SURVIVING DEPRESSIVE ILL-HEALTH – A QUALITATIVE SYSTEMATIC REVIEW
OF OLDER PERSONS' NARRATIVES

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Running headline: Surviving depressive ill-health

Conflict of interest statement

Acknowledgements

Funding

Surviving depressive ill-health – a qualitative systematic review of older persons' narratives

ABSTRACT

The aim of this qualitative systematic review was to report a comprehensive literature synthesis of older persons' narratives about what they need in order to survive when suffering from depression. Their survival strategies seem to be a state rarely outlined in the literature. A systematic search of EBSCOhost/Academic Search Premier, ProQuest and PubMed was conducted for the period January 2000 to April 2012. Data were analysed by means of thematic analysis. Thirteen studies were selected and three themes emerged from synthesis; *The need for courage, strength and self-reliance, The meaning of responsibility* and *Wearing a mask of normalcy to hide the shame.* The first comprised two sub-themes; The value of faith and Distraction and activity, while the second had no sub-theme and the third one sub-theme; Reaching out of loneliness towards aloneness and connectivity. Further research should be focused on how community projects can improve health services such as enhancing the safety of health care and disseminating health information.

INTRODUCTION

Globally, over 350 million people fail to acknowledge that they suffer from depressive ill-health and do not seek treatment (WHO, 2012). The rate of depression has increased markedly over the past decade (Compton *et al*., 2006). By the year 2020, it is predicted to reach 2nd largest cause of injury and disease in the world for all ages and both sexes (WHO, 2004). A recent World Health Assembly called on the World Health Organization and its member states to take action in this area (WHO, 2012). Depressive ill-health in the elderly is a complex issue (Hedelin & Strandmark, 2001a) and extremely common in primary care settings, affecting at least 5 to 10% of old persons (Blazer, 2003). A systematic review and meta-analysis revealed that bereavement, sleep disturbance, disability, previous depression and female gender are important risk factors for depression among elderly persons who live in the community (Cole & Dendukuri, 2003).

Depression has been described in quantitative research as a mortality risk in older persons (Sutcliffe *et al.*, 2007; Wilson *et al*., 2007). Sampson *et al.* (2009) revealed that cognitive impairment and lack of social support are independent mortality risk factors for older depressed persons*,* while Greenlee *et al.* (2010) demonstrated how anxiety impairs remission of depression during treatment of older persons. Pulska *et al.* (1997) found that a previous diagnosis of depression is not predictive of increased mortality in elderly persons (>60) when other factors known to influence survival are taken into account.

The medical model of depression continues to be dominant in Western society (Rapaport *et al*., 2002; Simon *et al*., 2002). In this paradigm, the person's story is used in the diagnostic process to identify symptoms of depression (Casey & Long, 2002; Moyle, 2003). Some cultures and societies seem to understand depression differently (Herrick & Brown,

1999; Raguran, 1996; Mills, 2000; Schreiber *et al*., 2000; Wolpert, 2001). In Asia*,* depression

is seen as a cultural phenomenon (Raguram, 1996). The depressed persons suffer from

emotional distress expressed through somatisation and tend to be stigmatized (Raguram,

1996). In America*,* depression is described as an illness affecting middle-class white women

(Beauboeuf-Lafontant, 2007). Mills (2000) reported that in elderly Afro-American women, a

lifetime of discrimination, poverty as well as poor living and working conditions makes

depression in old age a normative reaction to the stress of living a long life. In Afro-American

culture, women suppress the feeling of being depressed and instead adopt survival strategies

that are deemed culturally appropriate such as faith, silence and strength (Schreiber *et al*.,

2000). In England*,* Wolpert (2001) found that depression is very difficult to understand and

thus considered a sign of weakness. The stigma of depression differs from that of other mental

illnesses that cause the sufferers and their families to experience shame.

The experience of being depressed seems to be a state of ill-health that is seldom

understood by others (Mills, 2000). Three theoretical papers (Feely *et al.,* 2007a; Feely *et al*.,

2007b, Feely *&* Long, 2009) discussed different aspects of depression. Feely *et al.* (2007a,

p.393) explored the participants' perceptions of their pre-diagnosis encounter with depression.

The main category was 'the pre-diagnosis phase of depression and the now experience'*,*

containing five themes: Negative impact significant life events; Self-blame, Personal

characteristics; Pre-diagnosis, Depression unknowingness and Pre-help seeking. The findings

suggested that those who work in the field of human services need to understand the lived

experience of persons with depression in order to provide holistic treatment and care. Feely *et*

al. (2007b) aimed 1) to add to nursing knowledge by depicting the grounded realities of the

experience of depression and 2) to stimulate discussion on the need to provide holistic care

pathways that are responsive to the uniqueness of this lived experience and finally 3) to

encourage further research on key psycho-social factors associated with depression and the advancement of nursing care. According to Feely and Long (2009), depression is a personal, individually experienced and complex phenomenon. Connectivity constituted a significant platform for understanding and responding to the life experience of depression (Feely & Long, 2009) and provided a framework for helping mental health nurses to address the life experience of people living with depression.

Over a decade ago, Moore (1997) stated that society was structured around ageist biases, which contributed to old persons feeling isolated and alienated. Thus older persons' survival strategies need to be explored. Nurses should be able to respond effectively to older persons' needs in order to help them survive depressive ill-health, as their practice can be intuitive and humanistic as well as evidence-based. In order to find out more about older persons' narratives and their experiences of the survival of depressive ill-health, the authors of the present qualitative systematic review included several papers that mainly described older persons in such a state as well as their will to survive. The purpose of a systematic review is to combine previous research results to form a basis for further studies (Conn *et al.*, 2003). Evidence contributed by qualitative studies is a prerequisite for evidence-based nursing, as stated by Goding and Edwards (2002) and Hewitt-Taylor (2002). Qualitative research makes it possible to gather information about how older persons experience depressive ill-health and their overall mental health.

