

PERSPECTIVES ON THE PROCESS OF RECOVERY FROM DEPRESSION BY
OLDER ADULT CLIENTS: A GROUNDED THEORY STUDY

by

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Abstract

Depression in the older adult remains a serious public health concern. An understanding of the process of recovery from depression from the older adults' perspective will assist care providers to plan strategies for the most effective treatment of depression. With effective treatment we would expect to see a lower suicide rate and lower demand for unnecessary resources which will both contribute to improve the quality of life for older adults. The purpose of this grounded theory study was to describe the process of recovery through the experience of depression from the perspective of older adults who were considered to have recovered from their depression.

Open-ended interviews were conducted with seven older adults who had recovered from depression. Analysis of the interviews involved identification of a process of recovery that consisted of four phases: 1) Spiraling Down, 2) Changing Direction, 3) Working the Way Out, and 4) Staying Out. Older adults who had recovered from depression described a general sequential process while going through the phases. If a recurrence or relapse occurred, the same four phases were experienced again. A preliminary substantive theory of the process of recovery emerged from the findings. Triggers were experienced which led to increasing feelings of discomfort and distress. Older adults relied on their own strength as well as supports from others as they worked to implement strategies to achieve recovery.

The process described in this study provides a beginning understanding of the experience of older adults as they recovery from depression. The findings of this study will help nurses and other health care professionals in providing care to older adults recovering from depression.

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CHAPTER ONE

INTRODUCTION

This thesis describes a grounded theory research study which aimed to describe the process of recovery from depression from the perspective of the older adult. Chapter one provides the background to the study.

Background

Depression in the older adult (age 65 years and over) is a common and debilitating illness (Badger, Dumas & Kwan, 1996; Proffitt, Augspurger & Byrne, 1966). It is estimated that up to 35% of residents in long term care facilities and up to 15% of older adults in the community experience depression (Blazer, 1994; Khan, Mirolo, Mirolo & Dobie, 1993). Of older adults in acute hospital beds, it is estimated that up to 30% suffer depression (Blazer, 1994). The following three factors make depression in the older adult important to address: 1) the suicide rate in the older population is higher than in any other age group, 2) functional decline alone necessitates a great deal of assistance from caregivers (both paid and unpaid) and in extreme cases may precipitate unnecessary placement into a care facility, and 3) up to 80% of depressed persons in this age group respond to treatment (Drance, 1991; Flint & Rifat, 1997).

The incidence of recurrence of depression is high. In the adult population, the likelihood that a person who had suffered one episode of depression would experience a second episode is greater than 50% (Banerjee, Shamash, Macdonald, & Mann, 1996; Cole & Bellavance, 1997; Hawley, Quick, Harding, Pattinson, & Sivakumaran, 1997; Hinrichsen, 1992; Keitner, Ryan, Miller & Norman, 1992; Kupfer & Frank, 1992; Maj,

Veltro, Pirozzi, Lobraccio, & Magliano, 1992; Piccinelli & Wilkinson, 1994). Of those who experience a second episode, the probability that a third episode will be experienced is 80-90% (Kupfer & Frank, 1992). In studies specific to older adults, the statistics were similar (Ames, 1990; Baldwin, 1995). Major depression that persisted for at least five years occurred in at least 12% of adults (Keller, et al., 1992; Reynolds et al., 1992). Therefore, the successful long-term treatment of depression rested on addressing both recovery from the initial episode of depression as well as in maintaining recovery.

The term 'depression' is not a unitary construct but is described on a continuum from experiencing the 'blues' to experiencing 'major depression' (Friedhoff, 1994). At points along the continuum, 'depression' has diagnostic categories including dysthymia (symptoms were less severe from day to day but remain longer than in major depression), seasonal forms of depression, adjustment disorders with depressed mood (where there were marked psychosocial factors that influence depression), bipolar mood disorder (where periods of mania are also experienced), organic mood disorder (where depression is caused by an organic problem), and major depression.

There is no 'test' for depression and we are reminded of the difficulty in determining exact criteria by the fact that diagnostic criteria for depression changes with each edition of the Diagnostic and Statistical Manual (DSM). In the current DSM Fourth Edition (DSM-IV) (1994), diagnosis of major depression is based on identifying the following symptoms during a two week period: 1) a change from previous functioning, 2) at least one of the symptoms of depressed mood or loss of interest or pleasure, and 3) at least four of the following list of symptoms: significant weight loss, insomnia or

hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished concentration, or recurrent thoughts of death. These symptoms must not meet the criteria for a Mixed Episode and they must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. As well, the symptoms must not be due to the direct physiological effects of a substance or a general medical condition and they must not be better accounted for by bereavement (DSM-IV, 1994).

Although older adults may display some of the behaviours that were part of the DSM-IV criteria for depression, older adults typically present with somatic symptoms (Gurland, 1994; Reifler, 1994). They often attribute loss of energy and interest to normal aging, concomitant medical disease and/or medications and therefore discount their problems (Ruggles, 1998). This atypical presentation is complicated by the fact that geriatric patients are more likely to report concerns about their body than concerns about their mood. Even if they seek medical care, their somatic problems may be treated without uncovering an underlying depression. Therefore, many depressed geriatric clients remain untreated (Bienenfeld, 1990; Ruggles, 1998).

Blazer (1994) reports that “additional diagnostic categories may be needed to adequately classify the depressive disorders experienced by the elderly. . . . Minor depression [with or without self report of depressed mood] . . . is a collection of less severe though potentially dysfunctional disorders afflicting the elderly . . . and is more frequent in the elderly than in any other age group” (p.155). Geriatric clients often deny a depressed mood, irritability was often the most prominent affect, and, as already stated,

they frequently present with somatic complaints, agitation or anxiety, and cognitive thinking problems (Bienenfeld, 1990; Drance, 1991).

There are many suspected causes of depression in the elderly and many of the identified causes may have actually been more accurately defined as comorbid problems. These include: drugs and medications, malignancies, infections, metabolic disturbances, endocrine disorders, neurologic disease, vitamin deficiencies, genetic predisposition, chronic physical illness, and psychosocial conditions (Drance, 1991; Distance Learning, 1997). Treatment of comorbid problems usually resolve depression.

The successful long-term treatment of depression rests on a precise understanding of the process of recovery from depression. The multiple etiologies of depression are reflected in the multidisciplinary treatment modalities that include medication, social support, psychological support, and electroconvulsive therapy (ECT) (Klawansky, 1994; Reynolds, 1994).

Few studies have explored adults' experiences in the process of recovery from depression. Those done have been conducted primarily on adults under the age of sixty (Heifner, 1997; Schreiber, 1996; Steen, 1996; Wilkinson & Pierce, 1997). All participants in the studies considered themselves to have recovered from their depression. While these adults identified their experiences of gaining strength and experiencing positive change within themselves as factors influencing their recovery, no evidence was found to suggest that older adults have similar experiences that influence their recovery. No studies were found that described older adults' perceptions of the process of recovery from depression. Frank, Prien, and Jarrett (1991) developed a comprehensive conceptual model of

recovery from depression from the providers' perspectives Through the addition and integration of the older adults' perspectives, a more comprehensive understanding of the process of recovery will be gained that will enable more efficient and effective support and treatments to be utilized.

Problem and Purpose

Research in depression in the older adult has focused on recovery rates and treatment outcomes. Although phases of the recovery from depression have been described from the providers' perspective, we have little knowledge of the process of recovery from the perspective of the older adult who have recovered from depression. Without this knowledge we are hampered in providing optimal treatment for older adults in their process of recovery from depression. The addition and integration of the older adults' perspective provides a more comprehensive understanding of the process of recovery that will enable more efficient and effective support and treatments to be planned and utilized. The research to date has focused on recovery rates but has not focused on the actual process of recovery from the older adults' perspectives.

The purpose of this research was to describe the experience of the process of recovery from depression from the perspective of older adults who have recovered.

Research Question

The research question that guided this study was: From the perspective of the older adult who has recovered from depression, what is the experience of recovery from depression?

Significance

Depression in the older adult population remains a serious public health concern due to the incidence, atypical presentation, often missed diagnosis, lack of treatment, and high recurrence rates. An exploration of what occurs in the process of recovery could be helpful in not missing the diagnosis and in providing earlier and more effective treatment. An understanding of the process of recovery from depression from the older adults' perspective will assist providers to plan strategies for the most effective treatment of depression. With effective treatment we hopefully expect to see a lower suicide rate and lower demand for unnecessary resources which will contribute to improve the quality of life for older adults. With effective treatment, many of the symptoms of depression will resolve and the individual's level of function will improve, thereby decreasing the level of care required (Badger, Dumas & Kwan, 1996). This will improve the quality of life and decrease the financial demand required when extra care or placement is necessary when satisfactory recovery does not occur (Drance, 1991).

Summary

Depression in the older adult is a serious concern. If left untreated it has deleterious effects on the quality of life of older adults and may result in debilitating functional decline or even suicide.

Care providers are limited in providing support and optimal treatment because of a lack of understanding of the actual process of recovery from depression. Few studies have examined the process of recovery, particularly related to older adults. The purpose of this

study was to describe the experience of the process of recovery through the experience of depression from the perspective of older adults who are considered to have recovered.

Overview of Thesis

This thesis consists of six chapters. In chapter one an introduction to the thesis is presented. It consists of background information, the problem and purpose, the research questions, and significance of the study. The literature review is presented in chapter two. Diagnostic challenges, treatment of depression, outcomes of treatments, information about recovery from depression, and the processes and models of recovery from depression are described. Chapter three presents the methods chosen to guide this study. Grounded theory is explained as are the sampling and data collection procedures. Ethical considerations are discussed and descriptions of the sample of older adults and data analysis are presented. Evidence of rigor and limitations of the study are also presented.

In the fourth chapter, the findings are presented. The four phases of the process of recovery through the experience of depression are presented and described in detail. The preliminary substantive theory that evolved from the data is discussed. Chapter five contains the discussion of the findings and is presented as the findings related to each of the four phases and the preliminary substantive theory. The summary, conclusions, and implications are presented in chapter six.

CHAPTER TWO

LITERATURE REVIEW

In chapter two a review of the literature is presented. The review includes a description of what is known and not known about the course and outcome of depression in the older adult and the process of recovery from depression. The literature provides a framework for this study by evaluating the current knowledge base and providing additional background for the study. In keeping with the procedures of grounded theory methods, this review aims to identify gaps in the current knowledge about the phenomenon of the process of recovery from depression in the older adult. Identification of gaps provides a rationale for launching this grounded theory study. The information substantiates the need to understand the experience of the process of recovery from depression as described by the older adult who has recovered from depression.

The literature review will be presented in the following manner. Diagnostic challenges to depression in the elderly will be reviewed followed by a review of common treatment methods for depression and outcomes of these methods. Factors that influence recovery will be discussed. These sections provide the basis on which to review the course and outcomes of depression. The concept of recovery from depression is defined, the processes of recovery from depression are reviewed, and then models of recovery from depression will be explained.

Diagnostic Challenges

Given the diagnostic criteria for depression (DSM-IV), it seems that diagnosing depression in the older adult would be relatively straight-forward. There are, however, a few challenges that are confronted when diagnosing depression in the older adult.

Criteria for depression are often identified in the clinical interview and most of the questions that need to be asked can be incorporated into the medical history. However, Reifler (1994) describes two common situations where diagnosing depression in the older adult becomes complicated. The first involves older adults who focus on somatic concerns and deny depressed mood, and the second involves older adults where depression is superimposed on a dementia in which cases memory loss may interfere with accurate recall or reporting of problems. These two situations occur frequently and have been described by other clinicians (Gurland, 1994; Reifler, 1994; Reynolds, 1994; Ruggles, 1998).

Despite the fact that depression is highly prevalent, numerous studies have found a discouraging disparity between the estimated expected prevalence rates and actual detection rates in clinical settings. Among the most likely reasons for failure to make the correct diagnosis are the stigma of mental illness and age bias on the part of physicians who may regard depressive symptoms as part of the aging process.

It is important when diagnosing depression in the older adult to distinguish between primary and secondary depression. Reifler (1994) described primary depression as a person's only diagnosis whereas secondary depression is where depression is found comorbidly in a person with another medical illness. Some medical illnesses (e.g.; Parkinson's Disease, dementia, and stroke) have been shown to biologically produce

depression in the older adult (Reifler, 1994). Distinguishing between these diagnoses may provide the base on which treatment is decided. For example, potential medication-induced depressions are treated by removing or decreasing medication. The potential drug interactions must also be identified. These diagnostic challenges in depressed older adults present particular difficulties in treatment options that distinguish this group to some degree from the general adult population.

Common Methods of Treatment for Depression

Treatments and goals of treatment vary. Initially, the aim of treatment is to completely remove symptoms in the shortest period of time. Medication, psychosocial support, a combination of medication and psychosocial support, and/or electroconvulsive therapy (ECT) may be used to do this (Rush, 1994). When symptoms resolve, the goal is then to prevent relapse. The treatment of choice is a full dose of medication with the provision of monthly social support (Alexopoulos et al., 1996; Flint & Rifat, 1997; Hawley et al., 1997; Orrell, Collins, Shergill, & Katona, 1995). To maintain recovery, the goal is prevention of recurrence. To do this, ongoing treatment is encouraged (Keller et al., 1992; Reynolds et al., 1992; Salzman, 1995).

Much of the available pharmacological information is based on evidence from randomized clinical trials of medications with adults most of whom are younger and middle-aged. Clinical recommendations for the use of medications in the older adult population are therefore derived primarily from experience with younger and middle-aged adults that is extrapolated for use to older adults (Salzman, 1994). The older adult presents particular challenges not only in diagnosing depression, but in selecting treatment

due to the potential complications associated with the normal process of aging and comorbid medical conditions. Awareness of potential drug interactions, use of concurrent medications, and the impact of comorbid general medical conditions is essential (Rush, 1994). Physical assessment is critical before older adults are started on antidepressants or receive ECT.

Outcomes from Treatments for Depression

Outcomes from treatments for depression have shown that depression is a serious illness that often responds well to treatment. Recent studies that have provided valuable information about the prognosis of depression in the older adult will be reviewed. Attempts to identify factors that influence recovery from depression have been made.

Complications to Interpreting Studies

Two complications to interpreting studies were the short length of research studies, and the lack of consistency in the definitions of response, relapse, remission, and recovery as they relate to depression and both will be discussed. Attempts have been made to resolve these problems.

Length of Studies

Initially, studies were done that followed older adults for a period of 1 - 2 years after a first depressive episode based on an understanding that recovery would be completed in that time frame. Because of the numbers of subjects with persistent symptoms, relapses, and recurrences, the lengths of studies expanded to 10 - 20 years to more accurately describe the course of depression and its responses to treatment.

Lack of Consistency of the Definitions

Difficulties caused by lack of definitions of response, relapse, remission, and recovery prevented accurate interpretations and comparisons of results between studies. To address the concern about inconsistency of definitions, in 1988 the MacArthur Foundation Research Network on the Psychobiology of Depression convened a task force to examine how change points in the course of depressive illness had been described and the extent to which inconsistency in these descriptions might be impeding research on this disorder. Frank et al.(1991) found considerable inconsistency across and within research reports. They concluded that research on depressive illness would be well served by greater consistency in the definition of change points in the course of illness and proposed an internally consistent, empirically defined conceptual scheme for the terms remission, recovery, relapse, and recurrence. They also proposed operational criteria for each term.

Prognosis after Diagnosis of Depression

There has been much controversy regarding the prognosis of depression in the older adult. In 1990, Cole conducted a meta-analysis of the outcome of depression that included ten studies that involved a total of 990 subjects. They were all over 60 years of age. Cole concluded that 60% had remained well or had relapsed with recovery, and that 25% had remained continuously ill within the mean follow-up of 32 months. One of the flaws he encountered was the lack of continuity in the definitions of remission, relapse, recurrence, and recovery.

Keitner, Ryan, Miller and Norman (1992) published results of a study conducted to determine which clinical and psychosocial variables were associated with recovery. They examined the probability of recovery from depression of 78 hospitalized patients, aged 28 to 57, twelve months after discharge. Patients were interviewed in hospital and then at monthly intervals up to the twelve month mark. Of the 70 that finished the study, 34 (48.6%) met the criteria for recovery after 12 months. The study concluded that patients hospitalized for major depression have a less than 50-50 chance of recovery by one year. Interpretation of results was complicated by the lack of consistent definitions of remission, relapse, recurrence, and recovery.

In 1992, Maj, Velto, Pirozzi, Loblance, and Magliano assessed the pattern of recurrence of illness after recovery from an episode of major depression. The study group included 72 patients with an age range from 27-55 years. The probability of maintaining recovery at 6 months was 76%, at one year was 63%, and at 5 years was 25%. They concluded that depression had a high rate of recurrence and that prophylactic drug treatment reduced the risk of recurrence but did not affect the trend toward increasing severity of subsequent episodes.

Later in 1992, Thase stated that it was clear that virtually all recently remitted patients should receive 4 to 6 months of continuation therapy and that depressive disorders appeared to become more autonomous, severe, and potentially refractory with each new episode. Using Frank et al.'s model, he focused his work on prevention of recurrent depression. After reviewing the literature, Thase concluded that ongoing maintenance therapy was indicated in cases of recurrent depression and for those with

heightened vulnerability and that full dosages of antidepressants were recommended for use in maintenance phases.

Thase (1992) was one of the first to talk of the vulnerability of depression. In 1997 Bothwell and Scott included 42 depressed adults in their study that attempted to identify vulnerability factors for persistent depression. They concluded that traits of neuroticism including presence of dysfunctional attitudes and low self-esteem contribute to vulnerability to depression.

Keller et al. (1992) published results of a prospective study observing the course of depression of 431 adults over 5 years. The purpose of the study was to extend the duration of follow-up to determine the rate of recovery from depression attained after 2 years. The results indicated that 12 % of the subjects had not recovered in 5 years. Because of a continuous 5 year duration of depression, these subjects were determined to have a chronic depression. In 1993, Brodaty et al. investigated the prognosis of depression in the elderly in a mixed age sample of 242 consecutive referrals with depression. Subjects were followed at one year and at four years. There was no significant difference in outcome between younger adults and older adults. They suggested that a more optimistic outlook and longer, more assertive treatment for depressed older adults were needed. Alexopoulos et al. conducted a similar study in 1996 with a mixed age sample of 86 subjects. They found no significant difference in outcome between younger adults and older adults and like Brodaty et al. suggested that depressed older adults needed longer, more assertive treatment.

