ELDERLY WOMEN'S
Explanation of Depression

ABSTRACT

Using the Kleinman explanatory model, 30 elderly women with depression were interviewed about their depression and its treatment. Content analysis was used to classify data into cause, effect, severity, expectations, fears, and treatment. Identified causes were loss of health, family, and role. Depression caused somatizations and a decrease in functional level. Women considered depression to be severe and chose medication as the preferred treatment. Their model of depression differed from that of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) because fatigue and weakness were emphasized more than any other symptoms. Feelings of guilt and worthlessness, weight loss, and suicidal ideation were minimal.

In an attempt to better assist elderly individuals who suffer from depression, nurses need to understand what depression means to those affected. Because beliefs about causes and treatment of all conditions and illnesses can vary among people, health care providers included, it is important for nurses to understand the illness from the point of view of the individuals affected. Depression may be even more difficult to understand than most other illnesses and conditions because depression may take on different meanings when subjected to age and cultural variables.

Long steeped in notions of flawed character, spiritual weakness, and sin or retribution, depression is only now losing the stigma once surrounding its meaning (Swan, 1999). An understanding of depression as illness is often difficult for the general population to grasp. It makes sense that older people, who may not have had exposure to psychosocial or biomedical theories related to affective disorders, have an even more difficult time understanding depression.

In addition, despite education level, most elderly individuals currently have not been exposed to psychological language and may not have the vocabulary necessary for

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psychological mindedness about illnesses such as depression. Therefore, to help older adults with depression, it is important to understand the role age and culture play, and the beliefs older adults may have about treatment. To that end, the following research question was posed: What is the explanation of depression given by a group of older women with depression?

**LITERATURE REVIEW**

**Depression and Elderly Individuals**

The term depression is confusing because it encompasses at least three separate and distinct meanings. Depression can be, and is, used to describe a mood, symptom, or syndrome. It can be characterized by intensity as mild, moderate, or severe (Kessler, Zhao, Blazer, & Swartz, 1997; Koenig, 1999). As a mood, depression is expressed as sadness, discouragement, and disappointment. An example of depression as mood is the grieving process (Horowitz et al., 1997).

As a symptom, depression is manifested as disturbances in cognitive, affective, or psychomotor arenas. These symptoms are frequently found concomitant to chronic illness or as side effects to medication (Patten & Love, 1997). According to the American Psychiatric Association (APA, 1994), as a syndrome, depression is a major psychiatric disorder.

The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), outlines major depression as follows:

- Depressed mood.
- Markedly diminished interest or pleasure in all or almost all activities for most of every day.
- Significant weight loss or gain; decrease or increase in appetite every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or inappropriate guilt nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death, recurrent suicide ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide.

To meet the diagnostic criteria for major depression, at least five of the symptoms listed above must be present for at least 2-weeks and must represent a change from previous functioning (APA, 1994).

The elderly population in the United States is growing. As it grows, the number of elderly people with depression will increase. This rate increase coincides with a population of elderly individuals who suffer from age-related disabilities and chronic illness, not the least of which is depression (Barry, Fleming, Manwell, Copeland, & Appel, 1998; Kurlowicz & Strein, 1998).

According to Blazer and Cassel (1994), depression in older adults differs from depression in other age groups because it is either initiated by or complicated by physical illness. The authors say older patients with depression are more likely to lose weight than younger patients. They also do not have feelings of guilt and worthlessness seen in the depressed younger aged population. Also, older adults with depression complain of a sleep disorder consisting of ability to fall asleep, but inability to stay asleep during the night. Older adults with depression often have more symptoms of somatization and hypochondriasis than younger adults, and focus on physical rather than affective complaints (Monopoli & Vaccaro, 1998).

**Prevalence of Depression**

Depression is the most common psychiatric illness of late life (Koenig, 1999; Shua-Haim, Shua-Haim, Comst, & Ross, 1998) and ranges from adjustment disorders triggered by life events, such as a move or loss of a loved one, to major affective symptomatology with life threatening implications. The prevalence of clinically significant depressive symptoms in late life, estimated at 14.7%, and of major depression in late life, estimated at 1.8%, remain unchanged since Blazer and Williams’ (1980) first epidemiological study.