AIM

The aim of this qualitative systematic review was to report a comprehensive literature synthesis of older persons' narratives about what they need in order to survive when suffering from depression.

METHOD

The systematic review method was used to gather existing qualitative knowledge (Polit & Beck, 2012).

Literature search

The following electronic databases were searched; EBSCOhost/Academic Search Premier, ProQuest and PubMed for the period from January 2000 to April 2012. The search words used in combination and separately were; depression, lived experiences, elderly, mental health, nursing, old, survive, qualitative. An electronic search was conducted related to the topic of the included papers in addition to a manual search of significant references.

Inclusion and exclusion criteria

The inclusion criteria were; qualitative study, published in English, persons 60 years of age and over, depression, lived experiences, nursing. The exclusion criteria were; medical

treatment, reviews, younger persons, quantitative research and qualitative studies that did not include mental health and older persons' descriptions of survival strategies.

The searches revealed 540 abstracts, review papers, qualitative (theoretic and empirical) and quantitative empirical studies. 37 were retrieved, the vast majority of which did not meet the inclusion criteria (Figure 1). The studies were read several times in order to identify expressions of survival strategies.

Please insert Figure 1 about here

Thematic synthesis

A synthesis can identify a range of common themes as well as any divergent views (Ring *et al.*, 2010). A synthesis of qualitative evidence may seek to expand understanding of a phenomenon or patient experience (Ring *et al.*, 2010). The degree and type of interpretation can be a major issue for a reviewer trying to synthesise data from several different primary studies. There seems to be no consensus on appropriate guidelines for the systematic review of qualitative evidence in the areas of health and social care (Ring *et al.*, 2010).

This systematic review was carried out by means of thematic synthesis, i.e. the authors organised and abstracted the findings in accordance with the themes identified in the data. DeSantis and Ugarriza (2000, p. 362) stated that 'a theme is an abstract entity that brings meaning and identity to a current experience and its variant manifestations'. However, these authors were referring to qualitative research and not qualitative systematic reviews. We believe, that in qualitative systematic reviews, a theme can also be used to combine different

experiences into a meaningful whole. Each study was read several times until themes emerged and a natural coherence was identified (Polit & Beck, 2012).

According to Ring *et al.* (2010)*,* synthesis is a general term used to describe the 'bringing together' of a body of research on a particular topic. According to Thomas and Harden (2004)*,* thematic synthesis draws on primary qualitative research and other established methods. In this process, the reviewers applied the stages described by Thomas *et al.* (2003) and Thomas and Harden's (2008) when developing the thematic synthesis. In the first stage the reviewers read the studies carefully to gain an overall impression of survival strategies, using free line-by-line coding. Each statement was associated with the older persons' experiences of surviving depressive ill-health. In the second stage, pen and paper were used to develop the codes into descriptive themes (Figure 2). In the final stage, the reviewers used the descriptive themes in the interpretation of a new thematic synthesis of themes and sub-themes that went beyond the original studies (Table 2).

Please insert Figure 2 about here

QUALITY ASSSESSMENT

According to Thomas and Harden (2008), there is little consensus regarding how quality should be assessed or whether it can or should be assessed at all in relation to qualitative research. In order to determine the quality of the methodology, the authors of this systematic qualitative review focused on the analysis and trustworthiness of the included studies. In the assessment of trustworthiness, the concept of credibility was used to evaluate confidence in the interpretations as described by Lincoln and Guba (l985). Dependability refers to the

stability of data over time and we assessed whether the results could have been influenced by any form of change over time. When assessing transferability we discussed whether the evidence, knowledge and understandings were meaningful in and applicable to similar situations (Lincoln & Guba, 1985).

We ascertained whether a description of the steps or stages in the analysis process was provided and identified the type of analysis performed (see Table 1). We also assessed the demographic and ethical aspects (approval) of the included studies.

RESULTS

Thirteen qualitative studies were included in the review. Eight studies were conducted in the USA (Ugarriza, 2002; Pierce *et al*., 2003; Barg *et al.,* 2006; Soonthrochaiya & Dancy 2006; Black *et al*., 2007; Switzer *et al*., 2009; Wittink *et al*., 2009; Conner *et al*., 2010), one in the UK (Lawrence *et al*., 2006), three in Sweden (Hedelin & Strandmark, 2001a; Hedelin & Strandmark, 2001b; Hedelin & Jonsson, 2003) and one in New Zealand (Allan & Dixon, 2009).

One study used a hermeneutic phenomenological approach (Allan & Dixon, 2009). Three studies employed a phenomenological approach (Hedeling & Strandmark, 2001a; Hedelin & Strandmark, 2001b; Hedelin & Jonsson, 2003)*,* while another used cultural consensus analysis (Barg *et al*., 2006). Two studies employed content analysis (Ugarriza, 2002; Conner *et al*., 2010), two studies qualitative content analysis (Soonthorchaiya & Cancy, 2006; Black *et al.* 2007), while a further two applied grounded theory (Lawrence *et al.,* 2006; Wittink *et al.,* 2009). Two studies did not describe the analysis method (Pierce *et al*., 2003;

Switzer *et al.*, 2009). Hedelin and Strandmark (2001a) used a phenomenological approach and an audit trail, which means that other researchers can follow their analysis step by step. Five studies clearly described the steps or stages utilised for identifying categories and themes in the data analysis (Hedelin & Strandmark, 2001b; Hedelin & Jonsson, 2003; Switzer *et al.,* 2006; Allan & Dixon, 2009; Conner *et al.*, 2010).

