

# How do older adults understand and manage distress? A qualitative study

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## Research article

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# Abstract

Background Anxiety and depression are prevalent in older adults, however, older people may be reluctant to seek medical help and may manage their own mood problems. Due to stigma, older adults are more likely to perceive and/ or recognise their mood problems as distress. Whilst previous literature has focused on how younger adults self-manage mood problems, little research has explored how older people self-manage distress. The study reported here seeks to address this gap through qualitative methods.

Methods This study was approved by Keele University's ethical review panel. Older adults who self-identified as distressed, depressed or anxious within the previous 12 months were recruited from community groups in North Staffordshire, England. Data were generated through semi-structured interviews and analysed thematically using constant comparison methods. A public and patient involvement and engagement group contributed to development of the research questions and methods, and offered their perspectives on the findings.

Results Data saturation was achieved after 18 interviews. Key themes were: experiences of distress, actions taken, help-seeking from healthcare services and perceptions of treatments offered in primary care. Various forms of loss contributed to participants' distress. Participants initiated their own self-management strategies which included: pursuing independent activities, seeking social support and attending community groups and church. Five participants reported having consulted a GP when distressed but described a lack of acceptable treatments offered.

Conclusions To support older adults who are distressed, primary care healthcare professionals need to explore patients' existing ways of managing mood problems, provide information about a range of management options and consider the use of sign-posting older adults to community resources.

## Introduction

Anxiety and depression are prevalent in older adults, particularly in those experiencing long-term physical conditions<sup>1,2,3</sup>, and are linked to a reduced quality of life and increased risk of suicide<sup>4</sup>. However, the Mental Health Foundation<sup>5</sup> reported that 85% of older people experiencing mood problems do not seek help from healthcare services. Older people may be reluctant to recognise symptoms of mental health problems as reasons to consult a General Practitioner (GP)<sup>6</sup>, this reluctance may stem from stigmatised attitudes towards such problems<sup>7,8</sup>. Older adults are more likely to self-identify with the less stigmatising terms such as low mood, stress or distress<sup>9</sup>.

Distress is a subjective experience<sup>10</sup> which may be triggered by a range of life events such as bereavement or receiving a diagnosis of a physical health problem<sup>11,12</sup>. Distress is related to depression and anxiety, but can also be distinct<sup>11</sup>. Distress, as a construct, is not used as a diagnostic label but as a means of better representing an individual's sense of their lived experience of a mood problem<sup>10</sup>.

Geraghty et al<sup>11</sup> suggested that an individual reaching the diagnostic criteria for depression is likely to have expressed feelings of distress. However, the reverse may not be the case, an individual experiencing distress may not meet the diagnostic criteria which would infer a diagnosis of depression or anxiety.

As older adults perceive mental health problems as stigmatised<sup>7,8</sup>, they might not seek help from healthcare services and may prefer to self-manage their distress. Self-management is defined as 'taking increased responsibility for one's own health, behaviour and well-being'<sup>13</sup>. Effective self-management encompasses the ability to monitor one's own health problems and to have the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life<sup>14</sup>. Policy initiatives support GPs to encourage older adults to self-manage both physical and mental health problems<sup>15,16</sup>.

Whilst research has explored how younger adults self-manage depression and found that a number of strategies are used (e.g. exercising, socialising with friends and internet use)<sup>17,18,19</sup>, previous research has not explored how older people self-manage mood problems. The aim of this study was to identify the self-management strategies older adults with distress employ. This could be useful information as healthcare professionals could support the use of these strategies and potentially refer older people to a range of local, non-clinical services, known as social prescribing<sup>20</sup>.

## Methods

### Study design

A qualitative approach was adopted to explore how older adults self-manage distress. Ethical approval was obtained from Keele University's ethical review panel (ERP1279; 16.9.2016). Written consent was obtained from all participants prior to data collection.

### Sampling strategy and recruitment

Recruitment was conducted through existing community groups in North Staffordshire, England. As stigma may prevent older adults from seeking help from healthcare services for their mood problems<sup>7,8</sup>, recruiting from community groups provided access to older people who may not have presented their distress within primary care settings.

A purposive sampling strategy<sup>21</sup> was used to ensure the sample consisted of a mixture of participants from various demographic backgrounds. Inclusion criteria were used to ensure the sample consisted of individuals who were 65 years or older and who self-identified as distressed. On the information leaflets, distress was described as feeling 'low', 'stressed', 'anxious' or 'depressed'. The information sheet also stated that participants had to currently self-identify as distressed, or have been through an experience of distress within the past twelve months. The authors also tried to recruit older adults who did not attend community groups through snowball sampling techniques<sup>22</sup>. Older adults who attended the community

groups were given additional information leaflets and were asked to pass them onto friends who might be interested in participating in the study; this was not fruitful.

