

Qualitative study of depression management in primary care: GP and patient goals, and the value of listening

Olwyn Johnston, Satinder Kumar, Kathleen Kendall, Robert Peveler, John Gabbay and Tony Kendrick

ABSTRACT

Background

Guidelines for depression management have been developed but little is known about GP and patient goals, which are likely to influence treatment offers, uptake, and adherence.

Aim

To identify issues of importance to GPs, patients, and patients' supporters regarding depression management. GP and patient goals for depression management became a focus of the study.

Design of study

Grounded theory-based qualitative study.

Setting

GPs were drawn from 28 practices. The majority of patients and supporters were recruited from 10 of these practices.

Method

Sixty-one patients (28 depressed, 18 previously depressed, 15 never depressed), 18 supporters, and 32 GPs were interviewed.

Results

GPs described encouraging patients to view depression as separate from the self and 'normal' sadness. Patients and supporters often questioned such boundaries, rejecting the notion of a medical cure and emphasising self-management. The majority of participants who were considering depression-management strategies wanted to 'get out' of their depression. However, a quarter did not see this as immediately relevant or achievable. They focused on getting by from day to day, which had the potential to clash with GP priorities. GP frustration and uncertainty could occur when depression was resistant to cure. Participants identified the importance of GPs listening to patients, but often felt that this did not happen.

Conclusion

Physicians need greater awareness of the extent to which their goals for the management of depression are perceived as relevant or achievable by patients. Future research should explore methods of negotiating agreed strategies for management.

Keywords

depression; interviews; mental health; qualitative research; treatment goals.

INTRODUCTION

Despite the development of guidelines,¹ educational programmes, and organisational interventions, which have sometimes proven successful,²⁻⁵ the management of depression in primary care is often said to be suboptimal. Research has suggested that GPs often do not follow treatment guidelines, patients often do not take the antidepressants prescribed for them, and simply educating GPs about management is unsuccessful in itself in changing practice.⁵ A proportion of patients decline to accept organisational interventions such as systematic care management, within the research studies that have been carried out.²⁻⁴ Among many possible obstacles to implementing best practice may be differences between GP and patient views about depression. Patients may be less likely to engage with the recommended management for their depression if they think it unlikely to respond to the drug or psychological treatments on offer, or if their goals for the management of depression differ from those of their practitioners.

O Johnston, BA, PhD, clinical psychologist in training, Department of Psychology, Institute of Psychiatry, King's College London. **S Kumar**, PhD, MRCP, senior lecturer and honorary consultant in primary care, Brighton and Sussex Medical School, University of Brighton, Brighton. **K Kendall**, PhD, senior lecturer in sociology as applied to medicine, Division of Medical Education; **R Peveler**, MA, DPhil, FRCPsych, professor of liaison psychiatry; **J Gabbay**, MBChB, MSc, Dip HPS, FFPH, emeritus professor, Wessex Institute for Health Research and Development; **T Kendrick** BSc, MD, FRCGP, FRCPsych, professor of primary medical care, Community Clinical Sciences Division, School of Medicine, University of Southampton, Southampton.

Address for correspondence

Professor Tony Kendrick, Primary Medical Care, University of Southampton, Aldermoor Health Centre, Aldermoor Close, Southampton SO16 5ST.
E-mail: A.R.Kendrick@soton.ac.uk.

Submitted: 29 January 2007; **Editor's response:** 17 May 2007; **final acceptance:** 14 August 2007.

©British Journal of General Practice 2007; 57: 872-879
(online version e1-e14).

Previous qualitative studies have highlighted patients' self-imposed restraint regarding the length of depression consultations,⁶ and the importance of GP intuition⁷ and tacit knowledge,⁸ in influencing clinical decisions in this area, and GPs' preference for treating depression medically despite acknowledging the difficulty of a 'cure'.⁹ Where GPs consider patient preferences when contemplating antidepressants, their assessments of patients' attitudes to treatment may differ from patients' self-reported views.¹⁰ If adherence to treatment relies on concordance of views about the illness, we need insights into what patients and GPs think about depression and its treatment. The aims of this study were to explore the beliefs and attitudes of GPs, patients, and patients' supporters (friends, family, and carers) about the nature of depression and its management. The emergent theme of participants' goals for the management of depression became a focus of the study. Understanding these goals is vital to achieving a negotiated strategy for management.

METHOD

A grounded theory approach was adopted,¹¹ using interviews to explore how GPs, patients, and informal supporters of depressed individuals understand depression and its management.

Participants were recruited in and around Southampton, apart from two GPs in Leicester. A total of 135 GP study information packs and 1078 patient and supporter packs were mailed to potential participants at seven primary care trusts, and posters were displayed in a students' union, public library, and a hospital. Each pack contained a response slip and freepost envelope for individuals to submit contact details. Participating GPs came from 28 practices. Most of the patients and supporters were recruited through 10 of these practices via mail or face-to-face distribution of information packs by practice staff. Thirteen were recruited through other routes through mental health support groups, a carers' group, a youth service, poster advertising, snowballing (participant identification of further participants), and word of mouth.

The patient and supporter information sheets stated that 'The purpose of this study is to explore the different ways people experience and understand depression. To do this, we will be asking you about your thoughts and/or experiences of depression'. The GP information sheet stated that 'The purpose of this study is to clarify how medical practitioners, their patients, and their patients' significant others understand depression in relation to its management'.

A total of 147 participants agreed to participate. As recruitment criteria and data gathering were refined through theoretical sampling and analytic saturation,

How this fits in

Guidelines for depression management have been developed but little is known about GP and patient goals, which are likely to have an impact on offers of treatment, uptake, and adherence. While GPs take patient preferences for treatment into account, their perceptions of patient attitudes are only moderately related to patients' self-reports. GPs, patients, and their supporters describe a wide range of different concepts of depression and goals for its management. GP goals for managing depression may be perceived as irrelevant or unachievable by some patients, and GP responses may be considered as unhelpful; therefore findings emphasise the value of listening to patients, and sensitivity to alternative perspectives.

23 offers of participation to patients and supporters were declined; a further seven could not be contacted and six withdrew. Sampling was carried out purposively to obtain a diverse range of participants, summarised in Table 1. A total of 111 participants were interviewed: 61 patients (28 who were experiencing an episode of depression at the time of the interview, 18 with a past history of depression, and 15 who had never been depressed), 18 supporters, and 32 GPs. Some of the supporters and GPs had experienced depression themselves. Exploring GP experiences of depression had not been an aim of the study, and so participating GPs had not given informed consent for these issues to be explored during the research interview. Therefore in-depth information was not gathered on these experiences, and they are not included in the analysis. Most participants with experience of depression had suffered recurrent or persistent, rather than acute, depression. The group was heterogeneous as to severity of depression, which was self-defined rather than based on standard psychiatric classification.