Five of the other studies clearly described the steps or stages used for identifying categories and themes in the data analysis (Hedelin & Strandmark, 2001b; Hedelin & Jonsson, 2003; Switzer *et al.,* 2006; Allan & Dixon, 2009; Conner *et al.*, 2010). Hedelin and Strandmark (2002a), Hedelin and Strandmark (2001b) and Hedelin and Jonsson (2003) stated that they employed Giorgi's (l985; 1989; l997) method of analysis, which is inspired by Husserl's phenomenology and that the purpose of the findings was a synthesis. Allan and Dixon (2009) based their analysis on van Manen's (1997a, b) six methodological themes, while four studies described how the authors identified categories and themes in different ways (Barg *et al.*, 2006; Soonthornchaiya & Dancy, 2006; Black *et al.*, 2007; Wittink *et al.*, 2009)*,* albeit without clearly demonstrating how the themes emerged from the data. In one study it was stated that the analytic strategy was explained in detail elsewhere (Lawrence *et al.*, 2006). Two studies provided no description of the stages or steps in the analysis (Ugarriza, 2002; Pierce *et al.* 2003).

Eleven of the studies (Hedelin & Strandmark, 2001b; Ugarriza, 2002; Hedelin & Jonsson, 2003; Pierce *et al.*, 2003; Barg *et al.*, 2006; Lawrence *et al.*, 2006; Soonthornchaiya & Dancy, 2006; Black *et al.*, 2007; Allan & Dixon, 2009; Switzer *et al.*, 2009; Conner *et al.*, 2010 did not state whether or how they achieved credibility as described by Lincoln and Guba (l985).

One study (Barg *et al.*, 2006) used several strategies to address credibility including immersion in the data through multiple readings, discussions by the study team, searches for discrepant cases and peer debriefing. Four studies mentioned limitations related to generalisability of the results (Ugarriza, 2002; Lawrence *et al*., 2006; Allan & Dixon, 2009; Conner *et al*., 2010).

Nine of the studies included demographic data (Hedelin & Strandmark, 2001a; Hedelin & Strandmark, 2001b; Ugarriza, 2002; Barg *et al.*, 2006; Lawrence *et al*., 2006; Soonthornchaiya & Dancy, 2006; Switzer *et al.*, 2009; Wittink *et al*., 2009; Conner *et al*., 2010), while four provided no such information (Hedelin & Jonsson, 2003; Pierce *et al*., 2003; Black *et al.*, 2007; Allan & Dixon, 2009).

Eight of the studies were granted ethical approval by institutional review boards (Hedelin & Strandmark, 2001a; Hedelin & Jonsson, 2003; Barg *et al.*, 2006; Soonthornchaiya & Dancy, 2006; Wittink *et al*., 2009; Allan & Dixon, 2009; Switzer *et al.*, 2009; Conner *et al.*, 2010) but five provided no such information (Hedelin & Strandmark, 2001b; Ugarriza, 2002; Pierce *et al.,* 2003; Lawrence *et al*., 2006; Black *et al.*, 2007).

Please insert Table 1 about here

Methodological quality of the included studies

The methodological quality varied. Nine of the studies based the analysis on methodological literature (Hedelin & Strandmark, 2001a; Hedelin & Strandmark, 2001b; Hedelin & Jonsson, 2003; Barg *et al.*, 2006; Soonthornchaiya & Dancy, 2006; Black *et al.*, 2007; Wittink *et al.*, 2009; Allan & Dixon, 2009; Conner *et al.*, 2010), thus strengthening the methodological quality.

The methodological quality were associated with lack of understanding of trustworthiness. The study by Barg *et al.* (2006) applied the concept of reliability to assess the coding of the data, which was stated to have been agreed upon by the team in relation to the codes developed from the text. However, the use of both trustworthiness and reliability was confusing (Barg *et al.*, 2006). Interrater reliability appeared in two studies, but no information was provided on how consensus was achieved (Ugarrazia, 2002; Soonthornchaiya & Dancy, 2006). According to Schneider *et al.* (2007), interrater reliability assesses the instruments employed in quantitative research. As qualitative research is a different genre, the criteria for ensuring objectivity, internal and external validity as well as reliability serve to establish trustworthiness. In one study in which the authors employed the concept of reliability (Conner *et al.*, 2010) the reason reported was that the data were read and coded by all the authors. It was explained in another study (Hedelin & Strandmark, 2001a) that credibility was a method for validating the data. Allan and Dixon (2009) described interpreting the text using hermeneutic phenomenological reflection. Rigour was achieved by explicating the researchers' pre-understandings and tracking the research process (Allan & Dixon, 2009). Allan and Dixon (2009) did not outline the methods applied to ensure scientific rigour.

One study described employing a non-probability purposive sampling method that could limit generalisability (Ugarriza, 2002). According to Schneider *et al.* (2007)*,* non-probability sampling is used in qualitative research, as the participants are chosen in a non-randomised manner. The study by Lawrence *et al*. (2006) also stated limitations in terms of generalizability. Ugarriza (200*2*) mentioned that the sample might be a limitation. Two studies stated that generalisation was not possible due to the small sample (Allan & Dixon, 2009; Conner *et al.*, 2010). However*,* Polit and Beck (2012) pointed out that a small sample size is not a limitation in qualitative research.

One study addressed potential limitations but in the form of an ordinary as opposed to a methodological discussion (Wittink *et al.*, 2009). Another study mentioned that a limitation was the absence of persons willing to be screened for depression (Switzer *et al.*, 2009), although screening does not appear to be relevant in a qualitative study.

The result from the thematic synthesis

The results from the descriptive themes (Table 2) that described ways of surviving depressive ill-health were; *The need for courage, strength and self-reliance, The meaning of responsibility* and *Wearing a mask of normalcy to hide shame.* The first theme comprised two sub-themes, The value of faith and Distraction and activity. The second theme had no sub-theme and the third one sub-theme; Reaching out of loneliness towards aloneness and connectivity.