## **Data generation**

Interviews were conducted between September 2016 and March 2017. Interviews lasted between 44 and 92 minutes (mean 63 minutes). All participants were given a choice of a preferred venue in which to be interviewed (within the community group building or at home). Each participant chose to be interviewed within a private room at the building where the community groups were held. Semi-structured interviews were used to collect the data as they were sufficiently structured to address dimensions of the research question, but also permitted participants to offer new meanings to the topic under study<sup>23</sup>. Whilst data collection was on-going, the authors met regularly to discuss the data, and the topic guide was refined as recruitment continued.

Interviews were digitally recorded and transcribed. Data was analysed thematically<sup>24</sup> drawing on methods of constant comparison<sup>25</sup>. This method of analysis captured developing and recurrent themes within and between transcripts. Data analysis was conducted by three researchers from various disciplinary backgrounds. Emerging codes and themes were discussed as a team until a consensus was achieved. To increase the trustworthiness of the interpretation<sup>26</sup>, PPIE members were shown quotes which illuminated a theme or sub-theme. PPIE members' interpretations of the data did not differ from the researchers'. Recruitment ceased once data saturation, defined as when no new codes or themes were identified in the data<sup>27</sup>, was reached. NVivo 10 was used to facilitate the analytic process.

## **Patient and Public Involvement and Engagement**

A Public and Patient Involvement and Engagement (PPIE) group, convened of older adults with mood problems, advised this study. We sought PPIE advice when developing the research questions and methods, and when analysing the data. PPIE members suggested that older people would identify as distressed, but not with terms such as anxiety or depression due to the stigma surrounding these mood problems; therefore our research focused on distress not depression or anxiety. Modifying the research questions ensured relevant questions were being addressed. Developing the methods with a PPIE group ensured that public facing documents, the topic guide and 'think aloud' activities were appropriate for the target audience and gaining PPIE members' perspective of the data could have arguably enhanced the trustworthiness of the interpretation.

# **Results**

## **Sample characteristics**

Eighteen older adults were interviewed (11 females, 7 males) with a mean age of 77.5 years (range 65–91 years). All participants were White British.

(Insert Table 1 here)

The following themes will be presented: experiences of distress, actions taken, help-seeking from healthcare services and perceptions of treatments offered in primary care. Illustrative data are presented to support interpretation and are identified by participant pseudonyms.

### **Experiences of distress**

Within this theme two subthemes will be presented which detail the language that participants used to describe their distress, and the reported causes of distress.

### **Language of distress**

Participants drew on a variety of terms to describe their distress, including feeling: “*low*”, “*stressed*”, “*worried*”, “*run down*”, “*off*” or “*angry*”. Participants often used terms in combination with each other, as illustrated by Leslie when he described how older adults conceptualise distress:

*“I think that they'd think that they're just a bit run down and feeling a bit low and that they'd just get on with it.”*

(Leslie)

The participants who had sought help from healthcare services used language which was informed by contact with such services. Three participants disclosed seeking help from a GP when distressed and reported receiving a label of depression, these participants used terms such as “*depressed*” to describe their mood problems:

*“I went to the doctors and I said, ‘I don't feel very well and I don't know why’ and he said ‘I think you're affected by stress, you're depressed’ and I said why? And he just put me on these tablets.”*

(Owen)

A further two participants consulted a GP and reported receiving a label of anxiety:

*“Fortunately when I went to the doctors and he said I was anxious, it was only short-term anxiety, it didn't go on and on and on.”*

(Helen)

Helen suggested that her anxiety represented a short-term state and went on to report her mood problem lasted ‘*a few weeks*’. Helen did not conceptualise her anxiety as a long-term, persisting problem. When discussing their mood problems, the terms “*depressed*” or “*anxious*” were only used by participants who had received a label of anxiety or depression from a GP.

### **Perceived causes of distress**

All participants reported attributing their experiences of distress to some form of loss, one being the loss of a job, through retirement:

*"After retirement and at first when I retired, because I enjoyed the job meeting them many people, it was hard, it was difficult, as I say you knew all the secretaries they knew you and they just let you get on with your job, and obviously you had to be certain places like when taking the meals to the wards and stuff and you had to be a certain places at certain times, but the rest of the time you were fetching and carrying people and it was a complete pleasure."*

(Leslie)

Most retired participants reflected positively on their previous employment as it had provided an opportunity for them to socialise with other employees and members of the public, retirement took this opportunity for social contact away.