The concept of chronicity was again described in 1994 in an article written by Piccinelli and Wilkinson. They reviewed 51 articles published in peer-reviewed medical journals between 1970 and 1993. They concluded that 12% of patients experienced depression as a chronic illness, and that many patients with depression received inadequate treatment. In May, 1994, Coryell et al. studied the regularities in the timing of recovery from depression in nonchronic depression. They followed 605 subjects and 826 nonclinical subjects over a six year period. Recovery occurred within three months in 40% of episodes, within six months in 60%, and within one year in 80% while 20% had a more protracted course. Interestingly, age of subjects was not mentioned.

In 1997, Flint and Rifat emphasized that because of the high rate of relapse and recurrence and because of age-related factors, long-term collaboration between the patient and the physician was required to successfully manage depression in the older adult. Hawley, Quick, Harding, Pattinson, and Sivukumaran (1997) concurred with Flint and Rifat's conclusion that older adults needed regular review to detect early signs of relapse or recurrence.

Treatment of depression in older adults relies heavily on inferences drawn from studies involving general adult populations. In the older adult, there is a decrease in the likelihood of relapse with continuation of treatment (Murphy, 1994). Continuation of treatment includes taking the full dose of antidepressant medication for at least 2 years and receiving psychosocial support at least monthly during that time. Flint and Rifat (1997) followed depressed older adults for 2 years after their initial depressive episode and found that with continuation of treatment, 74% had no recurrence or relapse. Of those who did

have one recurrence or relapse, 71% recovered and remained well for the remainder of the study.

One common characteristic of the studies described is that the course of depression was measured by the number of symptoms and length of time since diagnosis. Outcomes were similarly classified as to whether or not the criteria for major depression were met. Even though psychosocial treatments were included in many of the studies, the actual experience of depression and recovery from depression were not described. A medical model was used in an attempt to describe the behaviours and experiences of older adults with depression.

Factors that Influence Recovery

Many factors have been identified that influence outcomes in patients with depression. Factors associated with poor outcomes include comorbid physical illness (Ames, 1990; Cole, 1990; Cole & Bellavance, 1997; Keitner, Ryan, Miller, Kohn & Epstein, 1991), cognitive impairment (Ames, 1990; Cole & Bellavance, 1997), severity of depressive symptoms (Ames, 1990; Brugha, Bebbington, Stretch, MacCarthy, & Wykes, 1997; Cole, 1990; Cole & Bellavance, 1997; Taylor & McLean, 1993; Viinamaki et al., 1996), long initial episode (Brugha et al., 1997; Keller et al., 1992), inadequate length of treatment (Brodaty et al., 1993), decreased social activity (Ames, 1990; Veiel, Kuhner, Brill, & Ihle, 1992), and poor self-confidence (Andrew, Hawton, Fagg, & Westbrook, 1993; Surtees & Wainwright, 1996; Veiel et al., 1992).

Factors associated with positive outcomes from recovery include adequate social support (Humphreys, Moos & Cohen, 1997; Hinrichsen & Hernandez, 1993; Keitner et

al., 1991; Lara, Leader & Klein, 1997; Viinamaki et al., 1996), opportunity to contact the therapist outside of fixed treatment visits (Viinamaki et al., 1996), effective coping skills (Moos, 1994), absence of comorbid illness (Keitner et al., 1992), maintenance of treatment for at least 2 years (Flint & Rifat, 1997), and therapeutic empathy of the therapist (Burns & Nolen-Hoeksema, 1992). The factors identified by these researchers were rated from the perspective of the caregiver. None used a perspective from the older adult experiencing depression.

Concept of Recovery from Depression

Recovery from illness has been described by some as the “process of returning to the patient’s premorbid level of health” (Wilson-Barnett & Fordham, 1982, p.1) while others view recovery as “the state of being symptom free” (Kupfer & Frank, 1992) or “the resolution of impairment in functioning” (Wilson-Barnett & Fordham, 1982, p.15). While some clinicians focus on treating a disease, others focus on improving function. The idea is that improved function should derive from remission of the disease. “Nevertheless, function has a special relevance in the care of older adults and the improvement and maintenance of physical functioning is often the primary goal” (Blazer, 1994, p.157). Recovery is often a cooperative venture involving participants (family, friends, health care professionals, and the clients themselves) who may have differing views of health and illness. Because the purpose in recovery is to enable and assist clients to regain their premorbid health, the views of illness and health by the client are of central importance (Wilson-Barnett & Fordham, 1982).

The complexity surrounding the construct of the process of recovery from depression in the geriatric population arises from its multi-level and dual process/outcome dimensions. Purdy, Adhikari, Robinson, and Cox (1994) admit that when trying to understand a concept whose nature is dynamic and evolutionary, earlier outcomes often become process indicators because they set the stage for subsequent outcomes. Wallerstein & Bernstein, (1994) have noted the difficulty posed by the inter-relationship between the process and outcome of a concept. Eisner (1994) concludes that to distinguish rigidly between process and outcome when trying to understand the process of recovery from depression, is to miss the generative quality of the process.

Although recovery from depression has been defined in a variety of ways, there are two central themes on which recovery is based. These are improvement in level of functioning (which is directly related to quality of life) and improvement in symptoms of depression. Shea et al. (1992) defined recovery from depression as having minimal or no symptoms for at least 8 weeks following the end of treatment while Priest et al. (1996) defined recovery from depression as a score of less than seventeen on the Hamilton Depression Scale.

Coryell et al. (1993) reported that although recovery had been thought of as a resolution of the clinical symptoms of depression, the persistence of impairment in level of functioning was debilitating for clients to the degree where they reported that they did not feel they had recovered. Therefore, recovery needs to be assessed in terms of both quality of life as well as symptomatic improvement (Angst, Kupfer & Rosenbaum, 1996;

Friedman & Kocsis, 1996). Self-report from patients and reports from family must be included in the evaluation of both concepts.

Processes of Recovery from Depression

It is important to understand the process of recovery from depression as it is described by persons who have recovered. Five perspectives will be discussed in the following section. Some describe transitional phases as part of the process of recovery and one refers to depression as a chronic illness.

Schreiber (1996) conducted a grounded theory study that examined the process of recovery for 21 women (aged 32-69) who identified themselves as having recovered from a depression. The women were interviewed and described the process of recovery as '(Re)Defining My Self'. (Re)Defining My Self was a process of finding the answer to the question 'Who am I?' and consisted of six phases: 1) 'My self before' as the period of time prior to depression, 2) 'Seeing the abyss' where women confronted their depression, 3) 'Telling my story' where women opened up and talked about what was happening, 4) 'Seeking understanding' where women identified the cause of their depression and sought help, 5) 'Clueing in' where women made connections between how they felt and what they experienced which led to understanding the self and the environment differently, and 6) 'Seeing with clarity' where women looked back and reflected on where they had been and where they were at that point. For many women, the process of recovery from depression was a growth experience, as they developed skills and knowledge they lacked before. Once the six phases were completed, the process of recovery ended and as a result of their newly developed skills and knowledge, relapses or recurrences were not expected.

As the criteria for inclusion in this study was a self-report of depression, there was no requirement for participants to meet medical diagnostic criteria for depression such as those defined in the DSM-IV or those identified in various diagnostic tools. Dr. Schreiber (personal communication, 1998), informed me during a telephone conversation that she questioned the self-report of depression by some of the participants as she queried whether some participants who reported depression were actually experiencing a depressed mood, a developmental adjustment disorder, or a personality disorder.

Steen (1996) conducted a phenomenological study concerning the meaning of 22 women's (aged 40-55 years) experiences of recovering from depression. Five phases in the recovery process were identified: 1) 'existential alienation/pain' that included childhood and early memories prior to depression, 2) 'crises of adulthood' where women struggled through the stages of adult development using messages they brought from childhood that influenced the way they felt about themselves, the changes they made, and the coping methods they used, 3) 'first turning point' where they first developed an awareness that they needed help, 4) 'second turning point' was a transition period as the women began to take charge of their own recovery process after losing trust in the medical experts, and 5) 'becoming a gardener' was where the women found themselves having developed skills to keep them from sliding back into depression. Of those few participants who accepted medication as a form of treatment, all discontinued medication prior to the end of the study. The criteria for inclusion into the study was a self report of clinical depression. Again, once the five phases were completed, there seemed to be an understanding that

using the skills developed during the process of recovery would provide them with the necessary tools to prevent relapses or recurrences.

In a qualitative study using the grounded theory method, Heifner (1997) explored the experiences of depression of 14 men (aged 30-51 years) who were diagnosed and treated for major depression. The men in this study defined their experience of being depressed through their experience of 'being male', implying that the experience of depression for men was different than that for women. The emergent themes focused on the causes of depression and factors that predisposed men to depression. Heifner concluded that men's beliefs about being male influenced their process of recovery from depression but the process was not described.

Wilkinson and Pierce (1997) conducted a phenomenological study to answer the question 'What is the lived experience of aloneness for older women currently being treated for depression?' They interviewed eight older women (minimum age of 65 years) who were being treated for depression. These women identified five themes in their experiences of 'aloneness' that influenced their recovery processes: 1) vulnerability versus self-reliance, 2) fear versus hope, 3) helplessness versus resourcefulness, 4) loss of self-control versus self-determination, and 5) identity confusion versus self-reflection. The participants identified feelings of movement between these themes as they gained clarity of insight into their experiences of recovery from depression. They did not identify these themes as phases and did not say if they progressed chronologically or whether these themes were re-experienced in the event of relapses or recurrences.

Weingarten (1994) wrote about his experience with depression and called it "The Ongoing Processes of Recovery." Although Weingarten did not identify phases in the process of his recovery, he did emphasize the work he did to get out of depression and the importance of being involved with activities. He described the changes he noted in himself as he recovered. He described the process of recovery as being ongoing and he described depression as a chronic illness. He regarded his susceptibility to depression as an ongoing challenge with which he had to deal.

Models of Recovery from Depression

Recovery from depression has been looked at for years but only in the last ten years have people tried to put it into a model format. Only two models were found in the literature (Frank et al., 1991; Priest et al., 1996). The model by Priest et al. will be presented first, but the one by Frank et al. has been more readily accepted and has been adopted by the National Institute of Health.

In 1996, a group of psychiatrists in England, tested an exponential model of recovery from depression (Priest et al., 1996). They tested a hypothesis that the curves of the recovery scores followed a curve provided by a mathematical formula. To construct the curve, scores from a depression rating scale were plotted on a graph. They concluded that the exponential decay curve is a suitable model for describing the recovery of the average patient with depression. This hypothesis was tested in a double-blind controlled study of 112 depressed adults. The main limitation of this model is that it is based solely on the effect of an antidepressant on the Hamilton Depression Scale (HAM-D) rating

score which measures the presence of symptoms and excludes assessment of functional impairment. The validity and reliability of the HAM-D were not described.

A more accepted model was the 'Response, Remission, Recovery, Relapse, and Recurrence Model' of recovery developed by Frank, Prien, and Jarrett (1991). Because of the uncertainty with how terms such as 'recovery' and 'response' were used, the project to develop the model was sponsored by the MacArthur Foundation to clearly define clinical terms. According to the model: 1) *response* refers to a change of sufficient magnitude that the patient no longer meets criteria for depression, 2) *remission* refers to a relatively brief period during which the individual is essentially returned to his or her normal baseline condition and exhibits no more than minimal symptomatology, 3) *recovery* refers to a sustained period (usually a few months) during which the criteria for remission continues to be met, 4) *relapse* refers to the return of symptomatology after a remission but before the achievement of the sustained well interval required for a recovery, and 5) a *recurrence* represents the appearance of an entirely new episode of depression. This model also describes the three phases of the process of recovery from depression: 1) *acute* refers to the period of time from the initial experience of depression to onset of remission, 2) *continuation* refers to the onset of remission to the onset of recovery, and 3) *maintenance* refers to the period of time after recovery.

Summary

Depression is a serious and often chronic illness that in most cases responds to treatment. Two common diagnostic challenges include older adults often focusing on somatic concerns and interference with accurate recall or reporting as seen when

depression is superimposed on dementia. Common methods of treatment include medication, psychosocial support, and/or ECT. The initial goal of treatment is to remove symptoms as quickly as possible and later to prevent relapses or recurrences. Although many older adults initially respond to treatment, the often cyclical and sometimes chronic course of depression was discussed.

Factors that lead to poor outcomes include existence of comorbid illness, cognitive impairment, the severity of depressive symptoms, a long initial episode, inadequate length of treatment, decreased social activity, and poor self-confidence. Factors leading to positive outcomes include adequate social support, opportunity to contact the therapist outside of fixed treatment visits, effective coping skills, absence of comorbid illness, maintenance of treatment for at least 2 years, and therapeutic empathy of the therapist. Goals of recovery include resolution of symptoms and optimal levels of functioning. The 'Response, Remission, Recovery, Relapse, and Recurrence Model' of recovery developed by Frank, Prien, and Jarrett provides clear definitions of the change points in the process of recovery. The review of the literature provides information about the process of recovery in adults but there is a lack of information about how this relates to the process of recovery in the older adult population.

CHAPTER THREE

METHODS

Grounded Theory

The grounded theory method of qualitative analysis guided this study. This method was chosen for three reasons: First, it is appropriate when looking at the concept of recovery from depression in the older adult population where there is lack of theoretical and knowledge basis. Second, the method accommodates the developmental and multi-level nature of recovery from depression as an evolving process using a symbolic interactionist perspective. Finally, grounded theory has been used in a variety of disciplines for many years (Glaser, 1992) and has established credibility.

The proposed research was designed to generate a preliminary substantive theory of the process of recovery from depression in the geriatric population. Grounded theory proposes a systematic process for generating and verifying theories. Glaser and Strauss place theory construction in the mainstream of scientific research by offering researchers a systematic qualitative alternative to the discovery and verification of theory (Strauss & Corbin, 1990). With the grounded theory method, theory generation becomes an important part of the scientific reasoning process.

Sampling Procedures

Theoretical sampling

Theoretical sampling provided deliberate selection of clients based on their past experiences, their ability to recall, their ability to articulate, and their receptivity to being interviewed (Morse, 1986). Theoretical sampling and the making of comparisons provides

the backbone of the grounded theory method. With theoretical sampling, the researcher samples on the basis of inductively derived theoretically-relevant concepts. Guided by the question “where can I find instances of X”, the researcher searches for incidents and events that will refine or elaborate on the existing concept.

For this study, the researcher identified Greater Vancouver Mental Health Services (GVMHS) as a society that provides continuing services to older adults throughout their experiences of depression. Individual case managers who knew their clients well were asked to identify potential participants that had the ability to remember and articulate their experience. Arrangements were made for the case manager to approach potential participants to determine their willingness to participate.

Unlike traditional quantitative analysis, the emergent themes are tested iteratively and cyclically as they are generated, through the use of theoretical sampling and constant comparisons. Theoretical sampling and constant comparisons work simultaneously and together. Through theoretical sampling, researchers are constantly comparing the similarities and differences between incidents and events, and the relationship between them to develop theory and to test the existing linkages. This was done by identifying themes generated by one interview and then looking for these themes in other interviews. One problem experienced initially was that the themes emerging from first interviews influenced the analysis of subsequent interviews. When this problem was identified, the researcher went back and reanalyzed the transcriptions.

The use of theoretical sampling and constant comparisons relies on the use of both inductive and deductive modes of reasoning while the researcher constantly looks for

patterns. In this respect, grounded theory is unique for its circular approach to theory generation and testing (Blaikie, 1993). Deduction is used in theory generation and testing. The researcher addressed and framed the research questions on the basis of existing literature deemed deductively to be relevant. Therefore, the researcher was sensitized to certain concepts that included wanting to elicit the experience of the course of depression and any factors that may have influenced the course. These concepts shaped the trigger questions.

Sampling Criteria

Many depressed older adults living in the large urban areas of Vancouver and Richmond, are followed by the multidisciplinary teams comprising the Greater Vancouver Mental Health Services (GVMHS). Each client of GVMHS is followed by a case manager and a physician. Because of easy access to this otherwise diverse group of older adults, participants for this study were selected from the large client base of GVMHS. A theoretical sample consisted of older adults (aged 65 and over) who met the following criteria. To ensure the accuracy of the diagnosis, participants had a diagnosis of major depression as made by a physician. This excluded persons who incorrectly believed they were depressed. Participants needed to be in remission as identified by the mental health team. This involved maintaining at least an 8 week period after symptoms resolved. To enable collection of reliable and valid information, participants needed to be willing to participate, to be able to provide articulate and accurate information, and to be receptive to being interviewed. Seven clients were asked to participate in in-depth interviews.

Recruitment Procedures

At a monthly meeting of psychogeriatric team members of GVMHS, the researcher explained the purpose and process of the proposed study. Sampling criteria were explained. Mental health teams were asked to identify potential participants from their case lists, to make initial contact, to briefly explain the study to clients, and to get their permission, if interested, for the researcher to contact them. The researcher arranged to meet potential participants at which time written consent (see Appendix B) was obtained.

Potential participants were told that for the purpose of the study they would be asked to describe their experiences with depression. It was explained that in order to capture all the information, permission to tape record interviews was requested. Potential participants were informed that their participation was voluntary and that refusal to participate would not interfere with their relationship or treatment program with the team. An initial appointment was set up for the researcher to meet with the client and conduct the first interview. Participants were informed that they could withdraw from the study at any time and phone numbers were provided to the participants should any concerns arise.

Data Collection Procedures

Data were gathered using individual interviews with clients which captured the clients' feelings and experiences. The researcher conducted all the interviews. Three of the participants were interviewed twice. Data were also collected on demographic information such as the participants' age, sex, family situation, ethnic origin, language, location of residence, and community supports they had received. The taped interviews were transcribed immediately and the analysis procedure began.

Several open-ended trigger questions that focused on describing the course their depression took, identifying things that were helpful or not helpful, and describing their awareness of changes during the process of recovery, were used to guide the interview (see Appendix C). Initial interviews were conducted in the participants' homes and were tape recorded and subsequently transcribed verbatim. Although open-ended trigger questions were used, in all cases the interviewer had to repeat and/or elaborate on the questions to either refocus older adults to the subject at hand, or to probe for more detail and clearer descriptions. Initial interviews lasted from forty-five minutes to one and three quarter hours. This enabled the researcher to elaborate on themes or constructs previously identified. Three persons were interviewed a second time at which time they validated the information and provided clarification and verification of the provisional analysis. These second interviews tended to be shorter, lasting from forty-five minutes to just over one hour. When the first interview was completed, transcription and coding of the taped interview took place before the next interview was started. Data was also validated with other health care professionals involved in providing geriatric mental health services.