Please insert Table 2 about here

The need for courage, strength and self-reliance

Eight studies reported that older persons need courage, strength and self-reliance to survive with depressive thoughts (Hedelin & Strandmark, 2001a; Hedelin & Strandmark, 2001b; Ugarizza, 2002; Hedelin & Jonsson, 2003; Lawrence *et al.*, 2006; Black *et al.*, 2007; Allan & Dixon, 2009; Conner *et al*., 2010). According to Hedelin and Strandmark (2001a)*,* the participants experienced a state of struggle that manifested itself as resignation. In Hedelin and Strandmark (2001b)*,* the participants expressed the conviction that by meeting the challenges of life and relying on themselves and others, everything would turn out for the best. According to Ugarizza (2002), the participants stated that they needed strength and were helped by medication and treatment. Hedelin and Jonsson (2003) explained that the participants needed courage and the will to safeguard their autonomy, self-respect and integrity. Lawrence *et al.* (2006) reported that the majority of participants felt they had to combat the depression themselves by drawing strength from inner resources, being self-motivated and having a positive attitude. Black *et al.* (2007) described that the participants' strength illustrated how an elderly person constructs depression in the context of her/his personal and communal history as well as current situation. In the study by Conner *et al.* (2010) self-reliance was also a common survival strategy when suffering from depressive ill-health.

The value of faith

Five studies demonstrated that the primary survival strategy was faith and religious belief (Lawrence *et al.*, 2006b; Soonthornchaiya & Dancy, 2006; Black *et al.*, 2007; Wittink *et al.*, 2009; Conner *et al.*, 2010). Lawrence *et al.* (2006) described prayer as an active strategy for seeking guidance and helping oneself. Soonthornchaiya and Dancy (2006) used different coping mechanisms such as practising Buddhist teaching and meditation, going to the temple and participating in pleasant activities. Black *et al.* (2007) revealed that the means to counter depression or any difficulties in life was faith in God and especially in themselves. Wittink *et al.* (2009) found that elderly Afro-American persons frequently mentioned the term 'faith' when discussing depression. Religious beliefs were described as an active decision to adapt to the diminished strength that occurs in old age by entering into a relationship with God (Conner *et al.*, 2010).

However, not only meditation and faith were described as calming. Lawrence *et al.* (2006) described the benefits of having a professional counsellor who can 'calm the nerves' and 'help you lead a normal life'. The participants in the study by Soonthornchaiya and Dancy (2006) tended to report acceptance of their life situation and that talking to a monk helped them to solve their problems, especially if he was knowledgeable about psychology.

Distraction and activity

Three studies revealed that distraction and activity was a way to push negative thoughts and worries out of one's mind (Lawrence *et al.*, 2006; Soonthornchaiya & Dancy, 2006; Conner *et al.*, 2010). Lawrence *et al.* (2006) described a desire not to dwell on things and that activity

took the mind off negative thoughts. However, distraction did not necessarily involve

engagement in specific activities (Lawrence *et al.*, 2006). Soonthornchaiya and Dancy (2006)

stated that engaging in activities such as talking to friends, travelling, going to parties and

participating in hobbies had a calming effect (Soonthornchaiya & Dancy, 2006). Conner *et al.*

(2010) explained that the participants denied that their depression was due to their role of

carer for others and that they did not want to worry their family members and therefore

engaged in activities to keep themselves from becoming progressively worse (Conner *et al.*,

2010).

The meaning of responsibility

The elderly persons seemed to struggle to survive depressive ill-health in order to take care of

themselves and their significant others. However, this struggle appeared to result in a feeling

of rejection by themselves and others if unable to live up to demands and expectations. Three

studies described how the participants held themselves responsible for their illness (Hedelin &

Strandmark, 2001a; Black *et al.*, 2007; Switzer *et al.*, 2009). Hedelin and Strandmark (2001a)

reported that the participants felt responsible and blamed themselves for their illness,

believing that they had been selfish in their lives and not sufficiently active in terms of

helping others. The participants wished to devote themselves to the well-being of their

significant others and support them, even to their own detriment. Acting unselfishly was

described as a way of finding contentment and meaning in life (Hedelin & Strandmark,

2001a). Black *et al.* (2007) explained that the participants' lived experience was characterised

by a sense of responsibility to combat depression. Switzer *et al.* (2009) identified a personal

responsibility for their depression and curing themselves. The term personal responsibility

denotes the individual concerned taking control and initiating change towards improving

health and well-being, thus alleviating depression (Switzer *et al.*, 2009).

Wearing a mask of normalcy to hide the shame

In three studies the participants*'* narratives revealed the need to hide their depressive ill-health

from other people (Ugarriza, 2002; Allan & Dixon, 2009; Conner *et al*., 2010). Ugarriza

(2002) explained that they felt too weak or had low energy levels, which caused them to

withdraw from the company of other people. Allan and Dixon (2009) reported that the

participants were unable to connect with people and therefore withdrew, which resulted in a

feeling of being alone and isolated. The participants explained how they struggled to maintain

a façade of normalcy in the company of family and friends, despite feeling isolated and

lonely, describing the sense of isolation as 'withdrawing into a shell'. In Conner *et al.* (2010),

the participants talked of wearing a mask to hide their feelings. Some lied and denied their

feeling of depressive ill-health, even to themselves, due to a lack of information and education

about depressive ill-health and other mental illnesses in the Afro-American community.