Sixteen participants disclosed suffering from various physical health problems, as described in Table 1. Some participants reported that physical health problems had caused a loss of physical mobility:

*"I've had my hips done, I've got arthritis in my back so that limits my walking."*

(Elizabeth)

A few participants described that a loss of mobility had resulted in them becoming isolated within their homes:

*"I have recently err last year, had a fracture on my hip and the err, fractured the femur so I was in the house for ... from October to March without going out."*

(Anne)

After undergoing hip surgery, Anne also discussed that her friends struggled to visit her at home:

*"People were very, a lot of people around me are elderly and I live up steps, like this (shows steep angle with arm) and they don't like coming up the steps."*

(Anne)

Anne described being housebound, which led to social isolation further compounded by friends who themselves had a lack of physical mobility. Along with their own loss of mobility, participants also attributed experiences of distress to a spouses' loss of physical mobility:

*"My husband had sciatica for two years, for the first four months he didn't move out of the chair except to go to the toilet and back, I had to take his food to him, everything. He was in so much pain and that stressed me out a lot."*

(Helen)

Some participants reported taking on a caring role for their spouses to ensure that their spouses' basic needs were met (e.g. having food to eat). Helen described that she "*had to*" care for her husband, this suggested this role was obligatory.

A few female participants attributed their experiences of distress to grief. Carol described her grief following the death of her husband:

*"When my husband died, I thought ... I'd be saying to friends that had lost someone dear to them, 'I am sorry and I am sorry' but I didn't know the depths of it until it happened to me."*

(Carol)

Following the loss of a spouse participants reported feeling alone, Diane's husband died over twenty years previously and she still described feelings of loneliness:

*"I start dulling my mind and not being interested, I don't know, so I think keeping interests helps with loneliness but you can still be lonely at times, I still miss my husband."*

(Diane)

A few participants described that the loss of multiple friends added to their feelings of loneliness and distress:

*"I went to erm two funerals recently and somebody said 'are you alright [Anne]?' to me when I was at the second one, and I said not really because I had a phone call just before I came out to say another friend had died."*

(Anne)

With the loss of each friend, participants reported having to deal with an accumulation of grief and the loss of social contacts.

## **Taking action**

Once participants had recognised that they were experiencing distress, they each described taking some form of action. Most of the participants identified their own ways of coping/managing with distress rather than seeking help from healthcare services:

*"You can't say what everyone would do, but personally, I would try and work things out for myself."*

(Michael)

Some participants had stoical attitudes towards their mood problems, as described by Elizabeth when discussing the management of her distress, which she attributed to a hip replacement she had one year prior to the interview:

*“Erm so I had to sort of wash myself, strip washes and things because you weren't allowed in the bath erm ... it was stressful but I just had to get on with it, I just had to get on, I think it is because all of my life I've had to work, I've never had anything given to me on a plate ... erm ... erm, I brought my children up, my first husband left and left me with two teenagers, which was a struggle, but I managed and I married again and I was married for over twenty years and he died eight years ago. But you know what? I just got on with it, so that is what I do now.”*

(Elizabeth)

Participants who reported experiencing previous challenges within their lives described self-managing their distress as they held life-long stoical attitudes towards their problems.

To manage their distress, participants pursued independent activities such as reading. In the case of Gill, reading helped to occupy her mind away from her worrisome thoughts:

*“Oh yes, I'm an avid reader, when I go to bed at night I cannot go to sleep unless I have read, sometimes I've been known to, if it is a good book, to read all night, if it is a good book, it does help because you've got your mind on the book instead of on the things that are worrying you because you put yourself in the situation that you're in in the book.”*

(Gill)

Some participants also reported gardening as an activity that provided distraction from their distress:

*“I just see [the garden] as a place where I can go out and forget about everything and I do (laughs) yeah it takes time and effort and it is an on-going job, but I like taking the cuttings and everything about it.”*

(Helen)

Participants described the need to put continuous effort into maintaining their garden, this provided participants with a task to distract them from their feelings of distress. Some participants, however, described that a lack of physical mobility presented a barrier to gardening:

*“My garden is beginning to look a bit untidy and it erm, it is getting at me, so when I go out I start pulling weeds and what not, then my back starts so I best be careful.”*

(Gill)

Other participants managed their distress by walking, as described by Peter:

*"The walks, erm well they keep me going mentally and physically, erm if I, if I stayed in I don't think that would be good, I think the mind would start to play tricks and I think I'd get problems but I go out, I have to go out."*

(Peter)

Peter suggested the importance of leaving the house to prevent the worsening of his feelings of distress and that walking was a positive source of distraction.