More than 15% of older adults with chronic physical conditions are depressed (Fogel, Gottlieb, & Furino, 1990; Sadavoy, Smith, Conn, & Richards, 1990). According to Bushman, Dixon, and Tichey (1995), older adults with depression are at high risk for mortality and suicide behavior. Although older adults comprise 13% of the population, they are responsible for 25% of all suicides.

Seven million American women are depressed compared to slightly more than 3 million men (Hughes-Hammer, Martsdolf, & Zeller, 1998). However, there are some interesting and conflicting findings related to the incidence of depression when age and gender are both considered.

Holtzer, Leaf, and Weissman (1985) concluded that the prevalence of depression is greater in women of all ages with the gender ratio highest in the 30 to 44 year age group. In a classic study of 3,058 participants 18 to 64 years old and 1,977 participants 65 years and older, the authors found the prevalence of depression in elderly...
women was greater than in older men. However, the prevalence was lower than that found in younger men and much lower than the prevalence found in younger women.

Roberts, Kaplan, Shema, and Strawbridge (1997) found the prevalence of 2,417 older adults with depression in Alameda County, Texas was 6.6% for men and 10.1% for women. When the effects of psychosocial risk factors were controlled, there were no significant age effects. The authors concluded that age-related effects on depression are attributable to physical health problems and disability. Increased rates of depression in older women compared to older men may be because of the gender differences in bereavement and financial problems of widows.

Etiology of Depression

The causes of depression are multiple. Both biological and psychosocial factors play significant roles in the development of depression. Genetic transmission for depression in older adults is unlikely because older adults frequently are experiencing their first episode of the illness. This factor, according to Buschman et al. (1995), leads to an increased probability that depression in older adults is physiological, psychological, or social in nature.

Physiological theories of the etiology of depression in older adults suggest that age-related biochemical abnormalities in the norepinephrine system play a part. Deficiencies in the concentrations of neurotransmitters such as dopamine, norepinephrine, serotonin, and acetylcholine, as well as elevated levels of cortisol, sodium, and monoamine oxidase levels have been linked to the development of depression (Kinney, Vogel, & Feng, 1997).

Psychosocial theories of depression posit that depression can develop as a reaction to critical events coupled with failure of adaptive coping mechanisms (Li, Seltzer, & Greenberg, 1997). Old age is filled with critical events, many of which are exit events. Death of loved ones, chronic or acute illness, and financial concerns are common in old age. The loss of social support, personal resources, and physical strength can be acute, and can trigger a major depressive episode.

Chronic illnesses are more common in old age than in any other age. It is accepted that individuals suffering from chronic illness are vulnerable to the development of depression. Depression may be secondary to recognition of a decreased life expectancy, a concurrent change in neuroendocrine function, or a response to drug and other types of therapies. Finally, there is a correlation between depression and early dementia (Ugarriza & Gray, 1993).

The causes of depression are still being investigated. Interplay of genetic, physiological, psychological, and social factors should not be ignored or underplayed. However, according to Kaas (1984), most scholars in the field agree that women's experiences in the American culture predispose them to depression.

THEORETICAL FRAMEWORK

Kleinman (1980) developed an explanatory model describing individual interpretation of an illness. The explanatory model is determined by an individual's general beliefs about health and illness and is specific to a particular illness. According to Kleinman, health practitioners and patients use explanatory models, and they may not necessarily be the same. The patient's explanatory model provides personal and social meaning to the illness experience and gives direction for treatment choices. It allows patients to construct, from their various beliefs, an explanation of the events of an illness and to plan a course of action appropriate to that explanation.

The explanatory model is the basis for the fundamental processes in all health care care systems. These are:

- The cultural construction of illness (i.e., the assignment of meaning to the illness episode in terms relevant to the individual).
- The establishment of strategies for choosing and evaluating health care alternatives.

- Communication necessary for managing the illness episode.
- Healing activities.
- Management of therapeutic outcomes, whether they be cure, recurrence, chronic illness, impairment, or death.