Reaching out of loneliness towards aloneness and connectivity

Three studies described problems with aloneness and connectivity when surviving from

depression (Pierce *et al*., 2003; Bark *et al*., 2006; Allan & Dixon, 2009). Pierce *et al*., (2003)

analysed the concept of aloneness in older women being treated for depression. When the

women were depressed, they viewed aloneness as being vulnerable, fearful, helpless, as

identity confusion and loss of control of self. As they progressed in their recovery, they

viewed aloneness as being self-reliant, hopeful, resourceful as well as having self-determination and the ability to engage in self-reflection. Bark *et al.* (2006) explained the participants' state as associated with aloneness, which indicated independence and autonomy. The participants did not equate depression with loneliness, despite the fact that it seemed to lead to depressive ill-health. The narratives in the study by Allan and Dixon (2009) revealed the need to be understood by at least one person in order to avoid loneliness and isolation. This understanding was crucial and enabled the person to reach out and try to connect with the other.

DISCUSSION

The aim of this qualitative review study was to provide a comprehensive literature synthesis of older persons' narratives about what they need in order to survive when suffering from depression. Three themes emerged as important for enhancing and increasing the participants' ability to survive and handle their depressive ill-health; *The need for courage, strength and self-reliance, The meaning of responsibility* and *Wearing a mask of normalcy to hide shame*.

In the first theme, the older persons revealed an existential despair where they narrated about their *need for courage, strength and self-reliance*. Thus, despair seems to be a longing for confirmation from another human being. Confirmation can be considered an essential step towards acceptance of oneself and others, where mental health emerged in the experience of relationships and dignity as described by Hedelin and Strandmark (2001b). This seems to underline the cathartic value of discussing worries and concerns with friends as well as willingness to talk about emotional problems. Relationships have been described as essential for human beings' view of themselves (Peplau, 1988). From an existentialist perspective,

human beings are unique but always connected to the world and others (Watson, 2005). An important aspect is the basic assumption that one always has the freedom to decide how to face the challenges in life (Hedelin & Jonsson, 2003). Nurses must understand that older persons need courage and strength in their struggle to connect with other people. They should listen to older persons and help them find strategies to create a connection, where thoughts and feelings can be openly shared.

The older persons' experiences, perceptions and coping mechanisms revealed an existential struggle to grasp the meaning of responsibility in the light of suffering from depressive ill-health. The origin of the feeling of responsibility seems to be a search for meaning (*cf.* Frankl, l971) that may help these elderly persons to regain emotional balance and reconstruct their selves. Such a fundamental existential situation requires awareness of the dark side of life and within oneself. Despite a depressive inner state of emotional pain (*cf.* Holm, 2009), human beings seem to struggle to go on living. Assuming responsibility may be a virtue and a consequence of being human. As Frankl (l971) argued, life often has a meaning and every person creates her/his personal meaning. The origin of the feeling of responsibility seems to be a search for meaning that may help these elderly persons to regain emotional balance and reconstruct their selves. Personal responsibility appears to be a means to force oneself to engage in activities, thus constituting an effective form of self-help.

The value of faith revealed in the results illustrates its importance in helping elderly persons to survive depressive ill-health. Faith is related to self-help and regaining belief, while a way in which depression could be alleviated was engaging in religious activities such as prayer, talking to a pastor or going to church (*cf.* Wittink *et al.*, 2009). Faith and spiritual beliefs can promote the survival process rather than avoidance and withdrawal. Spirituality can develop engagement with the sacred through religious activities such as prayer,

meditation and other practices. It can be a way to survive in difficult existential situations, as it provides an opportunity to talk without fear of boring others and becoming a burden. However, depressive ill health seems to be a spiritual crisis characterised by a lack of faith in oneself and others. Acquiring the ability to seek help from a physician or a psychologist can be considered an increase in faith. As Wittink *et al.* (2009) suggested, health professionals and faith can work together in a synergistic way to enhance the survival process. Elderly persons may describe depression in different ways such as sadness, depressed mood and lack of interest. They seem to need self-reliance strategies (*cf.* Conner *et al.*, 2010), find religious activities helpful in relieving their emotional pain and manage depression on their own by trying to push themselves through it and hand everything over to God.

The older informants narrated that *Being involved in activities* was an effective means of self-help and that concentration on tasks can help to reduce negative thoughts and feelings (*cf.* Allan & Dixon, 2009). Older persons often need to engage in activities to keep themselves from getting worse. Their survival strategies can be effective and acceptable, i.e., acceptable to others, thus not leading to stigmatisation.

The strategy of withdrawing from the world can be seen as the only way to survive. Shame seems to lead to avoidance and defensive feelings, where one wants to sink into a deep hole and disappear. One does not want anyone to interfere and cannot face anyone, not even oneself. Wearing a mask of normalcy was a common survival strategy, where the elderly persons tried to hide the feeling of being depressed. Concealment seems to be a way for the elderly persons to avoid having to reveal their true feelings. However, it can also prevent them from surviving their depressive ill-health. Suppressing one's feelings in the long-term and being unable to talk about the shame can make the dark feelings become overwhelming, leading to chaos and despair. Stigma can explain why one suppresses depressive ill-health and

denies the problem. An existential state of despair is when life is too difficult to bear and living more frightening than death.

Hiding and silencing seem to be the concepts that describe aspects of shame (Crowe, 2004). Shame implies that one conceals depression because of the stigma involved (Allan & Dixon, 2009). One can experience a turning point, a need of transformation that can be painful, especially if one has repressed trauma from earlier in life. Suppression can remain in one's consciousness. Integrating painful events that have violated one's self-respect might be difficult. Depression can be shameful and one feels that one has a duty to try different solutions to overcome the emotional pain. In the survival process one has to redefine one's self, which could imply a search for one's own identity, involving cognitive and emotional elements. Re-experiencing the painful events could be an attempt to become reconciled with them (Holm *et al.*, 2009). Wearing a mask seems to be a way to suppress feelings of despair (Allan & Dixon, 2009). The attitude to depression can shape understanding of it and influence one's identification of survival strategies. Internalising the stigma of depression can challenge such beliefs.