Interviews were conducted between May 2002 and March 2004 and usually took around an hour, ranging from 30 to 150 minutes. Data collection ceased when saturation of categories was achieved. Data were collected and analysed iteratively, starting with a semi-structured topic guide (Box 1), but allowing the interviewers to follow participants' responses, gradually focusing on emerging themes (for example, in order to further explore the emergent theme of goals for the management of depression, later participants were asked about their main goals and how they viewed their GP's role in achieving these). All team members engaged in the analysis, which followed grounded theory procedures,¹¹ and assumed the principles of the 'critical realist perspective',¹² or 'subtle realism'.¹³ Each transcript was analysed independently by the interviewer and another team member. For each group of participants (for example, GPs, supporters), one researcher reviewed the whole dataset.

Table 1. Participant characteristics.

	GPs	Patients	Supporters
<i>n</i> (total <i>n</i> = 111)	32	61	18
Age range, years	30–58	18–83	36–76
Females/males	12/20	44/17	12/6
Self-reported ethnic group	31 White, 1 South Asian	58 White, 1 Black Caribbean, 1 Pakistani, 1 Chinese	17 White, 1 Indian
Relationship status	N/A	24 married, 4 cohabiting, 2 in long-term relationship, 1 in short-term relationship, 11 single, 2 separated, 9 divorced, 8 widowed	13 married, 3 cohabiting, 1 single, 1 widowed
Occupational status	18 full time, 14 part time	34 in paid employment, 13 retired, 9 unable to work, 1 unemployed, 3 looking after home/family, 1 student	6 in paid employment, 8 retired, 1 unemployed, 2 looking after home/family, 1 engaged in voluntary work
Number who had ever received a diagnosis of depression	N/A	33 (6 uncertain)	6 (4 uncertain of own diagnosis)
Number who accepted this diagnosis	N/A	32	6
Number who had ever been treated for depression	N/A	40 (1 uncertain)	10
Type of practice	3 single handed, 29 group	N/A	N/A
Location: practice (GPs)/Home (patients and supporters)	9 inner city, 5 urban, 7 suburban, 10 semi-rural, 1 rural	24 inner city, 21 urban, 14 suburban, 2 semi-rural	4 inner city, 5 urban, 7 suburban, 2 semi-rural
Teacher/tutor/trainer/academic	13 teachers, 2 tutors, 12 trainers, 4 academics (with some GPs falling into more than 1 of these categories)	N/A	N/A

N/A = not applicable.

Transcripts were divided into meaning units (the smallest self-explanatory piece of information), which were grouped into categories. Constant comparison of units and categories stimulated thinking on the properties of, and relations between categories which developed iteratively from the descriptive towards higher-order, more abstract categories. Theoretical sampling (recruitment of participants guided by the emerging themes so as to develop the analysis by obtaining crucial new information) and comparison of data from different participant groups constituted a form of triangulation;¹⁴ the goal in this context was completeness rather than convergence or consensus.¹⁵

The interdisciplinary team procedures helped to develop both depth and range of meaning in the data, and to assure the 'trustworthiness' of the analysis.^{16–18} They included:

- an audit trail for transparency of methodology and analysis development (for example through transcribing analysis meetings);

- all team members keeping reflective diaries, discussed regularly during meetings, which tracked developing ideas and explored the links between the researcher and the research; and
- agreement on 'waving a red flag',¹⁷ should any researcher be concerned that unwarranted assumptions or beliefs were beginning to drive the analysis.

RESULTS

The main themes that emerged from the analysis were: constructing and resisting boundaries between depression, the self, and 'normal' sadness; widely ranging goals for the management of depression; GP frustration with chronic depression; and the failure of GPs to listen to their patients.

Boundary construction and resistance

Participants often described 'depression' as a vague, ambiguous, highly individual concept, imbued with moral and cultural values. GPs often acknowledged that it was difficult to separate experiences of depression from just feeling sad about one's life:

Box 1. Topic guides.

GP topic guide

General management, consulting style

- Can you tell me a bit about your management of patients experiencing depression?
- Can you describe a typical consultation with someone whom you think is depressed?
- How do your consultations for depression compare to consultations for, say, angina?

Defining depression

- What does depression mean to you/what is your definition of depression?
- What are your criteria for labelling a patient's responses to an adverse life event as depression or just a normal response to a bad situation?
- What factors would you take into account when considering whether or not to make a diagnosis of depression?
- Can you tell me about how your diagnosis/lack of diagnosis of depression tends to relate to the views of the patient concerned?

Helpseeking and causes

- What do you think encourages people to seek help if they are feeling depressed?
- What do you think can lead to depression?
- What adverse events do you think contribute to depression? How do you weigh these relative to other more long-term factors (for example, poverty)?

Literature, media, teaching

- How does what you see of depression in practice fit with what you read in medical journals and books/other sources such as media?
- Do you deal with the topic of depression in your tutoring/teaching/academic/training work (if applicable)?
- If so, can you tell me a bit about that?

Treatment

- What do you think is the best treatment for depression? Why do you think this? Is this the treatment you most commonly use?
- If not, why not?
- What do you think about different types of anti-depressant medication? Which drugs do you use for depression?
- Why do you use these drugs? How do you decide which drug to use for a patient? What kind of doses do you use for different patients?
- Do you ever use less than the recommended dose?
- What are your views on talking therapies, such as counselling? Do you ever manage people by counselling alone, without any antidepressants?
- Why is that? How do you come to those decisions? How many of your depressed patients receive counselling?
- What do you think about alternative therapies, such as aromatherapy or yoga? Do you recommend these to your patients? Why?
- Are you aware of guidelines for treating depression? What do you think of these guidelines? To what extent do you follow them?
- When do you follow them? What prevents you from following them?

Communication about treatment

- What do you tell your patients about the treatment you are recommending for them? Are there things you don't tell them about, such as side-effects, withdrawal, or duration of treatment?
- What concerns about treatment do patients raise with you? How do you address patients' concerns about treatment?
- Do you give written information about treatment to patients?

Compliance/concordance

- Do you find that your patients comply/concord with your treatment decisions? If no: Why do you think this is? How do you respond to non-compliance?

Any other issues

- Are there any other issues we haven't addressed that you would like to mention?

Patient topic guide

General experience of/views on depression, GP involvement

- As you know, we're looking at what different people think about depression. Have you ever had any experience of depression?
- If yes: can you tell me a bit about your experience of depression? Did you have any contact with your GP about your depression?
- Can you tell me a bit about that?

Defining depression

- What does depression mean to you? Do you think your definition is the same as or different than how your doctor defines depression?
- In what ways?
- [If has been depressed] How would you describe depression to someone who has not experienced it?

