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Late Life Depressed Mood:
Crafting Meaning from Experience and Knowledge

By

Kristen Ann Gustavson

A dissertation in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

Social Welfare

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Andrew E. Scharlach, Chair

Professor Eileen Gambrill

Professor Lawrence Cohen

Professor Sharon Kaufman

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Abstract

Late Life Depressed Mood: Crafting Meaning from Experience and Knowledge

By

Kristen Ann Gustavson

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University of California, Berkeley

Professor Andrew E. Scharlach, Chair

This exploratory study elicited descriptions of the experience of depressed mood in later life as well as older adults' knowledge about depression. The researcher purposively recruited thirty-six participants age 75 and older, who participated in an in-depth, in-person interview. The research design and analysis were informed by a conceptual framework integrating Pearlin's Stress Process model and social learning theory.

Three major themes emerged from the data: the importance of context and life experience, the power of personal choice, and the disconnection between knowledge and personal experience. Study participants, in describing their experiences of depressed mood, reported the importance of the context in which their depressed mood developed. Further, they saw themselves in light of their whole life experience and conveyed the relevance of earlier significant life events to their late life depressive symptoms. Early life events shaped both how they saw the world and how they coped with stressful life events in later life. Study participants also described the power of their own attitudinal and behavioral choices to improve their mood, often choosing to do things by sheer force of will, even though they didn't feel like doing these things because of their depressive symptoms. Participants understood depression in terms of both social and biological explanatory models. However, though they understood that depression may be caused by biological factors, none of the participants attributed such causes to their own depressed mood, but instead, relied on social causes to explain their own experience. In other words, no one spoke about biological causes of their own depressive symptoms even though they knew about such possible causes when relaying their knowledge about depression. This finding has possible implications for the stress process theory, which suggests that knowledge influences the judgments we make about our own experience. However, these study findings suggest that the influence of external knowledge may not be as powerful an influence on the judgments and meanings older adults ascribe to their own experience of depressive symptoms as are the context and lived experience of the individual.

Practice and research implications of these findings include the need to explore across more diverse samples of older adults the choices older adults make related to improving their mood. Research exploring the knowledge older adults have about

depression and the explanatory models they use to describe their own experience is an important next step. Study participant's stress on the importance of context in understanding depressive symptoms in later life should cause clinicians to rethink their dependence on diagnostic and treatment tools that ignore the larger experience in which depressive symptoms arise for older adults.

Dedication

This work is dedicated first to my husband, Jan Erik, whose love, faith, and encouragement sustained me in many ways. He listened to endless dissertation minutia without nodding off and brought home dinner more times than I can count so that I could work and write. It is also dedicated to my darling sons, Lenny and Martin, who kept me grounded with dirty diapers that needed changing and trips to the park that could not be delayed. They made me laugh and yet stayed out of the office when I needed to work. It is dedicated to the older people who participated in this study. Without their honesty and commitment, this research would have been impossible. Finally, this dissertation is for my parents who read to me from a young age and instilled in me a love of learning that was allowed to flourish. They repeatedly told me that I could be anything I wanted to be; for that, I will be eternally grateful.

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Preface

After receiving my MSW degree in 2001, I spent some time working for Orange County Mental Health Services in the division of Older Adult Services. My experience working with older adults struggling with mental health issues was challenging, humbling, and inspiring. Though my experience in the two years I worked for Older Adult Services was varied, I often encountered a family member or other concerned person who would refer an older adult to our services with a comment like, "I think my mom is depressed," or "Would you please help my elderly neighbor, I think he is depressed." When I would follow-up on the referral with a scheduled visit to the home of the elder, I invariably heard the same refrain, "I'm not depressed!"

I wondered, why do people think that older adults are depressed, but the older adults themselves don't see themselves as depressed? What is it that older adults are experiencing that makes people think they are depressed? How do they describe and explain this experience? These practice-related questions were the reason for this study; I was simply a curious social worker seeking a deeper understanding of my clients. This study was motivated by a desire to answer these questions and, ultimately, to learn how to better serve and support older adults living with myriad moods and emotions in later life.

Acknowledgements

I have had the great pleasure of working with many mentors, colleagues, and friends throughout the dissertation process. My committee chair, Andrew Scharlach, has been a wonderful mentor and role model. He respected the goals of this research, and offered constructive suggestions to strengthen it. Despite his formidable workload, he remained accessible and friendly. He has shaped my academic work and thinking more than any other and it has been an immense privilege to work with him.

I am indebted to my other dissertation committee members for their thoughtful comments and reading of the many iterations of this manuscript. To Eileen Gambrill, I am grateful for her critical eye and for pushing me forward in my reading and learning. I appreciated Lawrence Cohen's anthropological perspective that challenged my thinking and the boundaries of this research. Sharon Kaufman met with me repeatedly to discuss methodological issues, themes emerging from the data, and she helped me strengthen my interpretations of the results of this work.

This research was supported by generous funding from the John A. Hartford Foundation's Geriatric Social Work Initiative, Hartford Doctoral Fellows Program. The funding, professional training, and mentorship provided by the John A. Hartford foundation have helped not only in the completion of this dissertation, but also in navigating the complex maze of academic life. I am grateful for the support of the Fahs Beck Fund for Research and Experimentation, which provided funds for the participant stipends and for transcription. I also appreciate the support of the START-MH training program in geriatric mental health, which supported preliminary data analysis of this research.

Again, I am grateful to my husband, Jan Erik, who read countless drafts of this, and of most of my academic work, and as the grammarian of the family improved my writing beyond measure.

Throughout my time at Berkeley, I have been fortunate to collaborate, learn from, and enjoy the company of a number of bright and inspiring professors, colleagues, and friends. These people have included Jim Midgley, Yu Wen Ying, Teresa dal Santo, Lorraine Midanik, Steve Segal, Michelle Johnson, Sarah Taylor, Nancy Giunta, Jill Messing, David Androff, Amy Benton, Joe Magruder, Kya Fawley-King, Lizzie Horevitz, Barrie Robinson, Jay Unick, Krista Drescher-Burke, Amanda Lehning, and Erica Auh.

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Chapter 1: Introduction

Depression in Late Life

Depression is an important social and public health problem among older adults in the United States. Indeed, the World Health Organization has projected that major depression will be the second highest cause of disability after heart disease in all countries by 2020 (Murray & Lopez, 1996). According to the Diagnostic and Statistical Manual for Mental Disorders, 4th Edition (DSM-IV); (American Psychiatric Association, 1994), a diagnosis of major depressive disorder (MDD) requires that five or more depressive symptoms be present, and those symptoms must persist for 2 or more weeks. Depressive symptoms include depressed mood, anhedonia (an inability to derive pleasure from pleasurable activities or events), significant change in weight or appetite, changes in sleep patterns, decreased concentration, decreased energy, inappropriate guilt or feelings of worthlessness, psychomotor agitation or retardation, and suicidal ideation. A diagnosis of MDD requires that either depressed mood or anhedonia be present.

Among older adults, non-major depression (i.e. depression that contains some but not all of the features of MDD described in the DSM-IV) is also an important problem that contributes to significant morbidity and disability. Studies have suggested that up to 14 percent of patients in primary care settings meet criteria for MDD (Leon, et al., 1995), whereas estimates of the prevalence of subsyndromal depression among older adults in the primary care setting range as high as four times that of major depression (Gallo & Lebowitz, 1999). Depression that does not meet standard criteria for MDD is of particular importance for older adults because rates of MDD decline with advancing age, while rates of depressive symptoms and suicide increase (Gallo & Lebowitz, 1999).

Non-major depression is likely to coexist with other medical problems in older adults (Stockton, Gonzales, Stern, & Epstein, 2004; Zung, Broadhead, & Roth, 1993). Thus, persons with depressive symptoms are more likely to seek care from their primary care provider than from specialty mental health providers including social workers (Pincus, Davis, & McQueen, 1999), yet older adults may not accept the diagnosis or treatment of depression, in part due to beliefs and explanatory models of illness that do not line up with the treatments most commonly offered by primary care physicians (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006).

Anthropology's focus on the importance of culture opens up different ways of theorizing the meaning and effect of depression in different patient populations. As anthropological research has shown, culture is an important determining factor in the experience and expression of psychiatric symptoms (Good, 1992; Kleniman, 1980; Kleinman & Good, 1985). Older adults in the United States represent both an age and cultural cohort with unique life experiences and sets of relationships, attitudes, and orientations toward mental health and health care services (Gallo & Lebowitz, 1999).

The qualitative paradigm, familiar to anthropologists, uses an inductive approach to uncover principles, theories, patterns, and trends over time in naturally occurring circumstances. As such, a qualitative approach facilitates a more central role for stakeholders in the assessment of their opinions, preferences, and perceptions about mental illness and its treatment (Hohmann, 2002). Classic qualitative research methods such as in-depth informant interviews can be used to elicit definitions and descriptions of

depression independent of professionally defined criteria (Bernard, 2002; Weller, 1998). Key to getting at the root of the difficulty in assessment and treatment of depression in older adults is not just an understanding of the experience of the illness but also an appreciation for what older adults conceive of as “depression” in the first place.

In summary, depression is an important issue for older adults. Although they seek care from their primary care providers for medical problems, they may not discuss depressive symptoms with their primary care providers, and they are even less likely to seek specialty mental health care (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006). When older adults do discuss depressive symptoms with their provider, they may be inclined to use social rather than biological explanatory models (Givens, et al., 2006). For these reasons, it is important to explore the subjective experiences of older persons regarding depressed mood. This type of qualitative exploration may help us understand late life depressed mood from the perspective of older adults as well as how best to help older adults manage their depressive symptoms.

Purpose of the study

The purpose of this study was twofold: 1) to understand the meaning and experience older adults ascribe to depressed mood in late life, and 2) to explore how older individuals define and conceptualize depression, its causes and its treatments. As subjects were asked to convey their knowledge and understanding of depression, its concepts, definitions, causes, and treatments, this study aims to link understanding about the nature and causes of depression and its treatment with the meaning and experience of depressed mood among older adults themselves.

This study contributes to the health and well being of older adults and their families by providing a means to understand the experience of depression and depressed mood in late life. In addition, this study details the knowledge and understanding older adults have about depression. Specifically, this investigation attempted to elicit, via in-depth interviews, information regarding older adults’ beliefs and perceptions in the following two domains:

1. Lived Experience of Depressed Mood
2. Knowledge of and about Depression in Later Life

Overview of Chapters

Chapter 2 reviews theories related to depression and includes a brief history of the understanding of depression and a disease construct and diagnosis. Chapter 2 reviews research related to the experience of depression, specifically in later life, and the knowledge about depression. Finally, the chapter concludes with the conceptual framework on which this study was based.

Chapter 3 focuses on the design on methodology of the study, including rationale for the study design, and a brief presentation of sample characteristics.

Chapter 4 summarizes the results and key findings of the current study and is organized along the components of the conceptual framework: antecedents, reactions, judgments, actions, and conceptual constructs. The first section addresses the context of depressed mood among study participants. The second section explores the lived experience of depressed mood and attempts to address the overarching research questions

related to this domain, including: “What is the lived experience of depressed mood in old age?” “What words do older adults use to describe their depressed mood?” The third section presents study findings related to the judgments and meanings study participants ascribe to their experience of depressed mood in later life. The fourth section displays the actions study participants take to cope with their depressed mood. Finally, the fifth section presents study participants’ knowledge of and about depression in later life. This section describes how study participants define and describe depression, what they state are the cause(s) of depression, and their knowledge of how depression is treated.

Chapter 5 relates the findings to the broader research literature described in Chapter 2. In addition, it discusses study limitations and presents implications for theory, practice, and research. Finally, the chapter presents study conclusions.

Chapter 2: Depression in the Elderly: Theoretical Constructs, Previous Studies and Conceptual Framework

It seems that everyone has periods when they feel sad or “blue.” Often times we hear people describe these feelings by saying they are “depressed.” The word depression takes on multiple meanings and nuances. What does it mean to be depressed? What is depression?

The purpose of this chapter, in part, is to explore and describe the concepts, theories, and constructs that will, together, provide the reader with a profile, a picture of depression, specifically of depression in late life. Controversies in the construct of depression, and psychopathology in general are explored. Varying causal theories of depression are also discussed. This chapter will address the current literature related to the experience of depressive symptoms and public knowledge about depression, its definitions, causes and treatments. Finally, the conceptual framework for the study is presented.

Definitions and Concepts

With all the varied uses of the word depression, it is important to explore the multiple perspectives on its meaning. We are all familiar with the everyday language of depression that is used to describe a range of experiences. It is not uncommon to hear the average passerby declare, “This weather is depressing,” or “I’ve gained weight. How depressing!”

There is a more serious side to depression as well. Depression has been described as “a universal, timeless, and ageless human affliction” (Hammen, 1997c). In fact, among those who first described the features of depression in clinical terms was the classic German scholar and father of modern pharmacology, Emil Kraepelin, who stated, “The patient’s heart is heavy... nothing gives him pleasure. He feels solitary, indescribably unhappy” (Kraepelin, 1921). We are all familiar with such statements. Even so, it seems that most individuals, at least in Western societies, are raised to expect to have considerable control over moods, and are exhorted not to let themselves suffer from depression. Thus, it can be frustrating to us when a loved one or friend does not “snap out” of depression.

Many theorists and clinicians have attempted to distinguish between the feelings of sadness everyone experiences and those of the more debilitating depression. Some make this distinction by seeing depression as more intense and lasting longer than just sadness or feeling blue. Clinicians see depression as significantly interfering with day-to-day functioning whereas feeling down does not result in such a marked impact (Lewinsohn, Munoz, Youngren, & Zeiss, 1978).

The conceptualizations are further complicated when we focus on how depression presents specifically in elderly persons. The concept of late life depression has been thoroughly debated, and a question remains: is depression a natural component of the aging process? Some practitioners see depression as a normal reaction to life conditions and losses that occur in the lives of older adults such as bereavement, retirement, reduced income, and declining health (George L. , 1993; Grossman, 2004; Kraaij, Arensman, & Spinhoven, 2002; Tice & Perkins, 1996). In fact, given the common stereotypes and misconceptions of old age, it is not surprising that depression and old age have become

synonymous to some (Kermis, 1986; Solomon, 2001). Though many older adults must contend with depression, it is often a good deal more than sadness. Physicians define depression as a clinical problem, a syndrome, a disorder made up of a set of symptoms that mean something serious is going on with the affected person (Billig, 1987; Butler, Lewis, & Sunderland, 1998).

Controversies in Conceptualizing Deviant Behavior

Many practitioners, researchers and clinicians have raised concerns about the means by which mental disorders, such as depression, are conceptualized, as well as the *very existence* of such disorders or psychopathologies in the first place. Thomas Szasz (1961) argued that the concept of mental illness is a myth and that “mental illness” is an expression or metaphor that describes the disturbing, deviant, shocking or vexing conduct, action or pattern of behavior, such as seen in schizophrenia, as an “illness” or “disease.” He believed that while people behave and think in ways that are very disturbing and that may resemble a disease process (e.g. pain, deterioration, or response to various interventions), this does not mean that they actually have a disease. To Szasz, disease can only mean something people “have” while behavior is what people “do.” He suggests that psychiatry actively obscures the difference between (mis)behavior and disease, and by called certain people “diseased” psychiatry attempts to deny them responsibility as moral agents in order to better control them (Szasz, 1961; 1987).

Many mental health agencies are founded on the concept that there are discrete “disorders” that are “mental.” There is little agreement among mental health experts that disorders can be easily or clearly separated from non-disorders. Critics of psychiatry were asking about the construct validity of “mental illness.” Even more divisive among scholars is the notion that the mental can be separated clearly from the physical, behavioral, social, or moral. The fundamental concepts of mental health and mental illness and how well they actually apply to those receiving help from therapists have been hotly contested for years (Kirk & Kutchins, 1992b; Leighton A. , 1959; Leighton, Harding, Macklin, Macmillan, & Leighton, 1963; Levitt, Lubin, & Brooks, 1983; Wakefield J. C., 1992a; Wakefield J. , 1992b; Conrad & Schneider, 1980).

Wakefield (1997) discounts the adequacy of existing definitions and concepts for understanding mental health issues. He asserts that predictive-validity criterion is not valid in determining disorder, nor do current classification systems (such as the Diagnostic and Statistical Manual of Mental Disorders (DSM)) provide the needed criteria to conclude disorder. He expands current understanding of mental health functioning with his *harmful dysfunction* analysis of the concept of disorder. The harmful dysfunction analysis holds that a disorder is a condition that is both harmful according to social values and caused by an internal dysfunction (Wakefield J. C., 1997). However, his analysis implies the importance for psychopathological theory of identifying normal development mechanisms and the many different functions those mechanisms are selected to perform. The nature and proper classification of a disorder such as depression depends on the mechanism that is malfunctioning and on the specific dysfunction affecting the mechanism. His harmful dysfunction analysis encourages us to better distinguish various pathways that lead to symptomatic outcomes. Only then, he suggests, can we identify those harmful outcomes that are due to dysfunctions and thus are disorders (Wakefield J. C., 1997). Applying

Wakefield's harmful dysfunction analysis to depression for example, one must first understand the normal, functional pathways and fluctuations of human emotions (including periodic sadness) in order to distinguish the more destructive or abnormal outcomes that result from disorder. This is no easy task.

However, Wakefield's theory of harmful dysfunction has been widely criticized. Lilienfeld and Marino (1995) dispute his theory by suggesting that Wakefield's concept neglects the fact that natural selection almost invariably results in substantial variability across individuals and that many consensual disorders represent evolutionary adaptive reactions to danger or loss. Further they suggest that mental disorder is characterized by fuzzy boundaries and that Wakefield's proposed theory only prolongs scientific debate of a fundamentally non-scientific issue (Lilienfeld & Marino, 1995). McNally (2001) takes issue with the dysfunction component of Wakefield's analysis due to its "hybrid" nature comprising both a factual assertion about the state of a mechanism and a normative assertion implying that the mechanism is not functioning as it ought to be (pg. 309).

Leighton & Murphy (1997) suggest the concept of *impairment-risk*, which they define as the danger that functional impairment carries for subsequent health adversities. They suggest that the mental health field remains largely and erroneously focused on specific details by which psychiatric syndromes can be identified, and neglects assessment of functioning in determining psychiatric impairment. They assert that current classification systems, such as the International Classification of Diseases (ICD) and the DSM, do a poor job providing detailed guidelines for rating distress and functioning. This omission makes it difficult for researchers and practitioners to distinguish between normality and pathology (Leighton & Murphy, 1997).

Further controversy lies in the subject of diagnosis. Since diagnosis guides decisions about treatment, diagnostic confusion can have profound consequences for both patient and practitioner. One need only look to recent legal cases in the popular media to view such diagnostic confusion. To some observers, recent legal cases relying on mental health professionals as expert witnesses suggest that such professionals are merely paid to say whatever will help their clients. In this light, testimony of mental health professionals is predictably divergent; their professional status as experts merely serves to cloak their paid performance in respectability. To other observers, mental health professionals are objective, scientific practitioners trying to bring their best professional judgment as competent experts to bear on difficult legal cases. Their sharply divergent opinions, therefore, must be due to the uncertain state of psychiatric knowledge or the uncertain art of psychiatric diagnosis (Faust & Ziskin, 1988). Neither of these two explanations would please the American Psychiatric Association (APA), which has spent the better part of three decades trying to remedy such diagnostic problems, or at least keep them from public view (Kirk & Kutchins, 1992b; Levitt, Lubin, & Brooks, 1983). Proponents of the APA and their Diagnostic and Statistical Manual of Mental Disorders (DSM) suggest that major DSM revisions (DSM-III & DSM-IV) have replaced psychoanalytic psychiatry with scientific psychiatry (Maxmen, 1985). Maxmen goes on to assert that this switch is profound in saying, "Psychoanalytic psychiatry bases truth on authority; something is true because Freud said so. Scientific psychiatry bases truth on scientific experimentation... The old psychiatry derives from theory, the new psychiatry from fact." (Maxmen, 1985, p. 21).

Critics such as Kirk & Kutchins (1992b) discount Maxmen's and the APA's claims on the new scientific authority of the DSM stating,

It is often a debater's trick to claim that one's position is accurate because it is factual, in contrast to that of one's opponent, who has invented justifications for his or her position. What was at stake was the fate of the psychiatric profession and the enormous, multibillion dollar mental health industry. DSM-III and 'the new psychiatry' that it reflected were important features in the effort made by a new generation of psychiatrists to gain control over the infrastructure of the psychiatric profession (p. 7-8).

The favored explanation of the APA regarding diagnostic confusion or errors was that any unreliability in the DSM was a result of error - errors in gathering information, errors in organizing information, errors in using information to reach decisions, errors prompted by ambiguities in nomenclature, and so forth. In other words, diagnostic error was due to the failure of clinicians to conform to the full agenda of technical rationality. These assumptions about the nature and sources of diagnostic error were fundamental to the entire strategy and rationale for developing the DSM-III, and for subsequent revisions, because they suggested that these errors could be remedied through technical solutions (Kirk & Kutchins, 1992a; 1992b; Kutchins & Kirk, 1986; 1997).

Even so, concern about clinical errors is well founded. Mental health practice, like other endeavors, is not immune to error. An incorrect diagnosis may be made, the wrong treatment may be employed, or the patient may be neglected. The clinician may be ignorant of readily available knowledge, possess unrefined skills, or have poor professional judgment. There is extensive literature on the myriad ways in which clinical perception, reasoning, and judgment may waver from the ideal of rationality (Gambrill E. , 2005; Kirk & Kutchins, 1992a; Levitt, Lubin, & Brooks, 1983; Nurius & Gibson, 1990; Kutchins & Kirk, 1997). Formulating a diagnosis is dependent on complex perceptual, cognitive, and interpersonal processes. These processes are easily distorted by the clinician's past personal experiences, expectations, emotions, and by illogical thinking, unfounded inferences, selective attention, stereotypes, and all sorts of other subtle biases.

Current diagnosis of depression is generally done based on observable symptoms and diagnostic categories. However, recent research points to serious problems regarding the reliance on diagnostic categories suggesting that a classification system of depression based on an assessment of manifest symptoms alone is flawed (Blatt, 2004; Parker, 2000; Westen, Novotny, & Thompson-Brenner, 2004). Increasing evidence suggests that factors such as personality (Blatt & Zuroff, 2005; Clark & Beck, 1999; Kendler, Kuhn, & Prescott, 2004; Parker, 2005), and early (Claes, 2003; Gilmer & McKinney, 2003; Gold & Chrousos, 2002; Gutman & Nemeroff, 2003; Heim, Plotsky, & Nemeroff, 2005) as well as current (Hammen, 2005; Kendler, Kuhn, & Prescott, 2004; Kessler, 2003) life stress is associated with a different etiology, pathogenesis, clinical presentation, course, and treatment response (Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006). Thus attempts to diagnose depression based on manifest symptoms alone have led to categories that are often heterogeneous and therefore impede research efforts and limit the clinical utility of DSM and other categorical diagnostic tools (Blatt & Zuroff, 2005).

In addition, research suggests that many mental health disorders share causal and developmental factors (Kessler, Merikangas, Berglund, Eaton, Koretz, & Walters, 2003; Ormel, Oldehinkel, & Brilman, 2001; Weissman, et al., 1999a; Weissman, et al., 1999b), leading to an artificial separation between research on the etiology of depression and other disorders. This argument is especially salient for older adults who often have multiple health complaints or diseases in addition to their presenting depressive symptoms. It has been suggested that future research should therefore aim at developing a system of diagnosis that extends beyond manifest symptoms and takes into account potential causal and developmental factors (Blatt & Zuroff, 2005; Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006).

Epidemiology

History of General Psychiatric Epidemiology

Studies in psychiatric epidemiology following World War II no longer focused on the prevalence of people under treatment for mental illnesses, but instead on identifying and tabulating cases of mental illness in geographically defined populations, independent of whether these individuals were known to any care-giving agency or practitioner (Leighton A. , 1959; Leighton & Murphy, 1997; Leighton, Harding, Macklin, Macmillan, & Leighton, 1963; Strole, Langner, Michael, Opler, & Rennie, 1962). This shift in focus came primarily from two sources. The first consisted in professional, governmental, and civic concern about the unexpectedly large numbers of men rejected from the armed forces because of mental disorders (Brill & Beebe, 1955). This experience raised questions about the mental health of the population from which such men had come and whether health policies and services should be reevaluated.

The second source of this shift came from increasing need for scientific investigation of etiology in mental disorders, especially with regard to the nature of genetic contributions, psychological experiences, and cultural and socioeconomic influences (Leighton & Murphy, 1997). As a consequence of this change in focus, psychiatric epidemiologists were confronted with the task of determining, in general populations, who is and who is not a case of psychiatric disorder. This brought to light the fact that neither the diagnostic methods of psychiatry nor the theories governing them were adequate for the task (Leighton & Murphy, 1997; Leighton, Harding, Macklin, Macmillan, & Leighton, 1963).

In the decades since World War II, much has been accomplished toward standardizing diagnostic methods and toward providing psychiatry with a system of classification as exemplified in the contemporary revisions of the DSM and ICD (American Psychiatric Association, 1994; World Health Organization, 1992). However, some suggest that despite these accomplishments, especially in light of the current swing from extremes of preoccupation with psychodynamic theory to equally exclusive concern with biologic etiology, there remains the need for reexamination of the conceptualizations that govern the operations of systemic diagnosis and thereby affect psychiatric epidemiology (Leighton & Murphy, 1997).