Although there had been some apprehension expressed by participants before the interview started, older adults were very enthusiastic about participating in this study once they started telling their stories. At a second interview, one woman expressed how telling her story initially had provided her with greater insight into her depression and how helpful she had found this when faced with a recurrent episode.

Ethical Considerations

Participation was voluntary and participants were free to leave the study at any time. Consent to participate was established by signing the consent form. Participants were informed that no remuneration was offered and there were no known risks from participation. Confidentiality was maintained. Tapes and transcriptions were coded and were kept in a locked safety box when they were not being used.

Identifying information was kept separately and not accessed during data analysis. Participants were told that they would be provided with an abstract of the results of the study if they wished. Participants were informed that the findings of the study would be published and be available for presentation at conferences.

Description of the Sample of Older Adults

The sample consisted of seven older adults whose ages ranged from 67 to 94. They had been diagnosed with major depression and, before being interviewed, had met the criteria for recovery from depression. The criteria for depression included maintaining at least an 8 week period after the criteria for major depression as specified in the DSM-IV were no longer met. Six persons had experienced at least two previous episodes of depression and three had experienced four or more episodes in their lifetime. Of those who experienced recurrent episodes, onset of initial episodes occurred between the ages of 22 and 64 years.

Of the seven participants, three members had never been married. The four others had lost at least one spouse to death. While two lived in long term care facilities, others lived alone in their house or apartment and one woman lived in a subsidized seniors'

housing complex. Six participants were involved in at least one community activity and/or program. As part of the inclusion criteria, all had received services provided by one of the multidisciplinary mental health teams which comprise Greater Vancouver Mental Health Services. In addition to receiving regular psychosocial support, all but one of these older adults had continued with pharmacological treatment. The woman not taking pharmacological treatment had previously not responded to medication and was treated successfully with ECT which were being continued.

Description of Data Analysis

Grounded theory analysis proceeded in three steps according to Strauss & Corbin (1990). The first was to identify categories, properties, and conditions (open coding). The second was to hypothetically propose and test relationships between categories, properties and conditions (axial coding) through the use of theoretical sampling and constant comparisons. The third was to identify the core variable that represented the main themes of the theory (selective coding). During the course of grounded theory analysis, the researcher identified a core variable that illuminated the main theme that explained what is going on in the data. The main themes served as a further guide to data collection and analysis and once it has emerged, the researcher coded data related to it. Through theoretical sampling and constant comparisons, all data related to the themes should have been identified and verified until the concept reached theoretical saturation. Theoretical saturation was not reached in this study.

Open coding was the first step in the analysis process. In open coding the researcher coded the text by sentence and by paragraph. The purpose of open coding was

to name and categorize dimensions as they related to the phenomena of interest, in this case, the process of recovery from depression in the geriatric population.

The aim of grounded theory was to conceptualize these codes into groups that varied according to different levels of abstraction. Open coding, however, was limited to generating codes and grouping codes relating to the same concept into three domains: 1) categories, 2) properties, and 3) types, circumstances, and conditions. The researcher started by coding at the lowest level of abstraction (types, circumstances, and conditions) which included such things as when depression started, what the signs and symptoms were, what had happened to precipitate depressions. The goal of sampling during open coding was to expose as many potentially relevant categories along with their corresponding properties and conditions as possible. As the categories became apparent, the researcher was alerted to elaborate on these areas. Categories included things participants and others did to support recovery, and the emergence of phases of recovery. The data were not focused only on these categories, as other categories emerged as data collection and analysis progressed.

The second step of analysis was the use of axial coding where categories were conceptually linked. During this step the researcher moved through four distinct stages from relating subcategories to a category within one of the identified models, verifying statements against the data, further developing categories and subcategories in terms of their properties and conditions, and exploring the similarities and differences among and within categories (Strauss & Corbin, 1990). During axial coding, theoretical sampling focused on identifying relationships and verifying the relationships stated in the form of

propositional statements to determine their validity. As with open coding, theoretical sampling was used to maximize the differences with respect to the concept of interest. Initially, the researcher identified the core concept of interest as control. While loss of control was a main theme in the first two phases, it was not identified as the main theme during phases three and four and when second interviews were done, participants did not support the central concept of control. The researcher was required to review all the data and clarify themes and concepts. As a result, the core concept of 'working' through the experience of depression emerged from the data. Identifying the core concept was not as straight-forward as was expected.

The researcher deductively proposed questions or statements in relating subcategories to a given category. These deductions took on some combination of what had been read in the literature and what had been transcribed in an interview. In any case, asking questions was central to the coding process. With specific questions, the researcher went back to the data and looked for specific incidences, events, or evidence to support or refute the question.

The researcher moved back and forth between inductive and deductive modes of thinking in generating a preliminary substantive theory. The researcher deductively generated statements of relationships between categories, properties, and conditions, and then verified the statements against the data. Concepts and relationships generated through deductive thinking were verified in the data but theoretical saturation was not achieved.

When open and axial coding had been completed, the researcher moved on to the third step in data analysis which was that of selective coding. In selective coding, the researcher selected the core category, systematically related it to other categories, validated those relationships, and filled in categories that need further refinement (Strauss & Corbin, 1990). Selecting the core category emerged after coding the data a second time.

Evidence of Rigor

“Rigor in qualitative research is associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase. Evaluation of the rigor of a qualitative study is based, in part, on the logic of the emerging theory and the clarity with which it sheds light on the studied phenomenon” (Burns & Grove, 1993, p.64).

Strauss and Corbin (1990), developed criteria for evaluating a grounded theory study which was applied to this study. One of the common errors in research is for quantitative criteria to be applied to qualitative research. This is inappropriate given the differences in the form and context of qualitative data (Cargo, 1995). Sampling, validity, reliability, and generalizability need to be reformulated when applied to qualitative research. However, because, through the processes of coding and theory development, the data were compared and contrasted. Had theoretical saturation been achieved, the resulting preliminary substantive theory would have, in fact, been checked many times.

To be trustworthy, the combined qualities of an inquiry that “demonstrate its truth value, provide the basis for applying it, and allow for external judgments to be made about the consistency of its procedures and the neutrality of its finding or decisions” (Erlandson,

Harris, Skipper, & Allen, 1993, p.29). Terms such as credibility, transferability, dependability, and confirmability are appropriate indicators of trustworthiness of grounded theory.

Credibility is the degree of confidence in the truth that the findings have. It was assessed by determining that the description developed through the inquiry 'rang true' to the persons in the settings studied. The researcher in this study spent time with participants to understand their experiences and to overcome the researcher's initial personal biases. The researcher collected information about events from different points of view and considered alternative explanations for sets of data (Erlandson, Harris, Skipper, & Allen, 1993). Data and interpretations obtained were verified by three participants from whom the data were collected.

Transferability is the extent to which the results can be applied in other situations. Although transferability occurred because of shared characteristics, the aim in qualitative research was to describe in great detail the interrelationships and intricacies of the concepts being studied. This enables readers to use certain observations as a base on which to guide further inquiry. Transferability was facilitated by the use of very detailed and precise descriptions of observations and experiences as well as by the use of purposive sampling that enabled rich detail to be obtained from data (Erlandson, Harris, Skipper, & Allen, 1993). However, the sample population consisted of older adults who were referred for treatment when primary physicians' management plan had failed. This sample may have represented a more refractory group of clients than would be expected in the general population.

Dependability is the evidence that if the study was replicated with the same people in the same setting, its findings would be repeated consistently. In qualitative research, observed instability or changes may be attributed not only to error but to reality shifts. Therefore, it was important to identify the source of instability or change, whether it was due to error or better insights (Erlandson, Harris, Skipper, & Allen, 1993). Discrepancies in reporting were identified and clarified before analysis.

Confirmability is the degree to which the findings are the product of the focus of its inquiry and not of the biases of the researcher (Erlandson, Harris, Skipper, & Allen, 1993). To ensure confirmability the researcher made sure that the data could be tracked to their sources and that the process of interpreting the data was logical.

Limitations

The following limitations were identified. Premature closure occurred due to time constraints with the result that saturation did not occur and the preliminary substantive theory was not complete. As a novice, the researcher's lack of experience and skill in data collection and coding may have compromised results.

There are limitations of this project that affect transferability. First of all, because only a small number of subjects were interviewed and because the sample may have represented a more refractory group, transferability was decreased. The other limitation was that the sample was taken from a relatively homogeneous group as all the participants were fortunate to have accessed the health care system and continued to have on-going support. Persons who were omitted included those who did not have the ability to access the health care system and those who did not have any advocate to access the system on

their behalf. Persons who refused services for any reason are also excluded from this study.

Summary

Grounded theory methods were described in this chapter as a means to investigate the process by which older adults recover from depression. The sample selection and criteria, the data collection procedures, and the processes involved in data analysis were also outlined. Credibility, transferability, dependability, and confirmability were described as indicators of trustworthiness and rigor of grounded theory. Ethical considerations were also discussed and a brief description of the sample was also provided.

CHAPTER FOUR

FINDINGS

In this study, the process of recovery from depression was explored in a group of older adults who had recovered from depression. The findings provide a glimpse into the experience of older adults during the recovery process. A preliminary substantive theory of the process of recovery from depression from the perspective of the older adult evolved from the data. This preliminary substantive theory is based on a process older adults went through in their recovery from depression that was made up of what the author has chosen to call phases. The findings are presented in the following manner. A brief overview of the phases of recovery from depression is followed by detailed descriptions of the phases. Finally, the preliminary substantive theory is explained as it emerged from the findings.

Phases of Recovery from Depression

Overview of the Phases

Four phases identified in the process of recovery from depression included: 1) **Spiraling Down**, 2) **Changing Direction**, 3) **Working the Way Out**, and 4) **Staying Out** (see Figure 1). Older adults who had recovered from depression described a general sequential process while going through these phases. As well, the length of time in each phase differed between individuals. In addition, when recurrences were experienced, older adults described going through the same phases again.

Although the first phase started with experiencing 'triggers' that often included unresolved grief and regret following losses, '**Spiraling Down**' reflected a phase that was generally identified by experiencing progressively increasing somatic discomfort and/or

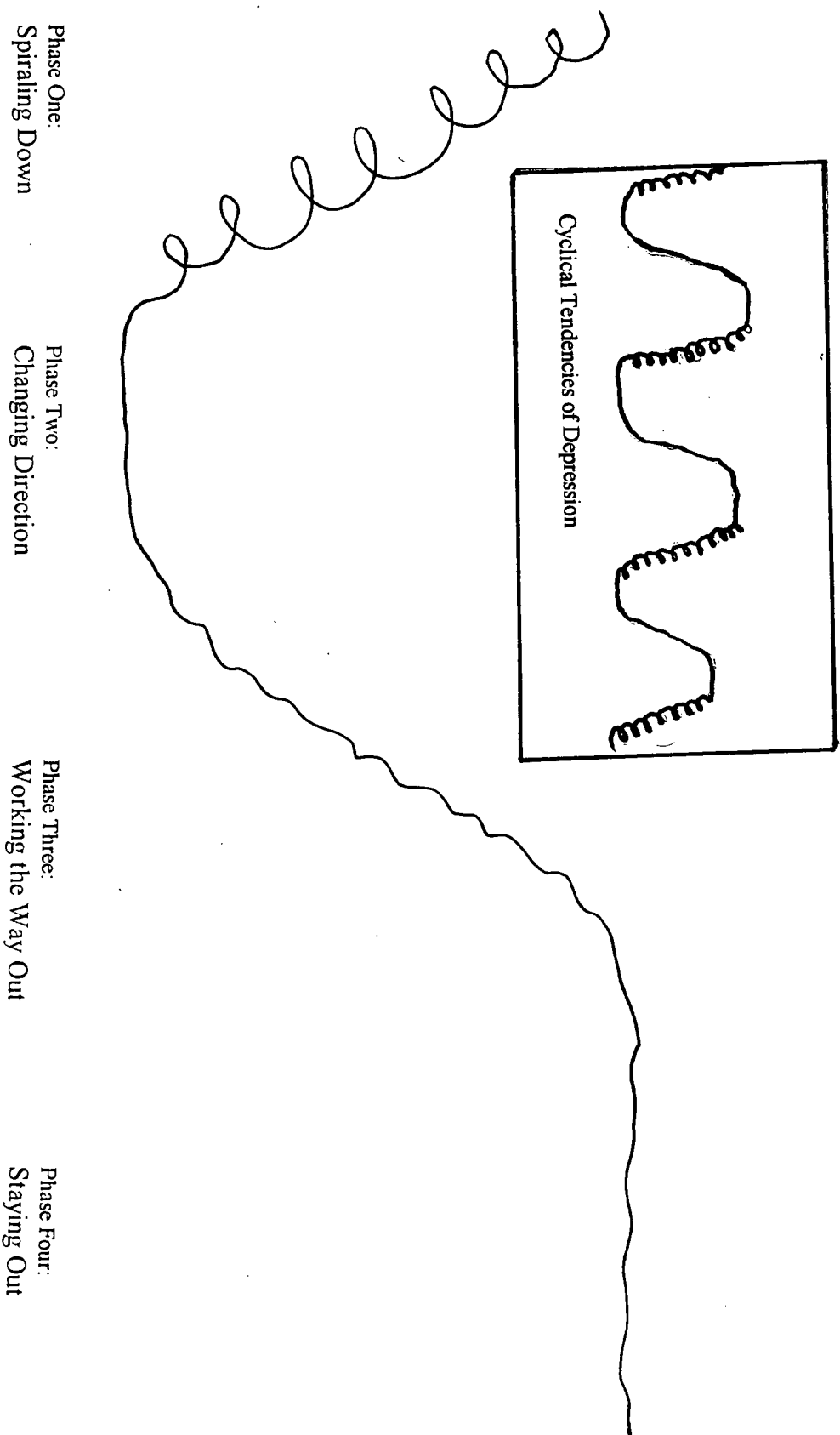


Figure 1. The Process of Recovery Through the Experience of Depression

emotional distress. During this time, a lack of awareness of the process was described and as the spiral continued downward, feelings of sadness, helplessness, and the sense of losing control were experienced. Eventually the 'bottom' was hit. Although the time it took to reach bottom varied between individuals, the 'bottom' was described as the 'lowest' time where people felt that things couldn't get any worse.

The second phase '**Changing Direction**' started with the emergence of a sense of awareness that something was very wrong and the knowledge that they couldn't keep going with the level of distress being experienced. At this time, hope and determination surfaced which, accompanied by a positive attitude, provided motivation to change direction and start working on the journey out of depression. Facing the diagnosis of depression and internalizing the meaning of the diagnosis usually occurred in this phase, but there were instances where changing direction occurred before a diagnosis was made.

After changing direction, there was a phase, '**Working the Way Out**' that reflected a real determination and drive to get out and stay out of depression. The course out was variable in terms of speed and smoothness. Increased levels of involvement were described as were different types of support that older adults found beneficial. The point at which recovery was achieved was elusive mostly because the work in this phase did not stop at that point. When recovery was achieved, there was a phase, '**Staying Out**' where there was a continuation of work and effort required to maximize the chances of remaining free from depression. The perceptions of the persons interviewed were that they had not recovered from depression even though they were identified for the study as having recovered using the criteria provided in the literature. They identified remaining vulnerable

to relapses and recurrences and it was because of this vulnerability that they continued working to stay out of the depths of depression. These older adults didn't have a sense that there was an end to their depression even though they had recovered.

Description of Phases

A detailed description of each of the four phases will be presented in this section. There are some subphases within the phases. These illuminate some of the major themes that were described by older adults in this study.

Phase One: Spiraling Down

The spiral process was usually triggered by the experience of significant and sometimes multiple losses. These losses might have occurred recently or in the distant past but it was as if a giant spiral had begun with these losses, particularly because many of them were associated with unresolved grief and feelings of regret. The distress associated with these losses seemed to accumulate and escalate putting the person into a downward spiral. It seemed to these older adults that they were generally unable to resolve or handle the losses and they remained vulnerable, this adding to the sense that things were out of control. In addition, increased vulnerability for the spiral to continue to progress downwards likely resulted because they reported a lack of awareness about what was happening. Because of this, they were unlikely to have used coping strategies to stop the process.

Spiraling down reflects a phase that was generally identified by experiencing increasing somatic discomfort and/or emotional distress. It was in hindsight, after their depressive episode, that most were able to identify changes they experienced as being

signs of spiraling into depression. The lack of awareness at the time these changes were noticed may have been partly related to the fact that most experienced symptoms that they would associate with physical health and not with mental well being. Most experienced physical types of symptoms such as lethargy and pain, and made no connection to this being reflective of a depressive situation. There were also some emotional symptoms which were blatant symptoms of depression but which weren't recognized as such.

The spiral drew them deeper and deeper into a tailspin. For some individuals this spiraling action occurred fairly rapidly while for others it was a slower process which gradually took over their lives. They felt they were no longer in control. It was more in control of them, giving rise to feelings of uncertainty, helplessness, and fear. The spiral moved downwards, continuing to consume them and take hold of them. They talked of this period as being an "awful time". This phase culminated in hitting bottom where some of them were totally incapacitated and unable to function. For others, they continued to function but every action required effort.

Triggering the spiral down.

The spiraling process seemed to be triggered by significant losses which might have occurred years before or fairly recently. The losses related to the death of family members or friends as well as to that of health, and work. It seemed that in the group where a loss triggered a spiral down, there was an accompanying sense of unresolved grief and regret associated with the loss.

Participants in this study described how both biological predisposition and regrets associated with their experience of loss increased their sense of vulnerability toward

depression. Many of those who had experienced recurrent episodes of depression identified biological factors as contributing to their vulnerability. One man said "I've had depression before, I guess somehow I was made prone to it" while another acknowledged that "there were biological factors of course."

While some people got into the downward spiral after experiencing one loss, others had experienced many losses. One woman had lost two husbands, two sons, a partner "companion," a sister-in-law, and a son-in-law over the course of twelve years. For this woman, it was the loss of her second husband who had died five years prior to the interview date, that had triggered her depression, not her most recent loss of partner. She had been unable to continue caring for the second husband at home and she was "always sorry" she had to put him in a nursing home for his Alzheimer's. That "kind of made me feel down." Although her family helped her keep him home with additional support over Christmas, when he was placed in a long term care facility he died within six weeks. "Had I known, I would have managed somehow myself. That always bothered me." People expressed a feeling of loneliness after the death of a loved one as "feeling alone," "being on my own," and "having no family or friends around any more."

Another woman felt concern and disappointment with her husband's care in a long term care facility and she related this to the onset of her depression:

I know they didn't care for him. What I've seen I was very disappointed. . . so that was the start of that illness and everything.