Ten participants identified as either Catholic or Christian and suggested that practising their religious beliefs provided them with a sense of inner-strength, as described by Diane:

*Diane: "Yes, yes, I am a Roman Catholic."*

*Interviewer: "How does that help?"*

*Diane: "It equips you for when the storm hits you, somehow, I don't know what it is, you don't avoid that storm but somehow you're not alone in it and, you know someone is there, and it provides inner strength."*

The perception that God was present within their lives prevented some participants from feeling like they were facing their distress alone. Some participants, who held religious beliefs, also described attending church as it provided a source of social contact:

*"Going to church, there is a friend, this is how we became friends, she used to sit sometimes beside me, she lived over the other side of the village and she is a spinster, she is a lovely person and erm I, again we sat together and then we started cleaning the alter silver together."*

(Anne)

Attending church permitted friendships to form between members of the congregation. Many participants, who did and did not attend church, sought social support from their friends to self-manage their distress, female participants particularly reported seeking social support from their female friends:

*"Call my friend [Helen] who I'm here with today and erm we talk a lot, we talk a lot on the phone, erm and sometimes I shall say right I'm going see [Helen] and my husband will say 'oh I'll come with you' and I say, 'no you're not it is going to be a ladies' afternoon'."*

(Irene)

Female participants expressed a preference to discuss their problems with female friends, rather than their spouses. Although participants felt that their family members were a constant presence in their lives, some were concerned about discussing factors which contributed to their distress with members of their family. Carol discussed how she told her sister that she was suffering from a physical health problem:

*"I was apprehensive, erm my sister was saying 'why are you going to the hospital?' and I said, 'oh I've got a cyst' and she was saying 'are you sure it is a cyst, are you sure? What have they told you? Have they done this and that?' and I said, 'yeah they've done everything there is to do and it is alright, don't worry', oh she was on the phone at me, so I thought, no, it is alright, it is alright, it is alright, you know and then I didn't want her to know because I knew she'd fall apart, so I had to write it all down in a letter and she was on the phone five minutes after she'd opened it (makes sobbing sounds)."*

(Carol)

Participants perceived that discussing factors which contributed to their distress (e.g. suffering from a physical illness) with family members was potentially burdensome due to the family members' emotional reactions. Such reactions from family members caused participants to reassure themselves that they could overcome the issue they were facing.

Participants sought practical support from younger family members:

*"Well my son was the main one, he'd come and take me shopping and when they were shopping I'd go with them him and his partner, he'd drop her off then come back with me and he'd get it all out and pack it all away."*

(Helen)

Some participants described that their children were a means to access supermarkets; this helped participants to fulfil their basic need of having food to eat.

Instead of seeking support from family members, most participants valued socialising with their friends as they often had similar problems, as reported by Diane:

*"I always feel better having been out and had a good gossip, usually we start off with all our ailments then we have a good laugh and get on with it, oh yes, having a laugh is very important, you feel better with your friends because we all suffer from one thing or another."*

(Diane)

Community groups helped participants to retain friendships which was important as participants sought social support from friends to self-manage their distress.

### **Help-seeking from healthcare services**

Stigma impacted some participants' decisions to seek help from healthcare services. Participants who had not consulted a GP when experiencing distress discussed the negative perceptions associated with mental health problems:

*"Hm, yeah, I think, well with depression and that, I don't want to be seen as having stuff like that, do I? Its frowned upon and you shut up and shut shop and you find people say 'no that doesn't happen to me or in my family'."*

(Elizabeth)

Some participants held stigmatised attitudes towards mental health problems and did not wish to be labelled as having such problems, this perhaps prevented them from consulting a GP.

Within the twelve months prior to being interviewed, five participants described consulting a GP for their mood problems. These participants described taking the decision to consult a GP due to persistent experiences of distress:

*Interviewer: "What do you think about going to the doctors [about] mental health problems?"*

*Diane: "Yeah, I tried to do it on my own until I realised I was getting churned up and I thought, I need some help."*

Diane reported reaching a point where she could not manage her distress alone as this was not alleviating her mood problems. By reporting "*I need some help*", Diane is gaining a sense of control over her mood problems by consulting a GP.

When asked if they had sought help from healthcare services when experiencing distress within the twelve months prior to the interview, thirteen participants disclosed that they had not consulted a GP. Reasons for this included a lack in continuity of care:

*"I don't bother with the GP if I'm honest at all, having the same GP is important and seeing a different one all the time well that stops me from saying I need something, seeing a familiar face would be important."*

(Kathleen)

Some participants described how seeing the same GP helped them to disclose symptoms of distress. Participants' reported relationship with a GP affected their decision to seek help from healthcare services. Participants who had received a label of a mental health problem described existing positive relationships with GPs:

*"My doctors are very good they are yeah, so I feel as though I can speak to them and I've seen how they are with my husband when they've come out to him when he's been really poorly."*

(Helen)

Participants who took the decision to seek help from healthcare services when experiencing distress reported that they could discuss their problems with a GP.