Description

One must proceed with caution in the discussion of the prevalence and distribution of depression, as the above sections indicate that there are many ways to conceptualize and

define mental illness in general and depression specifically. This dilemma carries itself into the epidemiological discussion since researchers and policy makers vary on the criteria they use to define depression, which directly affects their stated prevalence rates. Though the strategy of grouping individuals into classes for comparison is essential to the scientific method, these groupings vary from discipline to discipline. Further, the screening tools used to capture these varying groupings and classifications vary from discipline to discipline and researcher to researcher. Some of the goals of epidemiological studies of depression are to identify cases, ascertain distribution, uncover historic trends, identify causes, and suggest prognosis (Blazer D. , 2002a). However, the tools used to reach these goals differ widely from study to study, and which the following sections will discuss.

Identification of Cases

Grouping individuals into classes for comparison is essential to the scientific method. Criteria are used to group persons according to similarity of symptoms, signs or physiologic changes. These groupings can be made a priori (deductive) or a posteriori (empirical). The diagnostic system of the DSM (American Psychiatric Association, 1994) is an example of an a priori grouping of symptoms, what some might consider a consensus of clinical opinion about the core criteria of psychiatric disorders. A posteriori case identification has also been applied to the study of depressive symptoms in older adults. Blazer and colleagues (1986) reviewed subjects who were hospitalized with the diagnosis of major depression with melancholia, and found that symptoms did not differ across age groups.

Causal criteria are also used to group individuals according to a specified experience believed to be the cause of the disorder (MacMahon & Pugh, 1970). An example of causal criteria is the cluster of symptoms that follow a catastrophe and constitute bereavement. Persons classified by one set of criteria may be distributed differently if other criteria are used.

When posing the question: "What is a case?" Some have also wondered, "A case for what?" (Copeland, 1981). Copeland suggests that the concept of the case exists only in the mind of the investigator and is not a "reality." He notes that case identification can therefore be accomplished by methods other than diagnosis. In reality, diagnosed "cases" of major depression are not isolated from cognitive impairment, anxiety, and disruptions in the support networks of depressed individuals (Copeland, 1981). Alternative approaches to case identification, other than specific diagnoses, have been used in psychiatric epidemiological studies.

The most frequently used approach to case identification in epidemiologic studies is not the use of diagnostic criteria (because criteria are difficult to assign, especially in community populations) but rather exceeding a *threshold of frequency* of depressive symptoms (Berkman, Berkman, Kasl, Freeman, & Leo, 1986; Murrell, Himmelfarb, & Wright, 1983). Yet another approach to case identification, often used in the study of psychiatric disorders in late life, is *mental health functioning* (Blazer D. , 2002a). The scientific study of late life depression depends on reliable and valid case identification. Prevalence and incidence studies, discussed next, are especially dependent on accurate case identification.

Sources of Data and Measurement

Three sources of data have traditionally been used to study the distribution of late life depressive disorders: psychiatric case registries, clinical population surveys, and general population surveys (Blazer D. , 2002a; Butler, Lewis, & Sunderland, 1998). Each source has limitations and advantages for determining the distribution of depression in the elderly. For example, case registries only reveal information on people with diagnosed mental disorders, and therefore are unable to contribute to understanding the rates of depression in those who never receive a diagnosis or who never seek treatment. Similarly, surveys of institutions or clinical populations only address those who have sought treatment or who have been formally diagnosed with a depressive disorder. To avoid these limitations, many epidemiologists rely on population surveys and have used symptom screens to evaluate the impact of symptoms of community residents rather than using diagnostic criteria for depressive disorders. One major limitation of this tactic is that the presence of specific psychiatric disorders often cannot be identified or confirmed.

Most psychiatric epidemiologic surveys have used symptom screens to evaluate the burden of symptoms in community residents rather than using diagnostic criteria for specific psychiatric disorders. Symptom screens, usually in the form of checklists, are easily administered by nonprofessionals to community residents and are nonthreatening to persons being interviewed. Unfortunately, most screening tools cannot identify cases of specific psychiatric disorders (Gotlib, Lewinsohn, & Seeley, 1995; Gilbody, House, & Sheldon, 2005). In other words, most epidemiological tools may sacrifice validity for reliability.

However, Christenfeld, Lubin, & Satin (1978a) found that each of 3 depression scales (the Beck Depression Inventory (BDI), the Zung Self-Rating Depression Scale, and the Depression Adjective Checklist (DACL)) successfully distinguished between levels of depressed mood as determined through psychiatric interview. However, this research has been called into question and opposing viewpoints put forth (Gruenberg, 1978). Dr. Gruenberg asserts that his colleagues' conclusions are not only overstated but false. He asserts that the DACL, like other screening tools, is prone to *false positives* and *false negatives*. For example, use of the DACL produced high scores of 10 or more for 37 participants, whereas two research psychiatrists only rated 4 of these participants as having a depressive disorder. These psychiatrists found another 3 individuals as having a depressive disorder, which use of the DACL did not confirm (Gruenberg, 1978).

In response to Dr. Gruenberg's criticisms, Dr. Christenfeld and associates stand by the rigor of their research stating that "a psychiatric interview gains flexibility and insight at the cost of introducing the vagaries of interpretation and interpersonal dynamics" (Christenfeld, Lubin, & Satin, 1978b, p. 1437). In other words, they blame any imperfect correlations, not on the screening tools, but on biases of the psychiatrists involved in the study. Even so, they continue to assert that all of the instruments used, as well as the psychiatric ratings, help to clarify the concept of depressed mood. Further, these researchers highlight the purpose of their study: to develop a depressed mood scale that could be used epidemiologically to describe patterns in populations, not individuals, making the problem of individual miscalculations irrelevant (Christenfeld, Lubin, & Satin, 1978b). They suggest that the DACL, like other symptom screening tools, is a research instrument and not a clinical one. This is an ironic line of defense since the purpose of

employing such research tools is to better understand the clinical concept of depressed mood.

The Hamilton Rating Scale, the gold standard for the assessment of depression for the past forty years has been coming under increasing criticism. In 2004 researchers reviewed studies published since the last major review of the instrument in 1979 that explicitly examined the psychometric properties of the Hamilton Depression Scale. Seventy studies were selected and results indicate that though the Hamilton's internal reliability is adequate, many scale items are poor contributors to the measurement of depression severity; others had poor interrater and retest reliability. Content validity was also poor. This evidence suggests that the Hamilton depression scale is psychometrically and conceptually flawed. The authors go so far as to suggest that the problems are too big to be fixed and that it is time to embrace a new standard for the assessment of depression (Bagby, Ryder, Schuller, & Marshall, 2004).

In an attempt to avoid the problems associated with using symptom screens, some population surveys have used clinicians for case identification. The cost of fielding a survey with trained mental health personnel to screen enough persons within the community for reliable prevalence of major psychiatric disorders, such as depression, is usually economically unfeasible. Even when such surveys are feasible, the reliability of psychiatric diagnosis may be poor.

To facilitate improved reliability of clinical interviews for depression and dementia among the elderly in the community, the Geriatric Mental State (GMS) was constructed (Copeland, Kelleher, & Kellet, 1976). The GMS requires clinicians to administer the exam. A similar tool is the Structured Clinical Interview for DSM Diagnoses (SCID; (Spitzer, Williams, & Gibon, 1992). Spitzer and colleagues suggest the SCID is more structured than the GMS.

The Diagnostic Interview Schedule (DIS) was designed for use by lay interviewers, and is intended to identify cases of specific psychiatric disorders as defined by DSM-III (and its successors) nomenclature (Robins, Helzer, Croughan, & Ratkloff, 1981). Similarly, the Schedule for Affective Disorders and Schizophrenia (SADS) was also developed as an interview-based measure of depression (Endicott & Spitzer, 1978).

There is a related body of research examining the concordance of a symptom-based assessment of depression, such as the Beck Depression Inventory (BDI) or the Center for Epidemiologic Studies Depression Scale (CES-D), and diagnosis-based assessments of depression, generally using such interviewer-based measures of depression as the SADS or the DIS (Endicott & Spitzer, 1978; Robins, Helzer, Croughan, & Ratkloff, 1981). Much of this research has been conducted with the goal of assessing the ability of symptom inventories to identify individuals who meet psychiatric diagnostic criteria for major depressive disorder. In these studies, an interview-based psychiatric diagnosis of depression is typically used as the standard; individuals are considered to represent cases of depression only if they meet explicit interview-based criteria. To evaluate the ability of self-report symptom measures to detect cases of depression, investigators have examined the specificity and sensitivity of the measures. Sensitivity refers to the capability of an instrument to accurately identify cases (i.e. true positives) as determined by an independent and acceptably valid criterion (typically a diagnosis derived from a reliable

structured psychiatric interview). Specificity refers to the capability of the instrument to accurately identify noncases (i.e. true negatives) by the same criterion.

One elderly-specific screening tool, The Geriatric Depression Scale (GDS), has been found to have sensitivity and specificity ranging from 79%-100% and 67%-80%, respectively (Watson & Pignone, 2003). Investigators have found the sensitivity of the CES-D to range from 70% (Radloff, 1977) to 99% (Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977) and its specificity to range from 56% (Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977) to 94% (Boyd, Weissman, Thompson, & Myers, 1982). Research on the BDI is consistent in suggesting that the instrument is relatively sensitive (84%) but only moderately specific (61%) to a diagnosis of depression. In other words, significant proportions of high BDI scorers do not have a diagnosable depressive disorder (Kendall, Hollon, Beck, Hammen, & Ingram, 1987; Oliver & Simmons, 1984; Rudd & Hasan Rajab, 1995).

From these data, it appears that the GDS, BDI, and CES-D scales may be reasonably successful in detecting diagnosable depression. Attesting to this success, a number of investigators have advocated the use of symptom-based self-report measures of depressive symptomatology, such as the CES-D, as a first-stage screening measure for diagnosable depression in community samples (Lewinsohn & Teri, 1982; Shrout & Fleiss, 1981). By this procedure, only individuals who obtain high scores on the CES-D (typically 16 and above; (Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977) are administered a subsequent structured psychiatric interview to determine diagnostic status (Gotlib, Lewinsohn, & Seeley, 1995).

It is clear from this work that the critical referent is a psychiatric diagnosis of depression. Indeed, individuals who obtain high scores on self-report measures of depression but who do not meet psychiatric diagnostic criteria are labeled as “false positive” and discarded as noise in these investigations or examined to determine why they do not meet diagnostic criteria (Boyd, Weissman, Thompson, & Myers, 1982; Breslau, 1985). An explicit objective of most of these studies, in fact, is to reduce the number of false positives because they are regarded as less clinically important than the true-positive participants (Gotlib, Lewinsohn, & Seeley, 1995). An implicit assumption of this work is that individuals who both obtain high scores on self-report measures of depressive symptoms and meet interviewer-rated psychiatric diagnostic criteria (true positives) differ in important ways from individuals who obtain similarly high scores on self-report measures of depressive symptoms but do not meet interviewer-rated criteria for a diagnosis of depression (false positives), which may or may not be an accurate assumption. In fact research suggests that false-positive study participants do not differ significantly from true-positive participants on most measures of psychological dysfunction, meaning that being “false positive” may not be a benign condition (Gotlib, Lewinsohn, & Seeley, 1995; Kessler, Merikangas, Berglund, Eaton, Koretz, & Walters, 2003)

It is important to note that the number of false-positive participants in these investigations is typically very large (65 – 90 % of participants) (Gotlib, Lewinsohn, & Seeley, 1995; Kendall, Hollon, Beck, Hammen, & Ingram, 1987; Oliver & Simmons, 1984). Given that a higher proportion of the population is characterized by elevated depressive symptomatology than meets formal psychiatric diagnostic criteria for depression, it is apparent that only a subset of those individuals who obtain scores above the cutoff on the

CES-D (generally 16 or higher) will meet diagnostic criteria for depressive disorder on clinical interview. For example Boyd, et al. (1982) found that only one third of a large community sample who obtained high scores on the CES-D received a psychiatric diagnosis of depression. Similarly, Breslau (1985) found that only 18% of high scorers on the CES-D met clinician-rated diagnostic criteria for depressive disorder. A similar rate was found for high scorers on the BDI (17%) (Gotlib, Lewinsohn, & Seeley, 1995). Finally, Roberts, et al. (1991) found that only 10.3% of respondents who obtained high scores on the CES-D were diagnosed as depressed on interview. Although all of these rates are superior to the population base rate for clinical depression of between 2% and 4%, it is clear that the use of these types of symptom screening measures yields many false positives. These individuals are typically eliminated from further consideration in clinical investigations; indeed, given that they do not meet full diagnostic criteria, in clinical practice these individuals would likely not be considered cases of depression.

Gotlib et al. (1995) attempted to identify psychosocial and clinical characteristics that would differentiate those persons who both scored high on a self-report measure of depressive symptomatology and met the DSM-III diagnostic criteria for major depressive disorder (true positives) from those who scored high on the symptom measure but did not meet diagnostic criteria for clinical depression (false positives). They also contrasted the group of false positives with a group of true-negative participants (i.e. low symptom self-report and no diagnosis of major depressive disorder) with respect to a broad range of psychosocial characteristics to determine how false-positive participants differ from asymptomatic participants. They found that although the false-positive participants manifested higher levels of current and future psychopathology than did the true-negative participants, they did not differ significantly from the true-positive participants on most of the measures of psychosocial dysfunction. They conclude that “false positive,” therefore, is a problematic condition (Gotlib, Lewinsohn, & Seeley, 1995).

This problem of what to do with false-positive participants is an important one as the exclusion or inclusion of false-positives influences estimates of distribution. In addition, this problem of false-positives confuses a discussion of the signs and symptoms of depression. Specifically, how is the threshold of symptoms decided, and by whom? When does one cross the line from merely exhibiting signs and symptoms of depression to suffering from a major depressive syndrome? If indeed false positive is not a benign condition, then are established clinical diagnostic criteria accurate for understanding the problem of depression? Clearly this and other problems of measurement should lend further temperance to the following discussion of distribution and the signs and symptoms of depression.

Distribution

Community surveys are the only direct means for estimating prevalence, assuming that it is possible to accurately identify and measure cases. However, most community surveys fail to accurately sample persons with psychiatric disorders who intermittently reside in institutions and the more impaired elders in the community who may refuse to participate in the survey. Accurate assessment of prevalence is possible only when community and institutional residents have been surveyed simultaneously (Blazer D. , 2002a). However, as mentioned before, the lack of a standard method of case identification makes comparisons across epidemiological studies difficult. Narrow and colleagues (2002)

have criticized the accuracy of high prevalence estimates of mental illness in general stating that screening tools assume clinical significance of symptoms that is not warranted. In other words, high prevalence estimates showcase the oversensitivity of survey tools rather than true identification of cases on which such estimates are based. By using a clinical significance criterion, they lowered lifetime prevalence estimate rates by up to 32%, resulting in a revised lifetime estimate for any disorder of 18.5% (Narrow, Rae, Robins, & Regier, 2002).

Even so, a review of several epidemiological studies by Blazer estimates the prevalence of significant depressive symptoms among older adults at around 15% with a range from 10% to 31% (Berkman, Berkman, Kasl, Freeman, & Leo, 1986; Blazer D. , 2002a; Gurland, Dean, Cross, & Golden, 1980; Hendrie, et al., 1995; Kennedy, Kelman, & Thomas, 1990; Klerman, et al., 1985; Murrell, Himmelfarb, & Wright, 1983). Prevalence of major depression or more serious and persistent depressive symptoms among older adults seems to be somewhat lower, between 1% and 5%. Most study subjects suffering from depressive symptoms in the community do not meet the criteria for either major depression or dysthymia as defined by the DSM-IV (Blazer D. , 2002a; Grossman, 2004). Expanding on the notion of prevalence, one research review noted that older adults report as many depressive symptoms as do younger adults, but that older adults are less likely to be treated and to seek treatment for depressive conditions (Burke, Burke, Regier, & Rae, 1990; George L. , 1993; Grossman, 2004; Harman, Crystal, Walkup, & Olfson, 2003). Paradoxically, in this country older adults consume a grossly disproportionate amount of antidepressants: approximately one out of every three antidepressants despite continuing to be perceived by clinicians as under-diagnosed and under-treated for depression (Grossman, 2004; Higgins, 1994; Whooley, Stone, & Soghikian, 2000).

These above discrepancies across studies over the last twenty years regarding the rates of depression in the elderly are perplexing and have been widely critiqued. They may in part be explained by the higher rates of atypical symptoms in the elderly, which will be discussed in the next section (Baldwin, 1994; Butler, Lewis, & Sunderland, 1998; Grossman, 2004; Ruegg, Zisook, & Swerdlow, 1988).

Symptoms and Signs

Since there is no clear definition of depression, many clinicians across multiple disciplines focus instead on the signs and symptoms of depression as perceived by the individual or their family and friends who notice marked changes in behavior, mood, affect, or cognition. But what are these symptoms and signs that might indicate an underlying depressive disorder? Further, what are the symptoms and signs in the older adult that imply a problem with depression?

Symptoms of a depressive disorder are changes in physical, psychological, or social functioning *subjectively* reported by the patient that might be indicative of a depressive problem. Signs of depressive disorders, on the other hand, are *objective* indications that depression is present. Signs can be observed by the individual, or by other people in the environment, like family or friends (Beck, 1967; Billig, 1987; Blazer D. , 2002a). It is crucial to examine signs and symptoms of depression among the elderly, as many older adults often deny being depressed, or at least they don't use the word to describe their condition. Depression is not just ill-defined, but may not be a word that the current generation of elderly feel comfortable using (Billig, 1987). As a result, elderly people may complain of

symptoms or their friends may observe signs that could indicate an underlying depressive disorder.

Researchers and clinicians generally agree on the *core* symptoms and signs of depression at all stages of the life cycle, which provided much of the rationale for the development and use of current symptom-based diagnostic systems (e.g. DSM-IV) (Billig, 1987; Blazer D. , 2002a; Butler, Lewis, & Sunderland, 1998; Hammen, 1997c). Beck found a remarkable consistency in the description of depressive disorders by clinicians and investigators from the earliest writings of depression (Beck, 1967). Beck further categorized depressive symptoms into emotional, cognitive, physical, and volitional symptoms. Core symptoms and signs of depression include low mood, sadness, self-criticism, poor attitudes about the future, self-blame, motor retardation or agitation, slow thinking, and difficulty concentrating. Core somatic symptoms include appetite and sleep disturbances (Beck, 1967; Blazer D. , 2002a). Some signs and symptoms of depression are universal regardless of age, such as the core symptoms and signs above. However, there seem to be other indications peculiar to the depressed elderly (Billig, 1987; Blazer D. , 2002a; Butler, Lewis, & Sunderland, 1998).

The most common symptom described by depressed persons is dysphoria or sadness. However, dysphoria is not thought to be as common in the elderly as in younger persons (Alexopoulos, Young, Meyers, Abrams, & Shamoian, 1988; Blazer D. , 2002a; Blazer, Bahar, & Hughes, 1986; Gallo, Anthony, & Muthen, 1994; Salzman & Shader, 1978a).

Decreased life satisfaction is another common emotional symptom among depressed individuals of any age. In fact, Beck found that 92% of severely depressed patients reported a loss of life satisfaction (Beck, 1967). Though this symptom is not pervasive in late life, it is common and often associated with such factors as widowhood, retirement, or declining health. Therefore, especially in consideration of the life events faced by older persons, decreased life satisfaction is a normal response to adverse experiences and social losses or changes, not a symptom of a mood disorder (Blazer D. , 2002a; Cole & Dendukuri, 2003; Kraaij, Arensman, & Spinhoven, 2002; Thoame, 1980).

Low self-esteem is thought to be less common among elderly persons with depression. It is possible that a negative outlook about the future replaces this symptom. Statements such as “I will be gone in a couple of months,” or “I don’t have anything to look forward to,” are commonly stated by depressed older clients (Blazer D. , 2002a; Lewinsohn, Munoz, Youngren, & Zeiss, 1978; Salzman & Shader, 1978a; Thoame, 1980).

Regardless of age, the most common somatic symptoms of depressed individuals appear to be sleep problems (36%), fatigue (34%), dizziness (29%), appetite changes (21%), and gastrointestinal problems (20%) (Berry, Steorand, & Coyne, 1984; Blazer D. , 2002a; Casper, Redmond, Katz, Schaffer, Davis, & al, 1985; Zemore & Eames, 1979). Some clinicians suggest that older adults become preoccupied with their physical symptoms, and that these complaints tend to disguise depression (Billig, 1987; Cole & Dendukuri, 2003; Hammen, 1997e; Solomon, 2001).

Although cognitive disturbances occur among depressed individuals in general, older people tend to specifically manifest thinking disturbances with memory failure or difficulty, or problems concentrating (Billig, 1987). These thinking disturbances are often termed “pseudo-dementia” or the “dementia of depression” when they accompany other signs and symptoms of depression in the elderly (Billig, 1987). Elderly persons with a

dementia of depression often have a more rapid onset of the memory impairment and are more consistently depressed than older persons with a true organic brain dementia (Baldwin, 1994; Billig, 1987; Blazer D. , 2002a; Blazer, Bahar, & Hughes, 1986; Ruegg, Zisook, & Swerdlow, 1988; Solomon, 2001).

The signs and symptoms of depression discussed above are useful, but imperfect attempts to describe those who suffer from depression. Even so, one person with depression is not necessarily like another. Each may present with very different signs and symptoms. This wide variability in signs and symptoms adds further confusion to the questions: "What is depression?" and "Who are the depressed elderly?" In addition, each clinical and research discipline contains its own theories and concepts for how to organize and understand depression. The disciplinary constructs will be discussed in the following section.

Theories of Late Life Depression

Any review of theories of depression must be tempered with the understanding that the same controversies of definition and concept, the same struggles with clinical syndrome versus depressive symptomatology, the same arguments against pathologizing the human experience of sadness are present in such a discussion. The previous sections of this chapter have striven to delineate the complexities of the problem of depression. It may be suggested that any discussion on the origins of depression takes place on shifting sand, at best. Therefore, let us proceed with caution.

Biomedical Theories and Concepts

There are several components of depression that suggest that biological features may play an important role. First, it is well known that depression runs in families (Butler, Lewis, & Sunderland, 1998; Hammen, 1997b). Second, the symptoms themselves include biological changes such as disruption of sleep schedules, appetite changes, psychomotor changes, and the complaints of fatigue and lack of energy (Blazer D. , 2002a; Hammen, 1997a; 1997b). Finally, it is also known that particular types of illnesses and head injuries may lead to depression (Blazer D. , 2002a; Hammen, 1997a; 1997b). These above considerations all support the importance of discussing the possible biological theories of depression.

Environmental as well as genetic factors are thought to contribute to depressive symptoms among older adults. In one twin study, genetic influences were found to account for 16% of the variance in depression scores (Gatz, Pedersen, Plomin, Nesselroade, & McClearn, 1992). Further, genetic factors appeared to matter more for twins over the age of 60 than for younger twins (Gatz, Pedersen, Plomin, Nesselroade, & McClearn, 1992). As one might imagine, the strongest evidence for heredity contributing to the etiology of depression in the elderly comes from family and twin studies (Slater & Cowie, 1971; Winokur, Coryell, Keller, Endicott, & Leon, 1995). According to one twin study, if one identical twin develops a mental disorder, the risk is 68% for the other and 23% for non-identical twins (Price, 1972). These findings are interesting but one would expect the frequency of depression in twins or other relatives to be lower when the onset of the depression is in late life since genetic determination should exert its influence before later life with environmental factors becoming more important as a person ages (Blazer D. , 2002a).

Some evidence suggests that another biological origin of depression could be found in the association between decreased cerebral blood flow and metabolic activity with depressive episodes (Joyce, 1991). Since a decrease in metabolism is associated with normal aging, it is possible that older adults are more susceptible to depressive disorders (Blazer D. , 2002a). Boosted by new tools of inquiry, especially magnetic resonance imaging (MRI), investigators have proposed a vascular-based depression among the elderly (Kumar, et al., 2002; Olin, et al., 2002). Vascular depression is linked with white-matter hyperintensities (WMH) bright regions seen in the brain on MRI scans that are thought to represent injury to white-matter tracks and may contribute to the disruption of neural circuits associated with depression (Taylor, et al., 2003).

There has been longstanding interest in the potential role of neurotransmitters (especially serotonin, norepinephrine, and dopamine) in depression and other mood disorders. Neurotransmitters are the “chemical messengers” by which neurons communicate and link the regions and functions of brain. These above neurotransmitters were known to be important in limbic system functioning, areas of the brain that play a major role in the regulation of emotion (Schildkraut, 1965). Attention has been directed to the role of serotonin in the development of depressive disorders. A number of researchers have found reduced levels of a metabolite of serotonin in depressed individuals (Post, Ballinger, & Goodwin, 1984; Sheline, Mintun, Moerlein, & Snyder, 2002). Serotonin levels have also been found to be low in autopsy studies of suicide victims (Pare, Young, Price, & Stacey, 1969).