Causes, helpseeking/coping

- [If has been depressed] Can you tell me in your own words about why you think you became depressed?
- When did you first think that you might be depressed? Can you tell me about how you decided to go and get help?
- [If has not been depressed] If you've never been depressed, how do you manage in difficult times? What do you think can cause depression?

Diagnosis

- Have you ever been diagnosed with depression?
- [If yes] Can you tell me about that experience? What was the diagnosis? When was the diagnosis made? Did you agree with the diagnosis?

Box 1 continued. Topic guides.

Treatment

What do you think is the best treatment for depression? Why do you think this?
 What do you think about tablets or medication for depression?
 What are your views on talking therapies, such as counselling?
 What about alternative therapies, such as aromatherapy or yoga?

Do you belong to any support group?

[If yes] Can you tell me about that? How helpful is the group?
 [If no] Would you consider joining such a group?
 What treatment, if any, have you had for depression? What did it do for you? How helpful was the care you received? Drug(s), dosage(s), experience of other therapies. What treatment would you like to try that you haven't already tried?

Response of other people

How have other people reacted to your depression?
 Did you feel you had somebody to help you? In what ways were they helpful?
 In what ways were people unhelpful?

Supporter of depressed people

Do you know of anyone else who is depressed?
 [If yes] Can you tell me about your relationship with them? Do you try and support them?
 How do you find this?

Any other issues

Are there any other issues we haven't addressed that you would like to mention?

Supporter topic guide

Experience of supporting someone with depression

Could you tell me about ****s depression?
 How has their depression affected you?
 How has it affected your relationship with them?
 In what ways do you support them?

Defining depression

How would you define depression? Do you feel **** fits this definition? How would you describe depression to someone who has not experienced it?

Views and experiences of depression

Why do you think **** is depressed?
 Tell me about their depression.
 Have you ever been depressed?
 [If has been depressed] Tell me about your depression.
 [If has not been depressed] If you've never been depressed, how do you manage in difficult times?

Treatment

Is **** receiving treatment for their depression? What treatment are they receiving? What do you think about their treatment?
 What do you think is the best treatment for depression? Why do you think this?
 Do you talk to **** about their treatment? What do you talk about?
 Help with supporting someone with depression
 Do you receive any help in supporting ****? [If yes] What help do you receive?
 Would you like help/more help? If so, what kind of help?

Any other issues

Are there any other issues we haven't addressed that you would like to mention?

'There's a grey area. There are people about whom I'm not certain, you know, they've had, er, low mood, unhappy, for a long, long time. They might report an increase in the symptoms, the stress they're experiencing in the last month. Now is this ... is an unhappy person who's become depressed, or has their unhappiness increased? Um, I don't know.' (GP31, 45-year-old white male)

Nevertheless, some GPs encouraged patients to regard depression as something ontologically separate from the self and the mere experience of sadness, for example, to clarify the ambiguous

experience of depression, to remove blame and minimise stigma, and to provide a way forward in the form of antidepressant treatment. This involved attempting to convey to patients certain perceptions of depression (identity: illness distinct from everyday life; cause: neurotransmitters; treatment: medical cure, usually antidepressants):

'I tell them ... you know ... I tell them it's a genuine illness, usually caused by an upset in transmitters in the brain, and I'm usually suggesting tablets which will ... the object of which is to restore the balance of the chemicals in the brain. [I choose

this explanation] *Because I think a lot of people find it more acceptable to look on it as a ... physical biochemical illness rather than a personality defect.*' (GP12, 49-year-old white male)

'Patients are often very relieved to have some clarification, where before there was only sort of uncertain vague feelings about things, or maybe, um, somatising a bit or, but, you know, their illness was a bit of a riddle. To have somebody to help, help formulate what is wrong with them and if you can give an explanation that, you know, it's how the brain chemistry works. They don't need to blame themselves, er, about things, or you can allay guilt. There's, there's a huge amount of things you can, you, that are very worthwhile.' (GP18, 51-year-old white male)

Patients and supporters welcomed clarification of their experiences and the provision of a way forward; and some willingly accepted (or already held) a biochemical explanation for depression. However, others questioned the validity of constructing boundaries between life, illness, and the self, which was associated with rejecting a medical cure and emphasising self-management. Stressing self-management was sometimes linked to a perceived obligation to take responsibility for oneself, but could also simply represent the most productive way of dealing with depression (for example some felt that no-one else could help, and emphasised the benefits of self-control):

'I mean, you know, if you can't cope with the world and with the job, that's what people do isn't it? They call it depression ... You know he is relying on the fact of the magic pills ... he would take that [self-help advice] with a pinch of salt and pooh-pooh it, because it's easier not to bother.' (Supporter01301, 54-year-old white female, discussing persistently depressed husband)

'Well, I always feel it is my responsibility, I think it is. You know, it's my body, it's my mind and I need to sort it out myself. And I don't believe there's anybody out there that can sort it out for me.' (Participant0450165, 46-year-old white female, recurrent depression)

Differing goals for the management of depression

The 28 patients with current depression, and eight other participants who were considering how to manage their recurrent depression, described a spectrum of therapeutic goals. The majority wanted to

'get out' or 'get rid' of their depression, that is, they were focused on curing or controlling (in the sense of 'delimiting') their depression. They included individuals with persistent or recurrent depression who wanted to prevent further depression (for example, those whose goal was to ward it off by measures such as long-term medication):

'So that's it really, best of luck to anybody that gets depressed but, there is a way out of it I think anyway. Well I found that I'm getting there anyway. A way out of the tunnel.' (Supporter0450111[1], 47-year-old white female, recurrent depression)

'I just want to get rid of it [depression]. I just want to feel normal again.' (Patient052019[1], 34-year-old white female, recurrent depression)

However, nine participants (25% of those currently considering goals for dealing with their depression) did not see curing/controlling their depression as an immediately relevant or achievable goal, but focused on simply getting by from day to day. Rather than aiming to cure their depression, some described goals like 'going with the flow', 'living with it', or getting medical help to get on with life when it gets too bad:

'When it comes, it comes. There doesn't ... you've just got to go with the flow. I mean, sometimes, you know, it's like me mate, if, you know, I can go and see me mate, if I can try to occupy my mind then it's not too bad. That's why I like to, do try to keep myself occupied at all times. But sometimes you can't always do that..' (Supporter 04501[1], 47-year-old white male, recurrent depression)

Potentially, at times this could clash with the GPs' priorities:

'... I know I'm never going to get rid of it, it's always going to be there and I'm going to have to keep going back to the doctor every now and again when it gets too bad and get some sort of help in that way ... They [antidepressants] just let me get on with my life, sort of thing, instead of sitting there wallowing about what, what had happened, or my woes. He [GP] said, "It costs a lot of money to prescribe these drugs and you've been on them a long time" [laughs]. So that was, "oh", I thought, "oh, right, OK, thought you were worried there for a minute". Um ... so I felt obliged to come off them basically. So I did come off them.' (Patient0450205[1], 34-year-old white female, recurrent depression)

Goals were influenced by perceptions of the cause, controllability, and duration of depression. As these perceptions were complex and fluid, participants rarely fell neatly on one point of the spectrum of goals. Long-term goals could be very different from short-term goals (for example, due to anticipated shifts in the controllability of depression), and participants' developing experiences could alter their perception of goals:

Interviewer: *'... some people that we've talked to who have experienced depression, perhaps for a long time, maybe on and off, have talked about sort of adapting to living with depression and managing it, and other people have perhaps focused more on getting out of depression. Would you see yourself as falling into either of those groups at all?'*

Patient: *'Um, just managing it really because ... I think most of the time I probably am quite depressed ... as long as I'm moving in the right direction, then, you know, eventually it will go. Because eventually all the thoughts that ... the ... er, like I'm reprogramming the way ... I think, and eventually, you know, ... those old thoughts will be in the past and I'll have a new way of thinking and a new way of, way of dealing with things.'* (Patient05201[1], 25-year-old white female, recurrent depression)

'I just wanted the help, something, to, relieve me of the anxiety, the stress, the depression I'm going through. I sort of wanted something to relieve me of that, but there's no quick solution to depression ... There is no quick solution unfortunately. I've learned to live with that, and come to that conclusion. So I feel sorry for people who are in a worse state than me but, I try to handle it as well. You know, I am coping with it but, but there are days when it's hard to cope with.' (Patient0450181[1], 64-year-old white male, persistent depression)

Different goals were associated with an appreciation of diverse styles of general practice. For example, those wanting a cure valued fast, definite diagnosis and action; those aiming to get by with their depression emphasised more the listening ear, maintenance medication, and practical (for example, financial) help. There appeared to be no association between preferred goals and previous or current experience of talking therapies (such as cognitive behavioural therapy or counselling), which had been undertaken both by those aiming for cure/control and those aiming just to get by.

GP goals and management approach

GPs typically stressed the goal of curing or controlling depression, often describing depression as 'treatable':

'My vision is that depression is ... an acute but slightly long illness but the majority of people get better from it. They may get another bout later, but I see it as something that I'm successful in treating. An acute treatable illness.' (GP13, 48-year-old white female)

'I mean my experience with antidepressants is, they all work, it doesn't matter if it's the old tricyclics or whether, as long as you have the levels high enough, then you've just got to balance that against side-effects. I can virtually say, I can guarantee that you'll feel better er just you know, just I suppose you could say trust me, um just give it time and we can make it better.' (GP9, 47-year-old white male)

'Our remit here [counselling for depression] in-house is short-term treatment. So in the main, we're looking at things, er, at depression or other emotional problems which probably have an identifiable cause that can be treated in a relatively short time span, or addressed, or that you can address in a relatively short time span.' (GP5, 53-year-old white male)

Even where GPs saw depression as a longer-term problem, they often described their role as being well-suited to the treatment of depression. They emphasised the utility of an individualised management approach based on human connection — not technical but accessible, supportive, and empathic. GPs described providing support to their patients in a disconnected and unsupportive modern society:

'You know I mean in, in the past, maybe people would have gone to see the parish priest or the vicar or they'd have had extended families and sort of uncles, or mums, or dads, or whatever or, or someone, brothers or sisters to turn to. But ... looking round in society, I mean, we do seem to be the main front door, that's there to, to help people.' (GP2, 49-year-old white male)

'I think some of my partners will give a prescription, say oh you know, there we are, this will make you feel better and they don't, they don't want to get involved or follow the patients up. I feel that, you know, part of them getting better is actually to provide support and let them feel that there's someone there that actually is

bothered about how they're feeling.' (GP10, 44-year-old white female)

An important part of this support consisted of providing an opportunity for the patient to talk, outlined in more detail below. This gelled with an emphasis by patients on the helpfulness of connection with others:

Interviewer: *'What sort of, um, help d'you think would be useful to people in that situation [experiencing mental health difficulties]?'*

Patient: *'Um ... to know that they're loved, to know that somebody cares, to know that there's somebody they can talk to when they need to talk to them ...'* (Patient0401, 59-year-old white female, recurrent depression)

GPs described individual responsiveness rather than generalised scientific responses when dealing with emotional difficulties in patients, and an empathic rather than mechanical approach:

'In terms of people coming to me with emotional problems or distress problems, we will tend to talk through what's going on. If somebody comes with angina it's a more technical exercise about the problem and checking technicalities.' (GP2, 49-year-old white male)

'The only thing is they [guidelines for depression management] seem awfully mechanical.' (GP5, 53-year-old white male)

[Discussing what medical school had not taught her about managing depression] *'... to actually ... understand the feelings that were coming from the patient and possibly to be able to reflect that back, and ... to actually be able to follow through quite painful things enough, really. You know, I think that's a bit of maturity and experience of life as well really.'* (GP19, 49-year-old white female)

However, GPs often applied this 'fit' between primary care and depression only to patients whose depression could be removed or prevented (for example, through short- or long-term medication).

GP responses to chronic depression

GPs often described frustration and uncertainty when depression resist cure, regarding such patients as inappropriately seeking help and 'difficult':

'The chronic ... nature of depression, it's a large workload in general practice and a lot of long-

term depressed people come regularly to the surgery. So I see a lady who's been depressed for 20, nearly 20 years, and she comes once a week. That's a huge burden of work. She phones the surgery a lot and we have a system whereby we don't let her talk to me. I mean, a more appropriate person would be someone like the counsellor, but they'll only ... see them six times. (GP16, 46-year-old white male)

'I suppose some of the more chronic ones ... um, I can think of one person in particular at the moment who I found exceptionally difficult over the years to manage who hasn't responded to pharmacological therapies, hasn't responded to psychological therapies, hasn't responded to supportive therapies, hasn't responded to anything and is chronically depressed, and I suppose ... my problem is that I assumed, naively, that one can, in the majority of cases, one can ... control or cure, well, probably control depression.' (GP30, 53-year-old white male)

GPs' curative goals may therefore be incongruous with patients' experiences of chronicity. The negative reactions of some GPs to chronic depression may have resulted in part from a challenge to the notion of depression as a curable disease, distinct from normal experience and amenable to medical control (as described above, GPs often attempted to present depression to patients in these terms). But GPs did diverge on this point — some accepted chronicity:

'There's a big group of people, I mean, we tend to know them by name, who have sort of long-term anxiety disorders, depressive diseases, who are managed all the time in general practice. They go on having this illness which we have to look after, and help them manage their life with.' (GP20, 51-year-old white female)

The importance of listening

As mentioned above, GPs acknowledged the importance of listening to patients with depression, and viewed empathy and support as constituting important aspects of their role in managing depression. Listening was described as being central to the GP role:

'Well I think we do a lot just by talking to people ... so, I mean, we see a lot of people, just to support them really ... to talk about things. Well I think it's our bread and butter of our job actually.' (GP19, 49-year-old white female)

Listening in the consultation was described by

GPs as serving a range of functions. These included information functions such as aiding diagnosis (gathering information about symptoms and context), and monitoring effects and side-effects of antidepressants. Non-specific therapeutic effects of listening were also mentioned. For example, GPs pointed to the benefits of non-judgemental listening, normalisation of patients' experiences, and providing an opportunity for patients to vent their emotions:

'So just the listening quite often, you know, allowing, er, patients to vent their feelings will help. Perhaps, you know, being in a position to sympathise with patients and to say, "I can understand what you're saying and I can see where you're coming from and I sympathise", er, so that patients don't feel that they are being unreasonable can sometimes help.' (GP25, 42-year-old white male)

'Something will come out and ... they'll tell you something that, you know is at the heart of the matter and then, you know some of them will actually go out saying, "well I feel better for the talk" and ... they will you know, improve.' (GP4, 52-year-old white male)

'Half of treatment isn't necessarily just the tablets, it's the interaction with the patient, the fact that you listen to their story, you give them time.' (GP16, 46-year-old white male)

'I think I'm just constantly surprised throughout my practice is that er ... that people come back and just say, actually ... having the consultation, being able to share it, etcetera, was ... all I needed, so, and I, I think, we underestimate the power, we end up by prescribing when we may not need to.' (GP30, 53-year-old white male)

'I think a lot of people that do come actually don't need antidepressants, they need an ear, and time, and so on.' (GP22, 48-year-old white male)

Some GPs felt that listening to the patient was important for building trust and maintaining the doctor-patient relationship:

'I think a lot of listening and a lot of explanation [is needed]. A lot of pacing ... understanding, going at the ... the rate that the patient ... wants to go at. A lot of checking back, um, a lot of open access, I'm at the end of the phone if you should want to talk about it.' (GP28, 56-year-old white female)

For some GPs, their listening could borrow components of various therapies, and constituted a type of counselling role. This could include exploring and challenging the patient's perspective, in an attempt to increase their self-awareness and help them to find a way forward. A few described satisfaction in taking on this counselling role:

'I suppose it's brief interventional counselling that we're doing on most of these things, isn't it? I mean, you try and say to somebody, you know, of all those horrible things that are going with you, what is actually manageable, what can we do something about now, how can we move you forward? What would be the smallest thing we could do to actually make an improvement? Sorry, not we, you can do, not we can do. But, yes ... I'm sure, I'm sure we're not, we're not counsellors, obviously. We don't have an hour with patients, we haven't got the skills of a counsellor for reflection but we have, I think GPs underestimate their skills or the effect of the consultation.' (GP30, 53-year-old white male)

'It's something that I've learnt that I can do and that I get probably more satisfaction from than any other aspect of the job ... you really can turn somebody's life around. There's a point in a lot of that type of consultation where I feel such a depth of intimacy, such a contact going on and if I get that feeling, I love that, I really do and it feels crucial, it's a turning point for the patient when that happens and once that that's happened, I know that they're safe.' (GP3, 45-year-old white female)

However, many GPs described obstacles to listening. Most commonly these included time and workload pressures:

'I think you've got to remember the context in which we're, we're doing this ... which is a 10-minute consultation ... with another 20 patients lined up and sometimes I worry that I'm a little bit, sort of, methodical with it. "Oh right, good, depression, Prozac, explain about it, off you go", and that does happen. But it's the best, I think it's the best I can do for that person.' (GP21, 44-year-old white female)

Other barriers to listening mentioned by GPs included the inability of patients to 'open up' in the short time available, an inability to empathise with a patients' context (for example, their chosen lifestyle), or fear of uncovering feelings they were powerless to help with (opening 'Pandora's box'):

'... sometimes I think you don't want to ask the questions [laughs] ... we all have our, our weaknesses and strengths as far as ... tolerance and recognition of ... symptoms and lifestyles and so, and those would differ from doctor to doctor.' (GP5, 53-year-old white male)

'The other thing I'm wary of is not, is not getting too involved in difficult things, which I wouldn't know what to do with. If you uncover something which is very difficult because, again, it's this thing of time, sometimes you can't suddenly let people open up about lots of problems then say, "Actually, your time's up".' (GP20, 51-year-old white female)

'I mean we're fairly lucky in this practice, we've always had 10-minute appointments, and one's got to be aware of Pandora's box, if you like. So, in some ways, if I feel that there is a particular problem and I know that, full well, that this is going to be better dealt with by someone else, at least I hope I would, at least acknowledge that I've recognised what the problem is but actually I'm not the right person to deal with it. The danger is that you will open up, a particular problem and if you're going to do that, you've got to be prepared to then put in the commitment and the time, even if it's just listening and things.' (GP25, 42-year-old white male)

Most patients also placed great value on being listened to. Patients were aware of the time pressures under which GPs were working, and it seemed that as a result, provision of time by the GP could signify to patients that they were valued as a person. This could provide a sense of connection, and a feeling that their problems were understood:

'I mean both, the doctors at this surgery I go to, I just find them absolutely fantastic. They don't treat you as a number, they treat you as a person and I just found that they would have the time to talk.' (Participant05202, 38-year-old white female, previously depressed)

'They take the time to talk to you ... my doctors, I know they're very busy and everything and that, but my doctor in particular likes to keep that personal side of things going and he's generally interested in how things are for you, how you're managing financially, and ... things like that. He does try and talk to you and get you to answer him and tell him what the root of the problems are, you know. He knows us very well, we've been going for about 17 years there.' (Participant0401, 51-

year-old white female, recurrent depression)

'She [GP] just listened, she just listened and took the time, that was one of the most important things. She had a really good way of summing up exactly what you'd said at the end so you knew you'd been listened to properly.' (Participant04501, 32-year-old white female, past experience of depression)

'Initially as soon as I went in she just initially just sat with me, and listened ... until I'd sort of warbled on a bit and ... then she said "I think you're depressed" but we kept on talking, it then became a conversation, she asked, you know, I said about the children, she asked how I felt about it and I said that I felt this anger and the raging and I also said about my relationship with my husband and ... she just ... conversed with me, I didn't feel at any time that she was trying to get rid of me. She was, she wasn't sort of moving away trying to write the prescription out [laughs]. Before I'd finished talking.' (Participant06021, 46-year-old white female, currently depressed)

