrinsic causal factors to explain their experiences. This shows that the women held different views concerning explanatory models for depression, and that different explanatory models could be adopted at different times, depending on their personal experiences and circumstances. The adoption of a particular discourse was not static but was dynamic and contextual. Therefore the women in this study could not be said to adopt the dominant medical discourse (be this a bio-medical or biopsychosocial) but displayed agency in their choice that was appropriate to their own understandings of their problems at any given time.

Women with relatively new experience, and who perceived their problems were the result of extrinsic causal factors, were generally reluctant to accept a 'technical fix' for their problems in terms of medication use. Women with more long-term experience generally accepted the use of medication, even although they still held negative views of antidepressant medication. This raises the question as to whether women with more long-term experience are more medicalised and more accepting of a bio-medical solution to their care. Women with more long-term personal experience had more experiential knowledge of the distress depression caused in their lives and of the benefits that antidepressant medications had brought to them. Their accounts reflected many instances when they had tried to control their illness and cope with it by themselves. Their use of antidepressants was explained by their acceptance that they could no longer manage this problem by themselves. Indeed, this type of explanation was also used by women with relatively new experience to account for their help seeking and medication use (as a last resort when they could no longer cope on their own). Like people in Lupton's (1997) study, these women were not passive docile subjects, but could be seen as engaging in practices of the self because help seeking and medication use was '*vital to their own well-being and freedom from discomfort and pain*'. It is this explanation that offers a more appropriate understanding of the findings of this thesis. Hence the thesis challenges the notion that patients are passive recipients of medical care and asserts that patients accept and use medical care to meet their own needs.

The women in this study also consulted other sources of knowledge and opinion out with the medical encounter (friends, family, books, internet). They continually evaluated their medication use with reference to this knowledge and with reference to experiential knowledge and other common-sense knowledge surrounding medication taking. Hence the women's accounts suggest that patient agency was continually being employed in evaluating both the explanation for their problems and their need to take medications. They evaluated the physical, social and moral implications of medication use. Furthermore, their accounts of decisions to accept help were also framed around the needs of their family and to alleviate their own distress. This adds support to the argument that patients are 'active' in decisions regarding their care and are indeed engaging in the practices of the 'technologies of the self', and therefore offers a further challenge to the notion of that patients are medicalised through their passive acceptance of care and acceptance of medical advice.

The women were very clear about the type of relationship they expected and valued. This was very much about having their opinions valued and sharing knowledge and decisions with the general practitioner. They expected more than 'the voice of medicine' (Mishler, 1984) speaking to them and actively sought to engage in the 'voice of the lifeworld' in interactions with their general practitioner. The women generally valued a relationship that was based on partnership and reciprocity in which their own contribution was valued by the general practitioner. The women also had expectations of what a general practitioner should offer them or how he should care for them. This included 'listening' to their stories and engaging with the problems of their day-to-day lives. The women expected and actively encouraged their general practitioner's involvement in their private lives and this was influential in their evaluations of their care and treatment. The women often sought reassurance or support (through mediation and arbitration) or advice in relation to personal issues. In this sense the women actively encouraged a biopsychosocial approach to their management. However, rather than adopting such an approach to care on doctor's terms that might serve to control them, I would argue that the women were meeting their own needs and using the general practitioner interaction as a therapeutic intervention in itself. Hence, rather than being 'duped' into accepting a biopsychosocial discourse that ultimately serves to control them, the women presented themselves as active in constructing their own theories using their own as well as doctors knowledge and using treatment (or not) in relation to this.

Thus the medicalisation thesis appears to have little relevance to our understanding of the lay and professional interaction in the management of depression. I will now consider the alternative hypotheses, proletarianisation, de-professionalisation and lay-re-skilling.

8.4.2 Proletarianisation, de-professionalisation and lay re-skilling?

As I stated in chapter 2, there have been more recent challenges to the medicalisation thesis which support theories of: proletarianisation (involving de-skilling of medical professionals, a loss of economic independence and medical professionals working under managerial rule); de-professionalisation (reflected in the changing doctor-patient relationship owing to increased knowledge available to patients and a reduction in the knowledge gap, a decline in patient trust and confidence and patient willingness to resort to other providers); and lay re-skilling (whereby knowledge and skills are re-acquired and re-appropriated by lay persons and routinely applied in day to day activities).

In relation to the first of these – proletarianisation – one area that can be commented upon is in relation to de-skilling of professionals. Medical adherence to clinical guidelines could be seen as a de-skilling process where the work of the doctor becomes routinised and bureaucratised as targets and standards are achieved. These data reflect the management of depression as more than the routine application of diagnostic and treatment criteria. The management of depression involves more of the 'art' which the discipline of general practice has used to distinguish itself from other branches of medicine. The detection of depression involved the doctors' experiential knowledge and in many cases some knowledge of the patient. The patient-centred approach was very much evident in both general practitioner and women's accounts.

This approach requires more skills and experience, both technical and interpersonal rather than less. Therefore, in relation to the data presented in this thesis there was no evidence of the work of general practitioners in managing depression being reduced to a routinised and bureaucratised process.

Similar findings have been reported by Armstrong (Armstrong, 2002) in discussing whether professional dominance has given way to deprofessionalisation and proletarianisation. Armstrong is interested in how the medical profession itself has reacted to challenges to its traditional autonomy via the '*intra-professional formalisation of control*' or '*evidence-based medicine*'. He sees evidence-based medicine as being promoted by an 'administrative elite' in order to enhance the defence of professional autonomy but that this comes at the expense of the individual freedom of practitioners who then have to conform to evidence-based decision criteria. Armstrong, in studying medical professional autonomy in everyday clinical practice, explored how GPs described managing depressed patients and how they reacted to or incorporated the new SSRI drugs into their treatment repertoires. He found that general practitioners developed and stabilised a repertoire for prescribing based on familiarity through experiment and experience and grounded in the idea of patient specificity. General practitioners, therefore, practiced 'patient-centred' medicine rather than evidence-based medicine, and that it was through attending to the idiosyncratic needs and personal characteristics of their patients that general practitioners came to justify clinical discretion and hence established 'an alternative individualised autonomy', thereby resisting the formalised systems of control that are promoted though evidence-based approaches.

This reflects similarities with the data in this thesis that general practitioners experiential knowledge was foremost in their decision making rather than formal medical knowledge. Armstrong also concludes that the lack of congruence between 'evidence-based' decision support and their experiential knowledge might explain the relative failure of educational strategies to promote the use of evidence-based approaches.

In relation to de-professionalisation the data demonstrated that the women held a wide range of knowledge (experiential and common-sense) relating to depression. Both general practitioners and patients shared some common-sense knowledge and general practitioners provided additional knowledge to patients. However, the women also consulted other sources of knowledge beyond the medical encounter. The women did not present themselves as perceiving their own knowledge to be inferior to medical knowledge and appeared to be more satisfied when their knowledge was recognised and taken seriously. The women expressed a preference for a relationship based on mutuality and reciprocity and in which there was a partnership. They placed importance on the development of trust in the relationship and some women indicated that there was still an inherent trust in medical professionals. However, some accounts also reflected a degree of scepticism about medical professionals, and support for their decisions was not always granted. Nonetheless, the importance of trust and the importance of the relationship were still very much at the heart of care in the management of depression. The women also reported that they consulted other sources of knowledge in addition to their general practitioner and the women showed agency in their adoption or rejection of medical advice. Hence this thesis supports the notion of de-professionalisation in that women valued their own knowledge and brought this into evaluations of doctors' knowledge. However, doctors' knowledge was also valued and very influential as long as it was presented in a way that respected women's own knowledge.

Lay re-skilling suggests that individuals take back control over matters of health and illness and return to natural rather than technical forms of healing in an attempt to de-medicalise society (Williams and Calnan, 1996). Therefore non-compliance with medication would support the notion on lay re-skilling It also suggests that individuals may use medical technology (or re-appropriate it) for their own ends as a potential means for liberation.. The women's accounts demonstrated that they developed their own knowledge based on their experiences of taking medication and they used medication in a way that suited their own needs. The women self-titrated their medication and stopped when they felt it was appropriate. They also rejected medication when it was seen as inappropriate. As has been explained above, this thesis contends that the women used medication for their own ends, to relieve their distress and for the needs of their family. This could be seen as evidence of lay re-appropriation of technical knowledge. This thesis supports the notion of lay re-skilling in the sense that women evaluated and used technical knowledge for their own ends and also displayed agency in their acceptance and use of medication.

8.4.3 The doctor-patient interaction: system or lifeworld rationalisation?

Scambler (2002) comments that the emphasis on patient-centred styles of communication, emphasising 'mutuality' and 'reciprocity' has meant that open strategic action - where the speaker openly expresses their intention of influencing the hearer, with a typical example being the paternalistic doctor who tells the patient what is to be done - has become less acceptable to patients. Scambler therefore notes, that in the context of changing patient expectations of the relationship, that Habermas's analysis of concealed strategic action gains in salience. This study's attention to 'how general practitioners manage depression in the context of current everyday practice' provides empirical evidence to support Scambler's premise.

In chapter 7 I demonstrated how the general practitioners described employing strategies to convince their patients to consider that their problems were psychological and also to persuade them to try antidepressant medication. They admitted to manipulating the situation in their speech acts and could be said to use distorted communication to achieve their own purpose. However, the question remains as to whether this is evidence of the 'system rationalisation' whereby the system, which represents technical interests and the scientific attitude, is seen as engulfing the 'lifeworld'.

From the perspective of system rationalisation, medical teaching (whose ends would be defined by technical considerations) would ensure that general practitioners (through the use of strategic action) served to promote system rationalisation and so medical teaching would determine the behaviour of general practitioners in their consultations with patients.

The difficulty with Habermas's theory of the possibility for 'unconscious strategic action' is how to research such a concept– how can we empirically determine an 'unconscious' strategic action? This 'unconscious strategic action' implies no agency on the part of medical professionals. Unconscious strategic action:

> ...allows for doctors to act in good faith, and satisfy patients' expectations, and yet still be capable of systematically distorted communication without either party being aware of any problem...(Barry et al, 2001:489)

This is somewhat incompatible with my interpretivist stance which holds that people bring meaning to the consultation and that the interaction itself also serves to create the social world. Patients enter the consultation with knowledge about what it is to be a patient, or a mother and so on. General practitioners also bring their own knowledge to the interaction, for example, knowledge of expectations of the role of the general practitioner, knowledge of the lifeworld or common-sense knowledge, and knowledge of the patient. The interaction also takes place within a particular organisational system that sets up the boundaries of the interaction. The interaction of the consultation involves the intersection of the different social worlds of the doctor and the patient within the structural and organisational constraints of general practice consultations. Thus, there is more to affect the behaviour of the general practitioners than the system itself. However, as the quote at the beginning of this chapter reminds us *'it is neither necessary nor credible to choose between agency and structure'*

Furthermore within my interpretivist stance and the methodological approach adopted it is not possible (and was never intended to) be able to identify 'unconscious strategic action'. Within these data doctors described incidences of conscious strategic action where they were aware that their verbal speech interactions were oriented towards success. This is as far as these data can comment on in relation to concealed strategic action.

What these data have demonstrated is that general practitioners do not rely solely on formal medical knowledge and technical considerations to determine their behaviour in managing patients. They engaged in communicative action and were also willing to allow patient agency in decisions to use antidepressants. However, when they perceived that it was in the best interests of the patient then they invoked the voice of medicine in a strategic act with an orientation to success – which was mainly to convince the patient of the necessity for antidepressant medication. There was certainly evidence in their accounts of manipulation and distorted communication. This could be viewed as using the 'voice of medicine'(Mishler, 1984) to 'colonise the lifeworld' (Scambler, 2002). In other instances the general practitioners used the voice of medicine to address the patients' concerns (for example fears and concerns about antidepressants) that were raised when they engaged with the voice of the lifeworld. These could be perceived as examples of the voice of medicine being used to suppress the voice of the lifeworld to promote system rationalisation. However, the promotion of system rationalisation was not always the 'endpoint' in consultations. General practitioners demonstrated agency in not seeking to colonise the lifeworld and raised concerns about this. They also used the voice of the lifeworld and engaged in managing problems of patients' day-to-day lives in order to prevent the promotion of technical/medical solutions. General practitioners demonstrated agency in promoting or not promoting system rationalisation and in encouraging or not encouraging the voice of the lifeworld.