It follows, then, that drug treatments targeting serotonin, the selective serotonin reuptake inhibitors (SSRIs), which presumably correct this chemical imbalance, are the appropriate response to depressive disorders. Many antidepressant drugs have been developed, which have immediate effects in increasing neurotransmitters. Unfortunately, across the board, these drugs do not immediately alter mood; it typically takes several weeks for the depression to diminish (Blazer D. , 2002a; Hammen, 1997a). Due to this delayed medication effect, it seems that the neurotransmitter theory of depression is flawed at best. In addition, these are the same drugs that are often used to treat anxiety (and there is a strong connection between anxiety and depression) undergirding the confusion over what these drugs actually do (Antonuccio, Burns, & Danton, 2002; Kirsch & Antonuccio, 2002).

A fundamental problem with the neurotransmitter theory of depression is that they hypothesized deficiencies of serotonin or other brain chemicals may be the consequences, rather than the causes of depression. No evidence thus far has demonstrated that chemical imbalances actually precede and cause depressive disorders (Lacasse & Leo, 2005). Instead, depression itself could be responsible for the inferred deficiencies that exist in patients with depression. Further research showed that flooding the brains of depressed veterans with massive increases in serotonin had no effects on their moods, which is sharply inconsistent and actually refutes the theory that depression results from a brain serotonin deficiency (Mendels, Stennett, Burns, & Frazer, 1975).

Another serious conceptual problem with the neurochemical deficiency hypothesis is that no adequate contextually grounded standard exists for normal versus disordered levels of serotonin or other amines (Horwitz & Wakefield, 2005). High or low levels of any neurochemical are not abnormal in themselves, but only in relation to a particular set of

circumstances and to the way the brain is biologically designed to respond to these kinds of circumstances. For example, primate studies show that serotonin levels vary substantially as a function of social situations: gains and losses of social status are associated with rising and falling levels of serotonin, respectively (McGuire, Raleigh, & Johnson, 1983; Raleigh, McGuire, Brammer, & Yuwiler, 1984). In these studies, extreme levels of neurochemicals do not indicate disorders but show instead the way the brain responds to stressful situations.

Despite evidence to the contrary, the neurotransmitter theory of depression has been and continues to be relentlessly (and erroneously) promoted in many ways: pharmaceutical advertisements emphasize how correctable chemical imbalances cause depressive disorders, public service messages stress that depression stems from flaws in brain chemistry rather than in character, and mental health advocacy groups advance the message that depression is a physical, brain-based illness, just like asthma or diabetes (Lacasse & Leo, 2005).

Further investigation of the biomedical literature provides yet another association between a biomedical process and depression. In this case, thyroid function and depression seem to be highly associated. In fact, patients suffering from hypothyroidism present with many of the same signs and symptoms of major depression, such as apathetic mood, difficulty concentrating, and slow movement (Whybrow & Prange, 1981; Blazer D., 2002a).

Since older adults are often the victims of stroke, it is important to note that people in the first year after a stroke are twice as likely to develop depression as are others (Solomon, 2001). This may be the result of biological damage to particular parts of the brain, and some research suggests that frontal lobe strokes are particularly likely to disrupt emotion (Solomon, 2001).

The biologic changes that occur with aging may indicate that older persons are at greater risk for developing a depressive disorder biologically than younger persons. No comprehensive theory has been put forth to explain the above and other biologic changes and associations. Nevertheless, the biologic factors undoubtedly contribute to understanding the complexities of depression in late life. Most researchers agree that biological theory is important in explaining the mechanism of depression, but it is likely that the processes are so complex that we have so far only achieved partial understanding of these biological components (Blazer D., 2002a; Hammen, 1997a; Solomon, 2001; Veith & Raskind, 1988).

Even so, a basic problem with a biological cause of depression is simply that biological processes underlie nondisordered, as well as disordered, human traits. Salient to this research, it is possible that disordered depressive reactions may be due, in part, to underlying biological malfunctions, but the same symptoms are present in both disordered and nondisordered conditions. Therefore, the biological responses that are specific to disorder must be distinguished from the biological processes that underlie a normal or nondisordered depressive response (Horwitz & Wakefield, 2005). In fact, neurobiological researchers suggest that one of the major needs in the field of depression research is a better understanding of the neural circuits in the brain that control mood under normal circumstances and mediate manifestations in mood that are seen in depression (Nestler, Barrot, DiLeone, Eisch, Gold, & Monteggia, 2002)

Psychological Theories

Psychology literature is full of discussions of the psychodynamic theories of depression across age groups (Beck, 1967; Freud, 1950a; 1950b). Among psychological theories of depression, no approach has stimulated more research than the cognitive theory of Aaron Beck (1967). More than anything, Beck was struck by the expression of self-criticism and blame in his patients, the negative thinking, the exaggeration of misfortune and the beliefs about futility and helplessness. He observed these thoughts to be distortions of reality and therefore dysfunctional and serving to prolong symptoms of depression. Out of these observations, he formulated a cognitive model of depression with 3 key elements: the cognitive triad, faulty information processing, and negative self-schemas (Beck, 1967; Hammen, 1997b).

The “cognitive triad” refers to thinking that emphasizes negative expectations, interpretations, perceptions, and memories about the self, the world, and the future. Self-critical, defeated, and hopeless thoughts were believed to contribute to the mood, behavioral, psychological, and motivational deficits in depression. People who are depression-prone are more likely to think of themselves as defective, and to think of the future as futile (Rude, Krantz, & Rosenhan, 1988; Beck, 1967). According to Beck, these thoughts are automatic, without deliberate choice or conscious motivation. Persons with this cognitive triad automatically think negatively, and are thereby predisposed to depression (Beck, 1967).

As an additional component of his theory, Beck argued that depressive thinking is typically distorted, and that individuals selectively attend to the negative even when alternative positive events and interpretations are plausible, and they greatly overgeneralize and magnify adversity while minimizing or misinterpreting positive information. Human information processing is characteristically biased in the sense that people are selective in what they attend to, and often leap to conclusions that may not be warranted.

The third component of Beck’s theory is the idea of a negative self-schema. The schema concept generally refers to organized representations of experiences in memory that serve as a kind of mental filter, guiding the selection, interpretation, and recall of information. Thus, by selectively attending to or interpreting certain information, schemas help fill in “missing” information based on what is expected by a particular individual. A self-schema refers to organized beliefs and propositions about the self, and according to Beck, the depression-prone person holds a set of negative beliefs. Because the schema is selective in “taking in” only negative information, beliefs are retained despite additional accumulated evidence to the contrary (Beck, 1967).

Martin Seligman and his colleagues were first to observe that animals who had been exposed to uncontrollable negative events failed to take action to escape such situations when outcomes were no longer uncontrollable; a condition now commonly referred to as *learned helplessness* (Seligman, 1975). Seligman applied this theory to human depression, suggesting that when one has false expectations that no control is possible in either obtaining desirable outcomes or preventing undesirable ones, then one fails to take action with resulting depressive symptoms. This theory was later reformulated to include the *attribution theory* that linked depression to the tendency to ascribe the causes of negative events to qualities in the self perceived to be unchanging and pervasive (Abramson, Seligman, & Teasdale, 1978). Seligman later argued that some people characteristically

show a “negative explanatory style” of stable, global, and internal cause attributions for negative events. Thus, when something bad happens, those prone to depression are more likely to believe that it was caused by global and persisting attributes in themselves that are undesirable and unchangeable (Seligman, et al., 1988).

Similarly, Gilbert (1992) explores the implications of humans as evolved social animals and suggests that evolution has given rise to a varied set of social competencies which form the basis of our personal knowledge and understanding. He classifies these competencies as: care eliciting, care giving, cooperating, and competing. Each of these is seen as a core feature around which knowledge is built, and from which, our propensity for suffering flows. Gilbert believes that the psychological systems of defense and safety dominate the unfolding of human mental life. Gilbert asserts that evolutionary approaches to psychopathologies can help illuminate how evolved functional systems (e.g. for specific moods and emotions) can come to be regulated by a variety of different processes, thus allowing for variation. In the case of depressions, some can represent maladaptive expressions of functional positive affect control systems. In short, he suggests that depression commonly emerges from the activation of defensive strategies that evolved in pre-human times. Specifically, he suggests that our brains appear to be wired to tone down positive affect in the face of poor attachment, affiliation or defeat (Gilbert P. , 1992; 2006).

There have been additional approaches to depression that theorize psychological origins. Rehm identified elements of a *self-control theory* of depression, hypothesizing that depressed people have deficits in the elements of self-regulation: self-observation, self-evaluation, and self-reinforcement (Rehm, 1977). Specifically, depressed people selectively observe negative events to the relative exclusion of positive, and they set unrealistically high expectations for themselves, making attainment unlikely. Moreover, they evaluate themselves negatively, and even if successful, devalue positive outcomes or attribute them to luck or factors for which they cannot take credit (Rehm, 1977).

Several researchers have observed that depressed people exhibit a heightened state of self-awareness, or self-focused attention (Ingram, 1990; Pyszczynski & Greenburg, 1987). Individuals with such inward focus invariably magnify their negative appraisals of themselves and the significance and meaning of their negative experiences. For example, it may be that self-focus increases negative affect and self-criticism, exacerbates the perceived negative consequences of unwanted events, and potentially interferes with appropriate social functioning, thereby perpetuating a vicious cycle. A number of experimental studies have supported this idea of self-focused attention or rumination being associated with more dysphoria, poor problem solving, and more negative thinking about the self and future (Ingram, 1990; Lybomirsky & Nolen-Hoeksema, 1995; Nolen-Hoeksema, 1991; Nolen-Hoeksema, Parker, & Larson, 1994; Pyszczynski & Greenburg, 1987).

Erikson, following the psychoanalytic tradition, suggests that persons must face multiple challenges throughout the life cycle. He asserts that the challenge of late life is to integrate one’s entire life. Successful resolution of this challenge results in wisdom whereas maladaptation leads to despair (Erikson E. , 1950). In our achievement-oriented society, imbedded incentives for activity and productiveness may not be adaptive or appropriate to changing life situations associated with advanced age (Wigdor, 1980). Since the mainstream society focuses on the need for achievement and recognition, retirement often

means elders can no longer attain this societal ideal. Substitution of alternative environments to meet these ideals is difficult since society does not have alternative roles for satisfying these needs (Blazer D. , 2002a; Erikson E. , 1950; Erikson, Erikson, & Kivnick, 1986; Wigdor, 1980). It seems clear that the inability to be productive or to find meaning in life events, especially at the end of life, contributes heavily to depressive symptoms among older adults.

Social Theories

Interpersonal behaviors and the nature of human relationships may affect individuals' interpersonal lives, even impairing their social functioning and leading to depression. Several theories about the causes of depression emphasize the role of relationships with others as a fundamental contributing factor. There is no single interpersonal perspective on depression; instead, there are diverse theories stemming from such topics as family functioning, attachment, loss and bereavement, social skills, and the effects of stressful interpersonal events (Hammen, 1997d; Lewinsohn, Munoz, Youngren, & Zeiss, 1978).

The psychodynamic theory of human development focuses on the importance of early-childhood experiences in the family environment. When those experiences are dysfunctional or lacking, the child may develop in maladaptive ways. This theory hypothesizes that depression might be a form of psychopathology as a result of certain unique and negative family experiences (Hammen, 1997d). Specifically, psychodynamic theory emphasized that depression is similar to bereavement and results from the loss of something or someone important. According to psychodynamic theory, significant loss, especially in childhood, produces sadness, but can also cause self-deprecation, guilt, and related symptoms of depression (Hammen, 1997d).

Recently, this theory has been expanded to emphasize the importance of early childhood attachment bonds between infant and parent, which has implications for depression and adaptive functioning (Bowlby, 1978; 1981). Bowlby argued that infants have a fundamental and innate drive to form attachment bonds to their caretaker. He argued that the development of a secure attachment bond is critical to healthy development. If this attachment bond is insecure due to loss, maternal rejection, inconsistency, or unresponsiveness, the person becomes vulnerable to depression. For instance, insecurely attached children may be highly needy and anxious, or alternatively, may become avoidant or reject closeness in order to deal with the lack of attachment (Bowlby, 1978; 1981). As an adult, actual or threatened loss of close relationships may trigger mourning, self-criticism, hopelessness, helplessness, feelings of abandonment, and other depressive symptoms. There is a considerable amount of empirical research validating Bowlby's ideas about attachment security and its consequences for maladaptive or healthy development (Blatt & Homann, Parent-child interaction in the etiology of dependent and self-critical depression, 1992; Cicchetti & Schneider-Rosen, 1986; Hammen, 1997d).

Social learning theory assumes a reciprocal interaction between people and their environments across the lifespan (Gambrill E. , 2006). Our expectations, goals, and standards influence social learning theory. Both thoughts and observational learning also play important roles in this theory. Thoughts are considered to matter in the complex processes that affect attention and in the degree to which different kinds of interventions

are effective. Observational learning refers to the acquisition of new behavior by observing modeled behavior. Contingencies are central to social learning theory, which are relationships between behavior and related cues and consequences. Depending on what happens after our behavior, we are more or less likely to repeat that behavior in similar situations in the future (Gambrill E. , 2006). Decades of research in both applied and laboratory settings show that our behavior is influenced by its consequences (Austin & Carr, 2000).

Social learning theory of depression recognizes that cognitions and adaptive skills are acquired through learning throughout one's life. Social interactions that lead to the person acquiring negative self-schemas or dysfunctional adaptive style can result in vulnerability to depression, especially in the face of stressful situations. Since coping with stressors throughout the lifespan necessitates learning appropriate coping and problem-solving skills, deficits in these areas may create vulnerability to depression (Brewin, Firth-Cozens, Furnham, & McManus, 1992; Hammen, 1997d).

The impact of a parent's depression is another reason the family context is important in exploring causal theories. Depressed parents commonly have problems in their parenting roles, and such difficulties may contribute to the high rates of depression in their children (Hammen, 1997d). The family is not the only context for social theories of depression. Relationships with those outside of the family may also have depressive consequences. For example, research with college roommates seems to indicate that when one roommate was depressed, the other roommate became progressively more depressed over several months (Hokanson, Hummer, & Butler, 1991; Hokanson, Rubert, Welker, Hollander, & Hedeem, 1989).

In considering late life depression, some hypothesize that decreased social supports and increased social stressors (such as loss or ongoing financial deprivation) contribute to depressive disorders (Blazer D. , 2002a; Erikson E. , 1950; Gallo, Anthony, & Muthen, 1994; George L. , 1993). Persons with late-onset depression are also less likely to report a family history of depression, suggesting that psychological and social factors predominate as causative (Blazer D. , 2002a). The elderly are considered by some to be at high risk of social stressors. Butler proposes that the elderly experience stressful events that force them into a preconceived societal definition as dependent, complaining, forgetful, irritable, and fretful (Butler, Lewis, & Sunderland, 1998).

Some social theorists postulate a disengagement theory or loss of social support theory, which suggests both society and the elderly themselves withdraw from roles and relationships, and that it is this disengagement or lack of social support that opens the door for vulnerability to depression (Blazer D. , 2002a; Blazer, Bahar, & Hughes, 1986; Butler, Lewis, & Sunderland, 1998; George L. , 1993).

Existential Theories

Meaninglessness is especially important in the manifestation of late life depression. Meaninglessness often takes the form of questions, such as "What is the meaning of life?" "What is the meaning of my life?" "Why do we live?" "Why were we put here?" "What have I accomplished in my life?" "If I must die, if nothing endures, then what is the sense of doing anything?" Camus, Cide and Jaffe (1970) suggest that the question of life's meaning is the most urgent question of all.

Persons struggling to answer such questions may exhibit other signs and symptoms common to a depressive disorder such as difficulty sleeping, problems in relationships and difficulty in completing everyday tasks. Though questions of meaninglessness are common, it is not well known whether such questions, left unanswered, precipitate depression, or whether, a depressive disorder provides the foundational melancholia for such questions to creep to the front of one's mind. It is possible that neither is true, but instead that issues of meaninglessness are a universal human struggle that need not be pathologized. In other words, the problem of existential depression is not really a depressive disorder, and is therefore best addressed outside the mental health arena.

The work of Erikson (1950) may provide the best approach to understanding meaninglessness in late life. In his discussion of lifelong psychological development, the conflict of ego integrity versus despair is the unique psychological crisis faced by older adults (Erikson E. , 1950). Resolution of this conflict leads to wisdom. This theory was later expanded towards a view of integration (Erikson, Erikson, & Kivnick, 1986). Erikson and colleagues (1986) suggest that during this last stage of life, the life cycle "weaves back on itself" leading to integration of hope, will, purpose, competence, fidelity, love, and care. To confront the dread of not being, which looms ever closer as one ages, the older person continually integrates previous actions and restraints, choices and rejections, and strengths and weaknesses of the present and past. In summary, integration is the "acceptance of one's one and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted no substitutions" (p. 3).

Meaning in life may be correlated with life satisfaction, but it is not necessarily the same. An older adult may have been chronically dissatisfied through most of his or her adult life and into late life, yet find significant meaning in life and a sense of purpose. A useful life may not be a meaningful life. Many persons find that they have served their spouses, children, and grandchildren, yet question the meaning of their lives (Blazer D. , 2002b).

Erikson's work suggests these questions are a normal encounter in old age, and *not a sign of pathology* or disorder despite the depressing and conflicting emotions that may arise as elders attempt to answer such difficult questions. What is meaning? There is no definition that will apply to each older adult. The question is one for philosophers to ponder and discuss. Existential concerns are not mere phenomena of biologic and psychological disorders. They are part and parcel of life.

Depression in Late Life: Experience, Meaning, Understanding and Knowledge

Differences in the experience and perception of depression and depressive symptoms have attracted considerable attention since Kleinman (1977) challenged the assumption that depressive reactions were identical across different cultures. He encouraged the distinction between disease or malfunction and illness, which is the personal, interpersonal and cultural reaction to disease. Various writers have pointed out that culture establishes not only what constitutes an illness, but also the appropriate response to that illness (Chang, 1988; Fernando, 1988; Furnham & Kuyken, 1991; Leff, 1988; Prince, 1990). Thus cultural identity affects the way in which biological changes in the body and psychological factors are perceived and acted upon or not depending on expectations, taboos, and current knowledge (Rack, 1982). Thus it can be argued that the

experience of symptoms is, in part, determined by culture, which in turn affects the account of the illness given to the professional (Furnham & Malik, 1994). Further, older adults in the United States represent both an age and cultural cohort with unique life experiences and sets of relationships, attitudes, and orientations toward mental health and health care services (Gallo & Lebowitz, 1999). For these reasons, it is important for researchers and practitioners in geriatrics and gerontology to be aware of the difference in depression symptomatology, and of the cultural and social reasons that affect the presentation of their symptoms, the account of their experience that they give, and their subsequent response to treatment, as all of these factors may be determined by their cultural experience as elders.

In their pathway to care model, Goldberg and Huxley (1980) described a succession of filters that determine whether people access specialist care. They argued that people's beliefs and perceptions about illnesses are fundamental to the way individuals respond to symptoms; they inform individuals' decisions to seek help and the manner in which they present to service providers (Goldberg & Huxley, 1980). Further, research specific to older adults and depression reveals that many older adults do not share their emotions beyond close family members and trusted friends, and in fact work to conceal their true emotional state from those outside this inner circle (Pope, Watkins, Evans, & Hess, 2006). Such research further presses the importance of understanding the beliefs, perceptions, and experience older adults have regarding depression and depressive symptoms. However, very few studies have examined beliefs, experience, perceptions or conceptual models of depression among older adults (Lawrence, et al., 2006; Marwaha & Livingston, 2002; George L. K., 1994; Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006).

Experience of Late Life Depression

What can we learn from the scientific study of subjective experience of late life depressive symptoms? The relevance of subjective patient accounts has often seemed far from obvious to clinicians and researchers (given the very few studies on the subject), for whom subjective experience interferes with scientific objectivity (Jenkins, 1997). As the mental health professions have become increasingly dominated by advances in psychopharmacology, neuropsychiatry, and genetics, research on subjective experience has receded to the periphery (Jenkins, 1997). However, there is value in asking open-ended questions concerning older adults' subjective experience of depressive symptoms for at least a couple of reasons. Such data can aid in accounting for the variability in depressive experience. Study of subjective experience may also represent a research progression from disease problems to subjectively assessed experience, and consequently from a disorder or disease conceptualization to a more holistic conceptualization of the person as part of our efforts to understand the course of depression and depressive symptoms.

Current research sheds some light on what we know about the experience and meaning older adults give their own depressive symptoms. Older persons may not accept the diagnosis or treatment of depression, in part due to beliefs and explanatory models of illness that do not line up with the treatments most commonly offered by primary care physicians (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006). When older adults attribute their depressive symptoms to social causes, they are less willing to view their condition as requiring medication or other treatment regardless of their diagnosis (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006). Another major reason for elderly people not reporting psychological symptoms to their primary care physician may be that such symptoms are seen as a normal part of aging and life, rather than an illness amenable to treatment (Givens, et al., 2006; Levkoff, Cleary, Wetle, & Besdine, 1988). Some older adults report a desire to experience natural sadness, which has important meaning especially in reaction to loss, and do not seek treatment, because they do not want to see this sadness prevented (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006).

Older adults may be inclined to describe depressive symptoms in terms of loneliness. Specifically, one study found that the most salient terms older adults used to describe themselves when they were depressed were: sad, lonely, tired, anxious, depressed, and physical pain (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006). The literature on the relationship between loneliness and depression in older adults emphasizes social support factors and the growing number of losses that older adults experience (Alpass & Neville, 2003; Andersson, 1998; Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Pinquart & Sorensen, 2001; van Baarsen, 2002).

It appears elderly individuals also feel the stigma of mental illness (Marwaha & Livingston, 2002; Levkoff, Cleary, Wetle, & Besdine, 1988; Schulman, 1989). Schulman (1989) argued that older adults are less likely to report lowering of mood as this generates feelings of shame. Levkoff and colleagues (1988) hypothesized that elders' discomfort in admitting symptoms of a psychological nature leads them to instead legitimize their help seeking with an overly negative appraisal of their physical health.

Lay Knowledge of Depression

Recent research has explored the understanding and knowledge adults and older adults have about depression. A British study examining older adults' beliefs about the concepts and causes of depression suggests a variety of definitions and a variety of causes (Lawrence, et al., 2006). Study participants conceptualized depression in very different ways, such as: sadness and grief, loss of confidence, hopelessness, low mood, a personality issue, worry, or as a medical illness. Study participants were also asked to identify the cause(s) of depression, and, again, a variety of themes were identified: loss, aging and loss of independence, bereavement, loneliness, relationships, biological factors, personality, social causes, and past history of depression. The authors concluded that older adults tend to use a conceptual model more akin to a social rather than biological schema implying a need for change in the clinical approach of engaging older people with depression (Lawrence, et al., 2006). However, these conclusions were not examined in the context of elder's own experiences of depressed mood.

Current research suggests that, at a minimum, older adults use different terminology in describing their depressed mood than used in traditional clinical phrasing (Alpass & Neville, 2003; Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006; Pinguart & Sorensen, 2001; van Baarsen, 2002). However, the issue seems to extend beyond a difference in semantics. Some research suggests that older adults do not define their experience of depressed mood as depression, even when they've been given a clinical diagnosis of major depression (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006).

Lay beliefs about the nature, causes, and consequences of depression vary as a function of one's own experiences with depression and sadness (Wernicke, Pearlman, Thorndike, & Haaga, 2006). For example, in previous research, people with a history of diagnosed depression considered interpersonal difficulties more important in the onset of depression than did those who had never been diagnosed as depressed (Furnham & Kuyken, Lay theories of depression, 1991; Wernicke, Pearlman, Thorndike, & Haaga, 2006). This exemplifies how an individual's experiences and beliefs may be fundamentally linked to differing explanatory models of mental distress (Glanz, Rimer, & Lewis, 2002; Goldberg & Huxley, 1980). Studies to date have lacked the attempt to link an older person's individual experience of depressed mood with his or her own understanding and knowledge about depression.

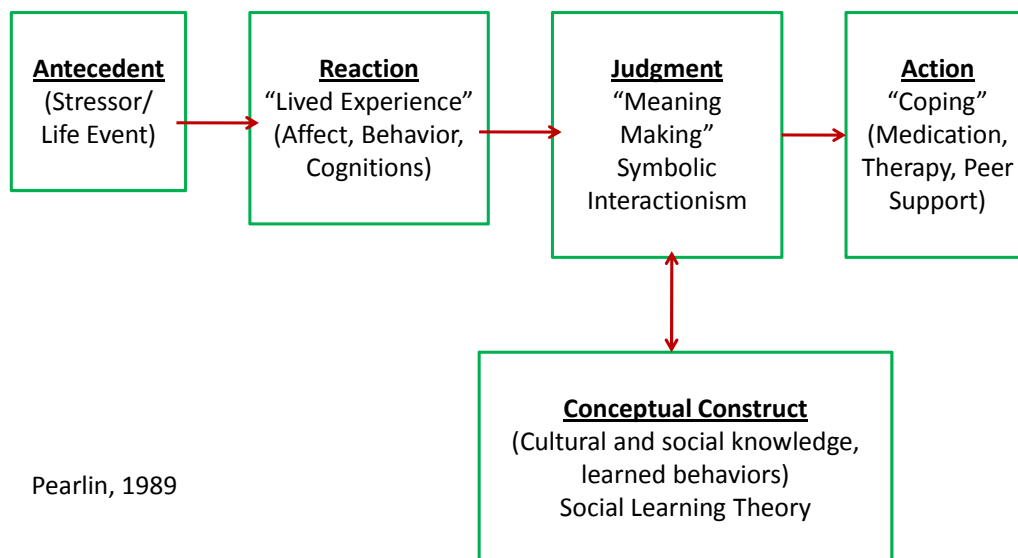
Conceptual Framework

An important reason for much of the mental health research conducted by social scientists has been the observed associations between psychological distress and disorder (Dohrenwend & Dohrenwend, 1969; Eckenrode & Gore, 1981; Ensel, 1986; Hollingshead & Redlich, 1958). A significant product of the effort to uncover the relationship between these variables has been the development of "stress process" models (Billings & Moos, 1982; Pearlin, 1989). For nearly two decades these models have substantially guided efforts to identify social experiences and circumstances that are associated with mental health risk and disorder (Turner & Lloyd, 1999). Pearlin's (1989) stress process model has

served as a guiding theoretical framework for studies of stress and depression in general (Turner & Lloyd, 1999) and in later life (George L. K., 1994).