As well as providing a sense of connection on a personal level, patients mentioned that talking to the GP could help them get things off their mind and release pent-up feelings:

'... So I mean, doctor [X] I mean, he's been absolutely brilliant. I mean they don't pay that guy enough ... but he has been really good you know, he's someone, if I go into his office, sit down, he'll talk to me, he will listen, which I think is very helpful ... I think if you've got ... a problem on your mind as well, 'cause sometimes if you want to try and get something off your mind, if you're unsure what's happening to you, I mean that's what the doctors are there for.' (Supporter04501[1], 47-year-old white male, recurrent depression)

Listening by the GP could also help patients to feel accepted and reassured (for example, providing a normalising function). They also found it helpful for someone to witness their sadness, acknowledge their resilience in the face of adversity, and provide encouragement that they would get through their current difficulties:

'I know he's encouraging. He's not condemning like most people are.' (Participant 03101, 60-year-old white female, recurrent depression)

'I feel you just get to the point where you just feel as though you're in it alone and, um ... like I get to

the point where I don't know what to do with myself and I just want someone to talk to and tell me that I'm not ... going mad.' (Participant 052019[1], 34-year-old white female, recurrent depression)

'It's the opportunity to, in a way, to have a good sob. Because that's something else, when I'm, when I'm depressed I do a lot of, um, a lot of crying ... an awful lot of crying. But I usually try and do it on my own so that I'm not causing distress to others. Sometimes you actually need to cry when there's somebody else there and let them witness ... how you're feeling.' (Supporter0450227[1], 56-year-old white female, persistent depression)

'I think the type of support I would have wanted was somebody just to talk to me or tell me I could make it ... more so than "here's medication".' (Participant01801, 28-year-old Pakistani female, currently depressed)

In addition, some patients mentioned that being able to talk to the GP enabled them to reflect on their difficulties, and to clarify or reframe their experiences.

'... you actually feel worthless and as though you can never, ever have a normal life again. And I know that's ridiculous because you do come out of it, but it's ... you, you just want to know why. And I mean probably a doctor or whatever can't tell you why but at least they can ask the questions which might make you think about it, why.' (Supporter 0450227[1], 56-year-old white female, persistent depression)

However, in practice many patients felt that they were not listened to in general practice consultations. Lack of time was frequently mentioned.

'I think that is the problem ... It's the fact that not able to talk to the GP or the GP not being able to talk, talk to them properly in the first place. Mainly because they've got this sort of 10-minute sort of thing or system, or whatever you want to, appointment system, haven't you.' (Participant0450155[1], 46-year-old white male, recurrent depression)

'When I went to see the homeopath, he had time to talk to me. Whereas my feeling with general practice is that they don't have time. It's always, you know, two appointments behind. So you, so I always feel that I'm rushed through. I would prefer not, not to bother to be perfectly honest.'

(Supporter0450457[2], 40-year-old white male, depressed in the past)

When discussing a lack of listening, patients also referred to dissatisfaction with the doctor–patient interaction in terms of lack of attention or acknowledgement on the part of the doctor (for example, dismissive reactions or preoccupation with note taking), and superficial responses (patients described how some doctors decided too quickly to prescribe antidepressants, so curtailing discussion).

'It's very impersonal, you look at a board, and your name comes on there and the doctors are just sat there looking at a computer. Nobody bothers really, and you're supposed to come out of there feeling better. Not as if you want to run under a bus, are you? Which is exactly how they make you feel.' (Participant0450194[1], 74-year-old white female, recurrent depression)

'I mean, I like doctor [X] he's fine, but ... I just don't get that personal thing with him, he's very, looking at his desk or the screen, he very rarely looks at you and I feel like I'm talking to the wall, basically. You know, when you're pouring your heart out to somebody [laughs], it kind of puts you off. If they're not ... showing any interest, it's like, sort of like, it makes it seem petty what you're saying ...' (Participant0450205[1], 34-year-old white female, recurrent depression)

'... you know, sometimes when you go in you just feel the impression that they're wanting you straight out the door, or they're writing out a prescription for something ... silly and, and just wanting rid of you.' (Participant04401, 27-year-old white female, recurrent depression)

Some patients considered that, as GPs did not have the time, it was preferable to be referred to counsellors or other professionals:

'I wouldn't go to them to talk about my problems, just to talk to them. They haven't got the time for that, it's not fair on them. I mean, yes, they're doctors ... but ... if you want to sit and talk to somebody then you go to counselling sessions, they're not there to counsel you ... they got a lot on their plate ... if I want to talk to somebody about my problems, I'll go to my doctor and ask them to refer me on to somebody.' (Participant0450205[1], 34-year-old white female, recurrent depression)

'Well, personally I think the thing with GPs is ...'

they simply haven't got time to discuss mental problems with a patient and I think what they fail to do is to refer them to psychiatry.' (Participant0450194[1], 74-year-old white female, recurrent depression)

DISCUSSION

Summary of main findings

Some GPs described encouraging patients to see depression as something separate from the self and 'normal' sadness (often adopting an oversimplified biomedical model akin to that promulgated in the marketing literature of antidepressants, rather than the more complex and subtle picture to be found in the scientific literature).¹⁹ Patients and supporters often questioned the construction of such boundaries, rejecting the notion of a medical cure and emphasising self-management. The majority of participants who were considering strategies for managing depression wanted to 'get out' of their depression. However, a quarter did not see this goal as immediately relevant or achievable. They focused on getting by from day to day, which had the potential to clash with GP priorities. GP frustration and uncertainty could occur when depression was resistant to cure. The importance of GPs listening to patients was identified, but participants felt that this did not happen often.

Strengths and limitations of the study

This study was strengthened by the use of in-depth interviews, rigorous iterative, reflexive, multidisciplinary data analysis, and exploration of patient perspectives. However, very few individuals were found in the early stages of their first episode of depression, and therefore most patients were recalling events over a long time period. Also, patients were not matched with GPs, so it was not possible to compare their accounts of specific interactions, and the study was based on retrospective accounts of doctor-patient interactions. Finally, sex, ethnic, or class differences were not addressed in this paper.

Comparison with existing literature

Previous research into patient views on depression management has, at times, produced contradictory findings. While a number of surveys have pointed to a preference for counselling over drug treatment for depression in general practice attenders and depressed primary care patients,^{20,21} other research has reported on the medicalised accounts provided by depressed individuals, involving biomedical explanations and positive evaluations of antidepressant medication.²² The present research contributes to the understanding of patient views on depression management by indicating the diversity of possible viewpoints, and the fluidity of these over time

(as highlighted by Karp in his work on 'illness careers' in depression).^{23,24} In line with the conclusions of previous qualitative studies on depression in primary care (for example, Gask *et al*.²⁵), the present findings highlight the importance of patient and GP beliefs in influencing management. The research extends these previous findings by exploring the varying goals of GPs and patients for the management of depression in primary care, with implications for clinical practice as outlined below.