The potential for lifeworld rationalisation and decolonisation (where the lifeworld has the potential to colonise the system) is through the development of patient empowerment (Scambler, 2002). This study has demonstrated that general practitioners' accounts suggested that women were encouraged to raise their own ideas, beliefs and concerns surrounding their problems or its potential management in the consultation. It was important for women themselves that the general practitioner took their own beliefs and concerns on board. They expected the voice of the lifeworld to be heard in consultations. The women also generally valued a relationship that was empowering to them and that included them as a 'partner' in their care and their accounts of their current relationships were generally supportive of the view that many of them perceived they were in a more reciprocal relationship. They also demonstrated empowerment in their ability to make their own decisions both within and outwith the consultation. Therefore the conditions for lifeworld rationalisation and de-colonisation existed.

General practitioners recognised that the women entered the consultation with their own ideas, beliefs and concerns and they had to engage with the lifeworld in order to meet the needs of the women. This was also of practical value for the general practitioners as it facilitated the management of their patients. In this sense their engagement with the lifeworld and their investment in the relationship could be seen as strategic, as it was 'a means to an end'. However, the 'end' was also to alleviate the women's concerns and to help them cope with the day to day problems in their lives. Knowing the patient and engaging in the lifeworld and or 'lifework' in the consultation could also reduce the likelihood of the patient being 'medicalised'. Engaging in the lifeworld and lifework was resource intensive (both personally and organisationally) and this therapeutic work was entered into with a degree of choice on the part of the general practitioners. It was recognised as an extension of their role and that it also had implications for the boundaries of their professional role.

Mishler (1981) found little evidence of general practitioner engagement in the lifeworld in his study, whereas Barry et al (2001) noted greater '*mutual lifeworld*' interactions when psychological problems were present and said:

> Perhaps the doctors most sensitive to the need to move into the voice of the lifeworld are those who are more skilled at reading the psychological status of their patients (Barry et al, 2001:501)

This study had demonstrated that when psychological problems are present general practitioners do engage in the voice of the lifeworld and that patients expect and value this type of interaction. Indeed, it may be more the case that the voice of the lifeworld dominates consultations where psychological problems are being discussed, and that this is both expected and valued by both women and general practitioners.

8.4.4 Summary

This thesis would argue that there is some evidence of a degree of de-professionalisation and lay-re-skilling as the patient-centred approach would intend. It also concludes that patient agency is evident in the negotiation of the management of depression and that patients are engaged in'technologies of the self' which places their acceptance of modern medicine as a strategy to relieve their own suffering rather than reflecting passive acceptance or having been 'duped' into colluding in their own control. It also concludes that general practitioners demonstrate agency from dominant medical discourses and attempts to proletarianise or routinise their skills.

They also demonstrate agency in their willingness to either engage with, or to colonise, the lifeworld. General practitioners actively encourage lifeworld rationalisation and decolonisation by the medical world and thereby encourage patient empowerment but at the same time will engage in concealed strategic action and use the voice of medicine when they feel that this is in the patient's best interests and is intended to alleviate the suffering and distress of patients.

8.5 Policy and Practice

No research is ever conducted in a policy vacuum or in a policy stable environment. Indeed, many general practitioners who declined to participate in the study during the recruitment phase cited the changing policy context (the emergence of LHCCs and Primary Care Trusts) and the ensuing workload involved, as reason for their inability to engage with research. From the time of starting on this thesis to its completion the topic of depression has received even more attention in the academic press and in the international and national policy arenas with the recognition of the substantial burden of depression and the subsequent focus on improving its detection and outcome. The promotion of evidence based medicine has gathered momentum since the inception of this project, as have the development of guidelines and protocols for the detection and management of depression. The research undertaken for this thesis appears even more timely and relevant than it was at its inception.

The National Institute for Clinical Excellence (Nice) guidelines for the treatment and management of depression are about to be launched (they completed the second stage of consultation in December 2003) and this is intended to have a major impact on the way depression is managed. The extent to which health and social care professionals are expected to adhere to these guidelines is reflected in the involvement of the Commission for Healthcare, Audit and Improvement who will monitor the extent those responsible for health and social care have implemented these guidelines.

However, it is also noticeable that, although it will briefly address the issue of diagnosis, it will not make evidence based recommendations or refer to evidence regarding diagnosis, primary prevention or assessment. Instead they rely on the International Statistical Classification of Diseases and Health Related Problems (ICD-10) and the research which they draw upon is mainly based on the DSM-IV criteria (these have previously been discussed in Chapter 2). These criteria would effectively rule out detecting and treating a substantial proportion of psychological distress that presents to general practices. Indeed, adhering to these guidelines may increase the likelihood of missing even more people with mental health problems. This research would indicate that the guidelines will have little relevance to general practitioners managing 'depression' in primary care, given that one of the main problems for them surrounds the diagnosis and their requirements for a broader definition than these current classification systems allow. I say more on the issue of guidelines below.

The Scottish Executive's National Programme to Improve the Mental Health and Well-being of the People of Scotland promotes promotion and prevention and recovery as well as effective treatment for mental health problems. It is also concerned with reducing stigma associated with mental health problems (culminating in a media campaign 'See Me'). One aim is to provide timely access to a range of interventions (psychological, social and pharmacological). The programme raises awareness of mental health issues at a population level, and via the expansion of a programme for Mental Health First Aid, it also aims to increase alternatives to the more formal medical responses for those seeking help, thereby reduce the likelihood of medicalising the effects of socio-economic problems requiring support. This thesis would support the expansion of such approaches across primary care as it would help to alleviate the moral dilemmas faced by general practitioners who want to offer help but as yet have little recourse other than medication.

Two policy issues considered to potentially have the greatest impact on the management of depression in primary care in the near future are now discussed in more detail below.

8.5.1 Should depression be managed as a chronic disease?

As stated in chapter 2 the call for depression to be managed as a chronic disease has major implications for patients, and it may impose a model of care that is in conflict with patients' perceptions of depression and their perceptions of its management. The study recognised patients may have different experiences of depression and therefore potentially different views concerning the management of depression depending on whether their experience was relatively new or more long-term.

Women made sense of their experiences (as perceived through physical, behavioural, cognitive/emotional and communicative cues) in relation to their own knowledge (experiential, biographical and common-sense) of health and illness, emotions and depression. In some instances their perception of symptoms and their current knowledge led them to make sense of their experiences as a physical illness. General practitioners had to respond to women's own theories regarding their problems and to take account of these in their subsequent management. The general practitioners' advice also had to make sense to the women in relation to their own knowledge. The women also faced a moral dilemma in accepting medication and general practitioners had to recognise and attend to this moral dilemma in order to negotiate the acceptance of medication. However, it was also clear that medication use was still only acceptable to many women on a short-term basis, that the women engaged in on-going evaluation of their use of medications, and that its use had to continue to make sense to the women. The women continued to seek advice elsewhere, and to evaluate their medication use with reference to broader social and cultural knowledge. Some women with long-term experience of depression had come to the decision that long-term medication use was in their best interests. This was based on an evaluation of their experiential knowledge of depression and medication and biographical knowledge and their current understandings of depression. To these women, at this time, such a decision made sense. However, for women with relatively new experience of depression, who were still engaged in evaluating knowledge and exploring understandings of their problems, the long-term use of medication would not make sense and would likely be rejected.

Some women had actively sought out a general practitioner who did not know them in order to preserve 'how they were known' by their usual general practitioner. If these women considered that their presentation of emotional problems might result in being placed on a 'register' of depressed cases then they may be more reluctant to present in primary care. This could have implications for the 'detection' of depression and may result in decreasing rather than improving detection. This would require further research, before adopting such a model of care.

The application of a chronic disease model of management to the management of depression in primary care would require careful consideration. This study has found that such a model of management would have to make sense to the individual involved in relation to their own experiences and understandings of depression. To the majority of the women in this study this model of management would be likely to increase rather than reduce the moral dilemma for women. Long-term use of medication is associated with addiction and dependence and the majority of women accepted it on a short-term basis only. There may be a stage when this model of care is acceptable to some women, although it would be difficult to predict when this outcome is likely. The only way to determine this would be through an understanding of the women's own experiences and an awareness of when such a model of care is likely to make sense within her own explanations for depression and in relation to her changing perceptions to medication use and let the patient be the expert.

Furthermore, although general practitioner and patient interviews were analysed separately (reflecting their different 'practical interests') there is also a striking similarity in their accounts in terms of the management of depression involving *moral decisions*. For the women, moral decisions were described when deciding to seek help and in their decisions to use medication. For the general practitioners, moral decisions came in to play when they understood that they were prescribing for essentially social problems but felt morally bound to do something to help the women. Therefore, the management of depression involves moral dilemmas for both patients and doctors, reflecting that the management of depression is not simply based on clinical decisions. To impose or promote a chronic disease management model may further increase the moral dilemmas faced by both patients and doctors.

8.5.2 Guidelines for the management of depression

Current guidelines do not take account of the problem of 'definition' of depression from the primary care perspective. The way patients present with depression in primary care does not always reflect clear signs and symptoms of depression. In determining that something is wrong, and that this is likely to be a psychological problem, general practitioners use a variety of different types of knowledge. Formal medical knowledge (including clinical diagnostic criteria) is only one of a variety of sources of knowledge that they utilise. The diagnosis of depression involves making use of everyday knowledge and experience and knowledge of the patient. Guidelines need to reflect a broader range of emotional and psychological cues, and to recognise the subjective nature of the diagnosis in primary care and the influence of the patient in diagnostic decisions.

In addition, formal medical knowledge takes no account of general practitioners' feelings of the need to do something to help women to cope with their difficult circumstances and that their decisions to manage are not always based on clinical need.

Criticisms have been levelled at general practitioners in relation to their prescribing of antidepressants and for the poor outcomes in relation to their use. However, this thesis demonstrates that it is the patient who is often most in control regarding medication use. Improving the management of depression would benefit from strategies that are targeted towards improving patient understanding of medications and their use and in encouraging concordant (rather that compliant) decisions about treatment than attempting to change general practitioner behaviour.

In evaluating the detection and diagnosis of depression by general practitioners, research should also take account of the subjective nature of the diagnosis in primary care and of the influence of the patient and structural factors that may affect their ability to define and manage problems as depression.

General practitioners in this study spoke of the benefits of knowing their patients and engaged in their day-to-day problems in helping them to cope. This is the type of care that patients valued and which also helped to promote acceptance (at least in the short-term) of medication use. Guidelines promoting better management should attend to the need to provide this type of care that may benefit patients.

Barriers to the recognition and diagnosis of depression were a lack of prior knowledge of the patient and a lack of time in which to explore their intuitive feelings that depression might be an underlying problem for patients within the current structures of primary care organisation. Structural reforms which reduce practice's abilities to provide continuity of care and which restrict the amount of time available to them to engage with patients, and to conduct lifework, will inhibit rather than promote detection and management of depression. Guidelines for the management of depression might serve both patient and professional needs better if they also addressed some of these structural reforms.

Table 1. Recent UK and Scottish Health Policy relating to depression

Body	**Date**	**Focus**	**Policy document**	**Key Themes**
Department of Health	1992	UK	Health of the Nation	Introduces promotion of mental health
Royal Colleges of General Practitioners and Psychiatrists	1992	UK	Defeat Depression Campaign	Consensus statement published in BMJ in November 1992 which recognised the central role of primary care in managing emotional distress
Scottish Executive	1997	Scotland	A Framework for Mental Health Services in Scotland	A joint planning template for health, social work, housing and voluntary sector
Scottish Executive	1999	Scotland	Towards a Healthier Scotland	White paper and vision for improving health for all and investing in good health
Secretary of State for Health	2000	UK	The NHS Plan: A plan for investment, A plan for reform	Recognised the importance of depression and its management in primary care and included plans to recruit 1000 new PCMH workers by 2004
Scottish Executive	2000	Scotland	Our National Health: a plan for action a plan for change	Combining the continuing modernisation of health services in Scotland with action for health improvement including mental health promotion
Department of Health	2001	UK	The mental health policy implementation guide	Calls for an improved level of integration between primary and secondary care and a shifting or

				roles for health care professionals for optimising the management of depression.
Department of Health	2001	UK	The Expert Patient: A new approach to chronic disease management for the 21st century	Supports patients as key decision makers in the treatment process and aims to empower patients to take some responsibility for the management of their condition and to work in partnership with their health and social care providers
Scottish Executive	2000- 2006	Scotland	Health Improvement Programme	On-going commitment to health improvement and to reducing inequalities. Supported by health improvement fund with four priority groups: early years, teenage transitions, workplaces and community health
Scottish Executive	2001-2006	Scotland	National Programme for Improving Mental Health and Well-being	Developed in consultation with the health improvement programme and funds initiatives relating to improving mental health and well-being.
Scottish Executive	2002	Scotland	Choose Life	National strategy and action plan to prevent suicide
Scottish Executive	2003	Scotland	Establishment of new Mental Health Division	To lead work of National Programme and to support implementation of *Improving Health in Scotland: the challenge*

				part of the *Partnership for Care* white paper
Scottish Executive	2003	Scotland	White paper: Partnership for Care	Partner organisations to work together to create networks for mental health services and to continue efforts to improve physical and mental health
Scottish Executive	2003	Scotland	Doing Well by People with Depression	Initiative of the Mental health Division and the Centre for Change and Innovation which outlines a whole systems approach to develop capacity for managing depression
Scottish Executive	2003	Scotland	Mental Health: Moving the Agenda Forward	Developed in response to slow and patchy implementation of National Framework and highlighted to need to develop comprehensive mental health services and support that are patient centred