The conceptual framework below provides a visual guide to the assumptions and theories that undergird the proposed study. The conceptual map details a path common to the stress process model mentioned above (Pearlin, 1989). For the purposes of this study and given the literature on the subject, it is assumed that older adults may first experience some sort of stressor or life event. This event triggers a response, which is manifested in the older adult's affect, mood, thoughts, and behavior. Thirdly, the elder makes a judgment about the trigger and their reaction; in other words, the older adult ascribes meaning to the situation. This meaning is influenced by various conceptual constructs, which allows for a variety of explanatory models of depression. For example, social and cultural knowledge about depressed mood, learned emotional response and behavior are a few examples of constructs that could influence the meaning older adults ascribe to their experience of depressed mood. The influence of these conceptual constructs is best supported by Social Learning Theory (Bandura, 1977; Rotter J. B., 1982). Finally, an older adult takes action or makes some sort of response based on the judgment. For our purposes, this action could be seeking mental health care to help with symptoms of depressed mood; it could be seeking peer support, meditating, or a combination of responses.

Conceptual Framework: Pearlin's Stress Process Model



Conclusions

Why is depression so hard to understand? One of the reasons discussed in this chapter is a failure of vocabulary. We use the word “depression” in everyday language to describe various states of mind. This sort of euphemistic “depression” lends confusion to the attempt to understand any sort of syndrome of major depression. Epidemiologic attempts to understand depression in the population are complicated by controversies in case identification, measurement, and overarching questions of the existence of psychopathologies including depression.

The clinical diagnosis of depression hinges upon a person’s self-report, elicited and interpreted by a clinician. There is much subjectivity and there are no objective blood, imaging, or psychological tests. The DSM-III & IV diagnostic criteria are very broad: either sadness or anger may define the depression. Insomnia and poor appetite are said to be characteristic of depression but many speak of hypersomnolence and increased appetite as characteristic of “atypical” depression.

Not surprisingly, the disjunctive nature (either this symptom or that one) of the depression construct leads to the collection of a clinically heterogeneous group under the rubric of “depression.” In geriatrics, this heterogeneity is amplified by the talk of “masked” depression, “subsyndromal” depression, and “vascular” depression, all of which may allegedly present without sadness or agitation but simply with diminished activity and interests. Here we have Depression without depression per se (Grossman, 2004; Blazer D. , 1990).

The myriad theories of depression in the biomedical, psychological, social, and existential arenas lend further complexity to the already confusing web of depression in late life. For example, much of the biomedical research on causes of depression merely provides associations, such as low neurotransmitter rates being associated with depression. These associations are seen as providing evidence for a biological cause of depression. However, here we have a chicken-or-the-egg problem. Does depressive mood somehow lower the presence of neurotransmitters or is it the low rate of neurotransmitters that results in symptoms of depressed mood? The same argument could be made for associations between depression and cortisol levels, thyroid function, and other biological markers. Future in-depth longitudinal studies involving detailed biological testing may provide better estimates of causation not found by current cross-sectional research.

Unfortunately, even with detailed longitudinal studies, it will be difficult to control for the psychological and social influences that are also put forth as causative of depression. Psychological theories suggest negative self-talk or self-schema as leading to depression, but like biomedical theories, such theories neglect the mind-body-spirit connection as a whole. Meaning, we end up with a similar chicken-or-the-egg dilemma. Does the negative self-schema lead to depression or vice versa? Further, does some other factor – such as the level of neurotransmitters lead to a negative self-schema, which in turn leads to depression? Similar problems with social and existential theories arise with regard to understanding the causes of late life depression.

Since the concept of depression remains convoluted and confusing, it is crucial that future attempts at decoding this problem are grounded in an understanding of normal emotional problems, and specifically how such normalcy plays out in late life. For example, Blazer (2002a) and Butler et al (1998) suggest that as older adults experience decreasing physical vigor, multiple health problems, and loss of emotional support due to losses and isolation, increased despair may be the predominant and appropriate presentation. If this then is normal in old age, when does it become a problem of clinical concern? Or does it? It could be that all these theories of depression seek to pathologize what is, at least to a certain extent, normal human experience in old age. However, until we have a thorough understanding of what is normal in terms of late life depression, we cannot understand that which is disordered.

The beliefs and thoughts of older adults themselves with regard to depression must also be explored further. What is the meaning of depression to elderly persons? Do they view it as a normal process of aging or as a disorder? What do older adults believe would help alleviate depressed mood among the aged? Just as researchers and clinicians have biases surrounding the causes and theories of depression, so do the elderly themselves. What are the beliefs and assumptions about depression that characterize older adults? Do older persons hold different beliefs about depression than younger cohorts? Just as negative self-schemas may influence depressed mood, so can the beliefs older adults hold about depression in general. Future research must focus on the beliefs of older adults in relation to the concepts and causation of depression.

Further, we must make an effort in research and practice to understand the subjective experience of depressive symptoms across the age range, and especially in later life. As discussed earlier in this chapter social and existential theories of depression in late life insist on the importance of context and contingencies in the development of depressed mood. If this is so, then it is crucial to explore the subjective experience of depressed mood, which in both research and clinical practice has been largely ignored.

In summary, even with all the concepts, definitions, epidemiological evidence and theoretical frameworks laid out on the table, the path to depression in the elderly remains unclear. Though our understanding of the problem of depression, its theories, origins and constructs, has grown, much remains elusive. Further research into the subjective lived experience of depressive symptoms is necessary, and may help determine that which is disorder and that which is not. Understanding older adults' knowledge of depression and exploring links between knowledge and experience are crucial as the field of geriatric mental health moves toward a more client-centered approach to care. As mentioned earlier, this study aims to focus on two domains related to late life depression and depressed mood: 1) Descriptions of the subjective lived experience of depressed mood, and 2) Older adults' knowledge of and about depression.

Chapter 3: Research Design and Methods

This chapter begins with a discussion of the overall methodological approach and rationale for the study design. It then describes sampling and recruitment, screening, data collection, and analysis. This study was approved by the University of California, Berkeley Committee for the Protection of Human Subjects in April, 2007, and the approval was renewed in April 2008 and April 2009. Rather than describing the measures taken to protect human subjects in a separate section, ethical considerations are described throughout this chapter.

Study Design

The proposed study is an exploratory and descriptive inquiry employing qualitative in-depth interviews. Since this study aims to focus on individuals' lived experience, qualitative interviews are the most appropriate methodological approach. Further, it has been argued that human actions cannot be understood unless the meaning that humans assign to them is understood (Gubrium & Holstein, 2002; Miller & Crabtree, 1999). Because thoughts, feelings, beliefs, values, and assumptive worlds are involved, qualitative interviews are needed to explore the deeper perspectives that can only be captured through face-to-face interaction (Holstein & Gubrium, 1995; Marshall & Rossman, 2006). In-depth interviews offer a means to preserve the complexity of lived experience.

The in-depth interview is a data-gathering technique focused on a creative search for understanding of a research topic where, in the interest of scientific knowing, meaning is constructed from viewpoints and experience (Miller & Crabtree, 1999). It is important to remember that all qualitative designs are flexible, iterative, and evolving. Interpretation and analysis are occurring during the interview itself, and interviews are analyzed, sampling strategies changed, and interview guides altered as the study proceeds (Miller & Crabtree, 1999).

Methodological Approach and Ethical Considerations

A primary consideration in the design and execution of this study was the potentially vulnerable situation of the participants and the need to treat them and their stories of depressed mood with great sensitivity. At certain moments during the interviews, responsibility to the participants was particularly clear and keenly felt. Many participants were curious as to who would read the study and wanted to receive their own copies of the study results. Several participants reported on the importance of asking older adults the interview questions and commented on the fact that few, if any, other individuals had ever inquired into their experience of depressed mood in later life. These meta-interview moments, in which participants and the researcher reflected on the study's goals and purpose, strengthened the researcher's desire to gather data sensitively and share it appropriately.

The researcher was similarly guided by a desire to engage sensitively and appropriately with the research participants. Developing a trusting relationship with the participants in which they felt comfortable sharing personal information was of high

importance. Toward this end, the researcher did not adhere strictly to a uniform set of interview questions, research settings, or interview lengths. However, for the benefit of the research, as well as for ethical reasons, it was important to make clear the role was that of researcher and not of friend or social worker. In establishing this friendly but professional researcher role, it was necessary to negotiate a range of acceptable variation in all aspects of the interview process, such as meeting in settings that felt safe for the research participant, conducting interviews lasting between 30 and 120 minutes, and scheduling interviews at the participant's convenience. In other words, there was no cookie-cutter approach to the interview process. Each interview was different from the next in terms of location, duration, and other aspects of the interview process.

To ensure study participant's comfort, participants were offered a variety of meeting places such as senior center public or private spaces, the researcher's personal office, or the participant's own home. The research participants, who were told that the interview included highly personal questions, selected the meeting place. For some, transportation was difficult, so their home was the preferred meeting site. For others, public or out-of-home meeting spaces afforded more privacy since they could get away from family members. In each case, the researcher confirmed with the participant his/her comfort with the chosen meeting space before the interview commenced.

The investigator wanted to elicit, with as little interference as possible, the described experience of depressed mood in later life including the coping strategies older adults use to address their depressed mood. Therefore, the researcher refrained from giving advice about coping mechanisms and did not provide direct counseling or assistance of any kind. Despite these efforts, several participants commented on the therapeutic nature of the interview. For example, one participant reported "feeling like she'd been to therapy" and was grateful for someone to listen to her. There was clearly a cathartic experience among most participants as a result of sharing and processing their personal experience of depressed mood in later life.

The interviews were generally conversational in tone, and though the participants did most of the speaking, the researcher did occasionally share personal information when appropriate. In particular, the age difference between the participants and the researcher was often a topic of interest, and many participants inquired as to the researcher's personal interest in aging research specifically and in the lives of older people in general. It seemed important to participants that they explore and affirm the researcher's commitment to aging research.

Study Procedures

The methodological approach selected for this study provided flexibility and structure. The flexibility allowed the researcher to adapt to participant needs and emergent findings, while the structure permitted the completion of a meaningful study despite limited time and resources. Miles and Huberman (1994) describe this flexibly structured approach as being distinguished both from a pure grounded theory methodology, in which the researcher is a blank slate, making no assumptions about her data, and from a highly structured investigation with pre-defined variables and hypotheses. It may be helpful to elaborate on this approach. The epistemological "camps" to which Miles and Huberman refer can be broadly categorized as logical empiricism and phenomenology, with

empiricism generally believed to be favored by quantitative researchers and phenomenology by qualitative ones. However, they argue that this is a false dichotomy, better understood as a continuum, and that most researchers, whether conducting a qualitative or quantitative study, utilize methods consistent with both traditions. Miles and Huberman (1984) therefore recommend that qualitative investigators adopt a systematic approach to research that includes the following steps, similar to those taken in a quantitative study:

1. Create a conceptual framework
2. Craft research questions based on the conceptual framework
3. Develop a sampling plan
4. Draft research protocols – i.e. interview guides, templates for field notes
5. Reduce the data primarily through coding and writing informal memos that describe the research process as it unfolds so that the researcher can track his or her analytic steps and record insights before they are forgotten.
6. Display the data using matrices, quote clusters, and flow charts that describe the data visually and illuminate the patterns found.
7. Draw conclusions and confirm them by looking for cases that do not fit the conclusions, triangulating the data, and testing rival explanations.

These steps are intended to make qualitative research more credible, meaningful, and useful, while giving researchers the flexibility to adapt to unique research situations, which is one of the strengths of qualitative inquiry.

In conducting this study, the researcher attempted to follow Miles and Huberman's (1984) steps. The overall study design, including the conceptual framework and research questions, was informed by the review of the literature, as described in Chapter 2. The researcher had some "hunches" about what the data might reveal, but was not seeking to prove a hypothesis. As described in the remainder of this chapter, the researcher used an interview guide with the research participants, but welcomed the natural tangents of conversation as they introduced unexpected and valuable lines of inquiry. Data analysis was also guided by this semi-structured approach. The researcher began with a list of codes, but added to these in the initial and later stages of analysis. There was an analytical starting point, but no pre-determined end point, other than that the researcher hoped to be able to address the initial research questions. The remainder of this chapter elaborates on the researcher's use of Miles and Huberman's approach.

Open-ended, in-depth interviews were selected because older people may be accustomed to responding in a perfunctory manner to close-ended questions about their health and mental health symptoms due to these methods dominating the current health care system. To elicit more detailed responses and diverge from the clinical assessment mode to which clients may be acculturated, the interview the investigator used a less structured format relying on open-ended questions, in which the investigator attempted to elicit the participant's own words and terminology. This had the advantage of creating opportunities to analyze *how* older adults talk about themselves and their depressed mood process in the absence of fixed questions or screening tools that may not be relevant or important to them.

Sampling and Recruitment

Participants were recruited between April 2007 and March 2008 through flyers and announcements at three San Francisco Bay Area senior centers. Because the investigator wanted community-dwelling participants, recruitment through senior centers was a reasonable choice for obtaining the study sample. Though the San Francisco Bay Area is a large region, most participants came from 2 counties: Alameda and Contra Costa. These areas share several features including high cost of living and lack of affordable housing (Association of Bay Area Governments, 2002). Participants also contacted the researcher directly after hearing about the study from another participant. A benefit of recruiting subjects from a large geographic area is that participants' confidentiality is more likely to be maintained, since it is less likely the researcher will encounter participants outside of the research interview.

The researcher began recruitment by contacting and meeting with the directors of four San Francisco Bay Area Senior Centers, describing the research project goals and objectives in detail. One senior center was going through a transition of directors and declined to be a site for study recruitment due to having been a site for multiple recent research projects and leadership difficulties during the transition period. Directors from the three remaining senior centers endorsed the study, and graciously provided space for hanging recruitment flyers, permitted in-person recruitment announcements during senior center meals and activities, and provided private office space for conducting in-depth interviews if desired. These three directors also agreed to share recruitment materials (flyers, study descriptions, and business cards) with older adults who met the study criteria. Membership data made available to the researcher from two of the three senior centers indicate a combined total membership of approximately 3400 seniors with an age range from 55 to 102.

Participants were required to meet the following selection criteria:

1. Be age 75 or older at the time of interview (as evidenced by self-reported birth date).
2. Be free from significant cognitive impairment (as evidenced by a score of at least 25 on the Mini Mental State Exam administered at the time of interview by the researcher).

To ensure that potential study participants did not feel coerced to participate, the researcher briefly trained senior center directors who agreed to assist in recruitment to provide potential research participants with a flyer and/or business card and repeat the following script:

I recently learned about a study at UC Berkeley. This study is about mood and emotions in later life and is for eligible seniors who are 75 years of age or older. If you would like more information, the researcher's phone number is on the flyer. I do not need to know if you choose to participate, and your participation in the study will have no effect on your receiving services or participating in activities at this senior center or any other social service program.

Once potential participants contacted the researcher to inquire about the study, the researcher's interactions were solely with them and the referring person was unaware of the individual's participation in the research unless the participant chose to disclose that information. In addition, senior center directors were instructed to consider the level of cognitive functioning of each potential participant. If cognitive impairment was known by the director, she or he was asked not to refer an otherwise eligible individual.

In an effort to assist with study recruitment, some senior center directors photocopied recruitment materials for distribution at multi-agency community meetings. Similarly, some research participants took recruitment materials to other non-senior center activities in order to refer their friends and to report on their own study participation. As a result, the researcher did not have direct communication with all of the agencies who referred older adults to the study. The researcher accepted all older adults into the study who met the criteria for participation, regardless of how they were informed of it.

Participants were offered monetary compensation for their study participation. The researcher decided to provide \$10 for completion of the first half of the interview (questions involving the older adult's personal experience with depressed mood) and another \$10 for completion of the second half of the interview (questions addressing the older adult's knowledge about depression, its definition, cause and treatment) for a total of \$20 cash compensation. As the stipend funds were made available through the Fahs Beck Fund for Research and Experimentation, it was necessary to collect a paper record of payment. The stipend for participation was paid in cash at the completion of the interview, and participants were asked to initial a ledger book confirming receipt of payment. There were no participants who declined to complete the entire interview, and every participant, therefore, received the full \$20 compensation. Completing this task at the end of the interview served as a mode of transition for termination of the interview.

Screening Procedures

Screening was completed in two parts: first, by telephone, and second, in-person. On the recruitment flyer, participants were instructed to call the researcher. During the roughly five-minute phone call, the researcher verified that the prospective study participant met the age eligibility criteria. No identifying information was recorded until the researcher confirmed the potential participant's age and interest in enrolling in the study. The researcher then invited the participant to meet in-person for a screening and possible interview at a mutually-agreed time and location.

The second part of the screening was an in-person meeting where the study was again described, including potential risks, and participants were asked to sign a written consent to participate and to be audio-taped during the interview. The participant was then briefly screened for cognitive impairment using the Folstein Mini Mental State Exam (MMSE); a score of 25 or higher was required for participation. The purpose of the screening meeting was to initiate face-to-face contact in a non-threatening environment, answer questions about the study, and assess level of cognitive functioning. Participation in the study could have been stressful or over-stimulating for an older person with moderate or severe cognitive impairment. Further, since much of the study involved emotional and experiential recall, poor memory or cognitive skill would have prevented the participant from answering the interview questions. If the participant met the study criteria (age, non-

cognitive impairment) and was willing to consent to participate, then the formal interview commenced immediately following this in-person screening meeting.

The completed MMSEs were retained with the rest of the data collected in the study. All data were labeled by participant identification number only, and stored separately from consent forms or other documents containing identifying information. The researcher was the only person with access to the documentation linking identification numbers with individuals' names and contact information. This information is stored by the researcher in a locked file cabinet.

All but five potential participants who called to inquire about the study were invited to have an in-person screening. Three individuals were younger than the required age of participation. One caller was the daughter of a potential participant who identified her mother as having a significant cognitive impairment. One individual declined to participate after hearing more about the study over the phone. Another four individuals called the researcher to inquire about the study, but did not respond to returned phone calls from the researcher and, as a result, did not participate in the study. There were no participants who were screened in-person but did not pass the procedures described above.

Figure 1. Sample Characteristics N = 36	
Age	80.28 years (Median)
Ethnicity	
Caucasian	80.6%
African American	5.6%
Asian/Pacific Islander	13.9%
Latino	0%
Gender	
Male	44.4%
Female	55.6%
Level of Education	
Less than High School	0%
High School Graduate	5.6%
Post High School Education	19.4%
College Graduate	33.3%
Graduate Degree	41.7%
Household Income	
Less than \$30,000 per year	27.8%
\$30,000 - \$49,999 per year	27.8%
\$50,000 or more per year	33.3%
Don't know	11.1%
Been told by a physician or health professional that you were depressed	
Depression Diagnosis	36.1%
No Depression Diagnosis	63.9%

The final sample was varied in terms of gender, race/ethnicity, age, education level, and income. Figure 1 provides a summary of demographic information for all participants. Over thirty-six percent of participants reported having a diagnosis of depression (answered “yes” to, “Has a doctor or other health professional told you that you were depressed?”). Further, thirty out of 36 participants described a significant experience of depressed mood in their later life (this group included all those with a reported diagnosis and another seventeen participants for a total of over 83% of the sample describing significant depressed mood. Six respondents did not describe an experience of depressed mood in later life; these six participants did respond to the questions regarding their knowledge about depression.

Data Collection

Prior to collecting data, the protocol for the first interview, as described below, was pre-tested with two volunteers. The first volunteer was an older adult known to the researcher, and the second was a fellow doctoral student ethnographic researcher who was completing her doctorate in Social Welfare. The older adult provided feedback from an older person’s perspective, while the fellow student researcher made methodological and substantive comments related to the objectives of the study. For example, the older adult suggested that the researcher inquire about mood rather than emotion as he felt it was a broader term that might better capture the range of late life experience. The fellow doctoral student advised the researcher to collect demographic information at the end of the interview so as not to “set the stage” for the flow of conversation with close-ended questions. Further advice was sought from a variety of Social Welfare researchers and mentors regarding the initial interview guide and overall data collection.

The two pre-test interviews lasted approximately one hour. The pre-test interviews were not recorded, but extensive notes were taken throughout each meeting, and the suggestions for revision were incorporated into the interview protocol. The notes taken concerned the process, format, and structure of the interview, not the content revealed by the volunteers. No audio recordings were made, and any personal information revealed in the pre-test interviews was kept confidential.

All of the data were collected in person between April 2007 and March 2008. A total of 36 interviews were completed. Participants signed an informed consent form at the beginning of the interview. Additionally, with the participant’s written permission, interviews were recorded digitally using a (provide name of recording device), uploaded into Sony digital editing software, and then uploaded to the transcription service’s encrypted, secure web-based storage system. The professional transcriber signed a non-disclosure agreement. The audio records and transcripts were labeled by participant identification number only. Names and other identifying information were mentioned incidentally in the course of the interview, and such information was deleted by the researcher from the transcribed records of each interview before input into Atlas.ti qualitative organizational software. Therefore, no identifying information can be gained from the interview data used for analysis.

The full interview protocol appears in the Appendix. The duration and process of the interviews were highly variable. Interviews were expected to last 60 minutes based on the researcher’s experience with the two pre-testers, but the interview length ranged

between 30 and 100 minutes, including time for completion of paperwork and stipend payment.

Interview Protocol

Following the screening process and informed consent procedures, each participant was asked if they had any additional questions or comments that they would like to make before interview recording commenced. After this, the investigator initiated the start of the interview by starting the digital recorder and marking the interview recording with, "Today is (insert date) at (insert time). This is an interview between (insert researcher name) and (insert subject ID #)."

Though there was variation between each interview, the investigator generally began every interview in much the same way, "I'm trying to learn more about older adults' experience with unpleasant or unhappy emotions and moods in late life. People have different words for these emotions. What do you call it?" The investigator would then write down the participant's own words and use them to describe such late life mood issues whenever possible throughout the interview. However, if additional prompting was needed, the investigator said something along the lines of, "Some people talk about these moods in terms like, 'feeling sad, lonely, feeling down, hopeless'. What do you call these moods?"

After this initial discussion of terminology, the investigator explored each participant's experience of depressed mood in later life and would usually ask a question like, "Would you please describe what life is like for you during times when you feel that way?", or "How would you describe yourself during these times?" Some participants were able to respond in great detail to these questions while others needed additional prompting. For example, the investigator often occasionally asked participants, "Can you recall a specific experience involving negative emotions or moods in your later life? What was life like while you felt that way? Please describe your relationships, activities, health, energy, etc. What were the circumstances surrounding that experience?"

While each participant was talking about an experience of depressed mood, the investigator kept a checklist similar to that in a clinical assessment interview. Many times, participants mentioned, for example, their symptoms, severity of symptoms or precipitating events during the natural flow of the interview. In other cases, the investigator, using the checklist (see Appendix) would prompt the participant with questions such as, "How did this/these moods impair your daily life? What brought on your symptoms? How much of your life was affected by these symptoms?"

It was also important to the investigator to gauge each participant's history of mood symptoms and impairments. Questions that helped explore this history included, "How would you describe your mood most of the time? Do you often feel (insert participant's terminology)? How would you characterize your overall mood in recent months? In later life? Thinking back to when you were younger, how has your mood changed? What else can you tell me about your own experience of (insert participants own terminology) in later life that you think I should know?"

These above questions comprised the portion of the interview that focused on trying to explore and understand older adults' experience of depressed mood in later life by eliciting their own descriptions. The next part of the interview explored older adults' knowledge about depression. Unless the participant had used the word "depression" to describe their own experience, this would be the first time in the interview that the term

was used by the investigator. The investigator helped make the transition from questions about experience to questions about knowledge by saying something like, “Thank you for telling me about your experience with (insert participant’s terminology). Your thoughtful comments are much appreciated. Now I would like to ask you a few more questions about what you know about depression. What does “depression” mean to you? How would you define depression?”

The investigator also explored participant’s knowledge about the causes of depression and treatments for depression. Examples of typical questions include, “What do you think makes people depressed? What causes depression? If you or someone you knew was depressed, what do you think would help? What would you do to treat depression? What helps people with depression get better?”

Generally, after these questions about knowledge were addressed, the investigator would simply state, “I don’t have any more questions for you, do you have any questions or comments for me?” Sometimes participants had other thoughts or comments on depression or on their own experience that they then shared. As the interview was drawing to a close, the investigator gave each participant a Social and Demographic Information Sheet (with their participant ID #) to complete. Information on this sheet included: age, ethnicity, gender, level of education, household income, being told by a physician or health professional that you were depressed (yes/no), taking or having taken antidepressant medication (yes/no).