A man described the experience of losing his wife, who died of cancer, and how he had to care for her but felt he didn't know how to do that. He and his wife had unfulfilled plans.

Although she wanted to die at home, he requested that she be hospitalized and felt badly about that:

I didn't know how to take care of her, you know, I would do the best I could . . . I said to my doctor one day, I said, I can't . . . it's hard to really find words to fully express myself . . . we'd made some plans. I was going to retire and make a couple of trips. She'd never been to Europe . . . I said I'm taking care of her until I die and do my best in every way I could, you know, and at the end though, she got mad at me. She wanted to die at home. I don't know why. . . we put her in the hospital in some palliative care . . . and she was mad at me.

Loss of their own health seemed to trigger the spiraling phase for some. For example, "an attack of shingles," and "my stroke" seemed to be triggers. Multiple physical problems limited one woman's ability to participate in activities and, as well, affected her sense of well-being. In this case, loss of health both triggered and inhibited recovery:

I have a lung problem and I am blind in one eye, and I have to have surgery, two surgeries because after I have the lung [operation], when the lung is healed then I have to have the eye removed completely . . . you see I can't read, I can't knit, I can't crochet, I can't, do anything where my eye has to move a lot because then it hurts after, so it really needs surgery right now but we can't do it with my lung in the shape it's in . . .

Loss of a job was identified by one woman as triggering her spiral downward. It seemed that the suddenness of this event and the resulting lack of daily structure acted as trigger:

There was a lay-off at work of a number of people in the company, myself included . . . the impending end of a job . . . I realized I needed structure in my life.

The compounding effect of multiple losses was also recognized: "there were all these types of things that happened and I kind of laughed them off but I guess it, it was a bit wearing, too." One woman who had experienced multiple losses began to wonder if she had been victimized as she kept repeating "why does it always happen to me?"

Feeling increasing levels of distress and discomfort.

The onset of depression was described as sudden for some while others described it as gradual. One man said his energy “disappeared overnight”. He was aware of earlier symptoms of “feeling sick” and “a poor feeling in the morning” but the experience of losing his energy to the extent that one morning it made getting out of bed difficult, was what he perceived as a ‘sudden’ onset. Another participant said, “I’d have to think in retrospect that it [onset] was fairly rapid,” while still another said, “it was like falling off a cliff. I didn’t know what happened. All of a sudden, it happened just one day, I was depressed.”

Onset of depression as a gradual process was frequently described: “morning by morning I was getting slower and slower,” “it come on gradually, you know, and then it just takes over,” “in the mornings getting up I started to have some difficulty buttoning my shirt, the buttons wouldn’t go in.”

Participants identified some differences in the onset of their most recent depressive episode compared to that of previous episodes. One man, who identified early symptoms of his depression said, “it was an unusual feeling because I never felt that way before . . . this one was, just seemed that much different, so I guess a person, the way it affects a person may not just always be the same.” When asked if he thought at that time that those symptoms were signaling the onset of a depression, he replied, “I couldn’t tell, it was so different.”

As participants descended into the spiral, they experienced progressively increasing levels of psychological distress and somatic discomfort. Many described suicidal thoughts.

People who were aware their symptoms reflected depression described their experiences. Lack of energy, fatigue, and lethargy were common: "I wasn't feeling good, all I want to do is sleep," "I was always complaining about being tired," "I wouldn't want to be bothered getting up and getting going," "extreme lethargy, it's different from the feeling of not wanting to get up which I don't think is at all the same." Lack of motivation was also described: "I didn't feel like doing any housework or the like," "everything being so hard to do, you've got no motivation . . . just a general feeling of you can't help yourself," "I had a very poor feeling, everything was so hard to do."

Although existing symptoms persisted during the spiral down, addition of strange beliefs and intrusive thoughts such as hearing voices, hearing music, and believing that God and others had special powers over the individual, were common. "You will talk strange and you won't be yourself . . . I wasn't acting myself at all." People who heard voices or music often tried to make sense of their experience. They often tried to figure out where the sound was coming from, "I figured that it was other people's music or noise and all the time it was my brain," "I'd be hearing voices that I couldn't figure out where they was coming from and they weren't clear, either, this voice that I kept hearing." One man was frustrated trying to locate the source of music:

I figured it was the neighbour's, I thought [they were] downstairs playing music, but I can remember one night getting up and going out the back door and walking down by their bedroom to see if I could hear music but all was quiet and I still had my music. You can tell if there's music coming out of the[room] or music in your head.

Experiencing intrusive thoughts was a very disturbing experience: "hearing voices and also music any time, it's just terrible. You get comfort where you can because it is

awful,” “It was so loud and it gives you an awful, awful feeling,” “I had bad dreams [when I was awake], they were wicked, frightening, terrible dreams and that bothered me a lot.”

People also described feeling “down”. They said: “I was just so down and anything I did, I did because I was supposed to do it, not because I wanted to do it,” “I was so tired, it was a terrible feeling.” “You lose interest in everything. Life loses its value . . . you don’t want to speak to anybody . . . you want to isolate yourself.” “You feel down because there isn’t anything you can do for yourself.” Distress and discomfort progressively got worse, gradually taking over their lives.

Generally, older adults felt unable to control changes they experienced while spiraling down. They also expressed uncertainty about what was going to come next:

It’s kind of frightening, kind of frightening because you don’t know where it’s going to end, you know, you don’t know what’s going to happen, you just get that sense of insecurity that you don’t know what’s going to happen next . . . it was very distressing.

Some were uncertain as to whether changes they experienced were due to depression or the aging process. One person said:

I lost my strength, I don’t know if it will ever come back at my age . . . as you get older you’re bound to slow down, so I look at it that way. I’ve never been this old before.

As the symptoms worsened, feelings of helplessness and being scared increased to the point where participants felt life wasn’t worth living.

It’s just that feeling of helplessness that comes over you and you feel down because there doesn’t seem to be anything you can do for yourself, you know . . .

As a result of feeling unable to control their symptoms, people described feelings of helplessness and wondering if life was worth living. Thoughts of suicide were described at the bottom of the spiral:

When you're down, when I think of some of the times when I was in bed and the music was just driving me crazy, I used to think why am I not taken . . . you wonder if life's worth living at your present state, you know, and you think it isn't.

Well, I'd like to say something about this here business of committing suicide, you know, you read about it in novels and you have friends who have done it and all this stuff and it's a very, very, very scary experience to think about . . . I used to think about what was the best way to do it and all that. I guess I never had enough nerve or enough, I don't know what to do it but, it's pretty scary. It's like a nightmare, and I hope it never comes back . . .

"It's not very pleasant and it worsens. It gets worse in that it just takes a complete hold of you . . . as it progresses it gets, it worsens".

One woman described how severely affected she had been during her recent episode of depression:

I'd say it's severe. I was not a functioning person . . . it must have been an altered state in my mind . . . I can assume that I wasn't always totally aware of what day of the week it was . . . I was so out of it apparently that I just don't know, you know, I don't remember ever having suicidal feelings, I don't even totally remember although I partially remember how much incontinence I had . . . I was told that it was on the record and so, how out of it I was, I think that's an example.

The speed at which people spiraled deeper into depression varied, but common features included the feeling that they were losing more and more control as they progressed downwards: "as it worsens it just takes complete hold of you," "it just takes over," "I wanted to go but my body wasn't mine . . . yeah and you can't understand it, you don't know why you can't do it." There was a sense that they could not control what was happening to them. One person explained:

With depression it isn't just something about the body that's gone wrong, it's the old mind and when the mind goes, your control goes pretty well . . .

Not connecting their state with depression.

People described varying levels of awareness of their depression. Some people were aware that their symptoms were related to depression while others seemed quite unaware. This might have been due to the fact that many of the symptoms experienced were physical. People did not associate them with depression. This lack of awareness impacted on their use of coping mechanisms.

One woman said. "You don't really know you're in a depression, you know, you're just feeling down and you figure well there's a lot of people ill like yourself." Another woman denied any conscious awareness of signs that she was going into a depression:

I hadn't really had any self awareness that I was in a pending crisis prior to that time . . . when I say I had no awareness, I wasn't consciously aware of having problems in my life . . .

She described receiving a phone call from her son after which he drove to her apartment and took her to the hospital. She said she still doesn't know what it was that alerted him to her problems but she says that she herself must have known something was unusual because she was willing to go to the hospital.

Another person described being aware of concerns she had but she didn't think anything needed to be done about them. She was teaching school at the time of the onset of her first depressive episode and it was the staff who arranged for her to go to the doctor. At the onset of this most recent episode, she once again described 'strange

behaviours' including losing her car "on purpose but for no reason," and feeling exhausted. Although she was aware of these symptoms, she did not seek help and it was her niece who eventually took her to hospital. Many people who lacked awareness of either their symptoms of illness or their need for help experienced intervention from family or friends to obtain help.

Nothing seemed to make a difference.

When participants experienced stresses they used coping mechanisms that had previously helped. Unfortunately, they did not necessarily help this time. As an example, in the past, many participants had relied on their spouses for support. Spouses provided support to each other during stressful periods and when the spouse died, so did a significant source of support. Therefore, coping mechanisms related to that spouse, that had previously been successful for participants, were ineffective to prevent most recent episodes of depression. One person described this experience:

I think a depression is more when you're alone. If you have a husband who cares and you care for them, I think it's easier to come out of because we just went gradually into doing the things we had done. We were always together. When we went out it was together. He didn't go one way and me the other . . . I lost him in '86 and I think it's been a struggle for me since then.

Another woman identified that her "young age" at the time of the first loss was the reason that she was able to "manage so well" but she was not able to describe what it was about being young that had made a difference. One man described the ineffectiveness of taking a medication that had previously worked well "this last time it just didn't work." If previous effective coping mechanisms became ineffective, participants in this study were not able to describe possible alternatives that would have helped.

Hitting bottom.

The spiraling continued until they hit the 'bottom' at which point they felt overwhelming distress with exhaustion and hopelessness at its maximum. While some people felt they spent a few hours at the 'bottom', others described spending weeks there. The lowest point was "the worst" they endured. When asked how they identified 'the worst', or the 'bottom', responses included "it was just terrible," "it was an awful, awful, awful feeling," and "it just couldn't be any worse." Only one person interviewed had experienced his first depressive episode. Hitting the 'bottom' for him was as if "it couldn't get worse." While one woman reported "extreme incontinence," "not being a functioning person," and "not being totally aware of what was happening around me," another person was "still doing my shopping and my cooking."

Participants felt that depression had taken over their bodies and their lives. They felt overwhelming hopelessness and exhaustion. "It's just a kind of a hopeless feeling." The distress of the experience of depression was at its maximum:

That feeling of helplessness that comes over you and you feel down because there doesn't seem to be anything you can do for yourself.

You're just down at the bottom and have a ladder to climb. At that time you don't know that. You think, I can't be depressed, but I think it maybe starts you on the climb out if you accept it, if you don't accept it then that's where you'll stay . . . you feel dropped down at the bottom.

Phase Two: Changing Direction

Changing Direction was the phase that reflected the time where participants felt they "couldn't take it anymore" and changed the direction of their journey by starting to move upward and out of depression. They changed direction out of their distress, not

necessarily out of their acceptance of the fact they were depressed. Some took the initial activities necessary to get help and some did not recognize they had a depression until after they had been either diagnosed or even treated. Therefore, changing direction was sometimes an acceptance of the fact they were depressed and at other times it was an acceptance of the fact that they needed help. The distress and discomfort they experienced was driving them to seek help.

The turning point.

After reaching an intolerable level of distress and discomfort at the 'bottom' of their depression, participants described a 'turning point,' when they first obtained help. People all described reaching a 'turning point'. One person described the suddenness of reaching the 'turning point' as something that "hit me on the head and woke me up" to what was going on. Generally, reaching the 'turning point' happened at the point when they felt unable to continue enduring the level of distress they had been experiencing. People described their perceptions of the 'turning point' as "I just couldn't take it any more," "I knew I had to do something," and "I knew something was wrong so I called a taxi and told them to take me to the General for a check-up." One woman said she called her daughter and said "I just can't take it," and another person said, "I think the turning point was when I wanted to help myself." Another describes her experience:

After I was alone, there was one time and I think that's where I helped myself, without realizing it because I was feeling so down and miserable. It was a Saturday morning. There was a pamphlet came in the BC Hydro statement, and it mentioned that there was help if you were not sure of your diet, that there was a dietitian, gave the number and I phoned and that was unusual for me to do so. I was just down at the bottom wanting to help myself because the doctors just didn't seem to be helping me . . . I phoned and she talked to me and she asked what I was eating and I told her. She says, you've got a very good diet and she says what you need is

a good doctor to go with it and this was when the changing point came . . . it was that phone call that woke me up to the, that I needed help . . .

Those who were able, reached out for help by themselves. For those who lacked awareness of the seriousness of their condition, or for those who reached out to family for help, others were relied upon to arrange initial contact for health care support. Generally, at the time of contact with physicians, the diagnosis of depression was made. Coming to terms with and facing the meaning of “depression” were necessary to facilitate acceptance of their depression. Often acceptance was accompanied by feelings of determination and hope. As a result of this acceptance, people took the first step out of their depression. This phase, changing direction, was relatively short-lived. Some described it as taking ‘days’ while others described its length in terms of ‘hours.’

Facing the diagnosis: the meaning of depression.

Although the participants experienced distressing physical and emotional changes, the word ‘depression’ often was not used until they were diagnosed. They were often unaware they had depression until they were face to face with it. They reacted in differing ways to the word ‘depression’ and what it meant. Some people reacted to the stigma that often accompanies having a mental illness:

It’s a terrible word. You hear people being depressed and they do very stupid things, like taking their own health or their own lives, and you can’t imagine someone would do that. The word depression just drains you . . . When the doctor told me I was in a depression, I said what have I got to be depressed about? But the word, when they tell you, then you start thinking, the word is in you mind and you start thinking about. You think, I can’t be depressed . . .

Like me thinking that’s a disgraceful kind of thing, you know, to think you’re depressed, what have you got to be depressed about. You don’t accept it I can tell you that.

One man said the word depression for him, and many others, “meant lack of money, so when I heard that word I didn’t attach much significance to it”.

‘Accepting’ / acknowledging depression as the first step out.

‘Accepting’ depression was described by some participants almost as a prerequisite of being able to get out of depression while others didn’t acknowledge that this was an important piece of recovery. ‘Accepting’ depression meant that they acknowledged they had a depression and they also recognized they were able to continue living in spite of this diagnosis. It was described by many as: “It maybe starts you on the climb out if you accept it, if you don’t accept it then that’s where you stay,” “I wasn’t accepting it , accepting it as such, and I wasn’t getting better.” Accepting depression was described as something that they each had to do. They took responsibility for this process and acknowledged the effort they put into this process. Taking personal responsibility and credit for this process was extremely important. “Gradually I came out of it myself,” “I knew I had to do my part which was accepting life as it was.”

Generally, before entering this phase, people described having lost control over many aspects of their health and their lives. At the beginning of this phase, participants indicated that they relied on others much more than they relied on their own strengths. They were either unaware of their potential strengths or were uncertain as to whether they could rely on these strengths. They felt limited in their ability to make decisions and as a result, relinquished most control to others.

Phase Three: Working The Way Out

After 'changing direction' there was a phase that reflected a real determination and drive to get out of depression. 'Working the way out' progressed at a fast pace for some and for others it was slow and tedious. For some the course was smooth while others had many obstacles to overcome. These older adults said they never could have done it on their own. Although they relied on their own strength, they needed support from others to continue working. Progressing through this phase required significant amounts of work and effort and was facilitated by increasing involvement in activities, programs, social interaction, and their own health care. Individuals relied on their inner strength, their own attitude, and their personal philosophy of life as they worked with family, friends, community, and health care professionals. Symptoms resolved as individuals progressed through this phase. In describing her efforts, one participant said "to get out of a depression you've got to fight yourself, I know that." One person acknowledged the work done by herself to recover from depression. She described:

The only way is to help themselves. They can let them [doctors] know what's wrong. I think what was happening to me was [I was] a guide to my doctors.

A sense of hope and determination surfaced when changing direction and this hope and determination served as sources of strength to help them take the first step out of their depression:

I always had that degree of hope, that maybe one day things might get better and from then on I was determined I was going to get back on my feet and accept life as it was . . .

One thing I knew was that I was going to get better and I was going to go home... you know, that's really given me a boost to be able to cope with the frustration . . .

Now I knew that I was going to get better and I was going home . . . that was the one thing I felt, I knew I was going to get better and I wouldn't let go of that . . .

It is, just kind of a hopeless feeling, you know and yet I figured in myself well, it don't matter how bad it gets, we'll get over it. There'll be a light at the end of the tunnel somewhere. It's just a matter of toughing it out . . .

Just as different speeds were described spiraling into depression, different speeds were also described working the way out of depression. The speed of working the way out seemed inversely related to the speed of spiraling down. For those who had a 'sudden' onset of depression, the work getting out was described as being more tedious with frequent obstacles to overcome. Generally, for these people it was a gradual process. As they worked their way out, they became "more aware of their surroundings," "little by little I was getting my strength back," "you can feel down and then feel good, it's a gradual thing," "just a little bit every day, I'd find interest in doing things and thinking about things."

On the other hand, for those who experienced a long journey spiraling into depression, working the way out seemed to proceed quickly. One man said "voices and music disappeared overnight," while another person described how "quickly [she] turned things around" and how "surprised the doctor was" at her speed of recovery.

Obstacles encountered while 'working the way out' included experiencing other losses, adjusting medications, receiving inadequate length of treatment, and coping with the stigma of mental illness. One woman, as mentioned before, experienced multiple losses including family members and her own health. Some treatments that had been effective during previous episodes of depression were not effective with the most recent episode.

As well, some treatments were successful in resolving symptoms but side effects emerged which necessitated a change in treatment plan. People had to adjust to necessary changes as well as the fear that “nothing might work this time.” Also, there were reports of treatments that had been discontinued prematurely and relapse occurred.

As people worked their way out of depression, they became aware of gradual changes in their symptoms and in their attitudes. Some symptoms resolved quickly while others seemed to resolve more gradually.

Getting involved.

People described their work as increasing involvement in activities and treatment. Before their most recent episode of depression, these older adults had generally maintained a low level of involvement in activities. However, while struggling and getting out of their depression, they purposefully got involved in physical and social activities and these were sources of support for them. They joined activities such as exercise programs, and activity groups. One woman described the “necessary structure” that this involvement provided to her life. One person attended three exercise programs and found pleasure not only from the exercise but also described the pleasure of the social contacts associated with programs as “just the fun of being with other people” and “the satisfaction” gained through interactions with others. Doing volunteer work also provided a sense of satisfaction and accomplishment for many of them. One woman described how having “a commitment and also, of course, a friendship for this person” as “being important” to her.