A patient's explanatory model is frequently disorganized and partially conscious in nature. Because patients do not normally volunteer their explanatory models to health care providers, Kleinman (1980) suggested that practitioners ask questions designed to gain the patient's perspective on the following aspects of the patient's illness:

- Etiology.
- Time and mode of symptom onset.
- Pathophysiology.
- Course of sickness, including severity and appropriate sick role.
- Treatment.

This model was the basis for the data collection and analysis of depression within a group of elderly women. This group was considered a cultural group based on VanMaanen and Barley's (1985) definition of culture as a set of solutions devised by a group of people to meet specific problems posed by situations they face in common...applicable to any group, be it a society, a neighborhood, a family, a dance band, or an organization and its segments (p. 33).

According to Andrews and Boyle (1998) all societies have a basic value orientation shared by the bulk of its members and it reflects the culture. The authors posit that the culture can also have subcultures categorized by geographic region, religion, age, and gender, for example. Age and gender were the characteristics of the subculture studied, namely, elderly women with depression.

METHOD

Sample

The convenience sample consisted of 30 elderly women with depression who were in-patients in a medium-sized, 300-bed, southeastern United
States private hospital. The women were admitted to the neuroscience unit by private physicians for treatment of depression. The average length of stay on the unit was 1 month. Treatment consisted of biochemical agents, electroconvulsive therapy, supportive care, and group and individual therapy. Women were asked to participate in the study if they provided informed consent and met the following study criteria:

- Diagnosis of major depression as evidenced in the medical record.
- Older than 65 years.
- Ability to speak English.

Women were not asked to participate if they met the inclusion criteria but were also receiving electroconvulsive therapy. Table 1 illustrates the demographic characteristics of the women.

The mean age of the women was 85, and all but three (27) were born in the United States. The three who were born outside the United States moved to this country before age 5 and all identified themselves as being of American background. Most women had a high school education. As illustrated, most of the women had never been hospitalized or had been hospitalized only once for depression. Three of the women had been hospitalized at least six times. One of them stated she was hospitalized more than 10 times in her life for depression.

**Data Collection**

The women were interviewed on the hospital unit by the principal investigator (D.N.U.) using an interview schedule based on Tripp-Reimer, Brink, and Saunders’ (1984) cultural interview assessment. The interview schedule is designed to elicit data on the meaning of a person’s illness and is based on the Kleinman (1980) explanatory model. The hand-recorded interviews, averaging 45 minutes, focused on the cause and contributing factors for the start of the illness, effects of the illness, perceived severity and duration of the illness, problems associated with the illness, fears of the illness, and expected results of treatment. Women who were interviewed once were asked to suggest ways family members could help them get better.

**Analysis of Data**

The hand-recorded interviews were transcribed using Ethnograph (Scolari—Sage Publication Software, Thousand Oaks, CA), a qualitative data analysis software program (Seidel, 1988). Content analysis on the responses to each open-ended question related to cause, reason, effect, severity, expectations, fears, and suggestions for treatment were identified.

To ensure interrater reliability, two qualitative researchers analyzed the responses separately and compared the analyses. Codes were established by consensus. A comparison method involving the development of a group response pattern was used as a norm to compare individual responses. Symptoms and course of illness of the group standard were compared to biomedical values, beliefs, and treatments as indicated in the DSM-IV (APA, 1994).

**Limitations**

Several factors deserve consideration in examining the findings. First, a nonprobability purposive sampling method was used, limiting the generalizability of responses. Second, the interviews occurred in a biomedical setting, which suggests admission to the hospital conveys the women’s belief in the biomedical treatment available. Third, the use of pen and paper to record responses may have had an intrusive effect or may have created an interruption to the responses the women gave. As is the case in most in-patient psychiatric mental health hospital units, audio and video taping was prohibited.

**RESULTS**

**Etiology and Onset**

Most of the women interviewed said their depression was a result of changes in their health. Such illnesses as cancer, stroke, and fractures were named as causes of depression. Women also said loss of function (e.g., poor eyesight, pain) contributed to depression. Most of the women said they had been in good health before the illness event occurred to trigger the depression. The women said it was the change from good health to poor health that contributed to the depression. One woman said

I never had any problems with my physical condition. I went to see a doctor about my stomach. There wasn’t any obstruction but something was wrong with me and I got depressed.