The investigator made a point of looking at the participant’s responses and would occasionally ask additional questions. For example, many participants spoke during the interview of being told they had depression by their health care provider, so this information did not come as a surprise on the demographic information sheet. However, on a few occasions, this information hadn’t been discussed earlier in the interview and would prompt a question from the investigator such as, “I notice that you checked the box on the info sheet saying that a health professional has told you that you were depressed. Can you tell me more about this? Do you agree with this diagnosis? Why or why not?”

Information regarding antidepressant medication use was handled similarly, and often prompted further clarifying questions such as, “I see that you’ve taken antidepressant medication, can you tell me when and for how long you took this medication? Did you find it helpful? How so? What were the circumstances under which you took this medication?”

Once the social and demographic information was collected and discussed, the interview began to draw to a close. The participant was thanked for their participation in the research study and was given \$20 compensation and initialed for receipt of such compensation. At this time, the investigator stopped the digital recorder and ended the interview.

Data Analysis

The data analysis was completed in three steps: 1) organization of the data; 2) index coding of major themes based on the research domains and theoretical framework; 3) within-and across-case analysis.

Preliminary Steps: Data Organization

Using inductive analysis, the researcher took a phenomenological approach to analyzing and interpreting the data, seeking to find the commonalities surrounding the experience of depressed mood in later life.

After each digitally taped interview, which were all conducted by the author, extensive notes were written. Included in the notes were themes that had arisen during the interview. Similarly, memos were written throughout the data collection phase, involving themes such as coping strategies used by older adults with depressed mood. The memos and after-interview notes informed revisions of the interview protocol, and interviews with subsequent participants were modified to include prompts about particular themes that arose during prior interviews. The author employed a transcription service to transcribe the interviews verbatim after they were conducted. After initial transcription, the author played each recording again to check for transcription accuracy. Initial coding was conducted as transcripts were completed. The researcher used coding and searching for patterns to address the research questions. Codes were developed both a priori from the literature and also as coding progressed. As new themes emerged that had not previously been identified by the author, new codes were developed for each theme.

SPSS (Version 11.0) was used to organize and analyze quantitative demographic information from the “Social and Demographic Information” sheet that participants completed at the conclusion of the interviews. Specifically, age, ethnicity, gender, level of education, household income, depression status, and antidepressant medication use were recorded into SPSS to allow summary statistics to be calculated.

Coding

The researcher employed Atlas.ti software to organize the transcripts and codes and to run reports of themes. The first step was to delete (using the “blackout” function) identifying information (such as proper names and places) from the completed transcripts. The researcher then imported the transcribed interviews into the software, and each transcript was identified with participant’s study ID number so that quotes could be directly linked with participants. Atlas.ti allows a researcher to highlight a passage and then double click on a code from a list developed by the researcher. A highlighted passage may be linked to multiple codes. Similarly, the researcher is able to highlight a passage and create a new code, which is then automatically incorporated into the full list of codes. The researcher is also able to group participants into “families” such as by gender or depression status for the purpose of exploring group differences. After all the interviews were transcribed, the transcriptions were read in full and coded at least three times by the author to allow for the assigning of newly generated codes and to check for errors.

A preliminary list of codes was generated based on the research domains and theoretical framework (see Figure 2). Using Lofland and Lofland’s (1995) technique of global organization, the research design, interview protocol, and index codes were broadly influenced by a reading of the academic literature, conversations with informed colleagues, and lay knowledge. The start list of index codes was descriptive; it simply indicated that data in a certain category were present. The goal of this stage of coding was to organize the data such that quotes related to a broad category could be easily retrieved. For example, using the index code for “vocabulary”, I labeled certain interviewee utterances as “vocabulary”, but without further analysis, I was unable to yet say anything about what was

there- what terms, comments or definitions were used with regard to depressed mood in later life.

However, after the data were coded into these large bins labeled with broad categories like “vocabulary”, I was able to use Atlas.ti to create a document listing this data, which could then be used for in-depth analysis. An advantage of using qualitative software like Atlas.ti is the ability to mark a selection of text with several codes at once. Some of the participants’ communications related to several categories/index codes, and Atlas.ti made it possible to code this appropriately.

Figure 2. Start List/Index of Codes
Vocabulary for Depressed Mood
Experience of Depressed Mood
Symptoms
Coping Strategies
Definitions of Depression
Causes of Depression
Treatment for Depression

Analysis

Analysis began with the specific areas that were investigated. Reports of codes associated with each of the research domains were generated to address each of the seven research questions. For research question 1: “How do older adults experience depressed mood in later life?” codes such as “experience of depressed mood” and “symptoms” were used. Before, during, and after the reports of relevant codes were generated for each research question/domain, the author wrote memos addressing each research question. These memos were revised as necessary to maintain consistency with the data. That is, an initial memo was written to address each of the research questions, based on the author’s memory of the interviews and on notes taken after each interview. The analysis included comparing groups of participants to each other (women to men, participants with a diagnosis of depression to those without) in order to uncover additional patterns. As themes were further analyzed and code reports were generated, the memos were revised to accurately reflect the data and emergent themes. This was an iterative process, and eventually the memos were edited to such an extent that they were deemed to be an appropriate and accurate summary of the data, and they are included in Chapter 5 as Results. Direct quotes from participants are used as supporting evidence for the results.

In general, the researcher relied on the comments of those who reported experiencing depressed mood, whether or not they had ever been told by a health professional that they were depressed, to address the research questions related to the lived experience of depressed mood. Participants who reported not experiencing depressed mood were examined for comparison purposes, but were not emphasized in determining the lived experience of depressed mood. However, the responses of both those who reported experiencing depressed mood and those who did not were used to address the research questions related to knowledge of depression. Further, the researcher was able to compare the knowledge of those who claim a depressed mood experience to those

who claim none in an attempt to discern any connection(s) between the experience of depressed mood and knowledge about depression.

To increase validity, the data was searched for instances in which the typology did not fit, a technique Miles and Huberman (1994) describe as looking for negative evidence. Peer-debriefing (Spall, 1998) was also used to increase the validity of the findings, throughout the data collection, analysis and writing process, the researcher met at least monthly with fellow doctoral candidates or members of the dissertation committee to discuss, refine, and hear constructive criticism on the research as it unfolded.

Specifically, the analysis used an immersion/crystallization method (Borkan, 1999) to examine the content of the interviews. This style of organizing information focuses on identifying themes and ideas that emerged from the data, and the discovery of how these concepts are integrated into a cohesive summary. The central tenet of the immersion/crystallization process is that interpretation and analysis are based upon the researcher immersing herself in the data and collateral materials. The researcher's experience as the study interviewer shaped all facets of the study. The data were filtered through the lens of the researcher's knowledge and experience, which contributed to insights and interpretations.

Chapter 4: Results

Purpose of the study

The purpose of this study was twofold: 1) to understand the meaning older adults ascribe to their experience of depressed mood in late life, and 2) to explore how older individuals define and conceptualize depression, its causes and its treatments. This study details the knowledge and understanding older adults have about depression. Specifically, this investigation attempted to elicit, via in-depth interviews, information regarding older adults' beliefs and perceptions in the following two domains:

1. Lived Experience of Depressed Mood
2. Knowledge of and about Depression in Later Life

Key findings of the current study are organized along the components of the conceptual framework: antecedents, reactions, judgments, actions, and conceptual constructs. The first section addresses the context of depressed mood among older adults. The second section explores the lived experience of depressed mood and attempts to address the overarching research questions related to this domain, including: "What is the lived experience of depressed mood in old age?" "What words do older adults use to describe their depressed mood?" The third section presents study findings related to the judgments and meanings older adults ascribe to their experience of depressed mood in later life. The fourth section displays the actions older adults take to cope with their depressed mood. Finally, the fifth section presents older adults' knowledge of and about depression in later life. This section describes how older adults define and describe depression, what they state are the cause(s) of depression, and their knowledge of how depression is treated.

Conceptual and Theoretical Framework

The conceptual map (pictured in Chapter 2) details a path common in social psychology and known as the Stress Process Model (Pearlin, 1989). As discussed in Chapter 2, for the purposes of this study, it was assumed that older adults would first experience some sort of stressor or life event. This event triggers a response, which is manifested in the older adult's affect, mood, thoughts, and behavior. Thirdly, the elder makes a judgment about the trigger and their reaction; in other words, the older adult ascribes meaning to the situation. This meaning is influenced by various conceptual constructs. For example, social and cultural knowledge about depressed mood, learned emotional response and behavior are a few examples of constructs that could influence the meaning older adults ascribe to their experience of depressed mood. Finally, an older adult takes action (internally or externally) based on the judgment. For our purposes, this action could be seeking mental health care to help with symptoms of depressed mood; it could be seeking peer support, meditating, or a combination of actions. This chapter utilizes the above conceptual framework as a helpful way to organize and present the results.

Antecedents – The Context of Depressed Mood

Study participants were asked to think of a moment when they had experienced depressive symptoms in their later life and to describe what life was like when they felt that way and why they felt that way. All participants (n = 30) who reported depressed mood in later life had some sort of stressful incident or life event that precipitated their depressed mood. Two participants considered themselves lifelong depression sufferers, but they also reported certain triggers or precipitating events that brought on another bout of depression. None of the participants who described a significant experience with depressed mood in later life reported that their depressed mood had developed without cause or for no discernable reason. Each person described a story, a context for their depressive symptoms as indicated by the following examples:

I can tell you that my son was here visiting from Australia this past spring. He's bipolar so he's very difficult to get along with for a while. He's loving and he means well, but after a while he really gets on my nerves and I can't handle it anymore. I love him, but I can't stand to be around him too long. I almost had a heart attack. I was in the hospital for two days and was very depressed, but then, after he left, I started feeling a little bit better. Subject 0014

I am aware that I was probably going through some depression because of the circumstances with the family and things that were happening. I had a real depression and aggravated it by becoming kind of a recluse and started being at home by myself, which I am a very social person, but because of the family circumstances, my relationship with my husband and the children leaving and my husband away at the shop all day. I was supposed to be working for his shop in the basement of our house with no windows and didn't realize what that was doing, what I was doing to myself. Subject 0010

I was so involved in taking care of him... I guess time consumed itself and I didn't stop to even think about myself. It was an all time effort and of course, after he died... that was two years ago, I was what, 73, and all of a sudden the house just felt horribly lonely, empty, very empty, and ... just didn't seem enough. It didn't fulfill the need for companionship. Like every night, my husband would sit there and I would sit here and after reading and so forth we always had our nightly game of cribbage before we went to bed and so I miss that. I was just wanting somebody there to be with you and maybe even an incentive to cook meals and provide for and take care of as much as you could, but it just seems horribly lonely. Very difficult to get over. It remains difficult to get over. Subject 0012

I wonder about the relationship between myself and my wife. Not even a sexual relationship...sometimes she would say something or do something that makes me think of divorce and that gets me down. Sex or

no sex, I mean, when I think of divorce, it is still a very big thing... that would get me down you know? Subject 0019

There are things in my life that I remember, that when I dwell on them too much, that can create a depression. I have four sons. I'm in my second marriage. We've been married forty-two years. The first marriage was nine years. That first marriage and the first part of my present marriage were very difficult for my partners. So when I begin to think about that and begin to think about the effect of my life on those four sons, that can cause a real depression...so the precipitating events can be memories of my fathering, of my acting out, or the depression through alcohol, things like that'll do it. Subject 0025

I was just doing great financially, and now I'm looking at a dismal situation. I'm trying to get the records together to get that house cleared. I don't know what I'm gonna do about my son. He knows that he's not producing the income. I can't handle the house payment, plus the debt I've accrued carrying him. It's around a hundred and forty thousand dollars...anyway, that tells you a little of the story of why I am depressed; and I'm having to fight it because I just want to sleep and forget it. Subject 0026

In addition to describing the context of their depressed mood in detail, many participants commented on the nature of sharing these stories saying, "No one has ever asked me about this," "Thank you for listening to my story," "Nobody ever wanted to know why I felt sad," and "It means so much to be able to tell you these things and have you listen." In other words, the story of the context of their depressed mood – why people felt that way – was seen by participants as being very important. This context was crucial to their described experience of depressed mood, to the judgments they made about their depressed mood, and to the actions they took to cope with their depressed mood. The context of depressed mood in later life matters.

Reaction – The Lived Experience of Depressed Mood

This section addresses the lived experience of depressed mood among older adults and attempts to address the overarching research questions related to this domain. Results for this section were gleaned from the 30 participants who reported and described having depressed mood in later life. Thirteen of the 36 participants reported having a received a diagnosis of depression. Seventeen participants had never received a diagnosis of depression, but reported having depressed mood or believing they were depressed at some point in their later life.

What is life like when you're depressed?

What is the actual experience of depression like? Participants described their experience of depressed mood in three thematic ways, in terms of 1) feelings, 2) lack of activity or motivation and 3) physical symptoms. Feelings were described most of the time as depression, but other feeling descriptors such as sadness, grief, poor self-worth, and

loneliness were also elicited. Lack of activity or motivation was described by a lack of desire or inability to do the things one would normally do such as cook a meal, tend to the garden, or listen to the radio. Participants were very focused on “doing” and being able to “do” seemed to be a mark of not having depressed mood. In other words, depressed mood equals inability to “do”. Participants also described their experience in terms of physical symptoms, such as sleeping more than normal, lack of energy, crying, and dizziness. Respondents did not talk about their experience in these three distinct categories, but rather as an integrated part of their larger story. The following quotes provide a sampling of how older adults describe their experience of depressed mood.

I couldn't quite understand it really, I just felt depressed. It seemed almost as if my mind could not function correctly and nothing seemed positive, everything seemed negative to me somehow and during those low moods I began to wonder what's my purpose here on earth? I mean, why, why do I even bother to continue living, I mean, why do I occupy this space? What good am I? I go through this kind of question and answer about the value of my own being and existence and, well, I guess it's part of getting old and having had two husbands die on me and I keep wondering, just what purpose am I fulfilling? Subject 0012

It's exhausting, and yet, here I've lived this long, in spite of it. So, depression is like a cloak around you that you can't shake off, you can't take it off... In other words, the thought comes in and, what it is, the emotion, and then the action, or whatever; something like that. I don't know. But I thought to myself, I don't wanna feel this way; or am I indulging myself; do I wanna feel this; am I feeling sorry for myself; am I, what it is. You know, you keep asking and asking and asking, that you don't really, this is not living. It was not living, although I went on living; and I wanted to live; but it takes so much out of you. I think it teaches you something, and you're always kind of aware that maybe it's over there; and it seems like a creature, (Laughs) that's going to come back and say, I'm back again, hello, hello. Subject 0003

I was busy. Then I was writing letters to annuity places here and there changing my name. That lasted to March or April, and then suddenly after doing all these changes, coming closer to the end, I get really depressed. Then I really-one morning I was so dizzy I had to crawl to the bathroom only ten feet. This was just quite recently... and I couldn't call the doctor but I was totally dizzy and it was funny that I couldn't do things. I didn't want to read. I didn't want to listen to the music. I was just unable to do things. I could barely see my cat and get up and drink tea or something. Subject 0020

I went into a really bad depression. We were all ready to go on a trip and my husband hates to anticipate a trip. He loves it once he's doing,

but he's impossible to live with for weeks before... We were all ready to leave to drive down south and I had done all this work, including ignoring his antics, and the morning we were to leave and we were going to drive he had health problems that were not life threatening an eye infection and something and he didn't go, he didn't want to go and I realized that much as I wanted to go, I wasn't willing to jump in the car and drive myself. It was just down to Los Angeles. I was going to do the driving anyway, but I thought about doing it without him and I just couldn't do that. That was very, that put me into a real funk. That was the one time that I experienced really not giving a damn about getting out of bed. Usually I get up early; I love the morning and all. I had a really bad time with that. Subject 0022

I'm still having problems with depression to the point where sometimes I just stay in bed. That's generally the way I deal with it. I used to deal with it with alcohol and that became so non-productive that I had to quit that, go through AA and learn to love sobriety, but still the dreams and nightmares come. They don't have to do with any person, usually; just terrible, awful nightmares to the point where sometimes I can't go [to work]. Subject 0025

I just don't feel like doing a lot of the things I need to do. I just let things go that I normally would take care of as I see them, you know. I need to get out and do yard work. I've got a couple of dozen plants, on the patio table that I just bought. I've gotta prepare the ground. I've gotta get them planted; and, of course, I had a long day yesterday. I didn't get home until after midnight; and my reaction, if you weren't coming, I might've just gone and conked out and, you know, the heck with it all. Subject 0026

Well, I wasn't doing things. I wasn't cleaning up the house, I was just ignoring things and I had a stack of things that I, some letters that I should have written, some thank you notes and I wasn't interested in cooking for myself. I mean, I am still not that interested in cooking for myself, but even less interested. Just a kind of a flat feeling, you know. Oh, I guess it's just that I am not, I have got things backed up to do and I am not doing them. It's like your ironing; you can just forget it and wear knit tops. But that's it for me. It's just that I am not doing my work. Subject 0028

Depression to me is when you don't want to get out of bed in the morning. When you don't know what your next hour is going to be like. When your activities are none or your emotion is drained. That was the experience I had when I lost my job. Subject 0037

Judgment – Crafting Meaning from Depressed Mood

This section attempts to present the judgments and meanings older adults attribute to their experience of depressed mood. What do they themselves make of their experience of depressed mood?

“I Choose to Get Up and Go” – Exercising Control in Spite of Depressed Mood

Older adults are part of their own treatment for depressed mood. They reported that though they often can't control their mood or emotions, they can control their behavior and attitudes. In other words, a participant may not have felt like going to her exercise class due to her depressed mood, but she chose to go anyway, seemingly by sheer force of will. What seems to follow is an understanding that their mood will eventually improve if they choose certain actions and attitudes. In other words, if you choose to go to your exercise class even though you don't feel like going to your exercise class you can affect your mood. Participants seemed to understand they would be “better off” for choosing and/or doing the things they didn't want to do. Again, the emphasis is on “doing.” Participants understood that their “doing” can positively impact or improve their mood. The quote that seems to best capture this theme is “I choose to get up and go...” Supportive quotes are listed below.

...I think it's an affirmation of life, and I think you could choose to die or you can choose to live, and I choose to live. If I'm going to do that, I'm going to make my time count; so I think that there is, at least for me, a sense that I had to feel what I was feeling, and it was awful. I had to pass through that; and then I do believe that there is a choice, that you can stay at the grieving stage if that's what you wanna do, but that's not really living. As I say, something that my daughter would really not be happy with, since she was someone who lived her life to the full; so I chose to live my life and that was a choice. What I do now is a choice, every day. I can choose to stay in bed or I can choose to get up and go; and I choose to get up and go. Subject 0008

...Even to bring myself to go through my morning indoor exercises. I mean I do floor exercises, weights and rowing and then I do my Tai Chi. I didn't feel like even doing that but I said, '[Becky], do it.' Because I have the strong self-discipline to do these things. I have always had determination and discipline within my being. Yeah, I didn't feel like doing those things, but I did and I'm better off for it." Subject 0012.

I don't know, I think it's a combination of you can't change things the way they are' maybe God has his reasons, but I'm not going to be mopey and droopy. What is the point? No one would want to be around me... I think you have to accept... I think that's a big thing: to accept what is... there are times when you're sad and you go to bed. The next morning

you get up and you're going to have a cup of coffee and start living again. Subject 0014

I think the important thing is to be aware, be mindful of what's happening to you..think what it does to your body and what it does to your mind and realize that it can be changed; that there's always the next fifteen minutes, which can still be down if you want, but you can be on your way if you want, 'cause you can make those decisions. You know that you can't change the situation that has brought you down, but you can change your attitude toward it. Subject 0015

When I say it's a 'downer', I know that there are always 'uppers' on the horizon, and I don't intend to stay down in any way. It's a kind of self-management that can work for you. The other thing I'm doing, well even if I feel, am I pretty lonely today or whatever, I call somebody up and I say, 'Let's do lunch, or come over for tea or something.' So there are ways to handle this kind of a mood. It doesn't help to stay in it, to get mired in it. Subject 0016

Int: So you mentioned earlier that when you're experiencing this depression you're telling yourself that you have to fight it. What sort of things do you do to fight it?

Resp: Well, I just have to get up and get going, and start taking care of things. My thinking, at times, has been, okay; as I see something, all right, let's go do it now. Do the thing. Quit procrastinating.

Int: So even if you don't feel like doing it, do it anyway?

Resp: I have to force myself to go ahead and do things sometimes.

Subject 0026

Well, I think it's always a process. I don't think you ever resolve it; you have to constantly work. I study a lot of books, I read a lot about it, depression ... and I can respond better. So, it's a work in progress. You're always working at it. Subject 0039

“This too will pass”: An understanding of time evolves in late life bringing perspective and resilience

Many participants discussed their experience with depressed mood in relation to time. Specifically, they were not troubled when faced with depressed mood, even when it lasted multiple years, because their total life experience enabled them to understand that things take time, and, “this too will pass.” They described themselves as survivors of incredible and terrible things, and so they had confidence that they would make it through even the lowest of lows.

Another element of time, which was common among participants, was the idea that recovery from depressed mood takes time. Participants reported that the work of “feeling the feelings” of depression or depressed mood is not something that can/should be

shortened, but that you need to spend the time to live through it. Supportive quotes are listed below.

“This Too Will Pass”

I'm not familiar with all sorts of depression, but I think you do get over it. I think time passes and whatever happens happens, and you can get past it, not necessarily through anything that you do. I must say-even though I was trying desperately to get over my own sadness over my daughter's death-I didn't feel I was particularly effective at it. In that respect, it was out of my control. I think time certainly has ameliorated that situation, for me at least. I just know so many people. Well, the people I know, whom I would describe as clinically depressed, are just helpless. There was a time when I felt helpless in the grip of, but I don't feel helpless anymore. I think I'm in pretty good shape. Maybe it's something I did. Maybe it isn't. I think it's just more the passage of time. Subject 0008

I know that it is going to get better so I don't go into a big therapy or fit about, you know, trying to make myself feel better. No, it just lifts after a while...there is a certain amount of wisdom that comes with getting older. You know, not a great deal, but some, which is nice. That part compensates in many respects for the fact that you are getting older. Subject 0023

Something like that happens to you early in your life, you realize you've gotta take hold, and focus your life in a positive way...If you believe in yourself and that you can do something, you can do it. I said, "If I ever recover from this I would do good in life." And so that's been my guiding thought; but now, if that hadn't happened, I don't know. I don't know what my life would've been...I think in life, looking back, things like that, traumatic, my having tuberculosis, sort of prepares you for something up the road, because I believe there is a pattern; there's a plan for you. I know I can handle what comes my way.. I think because, I think my religion has helped me there, my faith; because I've always felt, oh, this, too, will pass. Subject 0002

I don't think of myself as a delicate flower that's going to blow over. I've survived incredible stuff. So I can survive. Subject 0004

“I Had to Feel What I was Feeling”: Recovery from Depressed Mood Takes Time

I remember going to this agency, I can't afford private therapy, so it was nice at this agency and I saw this very nice woman, but I finally dropped it after a few months because she was under pressure to have me accomplish these goals in therapy. And at the end of a certain number of

weeks I dropped out because I wasn't making "progress." I didn't want her to feel bad and I didn't want to feel bad, but I can't work that way...Anyway, what I'm saying is when I let go, then this experience of kind of something else came forward. It's when I stopped forcing the practical coping side that should be doing these sensible things that everybody knows and that everybody prescribes... and that everybody would tell me to do. It was crushing me...I had to do it in my own way, in my own time. Subject 0004

Oh, well, it's modified. I still think of her every day, and I don't anticipate that that will change; but I don't wake up crying the way I did at the beginning and for several years thereafter. It's hard for me to find words to express that loss. It's hard to trace that because the amelioration of the loss-and that's about the best I can come up with as far as explanation-happened so gradually that I was almost unaware of it. It seemed to me years that I would awaken and realize that she wasn't there, and cry. I think it was several years-two or three, at least-when I really grieved for her in a very active kind of way; and then, imperceptibly, things got calmer, I guess, is the best way to describe it; and I didn't cry so often, or when I cried, I didn't cry as much. The last year has felt like a healing year. It will be four years in August, since her death, and I think this last year, I have really gotten much better about my own feelings and holding on to the positive things that I really believe in. When I think about her now, makes me wanna cry again, so, I won't say I'm cured. I mean, pain is pain, and that just never stops hurting, but I think I stopped focusing on it as much...I feel as though I've done the work of grieving and there's nothing to be gained by wallowing in it... Well, I've been in grief groups, where people have long prolonged grieving periods. As I look at these people, it seemed to me that what they had in common was, that they didn't allow themselves to feel the grief. Therefore, the grief kept going on and on; so I think that there is, at least for me, a sense that I had to feel what I was feeling, and it was awful. I had to pass through that. Subject 0008

Oh, well, I mean nobody wants to see somebody depressed; so, my friend, who used to say to her mother, get a grip, I think that's more the rule than the exception. People want to see you take hold and be the person that they know. I think, in that sense, people are impatient with people who are depressed.

Int: Having been through that, what do you think about that expectation?

Resp: Well, I think you can't blame the victim. I think people who are depressed are really the victims of their depression; and, to find fault with them for being depressed is a lack of understanding. No one-I shouldn't say this-it is my belief that people do not want to be depressed.

