

# Elderly Women's Experiences with Depression

ORIGINAL

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## Abstract

**Background:** The number of elderly in Brazil gradually increases. Among some chronic diseases that emerge with aging, depression is highlighted. In elderly women this problem is more prevalent due to factors related to the female population in this age group.

**Objective:** Comprehend the experiences of older women with depression.

**Methods:** Qualitative study, developed in four Psychosocial Care Center II, the city of Teresina, Piauí, Brazil with eight elderly women with depression. Data were collected in March and April 2015, through open interviews. Content analysis enabled the formulation of three categories. The study was approved by the Research Ethics Committee (Process nº 890 501).

**Results:** The experience of elderly woman with depression is permeated by emotional symptoms such as fear, depression, anhedonia, crying and suicidal ideas. That walk in the Depression they point to the need for aid (medical or otherwise) and coping strategies (walking and religion) to assist in overcoming this problem.

**Conclusion:** The experiences of these women contributes to the treatment, as there is wealth of information in these reports that enables the improvement of individual and humanized care.

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## Introduction

Developing countries – including Brazil, have undergone through deep changes in its age structure due to the aging of its population [1]. This phenomenon results from the reduction of infant mortality, decrea-

### Keywords

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sed fertility, in addition to technological advances in health. In Brazil, this process is configured as a predominantly urban phenomenon that reached a quota of 20.590,597 million older people, which corresponds to 10.8% of the population [2]. It is characterized as a multifactorial process with functional and anatomical changes, which generates chronic diseases as hypertension, diabetes mellitus, osteoporosis, dementia and depression [3].

The latter is considered a public health problem, with worldwide prevalence around 9.4% in the elderly living in the community and up to 42% in those institutionalized. In Brazil, epidemiological studies show that the prevalence of depressive symptoms in the elderly population in general, ranges from 19% to 34% [4].

Depression involves biological, psychological and social factors, able to cause loss of autonomy, worsening of pre-existing conditions, morbidity and consequent mortality. In the elderly, it is presented heterogeneously regarding its prevalence, etiology and treatment. It has as main risk factors: female gender, somatic diseases, functional cognitive decline and previous history of depression [5].

The onset of depression in elder women relates mainly to the fact that they live on average six years longer than men and are more likely to longevity, reduction of social perspectives, loss of spouse, retirement, the decline in health as well as the biological and functional changes of your body [6].

Considering the complexity of this problem, it is necessary the use of lightweight technologies such as therapeutic listening, because it allows the externalization of dormant feelings that reveal the life story of these women after the clinical diagnosis of the disease [7-8]. In this context, this study aims to understand the experiences of elder women with depression.

## Methodology

Qualitative study was carried out in four of Psychosocial Care Centers II (CAPS II) from the city of Teresina, Piauí, Brazil. It is noteworthy that the initial approach of the researchers with the scenario of the study took place in practical classes of Nursing undergraduate, which made possible the exchange of information between interviewer and interviewed.

Initially, in CAPS II was collected the number of elder women in treatment for depression. This information was obtained following the request for patient registration list, accounting 16 elderly women with depression.

The sample was intentional and used as criteria of inclusion / exclusion application of the Mini Mental State Examination (MMSE), because this tool has been used in research into the elderly in order to detect dementia, as well to assess the progression of disorders that can influence cognition and language [9], that could compromise the reliability of the data produced by interview. Thus, women, elderly and with literacy who obtained result MMSE less than 23 points were included in the study. Women, elderly and illiterate, who achieved coefficient less than 18 points were also included [10].

Eight women were excluded considering the following reasons: two were part of the pretest, two obtained MMSE results below the required score, two refused to participate, one was in treatment in private psychiatric clinic and was in the Therapeutic Residence, but at the time of data collection did not attend the service in the reference CAPS. Therefore, eight elderly women took part in the study.

The production data was conducted from March to April 2015, through open interviews, guided by the question: how is it for you to live with depression? Interviews were conducted in nursing offices, only with the participation of an interviewer, as to favor the privacy, confidentiality and expression of subjectivity of the interviewed. In order to preserve the anonymity of the participants involved in the

study it was used to identify the letter "E" and the number of interview order (E1, E2, E3 [...]).

It is noteworthy that occurred saturation information from the interviews. These lasted about 40 minutes and there was no need for repetition. For the record of these interviews was used a Mp3set, to reliably reproduce the answers provided by the participants, for later transcription and analysis of data.

After transcribing the interviews, were returned / read for the interviewed women for corrections or comments. Data analysis was conducted by content analysis [11], which enabled the extraction of converging cores and the formulation of categories.

The participants received detailed guidance on the study and signed in the Term of Consent (TC), taking into account the guiding principles of ethical research involving human subjects, arranged in Resolution No. 466/12 of the National Health Council. The study was submitted to Ethics in Research Committee (CEP) of the Federal University of Piauí (Opinion No. 890 501).