## **Perceptions of treatments offered in primary care**

Those participants who had consulted a GP were offered antidepressants:

*"You go to the doctor and say 'I'm feeling low, I'm feeling depressed erm I can't be bothered to get out of bed in the morning', he'll give you antidepressants."*

(Owen)

After receiving a label of depression, Owen reported that the offer of medication was made too quickly by the GP, before understanding his difficulties:

*"Essentially until they've looked at the problem, how can you diagnose a problem and give medication quite frankly? Well it is erm it is a stop-gap."*

(Owen)

Owen is suggesting that he wanted his mood problem to be understood by a GP before a treatment was suggested. The five participants who consulted their GP each reported being offered medication but this treatment was not acceptable and participants preferred to act by self-managing their mood:

*Frances: "My doctor, well he offered me, erm, Valium I think, but I will not-not-not take tablets for it, no way."*

*Interviewer: "What would you rather do to manage your mood, other than take medication?"*

*Frances: "Erm, well ... er, doing my garden, I love my pots or, er, seeing people, coming to these groups actually helps a lot."*

Rather than taking medication for mood problems, participants suggested that pursuing independent activities, or social contact with other people, would be a more acceptable solution.

Two participants, Owen and Diane, also reported being offered 'talking therapies' by a GP and referred to this form of treatment as "*counselling*". Both participants who had been given the opportunity to participate in 'talking therapies' reported that they did not attend, Diane described this in the following way:

*"Well the doctor once directed me to a spin-off, to a mental health charity, for an appointment for an interview, I didn't go ... they said 'if you feel the need to go, would you like to talk to someone?' and I said well that might be good, helpful, other than talking to the family because you don't want to burden them well, they are there for me, I know they are but they've got their lives bless them, but I didn't go."*

(Diane)

Although Dianne discussed the possible potential benefits of 'talking therapies' (i.e. not burdening family members with her problems), she did not engage with the treatment due to holding stigmatised attitudes towards counselling. Both Diane and Owen described counselling as stigmatising:

*“If a doctor says ‘I want you to go counselling’ that is pretty much like saying you’re going doo-lally and we’re going to stick you in a strait-jacket and stick you in a cubicle.”*

(Owen)

Participants who did, and did not, seek help from healthcare services when experiencing distress suggested that GPs should direct older people with mood problems to third sector services:

*Interviewer: “What do you think doctors should do for distressed older people?”*

*Stephen: “Hm, well, er ... maybe sending them to [community] groups like this, yeah, so they can get out and meet people and have a joke and a laugh, and maybe a piece of cake if it is somebody’s birthday (laughs) yeah, these groups are wonderful.”*

If GPs used sign-posted older adults to third sector services, such as community groups, this would permit distressed older people to have social contact with other individuals.

### **Visual representations of the analysis**

The concentric circle represented in Figure 1 identifies the management strategies participants used when distressed.

[Insert Figure 1 here]

Figure 1 does not represent a linear process. Individual participants did not necessarily move from independent activities to seeking social support and then to engaging with community resources to manage their mood problems. Figure 2 and 3 illustrate how two participants managed their distress in different ways. Figure 2 is a diagram of Anne’s self-management strategies and Figure 3 represents how Owen managed his mood problems. The colour of each self-management strategy represented in the diagrams corresponds to Figure 1.

[Insert Figure 2 and 3 here]

Figure 2 illustrates that once Anne had identified as experiencing distress, due to a loss of mobility and social contact, she took action by initiating self-management strategies. While Anne utilised reading as an independent activity that she did alone, most of the self-management strategies Anne employed revolved around seeking social support, such as socialising with friends. Seeking social support was linked to attending church and community groups as Anne sought support from individuals who also attended these community resources.

Unlike Anne, once Owen had recognised that he was experiencing distress due to physical health problems, he took action by consulting a GP who suggested a label of depression. Owen perceived the treatments offered by a GP (medication and ‘talking therapies’) as unacceptable and reported self-managing independently from healthcare services. Similar to Anne, Owen attended community groups.

Owen did not report attending community groups to seek social support but to learn a skill. Owen also described gardening as an independent activity he did on his own to self-manage his feelings of distress. Figure 2 and 3 show the nuances in how different participants managed their mood problems. Each participant utilised strategies that they deemed appropriate for the management of their own mood problems.