Table 2 Review of published findings into lay accounts of the experience of depression

Authors	**Date**	**Title**	**Aim**	**Sample**	**Methods**
Jack D	1991	Silencing the self: women and depression	To explore the potential sources of depression in women's lives	12 women aged 19-55 who had been diagnosed as clinically depressed	In-depth qualitative interviews were conducted during their depressive episode and approx. two years later
Walters V	1993	Stress, anxiety and depression- women's accounts of their health problems	To explore how women themselves understood or organise their experiences and how these experiences were structured by various socio-demographic variables	Stratified random community sample of 356 Canadian women with 32 qualitative interviews conducted with a random subset of respondents	Main sample interviewed using a questionnaire containing structured and unstructured questions, interviews with the subset had a major unstructured component
Karp D	1994	Living with Depression: Illness and Identity Turning Points	To explore the subjective experience of depression, the depression career and the implications of career turning points for transformations of personal identity	20 male and female respondents with severe, enduring depression who had experienced emotional discomfort from childhood and who were already diagnosed and treated by mental health professionals.	In depth qualitative interviews. Some respondents required two separate interviews to cover all issues being discussed

				Respondents were personal acquaintances of researcher or friends of respondents.	
Lewis S	1995	A search for meaning: making sense of depression	To investigate what is subjectively experienced as depression and whether individuals themselves define their experiences as depression	48 male and female respondents aged 20-70 who had either been diagnosed as depressed and non-patients who described themselves as depressed recruited through GPs or psychiatrists(9), a women's (motherhood) support group (19) and through notices placed in a University teaching hospital asking about experiences of depression	Semi-structured qualitative one-off interviews
Schreiber R	1996	(Re)Defining My Self: Women's Process of Recovery from Depression	To explore the process of recovery for women who have been depressed	21 Euro and Afro-North American women aged 32-69 who identified themselves as having	One in depth-qualitative interview with each respondent

				recovered from depression were recruited through a snowball sampling approach (self-referral and word of mouth. Sample covered depression experiences ranging from months to years	
Pilgrim et al	1997	Entering psychological treatment: decision-making factors for GPs and service users	To examine patient and referrer decision-making factors surrounding entry to psychological treatment in a primary care setting	15 patients and 15 general practitioners in a small town in semi-rural England	GP data consisted of questionnaire responses and interview material and patient data consisted of in-depth interviews
Gammell DJ and Stoppard JM As discussed in Stoppard JM, 2000	1999	Women's experiences of treatment of depression: medicalisation or empowerment	To explore women's experiences of treatment	Canadian women who had been treated for depression by a mental health professional	In-depth qualitative interviews
Scattolon Y and Stoppard JM As discussed in Stoppard JM, 2000	1999	"Getting on with life": Women's experiences and ways of coping with depression	To explore how women cope with their own depressive experiences	Women living in rural communities in Eastern Canada who identified themselves as coping with stress but had not sought help for depression	In-depth qualitative interviews were followed by respondents completing questionnaires in order to counter the

					criticism that the women were “not really depressed”.
Rogers et al	2001	Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors	To explore the ways that doctors and patients conceptualise and respond to depression as a problem in the specific organisational context of primary care	19 female and 8 male patients (aged 20-65) with a range of depression experience and 10 GPs were recruited from 10 practices. GPs referred patients who had consulted for moderate depression over a one-month period.	One-off semi-structured qualitative interviews.
Kadam et al	2001	A qualitative study of patient’s views on anxiety and depression	To explore patients’ views on anxiety and depression and their expectations about how the primary health care team might meet their needs	Interviewees were sampled from a larger quantitative survey of a random 50% sample from one general practice which identified anxiety and depression cases using the Hospital and Anxiety Depression Questionnaire. From 217 identified cases 82 agreed to an	18 individual interviews and two focus groups with a total of nine people were conducted

				interview and 27 of those randomly selected were interviewed	
Schreiber R	2001	Wandering in the dark: women's experiences with depression	This article discusses the findings resulting from examination of data from three grounded theory studies of women and depression: one investigated recovery (described above), one investigated Black West Indian Canadian women's strategies for managing depression and the third was a study of women's experience of treatment for depression	Sample included female respondents representing a mix of race, marital status, cultural background and sexual orientation, mothers and non-mothers aged 18 to 69	The data were gathered using participant observation and from 70 in-depth interviews.
Schreiber and Hartrick	2002	Keeping it together: How women use the biomedical explanatory model to manage the stigma of depression	To explore how women experience and manage depression and treatment and to investigate the core	43 women from a small city in Western Canada who had sought treatment within the previous five years were	One-off in-depth qualitative interviews

			components of women's explanatory models of depression	recruited through advertising in areas frequented by women and from notices in family physician and psychiatrists offices	
McNair et al	2002	Exploring the perspectives of people whose lives have been affected by depression	To identify the major concerns of people with depression and their families and carers	21 community meetings (1529 people, providing 911 evaluation forms) and nine focus groups (69 individuals) held nationally across Australia. Focus group participants were recruited from community meetings, contact with a national campaign web-site or participation in a current consumer or carer organisation	Meetings and focus groups were held in metropolitan, regional and rural settings across Australia.
Knudsen et al	2002	Perceptions of young women using SSRI antidepressants – a reclassification of stigma	To contribute to an understanding of young women's perspective on using selective serotonin re-uptake inhibitors	8 young women aged 21-34 using SSRIs recruited through pharmacies in Copenhagen	In-depth qualitative interviews with 8 women and four re-interviews

Garfield et al	2003	The paradoxical role of antidepressant medication – returning to normal functioning while losing the sense of being normal	To identify factors of importance to patients beginning courses of antidepressant medication in order to inform the development of partnerships between patients and health professionals	All practices in 3 locations in North London were asked to identify patients aged 18-65 beginning antidepressant treatment with an IDC-10 classification of depression from computerised records. 127 eligible patients were sent out recruitment packs and 51 were recruited for interview	51 participated in an initial interview and 44 in a follow-up interview three months later

Appendix A

Changed Name	Sampled as New/Previous Experience	Age	Marital Status	Children	Employment Status	During Study Period		Possible post natal	Previous experience of anti-depressants	Presentation of illness	Previous perceptions/use of anti-depressants	Prescribing taking behaviour
						Prescribed Medication	Referral Made					
Ailsa	previous/longterm	late 40's	widowed	2	unemployed	yes	no	no	yes	depression	Yes, many years, many different types. 'They just didn't work'.	uses in short bursts, has refused at times
Pat	new/likely	early30's	married	3	unemployed	yes	no	no	no	stress/depression	Mother has been on them longterm and made no difference. Did not want a prescription.	Refused - threw them away
Louise	previous/longterm	55	married	2	unemployed	yes	no	no	yes	depression/anxiety	Yes, many years. High dose of Amitriptyline.	Complies and knows she needs them but would do what the GP suggests. Would be more worried about not taking them.
Ann	previous/longterm	33	single	0	unemployed	yes	yes	no	yes	depression	Yes, many years. Used to be OK on one but then it didn't work and had problems finding one that suited.	Has taken them in past, OK. Had a period of difficulty settling on one and decided to stop altogether but got worse. Has now settled on one kind but increased dosage. Now needs them.
Janet	new/likely	24	married	1	employed	yes	no	yes	no	depression	Anti-drugs - friend who relies on them, uncle who is an addict.	Took them as prescribed. Came off gradually with doctors advice.
Peggy	previous/longterm	56	divorced	4	unemployed	yes	no	no	yes	depression	Yes (also valium). Needs her medication. Was on Amitriptyline for years even although it made her lethargic.	Likes medication, pill taker, previously addicted to valium. Will increase dosage but stricter controls now.
Amanda	new/likely	32	married	1	unemployed	yes	yes	yes	no	depression	None, but had a friend relying on Prozac. Dosen't like taking pills	Had a bad experience on stopping so then continued to take them. Finally she decided to just stop them.
Rebecca	previous/longterm	45	separated	2	unemployed	yes	yes	no	yes	anxiety/depression	Quite a few years now, different kinds, doesn't tolerate them well.	Reluctant but has taken them. Although takes less than prescribed. Would like to return to a particular drug because she knows how to use it.
Sandy	previous/longterm	29	married	2	employed	yes	no	no	yes	depression	Just once before, they did help. Was initially against them. Had to increase dosage once.	Taken as prescribed.
Carrie	new/likely	36	separated	2	unemployed	yes	no	no	no	anxiety/depression	Mother and sister on anti-depressants. Favourable outlook, wanted a prescription for panic attacks - but not longterm.	Taken as prescribed but no advice as to when to take them.
Tricia	new/likely	45	married	2	employed	yes	no	no	no	physical symptoms	Mother had a bad experience but doctor dealt with this and she took them.	Taken as prescribed.
Maeve	previous/longterm	52	divorced	2	employed	yes	yes	no	yes	depression	Yes, many times, they did help - but came off thinking 'I shouldn't need these'.	Usually compliant but has come off them herself. Has now decided that she may need them long term.
Linda	new/likely	31	married	2	employed	yes	no	no	no	physical symptoms	Expressed reluctance at first	Taken as prescribed. Has a plan for cutting down/coming off and will discuss this with GP.
Evelyn	previous/longterm	51	married	2	employed	yes	no	no	yes	physical symptoms	Had been on them for some time when interviewed but this was 'first-time'.	Taken as prescribed.
Nicki	new/likely	21	single	0	unemployed	yes	no	no	no	depression	None personally.	Taken as prescribed

						During Study Period						
Changed Name	Sampled as New/Previous Experience	Age	Marital Status	Children	Employment Status	Prescribed Medication	Referral Made	Possible post natal	Previous experience of anti-depressants	Presentation of illness	Previous perceptions/use of anti-depressants	Prescribing taking behaviour
Jeanie	previous/longterm	23	co-habiting	1	employed	yes	yes	yes	no	physical symptoms	Mother who OD'd on them - worries of addiction.	Seems to take as prescribed. Forgot for 2 days and felt ill so knows to keep going (possibly for 1 year).
Winifred	new/likely	35	married	2	employed	yes	yes	no	no	anxiety	Works in a psychiatric hospital. Thought she needed a tranquilliser to calm her anxiety and manic episodes. Sister-in-law had taken Seroxat - good impression of it.	Started on 20 - up to 40. Couldn't sleep so lowered it to 30 till she got used to them, now on 40.
Jill	new/likely	45	married	2	employed	yes	yes	no	no	anxiety	Family and friends persuaded her it was OK to take it.	Initially refused - already on blood pressure and HRT medication - too much. Takes it - as long as it is short-term.
Emma	previous/longterm	31	single	2	unemployed	yes	yes	no	yes	depression		Takes medication for epilepsy. Had to change anti-depressants to one that the dosage could be increased without triggering fit. Has stopped before but perceives that her depression becomes worse than before.
Ruth	new/likely	24	co-habiting	0	employed	yes	yes	no	no	anxiety	Thought Prozac was for 'loonies'. Mother attempted to take them off her saying they were for people with serious problems. Bad image of prozac rather than anti-depressants in general.	Delayed taking them for a couple of days and then took them. Only wants to be on them short-term.
Katie	new/likely	lt 20's/e30's	married	2	employed	yes	no	yes	no	depression/stress	None mentioned	Would have taken anything to help her get over it - even Valium.
Barbara	previous/longterm	32	single	1	employed	yes	yes	no	yes	depression	Yes, Prozac - felt bizarre on them, felt 'mad' because of the side effects - twitchy, bulging eyes, sweats - "you know you are on 'drugs'".	Just stopped them because she felt better and didn't need them. Reluctantly back on them again, but believes they will make her feel better.
Vicky	previous/longterm	53	married	3	employed	yes	yes	no	yes	depression	Yes, many and tranquillisers. GP has suggested St John's Wort which she and her husband use	Gets her medication when she feels she has to. Normally knows when she needs to see GP and takes his advice. Relies on medication when at her lowest, also uses marijuana.
Gwen	new/likely	20's	single	0	unemployed	yes			yes	physical symptoms	Side effects too much. Uses a lot of painkillers.	Didn't want to take them, gave them a try then just stopped. Uses painkillers (prescribed).
Sonia	previous/longterm	55	married	2	unemployed	yes			yes	depression	Lithium, came off it due to side effect of staggering. Different drugs tried. Asked to see psychiatrist in end. Lost faith in medication - related to son's experience.	Fine about taking it if you need it more concerned about side effects. Came off Lithium because of balance problems. Tried many different kinds - "getting mucked about".
Karen	new	31	married	2	employed	yes	no	yes	no	stress	Husband has been on them fairly long-term. Some reluctance but realises they will help - no magic wand.	Seems to be taking them, wants it to be short-term. Worries what she will be like when she comes off.
Amy	previous	36	married	2	employed	yes	no	no	yes	depression	Yes, believes if you need them you should take them. But also self-titrates and is trying to come off them.	Self-medicates, St John's Wort. Self-titrates. Stops herself - seems to be OK with GP. Increases when PMS starts.