People described a variety of levels of activity that they found beneficial. While some required almost daily involvement in physical activity, others described satisfaction

with lower levels of activity, but the structure provided by participating in groups and activities was essential:

One thing that would help a little bit would be if I got a little light reading in. I'd go to the library and get a book on animals or something . . . something that doesn't get too complicated and yet there's a little life to it, I found that helped a bit.

I go to a wellness group every Friday . . . I go to the gym and lift weights twice a week . . . I have organized a walking club . . . I volunteer at the community center . . . it gives me satisfaction . . . it's renewed my faith in life.

I have realized something that I probably just didn't acknowledge or didn't understand fully before. It is necessary to have some structure in your life. I have a commitment now.

I became very active in bowling . . . my friends pick me up and deliver me home . . . just gradually things happen . . . something of interest comes into your life and you start . . . it could be anything, for me it was my friends and my activities

While community centers were described as providing many resources, some people required a more supportive social group such as the Bright Spot (a social program for mentally ill older adults). Some of the participants attend the Bright Spot and describe what it means to them:

You see different people and they all have a story to tell which is quite interesting. I find it different as to sitting here talking . . . things like that give you a lift . . . I find that a change, too.

Increased involvement in treatment programs enabled participants to get a better handle on things. This increased involvement and activity increased their sense of satisfaction with life and provided a 'renewed' sense of gratification with life in general:

It's very beneficial. I find it gives you a good appetite. It gives you satisfaction. I sleep good and it's renewed my faith in life . . .

When you start to show interest in life again, no matter what you're doing, you don't realize that you are helping yourself, you are, by doing these things

[participating in community center activities] and then pretty soon you're feeling better.

Participants described that the resources they used during this phase were comprised of personal strengths as well as supports received from others. Personal strengths included inner strength, positive attitude, determination, a 'practical' philosophy of life, and a belief in a higher power.

Calling on inner strength.

These older adults described the importance of helping themselves. Although they relied on support from others, they attributed their successful recovery to their own personal strength. A philosophy of life, that included both a positive attitude and determination to keep going, was identified as a strength. When asked what had made a difference or helped while working to get out, people said:

My philosophy of life, I guess . . . if there's something you can do about [a problem] then do it and if there's not, then don't worry about it.

I was always a very positive person . . . you can't [complain] I never complained about anything.

Through life everyone of us has special things we've done and we should keep going [with them] or start up again.

Belief in a higher power was also a great support for some participants. One man explained:

I knew that I believed in God and that eventually He would get me out of it but it was in the mean time that bothered me. I mean you want answers now. You don't like waiting for them . . . I've always had a firm belief in God and there's no question that it helps.

The self-confidence that accompanied adjusting successfully to changes increased individuals' awareness of the personal strength. While working the way out of depression, older adults became increasingly aware of their own abilities, their own strengths, and their own skills. As symptoms resolved, increased awareness in these changes provided a form of positive feedback and seemed to motivate older adults to continue working to stay well.

Although older adults relied on a variety of strengths and supports, the effort they put into recovery in this phase was described as coming from themselves. As a result of working their way out, a resolution of emotional distress and somatic discomfort was described. Participants described their feelings:

I enjoy doing it [getting my vegetables ready for dinner], I make my own meals, I bake my own bread, I really enjoy doing it . . .

I sleep good . . . I look forward to going to the gym . . . it makes you feel real good, so ambitious and all that . . . I enjoy it [cooking] now and I like experimenting and stuff like that . . .

It's renewed my faith in life . . . everything is not perfect but I'm thankful for what I have.

I'm just thrilled, it's so wonderful to get up . . . makes me feel great.

A general increase in the feelings of hopefulness was noted as they worked the way out. "As I started to lift and I would say to myself, I guess I felt quite normal, you know, as if I could concentrate and remember and be normal." They described how their attitude changed during this phase. Even slight changes provided a greater sense of hope and encouragement to help them continue to work.

During the phase of 'working the way out', working 'partnerships' were developed. They developed and used their own personal strengths and began to feel more confident. With increased confidence came increased satisfaction and comfort which provided positive feedback to continue this increased involvement.

Working together.

Older adults developed and used their own abilities, skills, knowledge, and experience. As a part of helping themselves, they also developed and used supports from others. The actions that people took assisted them in recovering. While working the way out, people relied on external supports from health care professionals, family, and friends, social groups and activities, and community-based services. These older adults either *initiated* a connection with, or *accepted* help from health care professionals (psychiatrists, physicians, nurses, social workers, and support workers) both in the hospital and in the community. They described the role these supports played in facilitating their recovery and the 'partnerships' they developed.

I think you have to fight yourself, you can't do it alone but you've got to help or get pushed forward . . .

I think the thing to do is to get them [older adults diagnosed with depression] to understand that the only way is to help themselves but the doctors or whoever is working with them will help them if they can let them know what's wrong and then the doctors and, you, see, I think what was happening to me was a guide to my doctors, they knew I wanted to get better . . .

I was fighting a lot because like I know myself, I was fighting in order to, agree with the doctor into what treatment he was giving me into getting better. Then, when I got a little bit better we worked well together, but you have to be very positive person . . . gradually I guess I came out of it myself . . .

The characteristics of a supportive relationship with health care professionals (HCP's) were similar to the characteristics of a supportive relationship with family and friends. These characteristics included participants feeling that they could talk to and confide in HCP's, and that HCP's would respect, be "straight forward," be "honest," and "make time" for them. These types of relationships were described by the following statements:

They seemed that they couldn't do enough for me. They were busy people but they always had time for me.

The doctor there. He understood me. He takes an interest in you . . . He's the first doctor who even spoke [to me] . . . and I took my hat off to him.

Members of mental health teams were HCP's who also provided support. Talking with others, being encouraged, keeping busy, being accepted, and the availability to have professionals in whom "to confide" were described as being beneficial. One person said that when she became involved with a mental health team "it [depression] didn't seem to be nearly as hard to get out of." Another described how empathy provided encouragement: "I wouldn't be here if it hadn't been for the help they gave me . . . they have encouraged me just to know that they knew I was having problems." Having someone to talk to on a regular basis made a difference: "I was put back on the right road. If I had even minor problems, not problems but anything, I wanted as far as my well being, well they put me straight on stuff like that."

In addition to the availability of services, the attitudes and personalities of those delivering services provided support:

I would have to say there's just something about the individual personalities but also about the availability of this service to me . . . They have continued to support

me and offered their services, so it's partly the availability and it's partly individual personalities.

You have somebody [mental health team] that doesn't look down on you because you have been, you see it isn't everybody I tell that I had a mental problem because it's none of their business. Certain people I will tell because I don't act mental now so they'll never know that I was in a mental hospital or anything unless they're going to become a good friend, I will confide in a good friend, but I've got to make sure it's a good friend.

As a result of contact with HCP's, all participants were prescribed medication and some received electro-convulsive therapy (ECT). Those who had responded positively to medications continued to take them. They said that taking medication would probably be a long-term treatment and one person said she expected to take medication for the rest of her life. Another explained that when no medication seemed to work for her, she received ECT and continued the ECT, very successfully, on an out-patient basis for a further eighteen months.

Older adults described how family and friends were helpful in providing support. Having someone to talk to and someone in whom to confide was important. When asked what someone would do if they were depressed and had no family, one participant replied:

I don't know. They'd have to have close friends, somebody that showed them they cared and that's what they'd need if they have no family . . . They would have to have close friends that they really trusted and got along well and confided a lot of things with them and so on, that would be very helpful.

Others described how encouragement was provided by family and friends and how support was beneficial and, at times, reciprocal:

They [friends] encouraged me . . . things like that give you a lift and then the way I'm treated gives, I think if you have family who, now I'm talking about the bowling [team] as my family, all wanting to help me and give you this good feeling as though life is worth living . . . I think that's been a great boost for me.

I have my kids backing me up . . . my children and I are very close and I get a lot of support from them. Mind you I give support to them too. You know it works both ways.

Feeling that someone had time for them and cared about them provided a sense of respect and value.

My neighbours are good friends . . . She comes over quite often and pays me a little visit and she's very nice, very helpful, she's ready to do anything.

I have good friends at the assembly [church], they're always ready to come to my aid if I need it.

Receiving encouragement and being treated with respect also contributed to a sense of value and respect. One man said the thing that friends did that was most important was that they "treated me as though I was normal" while another person described the value of encouragement she received from her friends:

You and I will go in [bowling tournament] as a team, won't we and I said okay and a month ago I wouldn't have said that. A little encouragement from other people is a big help . . . When I went through a depression again, now I think this is where friends helped out . . . they've been so wonderful to me.

The practical support of family and friends included the provision of food, transportation, and having someone to 'check' on them.

I certainly had friends who were checking on me and were sympathetic and supportive and in practical ways, too.

This is why friends mean so much to us . . . it's through [friends] that I'm able to do these things [activities]. Otherwise I couldn't in that I have no ride . . . they're very important.

One woman described developing new friendships, “So we had a friendship going and it was a very happy time for us. He was lonely. I was lonely and the two of us just seemed to fit in.”

Phase Four: Staying Out

When symptoms resolved, participants focused on staying out of depression. Work was required to stay out. During this phase all participants continued with successful strategies and remained engaged in activities that had been helpful. A period of reflection provided the occasion for participants to identify their vulnerability to depression and for some to reflect on depression as a chronic illness.

Using strategies.

There was a sense of ‘staying with what worked’ and yet at the same time they were aware of the need to adapt to changes as they occurred. One man said, “I hope it [depression] never comes back but as I say I found it gives me satisfaction to keep busy”. Others also described what they did to maintain their level of health: “I enjoy doing it [walking] and when I’m feeling all right all these little jobs that you can do, you feel good doing them,” “I still read, just to keep my, oh I don’t know, maintain my status quo I guess”:

There are up’s and down’s of life, and they’ll continue to be up’s and down’s that you have to struggle with as I helped myself. I’ve been through the mill . . . but I don’t feel depressed because I’ve got friends. . .

Some participants believed that taking medication would prevent a relapse or recurrence:

I’ll be OK because I have got the right medication and I believe Dr. [name] when he said that it goes according to that [blood level] because if it wasn’t I’d have been in a depression again . . . No, I don’t think I’ll go into another depression.

In previous episodes of depression, many had taken medication while they experienced symptoms and then, when their symptoms resolved, they had discontinued their medication. With this latest episode, however, they recognized the importance of continuing to take their medication:

I'm getting on well and it's the first time I've been what you might say steady on an anti-depressant. Other times I've just taken it while my depression bothered me and then let it go . . .

Looking back, looking in, and looking forward.

As they continued their work to stay out of depression, participants spent time reflecting about their experience with depression and areas of increased awareness were described. Increased awareness in the need for structure through activity developed in this fourth phase. Awareness of continued vulnerability was also identified and, together, they provided impetus for older adults to continue working to maintain recovery.

During this phase some participants identified what they thought had triggered their most recent depressive episode. This awareness enabled some of them to identify potential precipitants and to either avoid them or be prepared to adjust to their effects. There were differing levels of awareness of early signs and symptoms of relapse or recurrence. Although some participants were aware of how to identify early signs of a depression should they reappear, others seemed quite oblivious to them. One lady said that the early symptoms she experienced included a desire to sleep and a decreased interest in reading. When asked what experiencing those signs might mean if they occurred again, she

said she did not know. When asked what she would do if she experienced those signs again, she also said that she did not know.

Another participant was asked if she thought her daughter would recognize early signs or symptoms of recurrence of depression. She said her daughter 'might' recognize the signs. She said her daughter would "tell me what I should be doing." A male participant explained that each depressive episode he had experienced started with different signs and symptoms, that made it difficult for him to detect early:

It's very distressing. You can't understand it. Other times I haven't found that problem [difficulty drinking fluids] when I was having a depression, getting a drink over was never any problem with the depression before but this one just seemed that much different . . . I guess the way it affects a person may not just always be the same . . . now I don't know whether another depression would hit me the same way. It might be entirely different.

Feeling vulnerable.

When they attained 'recovery', the work to *get* out of depression changed its focus and became the ongoing work to *stay* out of depression. As a result of ongoing work, it seemed that this phase continued indefinitely. There was no guarantee that recurrence would not happen and they knew they could cycle back into a depression. This made them aware of their vulnerability and the need to be vigilant. One person said, "I'm not complacent about the fact that I'm not still vulnerable because of my history," while others expressed positive outlooks, "I hope with all my heart that I can maintain the status quo right now" and:

I don't live in anticipation of going into another one [depression], I think that's bad, you're better to have a positive outlook and not worry about it till it comes, at least, that's what I think. If you're going to anticipate something all the time well it's pretty near as bad as being in it . . . I guess there isn't any more of a gamble there than with life in general.

Continuous work was required to adapt to changes as they occurred. Staying out remained a vulnerable phase, particularly for those who had experienced previous episodes of depression. People continued to remain actively involved. They 'stayed with what worked' while developing the skills required to adapt to changes. They remained involved with the health care system and continued with treatment that had been successful.

Preliminary Substantive Theory

From the findings, a preliminary substantive theory of the process of recovery from depression from the perspective of the older adult who had recovered from depression emerged (see Figure 2). The final paradigm evolved from the four phase process of recovery from depression but the central concept that distinguished the preliminary substantive theory from the process of recovery is that central to the preliminary substantive theory is the work throughout recovery which is facilitated by using different strategies and intervening conditions throughout the process of recovery through the experience of depression. Although in the early formative stages, an overview of the preliminary substantive theory is presented here.

Experiencing triggers was the **causal condition** that lead the older adult to become depressed. In order to develop and utilize the strengths and supports needed to **work** through the phases of recovery through the experience of depression, older adults used various **strategies** including, but not limited to: reaching out, accepting help, making sense of things, trying to identify triggers, facing depression, accepting depression, getting involved, calling on inner strength, working with others, continuing the work, and using supportive relationships. **Intervening conditions** such as awareness of resources,

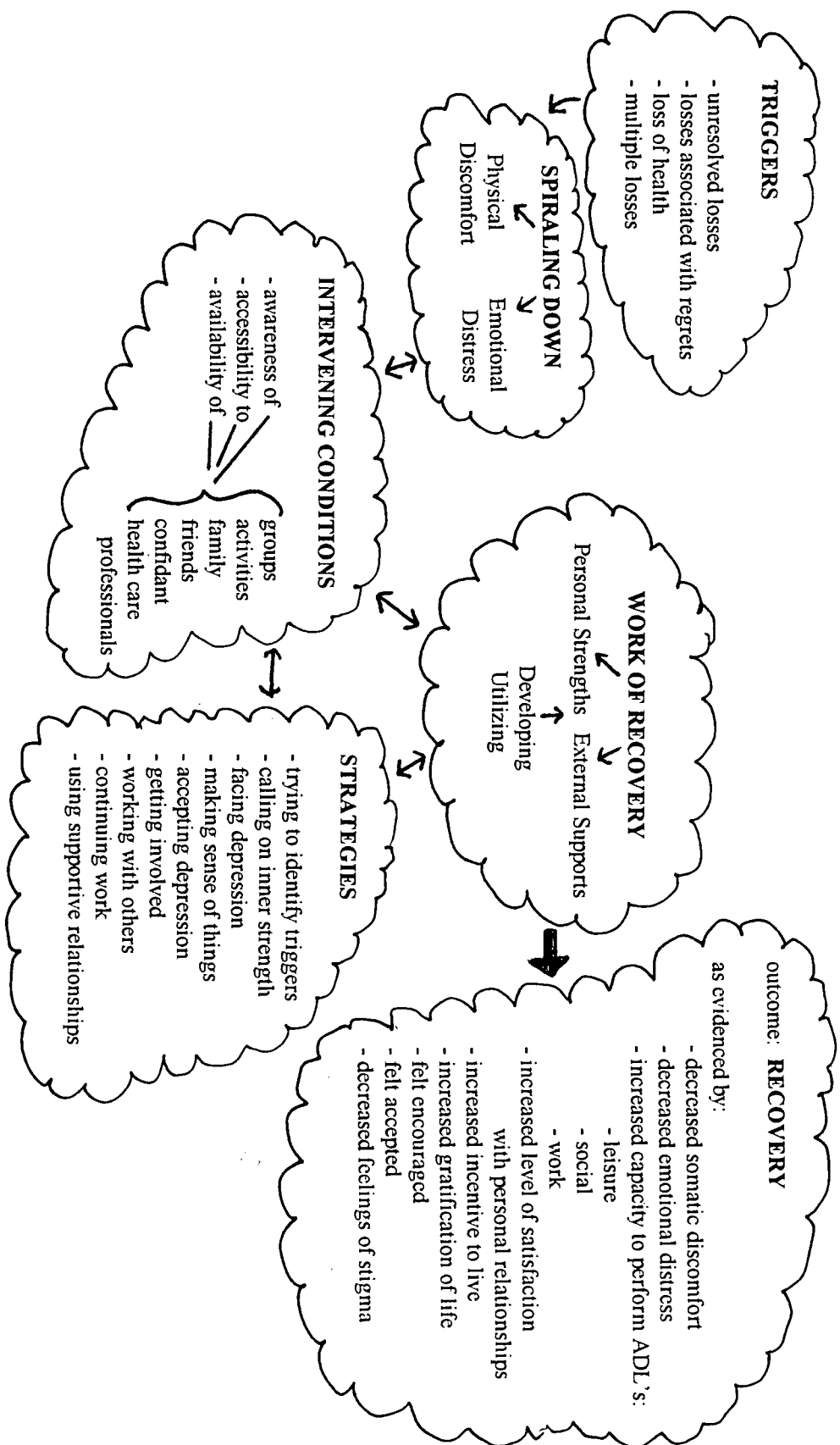


Figure 2. Preliminary Substantive Theory of Recovery from Depression

availability of resources, and accessibility to resources influenced the strategies that older adults used in their recovery from depression. Resources included groups, activities, family, friends, confidants, and health care professionals. Conditions and strategies enabled the work of recovery to be successful and ultimately resulted in the **outcome** of recovery which was evidenced by decreased somatic discomfort, decreased emotional distress, increased capacity to perform ADL's, increased level of satisfaction with personal relationships, increased incentive to live, increased gratification of life, feeling of being encouraged and accepted, and decreased feelings of stigma.