## Results and discussion

To understand the experiences of elder women with depression, there were successive readings of the material produced, emerging three categories that allow to understand them in their most subjective sense.

The eight elderly women had aged 61-70 years, most came from the interior of the State of Piauí, brown, married and with children.

### Emotional aspects experienced by elder women with depression

The depression is one of the most common types of mood disorders, well described in the scientific literature and prevalent in elderly women. From the women's testimony it is understood that their experience is permeated by the presence of emotional changes.

*[...] One day my boy arrives and I haven't done anything, I have no energy to do anything, if I could, I'd just be laid down, but then who has to do things is me.*

E1.

*I was always afraid, I think because of the disease. [...] But I have these problems with depression, I'm afraid to walk alone.*

E2.

*[...] I wonder bullshit. I've thought about to commit suicide. But only now I put it out of mind.*

E5.

*[...] There are days that I feel very sad, do not stand for anything, I'm exhausted and I was not like this, I've thought several times to die.*

E8.

It is observed that depression is a complex syndrome that affects the emotional and causes difficulty in performing activities of daily life, but also affects the social life of the participating elderly women, either by sadness, sometimes accompanied by suicidal ideas, difficulty in controlling crying or afraid to move alone.

The experience of these women corroborates with the literature, since the aging process brings about physiological changes that, in association with depression, end up generating processes related to reduced self-esteem, low astral times, moodiness, fear, insecurity, loneliness and, in particular, social isolation [12].

Associated with age, there is also the stigma of uselessness and, related to the development of depression, reduced willingness to perform home and work activities become even more evident.

With regard to unwillingness to perform daily activities, a study conducted in Rio Grande do Sul, found that the reduction of the provision corresponds to depressive symptom most often cited by elder respondents and, related to it, was also found

a lack of courage and deep sense of anguish. It is also observed in this research, the insidious decrease of pleasure and interest in performing their daily functions as an important marker of depression in this population [13].

In the women's speech was also found that the reduction of the provision leads to changes in the way they see themselves, and greatly contribute to the presence of thoughts of death, sometimes seen as a way to stop the suffering. The desire for death is strongly linked to the presence of psychiatric disorders, particularly, depression. It is believed, therefore, that this condition corresponds to a risk for suicide, as it is strongly associated with a state of great mental suffering [14-15].

Suicidal ideas are intertwined to the life of elder women with depressive symptoms because historically women has been educated under rules that deny their own needs at the expense of caring for others. Women see themselves, at this point, as renegade in the face of unwillingness to play this role [16].

### Treatments used by elder women with depression

The experience of elderly woman with depression is permeated by a variety of treatments, whether medical or otherwise, that contribute to the total or partial remission of symptoms and redirect the dealing with the disease.

With regard to used treatments, drug indication is justified to be used for the correction of chemical imbalances caused by the disease [17]. There is evidence that the use of psychotherapy is complementary to drug treatment, especially among the elderly [18]. But the drugs administration still dominates.

*I get all the time at the doctor, direct, it's been already eight years that I live taking medicine [...] If you see how much medicine I received at that moment! Every time I see this pile of medicine, it gives me a discouragement.*

E1.

*I'm controlling with medication. I have to take for now. [...] This doctor who is treating me now, she's newcomer, is making an appointment every month, because she's still not safe to give me two recipes, want to see me every month.*

E3.

The experience of elder women with depression involves adherence to drug treatment and regular visits to the medical professional. However, the treatment of this problem must include all levels of complexity, requiring not only pharmacotherapy, but the use of other strategies that might have affected the quality of life of these women.

There is, in the statements, nuisance arising from the use of large amounts of medication for a long period of time. Allusive to this, the literature indicates that the time and complexity of treatment may interfere in the values attributed to the disease and are able to develop negative feelings about the therapeutic project [19-20].

The mental health care with the implementation of CAPS and this new perspective provided by Individual Therapeutic Project (PTS), has evolved and provides comprehensive patient care in order to contribute to the improvement of life quality, through the articulation of all the care production ways, establishing a trust field, credibility and, especially, valuing the experience of patients [21].

PTS corresponds to a care model built from the health needs of each patient, with the participation of professional, family and especially the client, with the purpose of promoting mental health [22]. However, the use of traditional clinic is still rooted in the Brazilian health system, which disrupts the applicability of this new model, so that the professionals still work in view of the excessive medicalization and low user autonomy [23].

The importance of this diversification of treatments developed in the CAPS is evident in the life of elder women with depression and is expressed in the speech of E5:

*[...] I take the medication. I ended up going to the CAPS three times a week, Monday, Tuesday and Wednesday. Distract my mind, because I watch the group, do physical therapy, then I watch the relaxation.*

E5.