## Discussion

This is the first study which explores how older adults understand and manage distress. Older people use a variety of terms to describe their distress, which is often caused by various forms of loss. Most participants interviewed had not sought help from healthcare services; instead they preferred to identify their own ways of self-managing their experiences of distress. Self-management strategies included: pursuing independent activities (reading, gardening, walking and practising religious beliefs), seeking social support from friends and attending community groups including church groups. Five participants had consulted a GP and described existing positive relationships with these clinicians. Other participants, who did not seek help from healthcare services, reported a lack of a relationship with one GP and did not want to be defined as having a mental health problem. The five participants who consulted a GP were offered medication but this was perceived as an unacceptable treatment and these participants preferred to manage their mood in other ways. Two of these participants were also offered 'talking therapies' but the stigma of seeking 'counselling' prevented them from engaging with treatment. Participants suggested that, rather than offering medication or 'talking therapies', primary care healthcare professionals should direct older people with mood problems to third sector services (e.g. community groups).

Older adults using terms such as feeling "*low*" or "*stressed*" to describe their distress has been reported in previous research<sup>28</sup>. To support access to treatments believed to be the appropriate solutions for distress, Geraghty et al<sup>29</sup> reported that GPs were likely to label a distressed individual as 'depressed' because this enabled access to a broader range of treatment options such as antidepressants or 'talking therapies'. However, the current study indicates receiving a label of a mental health problem may change how older adults view their distress as only participants who consulted a GP, and received a diagnosis of a mental health problem, used terms such as "*anxiety*" or "*depression*" to describe their mood problems. Younger adults have previously described that grief, or a series of events or stressors, contributed to their experiences of distress<sup>28,29</sup>. In our study, experiences of distress were associated with various forms of loss, these findings are similar to previous studies reporting that older people view loss as a contributing factor towards low mood or stress<sup>30,31,32</sup>.

As most participants in my study preferred to self-manage their mood, this suggests that participants did not identify distress as a problem which required seeking help from healthcare services and, therefore, participants did not identify themselves as candidates for care. Candidacy describes the negotiation of eligibility for care and treatment between individuals and healthcare services<sup>33</sup>. Some distressed older adults may not identify themselves as candidates for care due to stigmatised attitudes and a reluctance

to receive a label of a mental health problem from a healthcare professional. Past research has also found that depressed older people, who held stigmatised attitudes towards depression, did not consult healthcare services for their mood problems<sup>7,8</sup>.

Older people in this study described a diverse range of self-management strategies in response to distress. Depressed younger adults self-managed their mood problems by using strategies such as: seeking social support from family or friends, exercising or internet use<sup>17,18,19</sup>. As most participants preferred to self-manage their mood and valued attending community groups or church, the current findings support Kennedy et al<sup>34</sup> who concluded that the self-management of physical health problems requires resources which extend beyond primary care settings. Participants in this study also suggested that GPs should direct distressed older adults to third sector services (e.g. community groups). Policy initiatives support the integration of services between primary care and the third sector<sup>16,35</sup>. In England, the NHS Long Term Plan<sup>35</sup> states that nearly one million people will qualify for referral to social prescribing schemes by 2023-24. The Royal College of General Practitioners<sup>36</sup> also recommended that general practices introduce social prescribing initiatives as research has indicated that such initiatives can reduce symptoms of depression and anxiety<sup>37</sup>. This study indicates that social prescribing could provide an efficacious intervention to support older people with distress, but this relies on presentation and discussion of symptoms in primary care consultations.

## Strengths And Limitations

To the best of our knowledge, this is the first study to explore how older adults understand and manage distress. The qualitative approach towards data generation and analysis was a key strength as it provided rich, in-depth descriptions of how participants managed their distress. Another strength of the study was the recruitment strategy: older adults may not seek help for their mood problems from healthcare services<sup>7,8</sup>, as participants were recruited from the third sector, this enabled us to reach older people who would not have presented their distress within primary care settings.

Although the sample was diverse in some respects (age, gender), all participants were White British. If the study had included older adults from different ethnic backgrounds this may have resulted in participants describing different understanding of distress and identifying other management strategies. The community groups this study recruited from charged attendees £2.50 per session: older people who could afford to attend these groups are perhaps more financially affluent than older adults who could not afford to attend. Whilst we attempted to recruit via snowball sampling, it was not fruitful and the final sample did not include any older adults who did not attend community groups. Individuals who attended community groups may have self-managed their mood somewhat differently than those who did not attend community groups.

## Conclusions

Older adults are more likely to conceptualise their mood problems as distress because the term represents a less stigmatising label in comparison to anxiety or depression. Experiences of distress may be associated with various forms of loss, particularly the loss of physical mobility caused by physical health problems. As all participants in this study reported taking some form of action once they had recognised that they were experiencing distress, this shows that older adults are active in wanting to improve their mood. Given that contributing factors to distress are experiences related to loss, it is important for primary care healthcare professionals to be mindful of these determinants of mental health. When older adults present within primary care, healthcare professionals could use this opportunity to discuss psychosocial factors which could cause distress, provide information about a range of management options (which may, or may not, include medication or a referral to ‘talking therapies’), and explore older adults’ preferences and views on different management options. If an older adult does not feel that medication or ‘talking therapies’ are acceptable, then healthcare professionals could explore how a distressed older adult may self-manage their mood and consider using social prescription by sign-posting older people to local third sector services.