Triggers to Depression

Unresolved grief and regrets associated with losses were identified as triggers for depression. Differing levels of awareness of triggers were identified. While some participants were aware of triggers, others were unaware of past or potential triggers, increasing their vulnerability to future episodes of depression. These were compounded by loss of health, multiple losses, biological factors, and loss of employment.

Spiraling Down

Spiraling down reflected increasing physical discomfort and emotional distress. As a consequence, a decreased interest in and capacity to perform activities of daily living in social, leisure, and work spheres were reported. People described withdrawing from functions and activities in which they would normally have been involved. A decreased level of satisfaction with interpersonal relationships and a decreased gratification of life also resulted. The most intense level of emotional distress was described as a decreased incentive to live. There was a sense of hopelessness and loss of control.

Working at Recovery

Recovering from depression was a process that required a lot of work. During this process personal strengths and other supports were developed and utilized by older adults. The types and amounts of resources needed differed between individuals. Participants explained that the common requirement to achieve recovery was the integration of *both* types of resources. Personal strengths and other supports were often developed and utilized simultaneously. For example, when someone joined an exercise group, they relied on their own internal strengths (e.g.: *initiative* needed to go to the group, *motivation* to keep attending, *knowledge* of where the group was, how to get there, how much it cost, etc., *ability* to arrange transportation and participate, the *coordination* necessary to plan the day, and the *experience* of perhaps having attended an exercise group in the past). At the same time they relied on other supports (e.g.: *availability* of the group, *accessibility* to where the group is held, *transportation* required, *money* to cover costs, and appropriate *clothing*).

Strengths were essential for the development and utilization of supports, and supports were essential for the development and utilization of strengths. Even though participants described developing and utilizing personal strengths and other supports concurrently, they placed greater importance on their personal strengths. The development and utilization of strengths and supports was influenced by intervening conditions and strategies to recover from depression.

Intervening Conditions

Intervening conditions that influenced the process of recovery included awareness of resources, availability of resources, and accessibility to resources. Resources included groups, activities, family, friends, confidants, and health care professionals. In order to make use of supports, people had to be aware that they existed. Information about activities, programs, and social groups was provided through local newspapers and advertisements. It was also provided by hospital staff and mental health team members. Availability and accessibility to the activity or program was vital. Having transportation arranged facilitated attendance at programs. Not having to worry about the 'extra' stresses of registering, arranging transportation, etc. facilitated involvement and increased older adults' level of satisfaction.

Strategies to Recover from Depression

Strategies to recover from depression included reaching out, accepting help, making sense of things, facing depression, accepting depression, getting involved, calling on inner strength, working together, trying to identify triggers, continuing the work, and using supportive relationships. These strategies enabled the effective development and utilization of the necessary resources. Strategies were not necessarily implemented in isolation of each other. For example, to get medical help, participants described 'getting involved' by going to see their doctor or going to the hospital. When contact was made with HCP's, they 'worked together' and accepted the advice or treatment suggested. Getting involved meant that older adults worked with HCP's and provided necessary feedback to facilitate successful treatment. By sharing control in this way, older adults

made decisions about how, when, and where HCP's would be involved. As older adults proceeded through the phases of recovery from depression, they became more actively involved, rather than passively accepting of assistance. They became more positive and determined to get out of their depression as they progressed through recovery. The pessimism described while spiraling down changed to optimism while working the way out.

Strategies were not used only in the third phase of the process of recovery. Some strategies were implemented as people spiraled down. For example, some older adults described using strategies that had been successful in a previous episode of depression but were no longer successful and therefore the spiral continued downward. As well, continuing the work is a strategy that was identified as being necessary in the last phase of the process of recovery. It is because of the existence of various levels of work of recovery in all phases that highlights the importance of this preliminary substantive theory.

Older adults were losing control as they spiraled into the depths of depression. While changing direction their attitudes changed and while working the way out they described changes associated with recovery. Although persons initially differed in their ability and willingness to implement strategies to recover, all persons described developing and using these strategies when recovering from depression. These strategies continue to be implemented indefinitely as the fourth phase, staying out, (see Figure 1) continued.

Recovery was attained as a result of working through a cycle of the phases of recovery from depression. Recovery was evidenced by a reversal of the signs and symptoms experienced while depressed. There was an increase in physical comfort and a

resolution of emotional distress. People were able to perform activities of daily living and experienced an increase level of satisfaction with interpersonal relationships as well as an increase gratification of life. Older adults in this study described a renewed incentive to live while continuing to work as they remained vulnerable to relapse and recurrence.

Summary

Four phases identified in the process of recovery from depression included: 1) Spiraling Down, 2) Changing Direction, 3) Working the Way Out, and 4) Staying Out. Older adults who recovered from depression described a general sequential process while going through these phases. The length of time in each phase differed between individuals. When recurrences were experienced, older adults described going through the same phases again.

The first phase, '**Spiraling Down**' started with experiencing 'triggers' that often included unresolved grief and regret following losses. This phase was identified by experiencing progressively increasing somatic discomfort and/or emotional distress. During this time, a lack of awareness of the process was described and as the spiral continued downward, feelings of sadness, helplessness, and the sense of losing control were experienced. Eventually they hit the 'bottom.' The second phase '**Changing Direction**' started with the emergence of a sense of awareness that something was very wrong and the knowledge that they couldn't keep going with the level of distress being experienced. Hope and determination surfaced which provided motivation to change direction and start working on the journey out of depression.

After changing direction, there was a phase, **'Working the Way Out'** that reflected a real determination and drive to get out of depression. Increased levels of involvement were described as were different types of support that older adults found beneficial. When recovery was achieved, there was a phase, **'Staying Out'** where there was a recognition of vulnerability and this promoted continuation of work and effort required to maximize the chances of remaining free from depression. Older adults remained vulnerable to relapses and recurrences and it was because of this vulnerability that they continued working to stay out of the depths of depression. These older adults didn't have a sense that there was an end to their depression even though they were considered to have recovered.

A preliminary substantive theory of the recovery from depression emerged from the process of recovery. As an older adult, work was required to progress through the phases of recovery from depression. This work was influenced by intervening conditions and strategies and evidence of work was apparent in all phases. Triggers of depression were experienced older adults lost control and hope and spiraled down into depression. Older adults developed and utilized various strategies that were affected by conditions that included awareness of, availability of, and accessibility to resources. Implementation of strategies resulted in a resolution of somatic discomforts and emotional distress, an increased capacity to perform social, leisure and work activities, an increased level of satisfaction with interpersonal relationships, an increased ability to perform activities of daily living, an increased incentive to live, and an increased gratification of life. The work

required to stay out of depression stemmed from the feelings vulnerability to recurring episodes of depression that participants described.

CHAPTER FIVE

DISCUSSION

A number of prominent findings about recovery from depression have been identified. First and foremost is that recovery from depression is a process consisting of four phases: spiraling down, changing direction, working the way out, and staying out. The process of recovery is ongoing because attaining recovery does not guarantee immunity to future episodes. If people do regress, they cycle back through the same phases. There is hard work involved in proceeding through these phases. Having completed the phases does not mean that the process has been completed because the ongoing vulnerability to depression suggests a sense of continuity. The four phases provide a framework in which to help understand the process of recovery from depression in the older adult population.

In this chapter the findings will be discussed within the framework of the four phases in the process of recovery. The process of recovery from the experience of depression will be presented followed by detailed discussion of the four phases of recovery. Finally, there will be a section discussing the preliminary substantive theory that emerged from the data. Sections will be divided into subsections that reflect the major themes identified in this study.

The Process of Recovery from Depression

Phases of Recovery

Recovery from the experience of depression in the older adult is a process with four phases consisting of Spiraling Down, Changing Direction, Working the Way Out, and

Staying Out. Generally, people proceed chronologically through these phases. For those who experienced relapse or recurrence, the process of recovery seemed to take them on a similar journey through the same four phases.

The process of recovery that emerged from this study was compared with processes identified in other studies. Overall, the phases of the process of recovery from depression identified in this study were similar to other people's descriptions (Schreiber, 1996; Steen, 1996; Frank, Prien, & Jarrett, 1991). Although each study described recovery in different ways, many included the sensation of 'hitting the bottom,' experiencing a 'turning point,' and feeling as if they were 'losing control.' Major differing areas between studies centered around the concepts of the work required during the process, and the sense of ongoing vulnerability. Both were main themes in this study but were not identified in others.

When comparing the phases to those described by other authors, similarities as well as differences were identified. Schreiber's (1996), and Steen's (1996), processes generally described personal development and the outcome of completing the phases was the acquisition of skills and knowledge that would provide them with the ability to prevent future episodes of depression. One of Schreiber's six phases, 'seeing the abyss,' is similar to 'hitting the bottom' that occurred in second phase in the current study as both reflected experiencing the 'worst' and 'lowest' times in their depression. Further on, the phases Schreiber described as 'seeking understanding' and 'clueing in' are very much like the portion of the phase 'staying out' where older adults look back and try to make sense of their experience and try to identify what triggered their depression.

Frank, Prien, and Jarrett's (1991) three phases in older adults' process of recovery are based on descriptions of symptomatology necessary to meet the criteria for moving from phase to phase. The phases are 1) Acute, 2) Continuation, and 3) Maintenance. They reflect similarities to those in the current study. It is important to note that Frank et al.'s (1991) phases included one of 'maintenance' which suggested 'continuation' of the process as was described in the current study. Weingarten (1994) identified his "susceptibility" to depression and described his 'ongoing process of recovery.' The other three studies mentioned here do not talk about relapse or recurrence and it seemed that the process of recovery from depression was something a person experienced only once, in linear fashion, and that successful completion of the process implied not having to go through it again.

Concepts

Many of the concepts described by adults from other studies on the processes of recovery are similar to those described in this study (Heifner, 1997; Schreiber, 1996; Steen, 1996; Weingarten, 1994; Wilkinson and Pierce, 1997). Although not identified as phases, the themes described by participants in the study by Wilkinson and Pierce (1977) were the same ones of vulnerability, fear, hope, helplessness, and loss of self control described by participants in this study.

Weingarten (1994) identified concepts that are similar to involvement described in this study. He talked of 'getting involved', 'accepting that I had an illness', and acknowledging his 'susceptibility' to depression as being important factors in influencing his recovery. He also described the role of his friends as 'providing support and

encouragement.’ Another similarity identified in the descriptions of the processes of recovery revolved around the work or active engagement required on the part of the depressed person. Steen (1996) described struggles during recovery and also identified that women developed skills to prevent relapse or recurrence. Weingarten described beginning to make real progress when he took control of his life and began doing things that utilized his strengths and abilities. He described consulting with his doctor as a sign that he was taking control of his treatment as well as his life. He described that when he was depressed it took a great deal of courage to do the simplest, most everyday kinds of things, that he was engaged in an inner struggle he couldn’t express and which consumed him. These comments were similar to those in the current study. Other studies, however, did not focus on any work necessary to proceed through recovery and as such it seemed that very little effort was required to go through the process of recovery from depression

The concept of the significance of ‘turning points’ was described by Steen (1996). She identified five phases in adult women’s recovery from depression. The ‘first turning point,’ where women began to take charge of their own recovery process described similar experiences of older adults in this study including reaching ‘the turning point’ in the second phase ‘changing direction,’ and at the end of phase three, ‘working the way out,’ where there is a gradual transition from being a passive recipient of care to becoming an active participant in providing direction for personal recovery.

Spiraling Down

The critical characteristics that will be discussed in the spiraling down, phase centre around the triggers to depression and to how depression was manifested.

Triggers to Depression

Participants described factors which they believed triggered the onset of their depression. Triggers were identified as stressful events that often included losses, especially multiple losses, and losses associated with unresolved grief or regret that often resulted in feelings of inadequacy. The experience of loss prompted older adults to 'do something' in an attempt to adapt to the loss.

The idea that unresolved losses and other stressful events led to depression is supported by Blazer (1996), who concluded from a study on older adults that it was "not uncommon for a stressful event to be associated with the onset of a severe depressive episode in late life" (p.1620). Smith and Allred (1989) also conceptualized depression as a reaction to unresolved past losses.

Many participants in the current study described multiple losses. They did not experience a depressive episode after each loss, but felt that the cumulative effect of the losses triggered their depression. Surtees and Ingham (1980) concluded from their study that the additive effects of several stressful life events had a 'wearing down' effect on the cognitive, emotional, and physical strengths of individuals. Experiencing several stressful events in a short time period was shown to shorten the length of time between the event experienced and the onset of depression. This wearing down effect compares with the cumulative effect described in this study.

When the actions taken were not effective in resolving signs and symptoms, feelings of hopelessness, sadness, and loss of control frequently emerged. These findings compare with those of Younger (1991) who concluded that increased feelings of

hopelessness led to increased feelings of loss of control, which led to increased feelings of hopelessness, and the cycle spiraled down. A sense of hopelessness was described in the current study and was also described by Beck, Brown, Stern, Eidelson, and Riskind (1987) as being specifically associated with depression as a result of lack of coping mechanisms to deal with losses.

Feeling out of control was described by participants in this study as well. In Heifner's study (1997), adult males described depression as an overpowering force that beat or 'drove' them down. Like participants in this study, they described the aggressive nature of depression as something that 'takes over and just gets worse.' Steen (1996) described the experience of going 'into' a depression as a "crescendo being reached as coping methods broke down and pain accrued from the stressors in their lives" (p. 79). The concepts of 'going down' and 'sinking' are similar to the concept of 'spiraling down' that was identified in this study.

Grief and Depression

In this study there was a close connection between grief and depression. Participants had all experienced losses, and, as already stated, some had experienced multiple losses. Although people experienced many stressful events, they described losses and the unresolved nature of the losses as being triggers to depression. There were those who described a single loss as the trigger to a major depressive episode. One explanation for this may be that the meaning of the stressful event, and not just the number of events, or the event itself, can be an important factor to consider in triggers to depression (Frank et al., 1996).

How Depression was Manifested

While spiraling into depression, physical discomfort and emotional distress were experienced. Physical discomfort included pain, discomfort, problems sleeping, poor appetite, weakness, dizziness, and loss of strength. Emotional distress included lack of motivation, decrease in interest in life events, poor concentration, hallucinations, feelings of frustration, and feelings of hopelessness. These are common signs and symptoms experienced by depressed older adults (Blazer, 1994) and closely resembled the symptoms and reactions to symptoms described by Gurland (1994). These changes seemed to decrease their level of interest in life and sometimes their incentive to live.

Some people were unaware that their signs and symptoms were related to depression. Of those who were unaware, a few knew that 'something was wrong' but did not believe it necessary to do anything about their symptoms. Others were not aware that there was anything wrong. This lack of awareness that the signs and symptoms were related to depression is described by Alexopoulos (1994), Blazer (1994), Murphy (1994), and Reifler (1994) and is reported as a common phenomenon by health care professionals providing geriatric mental health services. This lack of awareness is important not only in the initial episode but has potential negative consequences with subsequent episodes.

Participants in this study describe 'hitting bottom' as a time when they felt exhausted and hopeless. Differing levels of abilities were described while at the 'bottom'. They reported feeling that the depression was controlling their bodies and their lives. These changes paralleled the feelings of completely relinquishing control to depression as described in a study by Shapiro and Astin (1998). Participants described increasing levels

of distress, hopelessness, and lack of control at this time. It was at the 'bottom' where they described feeling their 'lowest.' Even though different levels of functioning were described by participants while at 'the bottom,' the perception that the level of the 'bottom' of their most recent episode of depression was lower than the level in previous episodes is explained by Thase (1992) and Maj, Veltro, Pirozzi, Lobrache, and Magliano (1992) who report that depression appears to become more severe and potentially refractory with each relapse.

Psychotic features, such as hearing voices and hearing music, were described by most participants. Although this may seem disproportionately high, Alexopoulos, Meyers, Young, Kakuma, Feder, Einhorn, and Rosendahl (1996) found that older adults have "a significantly higher proportion of patients with major depression with psychotic features" (p.311) than younger persons. The reason for a higher incidence of psychosis in the older depressed adult remains unknown.

Changing Direction

The phase, changing direction, revolves around the sense of a 'turning point.' Tension between sense of hopelessness and hopefulness was identified. Participants worked to seek help and face their depression.

Turning Point

As a result of feeling they 'couldn't take it any more,' participants described reaching a 'turning point' that facilitated them changing the direction of their journey through depression. This 'turning point' was identified as either an event (e.g.: called for help) or a feeling (e.g.: belief that they had to make a change) that had positive results.

The concept of 'turning points' is found frequently in the literature (Blazer, 1996; De Ridder, Depla, Severens, & Malsch, 1997; Shih, Chu, Yu, Hu, & Huang, 1997; Weingarten, 1994) related to events or time when perceptions changed.

Shih, Chu, Yu, Hu, and Huang (1997) conducted a study on turning points of recovery from cardiac surgery and found that turning points included events, actions, and time. Unlike participants in the current study, Shih et al (1997) noted that more than one turning point was described by some people and these turning points occurred at various times during the course of recovery. This concurs with the study on the meaning of recovery from depression by Steen (1996), where two turning points were identified by adult women. The first turning point occurred at a time when women first developed an awareness that they needed help, and the second turning point was a transition period when women began to take charge of their own recovery process. As in the current study, participants in that study did not describe what precipitated each 'turning point.'

As a result of experiencing a turning point in this study, a sense of hope and determination provided the motivation to take the first step out of depression. Hope, it is said, is the best medicine. It "nourishes, guides, uplifts, and supports a person in times of difficulty . . . the person who gains hope is committed to action, if action is possible. This might entail, among other things, seeking and following medical advice; eliciting social support . . . which in turn might increase the chances of successful coping" (Averill, Catlin, & Chon, 1990, p.100-101).

Hopefulness vs. Hopelessness

While spiraling into depression, participants described feeling 'hopelessness' and yet being 'hopeful.' How these co-exist is not clear, but it has been shown that people with an optimistic perspective often remain hopeful in the face of adversity because of their need to maintain a belief in a just society (Scheier & Carver, 1985; Taylor & Brown, 1988). In the midst of distress and uncertainty associated with depression, participants described a sense of hopefulness. It may have been that hopefulness outweighed hopelessness, but whatever the reason, the emergence of hope at difficult times like this is well supported in the literature. Moos (1994) said that "many people are remarkably resilient . . . they manage to confront and transcend the most profound life crises" (p.32). Caplan (1964) and Lindemann (1979) reported that life crises created turning points and presented times of opportunity. People can feel pessimistic but nevertheless hopeful, and Averill, Catlin, & Chon (1990) explain this by saying that "conceptually, hope is more closely related to fear than to optimism" (p.6).