The findings of this study on the value of listening are not surprising, as it is commonly taught that consultations should achieve a shared understanding of the patient's experience,²⁶ establishing a connection that will allow the exploration of ideas, concerns, and expectations and hence lead to shared decision making.²⁷ This has been shown to improve patient satisfaction and clinical outcomes.^{28,29} It is well-established that a positive therapeutic relationship in which patients feel free to discuss emotional problems and work towards their resolution is related to improved outcomes from psychological treatment, particularly in primary care.^{30,31} Thus, it is of particular concern that many of our interviewees believed that relatively little listening occurs. The present results support the findings of previous studies which indicate that patients place value on listening,³² and the potential for mismatch between patient and GP views (for example, Pollock and Grime found that patients held back from talking in consultations for depression because they believed GPs were too busy,⁶ but the GPs interviewed did not want more time when dealing with depression).³³

Implications for future research or clinical practice

Diverse views about the many dimensions of depression are likely to compromise the possibility of managing the illness, especially if GPs, by not listening sufficiently, fail to surface and deal with differing patient views to improve concordance. Understanding the variety of individual perspectives seems to be crucial: when some patients view their depression as a natural part of themselves while others appreciate the reassurance of hearing that depression is external to the self and medically curable, GPs would do well to engage, explore, and negotiate patients' perceptions before embarking on treatment. Moreover, as those views vary over time, this negotiation should be a continuing process. Likewise, treatment guidelines that presume a particular ontological disease concept for depression, as most do,¹ are likely to misfire with a substantial proportion of patients who view their depression, for instance, not as an illness needing specific medical interventions, but as a long-term problem to be coped with. Assuming that the current

findings apply not just in the UK, they may explain why some patients may be unwilling to accept the care-management approach that is currently promulgated in the US.²⁻⁵ Guideline developers should ensure that they take patient perspectives on depression and its treatment into account, as patients may not accept the disease model of depression implied by the approach being offered.

Listening in the consultation is not only helpful in terms of uncovering diverse perspectives, but is also valued by patients for its therapeutic benefits. The present findings highlight the potential relevance of narrative medicine,³⁴ which emphasises listening to patients' individual stories and exploring new meanings with them in ways that they find therapeutically helpful (although the extent to which GPs were adopting such an approach was not explicitly explored in this study).³⁵

The present findings highlight the often chronic relapsing nature of depression;³⁶ yet therapy is often reactive and episodic. The model of depression management currently being advocated, but not widely carried out in UK primary care, is for chronic disease management rather than acute symptom management.^{37,38} Tylee and Walters note that:

*'Unfortunately, the NICE guidelines fall short of describing a longitudinal model of care for people with chronic or relapsing depression, other than by combining medication and cognitive behavioural therapy.'*³⁹

They recommend that stepped care should be placed within a chronic disease-management framework. There is encouraging evidence for the benefits of chronic disease management of depression in primary care.⁴⁰

A number of patients and supporters emphasised self-management of depression. However, placing responsibility for managing depression solely with the patient would risk ignoring the context and blaming the individual,⁴¹ and would clash with the interviewees' experiences of depression as often being uncontrollable. Rather, while some GPs tend to try and provide some certainty about the nature and curability of depression, it may also be helpful for them to take on a facilitative role that aims to help patients to get through or live with their depression. Given the evidence that depressed individuals can contribute to their own care,^{38,42} the concept of 'supported self-care' (as opposed to simply self-management or medical treatment) seems particularly apt.⁴³

Implications for future research

Future research should include observing actual consultations as well as the development of methods

for improving mutual communication and negotiation about the handling of individual depression. Given the diversity of perspectives on depression and the implications of these for clinical practice, the development of tools or procedures to identify patients' models of depression and their attitudes towards various management options would be a useful way forward.⁴⁴ This study's finding of such a range of differing views on the desired outcome of managing depression also has implications for the outcomes assessed in clinical trials,⁴⁵ and for GPs' implementation of evidence-based medicine, since the evidence base may not address outcomes salient to all patients. Research methods as well as guidelines need to show greater awareness of the varied perspectives about depression.⁴⁶

GPs need greater awareness of the extent to which their goals for the management of depression are perceived as relevant or achievable by patients. Having explored patient perspectives, GPs should, where applicable, acknowledge their possible role in helping patients to live with depression, by adopting a facilitative approach and promoting supported self-care. Approaches that emphasise the delivery of drug or psychological treatments to cure or control discrete episodes of depression may fail to engage many patients.

Funding body

Funded by the Medical Research Council (grant number G0001105)

Ethics committee

Ethical approval was granted by Southampton and South West Hampshire Local Research Ethics Committee (LREC) (main LREC, reference number 024/02); North and Mid Hampshire LREC; Leicestershire LREC; Isle of Wight, Portsmouth and SE Hants LREC

Competing interests

Tony Kendrick has received hospitality, fees for speaking, and/or research funding from Lilly, Lundbeck, Wyeth, Pfizer, and Servier pharmaceutical companies which manufacture antidepressants. Robert Peveler has received hospitality, fees for speaking, and/or research funding from GlaxoSmithKline, Pfizer, Lilly, AstraZeneca, Wyeth, Lundbeck, Organon, Servier, and Boots plc (makers of dosulepin). The remaining authors have nothing to declare regarding competing interests

Acknowledgements

Thanks are due to the participants who gave up their time to be interviewed, and the GPs who helped with recruitment of patient and supporter participants

Discuss this article

Contribute and read comments about this article on the Discussion Forum: <http://www.rcgp.org.uk/bjgp-discuss>

REFERENCES

1. National Institute for Clinical Excellence. *Depression: management of depression in primary and secondary care. Clinical Guideline 23*. London: NICE, 2004. www.nice.org.uk/pdf/cg023fullguideline.pdf (accessed 17 Aug 2007).
2. Rost K, Nutting P, Smith J, et al. Improving depression outcomes in community primary care practice: a randomised trial of the QuEST intervention. *J Gen Intern Med* 2001; **16**(3): 143-149.
3. Katon W, Von Korff M, Lin E, et al. Stepped collaborative care for primary care patients with persistent symptoms of depression: a