Another woman said

A lot of worries…a lot of problems…I have a fungus on my feet and toes… I cannot control my urine…I have a lot of difficulties that made me depressed.

These statements were representative of the sudden and cumulative nature of their difficulties (Table 2).

The second most common reason given for the onset of depression was the death of family members. Most often this was the death of a husband. These deaths were said to con-
Three women stated they were always depressed. Two women said the depression occurred because of an accumulation of many things, such as illness and life changes. One woman said:

Well, you know, my husband had prostate problems...a lump...I didn’t want him to have surgery. They used a bean on him to get rid of it. Then, 1 year later he had open-heart surgery. Then, when we were down here, we found out our water pipes in our home up north froze causing $38,000 worth of damage. Then, we both got the flu. I got over it, but he didn’t. We went home. He woke up in the middle of the night with six bleeding ulcers. Then, he had kidney trouble. He had dialysis at home and he was very depressed and wouldn’t leave the house. But, he does now and he goes to his business. But, that’s when I broke.

Three of the women said change of residence or a move from one city to another was the reason for the onset of the depression, stating they missed their families, friends, or old apartments. Also, three women said depression was caused by being disappointed in or victimized by people or family members whom they had trusted. One woman stated:

I broke up my home and moved here. Immediately, my leg started to hurt me. I couldn’t enjoy the place. I got depressed.” Another said, “I’ve been forced to depend on my children. I am not sure what is going on. I trusted someone I shouldn’t have trusted. She was a stockbroker and a friend. I was taken hook, line, and sinker. I lost everything and I got depressed.

Problems
Forty-one percent (17) of the responses about the problems depression caused or how depression occurred were related to physical illness. Most responses were stated as generalized aches and pains, hurting all over, burning, headaches, or vague descriptions of feeling weak and dizzy. Thirty-two percent (13) were problems with activities of daily living (ADLs). The women said they felt too weak or had such low energy levels they were unable to get out of bed. This, in turn, caused them to withdraw from the company of other people. One woman stated:

I felt something but I didn’t know what it was. I was working and I felt dizzy. It got worse and worse, I went home. I was afraid to drive for fear something would happen. I couldn’t cope anymore. I just stayed home.

Three women said they had experienced difficulty with a loss of appetite. Two women verbalized being suicidal at times. Other responses consisted of feeling sad, feeling angry, decisional conflicts, and sleep disturbances. One stated, “I can’t make decisions. I am alone and I am too unhappy to live alone. I cannot sleep.”

Severity
When queried about the duration and the severity of the depression, all but five women stated emphatically that their depression was severe, deep, and of long duration. They said they were hopeless and helpless about their situation and their illness. They made statements such as:

- “Depression is the severest disease I’ve had. It tears you up inside.”
- “It is severe and it lasts all the time.”
- “Nothing helps me.”
- “I’ll never be better.”
- “I am dying of depression and I am not going to make it.”

Of the five remaining women, three said they had good days and bad days, so they labeled the depression as moderate in severity and
expected to get well. Two of the women believed the depression would “lift” any time and they would be back to normal.

Treatment Preferences

When asked what the best treatment would be for depression, 13 of the women (43%) said “the use of medication.” Five of the women said they did not know or could not say. Four women said talking to a psychiatrist, whom they referred to as their doctor, would probably be the best treatment for them. Four women said they thought therapy (e.g., group, occupational, movement, art) would be helpful. Other responses were sleeping, talking to friends, and changing settings.

Fears

Eleven of the women said the number one fear they felt concerning depression was that they would not recover the ability to accomplish things. They expressed feelings of uselessness and inadequacy and felt they would remain that way. Two women said they had fears that they would remain dependent and nobody would care for them.

Five of the women stated their number one fear was they would suffer physical damage or ill health because of their poor appetite or eating habits. They believed their inability to eat properly was causing problems in their general health or well being.

Four women stated their number one fear was that depression was permanent. They expressed despair that they would never get better and would never feel relief from uncomfortable symptoms. Three women feared they would suffer lasting mental problems, such as confusion or poor memory.