Working to 'Accept'/Acknowledge Depression

Participants in this study described 'facing' depression. When presented with the diagnosis of depression, reactions differed but the general response suggested an element of embarrassment or denial. The diagnosis of depression is often accompanied by a stigma of mental illness. The stigma associated with depression has its roots in a culture and tradition that have discouraged the recognition and treatment of late life depression. This stigma remains powerful among older adults and may be shared by their families, friends, and neighbours (Gottlieb, 1994; Reifler, 1994). In the current study, acknowledging or

'accepting' depression was described as a turning point that lead to their seeking help and acknowledging that this was a depression. Core to the turning point in this study was the hope and acknowledgment or acceptance of what was happening to them and the ensuing hope that was inspired.

Although they were unable to articulate what 'acceptance' meant for them, it seemed that accepting depression included acknowledging they had a depressive illness and beginning to make sense of what was happening to them. Accepting depression was described by some participants as a necessary step in order to move on in the process of recovery. People took personal responsibility and credit for this process. They acknowledged the work they did to start getting out of depression and also acknowledged the relationships they developed with health care professionals in order to start working their way out.

Working The Way Out

One of the central themes of the phase 'working the way out' was the hard work required. Work included active involvement, active engagement, and participation by older adults and will be discussed in this section. The concept of participatory control will be presented and the role of supports will be discussed. Finally, the course out of depression will be described.

Work

Older adults had to put a lot of energy into their recovery during this phase and because of the very nature of depression, they didn't have much energy to expend. They described the inner strength necessary to carry out the work. They relied on their inner

strength to help themselves. Inner strength included their philosophy of life, positive attitude, determination to keep going, and for some, their belief in a higher power. A strong sense of hope was described by most participants.

In the current study, work was described as a major component of the process of recovery and was the focus in 'working the way out' as well as in 'staying out.' Because other studies have described the changes and acquisition of skills and knowledge, work was implied in what they said but did not emerge as a central concept as it did in this study (Schreiber, 1996; Steen, 1996; Wilkinson & Pierce, 1977). The work of recovery consists of organizing and performing necessary tasks and actions that shape the recovery process (Lubkin, 1998). In addition to the daily struggle to manage depression and its symptoms, older adults must try to achieve a sense of control and normalcy in their lives. The work they do to pace activities, follow prescribed treatment, and carry on with their activities of daily living to maintain their household is often devalued, invisible, and unacknowledged by society. The invisibility of the work that individuals do and the extent to which it is not acknowledged or appreciated add to the burden of living with depression (Wiener, 1989). HCP's often regard participation and involvement as cooperation rather than work (Strauss et al., 1984).

Involvement and active engagement.

Participants in this study described the relationships they developed with others and the value of encouragement and reciprocity in maintaining relationships. Having a confidant was valued as was having people available who 'care.' The hard work itself was described as involvement and active engagement in activities as well as treatment

programs. Participants followed all doctors' advice and accepted rather passively the care that was provided as they were too ill to do otherwise. However, this type of relationship did not last long. As they worked their way out of depression, they actively engaged in the recovery process. They no longer passively followed all doctors' orders without question. They described communicating with and guiding their physicians. They described seeking advice from their physicians and accepting the expert advice provided. They described 'leading the way' and 'acting as a guide' to their physicians. Likewise, when interacting with other health care professionals, or family and friends, participants in this study described taking a similar role.

Participation.

Central to involvement and active engagement was the idea of participation which emphasized the establishment of reciprocal relationships. These comments compare closely with those of participants in this study. Van Ryn and Heaney said, "helping relationships based on social influence processes that reinforce or enhance client self-esteem, feelings of control, and sense of personal mastery are more likely to help clients achieve their behavioural and health-related goals" (1997, p.684). These processes are consistent with many definitions of personal empowerment and therefore the degree to which helping relationships are effective is at least partially determined by the degree to which these relationships are empowering (Israel, Checkoway, Schultz, & Zimmerman, 1994; Van Ryn & Heaney, 1997; Zimmerman, 1995).

Participatory Control

Reid and Stirling (1989) presented a reconceptualization of control that they described as *participatory control*. The strategies of recovery are central to the concept of participatory control. One of the components of participatory control is the understanding and acceptance of people that there are others who have more expertise or resources to respond to a situation than has the person. Following this, the person must accept that they need to depend on others. This may be difficult because in order to depend on others there must be an acknowledgment that the person is no longer able to act on his or her own, and there must be a feeling of trust that others will be acting in the person's best interest. One of the underlying dynamics is the understanding that by giving over such powers to others, the person is negotiating better control over their condition than would otherwise be achieved. With participatory control, the other becomes an agent of the person. By striking a partnership with a more competent other, the person responds to the situation and takes control by doing something about the situation.

Participatory control was of particular interest in understanding the process of recovery from depression because it explained how older adults can "maintain the experience of being in control in situations where changes in health would otherwise erode the patient's control" (Fry, 1989, p.219). The experience of control is the perceived balance between the *actual outcome* of response to stress, and the *expected outcome* of response to stress. When there is imbalance, there is potential for crisis. People wanted to know why the situation of depression arose because they felt that if the cause of the crisis was determined, action could be taken to regain balance and regain a sense of control.

They often relied on behaviours that had been successful to prevent relapses or recurrences while 'working their way out' of depression.

Support

Support from others was required to facilitate the work process. Supports included services offered by programs, family, friends, community services, transportation, and health care professionals. The important concept that arose from the interplay between utilizing inner strength and utilizing supports was that of increasing involvement by 'working with others.' Increasing involvement included reaching out, accepting help, and developing relationships with others. This provided support as well as empowered those working their way out of depression. The hope and encouragement they received from others were key factors in their ability to work their way out of depression.

When unsure of the reliability of potential supports, people test situations and gather information to determine their possible effectiveness. In this study, participants 'tested' many supports including, but not limited to, doctors' opinions, social programs, levels of social involvement, activities levels, and medications, and often made changes as a result of test failure. When the test failed, they (or family or friends) gathered information to see what alternatives there were before taking further action.

Participants described relying on others whom they believed had the expertise needed to help them. 'Others' included family, friends, community services, and health care providers. There was an element of trust involved as these older adults accepted the help offered. By accepting help, they became actively involved in the process of their recovery. Having someone in whom to 'confide' was described as being essential for

regaining control. Different persons were given the role of confidant. Brown & Harris (1978) identified the 'presence of a confidant' as an important variable in the prediction of positive outcomes in depression.

The roles that participants took differed from situation to situation. They frequently described acting as a 'guide' to others with the result that mutual sharing and respect developed in these relationships. 'Working' with others was also described as a way to develop relationships to build mutual trust and respect. Initially, participants described relying greatly on supports until they had the strength to rely a bit more on themselves. They described the development of their ability to regulate the balance between relying on internal strengths and external supports as they worked their way out of depression. Ebersole also explains this by saying, "We can increase our own personal control by taking charge of that which is possible, moving forward with small decisions . . . and seeking the impossible a step at a time" (1996, p.256).

Krause also (1997) explains the role of support:

"Particular supportive acts may not be what matters most. Instead, their greatest value may arise from what they convey indirectly. The sense of commitment and continuity, as well as the promise that someone will be there in the future, may constitute the most salient elements of the social support process. Perhaps these key features of supportive relations promote more effective coping by providing the impetus for self-directed action that is essential for the maintenance of independence and well-being later in life" (p.290)

This explanation can be applied to the strategy of reaching out for medical support. Khan, Mirolo, Mirolo, and Dobie explained that "the action of seeking professional help for their disorder is promising because it indicates they are taking control of the situation and may even be feeling better" (1993, p.16).

In this study, participants engaged in group activities and/or individual activities which that provided them with a level of involvement to which they were comfortable. Individual activity was important and may be explained by the fact that as people age, there may be an associated decrease in interest in maintaining a continued level of involvement with others. In this study, involvement in exercise programs was an important part of the recovery process for some participants. Physical activity increased social interaction which in turn decreased loneliness. While 'working their way out,' self-confidence was rebuilt and as the sense of hopelessness resolved, participants reported a greater sense of self-reliance and confidence. As a result, with recovery came an increased ability and confidence to rely on the self.

By incorporating the strategies of reaching out, accepting help, and being involved, older adults in the study worked their way out of depression. Their awareness of supports, the availability of supports, and people's ability to access supports played crucial roles in the recovery process. The development and utilization of internal strengths and external supports was affected by strategies and factors constantly influencing the process of recovery.

Course Out of Depression

In addition to the amount of work, people described experiencing various speeds and courses while working their way out of depression. It seemed that those who experienced a rapid spiral down, experienced a slow climb out and those who experienced a slow spiral down seemed to experience a rapid climb out. Those who had experienced a

relapse or recurrence tended to experience a longer climb out with each subsequent episode.

Many studies have been done to identify factors that influence the recovery process (Flint & Rifat, 1997; Hinrichsen & Hernandez, 1993). Findings in some studies support our findings as they show that if a relapse or recurrence is experienced, then a similar type of course is described but the duration of the climb out becomes longer with each subsequent episode. Other studies, however, found that early detection and intervention resulted in persons experiencing fewer and less severe symptoms and determining a faster, smoother course through recovery (Flint & Rifat, 1997; Hinrichsen & Hernandez, 1993).

Staying Out

Staying out of depression reflected ongoing work. In this section vulnerability to depression and the idea of depression as a chronic illness will be discussed. Strategies to stay out of depression will be described and include continuing treatment, maintaining involvement, and continuing the work. Lack of awareness of early signs and symptoms is discussed as it relates to staying out of depression. Finally, a brief discussion of the emerging preliminary substantive theory will be provided.

Vulnerability to Depression

There is increasing recognition that the majority of depressions are recurrent. Although participants in this study developed and utilized supports and strengths to help them recover, they were not sure whether they would be able to prevent relapses or recurrences. They were aware of their vulnerability which seemed to imply to them that there was a looming threat of relapse or recurrence. Looking ahead presented some

uncertainty and fear that once again, they could spiral down into depression. The literature supported this notion of vulnerability. Rogers (1997) described a model of vulnerability which assessed vulnerability as a measure of the relationship between supports and personal resources. That corresponded closely with personal strengths and external supports described in this paper.

Other factors compounded the effects of vulnerability in the older adult. During the course of the later years, many situations and conditions occur to which people need to respond, and yet the amount of energy they have has diminished. They have a decreased reserve capacity as a result of increased numbers of physical disabilities, chronic illness and other changes associated with normal aging (Ebersole & Hess, 1990).

Depression as an enduring disorder continues to be disputed in the literature. The question of what causes sadness, loneliness, and dejection has lead researchers to examine what factors may predispose older adults to be vulnerable to depression. Andrews and Withey (1976) concluded that life events and circumstances are not causes of unhappiness; the cause must be sought in enduring characteristics of the individual. Costa and McCrae (1994) use the term 'trait depression' to refer to the vulnerability to experience dysphoric moods. Traits are defined as "dimensions of individual differences in tendencies to show consistent patterns of thoughts, feelings, and actions" (McCrae & Costa, 1990, p.23). Hirschfeld, Klerman, and Lavori (1989) concluded that personality traits related to depression are a risk factor for major episodes of depression. Digman (1990) and John (1990) suggest that trait depression is a definer of the neuroticism factor that includes adjectives calm vs. worrying, even-tempered vs. temperamental, self-satisfied vs. self-

pitying, comfortable vs. self-conscious, unemotional vs. emotional, and hardy vs. vulnerable. When older adults in this study described their vulnerability, they may unknowingly be identifying their tendency toward trait depression. Trait depression offers one explanation of the high rates of relapses and recurrences of depression in the older adult.

Depression as a Chronic Illness

When considering the characteristics of recovery from depression as including continuous work, ongoing vulnerability, and significant rates of relapse and recurrence, the question is raised as to whether or not depression is a chronic illness. A chronic illness is described as being an illness with a course that varies and changes over time and will not be cured but managed. A person can “maintain a degree of wellness and keep symptoms in remission” by “balancing medical treatment and related regimens” (Lubkin, 1998, p.4). People can control their response to chronic illness, which, in turn, may affect the progression of the illness. This is what we see with depression. Corbin and Strauss (1992) explain that “chronic conditions have a course that can be shaped through proper management” (p.11) and this management requires lifelong work of being involved and being an active participant in working with others, getting involved, and engaging in treatment. Thus, participants in this study remain vulnerable even though they had achieved ‘recovery’ from depression. Achieving recovery did not mean that they were immune to further episodes but rather that the ‘condition’ was in remission.

In the literature, there is a lack of consistency of the definition for ‘chronic illness.’ The common element in the definitions is that recovery is only partial as it requires

periodic monitoring and supportive care (Cluff, 1981; Feldman, 1994). Lubkin (1998) defined chronic illness as “the irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care and self-care, maintenance of function, and prevention of further disability.” When applying the concept of chronic illness to depression, Bachrach (1992) described individuals with chronic illness as those who suffer major mental illness experiences resulting in severe disabilities for long periods, or lifetime. The length of time required to fit the criteria for a long time was not specified but others have defined the period of time as five years and that the rate of chronicity ranged from 12 - 15% (Alexopoulos et al., 1996; Coryell, Endicott, & Keller, 1990; Mueller et al., 1996).

Other research findings do not corroborate these findings. In the studies of recovery from depression by Steen (1996), Schreiber (1996), and Wilkinson and Pierce (1997), participants developed coping mechanisms with the goal of remaining free from depression. Vulnerability was not mentioned nor was the idea of depression being a chronic illness. When older adults described their sense of vulnerability, they were talking about how vulnerable they were feeling but also about looking for a cure as a sense of recovery. Looking at depression as a chronic illness helped put some of these discrepancies into perspective.

Strategies to Stay Out of Depression

‘Staying with what worked’ was a strategy utilized by participants with recurrent episodes of depression. The awareness of being vulnerable seemed to provide the motivation necessary to continue with ‘what worked’ in order to maximize resiliency.

Participants described their commitment to continuing with psychosocial involvement and biological treatments that they found effective in regaining control. The incentive to continue with these interventions was fueled by their sense of satisfaction and relief from symptoms that contributed towards a general increase in their perceptions of the quality of their lives. Participants described their efforts to maintain the status quo. They identified maintaining a structure in their lives, maintaining involvement in social and physical activities, and continuing with effective treatment as efforts that were successful. Continuing with activities and treatment has also been identified by others as a successful measure in the management of depressive illness (Flint & Rifat, 1997; Kupfer, 1993).

Continuing treatment.

Participants in this study requested to remain on the dose of medication that they were on during working their way out of depression. Some thought that staying on medication would keep them healthy while others wanted to continue with activities they had enjoyed. Most other studies done on maintaining health and preventing depressive episodes focused on medical intervention, specifically the types of medications and lengths of treatment that produced highest rates of remaining free from depressive symptoms (Georgotas & McCue, 1989; Reynolds, Schneider, Lebowitz & Kupfer, 1989). Of great importance was that biological interventions were not found capable of resolving all the problems associated with depression (Friedhoff, 1994). However, many authors reported that the combination of medication and psychosocial interventions was associated with a considerably lower probability of recurrence than the traditional strategy of lowering the

dose when symptoms resolved (Baldwin, 1991; Flint & Rifat, 1997; Frank, Anderson, Reynolds, Ritenour & Kupfer, 1990; Klerman, Weissman, Rounsaville & Chevron, 1984).

Maintaining involvement.

All older adults who participated in this study have continuing involvement with mental health teams within GVMHS. Such multidisciplinary teams use biological intervention in combination with psychosocial interventions to provide a wide range of supports to older adults as they develop and utilize their own strengths and supports necessary in each phase of their recovery from depression. Even given these ongoing supports and treatments, six of the seven participants relapsed into a depressive episode within nine months of the first interview. One person was taken off medication during a hospitalization for surgery and relapsed. Four participants identified early signs and symptoms and their depression was treated quickly and aggressively. For these persons, working the way out proceeded at a much faster pace than that in previous episodes. Two of these four had not believed that they would recognize signs and symptoms of early depression, but, in fact, they did.

Continuing the work.

It is interesting that all participants in this study were described by health care professionals as having 'recovered' from depression, however, participants did not describe themselves as having recovered. They talked about continuing the work to get out of depression in order to remain well. Even though they recognized that they had developed and utilized strengths and supports that had helped them out of depression, they remained cognizant of the fact that they were vulnerable to recurrences and relapses. By

continuing their work, some hoped to have longer stretches of time between episodes, some hoped to seek early intervention if they felt they were starting to get into a depression again, and others believed that they would stay well if they continued their work that had been successful.

Lack of Awareness of Early Signs and Symptoms

Of special interest to this author was that many participants lacked awareness of early changes in the initial phase of their depression. They also denied their ability to detect early changes should they be experienced again. Even when presented with hypothetical situations, they were not able to identify potential problems or explain what actions they would take if these situations occurred. This lack of awareness is reported consistently in the literature (Flint & Rifat, 1997; Sadavoy & Reiman-Sheldon, 1983). Flint and Rifat (1997) say that "if left to their own devices, many older people do not seek out treatment for relapses or recurrences of depression, and the longer the episode of depression goes untreated, the worse the prognosis" (p.271) even though it is clear that early detection and intervention is necessary to decreasing severity of depressive episodes.

Preliminary Substantive Theory of the Process of Recovery from the Experience of Depression

By examining the various phases that emerged, the author was able to develop the beginning of a preliminary theory of recovery from depression that identified core concepts of the process of recovery. Initial discussion is provided here but the reader needs to remain cognizant of the fact that the work is very preliminary and therefore discussion at this point is limited.

Contributing factors to depression included unresolved losses, losses associated with regrets, loss of health, and multiple losses. These triggered a spiraling down into depression which was manifested by increasing levels of physical discomfort and emotional distress.

The core concept of the preliminary substantive theory is the work of recovery. Work was described in all phases and involved developing and utilizing personal strengths and external supports. To accomplish this a number of strategies were used. Initially work was expressed as the effort required to just make it through the day. Eventually the characteristics of the work changed as older adults actively initiated change by facing their depression. Getting involved, working with others, and using supportive relationships were some strategies used to facilitate the work to get out of depression. Inwardly people were working by trying to make sense of things. Physical and mental effort were required. When depressive symptoms resolved, the work continued. In addition to continuing the work already started, older adults identified a sense of ongoing vulnerability to depression which provided motivation to continue working. Their awareness of, accessibility to, and availability of groups, activities, family, friends, a confidant, and health care professionals were essential in being able to implement strategies. It was the interrelationships of intervening conditions and strategies that facilitated the work of recovery.