	Sampled as					During Study Period			Previous	Presentation	Previous	Prescribing
Changed Name	New/Previous Experience	Age	Marital Status	Children	Employment Status	Prescribed Medication	Referral Made	Possible post natal	experience of anti-depressants	of illness	perceptions/use of anti-depressants	taking behaviour
Sarah	previous/longterm	72	married	5	unemployed	yes		no	yes	physical symptoms	Problems with balance and confidence. Amotryptoline for anxiety.	Supposed to take 2 and work up to 3 but takes one.
Norma	new/likely	50	divorced	1	unemployed	yes	yes	no	no	depression	None	Appears to take them.
Frances	new/likely	19	single	0	employed	yes	no	no	no	feeling low	Knowledge of a friend's experience who feels they can't stop them.	First interview only on them a week.
Lily	previous/longterm	early40's	married	3	employed	yes		no	yes	physical symptoms	Yes, unsure about whether they were effective. Image of Prozac - women she knew who was 'too happy'.	Seems to take them and sleeping pill when required.
Maria	new/likely	73	widowed	0	retired	yes			yes		Yes	Seems to take them but a lot of confusion as to what she is on at what stages or what these are for. Amotryptoline - just started staged doses.
Beth	previous	50's	single	2	unemployed	yes			yes	physical+depression	Yes, may have been on them a while. Now relying on medication.	Took advice from psychiatrist, GP gave conflicting advice. She had some side effects and stopped them until she can check with psychiatrist.
Fiona	new	38	co-habiting	0	employed	yes			yes	emotional/bereavement	Yes, Seroxat, tried once felt sick and wouldn't have Seroxat again. Has had Diazepam and now Tropiaden.	Has refused one after a brief trial but still willing to try others. Suggests she might have to half the dose if she was at work.
Alison	previous	55	married	2	unemployed	yes			yes	depression	Yes, tried a few, liked Amotryptoline until it stopped working. Prozac didn't work, didn't like it, started self back on Amotryptoline.	Self-titrates, has taken more than prescribed. Stopped one drug and started another on her own.
Susan	new	44	married	0	employed	yes	yes	no	no	depression/anxiety	Was on medication for panic attacks, now on an anti-depressant as well. Wanted to have something that would help.	Suffered side effects when changed medication.
Rachel	previous	28	married	3	employed	yes			yes	depression	Yes, tried quite a few. Psychiatric referral for medication. Problems with side effects and finding right dosage.	Tried a few before settling on Seroxat. Stopped on her own before, lowered dose herself before.

mean 40.5
excl.6 cases

Appendix B

General Practitioner Interview Schedule.

Background
There are a few questions which I need to ask just to place the rest of the interview in context.

How long have you been in general practice? Did you train in any other discipline before coming in to general practice?

How long have you been in this practice?

Can you give me a description of your practice population and some idea of the case-mix which you see?

Do you have any particular client groups within general practice that you have more of an interest (or specific skills) in dealing with?

Can I just ask you to tell me a bit about your background in terms of training and experience in dealing with patients with depressive illness?

In general probe if they use the terms 'intuition' or 'gut feeling' or 'viewing the patient holistically' to be more specific about what this might involve.

Management

Can you describe your general approach to the management of patients with depressive illness?

How would you approach the management of somebody that you thought might be depressed ?

How do you pick up on the fact that a patient might be depressed?

What would you say are the main difficulties in managing patients with depressive illness?

How do you overcome these difficulties?

Overall, how do you feel about working with patients who are depressed or seem to be depressed ?

⇒ How would you describe your role ?

What, if any, do you feel are the different categories or types of patients within this broad area ?

What do you feel are the issues from patients' points of view ?

Could you describe in general terms what you would see as the ideal process of care for people with likely depression ?

What would your ideal patient with depression be ?

Conversely, can you describe what would be the worst case process of care or kind of patient ?

Prescribing

Can you give me a broad description of prescribing for depressive illness ?

⇒ How do you decide when to prescribe medication for depressive illness?
⇒ What medications do you prescribe ?
⇒ How do you decide which type of medication to prescribe?
⇒ How do you determine the level of dosage for the patient?
⇒ At what point would you consider altering the dosage or the type of drug prescribed?
⇒ from your point of view, what are the main problems with prescribing
⇒ what is your perception of patients views on medication ?

Access to other services

Can you describe the full range of referral services which you have access to for dealing with patients with depressive illness? (Get names of institutions and location if possible)

⇒ How and when might you think of involving these services ?

⇒ In general terms, what are your views on these services?

⇒ How do these tie in with your own role?

⇒ Under what circumstances do you decide that a referral to psychiatric services is appropriate?

⇒ Under what circumstances do you decide that a referral to some other service is appropriate?

How much are other members of the primary health care team involved in the care of people who are depressed or who might be depressed ?

⇒ In what kinds of ways?

Are there any other services which you use or have used? What is your general impression of these?

⇒ : community mental health services,
⇒ OT,
⇒ Dietitians,
⇒ voluntary services,
⇒ self-help groups,
⇒ alternative therapies etc.

Specific Case Studies

I'd like to ask you first of all about NAME OF PATIENT, the patient who has fallen in to the category of a recent new episode of possible depression

What was the reason for consultation when the patient came to visit you and was selected by you for inclusion in this study?

⇒ *If for depressive illness:*
⇒ Probe for the reason for the consultation.(e.g. change of medication, recurrence of symptoms, regular GP follow-up, referral back to GP etc.)

Can you just start from the beginning then with this patient .

⇒ Could you just tell me about this patient ?
⇒ Have you known them long ?
⇒ How long have they been with the practice, OR was the patient well known to you?
⇒ Can you give a brief description of the patients history?
⇒ Can you remember when you first began to think that the patient might be depressed? (Probe if the presentation occurred over more than one consultation)
⇒ How would you describe your relationship with this patient
⇒ How would you describe the patient's health at present ?
⇒ How well do you feel you understand what's going on in this case?

⇒ Are there any things you're unsure about ?
⇒ Are there any things that you're finding difficult ?

What is your perception of the patients view of her problems and her health care?

⇒ How do these tie in with your views ?
⇒ If not, how do you handle this?
⇒ Have there been any problem areas in negotiating with this patient ?
⇒ Any communication difficulties?
⇒ Any difficulties because of understanding either the problem or possible ways of managing ?

How are you proceeding with things?

⇒ What suggestions have you made ?
⇒ How have they been received ?

Have you prescribed or considered prescribing for this patient ?

⇒ ***If not prescribed***
⇒ What are your considerations about prescribing ?

⇒ ***If has prescribed***
⇒ Did you decide to prescribe right away?
⇒ What influenced your decision to prescribe?
⇒ Which medication, dosage, length of prescription?
⇒ How do you think the patient viewed this decision?

Have you referred the patient on or are you considering this?

⇒ ***If not referred***
⇒ What are your considerations about this?

⇒ ***If has referred :***
⇒ Did you decide to refer right away?
⇒ Which service did you make the referral to?
⇒ What influenced your decision to refer?
⇒ How do you think the patient viewed this decision?

Overall, how do you feel things are going with this patient ?

Do you have any sense of how things might go in future ?

⇒ Can you foresee any particular problems
⇒ Do you have any idea of what the outcome of care is likely to be ?

Are there other options for treatment which you would have liked to or still would like to be able to offer?

⇒ Why was this not possible?

Could I now ask you about NAME OF PATIENT, the patient who has fallen in to the category of having been experiencing depression for some time

What was the reason for consultation when the patient came to visit you and was selected by you for inclusion in this study?

⇒ *If for depressive illness:*
⇒ Probe for the reason for the consultation.(e.g. change of medication, recurrence of symptoms, regular GP follow-up, referral back to GP etc.)

Can you just start from the beginning then with this patient .

⇒ Could you just tell me about this patient ?
⇒ Have you known them long ?
⇒ How long have they been with the practice, OR was the patient well known to you?
⇒ Can you give a brief description of the patients history?
⇒ How would you describe your relationship with this patient

How would you describe the patient's health at present ?

⇒ How does this compare with the past ?

How well do you feel you understand what's going on in this case?

⇒ Are there any discernible patterns in this patients experience of problems?

Are there any things that you feel now or have felt unsure about in relation to this patient's problems and history?

⇒ Have there been any difficulties ?
⇒ What have been the main problems from your perspective ?
⇒ From the perspective of other professionals involed in care?

What is your perception of the patients view of her problems and her health care?

- ⇒ How do these tie in with your views ?
- ⇒ If not, how do you handle this?
- ⇒ Have there been any problem areas in negotiating with this patient ?
- ⇒ Any communication difficulties?
- ⇒ Any difficulties because of understanding either the problem or possible ways of managing ?

How are you proceeding with things?

- ⇒ What suggestions have you made ?
- ⇒ How have they been received ?

Has the patient been on any medication ?

- ⇒ Could you just take me through the history of this ?
- ⇒ Have there been many changes in medication ?

Could you just take me through the patient's history in terms of other people or agencies that have been involved ?

Overall, how do you feel things have been handled with this patient ?

- ⇒ How do you feel things are going now?

Do you have any sense of how things might go in future ?

- ⇒ Can you foresee any particular problems
- ⇒ Do you have any idea of what the outcome of care is likely to be ?

Are there other options for treatment which you would have liked to or still would like to be able to offer?

- ⇒ Why was this not possible?

How representative is this patient of your experiences with patients having new/likely depressive illness OR having recent or previous depressive illness?

Can you think of anything else that you would like to say as regards the management of patients with depressive illness that we have not managed to bring out in any of the questions so far?

Are there any other factors which you think influence the GPs ability to manage the care of patients with depressive illness appropriately?

Guidelines

Are you aware of any current guidelines on the management of depressive illness?

Are there any guidelines which you personally use, either specific or general, in the management of depressive illness ?

Where did these guidelines come from?

To what extent do you follow these or any guidelines in the management of depressive illness?

What do you like about these guidelines, why do you implement them? OR What do you not like about guidelines, why do you not implement them?

Can you think of anything else that you would like to say as regards guidelines for the management of depression?

Do you think we have covered all the relevant topics that are important to understanding the processes of care involved in the management of depressive illness?

Patient Interview Schedule.

You have been chosen to take part in this study because of your recent visit(s) to your GP. Your GP is taking part in a research project to help us find out how he/she looks after patients who have some emotional distress or general symptoms of low mood. We need to know what you think of the care that your GPs offer. Quite often in this kind of research some people feel that their problems aren't serious enough, or that they've got over them quickly, to be of interest. We are interested in the experiences of a wide range of people.

Background

First of all could I ask you some general questions about yourself:

Could you just tell me a bit about your background, your age, family, what you do , that kind of thing?

In broad terms this interviews about health, how you're feeling and health services.

How would you describe your general health at the moment?

What kind of things in your life do you think affect your general health and how you're feeling ?

Do you have any particular health problems or illnesses , either just now or perhaps something longer term?

Do you think your health has affected other areas of your life in any way? If yes, in what way?

Is there anything else about your general health and well being which you think is important?

Could I just ask about the health of your family ? OR Is there anything about the health of your family in general that is affecting you or that you think is relevant?(Define family as those who live in their household and/or their children and/or any family member whom they care for regularly)

I'd now like to ask you some questions about your general practice.

How long have you been with this practice?

Is doctor (doctor's name) your usual GP?

How well do you know your GP? How would you describe your relationship with him/her?

How many times roughly have you consulted your GP in the past year?

Have you seen any other general practitioners, nurses or anyone else at the practice over the past year ?

Have you had much contact with health services generally for yourself ?

Have there been any times when you've felt uncertain about how well you're getting on with your doctor?

You were asked to take part in this study on the basis of a recent visit to your general practitioner, and I'd like to come back to ask you a bit more a bout that specific visit, but could you give me a bit of background on how you were feeling before this.