Reaching out of loneliness towards aloneness and connectivity was described as a way to survive. Reflecting on loneliness can be important when judging the older persons' ability to be alone. Loneliness seems to be associated with experiences of depression. This does not mean that depression is equated with loneliness, but rather that loneliness can lead to depression. The meaning of aging indicates that loneliness can be related to growing old. Loneliness has been described as one's own responsibility and a subjective condition that may or may not co-occur with being alone (Wilkinsen & Pierce, 1997). Aloneness in older persons seems to be associated with a form of strength that involves the ability to be alone, which Pierce *et al.* (2003) described as a recovery process, where a female participant likened the

transition from aloneness in depression to aloneness in recovery. It seems to be an experience of tolerating to be alone without feeling completely separated from others. However, various aspects of aloneness have been associated with loneliness and possibly depression as described by Pierce *et al*. (2003). The existential state of aloneness can be a component of empowerment and a positive mental health factor for older persons. Existential aloneness can be an awareness of one's strength because one has survived, even if life is hard to endure. This perspective revealed that some experiences can be shared while others have to be faced alone.

Limitations of this review

Reviews are secondary research prepared by someone other than the original researcher (Polit & Beck, 2012). As a review can be seen as qualitative research, the term trustworthiness as explained by Lincoln and Guba (l985) and Polit and Beck (2012) is useful for assessing the limitations and methodological strengths of a study. The thematic synthesis can be related to credibility, which concerns confidence in the interpretations and enables validation of the data (Polit & Beck, 2012). The interpretation of the themes and sub-themes was important for reaching consensus about the sorting and labelling of the data as well as for the interpretation of the underlying meanings embedded in the included studies. Both authors are familiar with the thematic synthesis method, which could increase the trustworthiness, as described by Holopainen *et al*. (2008). According to Droogan and Song (l996) and Magarey (2001), the participation of different researchers in the selection and analysis of studies increases the credibility of a systematic review. Thus the authors read and analysed the studies in order to reach consensus. The search strategy in a review can be a limitation because there is always a

possibility of excluding some relevant studies. The search strategy can be either too broad or too narrow. In the present review the restricting of the search period to 2000 can be a limitation. New evidence can change the relevance of a review in terms of the concept of dependability, i.e. the stability of data and conditions over time. The results of a systematic review cannot be directly transferred to experiences of surviving depression in other parts of the world and researchers themselves must judge whether they can be applied in their own context, as explained by Lincoln and Guba (1985). Another limitation is the fact that seven studies were from the USA, four from Europe (one from the UK and three from Sweden) and only one from the rest of the world (New Zealand). The culture reflected in the studies may vary between north and south. How older persons survive depression can differ according to culture as can their ways of expressing emotional pain and distress as stated in the Introduction. Further studies in other parts of the world are recommended in order to strengthen the trustworthiness of qualitative research.

Conclusion

This systematic review revealed that older persons survive depression in different ways. Their survival strategies indicated a need for courage, strength and self-reliance and revealed that they searched for the meaning of responsibility. In everyday life they have to wear a mask of normalcy to hide their shame.

Further research should be focused on how community projects can improve health services by including older persons in specific public health projects such as enhancing the safety of health care and disseminating health information.

Contributions

Study Design; E.S. and A.L.H., Data Collection and Analysis; A.L.H., Manuscript Writing;

A.L.H. & E.S.

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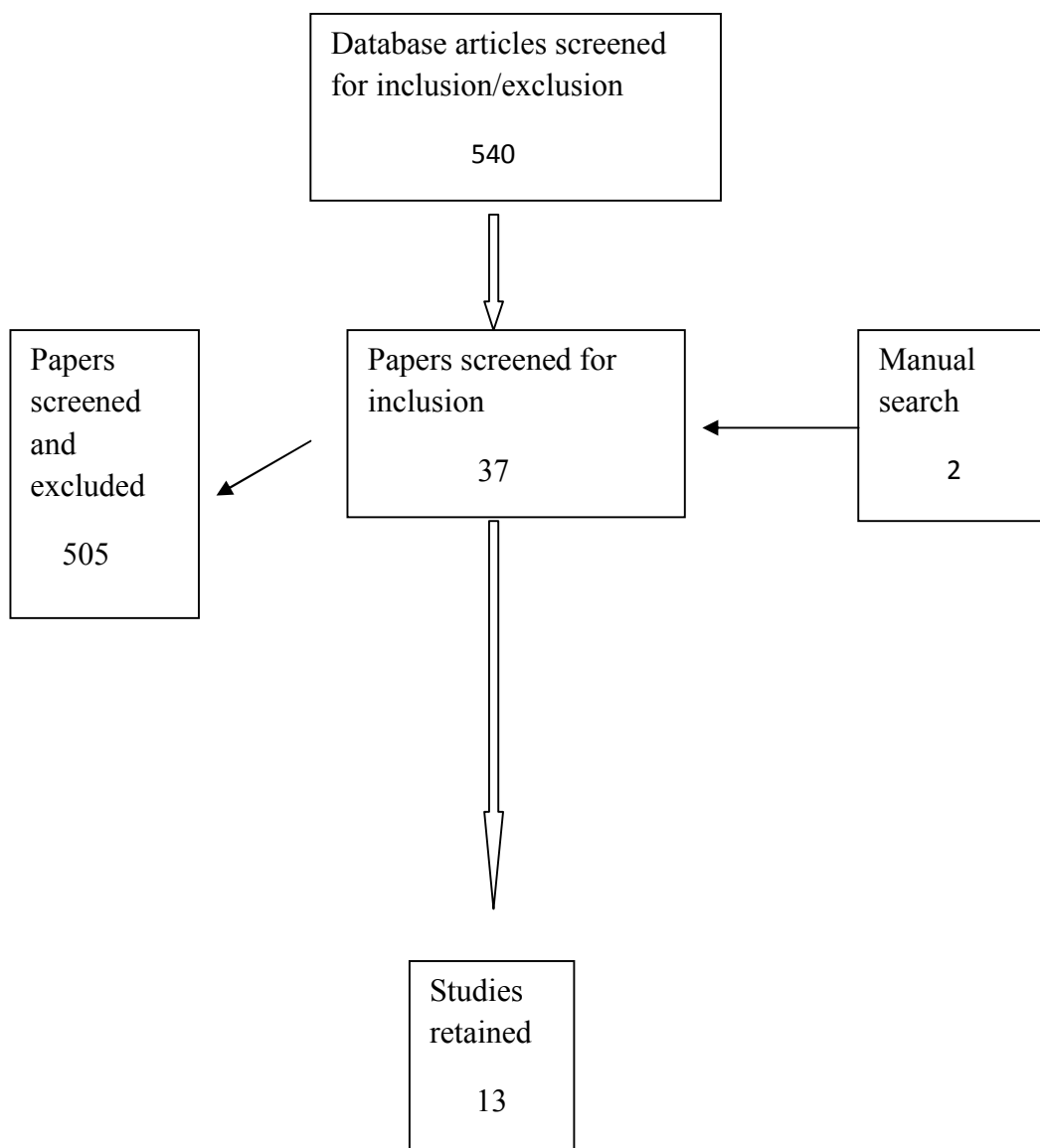http://www.who.int/mediacentre/news/notes/2012/mental_health_day_20121009/en/