Three other women said they had no idea what they feared, if anything at all. They did not convey they were hopeful. Rather, they expressed a type of resignation that fear was a useless sentiment in the presence of such illness. One said:

I don’t fear anything, I just don’t care. My doctor asked me if I think about suicide and I told him, I just don’t care one way or the other if I live or die.

Six other women expressed different fears such as the permanent separation from a family member, the inability to ever get a good night’s sleep, and the discomfort of being self-absorbed. They made statement such as:

• “I have a feeling that I won’t get better.”
• “I am so afraid that I am going to remain depressed. That is the only thing I fear.”
• “I am afraid I will always have nausea.”

DISCUSSION

The 30 women in this study may represent a large number of hospitalized elderly individuals with depression in the United States. Many of the women did have chronic illness, but in most cases the illness was either controlled or in remission. All of the women had been medically cleared for admission to this affective disorder unit. They were stable, oriented, and able to conduct their own ADLs. None were incontinent and, except for the possibility of a cane or walker, all were ambulating on their own. None had an acute or episodic illness at the time of admission other than the depressive episode itself.

All of the women completed a course of treatment and therapy. They said they felt better, even good, at the time of discharge from the hospital. However, feeling good or better was always relative to the somatic symptoms described upon admission and during the course of treatment. Weakness, fatigue, and issues related to appetite and sleep remained an overriding concern. The increase in functional ability was deemed to be another sign of feeling better and they expressed relief and gratification for that effect of treatment.

However, 20 of the 30 women expressed some pessimism about their ability to stay well after they returned home. Statements such as “I hope I stay better” or “I hope I don’t have to come back again” were representative of parting comments.

Using the Kleinman theory criteria for an explanatory model of illness, the following depression in elderly women was identified. First, the cultural construction of the illness or the relevant meaning of the illness was that depression developed as a result of loss. That loss was primarily loss of health, loved ones, and role. The women were most unsettled by the fact that they were unable to continue their caretaker role and expressed doubt that anyone would be able to care for them.

The quality of the depressive episode differed considerably from major depression described in the DSM-IV. The women did demonstrate dull or anxious affect and stated they were not interested in activities that once pleased them. The appetite loss they complained of was not necessarily correlated with a weight loss and only one patient had a significant weight loss of 15 pounds within the prior 2 months.

Many of the women were taking sedative or hypnotic medication as a sleep aid prior to admission, so it was difficult to assess the relationship of a sleep disturbance with the affective episode. Fatigue and loss of energy were similar to the DSM-IV symptoms of major depression and were the number one complaints of the women. Feelings of worthlessness or inappropriate guilt were virtually not present. The lack of ability to concentrate or to make decisions did not seem to be particularly bothersome to the women and thoughts of death and suicide were infrequently mentioned. When statements on death or suicide were discussed, the women said they wished it would be over or that they would die, but they denied having any intention to kill themselves.

The marked somatization exhibited by the women was reflective of the literature on depression in the elderly population. However, the relatively stable weight and sleep patterns in this
group differed from written accounts of weight loss and profound sleep disturbance usually found in older adults with depression.

Treatment choice and evaluation of health care was congruent with the biomedical model. Comments indicating the respect for and belief in the power of physicians permeated the responses. Many times this belief was unquestioning. Statements such as, "I'm here because my doctor told me to come to the hospital" and "I do what my doctor tells me to do" were quite common. They solicited medication and expected drug therapy to cure their symptoms. They were not resistant to taking medication, nor did they question the use of medication. Statements such as, "If that is what the doctor ordered, I'll take it," and "I don't know what medicine I'm taking. The doctor knows," were quite common.

The communication necessary for managing the illness episode reflected the value of the physician-patient relationship. The women gauged the status of their illness by their physical status. The women did not consider hopelessness, irritability, and sadness to be symptoms. They frequently asked nurses to call physicians to apprise them of any physical changes occurring.

Reluctance to attend group therapy was common and the women often had to be encouraged to attend group meetings. The use of medication as a treatment was well received by the women. In spite of verbalizations that the medication was not helping them or didn't work, the women took the medication and frequently sought nurses to ask for medication.