## **Abbreviations**

GP- General Practitioner

PPIE- Patient and Public Involvement and Engagement

## **Declarations**

Ethical approval and consent to participate: Ethics approval was obtained from Keele University’s ethical review panel (ERP1279). All participants gave written consent to take part in the study.

Consent for Publication: Not applicable

Availability of data and material: The datasets generated and analysed during the current study are not publicly available due to ethical concerns, anonymised datasets are available from the corresponding author on a reasonable request.

Competing Interests: Professor Carolyn Chew-Graham is a Section Editor for BMC Family Practice.

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Author’s contributions: AM and CCG contributed to the design of the study. AM conducted the interviews and transcribed each interview. AM, TK and CCG made substantial contributions to the data analysis process and the writing of successive drafts of the manuscript. All authors have read and approved the final draft.

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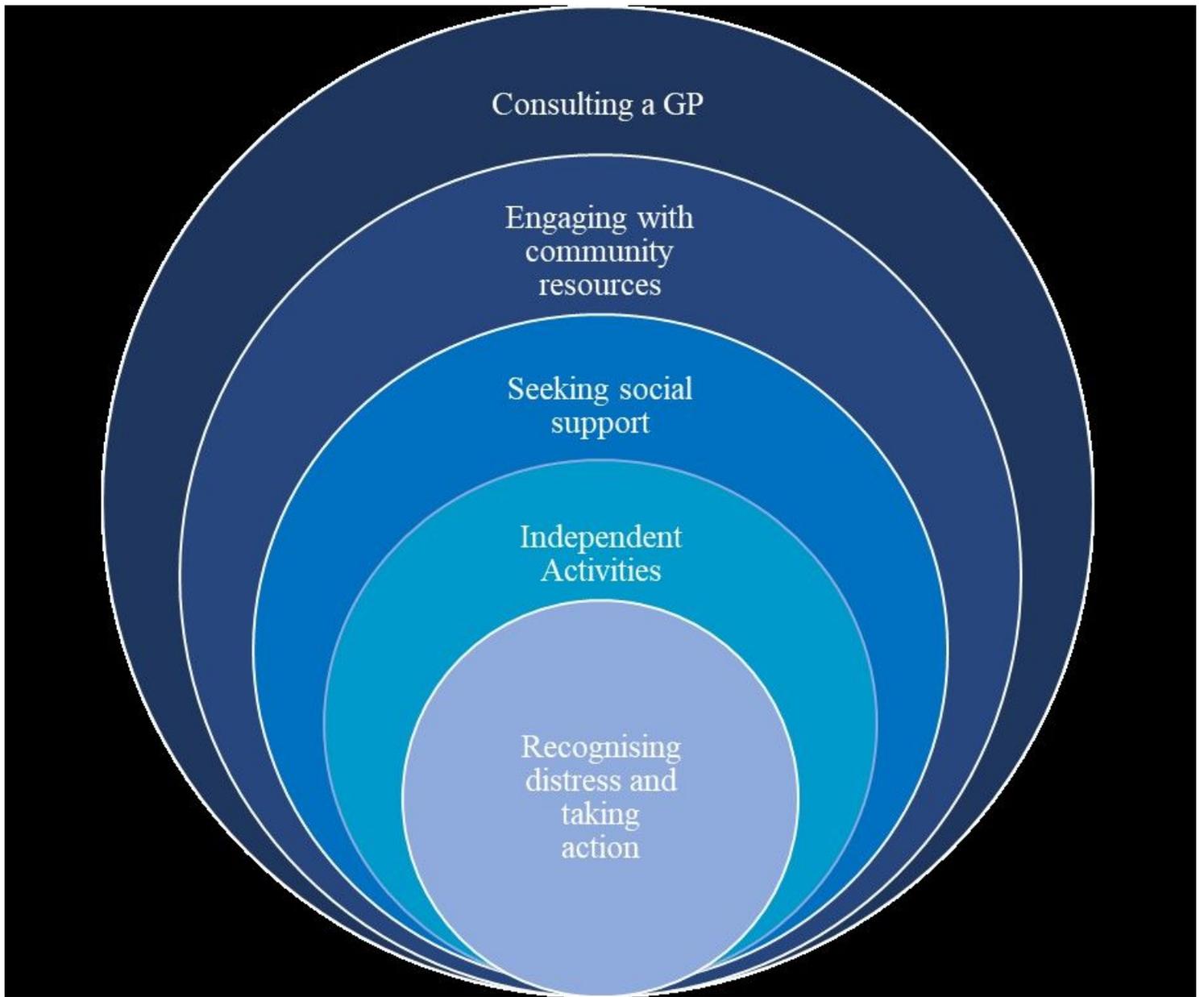
## Tables