In the speech above, it is observed that the participation of the elderly in CAPS, in groups, in physical therapy, as well as relaxation allows a better way to deal with the depression, as the activities that are developed in this environment of which they presented as a source of welfare and distraction.

The diversification of therapeutic programs is essential to support patients as they allow meeting clients in psychological distress and their integration, promotes exchange of experiences, learning activities such as knitting, crocheting and painting, so that they can rediscover their production capacity [24].

CAPS is more than a simple alternative to hospital model, being considered as a new possibility of life. In research conducted with professionals, family members and users of this type of service, in Rio de Janeiro, there were benefits such as the reduction of hospitalizations due to treatment combinations performed in this environment [25].

Similar speeches to the interviewed were identified in a survey of CAPS users of Ubá, in Minas Gerais, where it was shown that this social space allowed a change in their lives, so that the service has expanded the possibilities for patients, especially those with depression, to relief their suffering [26].

### **Fighting strategies used by older women against depression**

Depression causes changes in the lifestyle of those who experience it. Activities undertaken before become devalue, reducing happiness in doing them. However, some patients seek for fighting strategies, in order to minimize the impact on their daily activities.

These strategies also called coping, are characterized as cognitive and behavioral actions to deal with internal and external changes, and are subdivided into two types: the first concerns the confrontation based on the problem, which focuses on the action of the individual to modify the environment and reduce stress. The second relates to the emotion-based fighting, whose objective is the individual's own modification, by regulating your emotional distress [27].

*[...] I cling to my saints, pray, I begin to pray, pray.*

E1.

*I started to walk in the morning, the day I walk I get up five hours because the avenue here is beautiful, then I get, I get well, cheerful.*

E4.

*I do my things from home, I walk. This leaves my mind occupied.*

E7.

Tackling depression by elderly woman is driven in a particular way by each of them. The coping of experiences include: walking and praying. There is a predominance of emotion-based fighting, where modulation of their objective attitudes, basically reducing the influence of bad emotions triggered by depression, helping the well-being and quality of their lives.

Physical exercise as a strategy to deal with depression is identified as a factor that contributes positively in the health of these women. These benefits, in the elderly, are mainly related to the promotion of functional capacity and performance to perform the activities of daily life, but also helps to reduce joint pain, to increase strength and flexibility, and allow increased confidence, self-esteem and relief of depressive symptoms [27-28].

In a survey involving elderly participants of a group focused on the physical activities in the state of Maranhão, it was identified that the regular prac-

tice of walking results in improved mental health and social life, interfering in the mood, the feeling of success and the social relations, since this activity, especially in groups, enables the rehabilitation of these individuals, reducing the isolation – so common in people with depression [29].

Religiosity is configured as a fighting strategy used. Prayers made in times of crisis contributes to the pursuit of balance as well as assistance to cope with adverse situations that people are experiencing.

Religion and spirituality are associated with better quality of life. There is a strong relation between religious involvement and mental health, especially for people living with depression. This fact is justified by religion bring new meanings to psychological distress [30].

In a study developed with the elderly form countryside of Minas Gerais, it was found that they consider religion as a very important aspect in their lives. Therefore, this group religiosity remained associated with well-being indicators, satisfaction and positive affect [31].

The walking exercise and religiosity configured as fighting strategies designed as part of the troubleshooting process which, in the case of elder, corresponds to the depression, so that these activities contribute to the reduction of loneliness, the sense of isolation and the rumination of problems by the depressed individual, and allow it to deal better with the experience that you are going through [32].

The experiences of older women with depression are permeated by emotions from diagnosis to his face. Although the knowledge produced is relevant to the care of women, this study has limitations: the very bias of qualitative research and the small sample size.

As qualitative research seek to develop concepts and insights from participants feel or live, you can not measure the phenomenon, either generalize the results, since this approach works with the subjectivities of the investigation [33]. But highlights that

were addressed all older women with depression linked to the institution, the period of data collection.

## Conclusion

It was observed that there have been reports that complement each other, but there is uniqueness in each. The participants of this research experience major emotional implications that depression can cause, such as fear, depression, anhedonia, crying and suicidal ideas.

The experience of them is also marked by the treatments that are submitted, highlighted the drug one. However, it is clear that new opportunities have emerged with the implementation of the unique therapeutic project, since this technology enables the expansion in observing the patient in suffering, considering its multidimensionality.

The experience of these women includes adherence to fighting strategies, such as the practice of physical and religious activities. Listening to these experiences by health professionals, especially nurses, helps to treat them, as the wealth of information in these reports enables the improvement of individual and humanized care, in order to recover their health and improve the quality of life.

Although the knowledge produced is relevant to the care of women, the study has a limitation: reduced sample. However, it is emphasized that were addressed all elder women with depression linked to the institution, in the period of data collection.

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