How long had you been having the difficulties that you went to see your general practitioner about ?

Had you ever felt anything like this before ?

Did you have any of your own ideas about why you might have been feeling like this ? Either this time or in the past?

What made you decide you needed to see your GP?
If there has been a series of recent consultations which are all relevant then probe for how these went, what was said etc.

Can you tell me a bit about what it's like for you on a day to day basis?

- ⇒ How do you manage?
- ⇒ How do your family and friends manage?
- ⇒ Do you feel that people understand ?
- ⇒ Do you feel able to discuss how you're feeling with family and friends?
- ⇒ How do you feel about discussing it with them?
- ⇒ Do you ever discuss what its like for you on a day to day basis with your GP?

Have these feelings changed the way you feel about yourself at all?

These questions are for those with a history.

Have there been times before now when you've felt like this?

- ⇒ Can you tell me a bit more about this and how you've managed these feelings?

When did you first experience these types of problems?

- ⇒ Can you remember how you felt then and what you thought about it?
- ⇒ What did you do?
- ⇒ Did you speak to a general practitioner or anyone else about it ?
- ⇒ What help did he/she offer you?
- ⇒ Did you have any ideas about what brought on these feelings?

What's happened since then ?

What help have you had from general practitioners ?

- ⇒ Has this changed over time ?

Have you seen anybody else about these problems over the years?

who did you see
what happened
how did you feel about this
do you think this made a difference
are you still seeing them
what do you think about this now

Is there anything that you feel your general practitioner finds difficult about your case?

What have you found most helpful ?

Have there been any particular difficulties or misunderstandings or things that you have disagreed with ?

Have there been any times that you've had particular difficulties getting help?

- ⇒ Can you tell me about them?

If is on or has been taking medication

Can we just go over the medications you have received? Have the types of medication you've been taking changed at all?

⇒ What did you start on?
⇒ What did you think of this? (start of loop)
⇒ Did you take it as prescribed?
⇒ How long were you on this?
⇒ When did it change and why?
⇒ What did you think of this? (back to start of loop until all medications covered)
⇒ How have you found the different kinds of medication ?Helpful?
⇒ Have you always taken the medication as prescribed?
⇒ Have your views on medication changed at all ?

Do you think the types of care you have been offered have changed over the years? (Alternative prompt may be necessary, e.g. Have the options available to you changed over the years?)

Overall can you think of anything that might have been handled differently ?

Are there any areas that you've come across that might be generally difficult between doctors and patients ? (Alternative prompt may be necessary, e.g.Can you think of any areas where doctors and patients might have difficulty in understanding each other or talking to each other about).

For all subjects.
The next set of questions relate to your recent visit(s) to your GP, the one that got you into this study!

Could you just tell me about that visit ?
⇒ Could you tell me a bit more about what led up to this ?
⇒ How were you feeling ?
⇒ Could you say what the reason for it was ?
⇒ Did you have any of your own ideas about how you were feeling?
⇒ Did you have any ideas about what your doctor might do or say?
⇒ How did you explain things to the doctor?
⇒ What happened, what kind of things did you discuss?
⇒ How did you feel it went from your point of view?
⇒ How did you feel you got on with the doctor?
⇒ Did the doctor do or say anything that was particularly helpful?
⇒ Or unhelpful ?
⇒ Did your doctor give you an explanation as to what he/she thought was the problem or the cause of the problem? What did you think of this?
⇒ Did you tell your doctor how you felt about this? If not, why not?
⇒ Did you get to see the GP that you wanted to see?
⇒ Do you think that made a difference to the way things went?

⇒ Before this particular visit to the doctor, when was the last time you'd been? Was this for something similar ?

Did the doctor suggest anything specific ? For example seeing someone else, taking any medication or (something about what the doctor was going to do) things that you could do yourself?

How did you feel it went from the doctors point of view?

Overall how do you think it went? Was it as you had expected?

When you first went to see your GP did you have an idea of what you wanted him/her to do?

How were things left?

⇒ How are you feeling about what happens next ?

Were there any problem areas or issues that you didn't quite understand or agree with ?

If given or discussed medication

Could I just ask you a bit more about your views on medication ?

Do you know much about medication for this kind of thing?

For those with new episode:

Have you ever taken medication for this kind of thing (problem?) before ?

⇒ Can you remember what kind of medication, how long you took it for and how you felt about it, did you take it as prescribed, was it helpful ?

For all:
If given medication

Could you just tell me a bit more about the medication you've been given ?

Do you understand why you were given a prescription?

⇒ Do you know what the prescription does, what it is for?

⇒ Do you understand anything about the amount or the dosage which your doctor has prescribed for you?

Can you remember what the doctor said to you about the prescription ?

How do you feel about getting a prescription for this problem?

⇒ Do you have any concerns about taking this medication?

Are you taking the medication?

- ⇒ How do you take it ?
- ⇒ Are you taking it as prescribed or in your own way ?

If appropriate: i.e. in terms of the length of time on prescription.

Do you think the medication has had any effect?

Do you think you will keep taking the medication? Why?

If your GP was to ask you what you thought of the medication what would you tell him/her? Is that what you really think?

If just discussed medication

How do you feel about the discussion you had with your doctor about medication?

- ⇒ What was your doctor's view?
- ⇒ How did you feel about this at the time?
- ⇒ How are you feeling now?

If doctor suggested seeing someone else ?

You mentioned that the doctor suggested that you see a whatever, could you just tell me a bit more about that ?(ASK FOR ALL THINGS MENTIONED)

- ⇒ Do you feel you understand what this person/a whatever does and how they may help?
- ⇒ Do you feel you understand why the doctor suggested it ?
- ⇒ How did you feel about the doctor making this suggestion ?
- ⇒ Do you feel this will be helpful ? In what ways?
- ⇒ Is there anything else that you'd like to know more about in relation to this?
- ⇒ Do you have any concerns?
- ⇒ If your GP was to ask you now what you thought about this option what would you tell him/her? Is that what you really think?

If actually referred ?

Do you have any idea about how long it will be before you're seen ?

Did your GP suggest doing anything else in the meantime?

For those with new episode :

Have there been any times before now when you've felt like this ?

- ⇒ Can you tell me about the last time ?
- ⇒ What did you do?
- ⇒ What happened?
- ⇒ How do you think you got through it ?
- ⇒ Do you have any ideas about what brings on these feelings?

For those with history :

Overall what's your view of how general practitioners help people with these kinds of problems?

Have there been any times that when you've felt a bit uncertain or uneasy about something to do with your health care?

On the basis of your experience what can you think of anything that might be valuable to pass on to other people in a similar position ?

For both sets of patients:

How do you think things will go from now ?

- ⇒In terms of how you're feeling
- ⇒In terms of your health care

Do you foresee any problems?

(Only if seems appropriate) Will you go back and see your GP?

Is there anything else you would like to say about how you feel regarding your recent (health?) problems?

Is there anything else you would like to say about your health care ?

Appendix C

MOD Study
Patient Interview Guide

Introduction: cover confidentiality, purpose of study, obtain consent to continue with interview and permission to tape, format of interview and ability to terminate at any point in time.

1. Background
- personal details, age, family, occupation
- state of health, at present and historically
- perception of factors that affect health
- impact of health problems on other aspects of life

2. Relationship to General Practice
- relationship to G.P.
- frequency of consultations
- anyone else they see
- any uncertainties/difficulties

3. Time Surrounding Last Consultation
- Background and lead-up
- Any perceived triggers
- purpose/expectation of visit to G.P.
- current day to day experience
- availability of support
- attitude of family

4. For Patients with a history
- history/pattern of these types of feelings
- description and assessment of help from G.P/ other services
- any difficulties getting help
- identify most helpful factor
- any difficulties/ misunderstandings with G.P. or any other helping agency
- medication history, pattern of use, perceived effectiveness, general views
- any changes in types of care over years
- views on whether care should have been handled differently

5. Last Consultation(in detail)
- description of visit - doctor's contribution, patient's contribution
- what was helpful?
- assessment of how it went - for you? for the doctor?
- consistency with expectations
- any difficulties/ confusion/ misunderstanding

If given a prescription

6. Medication
- previous experience
- general views on medication
- understanding of why and what medication was given, dosage etc
- doctor's explanation/ instructions
- effectiveness, (if appropriate)
- pattern or anticipated pattern of usage
- ability to negotiate /give honest feedback to GP about use of medication

7. Reaction to other suggestions made at the last consultation
- insight into why doctor may have made that suggestion
- knowledge of referral agent(if appropriate)
- anticipated waiting time - what was suggested in meantime?
- perceived value/ appropriateness
- any uncertainty or disagreement with doctor's suggestion
- ability to give honest feedback to GP about views

8. New Patients
- any previous experience of these feelings
- course of action taken, if any

9. Closing Questions
- Overall opinion of GP's ability to help people in their situation
- recommendations to others in the same boat
- any difficulties or uncertainties about aspects of care
- future expectations as regards their feelings/their care

Any other comments

Thanks. Clarify what happens next

Appendix D

GP Interview Schedule Second Round –MOD study

**Remind GP's to bring patients' notes*

1. Introductions, Purpose of Interview 2, Reminder of some of ground covered in interview 1

2. Any changes in their role within the practice or training? How typical or otherwise do they think their management of patients with depression is, compared to partners/local colleagues?

3. Any changes in their perceptions of categories of depressed patients or overall management(medication, referral agents)?

4. Any changes in the organisational structure of the practice/NHS that have impacted on their management of depressed patients?

5. Any change in their use of guidelines? Explore to what extent and in what ways they feel their management of depression has changed over the years. Key influences on that – experience, the literature, colleagues?

6. Update on Patient 1

General

- Assessment of current state of health

Relationship with GP

- Quality of relationship with GP – habitual response to this patient
- Perception of strengths and weaknesses of relationship with patient

- if there are difficulties, explore why they think they occur

- Pattern of consulting -now and over period of depressive illness

Social Situation

- Any significant events in patient's life affecting their progress
- Perception of quality of patient's social support
- Effect of depressive episode on patient's ability to work/ manage their day-today lives
- Effect of depressive episode on patient's family/friends

Medication

- Perception of patient's experience of and efficacy of Medication – what,when, dosage, side-effects?
- Duration of medication and experience/management of withdrawal
- GP's role in managing withdrawal
- Who initiated coming off medication?
- What was the trigger?

- Ability of GP and patient to communicate honestly about medication

Referral Agents

- Who? When? What prompted the referral?
- Length of wait
- Quality/Efficacy of Service
- Patient/ GP satisfaction
- Communication between GP and Referral Agent

Other Helpful/Significant Factors

- Knowledge of any other actions taken by patient that may have affected their condition
- Self-help strategies? Complementary therapies? Exercise?
- Any other significant factors that may have affected patients progress e.g. life events

Repeat for Patient 2

General/Closing

  - Adequacy of support for doctors – where do they get theirs from? What would they like to see?
  - Views on non-medical management e.g Cognitive Behavioural Therapy/ Counselling
    - what experience/ knowledge do they have of these therapies?

    - What might enable them to treat depression more effectively?
- Is the negotiation of the management of depression different from negotiation of other illnesses
- Anything else they would like to raise?

Patient Interview Schedule Second Round MOD Study

Introductions, permission to tape, explain purpose and format of 2^{nd} interview. Recap impressions gained and stage subject was at at time of first interview. (? Summarise themes arising from first round of interviews).

1. Update since last interview
Current state of health and since last interview
When and how did they know they were starting to get better,(if appropriate)?

Family/Work/Everyday functioning
Effect of their problems on family
Social support
Any significant events?

2. Relationship to GP
Throughout episode
Pattern of consulting over depressive episode
Value of that relationship – what exactly?
Perception of GP's role during episode
Perception of their own role in managing what was going on
Last visit
(Detailed Description of last visit or a significant consultation)

How satisfactory?

3. Medication
Current?
What? dosage?
Previous?
Experience of medication?
How long?
Consistency with GP recommendations?
Side effects?
Effectiveness?