Figure 1 Search and retrieval process

Figure 2 The themes and sub-themes that emerged from the descriptive themes

The need for courage, strength and self-reliance	Will, self-reliance, autonomy
	Self-respect

The value of faith	Talking to the priest/monk
	Religious belief
	Prayer

Distraction and activity	Talking to friends
	Travelling
	Activities
	Not dwelling on things

The meaning of responsibility	Responsible for their illness
	Acting unselfishly
	Taking control

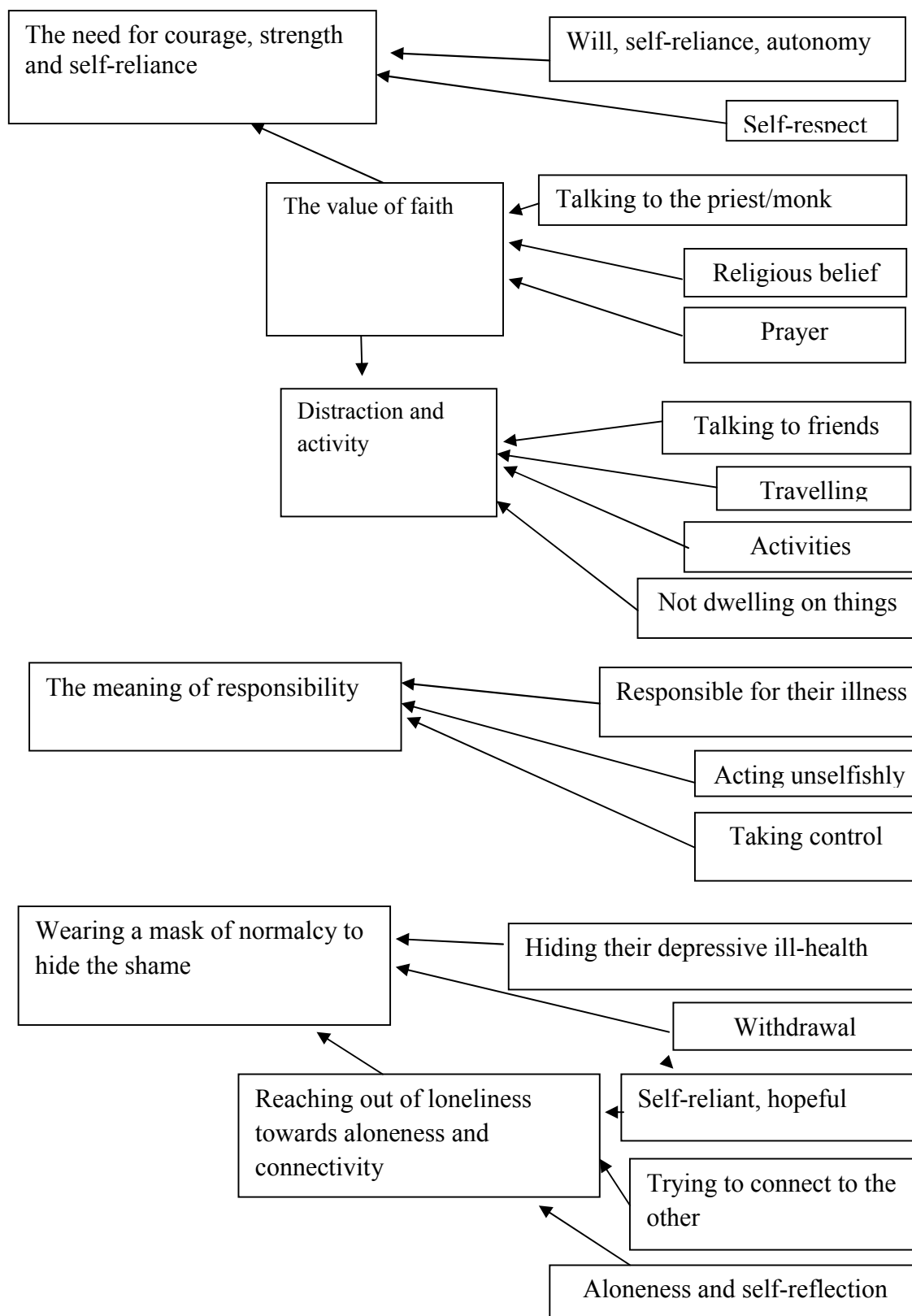|	
Wearing a mask of normalcy to hide the shame	Hiding their depressive ill-health
	Withdrawal
Reaching out of loneliness towards aloneness and connectivity	Self-reliant, hopeful
	Trying to connect to the other
	Aloneness and self-reflection