It's not a choice to be depressed. Therefore, I think the impatience that people have with people who are depressed is ill-advised. It doesn't do any good to be annoyed with someone who's depressed; doesn't help.
Subject 0028

The Relationship to Anti-depressant Medication is Complex

The relationship to anti-depressant medication was complex. Eleven participants reported using an anti-depressant. Some tried medications and found them helpful in treating their depressed mood. Some tried the medications and found they didn't help or that the side effects were severe. Many participants reported being prescribed an antidepressant or told they should take an antidepressant. Some refused to try the medication for fear of the side effects, such as the dulling of emotions. A few participants were suspicious of antidepressants or the "pill culture". Study participants reported surprise and frustration that medications were the only treatment offered to them for their depressive symptoms.

So I go to this doctor and I said, "I've lost my job and I think I'm going to be retired; there is nothing else." I was 64 at the time and she said, "Ok, we'll get you on Prozac, and then you'll really, it will be ok." Well, she never even asked me what I thought. And what it did was just make me feel like I have no feelings. Dulls everything and I finally, after awhile, I said, "I can't do this." I had no feeling of like excitement. Granted, I don't feel as depressed, but I have no feelings. I wasn't enjoying things, nothing, that's what it did. And they tried it again. I said, "I'm willing to try it because I know they have a million new drugs." And we tried I can't think of the name of it, but the same thing happened and I went back to my doctor and she recommended another one saying, "this isn't as strong a one and you can probably..." It was like suddenly I didn't want to go on medication anymore. So I've been off taking anything for about five months or more. Subject 0007

I did not [take antidepressants], and I thought about it, and my primary care physician asked me if I would like to do that. I said "no." I really felt strongly that I needed to feel the feelings, and, you know, I didn't want to be chemically lobotomized...I really had to feel it and deal with it in my own way, however haltingly I did that. Everybody would like the magic pill that makes it better, but I think, for me, the sense was that the magic pill would just make me want more magic pills. That wasn't the way I wanted to deal with this. Subject 0008

I've had depression and I've been treated for depression...about six months ago I decided to go off medication...I certainly have access to my emotions more, but I haven't found a balance. I think it's better to have access to your emotions as long as they don't overwhelm you. But I think

all these things that happened are really things that happened, not without reason. Subject 0013

I was prescribed one by my doctor who is my primary care doctor and not a psychiatrist and I looked up some of the possible side effects and decided not to take it. So I think it was a good choice and I've been meaning to follow through on that and see if I could find something else that would be appropriate...I have some friends who have taken anti-depressants and found them to be very useful but this particular one, as I say, I looked up and I felt it was just too much risk. Subject 0024

I'm on anti-depressants...I think I get some sense of a letdown when I miss taking them... I'm on a lot of medication because I had open heart surgery and heart problems and stuff like that... but I do take anti-depressants. They have helped me a great deal. Subject 0025

I refused to take an antidepressant...The great thing about the pill culture is that, you know, so many people are now out of mental hospitals because they can take drugs, but it doesn't do anything for their understanding. They in effect become automatons. They feel better, you can't blame them for taking the drugs, you don't want anyone to run around shouting and screaming and so forth, but is the culture getting any saner? No. Not a solution. There is a lot of money being made by the pharmaceuticals and it is going to get worse, there is more and more of that kind of control. Good thing I won't be around to see it. Subject 0023

Further, many participants reported surprise and frustration that anti-depressants were offered often as their only option for addressing their depressed mood. For the thirteen respondents who had been told by a health professional that they were depressed, only two reported that a health professional referred them to counseling in addition to offering medication. While many respondents found their way to counseling or other types of therapies, they did this on their own as they reported these referrals were not offered by their physicians or other health professionals.

I had one psychiatrist who I didn't especially like. He said, "There's really nothing we can do for you except give you medication and if you don't want to take that then there's nothing we can do." So, wherever I have gone for help, I immediately get hit with that, "You need to be seen – get on antidepressants," and I have refused ever since I gave it a try and paid the price. I'm not going to do that. Subject 0004

I went to see a therapist because I was "depressed". I knew it. I walked in, sat down... he said, "I can help you." And I said, "Swell." So what he did was he gave me some kind of antidepressant. I went home. I got violently sick; and I thought, there's something wrong, so, of course, I

called him and I went again. I said, "I can't take that, it just made me so nauseated, the whole nine yards." He said, "Well, I have something else. I want you to take just a quarter of it." Well, I got the same thing, so I went back. I said, "I can't take this stuff." And he looked at me and said, "I don't think you're depressed." And I didn't see him again, but I thought to myself, "maybe I better talk to a therapist instead," which I did... and basically, it was helpful. Subject 0003

The world we live in today, which I can't seem to get any rest from in terms of its impact on my psychic wellbeing...to think that a pill is going to make me feel better is insane...I don't buy it. Subject 0004

I had a really bad time with that... and I told the doctor how depressed I was and she wrote out a prescription for I can't remember, Prozac. So I started popping that. That changed my perspective a little bit. I was surprised that she so casually gave me the prescription rather than suggesting that I talk to someone. It wasn't any great thing... but it did change my attitude...probably took it about a year, and bless my baby I left my vitamins and minerals at his home once when I was visiting and he snooped in the little Ziploc bag and "What was that Prozac I saw in your bag of medicine and why are you still taking it?" So I stopped taking it..I mean I was just taking it mindlessly I think. I didn't notice any difference. It became just like my vitamin C or aspirin that I pop. Subject 0022

A Loss of Power and Credibility: The Stigma of the Depression Label

Study participants were resistant to having the diagnosis of depression or the label of depression put on them. Some respondents didn't feel that a diagnosis or label of depression applied to them; they held another perspective or saw another explanation for their depressed mood. It wasn't just the stigma that accompanies having a mental illness. Rather, it seemed to be tied to the idea that such a diagnosis or label would further undermine their power and control in society, power and control that was already diminished due to being older. Further, the stigma of a depression label was related to the fact that study participants saw themselves in the context of their lived experience and resisted a label that essentially ignored this larger story.

[It's] a unique set of interacting experiences. When you ask me about depression, it's not like I have, "I believe in it" like the American flag or "I don't." It's that how is that term being used? Is it useful? I know lots of people who have been on psychiatric meds or antidepressants and it helps them. Now I'm not going to sit in judgment and say, "You're deluding yourself..." which is imposing a worse label on them. I don't know. They're the best judge of that. I'm just looking at it partly as how it applies to me and how, in an large social scientific sense, that there are different ways to look on the same experiences and it would be helpful for people to learn to stand back and question some of these

taken for granted “realities” that our whole society operates on too vastly. Personally, that label was very damaging to me. Subject 0004

My wife and I went to a couples communication thing at Kaiser and we saw someone, a social worker, and I think we went for maybe six sessions or something like that and she said to me that I have a low grade depression...we I think at the time I was reacting to the social worker and my feeling was that she was taking my wife’s side on things and so I think I was inclined to take it lightly. I don’t think I completely discounted it, but I took it lightly. Subject 0024

I went to Kaiser and there you’re labeled boxed and sealed...so, once somebody says you’re depressed, then the next doctor they don’t even read your chart but it’s got a label. I was stuck with this depression and then this thing of having a panic disorder when I was having these cardiac symptoms... I couldn’t even walk a few steps without near collapse and I keep going to Kaiser and, “You have the flu” or “You’re having a panic disorder...” Well, I’m a psychiatric nurse and I knew I wasn’t. It kept going on and on and the emergency room time after time. It just seemed so bizarre to me that they couldn’t figure out what was going on and blaming me, you know. So finally after six months and my insisting on having different kinds of monitors that I could monitor at home, if I hadn’t pushed for that I’d probably be dead...what I’m saying is they stick a label on you and that determines how they perceive you. Subject 0014

You go through these unbelievable periods in your life...periods of depression, yes...I am old. I can’t believe it. I can’t believe I’m gonna be eighty-four years old. Nothing changes in your core, you know, but you know it. You know it when you walk down the street. Most old people are invisible, because this is a youth-driven society. You don’t count. You count with your peers, but you don’t count across the board. It’s dismissiveness. It isn’t cruelty. It’s just dismissiveness. You don’t count in my life on the street. You see it. You feel it. You know it...and my life is so much more than being old or being depressed...And now, my life is pretty good. I have three or four friends, I take cello lessons. I paint. I volunteer at the best job in the world. There’s so much more, well, more to me anyway. Subject 0003

“The Way I See the World”:

Family of Origin – The Late Life Scars of Early Wounds

Often times when describing the story of why they felt depressed, participants connected their late life experience of depressed mood with their earlier or even formative life experience (often related to their mothers). Seventy-five, eighty, ninety year old participants described earlier trauma that left indelible marks and affected their own understanding of their later life and depressed mood. These earlier wounds were

recollected with perfect clarity regardless of how many years had passed. It seemed like a scar, always visible, the recollection always close to the surface. These early life stories were told because participants felt such stories were relevant to their experience of depressed mood in later life. They often said things like, "I need to tell you this so you'll understand," or "I guess I should lead up to answer your question," or "Let me explain, because I think in life, looking back, things like that traumatic...sort of prepares you for something up the road." In other words, they wouldn't talk about their experience of late life depressed mood without placing that story within the larger story of their past life experience.

My mother was literally mentally ill and I am the youngest of three kids... my mother was diagnosed as paranoid, which is very, very extreme and I was the closest to her. Although she was very, extremely critical and emotionally abusive of me, at the same time, I was the most loyal. She was living in Oakland, but for years and years, she had been plying me with these stories, bizarre stories, mainly about my father being the agent of her persecution. Very painful stuff. Treating me as though I was her persecutor. The irony and push and pull of that relationship was intolerable, but that's all I knew was being battered, and at the same time being fiercely loyal for God knows what reason. Subject 0004

She married my dad and he was a very social, successful business insurance man...and so he did have affairs and she found out about this one he had, actually, while she was carrying me...I figured out, "well that's why she only had one child." She never had another child and she probably didn't even want me, maybe she even tried to get rid of me, you know. You think about all these things. All these shocking things the undercurrent actually going on in my life, I realize the influence on me emotionally. Subject 0010

You know my mother had this problem with light. Actually my mother committed suicide when she was sixty-two and she did this just before Christmas you know, when the day is so long and dark and that was a shock to get the phone call from my sister that Mommy had died. I don't know, part of it might be the light syndrome. I don't know, but she also felt worthless. Maybe this has a lot to do with my feelings on those low depression days that I also feel worthless. Subject 0012

My mother was very very depressed. My mother committed suicide. I had just gotten out of the service. I was twenty-five when she committed suicide... I think if you look at the formative early dynamics in a person, and try to figure out that I can see how that might have affected me, how I see the world...She was a very independent woman. As a result, I became the child of a black sheep and never felt connected, never felt wanted, never felt that I was a part of this family. We lived with her

parents off and on for several years when I was a very young kid. I do remember the alienation. I remember the feeling of people kind of walking by me and not wanting to have anything to do with me...I think that has a lot to do with the way I look at life. I look at life feeling unsafe. I feel like I'm just kind of out there on my own. This, of course, gathers a certain momentum into old age. Subject 0025

Action – Coping with Depressed Mood

Participants were asked to describe what they did to help them cope with their depressed mood. What helped them to feel better? Some participants accessed more traditional biomedical treatments such as antidepressant medication or psychotherapy. Some participants found alternative helps such as informal peer support, physical activity or volunteerism. Many participants used both biomedical and alternative solutions in combination. It was clear that older adults saw themselves as part and parcel to their own recovery. Even though, as mentioned earlier, they had an understanding that “this too will pass” they weren’t simply waiting for things to get better. They were active in their own treatment and recovery and engaged with their families, communities, society and the world along the journey out of depressed mood. Here are some of the types of coping strategies they reported finding helpful:

“Being Able to Talk to Someone” –

This type of coping included psychotherapy with a professional but also included seeking out attention or processing emotions with an informal support network such as family or friends.

But I think the therapist is extremely helpful too. Talking to someone you know has, is educated like the woman I have gone to see... but I think a therapist or someone who was depressed is very important. But it too has to be someone who can identify and feel, you know, be the right one. Subject 0007

I think I finally shared with [Barbara], that kind of helped to have someone to bounce it off of. Certainly, I know, I mean I did have good support in all three of those instances and so I think that helps a lot. Because if other people believe in you or whatever that it does give you some assistance... but I really think that having someone alongside, that really doesn't understand depression, but understands you was a great help. Subject 0041

You'd sit there and talk to a person who was interested in what you've got to say and what you are going to ask and a qualified individual who knows what they are talking about psychologically. It always calmed me down, but gave me answers you know. Subject 0016

I've been seeing an excellent psychologist for years and I've never focused on anything in particular, like, I'm going in to see somebody on a regular basis 'cause I think it's a good idea. You get to talk about and

think about. You can air out. You can blow off, and it's not real dramatic, but it's a very useful soul-nurturing. It's way beyond emotional. It's like spiritually nurturing possibility. Subject 0018

“Call the Good Lord”

Spiritual support was often reported as a resource that helped older adults cope with their depressed mood.

Call the good Lord. He's the only one who can help. It's the only thing that helped me. Subject 0017

I have to believe that my faith has helped me a lot. I mean I just gotta believe that...My faith has a lot do with that as well as the other people, influences, good friends, good relationships. And I think, people without that have a lot more problems because it becomes so inward. Subject 0041

I say it's the grace of God, because I have strong religious beliefs...I'm optimistic, I have a strong faith and this allows me not to be too worried. Subject 0034

I've been going to church all the time, but I think church is like a ritual. You go, you say the thing. I say my best prayers right here at home – I just talk to God. It helps, but I think, mainly, it's my own way of dealing with this. Subject 0014

The things that help me are actually Christ, the Lord Jesus, moving deeper into a relationship with you...It's forming a relationship with Him and learning how incredibly merciful He is, open, and how there's just no words to describe the mercy of God. That's what saves me. That's what saves me...His faithfulness is what holds me up. It just never runs out. I used to think it did. I used to think that God really didn't want to hear from me because I'd been so bad. It took a long time to get on the other side of that...that, more than anything else, more than any material goods, more than friends, more than anything else, that really keeps me – it'll never let me down. Subject 0025

Well, I go to religious services Monday and Thursday; and also Saturday and any Jewish holiday that might come in between. And besides that, I go to a Bible study class on Wednesdays. And I think that's very helpful. Subject 0038

“I Do All Kinds of Things to Improve My Mood”

Older adults reported engaging in a variety of activities in order to improve their mood. Many mentioned exercise or social activities as a means to coping with their depressed mood. However, participants reported a wide range of these coping activities

including reading, gardening, and playing piano. Some examples of coping activities include:

I keep very busy and I do all kinds of things to improve my mood. I've discovered the joys of exercise, so I get those endorphins working and I am very involved in social things to try to keep myself busy and happy. Subject0007

I was quite depressed and felt very, kind of disoriented with myself and of course the best thing for me to do, my therapy, is to go out and take a walk in nature, so, I did take a walk...but I felt it very important to, really, to just be in contact with nature at that point. Subject 0012

Well I'm really surprised at myself to say that I find exercise makes a big difference; seeing one's friends; activity of a selfless kind....helping other people, physical activity, being involved with a group of friends and family. Subject 0008

I try to laugh every day...Laughing and music will bring you out of anything; and I play with two instrumental ensembles a week, and then I sing in a chorus. I know that there are these moods, but I look them carefully and I decide how I am going to handle this. Subject 0015

Helping Others & Volunteering: "I do quite a bit of volunteer work... And the more wholeheartedly I enter that...the more healing goes on."

Participants reported that volunteering and helping others was a way to cope with their depressed mood. Some said that it helped them to not focus so much on their own problems. Others said that it made them feel useful or full of purpose. Older adults reported that there was something therapeutic and worthwhile about helping others that worked to improve depressed mood.

I'm going to make my time count; so there are a lot of causes that I want to work on...I did a lot of volunteer work. I still do quite a bit of volunteer work, and the more wholeheartedly I enter that, I think, the more healing goes on. Subject 0007

Well my daughter's death made me feel very impotent. I couldn't stop it. I couldn't protect her; so, the capacity to help other people and to do good for them feels like, oh, I don't want to say vindication, but in some ways, a relief from my own inability to help. And I think about her a lot; and one of the things that I do, and I've done – I think I've made something like forty-seven hats for chemo patients. I remember going shopping with [Denise] for a hat, and we were both so appalled at how expensive they were; so I thought, well, one of the things I can do is make hats for chemo patients, and I launched myself into that...I think

about these people who are losing their hair and I hope that they're warm and cozy. It feels good. Subject0008

The death of my husband was that was the most difficult and then my own retirement after 37 years of teaching. And then a neighbor up the street had too many [exchange] students and he said he wanted me to take one of them...and actually that was my salvation. It just turned everything around because the first student that I got...was extremely needy and it was wonderful because I really had something to give...and my whole focus was to help him, help him get adjusted and to teach him English, and I think he was in as much need of me as I was of him and that really absorbed my attention and made me feel, I think made me feel very useful. Subject0009

You know there are all kinds of volunteer work; I do feel that when I go to the nursing homes and I feel like, you know, it's a job but I feel like doing good and here, too, you know getting people to move and feel good. That's what makes me feel good too. Subject 0011

I also worked on the Alameda County Crisis Line. I do a four-hour shift once a week...that's been a really wonderful thing for me...they're extremely understanding, the crisis center guys, we're on the phones so we don't have much chance to talk back and forth, but what little they know, being crisis center workers they take that in stride. They get people like me on the phone (laughs). Of course, I have a wonderful openness, facility with people who are hurting. They say that it's important in this field to have experienced pain so that you can empathize with it, pain in other people. I certainly have that. Subject 0025

Conceptual Construct – The Knowledge of and about Depression

How do older adults define and describe depression?

After inquiring about each participant's lived experience with depressed mood, the researcher then directed study participants to detail their knowledge about depression. Often participants were simply asked, "What does depression mean to you?" or "How would you define and describe depression?" In general, study participants were able to express either a definition of depression or a description of depression and sometimes both. Depression as defined by its symptoms was the most common response to this prompt. Similar to earlier descriptions of depressed mood, study participants described and defined depression in three ways: 1) feelings, 2) lack of activity or motivation, and 3) physical symptoms. The following quotes give example of depression knowledge as evidenced by describing depression symptoms, including both moods and behaviors:

I've seen people who are depressed so to me, as an observer, it means a certain isolation, drawing away from people. On occasion it might be

recounting feelings, but the essence of depression to me might be associated with isolation. Subject 0001

Wanting to run, having thoughts of how to kill myself without harming other people or causing trauma; which is crazy because it always would; uh, loss of appetite, loss of interest in a lot of things...I couldn't sleep at night... and you ruminate. I said, 'You know, I am ruminating, and I don't like that.' That's what I did a lot when I was depressed... I mean a constant rumination on it, which was sick, really sick, and I knew it. Subject 0003

Anxiety if part of it; that panicky feeling, anxiety that you can't do something that you can't accomplish something, things just aren't going right. You are defeated in some ways; you just feel, I don't know, frustration, all those things. Subject 0010

Real depression, not just where you don't give a damn about anything anymore? You don't do the dishes, you don't care, you don't care. It's really bad. Subject 0014

Feeling withdrawn, feeling fatigued for no reason, feeling sleepy certainly not, at the moment, not being social at all and just kind of withdrawn. Subject 0024

Well I guess by its symptoms; sleeping a lot, not wanting to do anything, not being able to – waking up in the night and not being able to get things out of your mind. Not in my case, but I think, suicidal tendencies. Subject 0026

Chronically sad, uh, chronically preoccupied with negativism. Unhappiness, uh, blaming others, circumstances for, um, what happens or what you do. Subject 0027

A deep melancholy, a deep condition of melancholy where one feels, I suppose, either not worth much or just very unhappy with one's situation Subject 0031

Well depression is I guess it's not anxiety. You seem like you've lost control and you exhibit certain moods you know. You can be lethargic, you can be angry, you can be irritable, and you're not performing; you're not a happy person. So, you're going through all these different kinds of moods. That's how I define it. Subject 0039

Other respondents described or defined depression based on their own lived experience or their observation of another's experience with depression. In many ways, the symptoms, moods and behaviors described, and exemplified in the following quotes, are

similar to those given above (in terms of feelings, lack of activity or motivation, and physical symptoms), but also showcase the very personal connection between knowledge and experience as it relates to depression in later life. The language here is more personal (often in the first person) and less abstract.

The inability to get up and function, to participate in your life, to be totally turned off to whatever it offers. I mean, I've had that inability to get up and face life. Subject 0022

Depression is to me very worrisome because you do things that you normally wouldn't do, and you know, I feel, you know, like I had this weight on my chest, I mean, I'd feel it with pressure, headache pressure where nothing, like I couldn't come up with anything that would bring me up. Can't drink, don't take drugs... luckily I have AA, I have certain things but sometimes it would get so bad that that thing with the bridge came up and that was the first time I thought, 'Hey, I could do that.' You know, so I think depression just makes you feel like there is no hope. Subject 0004

Well I went through how I felt at that time, feeling somewhat worthless and "why am I here?" et cetera... I can't find the words for depression, I really can't. It's a very low feeling, heavy almost, as if your body just does not want to do anything, your mind does not want to function. Subject 0012

It was funny that I couldn't do things. I didn't want to read. I didn't want to listen to the music. I was just unable to do things. I could barely see my cat and get up and drink tea or something. "Subject 0020

For me, depression is like being in a black hole. Everything is shut down and I have no – it's the power of the emotions to totally immobilize me. They say to- others would say to a person like me, 'Well get over it. Snap out of it. Go do something.' That's not even on the table. It's just kind of a living paralysis of the total being and I can't see, emotionally, past my nose. There's books I want to read, people I want to see, things I want to do. It's all disappeared during that time. So it's a dark blackness where there's just no tomorrow; there's just totally black. I see, I really understand suicidal people; the feeling of hopelessness, which blanks out everything else. Subject 0025

Well I think that for myself- just this feeling of not being in control. I'm not really a control person, but my life, I could not cope with what was going on and it was not something that I had any control over. I don't know what I experienced, but when I really broke down and started crying it was- I had – I had no feeling that I could do anything about it. It was because – it was not something that I needed to have. It was not

something that I felt like I was- you know- it was just a weird experience that I had that was not from me. It was just sort of an outside thing that was causing it. Obviously, it was me internally, but it just felt like that. Subject 0041

I would say it's a debilitating illness, like it's an overwhelming sense of hopelessness, sadness that one cannot cope with. I think the truly depressed can't – we used to have this friend who would say to her depressed mother, "Just get a hold of yourself, get a grip." Well if you could get a grip, you wouldn't be depressed. I think it is often beyond the individual's ability to get over it. To my mind, it's not just sadness. I mean there is a sadness component to it, but I think it's much more debilitating. I think it's much more out of control, to my mind. Subject 0008

How do older adults understand the cause(s) of depression?

Participants were asked variations on the question, "What do you think makes people depressed?" or "What do you think causes depression?" Participants understood two types of causes for depression: 1) biomedical causes such as a chemical imbalance or genetic predisposition toward depression and 2) Contextualized causes or situational depression brought on by something such as a significant loss, financial worries or relational problems. Some participants thought that both causes could be at work in bringing on a depression.

Biomedical Causes

I'm sure it has something to do with your physical make-up. Subject 0007

It could be, I heard and read that it could have to do with the physical state of a person. Subject 0001

I think there are chemical imbalances that cause depression. Subject 0008

Well, a lot of people say that it is [due to] chemistry, because if you take some of those drugs or pills and so forth, it helps. Subject 0010

I've been studying the effects of the environment on genetic expression, so I'm moving past the ideas of, "you can have genetic causes" and I would say you have "family causes" that are both genetic and environmental. Subject 0018

I mean obviously there is a biological, you know, I am sure that some people are genetically set up to handle things better than others or to have worse moods than others. Subject 0023

Well I think part of it must be chemical, because my husband kind of became depressed as he got older...I am pretty sure it must have been chemical, or in part chemical because his father was like that and now my daughter has experienced some depression and in fact she is on medication for it...and she is very much in personality like my husband and so I kind of think that that is a chemical thing. Subject 0028

Well, I ascribe depression to a physiological cause. Subject 0029

Probably a predisposition. I suspect so. Because even in very bad personal circumstances a lot of people don't become depressed. They just talk it out and go along with their life, do the best they can, they don't become depressed, so I suspect it's a mental predisposition, might even be a genetic predisposition. Subject 0031

Contextualized Causes – Situational Depression

I think loneliness, maybe disappointments enough. Subject 0002

When you get old and cannot have as much activities as before and they're sad and then the impact of that is depression. Subject 0005

I think there's, in my mind, a situational depression where something has happened to make one depressed. Subject 0008

So what would make some people depressed? I guess just not an easy life I guess. No one to help you and not enough money to go on, I guess. Probably that is what makes a person depressed. Subject 0019

Financial concerns, social, not having companionship, infinite variety, but I should think that health and finances would be the main things. Subject 0022

I am sure that some people get depressed because of financial problems, marital problems, accidents, and sickness in the family and that sort of thing. Subject 0024

I think hopelessness would have to be at the top of the list; just a feeling of loss of hope would be number one. That could be caused by circumstances, the loss of family, significant others, but it would result in a feeling that there's no more hope for me. There's no more tomorrow. I think basically very simple about it; I think hopelessness would be a factor. Subject 0025

I think also depression certainly must hit people that are very deprived and so terrified of what the future is going to bring them because they haven't had any advantages. Subject 0028

I guess tragedy, like yesterday we were watching Oprah and we're watching this lady who was abused by her husband, that was very sad. But that could make someone depressed. Subject 0035

With me it was definitely loss of activity. I loved going to work in the morning. I couldn't do that anymore...people under my age have to work in order to succeed. When that's taken away from them, it's darn hard. Subject 0037

Well, I think what causes depression is that events occur, whether real or not, you perceive them as going to be catastrophe, it's going to be very negative on you emotionally, physiological, and you're losing, you're just not a happy person because you have all these emotions. Subject 0039

Things happen and there is a cause and effect...I think in my case, it was definitely caused by outside events. Subject 0041

What sorts of treatments do older adults recommend for depression?