4. Withdrawal/Discontinuation of medication
What were they told at the outset/subsequently?
Who/when was that process initiated?
How was it managed?
Experience of coming off medication

5. Experience of Referral Agents
When?
Who?
How valuable?
How was this negotiated?

6. Other coping strategies?
What helped?
What didn't help?
Self-help vs GP initiated

Assessment of most significant factor in their recovery(if appropriate)
Assessment of most significant obstacle to their recovery

7. General
Views on what causes depression
Perception of depression as an illness / a normal reaction to circumstances/ a weakness in the personality

8. Social Attitudes to Depression/ Stigma
Has it got less or worse in recent years
Employers attitudes
Medical attitudes

9. Closing
What would they do differently next time/ learning from the whole experience
Recommendations to people suffering from depression...or their types of symptoms a
Anything else they would like to raise

Appendix E

Chart 3. Negotiation

Patient ID	Illness experience category	Perception of self/identity	Relationship with GP	Role of GP	Perception of illness	Perception of medication	Participation/ contribution to negotiations
F0101	Recurrent	Confident Able to help herself	Friendly, but Does not always take doctors suggestion on board	Support through life crises Legitimate consequences of illness Advocacy	Mind over matter, down to yourself to sort out	Doubts efficacy, has had enough of them	Patient has own agenda (for support advocacy), agrees to take medication then reneges on this
F0201	New	Isolated, alone, sad	Although long-term she feels he doesn't listen. Not close and trusting	Should be there to listen but has only been there to prescribe	Not depression just stressed with no-one to talk to	Very anti medication, threw them away	Failed to communicate hidden needs to GP, failed to communicate her resistance to medication
F0202	Long-term	Worrier, tense, nervous	Relies on GP for close support	Support, counselling, advisor	Family problems but also within her nature	Relies on medication, would not like to come off	Happy to do as the doctor says but both agree on the purpose of medication
F0301	Long-term	confident and capable, independent, high expectations of self	Equal relationship, relates to GP in age and outlook	Very much along the lines of prescriber and referrer	Predisposed to depression, chemical imbalance	They do help and she now accepts that she needs them	Very active in negotiations re-medication and referral.
F0401	New	Worrier	Trusts GP, feels he empathised with her situation, listened to her	Support and advice, legitimise and normalise illness	Caused by stresses of life	Reluctantly accepted but they did help. Okay in the short-term	GP understood her concerns, she didn't have to voice them much. Accepted his advice
F0402	Long-term	Life past her by	Trusts GP	Legitimise illness, advocate	Caused by family circumstances/divorce	Depends on medication	Patient often has own agenda which GP complies with
F0501	New	Low self esteem, gets wound up easily	Did not appear to build a relationship with GP, but did with HV	seek medical advice and treatment	Possibly PND and life stresses but has felt like this throughout her life with no explanation	Did not like taking them but realised they did help up to a point	Did not engage much in negotiations, did not discuss her needs in relation to exploring her past/lost childhood

References

Adam, R.P. (2003). *Beneficence, Boundaries and Big Brother: Patients' and Doctors' Construction of 'Personal Care' in General Practice*. PhD Thesis. University of Edinburgh.

Adams, S., Pill, R., and Jones, A. (1997). Medication, chronic illness and identity: the perspective of people with asthma. *Social Science and Medicine*. 45: 189-201.

Altheide, D.L. and Johnson, J.M. (1994). Criteria for assessing interpretive validity in qualitative research. In Denzin, N.K. and Lincoln, Y.S. (eds). *Handbook of Qualitative Research*. pp 485-499. Thousand Oaks, CA: Sage.

American Psychiatric Association (1993). Practice guidelines for major depressive disorders in adults. *American Journal of Psychiatry*. 150: 1-26.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. Washington DC: APA.

Anderson, I.M., Nutt, D.J., and Deakin, J.F.W. (2000). Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 1993 British Association for Psychopharmacology guidelines. *Journal of Psychopharmacology*. 14: 3-20.

Anderson, S.J., Troein, M., and Lindberg, G. (2001). Conceptions of depressive disorder and its treatment among 17 Swedish GPs. A qualitative interview study. *Family Practice*. 18: 64-70.

Andrews, G. (2001). Should depression be managed as a chronic disease. *British Medical Journal*. 322: 419-421.

Armstrong, D. (1979). The emancipation of biographical medicine. *Social Science and Medicine*. 13: 1-8.

Armstrong, D. (1980). Madness and coping. *Sociology of Health and Illness*. 2: 293-316.

Armstrong, D. (1982). The patient-doctor relationship: 1930-1980. In Wright, A. and Treacher, A. (eds). *The problem of medical knowledge*. pp 109-122. Edinburgh: Edinburgh University Press.

Armstrong, D. (1984). The Patient's View. *Social Science and Medicine*. 18: 737-744.

Armstrong D (2002). Clinical autonomy, individual and collective: the problem of changing doctors' behaviour. *Social Science and Medicine*. 55: 1771-1777

Baker, C., Wuest, J., and Stern, P.N. (1992). Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing*. 17: 1355-1360.

Balint, M. (1957). *The Doctor, his Patient and the Illness*. London: Pitman Paperbacks.

Barry, C.A., Stevenson, F.A., Britten, N., Barber, N., and Bradley, C.P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science and Medicine*. 53: 487-505.

Bastian, H. (2003). Just how demanding can we get before we blow it? *British Medical Journal*. 326: 1277-1278.

Beales G (1976) Practical Sociological reasoning and the Making of Social Relationships among Health Centre Participants. In M. Stacey (ed). The Sociology of the NHS. *Sociological Review* Monograph No.22

Bensing, J. (2000). Bridging the gap. The seperate worlds of evidence-based medicine and patient-centred medicine. *Patient Education and Counselling*. 39: 17-25.

Berger, P. and Luckmann, T. (1966). *The Social Construction of Reality: A teatise in the Sociology of Knowledge*. London: Penguin.

Bhaskar, R. (1979). *The possibility of Naturalism*. Brighton: Harvester.

Bhaskar, R. (1989). *Reclaiming Reality: A critical Introduction to Contemporary Philosophy*. London: Verso.

Blashki, T.G., Mowbray, R., and Daview, B. (1971). Controlled trial of amitriptyline in General Practice. *British Medical Journal*. 1: 133-138.

Bowling, A. (1995). *Measuring Disease*. Buckingham: Open University Press.

Bradley, C. (1994). Learning to say "no": an exercise in learning to decline inappropriate prescription requests. *British Medical Journal*. 5: 112-119.

Britten, N. (1996). Lay views of drigs and medicines: orthodox and unorthodox accounts. In Williams, S.J. and Calnan, M. (eds). *Modern medicine: Lay perspectives and experiences*. pp 48-73. London: UCL Press.

Brown, G. W. and Harris, T. O. (1978). *The Social Origins of Depression*. London: Tavistock.

Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.

Bury, M. (1986). Social constructionism and the development of medical sociology. *Sociology of Health and Illness*. 8: 137-169.

Byrne, P. and Long, B. (1976). *Doctors Talking to Patients*. London: Her Majesty's Stationery Office.

Cape, J. and McCulloch, Y. (1999). Patient's reasons for not presenting emotional problems in general practice consultations. *British Journal of General Practice*. 49: 875-879.

Carr, A. (1990). Compliance with medical advice[editorial]. *British Journal of General Practice*. 40: 358-360.

Charon, R. (1989). To Listen, to recognize. In Brown, P. (eds). *Perspectives in Medical Sociology*. pp 529-536. Illinois: Waveland Press, Inc.

Chew-Graham, C.A., May, C.R., Cole, H., Hedley, S. (2000). The burden of depression: a qualitative investigation of general practitioners' constructs of depressed people in the inner city. *Primary Care Psychiatry*. 6: 137-141.

Chewning, B. and Sleath, B. (1996). Medication decision-making and management: A client-centred model. *Social Science and Medicine*. 42: 389-398.

Conrad, P. (1981). The discovery of hyperkinesis: notes on the medicalisation of deviant behavior. In Ingleby, D. (eds). *Critical Psychiatry: The Politics of Mental Illness*. pp 102-119. Harmondsworth: Penguin.

Conrad, P. (1985). The meaning of medications: another look at compliance. *Social Science and Medicine*. 20: 29-37.

Conrad, P. and Schneider, J.W. (1980). Looking at levels of medicalisation: a comment on Strong's critique of the thesis of medical imperialism. *Social Science and Medicine*. 14A: 79-

Conrad, P. and Schneider, J. W. (1985). *Deviance and Medicalization: From Badness to Sickness*. London: Merrill.

Cooperstock, R. and Lennard, H.L. (1979). Some social meanings of tranquilliser use. *Sociology of Health and Illness*. 1: 331-347.

Cornwell, J. (1984). *Hard-earned lives: accounts of health and illness from East London*. London: Tavistock.

Davenport, S., Goldberg, D., and Millar, T. (1987). How psychiatric disorders are missed during medical consultations. *Lancet*. 1: 439-441.

Davis, F. (1963). *Passage Through Crisis: Polio Victims and their Families*. Indianapolis: Bobbs-Merrill.

Department of Health (2001). *The Expert Patient: A new approach to chronic disease management for the 21st century*. London: Department of Health.

Donoghue, J.M. and Tylee, A. (1996). The treatment of depression: prescribing patterns of antidepressants in primary care in the UK. *British Journal of Psychiatry*. 168: 164-168.

Donovan, J.L. and Blake, D.R. (1992). Patient non-compliance: deviance or reasoned decision-making? *Social Science and Medicine*. 34: 507-513.

Dowell, J. and Hudson, H. (1997). A qualitative study of medication taking behaviour in primarycare. *Family Practice*. 14: 369-375.

Dowrick, C. (1992). Improving mental health through primary care. *British Journal of General Practice*. 42: 382-386.

Dowrick, C. (1995). Does testing for depression influence diagnosis or management by general practitioners? *Family Practice*. 12: 461-465.

Dowrick, C. and Buchan, I. (1995). Twelve month outcome of depression in general practice: does detection or disclosure make a difference? *British Medical Journal*. 311: 1274-1276.

Dowrick, C., Gask, L., Perry, R., Dixon, C., and Usherwood, T. (2000). Do general practitioners' attitudes towards depression predict their clinical behaviour? *Psychological Medicine*. 30: 413-419.

Dowrick, C., May, C., Richardson, M., and Bundred, P. (1996). The biopsychosocial model of general practice: rhetoric or reality? *British Journal of General Practice*. 46: 105-107.

Elston, M.A. (1991). The politics of professional power: medicine in a changing health service. In Gabe, J., Calnan, M., and Bury, M. (eds). *The Sociology of the Health Service*. pp 58-88. London: Routledge.

Elston, M.A. (1994). The anti-vivisection movement and the science of medicine. In Gabe, J., Kelleher, D., and Williams, G.H. (eds). *Challenging medicine*. pp 160-180. London: Routledge.

Elwyn, G., Edwards, A., and Britten, N. (2003). "Doing prescribing": How doctors can be more effective. *British Medical Journal*. 327: 864-867.

Elwyn, G., Edwards, A., and Kinnersley, P. (1999). Shared decision making: the neglected second half of the consultation. *British Journal of General Practice*. 49: 477-482.

Epping-Jordan, J., Kawar, R., Bengoa, R., Saraceno, B., and Yach, D. (2001). World Health Organization is managing depression as a chronic condition. *British Medical Journal (Rapid Response)*. http://bmj.com/cgi/eletters/322/7283/419#12839

Fava, G.A., Ruini, C., and Mangelli, L. (2001). Management of depression. *British Medical Journal (Rapid Response)*. http://bmj.com/cgi/eletters/322/7283/419#13256

Findlay, D.A. and Miller, L.J. (1994). Through medical eyes: The medicalization of women's bodies and women's lives. In Bolaria, B.S. and Dickinson, H.D. (eds). *Health, illness and health care in Canada*. pp 276-306. Toronto: Harcourt Brace Canada.

Fitzpatrick, R. and Hinton, J. (1984). *The Experience of Illness*. London: Tavistock Publications.

Foucault, M. (1967). *Madness and Civilisation: A History of Insanity in the Age of Reason*. London: Tavistock.

Foucault, M. (1972). *The Archaeology of Knowledge*. London: Tavistock.

Foucault, M. (1976). *Mental Illness and Psychology*. New York: Harper and Row.

Foucault, M. (1977). *Discipline and Punish : The Birth of the Prison*. Harmondsworth: Penguin.

Foucault, M. (1979). *Sexuality*. London: Penguin.

Fox, R.C. (1977). The medicalisation and demedicalisation of American society. In Knowles, J.H. (eds). *Doing better and feeling worse*. New York: Norton.

Fraser, R. C. (1999). *Clinical method: a general practice approach*. Oxford: Butterworth-Heinemann.

Freeling, P., Rao, B.M., Paykel, E.S., Sireling, L.I., and Burton, R.H. (1985). Unrecognised depression in general practice. *British Medical Journal*. 290: 1880-1883.

Freidson, E. (1961). *Patients' Views of Medical Practice*. New York: Russell Sage Foundation.

Freidson, E. (1970). *Profession of medicine: A Study in the Sociology of Applied Knowledge*. New York: Dodds Mead.

Freidson, E. (1985). The reorganisation of the medical profession. *Medical Care Review*. 42: 11-35.

Gabe, J. and Calnan, M. (1989). Limits to medicine - women's perceptions of medical technology. *Social Science and Medicine*. 28: 223-231.