- randomized trial. *Arch Gen Psychiatry* 1999; **56**(12): 1109–1115.
4. Lin EH, Simon GE, Katon WJ, *et al.* Can enhanced acute-phase treatment of depression improve long-term outcomes? A report of randomized trials in primary care. *Am J Psychiatry* 1999; **156**(4): 643–645.
 5. Gilbody S, Whitty P, Grimshaw J, Thomas R. Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *JAMA* 2003; **289**(23): 3145–3151.
 6. Pollock K, Grime J. Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study. *BMJ* 2002; **325**(7366): 687–690.
 7. Railton S, Mowat H, Bain J. Optimizing the care of patients with depression in primary care: the views of general practitioners. *Health Soc Care Community* 2000; **8**(2): 119–128.
 8. Andersson SJ, Lindberg G, Troein M. What shapes GPs' work with depressed patients? A qualitative interview study. *Fam Pract* 2002; **19**(6): 623–631.
 9. May C, Allison G, Chapple A, *et al.* Framing the doctor–patient relationship in chronic illness: a comparative study of general practitioners' accounts. *Sociol Health Illn* 2004; **26**(2): 135–158.
 10. Kendrick T, King F, Albertella L, Smith P. GP treatment decisions for patients with depression: an observational study. *Br J Gen Pract* 2005; **55**(513): 280–286.
 11. Glaser BG, Strauss AL. *The discovery of grounded theory: strategies for qualitative research*. New York: Aldine de Gruyter, 1967.
 12. Pilgrim D, Rogers A. Mental health, critical realism and lay knowledge. In: Ussher J (ed.). *Body talk: the material and discursive regulation of sexuality, madness and reproduction*. London: Routledge, 1997: 67–82.
 13. Hammersley M. *What's wrong with ethnography?* London: Routledge, 1992.
 14. Denzin NK. *The research act: a theoretical introduction to sociological methods*. New Jersey: Prentice Hall, 1970.
 15. Madill A, Jordan A, Shirley C. Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *Br J Psychol* 2000; **91**(Pt 1): 1–20.
 16. Henwood KL, Pidgeon NF. Qualitative research and psychological theorizing. *Br J Psychol* 1992; **83**(Pt 1): 97–111.
 17. Lincoln YS, Guba EG. *Naturalistic inquiry*. Beverley Hills, CA: Sage, 1985.
 18. Pope C, Mays N (eds). *Qualitative research in health care*. London: BMJ Books, 2000.
 19. Lacasse JR, Leo J. Serotonin and depression: a disconnect between the advertisements and the scientific literature. *PLoS Med* 2005; **2**(12): e392.
 20. Churchill R, Khaira M, Grettton V, *et al.* Treating depression in general practice: factors affecting patients' treatment preferences. *Br J Gen Pract* 2001; **50**(460): 905–906.
 21. Dwight-Johnson M, Sherbourne CD, Liao D, Wells KB. Treatment preferences among depressed primary care patients. *J Gen Intern Med* 2001; **15**(8): 527–534.
 22. Gammell DJ, Stoppard JM. Women's experiences of treatment of depression: medicalization or empowerment? *Can Psychol* 1999; **40**(2): 112–128.
 23. Karp DA. Living with depression: illness and identity turning points. *Qual Health Res* 1994; **4**(1): 6–30.
 24. Karp DA. Taking anti-depressant medications: resistance, trial commitment, conversion, disenchantment. *Qual Sociol* 1993; **16**(4): 337–359.
 25. Gask L, Rogers A, Oliver D, *et al.* Qualitative study of patients' perceptions of the quality of care for depression in general practice. *Br J Gen Pract* 2003; **53**(489): 278–283.
 26. Pendleton D, Schofield T, Tate P, Havelock P. *The consultation; an approach to learning and teaching*. London: Oxford University Press, 1984.
 27. Edwards A, Elwyn G. *Evidence-based patient choice*. Oxford: Oxford University Press, 2001.
 28. Gask L, McGrath G, Goldberg D, Millar T. Improving the psychiatric skills of established general practitioners: evaluation of group teaching. *Med Educ* 1987; **21**(4): 362–368.
 29. Roter D, Hall J. Recruitment and training of primary care physicians in interviewing skills to identify and address psychosocial distress. *The fifth annual NIMH International Research conference on Primary Care Mental Health Research: concepts, methods and obstacles*. Tysons Corner, Va: Primary Care Research Program, National Institute of Mental Health, 1991.
 30. Cape J. Patient-rated therapeutic relationship and outcome in general practitioner treatment of psychological problems. *Br J Clin Psychol* 2000; **39**(Pt 4): 383–395.
 31. Van Os T, van den Brink R, Tiemens BG, *et al.* Are effects of depression management training for general practitioners on patient outcomes mediated by improvements in the process of care? *J Affect Disord* 2004; **80**(2–3): 173–179.
 32. Ogden J, Bavalia K, Bull M, *et al.* 'I want more time with my doctor': a quantitative study of time and the consultation. *Fam Pract* 2004; **21**(5): 479–483.
 33. Pollock K, Grime J. GPs' perspectives on managing time in consultations with patients suffering from depression: a qualitative study. *Fam Pract* 2003; **20**(3): 262–269.
 34. Launer J. *Narrative-based primary care: a practical guide*. Abingdon: Radcliffe Medical Press, 2002.
 35. Launer J. A narrative approach to mental health in general practice. *BMJ* 1999; **318**(7176): 117–119.
 36. Kupfer DJ. Long-term treatment of depression. *J Clin Psychiatry* 1991; **52**(Suppl): 28–34.
 37. Andrews G. Should depression be managed as a chronic disease? *BMJ* 2001; **322**(7283): 419–421.
 38. Kendrick T. Depression management clinics in general practice? Some aspects lend themselves to the mini-clinic approach. *BMJ* 2000; **320**(7234): 527–528.
 39. Tylee A, Walters P. We need a chronic disease management model for depression in primary care. *Br J Gen Pract* 2007; **57**(538): 348–350.
 40. Kates N, Mach M. Chronic disease management for depression in primary care: a summary of the current literature and implications for practice. *Can J Psychiatry* 2007; **52**(2): 77–85.
 41. Ogden J. *Health and the construction of the individual: a social study of social science*. London: Routledge, 2001.
 42. Faulkner A, Layzell S. *Strategies for living: the research report*. London: Mental Health Foundation, 2000.
 43. Department of Health. Supporting people with long term conditions: an NHS and social care model to support local innovation and integration. London: Department of Health, 2005. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100252 (accessed 5 Oct 2007).
 44. Brown C, Dunbar-Jacob J, Palenchar DR, *et al.* Primary care patients' personal illness models for depression: a preliminary investigation. *Fam Pract* 2001; **18**(3): 314–320.
 45. Kelson MC. Consumer collaboration, patient-defined outcomes and the preparation of Cochrane reviews. *Health Expect* 1999; **2**(2): 129–135.
 46. Dowrick C. *Beyond Depression*. Oxford: Oxford University Press, 2004.