Participants were asked variations on the question of, "What do you think helps people with depression? What makes them better?" Their responses mirror their own experience of what they found helpful in terms of coping strategies. In other words, if they found exercise helpful in improving their depressed mood, then they recommended exercise as a treatment for depression. If they found talking to someone helpful in improving their depressed mood then they recommended talking to someone as a treatment for depression. Those who had experience depressed mood recommended treatment(s) that were often interlaced with their own experience of what they found helpful. For those who reported not having experienced depressed mood in later life, their recommendations for treatment often relied on their knowledge of what helped a friend or family member deal with his/her depressed mood.

Talking to someone – therapy, seeking out attention, processing emotion (with friends or in therapy), family support

Being able to talk to someone, to look at the situation with fresh eyes, new perspectives, re-examine, social contact, whether it's professional or not. Subject0022

"Talk to talk. Talk. Find a friend, talk. Meet somebody else, especially if you're an older person. Go to a senior center. If you don't like the first one... go find another one. There are lots of them all over, 'til you find something that's interesting and pleasant to you. Subject 0014

How you can help people who are depressed; I think they need a lot of friendly contact and there should be a kind of support circle that would be set up to help those people. That means taking them out of their

home, where they're apt to be more depressed as they look around and realize that they're alone...People should call them up and take them out and do things with them; walk, whatever..and I'm talking about a family circle, people who have known him and his, or her, and they know the whole story in a way. They're the ones who should be calling. Subject 0015

Spiritual Support

If you catch something that you can count on for answers, use it, for Christ's sake, you know, if you get a book, use it. Don't just let it lay there, you know. Subject 0016

Tell them to pray. Call the good Lord. He's the only one who can help. It's the only thing that helped me. Subject 0017

I might recommend somebody to join a social group or join a church or join something, perhaps where they can be helped and have fellowship with other people, although I am not a Christian. Subject 0019

Getting out and Keeping active "Doing" – exercise, gardening, reading

Encourage people to go out and be with others...do whatever they can to keep healthy, being healthy body for old people and that's good. I know that not too many people can be healthy to age of ninety-four like me but they still have to kind of take care of themselves to be healthy. Subject 0005

"Being with people, being with friends. I usually am not too good with groups of strangers, although I have tried to get better at that and approach people and get interested in them and not expect them to get interested in me and I think that helps. I think exercise helps, but I don't get a lot of that. I walk, but not enough. Subject 0024

I guess as much as you can just think away from yourself. Get some hobbies. I am interested in astronomy... I think that getting in with a group of people with same interests probably would help a lot and thwarting depression perhaps. Subject 0019

Thinking of others (not ruminating on your own problems) – volunteering

I did a lot of volunteer work. I still do quite a bit of volunteer work, and the more wholeheartedly I enter that, I think, the more healing goes on. Subject 0007

To get out, find something that interests them, to volunteer if they're physically able to, to get out and look at what's really going on in life. I

volunteer at a clinic for low income women who are struggling with cancer. I think getting out in the world rather than sitting at home thinking, 'Oh, poor me.' Subject 0022

Chapter 5: Discussion

Introduction

The purpose of this study was twofold: 1) to understand the meaning and experience older adults ascribe to depressed mood in late life, and 2) to explore how older individuals define and conceptualize depression, its causes and its treatments. Specifically, this investigation attempted to elicit, via in-depth interviews, information regarding older adults' beliefs and perceptions in the following two domains:

1. Lived Experience of Depressed Mood
2. Knowledge of and about Depression in Later Life

This chapter will attempt to synthesize and interpret the meaning of the results presented in Chapter 4. In other words, the work here is to tell the story of these study participants.

Three important themes of the research are discussed. The first relates to the recurrent idea that the context of study participants' experience matters. More specifically, the context of their depressive symptoms is imbedded in and related to their larger life experience as whole and complex people. Second, study participants are able to influence their mood through their choice of actions and attitudes. Study participants were part and parcel of their own treatment of their depressed mood, and the means by which they pursued that treatment were also important. Third, the experience of depressed mood is related to knowledge of and about depression. Possible implications for theory are presented. Finally, conclusions for social work practice and research are addressed.

The Importance of Lived Experience in Understanding Depressed Mood

Study participants were clear that describing the context of their depressed mood was important to understanding their lived experience. This story telling extended beyond the immediate context of their depressed mood, as they explained the importance of earlier life events or relationships as crucial for understanding their late life experience of depressed mood. For example, one participant saw the suicide of his mother when he was a young man as influencing how he perceives the other slings and arrows of life; because of this early life loss, he stated, "I can see how that might have affected me, how I see the world...I think that has a lot to do with the way I look at life. I look at life feeling unsafe."

In other words, not only did study participants describe their depressed mood as interwoven with the context of their lives; they spoke of themselves within the context of their entire lived experience. It is possible that this self-schema or self-perception may explain, at least in part, participants' resistance to labels or treatments that focus on a set of symptoms or categories when they see themselves as so much more than that. Study participants conveyed the importance of having these stories be understood. It's as if study participants perceive health professionals as ignoring the "forest" of who they are for the "trees" of their depressive symptoms.

The Context of Depressed Mood

What do we know about the importance of context in the development of depressive symptoms? Though the exact cause of depression, and mental illnesses in general, is unknown, a stressful social and family environment or other precipitating stressors contribute to both the onset and persistence of late life depression through time (Blazer D. , 1990; Schless, Teichmen, Mendels, & DiGiacomo, 1977; Hudgens, Morrison, & Barchla, 1967; Cole & Dendukuri, 2003). The influence of precipitating factors on the development of depressed mood in older adults has also been documented (Butler, Lewis, & Sunderland, 1998). A meta-analysis of negative life events and late life depression concluded that almost all negative life events appeared to have a modest but significant relationship with depression (Kraaij, Arensman, & Spinhoven, 2002). Given this knowledge about the onset of mental illness in general and depression specifically, participants in this study were expected to report some type of precipitating event prior to the onset of their depressed mood. This expectation was further supported by the conceptual framework: the Stress Process Model (Pearlin, 1989). This model suggests that depressed mood is a “reaction” or response to the “antecedent”, which is a preceding life stressor or event. As expected, all participants in this study who described a significant experience with depressed mood reported a precipitating event or stressful life situation that contributed to the onset of their depressed mood.

It is important to note that not only was the experience of depressed mood in later life precipitated by a stressor or significant life event, but that study participants felt compelled to share this story and to articulate the importance of sharing this story. Why? It could be that people in general, or older adults in specific, store information in context. In other words, we may store feelings, thoughts, and meaning in the context of particular experiences. It is also possible that sharing the context, as happened in these qualitative interviews, normalizes the experience of depressed mood. It may be that due to the stigma of depressed mood, which we will address further in this chapter, that older adults feel compelled to explain how or why they came to feel that way.

It is interesting that many participants commented on the nature of sharing these precipitating events saying, “No one has ever asked me about this,” “Thank you for listening to my story,” “Nobody ever wanted to know why I felt sad,” and “It means so much to be able to tell you these things and have you listen.” In other words, the story of the context of their depressed mood – what happened to make people feel that way – was seen by participants as being very important, and was often ignored by health care providers. This context was crucial to their described experience of depressed mood, to the judgments they made about their depressed mood, and to the actions they took to cope with their depressed mood. The context of depressed mood in later life matters.

Why is the context of depressed mood so important? What does this mean for social work practice and research? First, it is important to remember that, prior to the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), the primary means of systematically distinguishing depressed mood from depressive disorder was by the clinical exploration of the context of the depressed mood. Prior to the DSM-III clinicians attempted to distinguish depressive disorders from normal sadness that

arises in response to life's losses. For centuries, symptoms of sadness that were "with cause" were separated from those that were "without" cause." Only the latter were considered mental disorders (Jackson, 1986). This traditional common-sense distinction has broken down in contemporary psychiatry, resulting in the confusion of depressive disorder with the normal experience of depressive symptoms (Kirk & Kutchins, 1992a; Kirk & Kutchins, 1992b; Horwitz & Wakefield, 2005; Lehrer, 2010; Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006). The great weakness of earlier versions of the DSM was that their vague definitions were not capable of generating standardized methods of classifying and studying mental disorders. Because psychiatrists had to use considerable personal judgment in fitting a patient to a diagnosis, psychiatric diagnosis was notoriously unreliable. In other words, given the same information about the same patient, different doctors were likely to arrive at different diagnoses.

The DSM-III inaugurated basic changes in psychiatric diagnosis to address these challenges. Explicit diagnostic criteria based on lists of observable symptoms were provided as definitions for each of the disorders, including depression, allowing for improved reliability. However, a major drawback of symptom-based criteria was that they eliminated the consideration for the context in which symptoms arose. One reason for the abandonment of context was this quest for reliability. As mentioned previously, most depressions occur after some triggering event (Jackson, 1986), so requiring that reactions be disproportionate to the context would mean that clinicians would frequently be judging proportionality, substantially reducing reliability. Moreover, there was an impression that psychotropic medication worked on all depressions irrespective of the relation to triggering events, so that the origin or cause distinction was considered irrelevant to treatment decisions (Horwitz & Wakefield, 2005; Kirk & Kutchins, 1992a; Kirk & Kutchins, 1992b). Unfortunately, without an exploration of the context and meaning, one simply cannot tell whether someone is likely suffering from intense albeit normal depressive symptoms or depression (Cole & Dendukuri, 2003; Kraaij, Arensman, & Spinhoven, 2002; Wakefield, Schmitz, First, & Horwitz, 2007).

Another flaw of recent editions of the DSM is that they fail to exclude from the disorder category sadness reactions to events other than the death of a loved one (bereavement) that are intense enough to meet the diagnostic criteria, but may still be normal reactions. Normal depressive reactions that are symptomatically similar to depressive disorders encompass a wide range of negative events such as discovering a life-threatening illness, loss of significant social or professional roles, intense family conflict, or failure to achieve long-anticipated goals. There are many other intense reactions to loss that, like bereavement responses, might satisfy DSM-IV criteria but may not be disorders. These diagnostic flaws are even more pronounced in older adults, who are often experiencing multiple ongoing losses that can extend or at least complicate their bereavement or depressive response (Wakefield, Schmitz, First, & Horwitz, 2007).

On the one hand we have the older adults in this study who reported a contextualized depressed mood. Further, they repeatedly stated that this story, this context mattered to them and to their understanding of their depressed mood. On the other hand we have the mental health profession, which, in part due to a desire for more reliable diagnosis, has moved to disregard the contribution of the context of depressed mood. In addition, without ascertaining the context of the depressed mood, we are unable to

determine if older adults are suffering from a diagnosable depression or appropriate depressive symptoms. If, however, persons with normal sadness or a diagnosable depression both respond to treatment, then does the context really matter?

To the social work practitioner it certainly should. First, older adults in this study are stating that the context of their depressed mood is important and practitioners should listen to these stories. If such stories matter to our clients, they should matter to us. Findings from research on negative life events and depression also support practitioners paying attention to the context of depressed mood (Cole & Dendukuri, 2003; Grossman, 2004; Kraaij, Arensman, & Spinhoven, 2002).

Social workers also ascribe to the ecological systems model of human behavior. This approach integrates both treatment and reform by conceptualizing and emphasizing the dysfunctional transactions between people and their physical and social environments. Human beings are viewed as developing and adapting through transactions with all elements of their environments; this is also known as the person-in-environment conceptualization (Andreae, 1996). Social workers understand that persons with depressed mood experience that depressed mood in context, because of their direct involvement in a larger social environment or context. The profession of social work often differentiates itself from other helping professions by claiming it is the only profession to take into account this person-in-environment concept. In fact, the Person-In-Environment System Manual (1994) was developed as an alternative to the commonly used disease models (e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD)) to implement social work philosophy and area of expertise (Karls & Wandrei, 1994). Results from this study support the work of the social work profession in considering the person-in-environment and specifically the context of depressed mood. Further, results from this study suggest that the social work profession needs to actively resist diagnostic systems and models that simplistically ignore the context of mental health issues and must advocate for a return to the consideration of context in diagnosis and treatment of older adults with depressed mood, and perhaps of all clients suffering from mental health issues.

Certainly, some would argue that effective treatment of a disorder does not require knowledge of causality. This is true in the case of many cancers. We don't always know what causes cancers, but that certainly doesn't stop efforts, many of them effective, to treat cancer. Though we don't know what causes depression, that alone is not reason to ignore evidence-based interventions. It is also important to note that the context of study participants' depressed mood may likely be only part of the causal picture. Yet, this story is important to the study participants. As we seek to more fully understand the etiology of depression, we must also seek to uphold and understand the priorities of the clients we serve or we run the risk of doing more harm than good.

"The Way I See the World":

The Late Life Scars of Earlier Wounds

Often times when describing the story of why they felt depressed, participants connected their late life experience of depressed mood with their earlier or even formative life experiences. They described earlier trauma that left indelible marks and affected their own understanding of their later life and depressed mood. These early life stories were told

because participants felt such stories were relevant to their experience of depressed mood in later life. They often said things like, “I need to tell you this so you’ll understand,” or “I guess I should lead up to answer your question,” or “Let me explain, because I think in life, looking back, things like that traumatic...sort of prepares you for something up the road.” In other words, they didn’t talk about their experience of late life depressed mood without placing that story within the larger story of their past life experience.

Research suggests that adverse conditions and traumatic events during early life are a risk factor for stress-related diseases such as depression and post-traumatic stress disorder (de Kloet, Sibug, Helmerhorst, & Schmidt, 2005; Trappler, Cohen, & Tulloo, 2007). In a sample of elderly trauma survivors, 56 percent were diagnosed as having a major depressive disorder (Trappler, Cohen, & Tulloo, 2007). Such findings further highlight the potential of depression-targeted psychotherapies for older adults and the importance of exploring life experience as it relates to depressive symptoms (Antonuccio, Burns, & Danton, 2002; Hunkeler, et al., 2006). In fact, recent neurobiological research suggests that early adverse events and traumas can enhance stress responsiveness and lead to greater susceptibility for psychopathology, such as depression, in adulthood (Cirulli, Francia, Berry, Aloe, Alleva, & Suomi, 2009).

“You Can Take a Pill or We Can’t Help You”

Participants in this study reported that antidepressant medication was virtually the only type of treatment they were offered. Experimental studies comparing psychotherapeutic interventions and “usual care” of late life depression define “usual care” as an antidepressant prescription and one-time counseling by a primary care physician (Katon, et al., 1996; Hunkler, et al., 2000). In other words, study participants were correct; “usual care” translates into a conversation with your primary care physician as he/she writes out a prescription for an antidepressant.

This relates to our earlier discussion about the context of depressed mood and the importance of seeing the client as more than just a list of signs and symptoms of a disorder. Antidepressant medication attempts to treat what are seen as the biological causes of depression. This type of treatment ignores the unique context of the depressed mood and the larger story of why a person, or an older person for that matter, may be experiencing depressive symptoms. Since study participants reported the importance of contextualized understanding, it is not surprising that they also reported resistance to a purely biomedical antidepressant treatment regimen.

Further, evidence-based treatment is valuable to the extent that the evidence base is complete and unbiased. Though there is some evidence that supports the use of antidepressants as treatment for major depression in older adults (Wilson, Mottram, Sivananthan, & Nightingale, 2001), the strength and reliability of this evidence has been recently called into question. Consider a recent study that found that people on antidepressants had a 76 percent chance of relapse within a year when the drugs were discontinued. In contrast, patients given a form of cognitive therapy had a relapse rate of 31 percent (Hollon, et al., 2005).

In a meta-analysis of the Food and Drug Administration (FDA) database of controlled trials used in the initial approval for the most popular antidepressants it was found that antidepressants demonstrated a clinically negligible advantage over placebo

(Kirsch, Moore, Scoboria, & Nicholls, 2002). These results are surprising, because they come from studies underwritten by the pharmaceutical companies. According to Antonuccio & partners this analysis overestimates the antidepressant effect because placebo washout strategies, penetration of the blind, reliance on clinician ratings, use of sedative medication, and replacement of nonresponders may penalize the placebo condition or boost the drug condition (Antonuccio, Burns, & Danton, 2002).

Recently the New England Journal of Medicine reported that the makers of antidepressants never published about a third of the drug trials that they conducted to win government (FDA) approval, misleading doctors and consumers about the drugs' true effectiveness (Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). In published trials, about 60 percent of people taking the drugs report significant relief from depression compared with roughly 40 percent of patients on placebo pills. But when less positive unpublished trials are included, the advantage shrinks. The drugs outperform placebos, but by a modest margin. While 94 percent of the positive studies found their way into print, just 14 percent of those with disappointing or uncertain results did. Turner and colleagues (2008) suggest that the selective reporting sets patients up for disappointment.

These findings do not justify the popularity of antidepressants, which may have been fueled in part by publication bias and outstanding marketing (Antonuccio, Burns, & Danton, 2002; Lehrer, 2010). Given these controversies, is it any wonder that participants in this study expressed frustration and at times consternation that antidepressants seemed to be the only treatment offered for their depressed mood? Further, there is a danger that such prescription of antidepressants could tend to impede further clinical exploration of the patient's presenting problem, since the antidepressant is often seen as the definitive treatment. As with these study participants, the patient may very well have another significant reason why he or she is feeling sad, demoralized, or experiencing other depressive symptoms. If the patient's problems don't respond to the antidepressant then "resistant depression" is tagged on, bringing even more complex polypharmacy and probably still not addressing the circumstances that are driving the patient's presentation (Grossman, 2004).

In a recent interview with Jonah Lehrer (2010), Andy Thomson, a psychiatrist and researcher at the University of Virginia, said,

Sometimes the symptoms can spiral out of control. The problem, though, is that as a society, we've come to see depression as something that must always be avoided or medicated away. We've been so eager to remove the stigma from depression that we've ended up stigmatizing sadness...I remember one patient who came in and said she needed to reduce her dosage...I asked her if the antidepressants were working, and she said something I'll never forget, 'Yes, they're working great,' she told me. 'I feel so much better, but I'm still married to the same alcoholic son-of-a-bitch. It's just now he's tolerable.' (n.p.)

The point is that people, like Thomson's client, are often depressed for a reason; their pain is about something. In such a scenario, antidepressants only serve to interfere with the solution, so that clients are discouraged from dealing with their problems (Lehrer, 2010).

A Loss of Power and Credibility: The Stigma of the Depression Label

Study participants were resistant to having the diagnosis of depression or the label of depression put on them. Respondents didn't feel that a diagnosis or label of depression applied to them; they held another perspective or saw another explanation for their depressed mood. However, this resistance wasn't only due to the stigma that accompanies having a mental illness. Rather, it seemed to be tied to the idea that such a diagnosis would further undermine their power and control in society, power and control that was already diminished due to being older. Further, the stigma of a depression label was related to the fact that study participants saw themselves in the context of their lived experience and resisted a label that essentially ignored this larger story.

Current literature sheds some light on what we know about older adults' resistance to being labeled as depressed. Older persons may not accept the diagnosis of depression in part due to beliefs and explanatory models of illness that do not line up with the treatments most commonly offered by primary care physicians (Givens, et al., 2006; Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006). When older adults attribute their depressive symptoms to social causes, they are less willing to view their condition as requiring medication or other treatment. Another major reason for elderly people not accepting a diagnosis of depression may be that depressive symptoms are seen as a normal part of aging and life, rather than an illness amenable to treatment (Givens, et al., 2006; Levkoff, Cleary, Wetle, & Besdine, 1988). Many older adults report a desire to experience natural sadness, which has important meaning especially in reaction to loss, and do not seek or accept treatment, because they do not want to see this sadness prevented (Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006; Givens, et al., 2006).

It appears that elderly individuals also feel the stigma of mental illness. Schulman (1989) argued that older adults are less likely than younger adults to report lowering of mood as this generates feelings of shame (Schulman, 1989). Levkoff and colleagues (1988) hypothesized that elders' discomfort in admitting symptoms of a psychological nature leads them instead to legitimize their help seeking with an overly negative appraisal of their physical health. Sirey and colleagues (2001) purport that people of all ages perceive the stigma of depression. However, in their research only among older adults did perceived stigma predict discontinuing depression treatment (Sirey, et al., 2001).

Health and mental health services should aim to preserve dignity and autonomy among patients (British Geriatrics Society, 1997). Yet the literature suggests that, in many cases, these objectives are not being met. Surveys conducted primarily by older people's advocacy groups have directly obtained the views and experiences of older service users (Age Concern, 1999; Help the Aged, 1999; Henwood, 1998). They show an alarming picture of older people being treated unacceptably – with disrespect and indignity – by healthcare providers. Dignity refers to an individual maintaining self-respect and being valued in society. Autonomy refers to individual control of decision making and other activities. The literature suggests that both the dignity and autonomy of older people are often undermined in health and mental healthcare settings. Older people in particular become easily disempowered in healthcare settings (McWilliams, Brown, Carmichael, & Lehman, 1994; Lothian & Philp, 2001).

If the experience of aging threatens deeply held values – such as the desire to be independent, to have control, or be socially esteemed – then both society and individuals will seek to avoid it or deny it as much as possible (Moody, 1994). This denial and resistance are central problems for gerontology and social work (Becker, 1973). These findings point to the literature (discussed in the following section) regarding the importance of locus of control (Benassi, Sweeney, & Dufour, 1988; Voils, Steffens, Flint, & Bosworth, 2005). Specifically, practitioners must work respectfully to engage clients in decision-making and to empower clients regarding their own health and treatment if we are to see less resistance to depression care in later life.

Study findings suggest the importance of a holistic perspective and investigation regarding depressed mood in later life. The context and lived experience of older adults matter for both diagnosis and treatment of depressive symptoms. Geriatric practitioners caution health professionals to “be mindful of storytelling” (Grossman, 2004, pg. 41). We must not assume that every older adult experiencing a crisis is depressed. In fact, those who have been resilient all their lives are likely to remain so (Grossman, 2004). It is important to remember that we can’t cure all the problems that clients may bring to us. We can, however, help our clients to put a name to the problem and help them determine the next steps for help. We should not hand out a diagnosis and an antidepressant just because we want to do something or because we don’t have the time to do anything else.

Affecting One’s Mood through Choice and Initiative – Older Adults are Their Own Treatment

“I Choose to Get Up and Go” – Exercising Control in Spite of Depressed Mood

As presented in Chapter 4, study findings included the belief that though participants could not necessarily control their mood, they could control their thoughts and behaviors, and thereby affect their mood. Many participants engaged in activities or behaviors that they did not feel like doing due to their depressive symptoms, because they understood that these actions would positively influence their mood. Older adults are part of their own treatment for depressed mood. For example, a participant may not have felt like going to her exercise class due to her depressed mood, but she chose to go anyway. What seems to follow is an understanding that their mood will eventually improve if they choose certain actions and attitudes. Participants seemed to understand they would be “better off” for choosing and/or doing the things they didn’t want to do. Again, the emphasis is on “doing.” Participants understood that their “doing” can positively impact or improve their mood.

Briefly, locus of control is a theoretical construct designed to assess a person's perceived control over his or her own behavior. The classification *internal locus* indicates that the person feels in control of events; *external locus* indicates that others are perceived to have that control. There is a long history of investigation regarding locus of control (Rotter J. B., 1966). Research has documented the importance of locus of control in health and mental health. Specifically, locus of control orientation and the degree of depression are related; lower internal locus of control or higher external locus of control was associated with greater depression (Benassi, Sweeney, & Dufour, 1988). Locus of control was also found to be a predictor of adherence to antidepressant medication in an elderly population (Voils, Steffens, Flint, & Bosworth, 2005).

Though this study did not explore the concept of locus of control specifically, many participants certainly reported that they had the power to control their actions and behavior, which they saw as ultimately helpful for improving their depressive symptoms. Given the positive outcomes associated with higher internal locus of control, future research should explore ways in which clinicians can support or enhance the sense of control of older adults with depressed mood.

One way this may be possible is through the use of shared decision-making models in health and mental health care. It is well-documented that clients desire greater participation in decisions about their mental health care than they currently experience (Adams, Drake, & Wolford, 2007; Sutherland, Llewellyn-Thomas, Lockwood, Trichter, & Till, 1989). Research in several areas of medicine shows that active client participation results in a variety of benefits, from increased satisfaction to decreased symptom burden. Many current mental health interventions promote client-centered care, client choice, and self-directed care, but research on shared decision-making for clients with mental illness is just beginning (Adams & Drake, 2006). Toward this end, research on shared decision-making in treatment plans for late life depression may be an important contribution.