Gabe, J., Kelleher, D., and Williams, G. H. (1994). *Challenging medicine*. London: Routledge.

Gabe, J. and Lipshitz-Phillips, S. (1982). Evil necessity? The meaning of benzodiazepine use for women patients from one general practice. *Sociology of Health and Illness*. 4: 201-209.

Gabe, J. and Thorogood, N. (1986). Prescribed drug use and the management of everyday life: the experiences of black and white working class women. *Sociological Review*. 34: 737-772.

Gammell, D.J. and Stoppard, J.M. (1999). Women's experiences of treatment of depression: medicalisation or empowerment? *Canadian Psychology-Psychologie Canadienne*. 40: 112-128.

Garfield, S.F., Smith, F.J., and Francis, S.A. (2003). The paradoxical role of antidepressant medication - returning to normal finctioning while losing the sense of being normal. *Journal of Mental Health*. 12: 521-535.

Geddes, J.R., Freemantle, N., Mason, J., Eccles, M.P., and Boynton, J. (1999). SSRIs versus alternative antidepressants in depressive disorder (Cochrane Review). In *The Cochrane Library, Issue 4*. Oxford: Update Software.

Giddens, A. (1991). *Modernity and self identity*. Cambridge: Polity.

Gilbert, P. (2001). Depression - a need for a more complec biopsycosocial approach. *British Medical Journal (Rapid Response)*. http://bmj.com/cgi/eletters/322/7283/419#12778

Gilbody, S.M., Whitty, P.M., Grimshaw, J.M., and Thomas, R.E. (2003). Improving the detection and management of depression in primary care. *Quality and Safety in Health Care*. 12: 149-155.

Glaser, B. and Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine.

Goffman, E. (1961). *Asylums*. New York: Doubleday Anchor.

Goldberg, D. (1992). A classification of psychological distress for use in primary care settings. *Social Science and Medicine*. 35: 189-193.

Goldberg, D., Bridges, K., Cook, D., Evans, B., and Grayson, D. (1990). The influence of social factors on common mental disorders: destabilisation and restitution. *British Journal of Psychiatry*. 156: 704-713.

Goldberg, D. and Huxley, P. (1992). *Common Mental Disorders*. London: Routledge.

Goldberg, D. P. (1972). *The Detection of Psychiatric Illness by Questionnaire*. Oxford: Oxford University Press.

Goldberg D, Privett M, Ustun B, Simon G, Linden M. (1998). The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. *British Journal of General Practice*. 48(437): 1840-1844.

Green, J. (1998). Commentary: Grounded theory and the constant comparative method. *British Medical Journal*. 316: 1064-1065.

Greenwood, J. D. (1994). *Realism, Identity and Emotion: Reclaiming Social Psychology*. London: Sage.

Habermas, J. (1984). *Theory of Communicative Action. Volume 1, Reason and the Rationalization of Society*. London: Heinemann.

Hacking, I. (1999). *The social construction of what?* Cambridge, Mass: Harvard University Press.

Hammersley, M. (1992). *What's Wrong with Ethnography: Methodological Explorations*. London: Routledge.

Hassell, K., Whittington, Z., Cantrill, J., Bates, F., Rogers, A., and Noyce, P. (2001). Managing demand: transfer of management of self-limiting illness from general practice to community pharmacies. *British Medical Journal*. 323: 147-

Haug, M. (1973). Deprofessionalization: an alternative hypothesis for the future. *Sociological Review Monograph*. 20: 195-211.

Haug, M. (1988). A re-examination of the hypothesis of physician deprefessionalisation. *Millbank Memorial Fund Quarterly*. 66: 48-56.

Heath, I. (1999). There must be limits to the medicalisation of human distress. *British Medical Journal*. 318: 436-

Helman, C.G. (1981). "Tonic", "fuel" and "food": social and symbolic aspects of the long-term use of psychotropic drugs. *Social Science and Medicine*. 15B: 521-533.

Heritage, J. (1984). *Garfinkel and Ethnomethodology*. Cambridge: Polity Press in association with Blackwell Publishers Ltd.

Hochschild, A.R. (1983). *The managed Heart: The Commercialization of Human Feeling*. Berkeley and Los Angeles: University of California Press.

Hoff, P. (1995). Kraepelin. In Berrios, G. and Porter, R. (eds). *A History of Clinical Psychiatry*. London: Athlone Press.

Hollyman, J.A., Freeling, P., and Paykel, E.S. (1988). Double blind placebo contriolled trail of amitriptyline among depressed patients in general practice. *Journal of the Royal College of General Practitioners*. 38: 393-397.

Howe, A. (1996). "I know what to do, but it's not possible to do it" - general practitioners' perceptions of their abilioty to detect psychological distress. *Family Practice*. 13: 127-132.

Howie, J.G.R., Heaney, D.J., and Maxwell, M. (1999). Quality at general practice consultations: cross sectional survey. *British Medical Journal*. 319: 738-743.

Illich, I. (1975). *Medical nemesis: the expropriation of health care*. London: Calder and Boyar.

Jamison, K. R. (1995). *An Unquiet Mind: A Memoir of Moods and Madness*. London: Picador.

Joffe, R. and Sokolov, S. (1996). Antidepressant treatment of depression: a meta analysis. *Canadian Journal of Psychiatry*. 41: 613-616.

Johnson, M., Long, T., and White, A. (2001). Arguments for 'British Pluralism' in qualitative health research. *Journal of Advanced Nursing*. 33: 243-249.

Judd, L.L., Akiskal, H.S., Maser, J.D., Zellar, P.J., Endicott, J., Coryell, W., Paulus, M.P., Kunovac, J.L., Leon, A.C., Mueller, T.I., Rice, J.A., and Keller, M.B. (1998). A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry*. 55: 694-700.

Kadam, U.T., Croft, P., McLeod, J., and Hutchinson, M. (2001). A qualitative study of patients' views on anxiety and depression. *British Journal of General Practice*. 51: 375-380.

Karp, D.A. (1993). Taking Anti-Depressant Medications: Resistance, Trial Commitment, Conversion, Disenchantment. *Qualitative Sociology*. 16: 337-359.

Karp, D.A. (1994). Living with Depression: Illness and Identity Turning Points. *Qualitative Health Research*. 4: 6-30.

Katon, W., Von Korff, M., Lin, E., Bush, T., Ludman, E., Simon, G., and Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry*. 53: 924-932.

Kelleher, D. (1994). Self-help groups and their relationship to medicine. In Gabe, J., Kelleher, D., and Williams, G.H. (eds). *Challenging medicine*. pp 104-117. London: Routledge.

Kendrick, T. (1996). Prescribing anti-depressants in General Practice. *British Medical Journal*. 313: 829-830.

Kendrick, T. (2000). Why can't GPs follow guidelines on depression. *British Medical Journal*. 320: 200-201.

Kerr, M., Blizard, R., and Mann, A. (1995). General Practitioners and Psychiatrists: comparison of attitudes to depression using the depression attitude questionnaire. *British Journal of General Practice*. 391: 89-92.

Kessler, D., Lloyd, K., Lewis, G., Gray, D.P., and Heath, I. (1999). Cross sectional study of sympton attribution and recognition of depression and anxiety in primary care. *British Medical Journal*. 318: 436-440.

Kirsch, I. and Antonuccio, D. (2002). Antidepressants versus placebos: meaningful advantages are lacking. *Psychiatric Times*. 19:

Knudsen, P., Holme, H.E., and Traulsen, J.M. (2002). Perceptions of young women using SSRI antidepressants - a reclasification of stigma. *International Journal of Pharmacy Practice*. 10: 243-252.

Lawrie, S.M., Martin, K., McNeill, D., Drife, J., Chrystie, P., Reid, A., Wu, P., Nammary, S., and Ball, J. (1998). General practitioners' attitudes to psychiatric and medical illness. *Psychological Medicine*. 28: 1463-1467.

Lewis, S.E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health*. 4: 369-382.

Lilienfeld, S.O., Marino, L. (1995). Mental Disorder as a Roschian Concept: A Critique of Wakefield's "Harmful Dysfunction" Analysis. *Journal of Abnormal Psychology*. 104(3): 411-420

Littlejohns, P., Cluzeau, F., Bale, R., Grimshaw, J., Feder, G., and Moran, S. (1999). The quantity and quality of clinical practice guidelines for the management of depression in primary care in the UK. *British Journal of General Practice*. 49: 205-210.

Llewellyn-Jones, S. (2000). Why can't GPs follow Guidelines? *British Medical Journal (Rapid Response)*. http://bmj.com/cgi/eletters/320/7229/200#6453

Locker, D. (1981). *Symptoms and Illness: the cognitive organization of disorder*. London: Tavistock.

Lowenberg, J.S. and Davis, F. (1994). Beyond medicalisation - demedicalisation: the case of holistic health. *Sociology of Health and Illness*. 16: 579-599.

Lupton, D. (1997b). Consumerism, reflexivity and the medical encounter. *Social Science and Medicine*. 45: 373-381.

Lupton, D. (1997a). Foucault and the medicalisation critique. In Petersen, A. and Bunton, R. (eds). *Foucault, health and medicice*. pp 94-110. London: Rutledge.

Lydeard, S. and Jones, R. (1989). Factors affecting the decision to consult with dyspepsia: comparison of consulters and non-consulters. *Journal of the Royal College of General Practitioners*. 39: 495-498.

MacDonald, T.M., McMahon, A.D., Reid, I.C., Fenton, G.W., and McDevitt, D.G. (1996). Anti-depressant drug use in primary care: a record linkage study in Tayside, Scotland. *British Medical Journal*. 313: 860-861.

Marinker, M. (1973). The doctor's role in presecribing. *Journal of the Royal College of General Practitioners*. 23: 26-29.

Marinker, M. (1997). From compliance to concordance: achieving shared goals in medicine taking. *British Medical Journal*. 314: 747-748.

Marks, J., Goldberg, D., and Hillier, V.F. (1979). Determinants of the ability of general practitioners to detect psychiatric illness. *Psychological Medicine*. 9: 337-353.

Mason, J. (1996). *Qualitative Researching*. London: Sage.

McCall, L., Clarke, D.M., and Rowley, G. (2002). A questionnaire to measure general practitioners' attitudes to their role in the management of patients with depression and anxiety. *Australian Family Physician*. 31: 299-303.

McCallagh, M. (2000). Can primary care Improve care for depressed patients? *British Medical Journal (Rapid Response)*. http://bmj.com/cgi/eletters/320/7229/200#6514

McKinlay, J. and Arches, J. (1985). Towards the proletarianisation of physicians. *International Journal of Health Services*. 15: 195-

McNair, B.G., Highet, N.J., Hickie, I.B., and Davenport, T.A. (2002). Exploring the perspectives of people whose lives have been affected by depression. *The Medical Journal of Australia*. 176: S69-S76.

McNay, L. (1994). *Foucault: A Critical Introduction*. Cambridge: Polity Press in association with Blackwell.

McWhinney, I.R. (1966). General practice as an academic discipline. *Lancet*. i: 419-423.

McWhinney, I.R. (1984). Changing models: the impact of Kuhn's theory on medicine. *Family Practice*. 1: 3-8.

Mechanic, D. (1978). *Medical Sociology*. New York: Free Press.

Mechanic, D. (1982). The epidemiology of illness behavior and its relationship to physical and psychological distress. In *Symptoms, Illness Behavior and Help-Seeking*. New Brunswick: Rutgers University Press.

Mechanic, D. (1986). Illness behaviour: an overview. In McHugh, S. and Vallis, T.M. (eds). *Illness Behaviour: A Multidisciplinary Model*. New York: Plenum.

Mechanic, D. (1995). Sociological Dimensions of Illness Behaviour. *Social Science and Medicine*. 41: 1207-1216.

Mechanic, D., McAlpine, D., Rosenfield, S., and Davis, D. (1994). Effects of attribution and depression on the quality of life among persons with serious mental illness. *Social Science and Medicine*. 39: 155-164.

Meltzer, H., Bebbington, P., Brugha, T., Warrell, M., Jenkins, R., and Lewis, G. (2000). The reluctance to seek treatment for neurotic disorders. *Journal of Mental Health*. 9: 319-327.

Millar, T. and Goldberg, D.P. (1991). Link between the ability to detect and manage emotional disorders: a study of general practitioner trainees. *British Journal of General Practice*. 41: 357-359.

Mishler, E. G. (1984). *The Discourse of Medicine. The Dialectics of Medical Interviews*. Norwood, NJ: Ablex.

Moncrieff, J., Wessely, S., and Hardy, R. (2002). Active placebo versus antidepressants for depression (Cochrane review). In *The Cochrane Library, Issue 3*.