Table 1   An overview of the included qualitative studies on the survival strategies of older persons suffering from depressive ill-health

1st author, year, outcomes reference, country	Method, analysis, sample	Context	Summary
1.Allan & Dixon (2009) NEW ZEALAND.	Hermeneutic phenomenology. Interviews. Hermeneutic analysis. N=4 older women (69-82 years).	The women were recruited from an outpatient mental health unit.	The findings revealed that depression had a major effect on the women's beliefs about themselves. The participants had the impression that other people thought badly of them, which led to withdrawal. Their inability to connect contributed to feelings of being alone and isolated. Being met with understanding made it easier for these women to talk to other people.
2. Barg *et al*. (2006) USA.	Mixed method. Semi-structured interviews. Cultural consensus	Community dwelling elderly persons.	Loneliness was salient to elderly persons asked to describe a depressed person or themselves when depressed. They viewed loneliness as a precursor of

	analysis. N=102 (75 women, 27 men). Average age in years, 75.8.		depression, self-imposed withdrawal, or as a normal part of aging.
3.Black *et al.* (2007) USA.	Interviews Qualitative data analysis. N=20 Age 80 years and over.	Elderly community dwelling Afro-American women	The women's narratives formed three themes: Diminished personal strength, Sadness and suffering, and Preventable or resolvable through personal responsibility.
4.Conner *et al.* (2010) USA.	Interviews. Content analysis. N=37 (31 women, 6 men). 60-81 years of age.	Afro-American community dwelling elders.	The elderly Afro-Americans in this study identified a number of experiences in the black community that led to identification and utilization of cultural coping strategies to deal with depression.
5.Hedelin &	Interviews.	Elderly community	Mutuality in the relationship with themselves and others emerged as

Jonsson (2003) SWEDEN.	Phenomenological method and analysis. N=21	dwelling women.	a major element in the women's experience of mental health and depression. When their existence and value were confirmed in relation to themselves and others, mental health appeared as an ascending spiral.
6.Hedelin & Strandmark (2001a) SWEDEN.	Interviews. Phenomenological method and analysis. N=5 (75 - 92 years).	Elderly community dwelling women.	Recovery from depression was described as 're-experiencing a severe personal insult'. Depression affected them physically, mentally, socially and spiritually, where previous experiences merged with the present situation. Thus, their whole life was affected, which can be understood against the background of elderly persons' retrospection and summation of life.
7.Hedelin & Strandmark (2001b) SWEDEN.	Interviews. Phenomenological method and analysis. N=16, aged 72 and 92 years.	Elderly community dwelling women.	The essence of mental health is the experience of confirmation, trust and confidence in the future, as well as zest for life, development and involvement in the relationship with oneself and others.

8.Lawrence *et al.* (2006b) UK.	Grounded theory. Interviews. Thematic, categorical analysis (described in Lawrence *et al.* (2006). N=110 (72 women, 38 men).	Elderly community dwelling persons.	The participants believed that the responsibility for coping with depression was an internal and individual task where support was secondary. The majority expressed a willingness and desire to discuss psychosocial problems. Conversing with God through prayer was seen as an effective means of overcoming depression, while a large proportion mentioned families as an important source of help.
9.Pierce *et al.* 2003 USA.	Case studies. N=8 (women).	The participants were in-patients.	When the women were depressed, they viewed aloneness as being vulnerable, fearful, helpless, as identity confusion and loss of control of self. As they progressed in their recovery, they described aloneness as being self-reliant, hopeful, resourceful as well as having self-determination and the ability to engage in self-reflection

			Establishing and clarifying the concept of aloneness and its meaning for older women during their depression and recovery is necessary for using the concept in nursing theory development and gerontological nursing practice, education and research.
10.Soonthorchaiya & Dancy (2006) USA.	Interviews. Qualitative content analysis. N=20 (10 women, l0 men). 60 years and over. Thai immigrants.	Elderly community dwelling persons.	The results revealed that coping strategies comprised practising Buddhism and acceptance. Gender differences reflected cultural expectations.
11.Switzer et al. (2009) USA.	Interviews. No analysis described. N=71 (52 women, 19 men). Mean age 76 years. 30 were Afro-	Elderly community dwelling persons.	Personal responsibility for managing depression emerged as a common approach. Elderly persons used metaphors to describe the process of moving out of depression. They viewed initiation and follow-through of this process as their personal responsibility.

	American.		
12. Ugarriza (2002)

USA. | Interviews.

Content analysis.

N=30, Mean age 85 years. | Elderly community dwelling women. | The elderly women's description of depression differed from that of the Diagnostic and Statistical Manual of Mental disorders (DSM-IV). They needed strength to change from poor to good health. |
| 13.Wittink *et al.* (2009)

USA | Grounded theory approach.

Interviews.

N=47 (79% women). Mean age 78 years. | Afro-American community dwelling. | Faith and spiritual/religious activities were considered empowering as they can work together with medical treatment to provide strength for healing. |

Table 2 Developing a new thematic synthesis from the descriptive themes

Themes;	Sub-themes	
The need for courage, strength and self-reliance	The value of faith	Distraction and activity
The meaning of responsibility		
Wearing a mask of normalcy to hide the shame	Reaching out of loneliness towards aloneness and connectivity	