When queried about healing activities, such as follow-up plans or what they would do to keep from getting sick again, many women stated they intended to continue seeing their physicians. Five of them also had plans to attend a day treatment center in the same facility for a period of time after discharge. The day treatment center operated 5 days a week from 9 a.m. to 3 p.m. and consisted of group therapy and psycho-education classes with qualified therapists (e.g., psychologists, nurse practitioners, social workers). Many of these therapists had been treating the women in the in-patient course of treatment.

CONCLUSIONS

Responding to open-ended questions based on Kleinman's (1980) explanatory model and an interview guide designed from that model by Tripp-Reimer et al. (1984), this sample of elderly women with depression described their depressive illness different from the way the DSM-IV outlines major depression. The accumulation of events or losses was attributed as the cause of their illness. The number one loss was health. Although weakness and fatigue were present, weight loss was minimal, and feelings of worthlessness and guilt were virtually not present.

Some of the women were tearful at times during the interview. The tears were generally of a self-pitying nature. Suicide ideation was low and presented in a passive manner. The overwhelming discomfort the women verbalized was physical in nature. Weakness, dependence, and functional loss bothered them greatly.

Although they voiced hopelessness at the thought of getting better, the women endorsed the biomedical model, especially medication, as the appropriate treatment regime. The women gauged the severity of their illness by the way they felt physically. Although hopelessness and helplessness permeated the interviews, the women did improve and all interviewed returned to their previous residences within 6 weeks of admission.

Nurses can use the information from these interviews to better understand the concept of depression in older adults. This group of elderly women, although pessimistic about getting well, was willing to try medication for relief and experienced less discomfort from their illness after discharge from the hospital. The treatment protocol of medication, group therapy, and supportive care took at least 1 month before any notable relief was seen. Medications generally work within a 2-week period of time. Although the women did not acknowledge the effect of the hospital experience with its supportive therapeutic milieu, the combination of therapies need to be considered interventions for depression in older adults.

The Kleinman model is based on the assumption of great differences in the patient's explanatory model and the health care practitioner's explanatory model. The differences in this study were not great between the biomedical model and the women's model, but they were subtle and the emphases differed greatly. Treatment via use of medication and a belief in a physician-driven model for health care was evident in the responses of the women. Also evident was the women's limited realization of the value of the cadre of other therapy and treatments they had received during hospitalization. Supportive therapy, psycho-education, milieu, socialization, and problem-solving therapies were not recognized as contributing to their cure.

Given the growing numbers of elderly individuals in the United States, and the cost of in-patient treatment for depression, some degree of public education needs to be undertaken. Assuming the patriarchal health care view of this group of elderly women may be found in other elderly people, nurses have a responsibility to educate elderly patients on complementary and alternative forms of therapy for depression. An acceptance of the beliefs of elderly patients related to depression, its manifestations, and treatments can assist nurses to streamline plans of care and to support older adults through the illness. However, the value of support using multidisciplinary approaches needs to be articulated to the general population.

Many older adults suffer from chronic illness and loss, and many develop severe depression as a result of these factors. Treatment centers in syn-
agogues, churches, and other civic and social institutions, which focus on older women's loss of health and loss of role, would be ideal locations for advanced practice psychiatric mental health nurses to consult and practice.

The cultural display of depression and the treatment beliefs and preferences of many groups of older adults needs to be examined. The degree to which symptoms are related to age, religion, and mode of expression, along with cultural beliefs about the best treatment methods, need to be made explicit, compared, and used as foundations to provide better mental health care to elderly patients.

REFERENCES

KEY POINTS

**ELDERLY WOMEN'S DEPRESSION**


1. The major symptoms of depression for this group of elderly women with depression differ from the criteria for major depression outlined in the DSM-IV.
2. Elderly women with depression cited multiple losses, such as poor health, death of a family member, and role change as the main cause of their depression.
3. Somatization and loss of function were the major symptoms of depression for this group of elderly women with depression.
4. Elderly women with depression said their depression was severe and chose medication as the preferred treatment.

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