Related to locus of control is the concept of self-efficacy which has been described as the belief that one is capable of performing in a certain manner to attain certain goals (Ormond, 2006). It is a belief that one has the capabilities to execute the courses of actions required to manage certain situations, such as the experience of depressive symptoms. The concept of self-efficacy is especially relevant to these study findings since participants believed in their capability and ability to address their depressive symptoms regardless of any power and control dynamics manifested in the clinical relationship with their physician or other health care provider. Specifically, they engaged in a variety of activities and treatments for their depressive symptoms because they had hope that their depressive symptoms could be addressed and they believed they were capable of doing so themselves. Self-efficacy is strengthened, not by some general or abstract instruction, but rather by the experience of successfully dealing with and thus overcoming specific problems, like depressive symptoms or depression. Research suggests that many potential approaches may be available to develop and enhance self-efficacy in the elderly - approaches that potentially could be broadly applicable in community settings with older adults experiencing depressive symptoms (Blazer D. G., 2002).

Even though, as mentioned in Chapter 4, study participants had an understanding that “this too will pass,” they weren’t simply waiting for things to get better. It was clear given their choice of coping strategies that older adults saw themselves as part of their own recovery. They were active in their own treatment and recovery and engaged with their families, communities, society and the world along the journey out of depressed mood. Types of coping strategies used by participants included talking to someone (a therapist or a friend), finding strength from faith or spirituality, engaging in extracurricular activities (exercise, gardening, reading, playing piano, etc.) and volunteering.

Though study participants reported that these types of coping strategies and alternative treatments were helpful to them, this is their perception and not an experimental finding of treatment efficacy. So, the question remains, what can we say about the efficacy of typical and alternative treatments for depression and depressive symptoms? The literature suggests that many types of support or activities may help mediate

depression or depressed mood in later life. For example, a systematic analysis of studies of exercise and depressive symptoms indicated that exercise seems to improve depressive symptoms, but was unable to determine exactly how effective it is or the most effective type of exercise. The evidence did suggest that exercise needs to be continued in the longer-term for benefits on mood to be maintained (Mead, Morley, Campbell, Greig, McMurdo, & Lawlor, 2009).

Although it has received less attention in the literature on treatment of late life depression than antidepressant medication treatment, psychotherapy nonetheless is seen as central to the treatment of the depressed elder (Blazer D. , *Depression in Late Life*, 2002). Despite a number of articles and reviews advocating psychotherapy for the treatment of depression, there is relatively little evidence based on randomized controlled trials that specifically examines its efficacy in older people. Toward that end, a recent Cochrane review was only able to include a small number of patients and studies in their systematic review. They suggest that taken on their own merit, the findings (primarily due to the small sample size) do not provide strong support for psychotherapeutic treatments in the management of depression in older people. However, these same findings do reflect those of a larger meta-analysis that included patients with broader age ranges, suggesting that psychotherapy may be of potential benefit. However, more studies with older adults specifically, are needed to determine efficacy (Wilson, Mottram, & Vassilas, 2008).

Social support has been perhaps the most frequently examined factor in relation to depression outcomes, although the results of previous studies are inconsistent. Holahan & Moos (1981) reported that decreases in social support were associated with increased depressive symptoms. Henderson & Moran (1983) reported that objective social support was unrelated to changes in symptoms, but perceptions of inadequate support are associated with both the onset and continuation of symptoms. George and colleagues (1989) found that both the size of social network and subjectively poor social support were significant predictors of depressive symptoms across time; subjective social support ratings were most strongly associated with major depression (George, Blazer, Hughes, & Fowler, 1989). The methodological limitations of these studies must be recognized, and no systematic reviews of the effect of social support on depression in late life have been published. Additional scholarship is also needed to identify the personal, social, and clinical factors that affect the course, duration, and outcome of depressed mood and depressive disorders. Participants in this study self-reported social support being helpful, but the types and quality of these interpersonal relationships are unknown. Though social support may be helpful in improving depression, it is crucial to distinguish the types of relationships and the quality of social support provided by those relationships.

The relationship between religion and depression has been extensively explored. A review by McCullough and Larson (1999) of over 80 studies that examined the association of religion with depressive symptoms found that people with high levels of religious involvement or intrinsic religious motivation were at reduced risk for depressive symptoms and disorders. However, people from some religious affiliations appeared to have an elevated risk for depressive symptoms and people with no religious affiliation are at an elevated risk in comparison with people who are religiously affiliated. People with high levels of extrinsic religious motivation are at increased risk for developing depressive symptoms. The findings related to intrinsic versus extrinsic religious motivation further

showcase the importance of autonomy and the power of personal choice, which is particularly relevant among participants in this study. Although they found these associations to be consistent, they were modest and substantially reduced in multivariate analyses (McCullough & Larson, 1999). Recent research on the relationship between religion and late life depression suggests similar results; religiousness buffered against depression even after controlling for social support, but spirituality did not have the same protective effect (Wink, Dillon, & Larsen, 2005).

There is a substantial body of literature that documents the effects of volunteering on the health, mental health, and well-being of older adults. Reduced depressive symptomatology is associated with volunteering (Musick, Herzog, & House, 1999). Other research documents that depression was a barrier to volunteering among middle-aged but not older adults, and that depressed older adults selecting into volunteering experienced positive effects (Li & Ferraro, 2006). Most of the data sets used for analyzing volunteerism and well-being in older adults rely on information about volunteering that is very abstract. The nature of the volunteer work and many other factors remain unspecified. Thus, it is not clear what constitutes health-promoting volunteerism. In short, experimental designs are not achieved and causation remains elusive. In other words, volunteerism seems to have benefits, but how much benefit by how much and what type of volunteering have yet to be quantified.

There is some research moving in these directions. In regards to types of volunteer programs that produce positive outcomes, research has recently focused on the Experience Corps (EC) as a model of a civic engagement program for older adults. Experience Corps is a national program operating in 23 public school districts across the country. Older adults are recruited, trained, and supervised to work with students and teachers to improve academic outcomes. Volunteers commit 11 hours per week on average. In a quasi-experiment design, Morrow-Howell and colleagues documented that EC participants from 15 program sites across the country experienced improvements in depressive symptoms and functional limitations after two years of service compared to a matched group of older adults from the Health and Retirement Study (Hong, Morrow-Howell, Tang, & Hinterlong, 2009). In sum, there is a general understanding about the positive effects of volunteering on older adults. However, we need more clarity about specific conditions of volunteering that produce these positive effects.

Scholars have proposed that the altruistic nature of volunteering contributes to its health-promoting qualities. For example Brown and colleagues (2008) studied the effects of helping behavior on recovery from spousal loss and found that bereaved individuals who engaged in helping others experienced a more rapid decline in depression than those who did not. Greenfield (2009) assessed one aspect of altruism, the felt obligation to help others, and documented its protective role against psychological losses in the face of functional decline.

Participants in this study reported that helping others was a way to cope with their depressed mood. Some said that it helped them to not focus so much on their own problems. Others said that it made them feel useful or full of purpose. Older adults reported that there was something therapeutic about helping others that worked to improve depressed mood. However, it is important to remember that study participants were asked to describe what they did to help themselves cope with their depressed mood.

Therefore their report of civic engagement may reflect their personal therapeutic choice to cope with their depressed mood. It is therefore possible that this finding has, at least in part, more to do with elders' locus of control, self-efficacy and autonomy than with the benefits reaped from volunteering.

Even so, it seemed that, at least for some participants, the type of volunteering was directly related to the context of their depressed mood. For example, one participant became depressed for several years after losing her daughter to cancer and she chose to volunteer to make hats for chemo patients as a way to vindicate her inability to save her daughter from death. Another participant who has suffered from depression for many years of his life volunteers at a suicide hotline as a way to help others as he himself has been helped. One can imagine how this type of targeted volunteerism could be especially helpful in treating depressed mood. However, to date, there have been no studies empirically exploring the potential link between targeted volunteering as it relates to the context of depressed mood and depressed mood outcomes. This study suggests that as the research in civic engagement in later life progresses, it will be important to experimentally study the potential of volunteerism as a treatment for depressed mood.

In summary, there is some support in the literature for at least the modest efficacy of a variety of supports and interventions in treating depressive symptoms and depressive disorders. However, in all cases, the effect seems modest or promising with more research needed. Results from this qualitative exploration suggest that in addition to efficacy studies, research should focus on the roles of autonomy and shared decision-making in the variety of treatments available for depression.

Conceptual Construct – The Knowledge of and about Depression

How do older adults understand the cause(s) of depression?

Participants were asked variations on the question, "What do you think makes people depressed?" or "What do you think causes depression?" Participants reported two types of causes for depression: 1) biomedical causes such as a chemical imbalance or genetic predisposition toward depression, and 2) contextualized causes or situational depression brought on by something such as a significant loss, financial worries or relational problems. Some participants thought that both causes could be at work in bringing on a depression.

As discussed earlier with regard to stigma, resistance to the depression label and refusal of antidepressants, other research has shown that many older adults attribute depression to social or interpersonal causes (Givens, et al., 2006). Past research on physician and patient models of depression reveals a, "You're depressed", "No I'm not" dichotomy between physicians and patients (Ogden, et al., 1999). Specifically, general practitioners reported greater support for medical causes and medical treatments. This suggests that general practitioners have beliefs about depression that do not agree with those of patients, with physicians favoring a more medical model of depression than did patients. In fact, it appears that patients hold much more diverse models of health in general than physicians, suggesting that physicians and patients do not have a shared understanding of health or mental health (Ogden, et al., 2001). A similar study specific to the beliefs of depressed elders and their physicians confirms these findings (Murray,

Banerjee, Byng, Tylee, Bhugra, & Macdonald, 2006). These findings have implications for the effectiveness of primary care consultations regarding depression.

These opposing perspectives of clinicians and clients might best be explained by the social psychology fundamental attribution error, which describes the tendency to over-value dispositional or personality-based explanations for the observed behaviors of others while under-valuing situational explanations for these behaviors (such as clinicians may do to their depressed patients). The fundamental attribution error seems to be most visible when people explain the behavior of others (Gilbert D. T., 1998; Ross, 1977). In other words, this theory posits that we tend to attribute an observed effect to potential causes that capture our attention. When we observe other people, the person is the primary reference point while the situation is overlooked as if it is nothing but mere background. So, attributions for others' behavior are more likely to focus on the person we see, not the situational forces acting upon that person that we may not be aware of. Yet, when we observe ourselves (as the participants in this study did), we are more aware of the forces acting upon us, as is shown in the descriptions study participants give of their experience of depressed mood. Social psychologists suggest this differential inward vs. outward orientation may account for the opposing explanatory models of observers (clinicians) and actors (clients) (Storms, 1973).

Lay beliefs about depression seem to reflect the beliefs of patients, that depression is caused by the social environment, in particular recent stressors (Jorm, 2000). Further, when the lay public is asked about other mental disorders, they favor social causes for depression but, for example, biological causes for schizophrenia (Schomerus, Matschinger, & Angermeyer, 2006).

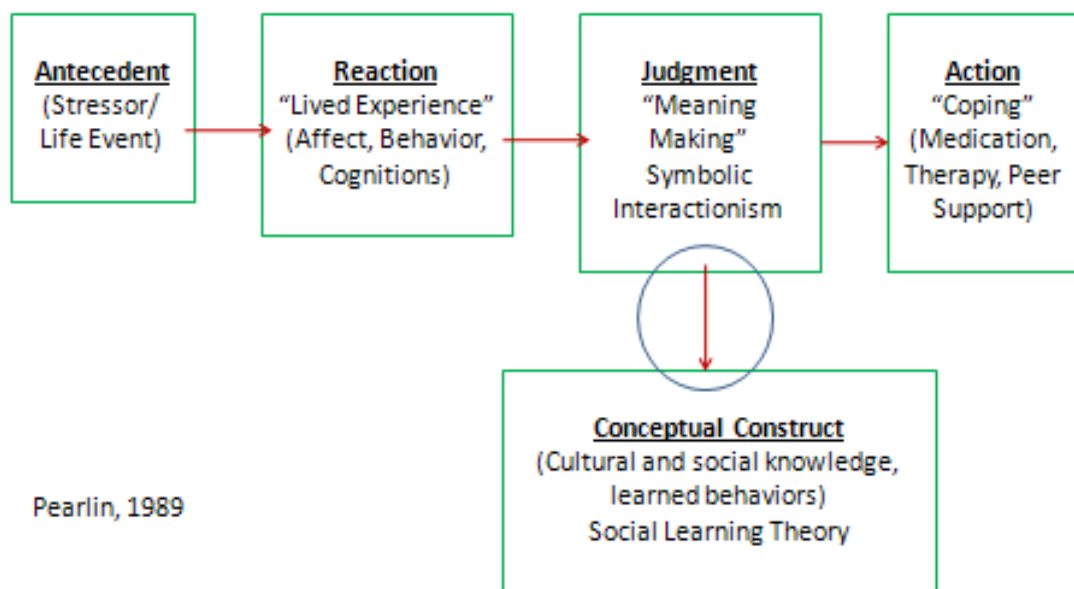
Older adults in this study, however, reported both psychosocial and biological causes for depression. However, participants reported biological models only in relation to an abstract understanding of what causes depression. For themselves, no one reported a biological reason for their own depressed mood or depression. In other words, no one said something like, "I think a chemical imbalance brought on my depressed mood." Rather, all participants who reported depression or depressed mood ascribed the onset to some sort of precipitating stressor or life event.

There may be several reasons for this disconnect between knowledge and experience. First, it could be that participants know that there may be both biological and psychosocial causes of depression and yet do not think the biological or medical causes apply to them. Or, it could be that older adults know the possible causes of depression, but do not think that their experience was depression, and so ascribe a more social cause to whatever it was they experienced. It is also possible that experience trumps knowledge. In other words, people may hold certain things to be true about depression, but application of this knowledge may shift in light of personal experience. It is possible that experientially informed knowledge is more influential in explaining causes of depression than other types of non-experiential knowledge.

If this is the case, a change in our conceptual framework may be in order. Specifically, the arrow between "Conceptual constructs" (knowledge) may not be as influential on "Judgments" (ascribed meaning) as once thought (see edited figure below), in so much as the model relates to knowledge and experience of late life depressed mood. Experience may inform knowledge, as reflected in the encircled "down" arrow on our

conceptual framework. Conversely, non-experiential knowledge may not inform judgments about the experience of depressed mood (as reflected in the removal of the “up” arrow on the conceptual framework. In other words, one might say that non-experiential (empirical, social or cultural) knowledge is overshadowed by experiential knowledge when accounting for study participant’s explanatory models of their depressive symptoms. Future research should explore the relationship between experiential and non-experiential knowledge.

Conceptual Framework: Pearlin’s Stress Process Model



It is interesting to note that in studies where patients or lay persons ascribe to a social or psycho social causal model of depression, the authors suggest that adults and older adults do not understand depression, in concept or cause. They suggest that the implication for practice is that we need to educate patients as to the true definition and cause of depression (Ogden, et al., 1999; Schomerus, Matschinger, & Angermeyer, 2006; Wernicke, Pearlman, Thorndike, & Haaga, 2006; Givens, et al., 2006; Barg, Huss-Ashmore, Wittink, Murray, Bogner, & Gallo, 2006). However, it is crucial to remember that the causes of depression are varied. Given that much remains unknown about the causes of depression, it seems inadvisable and even deceptive that educating those with depression about the biological ‘causes’ of depression is the best course. Rather, it seems as though practitioners may have something to learn from our depressed patients who seem to hold a more open-minded perspective on health and mental health than those attempting to help them.

Study Limitations

As with any research project this study has several limitations that are important to discuss. As mentioned in the sample description (see Chapter 3), participants in this study were overwhelmingly White, wealthy, and educated. This qualitative inquiry employed a purposive, convenience sampling strategy and therefore is not attempting to generalize findings to the larger older adult population. Even so, a goal of this study was to elicit descriptions of the experience of depressed mood from older adults of varying ethnic, cultural, educational and socioeconomic backgrounds. It is clear from the sample characteristics that this goal remains partially unmet and highlights an opportunity for future research.

A component of this inquiry explored older adults' knowledge about depression, its definitions, causes, and treatments. Since the study sample is very highly educated, one could expect that this sample would therefore have greater knowledge about depression than a less educated sample. It is important to temper any conclusions regarding older adults' knowledge about depression in light of the highly educated nature of the sample.

In terms of qualitative social work research, it is desirable to give voice to vulnerable populations who might not otherwise have the opportunity to tell their story. In many ways, older adults are a vulnerable and forgotten segment of our population, and this study aims to provide the means to tell a part of their story as it relates to their experience of depressed mood. Even so, given the sample characteristics, it is clear that many of the most vulnerable older adults (poor, less educated, minorities) were not given voice by this study. This presents an opportunity for future research that makes a special effort to explore the meaning and experience of depressed mood in the lives of such minority and vulnerable elders.

This study aimed to explore the experience of depressed mood across the range of later life. For this reason, the researcher chose a minimum participant age of seventy-five with the idea being that this would enable the elder to have enough late life lived to be able to reflect on their experience of depressed mood in later life. However, this also means that the overall sample was quite old with a mean age of just over 80 years. As a result, there is an opportunity to explore the lived experience of depressed mood in later life with younger elders who, for example, may ascribe different meanings and judgments than the much older respondents in this study.

Another difficulty of this study is that the depression status of the participants is unknown. The researcher did ask participants if in their later life "a physician or other health professional has ever told you that you were depressed or given you a diagnosis of depression?" to which thirteen out of 36 respondents reported "yes." However, this diagnostic proxy does not necessarily link to the experience(s) of depressed mood that they described in the course of the interview. In other words, we have no way of knowing if the depressed mood they describe is indicative of a diagnosable depressive disorder.

The researcher chose to not utilize a depression screening tool for several reasons. First, the study was designed to explore the experience of depressed mood across late life, and a depression screening would only have taken into account whether or not a participant had a likely diagnosis of depression on the day of the interview. Further, the researcher did not want to influence the words and phrases, which older adults chose to describe their experience, by introducing a depression screening tool or diagnostic

instrument. Research also indicates that many screening tools are a poor proxy for depression diagnosis and so were not employed by this study (Gilbody, House, & Sheldon, 2005). Further, because of the controversy in the literature, as described in Chapter 2, in defining and conceptualizing depression, especially in later life, this study explored the broader conceptualization of depressed mood, which also includes depression.

In other words, this is a study about the experience of depressed mood, and not the experience of depression. Specifically, while most participants in this study described an experience of depressed mood in later life, we are unable to determine exactly how many of those participants were depressed. Though information on the experience of depressed mood in later life is certainly valuable in its own right, there remains a difficulty in translating such findings to the larger body of literature on depression in later life.

It is possible that study participants reported social and contextualized depressive symptoms simply because they were asked about them. Specifically, participants were asked, "Why did you feel that way?" and "What was life like when you felt that way?" These questions may lend to more socially-oriented (rather than biologically-oriented) responses. Respondents were not asked, "Do you believe there were any biological reasons for your depressed mood or depressive symptoms?" In other words, more specific or probing questions may have revealed a more nuanced understanding of the origins of study participants' depressive symptoms.

It is the nature of qualitative research that the influence of the interviewer on the data must be acknowledged. This is especially true in this study where the researcher was both interviewer and analyzer of the data. Though this is not a limitation of the study, it is an aspect of the study design and implementation that needs to be explored. For example, several study participants were referred to the study by word-of-mouth from other participants who recommended the study; one of these referred participants informed the interviewer that she had a "good listening ear." Another participant commented about the interview that, "This was great! Even better than therapy." Comments like these suggest that the interviewer or the environment of the interview had an effect on the study respondents. Of course, we will never know to what extent this relationship between participants and the interviewer may have influenced study respondents and responses. It is important to acknowledge that this is not only possible, but likely given the nature of the research.

Conclusions

This research is representative of what anthropologists refer to as the emic perspective, which describes how insiders, in this case older adults with depressed mood, think about and categorize events regarding their depressed mood. This perspective is important given the movement toward patient-centered practice and the need for better practitioner-patient communications. Patient-centered practice is based on the premise that shared decision-making is a valuable goal of the therapeutic encounter. Specific tasks in this realm include elicitation of patient views regarding their condition and treatment options, exploration of those views, discussion of the pros and cons of treatment possibilities, and involvement of the patient in the treatment decision. A recent Presidential commission on geriatric mental health identified the delivery of patient-centered care as a

key component of improving the quality of mental health care for older adults (Bartels S. , 2003).

The issues raised by participants in this study may represent isolated views or may be representative of larger groups. Similar research including the views of poor and minority elders would likely expand these findings. Exploration of the context in the study of late life depression in larger studies utilizing various research methods will be important.

Study findings may benefit patients and providers by offering a starting point for exploring the attitudes of older adults being offered antidepressant therapy or other depression treatment. Respect for patient views may lead to alternative treatment decisions. For example, inquiring about elders' views of depression may allow for a discussion regarding whether antidepressants can be helpful to those who regard their depression as having social or interpersonal causes or whether psychotherapy would be more appropriate. However, clinicians must first engage older adults in exploring the larger story and context of their experience of depressive symptoms. These study findings (as corroborated by the literature) suggest that clinicians, in general, don't inquire about this context, despite its stated importance to the study participants. Instead, mental health and primary care clinicians have become dependent on diagnostic and treatment tools that ignore the person behind the symptoms and signs of possible disorder. In short, this displays disrespect and clinical laziness of the highest order. Researchers and clinicians alike must never lose sight of the person when considering and contemplating the relevant truths about the depressive symptoms experienced by older adults.

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Appendix

Interview Guide

Today is _____ *insert date* at _____ *insert time*. This is an interview between Kristen Gustavson from the University of California, Berkeley and _____ *insert subject ID #*.

What is the lived experience of depressed mood in old age?

I'm trying to learn more about older adults experiences with unpleasant or unhappy emotions and moods in late life. People have different words for these emotions. What do you call it? _____ [write in and use elder's own words when possible]. (Offer prompts if necessary... sad, worthless, lonely, feeling down, apathetic, hopeless, etc.)

Could you describe what life is like during times you feel that way? How would you describe yourself during these times?

Why do you think you felt that way?

Can you recall a specific experience involving negative emotions/mood in your later life? What was life like while you felt that way (e.g. sad, lonely, hopeless, apathetic, etc)? Please describe your relationships, activities, health, energy, etc.?

Clinical Interview Components: (Checkmark to make sure you have addressed each)

Symptomatology (tell me about as many as possible that you can remember)_____

Severity of symptoms_____

Frequency of symptoms_____

Scope (How much of your life was affected by these symptoms?) _____

Functional impairment (How did this impair your daily life, give examples?)_____

Duration of impairment (For how long did/have you suffered?)_____

Precipitating Events (Causality/Context - what brought on your symptoms?)_____

Self-perception of impairment (how does this compare to other pains you've experienced? How does this compare to how others suffer?)_____

Past history of symptoms and impairments (describe and give examples)_____.

How would you describe your mood most of the time? Do you often feel _____ (sad, worthless, lonely, apathetic, hopeless, etc.)? How would you characterize your overall mood in recent months?

Thinking back to when you were younger, how has your mood changed? Remained the same?

What else can you tell me about your own experience of _____ (use elder's own descriptive words whenever possible) [negative emotions] later life?

How do older adults understand depression?

What does "depression" mean to you?

How did you come to that understanding?

Is there a difference between the feelings you were just describing and depression? If so, how would you describe it?

How do older adults define the cause(s) of depression?

What do you think makes people depressed?

What causes depression?

How is depression treated? In other words, what helps older people with depression get better?

If you or someone you knew were depressed, what do you think would help?

What would you do to treat depression?

In other words, what helps people with depression get better?

How does aging influence the understanding of depressed mood?

Thinking back to when you were younger, how has your understanding of depression changed over the years? To what do you attribute these changes?

What are the similarities and differences in the experiences and understandings among older adults who've been labeled as depressed?

I notice that you checked the box on the info sheet saying that a health professional has told you that you were depressed. Do you agree with this diagnosis? Why or Why not? Explain.

If you've taken antidepressant medication, when and for how long? Did you find it helpful? How so? What were the circumstances under which you took this medication?

Under what conditions do older adults view their experience as depression?

Based on what you told me earlier about your experiences with _____ (use their word, e.g. sadness), I wonder if you think you were/are depressed at that time. Why or why not?

Can you recall times when you use the word depression to describe your own emotions? When? Under what circumstances?

Social and Demographic Information

SUBJECT ID#: _____

What is your birthdate? (e.g. 06/23/1930) _____ / _____ / _____

What is your gender? (circle one) *Male* *Female*

Are you of Hispanic or Latino origin? (circle one) *Yes* *No*

What is your race or ethnicity? (circle all that apply) *White or Caucasian*
Black or African American
Asian
American Indian
Pacific Islander
Other _____

What is your highest level of schooling? (circle one) *Less than High School*
Some High School
High School Graduate
Post High School Education
College Graduate
Graduate Degree
Other _____

What is your marital status? (circle one) *Married*
Living with Partner
Separated
Divorced
Widowed
Never Married
Other _____

What is your current household income? (circle best estimate)
Under \$10,000 per year (less than \$834/month)
\$10,000-\$19,999 per year (\$834-\$1666/month)
\$20,000-\$29,999 per year (\$1667-\$2499/month)
\$30,000-\$39,999 per year (\$2500-\$3333/month)
\$40,000-\$49,999 per year (\$3334-\$4166/month)
\$50,000-\$80,000 per year (\$4167-\$6667/month)
More than \$80,000 per year (More than \$6667/month)
Don't know

Continued on following page....

Has a physician or other health professional ever told you that you are depressed or given you a diagnosis of depression? (circle one)

Yes

No

Have you ever taken antidepressant medication? (circle one)

Yes

No

If so, what was the name of the medication? _____

Thank you for your time and participation in this research study.