Moore, R.G. (1997). Improving the treatment of depression in primary care:problems and prospects. *British Journal of General Practice*. 47: 587-590.

Morse, J. M. and Johnson, J. M. (1991). *The illness experience: dimensions of suffering*. Newbury Park, CA: Sage.

Munro, J., Nicholl, J., O'Cathain, A., and Knowles, E. (2000). Impact of NHS Direct on demand for immediate care: observational study. *British Medical Journal*. 321: 150-153.

Munro, J. F. and Campbell, I. W. eds (2000). *MacLeod's Clinical examination*. Edinburgh: Churchill Livingstone.

Navarro, V. (1986). *Crisis, health and medicine: a social critique*. London: Tavistock.

NHS Centre for Reviews and Dissemination (2002). Improving the recognition and management of depression in primary care. *Effective Health Care*. 7. Issue 5.

NHS Scotland: Information and Statistics Division (2003b). http://www.show.scot.nhs.uk/isd/mentalhealth/mhiphase.htm

NHS Scotland: Information and Statistics Division (2003a). *Primary Care*. NHS Scotland:Information and Statistics Division. http://www.show.scot.nhs.uk/isd/primary_care/gmp/gmp.htm

NHS Scotland: Information and Statistics Division (2003). *Unpublished Data.*

Oakley, A. (1986). Beyond the Yello wallpaper. In Oakley, A. (eds). *Telling the truth about Jerusalem*. pp 131-148. Oxford: Blackwell.

Office for National Statistics (2000). *Psychiatric Morbidity Survey: Prevalence of neurotic disorder among adults*. http://www.statistics.gov.uk

Osborne, T. (1994). Power and persons: on ethical stylisation and person centred medicine. *Sociology of Health and Illness*. 16: 515-535.

Parsons, T. (1951). *The social system*. London: Routledge and Kegan Paul.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Paykel, E.S., Hollyman, J.A., Freeling, P., and Sedgwick, P. (1988). Predictors of therapeutic benefit from amitriptyline in mild depression: a general practice placebo-controlled trail. *Journal of Affective Disorders*. 14: 83-95.

Pilgrim, D. and Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*. 8: 261-274.

Pilgrim, D. and Rogers, A. (1994). Something old, something new....sociology and the organisation of psychiatry. *Sociology*. 28: 521-538.

Pilgrim, D. and Rogers, A. (1999). *A Sociology of Mental Health and Illness*. Buckingham: Open University Press.

Pilgrim, D., Rogers, A., Clarke, S., and Clark, W. (1997). Entering psychological treatment: decision-making factors for GPs and service users. *Journal of Interprofessional Care*. 11: 313-323.

Plath, S. (1963). *The Bell Jar*. London: Heineman.

Priest, R.G., Vize, C., Roberts, A., Roberts, M., and Tylee, A. (1996). Lay people's attutudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. *British Medical Journal*. 313: 858-859.

Prior, L., Wood, F., Lewis, G., and Pill, R. (2003). Stigma revisited: disclosure of emotional problems in primary care consultations in Wales. *Social Science and Medicine*. 56: 2191-2200.

Pugliesi, K. (1981). "The Role of Emotional Behaviour in the Labelling of Mental Illness" M.A. thesis, Department of Sociology, Washington State University.

Reason, P. and Rowan, T. (1981). *Human Inquiry: a Sourcebook of New Paradigm Research.* Chichester: Wiley.

Richards, H.M., Reid, M.E., and Watt, G.M.C. (2002). Socio-economic variations in responses to chest pain. *British Medical Journal.* 324: 1308-1312.

Richardson, I.M. (1975). The value of a university department of general practice. *British Medical Journal.* 4: 740-742.

Rifkin, A. (2000). Guideliness can work (letter). *British Medical Journal (Rapid Response).* http://bmj.com/cgi/eletters/320/7229/200#6365

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In Bryman, A. and Burgess, R.G. (eds). *Analyzing qualitative data.* pp 173-194. London: Routledge.

Rogers, A., Entwistle, V., and Pencheon, D. (1998). A patient led NHS: managing demand at the interface between lay and primary care. *British Medical Journal.* 316: 1816-1819.

Rogers, A., Hassell, K., and Nicolass, G. (1999). *Demanding Patients? Analysing the use of primary care.* Buckingham: Open University Press.

Rogers, A., May, C., and Oliver, D. (2001). Experiencing depression, experiencing the depressed: The separate worlds of patients and doctors. *Journal of Mental Health.* 10: 317-333.

Rogers, A. and Pilgrim, D. (1993). Service users' views of psychiatric treatments. *Sociology of Health and Illness.* 15: 612-631.

Rogers, A. and Pilgrim, D. (1997). The contribution of lay knowledge to the understanding and promotion of mental health. *Journal of Mental Health.* 6: 23-35.

Ronalds, C., Creed, R., Stone, K., Webb, S., and Tomenson, B. (1997). Outcome of anxiety and depressive disorders in primary care. *British Journal of Psychiatry.* 427-433.

Rosch, E.R. (1973). Natural categories. *Cognitive Psychology.* 4:328-350.

Ross, S., Moffat, K., McConnachie, A., Gordon, J., and Wilson, P. (1999). Sex and attitude: a randomized vignette study of the management of depression by general practitioners. *British Journal of General Practice.* 49: 17-21.

Rost, K., Nutting, P., Smith, J.L., Elliott, C.E., and Dickinson, M. (2002). Managing depression as a chronic disease: a randomised trial of ongoing treatment in primary care. *British Medical Journal.* 325: 934-

Rost, K., Zhang, M., Fortney, J., Smith, J., Coyne, J., and Smith, G.R. (1998). Persistently poor outcomes of undetected major depression in primary care. *General Hospital Psychiatry.* 20: 12-20.

Roth, J.A. (1962). The treatment of tuberculosis as a bargaining process. In Rose, A.M. (eds). *Human Behaviour and Social Processes*. London: Routledge and Kegan Paul.

Roth, P.A. and Rohatyn, D. (1991). Meaning and method in the social sciences - a case for methodological pluralism [review]. *Philosophy of the Social Sciences*. 21: 412-

Royal College of General Practitioners (1972). *The Future General Practitioner: Learning and Teaching*. London: RCGP.

Ruston, A., Clayton, K., and Calnan, M. (1998). Patients' action during their cardiac event: qualitative study exploring differences and modifiable factors. *British Medical Journal*. 316: 1060-1065.

Scambler, G. (2002). *Health and Social change*. Buckingham: Open University Press.

Schreiber, R. (1996). (Re)Defining My Self: Women's Process of Recovery From Depression. *Qualitative Health Research*. 6: 469-491.

Schreiber, R. (2001). Wandering in the Dark: Women's Experiences With Depression. *Health Care for Women International*. 22: 85-

Schreiber, R., Stern, P.N., and Wilson, C. (1998). The contexts for managing depression and its stigma among black West Indian Canadian women. *Journal of Advanced Nursing*. 27: 510-517.

Schreiber, R.S. and Hartrick, G. (2002). Keeping it together: How women use the biomedical explanatory model to maage the stigma of depression. *Health Care for Women International*. 91-105.

Schutz, A. (1962). *Collected Papers, volume 1: The Problem of Social Reality*. The Hague: Martinus Nijhoff.

Scott, I.F. and Freeman, C.P.L. (1992). Edinburgh primary care depression study: treatment outcome, patient satisfaction and cost after 16 weeks. *British Medical Journal*. 304: 883-887.

Scottish Executive (1998). *Scottish Health Survey*. Scottish Executive Health Department. http://www.show.scot.nhs.uk/scottishhealthsurvey/sh81.pdf

Scottish Office (1998). *Designed to Care: renewing the National Health Service in Scotland*. Edinburgh: The Stationery Office.

Scottish Office: Clinical Research and Audit Group (CRAG) (1993). *Depressive Illness: critical review of current practice and the way ahead.*

Seale, C. (1999). *The Quality of Qualitative Research*. London: Sage.

Seligman, M. E. P. (1975). *Helplessness: on depression, development and death*. San Francisco: W.H. Freeman.

Silverman, D. (1993). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: Sage.

Silverman, D. (2001). *Interpreting qualitative data: methods for analyzing talk, text and interaction*. London: Sage.

Simon, G. and Von Korff, M. (1995). Recognition and management of depression in primary care. *Archives of Family Medicine*. 4: 99-105.

Song, F., Freemantle, N., Sheldon, T.A., House, A., Watson, P., Long, A., and Mason, J. (1993). Selective serotonin reuptake inhibitors: meta analysis of efficacy and acceptability. *British Medical Journal*. 306: 683-687.

Stimson, G. and Webb, B. (1975). *Going to see the doctor. The consultation process in General Practice*. London: Routledge & Kegan Paul.

Stoppard, J. M. (2000). *Understanding depression*. London: Routledge.

Stoudmire, A., Frank, R., Hedemark, N., Kamlet, M., and Blazer, D. (1986). The economic burden of depression. *General Hospital Psychiatry*. 8: 387-394.

Strauss, A. and Corbin, J. (1998). Grounded Theory Methodology: An overview. In Denzin, N.K. and Lincoln, Y.S. (eds). *Strategies of Qualitative Inquiry*. pp 158-183. Thousand Oaks, CA: Sage.

Strauss, A. L. and Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.

Styron, W. (1991). *Darkness visible*. London: Picador.

Taylor, S. and Ashworth, C. (1987). Durkheim and Social Realism: an Approach to Health and Illness. In Scambler, G. (eds). *Sociological Theory and Medical Sociology*. London: Tavistock.

Thoits, P.A. (1985). Self-Labeling Processes in Mental Illness: The Role of Emotional Deviance. *The American Journal of Sociology*. 91: 221-249.

Thompson, C. and Thompson, C.M. (1989). The prescription of antidepressants in general practice. I. A critical review. *Human Psychopharmacology*. 4: 91-102.

Thomson, J., Rankin, H., and Ashcroft, G.W. (1982). The treatment of depression in general practice. *Psychological Medicine*. 12: 741-751.

Tuckett, D., Boulton, C., and Olson, A. (1985). *Meetings between experts: an approach to sharing ideas in medical consultations*. London: Tavistock.

Tylee, A.T., Freeling, P., and Kerry, S. (1993). Why do general practitioners recognise major depression in one woman and miss it in another? *British Journal of General Practice*. 43: 327-330.

UMDS MSC in General Practice Teaching Group (1999). 'You're depressed' - 'No I'm not' : GPs' and patients' different models of depression. *British Journal of General Practice*. 49: 123-124.

Van der Geest, S. and Whyte, S.R. (1989). The charm of medicines: metaphors and metonyms. *Medical Anthropology Quarterly*. 3: 345-367.

Wakefiled, J.C. (1992). Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder. *Psychological Review*. 99: 232-247.

Wakefield, J.C. (1993). Limits of operationalization: A critique of Spitzer and Endicott's (1978) proposed operational criteria for mental disorder. *Journal of Abnormal Psychology*. 102: 160-172.

Waitzkin, H. (1979). Medicine, super structure and micro politics. *Social Science and Medicine*. 13: 601-619.

Waitzkin, H. (1991). *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New Haver, CT: Yale University Press.

Walters, V. (1993). Stress, anxiety and depression - women accounts of their health problems. *Social Science and Medicine*. 36: 393-402.

Weber, M. (1948). *From Max Weber: essays in sociology*. London: Routledge and Kegan Paul.

Wells, K.B., Schoenbaum, M., Unutzer, J., Lagomasino, I.T., and Rubenstein, L.V. (1999). Quality of care for primary care patients with depression in managed care. *Archives of Family Medicine*. 8: 529-536.

Wight, A.F. (1994). Should general practitioners be testing for depression? *British Journal of General Practice*. 44: 132-135.

Williams, G. and Popay, J. (1994). Lay knowledge and the privilege of experience. In Gabe, J., Kelleher, D., and Williams, G.H. (eds). *Challenging Medicine*. pp 118-139. London: Routledge.

Williams, M. (2000). Interpretivism and Generalisation. *Sociology*. 34: 209-224.

Williams, S. J. and Calnan, M. (1996). *Modern Medicine: lay perspectives and experiences*. London: UCL Press.

Wolpert, L. (2001). *Malignant Sadness: The Anatomy of Depression*. London: Faber and Faber.

World Health Organisation (1992). *International Classification of Diseases*. Geneva: World Health Organisation.

World Health Organisation (2003). *Depression*. World Health Organisation. http://www.who.int/mental_health/management/depression/

Wright, A.F. (1993). *A primary care perspective on depression*. HMSO Print Centre.

Wurtzel, E. (1995). *Prozac Nation*. London: Quartet Books.

Zigmond, A.S. and Snaith, R.P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica*. 67: 361-370.