Recovery was evidenced by decreased somatic discomfort, decreased emotional distress, increased capacity to perform activities of daily living, increased levels of satisfaction with personal relationships, increased incentive to live, increased gratification of life, feelings of being encouraged and accepted, and decreased feelings of being

stigmatized. Even when recovery was reached, the work to stay out of depression continued.

Summary

Recovery from the experience of depression was a process with phases that had similarities and differences with processes described by other authors. The central concepts as well as the preliminary substantive model of the recovery from depression will be summarized here.

In this study recovery from depression was a process that consisted of four phases. Other authors have also described phases during the process of recovery. Although the words used to describe the experiences of recovering from depression differed, the ideas of hitting the 'bottom', experiencing turning points, and the feeling of losing control are described in their studies. The main difference was the idea of 'completion' of the process of recovery that was prominent in others studies. These studies described going through the process of recovery once, and as a result of completing the process, skills and knowledge had been acquired that prevented further episodes of depression. Participants in this study describe the continuous 'work' required throughout the process of recovery from depression and the awareness of continued vulnerability directs the reader to question whether depression should be treated like a chronic illness in the presence of a relapse or recurrence. The high rates of relapses and recurrences do not fit into the 'completion' models.

Triggers to depression experienced were similar to those described by others. The experience of 'spiraling down' was unique to this study although similar signs and

symptoms were reported in the literature. The core concept of the preliminary substantive theory is the work of recovery. Personal strengths and external supports were described by others in their recovery process. Intervening conditions were also described but it seemed that the participants in this study relied more on family, friends, and social supports. The strategies used by older adults in their process of recovery from depression were commonly described by younger adults. The participatory control model that older adults valued was described by others as providing a sense of control. Calling on inner strength and getting involved also were described. The continuing work of the older adults was not a concept that surfaced in other studies. This preliminary substantive theory of the process of recovery from the experience of depression in the older adult is in its very early stages of development but has provided a base on which to build.

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Overview of the Study

The purpose of this study was to describe the experience of the process of recovery from the experience of depression from the perspective of older adults who had recovered from depression. Seven older adults were interviewed and data were analyzed using grounded theory methods. A preliminary substantive theory that evolved from the data describes an ongoing process of recovery from depression consisting of four phases. Progression through the four phases did not mean immunity to further episodes. If persons did regress they cycled back through the same four phases.

The first phase, 'spiraling down' was usually triggered by the experience of significant and sometimes multiple losses that were often associated with unresolved grief and feelings of regret. This phase was characterized by experiencing increasing somatic discomfort and emotional distress. There seemed to be little awareness on the part of the individual about what was happening. As the spiral drew them deeper into depression, they felt they were no longer in control, giving rise to feelings of uncertainty, helplessness, and fear. This phase culminated in hitting the bottom, where most were totally incapacitated and unable to function.

The second phase, 'changing direction' reflected a time when participants felt they 'couldn't take it anymore' and they took the first step out. Changing direction was sometimes an acceptance of the fact they were depressed and at other times it was an acceptance of the fact that they needed help. Participants described a 'turning point' where

they first obtained help. Coming to terms with and facing the meaning of depression were necessary to facilitate acceptance of their depression. Acceptance was often accompanied by feelings of determination and hope.

After 'changing direction' there was a phase that reflected a real determination and drive to get out of depression. 'Working the way out' was a phase that was characterized by hard and often tedious work. Older adults relied on their inner strength but indicated they never could have done it on their own. They needed support from others to continue working. As persons worked their way out they noticed a resolution of their discomfort and distress.

Central to the fourth phase, 'staying out,' was the concept of vulnerability. Although older adults in this study were identified as having 'recovered' by health care professionals, they felt vulnerable to relapse or recurrence and therefore continued to work to stay out of depression. When people were working their way out of depression, their goal was to 'get out' but when people were working to stay out of depression, their goal was to stay where they were.

A preliminary substantive theory of the recovery from depression emerged from the process of recovery. The core concept was that of the work of recovery. Work was necessary in all phases of the process of recovery and was facilitated by the integration of strategies and intervening conditions. The outcome of this work was recovery.

Limitations

The results of this study add to the knowledge about the process of recovery from depression from the perspective of the older adult. There are, however, some limitations

that must be acknowledged. The quality and depth of the data may be limited by the researcher's novice experience, specifically with data collection and analysis techniques. Limited time precluded conducting a second interview with all participants who had participated in initial interviews, however, the data analysis was validated with three participants, two older adults who had recovered from depression who were not participants in this study, three nurses who work in geriatric mental health, and two geriatric psychiatrists. These people provided valuable feedback and direction which were incorporated into the analysis.

Participants who agreed to participate in the study may represent a select subgroup of the older adult who have recovered from depression because they were referred to mental health teams as a result of the severity of their depression. Consequently, the findings of this study are limited to describing these participants' perspectives. It would be inappropriate to generalize the findings to a larger population of older adults who have recovered from depression. To do so was not the intent of the researcher.

Finally, all participants in this study were clients of the Greater Vancouver Mental Health Services and as such, they had quick and available access to both biological and psychosocial supports. The findings must be viewed with this in mind but it is equally important to acknowledge that this does, in no way, diminish or make the experiences of older adults in this study any less relevant or important. The findings presented in this grounded theory study can not be wholly applied to another setting, but the understanding of the phases and the preliminary substantive theory which evolved may be used to generate insight and understanding, which may be applied to new settings.

Conclusions

The following conclusions can be made from this study. Recovery from the experience of depression in the older adult is an ongoing process made up of four phases: Spiraling Down, Changing Direction, Working the Way Out, and Staying Out. When subsequent depressive episodes were experienced, participants cycled back through the four phases. Although the participants in this study had recovered, they described a strong sense of vulnerability to relapses or recurrences of depressive episodes. Because of the continuous work, ongoing vulnerability, and significant rates of relapse and recurrence, depression in the older adult can be viewed as a chronic illness.

Work surfaced as the core concept in the process of recovery from the experience of depression. Using internal strengths, accepting depression, and using supports lead to the development and use of strategies that included reaching out and accepting help. Work was involved in getting out and staying out of depression and continues indefinitely.

Implications

The findings have implications for practice, education, theory, and research. Some are clearly implications for one domain while others may overlap with two or three areas. While the main focus is on nursing, other health care fields are mentioned as there is a strong interdisciplinary focus in provision of care to older adults with depression.

Implications for Practice

Prior to supporting older adults with depression through the process of recovery, all health care professionals (HCP's) would benefit from increasing their understanding of the process of recovery from depression and what older persons need in the way of

support as they progress through the phases of the recovery process. HCP's would benefit from becoming better informed about depression in the older adult and about resources available in the community to assist older adults recovering from depression.

Identifying early signs and symptoms of depression leads to early treatment. Because some participants in this study were not aware of a connection between signs and symptoms experienced and depression, HCP's should not take for granted that those who have experienced depressive episodes would recognize a relapse or recurrence. In fact, because of high relapse rates, HCP's should be especially attentive to assess older adults who have had previous depressive episodes. For older adults who are unable to access medical help, the nurse is in a position to advocate for them if necessary. Because the triggers of depression included losses and losses associated with regret, grief counseling and support during bereavement would be helpful in assisting the older adult cope with their loss(es).

Thorough assessment of the client and the client's situation should be the first step taken by HCP's. Assessment of the client's support system as well as assessment of previous experiences with illness need to be part of the client assessment. Knowledge of how to complete a geriatric mental health assessment is helpful. Because nurses typically have longer contact with clients than other health professionals, they need to be acutely aware of their central role in assessment of depression in all older adults. It is of paramount importance for all HCP's to observe for signs of depression in the older adult and to initiate referral when necessary.

For depressed older adults experiencing signs and symptoms that interfere with activities of daily living, the nurse is in a position to provide information about services that could assist during this time. This requires in-depth knowledge and understanding about depression as well as knowledge about what resources are available and how to access them. Knowledge of available and accessible community resources and how to locate a variety of information is important. This information should include cost of services as well as the nature of the service to be provided. Information should also be provided about depression to the client and caregivers, if appropriate. It is essential for everyone to work together to ensure the best possible care for the client.

Throughout the recovery phases, clients require support as they experience changes in their lives. For those who felt they would be aware of changes indicating depression, health care professionals (HCP's) must be available to listen to concerns or receive information from this group of older adults. For those participants who believed they would be unaware of changes, the health care professionals' role expands to providing ongoing assessment to detect subtle changes as well as to providing education about signs and symptoms of depression to older adults and their families. Interventions have been defined as being helpful to older adults experiencing depression. Treating older adults with respect and offering hope, and reassurance is described as important. Support and understanding during the process of recovery, perhaps just by 'being there,' listening, acknowledging difficulties, and reflecting difficulties experienced in recovery are identified as helpful. As well, providing encouragement is essential to the management of the depressed older adult. It would be beneficial for HCP's to use strategies to provide or

facilitate effective support. Facilitating connections and developing links among clients, community resources, physicians, other health care professionals, service providers, and support systems, ensure that optimal care is provided and overlap of services is minimized. Communication and organization are helpful skills.

Some participants described having trouble 'making sense of what was happening.' HCP's can provide information about depression to clients and to family or caregivers to alleviate distress and fear. The nurse should foster participatory control by engaging clients to become involved as much as they can tolerate. Utilizing therapeutic communication skills provides the critical foundation on which to develop participatory control. Ensuring that the client has at least one confidant with whom the client feels safe is also beneficial. Although the HCP may be in a position to be that confidant, it is important to arrange for someone to fulfill that role well before professional services might be terminated.

Implications for Education

To develop the requisite knowledge, skills, and abilities to assist older adults in their process of recovery from depression, a number of educational strategies should be implemented. These strategies should be carried out at all levels, including basic nursing education programs, graduate programs, and continuing education programs for practicing nurses.

Because older adults need to be routinely assessed for physical as well as mental problems, including depression, it would be beneficial for all nursing education programs to include course content on geriatric physical and mental health concerns. These

education programs should include information on changes associated with the normal aging process, needs of the older adult population, developmental processes in older adults, and common disorders including movement disorders, sleep disorders, degenerative disorders, dementia's, and depression.

Not only do HCP's need to learn assessment skills, but they need to be taught how to access help when concerns are identified. Appropriate interventions in dealing with the depressed older adult, should be included in the curriculum. For those nurses who have completed their basic training, it would be helpful to arrange to spend time with a geriatric mental health nurse to update assessment skills.

In graduate schools, Clinical Nurse Specialty programs in geriatric mental health should be available to provide advanced skills to nurses. Education is not limited to being provided to only nurses. Since knowledge is the key to power, geriatric mental health nurses must also educate other HCP's, older adults, caregivers, colleagues, and legislators about depression in the older adult population.

Implications for Theory

A preliminary substantive theory on the process of recovery from depression in the older adult has been developed from this study. From this study, we know that recovery from depression in the older adult is a process with four phases. This, however, is just a beginning description which is part of the early phase of theory development. The next step to be taken is to expand this study to include a larger sample group to examine the process more thoroughly.

Implications for Research

This study represents the first qualitative exploration of the process of recovery from depression from the aspect of the older adult. Further studies should include participants who are not cared for by a mental health team to see whether the process of recovery is similar. Phenomenological studies of the experiences of spiraling down, the turning point, hitting the bottom, taking the first step out, working the way out, accepting depression, the use of supports, and the individuals' strengths, would add to our understanding. Studies that compare those who experience depression after loss with those who have not experienced depression after loss may provide insight into areas of resiliency and vulnerability to depression.

The process of recovery should also be examined with different populations to identify age-specific and population-specific processes. The concept of recovery needs to be examined in both the older adult and younger age groups to determine whether the existing definition of 'recovery' is appropriate. With findings provided by further research, nurses and other HCP's would be in a better position to provide optimal care and ensure that during the process of recovery from depression, the needs of older adults would be met efficiently and effectively.

Summary of the Study

The current study has provided a description of the process of recovery from depression from the aspect of the older adult. It identified recovery as a process with

phases that older adults work through and serves as a beginning to our understanding of this important health problem.

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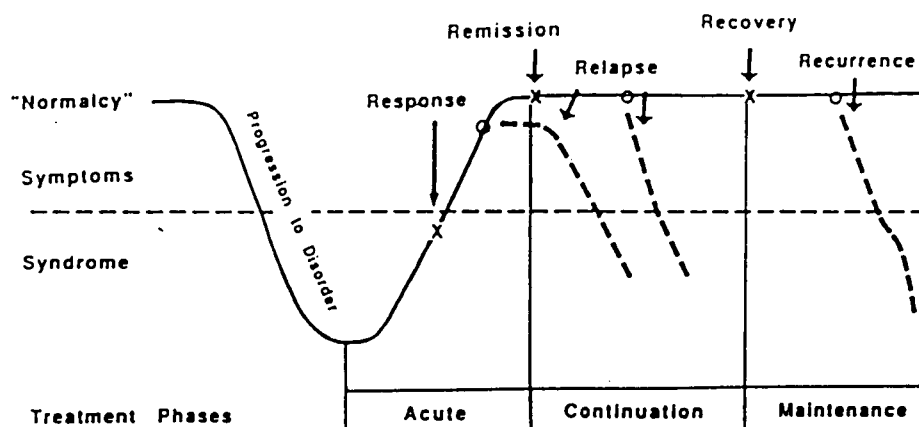
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Appendix A: Model of Recovery from Depression



Episode

Conceptualization of episode An 'episode' is a period of time, lasting longer than D days, during which the patient is consistently within the fully symptomatic range on a sufficient number of symptoms to meet syndromal criteria for the disorder. Syndromal criteria are defined by any of several criterion-based assessment systems, such as the Research Diagnostic Criteria or the Diagnostic and Statistical Manual of Mental Disorders. It should be noted that some of these assessment systems specify a pattern as well as number, severity and duration of symptoms.

Any time period prior to the patient's first episode, during which the patient is in the asymptomatic range except for short periods ($<D$ days), is said to be *disorder free*. A short ($<D$ days) time period during which the patient is outside the asymptomatic range is called a 'flurry'. A flurry can occur either prior to onset or after the resolution of an episode. An episode does not end until a patient reaches recovery (see below).

Rationale for the conceptualization of episode Both clinicians and researchers must decide when a patient is clearly ill. For the clinician, this typically triggers a decision to treat; for the researcher, this designation signals the appropriateness of including the patient in a group of individuals with the same illness.

Response and partial remission

Conceptualization of partial remission A 'partial remission' is a period of time during which an improvement of sufficient magnitude is observed such that the individual is no longer fully symptomatic (i.e., no longer meets syndromal criteria for the disorder), but continues to evidence more than minimal symptoms. Treatment is not a requirement of the definition; partial remission can be spontaneous.

A 'response' can be thought of as the point at which a partial remission begins. Theoretically a response, unlike a partial remission, *does* require treatment and, thus, implies that the cause of the change in the patient's condition is known, which may or may not be a valid assumption.

Full remission

Conceptualization of full remission A 'full remission' is a relatively brief ($>E$ days, but $<F$ days) period of time during which an improvement of sufficient magnitude is observed such that the individual is asymptomatic (i.e., no longer meets syndromal criteria for the disorder and has no more than minimal symptoms). Again, treatment is not a requirement; full remission can be spontaneous.

Rationale for the conceptualization of partial remission In deciding when and how to intervene, the clinician usually chooses to intervene when the patient suffers from the disorder. If the disorder is in partial remission (either by natural course or in association with treatment), the clinician may choose to observe rather than alter the patient's regimen. If a partial remission fails to become a full remission after a reasonable period of time, the clinician will typically alter treatment, either by increasing the intensity (through a higher dose of medication or more frequent therapy sessions) of the current treatment, adding additional treatments to the one associated with the partial remission, or by switching to a new treatment. If the disorder is not being treated and partial remission fails to become a full remission after a reasonable period of time, the clinician will typically initiate treatment. For the researcher, the failure to proceed from partial to full remission in a naturalistic study may imply the need for placing the subject in a separate category of patients. In a treatment study with a specified treatment protocol, it may imply the need to drop the subject from the study.

Rationale for the conceptualization of full remission A declaration of remission implies that no increase in the intensity of the treatment regimen is required. Depending upon the treatment and assumptions about its mechanisms of action, a full remission might imply that a decrease in the intensity of treatment could be attempted.

Recovery

Conceptualization of recovery A remission which lasts $\geq F$ days is a 'recovery'. Recovery can be spontaneous and can last for an indefinite period. The term is used to designate recovery from the episodes, not from the illness *per se*.

Rationale for the conceptualization of recovery In a clinical setting, a declaration of recovery raises the possibility that: (a) treatment can be discontinued; or (b) if continued, the aim is prevention of a subsequent episode. In a research setting, it might mean that treatment efforts can now be focused on maintenance of the well state or that the subject moves on into a no-treatment follow-up phase in which the focus is the extent to which treatment-associated improvement is maintained.

Relapse

Conceptualization of relapse 'Relapse' is a return of symptoms satisfying the full syndrome criteria for an episode which occurs during the period of remission, but prior to recovery as defined above. Relapse can represent a change from either partial or full remission to full syndrome criteria for the disorder.

Rationale for the conceptualization of relapse A relapse signals a need for treatment intervention or modification of ongoing treatment since the disorder has returned. In a study of acute or continuation treatment it may represent one outcome of interest.

In the distinction between a relapse and a recurrence (see below) relapse represents the return of the symptoms of a still ongoing, but symptomatically suppressed episode, while a recurrence represents an entirely new episode; however, in a definitional scheme based exclusively on observable events, this distinction must be made in probabilistic terms.

Recurrence

Conceptualization of recurrence A recurrence implies: (a) need for treatment; and (b) a revision in the history of the course of illness (i.e., a new episode has occurred). The latter may have prognostic and treatment implications. In studies of maintenance therapy, recurrence is typically the outcome of primary interest.

Frank, E., Prien, R., & Jarrett, R. (1991). Conceptualization and rationale for consensus definitions of terms in major depressive disorder: Remission, recovery, relapse, and recurrence. Archives of General Psychiatry, 48, 851-855.

Appendix B: Informed Consent

Appendix C: Trigger Questions

Trigger Questions:

"I would like you to tell me about the experience you have been through with depression"

1. How did your depression begin?
2. Can you describe the course it took?
3. What do you remember as things that helped you?
4. What do you remember as things that did not help you?
5. Were you aware of changes as your depression started to lift?
6. Have you been aware of any signs of depression recurring?
7. Were there times that were particularly difficult for you - can you tell be about those?
8. What things didn't happen that you think may have been helpful?