Table 1 Participant demographic and health information

Pseudonym	Retired	Lives alone/ lives with	Self-reported physical health problems
Anne	Yes	Alone	Diabetes, osteoporosis, recovering from hip replacement
Barbara	Yes	Husband	Stroke
Carol	Yes	Alone	Breast cancer (in remission), recovering from hip replacement, broken wrist and rib, bladder problems
Diane	Yes	Alone	Recovering from hip replacement, actinic keratosis
Elizabeth	Yes	Alone	Arthritis, COPD, recovering from hip replacement
Frances	Yes	Husband	Arthritis, high blood pressure
Gill	Yes	Husband	Heart murmur, stroke
Helen	Yes	Husband	Sleep apnoea, benign brain tumour
Irene	No	Husband	None
Janet	Yes	Husband	Arthritis, COPD
Kathleen	Yes	Husband	Burst ear drum, awaiting small bowel resection
Leslie	Yes	Wife	Broken ankle, high cholesterol
Michael	Yes	Wife	Minor hearing loss, glaucoma
Nigel	Yes	Wife	Recovering from heart surgery
Owen	Yes	Wife	Diabetes, high cholesterol
Peter	Yes	Alone	None
Robert	No	Son and daughter-in-law	Arthritis, COPD, awaiting shoulder and spinal surgery
Stephen	Yes	Wife	COPD, recovering from heart operation

\*All ages reported at time of participation, participants self-reported receiving a label of a mental health problem from a General Practitioner (GP) within past 12 months, COPD - Chronic Obstructive Pulmonary Disease)

## Figures



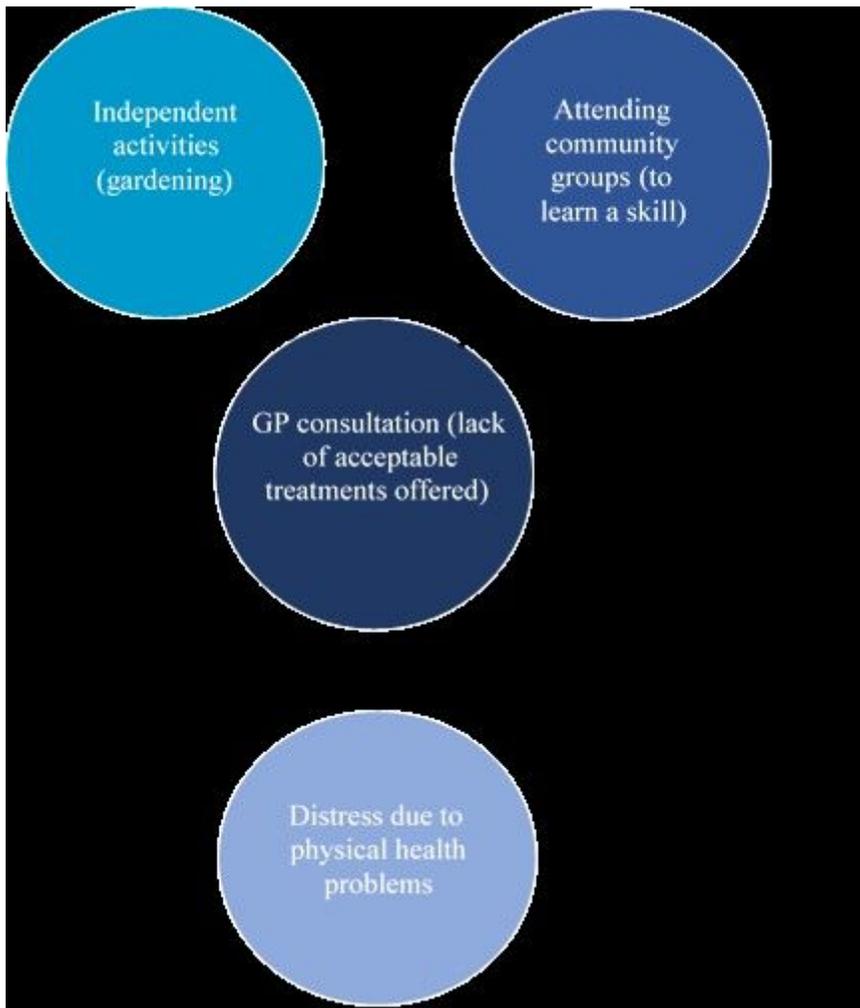
**Figure 1**

Self-management strategies



**Figure 2**

Anne's self-management strategies



**Figure 3**

Owen's self-management strategies