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How Older Adults Combine Medical and Experiential Notions of Depression

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Abstract

Past research has suggested that patients might not accept depression treatment in part because of differences between patient and doctor understandings of depression. In this article, we use a cultural models approach to explore how older adults incorporate clinical and experiential knowledge into their model of depression. We conducted semistructured interviews about depression with 19 patients aged 65 years and older who were identified by their physicians as depressed. We found that whereas older adults viewed as helpful the doctor's ability to identify symptoms and "put it all together" into a diagnosis, they felt that this viewpoint omitted important information about the etiology and feeling of depression grounded in embodied experience and social context. Our findings suggest that more emphasis on issues related to the etiology of depression, the effect of depression on social relationships, and emotions emanating from depression might lead to more acceptable depression treatments for older adults.

Keywords

depression; health concepts; older people; primary health care; qualitative methods; general

Depression is an important public health problem among older adults in the United States. Up to 14% of patients in primary care settings meet criteria for major depression (Leon et al., 1995), whereas estimates of the prevalence of depressive symptoms not meeting criteria range as high as 4 times that of major depression (Gallo & Lebowitz, 1999). Persons with depressive symptoms that do not meet standard criteria for major depression have significant disability and poor quality of life (Bruce, Seeman, Merrill, & Blazer, 1994; Wells et al., 1989) and are at increased risk for major depression (Horwath, Johnson, Klerman, & Weissman, 1992), and

although rates of major depression decline with advancing age, rates of depressive symptoms and suicide increase (Gallo & Lebowitz, 1999).

Because depressive symptoms not meeting criteria for major depression are common among older persons with coexisting medical conditions such as diabetes, cardiovascular disease, and cancer (Stockton, Gonzales, Stern, & Epstein, 2004; Zung, Broadhead, & Roth, 1993), it is understandable that older persons with depressive symptoms are more likely to seek care from a primary care provider than from a specialist in mental health (Gallo, Marino, Ford, & Anthony, 1995; Pincus, Davis, & McQueen, 1999). Because of factors related to the expression of depression in late life (Gallo, Anthony, & Muthén, 1994) or to physician skill and interest in mental health (Main, Lutz, Barrett, Matthew, & Miller, 1993), depression among older adults is often unrecognized, undertreated, or untreated (U.S. Department of Health and Human Services, 1999). Primary care physicians feel that barriers to depression treatment are most often patient centered and related to patient attitudes and beliefs about depression (Nutting et al., 2002). Older persons in primary care might not accept the diagnosis or treatment of depression that is offered, in part due to ways of understanding illness that do not align with the kinds of treatments most commonly offered by primary care physicians (Kleinman, 1988).

Previous studies have found that psychiatric symptoms are often conceptualized by patients as problems in living rather than medical conditions and suggest that older adults might believe that physical symptoms are necessary for a visit to a physician (American Attitudes About Clinical Depression and Its Treatment, 1996; Lawrence et al., 2006). Older adults might see depressed feelings as requiring personal responsibility for management, rather than treatment from a physician (Switzer, Wittink, Karsch, & Barg, 2006). Others have suggested that older adults (in contrast to younger adults) might feel less familiar with psychological terms and thus feel uncomfortable describing emotional symptoms to professionals (Murray et al., 2006). Murray and colleagues (2006) found that primary care professionals in South London said older patients rarely mentioned low mood or psychological symptoms, in contrast to younger patients who were well versed in the “language of stress.”

In this article, we describe how notions of depression held by older adults might articulate with, challenge, or incorporate “medical” definitions of depression. Our clinical interest in how patients experience and evaluate clinical interactions around depression identification and treatment led us to ask participants what they thought doctors meant when they use the word *depressed* and how their experiences and understandings compared to this medical definition. Unlike past studies that have separately interviewed doctors and patients to contrast their notions of depression, in this study we gained insight into the ways older patients hear and evaluate the messages they receive from physicians. Our methodology builds on the work of others who have illustrated the fallacy of a lay/expert knowledge dichotomy and indicated that individuals use knowledge or information in flexible ways that depend on factors such as social interaction, context, and perceived legitimacy of knowledge (Barth, 2002; Lambek, 1993; Longino, 2002). Our results challenge the conception that lay or folk accounts of medical phenomena are necessarily antagonistic to clinical accounts of the same.

Conceptual Guideposts

Key to improving depression recognition and treatment in older adults is a better understanding of how older adults conceive of, define, and experience depression. In other words, how do older adults incorporate various ideas about depression into their overall experiences and understandings of depressed states? Our practical goal is to shed light on how older adults understand the term *depression* so that clinical interventions might be adapted to improve acceptance and engagement with treatment. We draw on insights from cultural models theory

(Garro, 2000) and embodiment theory (Csordas, 1994; Scheper-Hughes & Lock, 1987) to develop a framework for understanding how older adults combine clinical notions of depression with personal experience.

A cultural model of illness is derived from mental associations called schemas among sets of information formed from individual experience and extrapersonal cues (D'Andrade & Strauss, 1992). As such, a cultural model can incorporate knowledge from a myriad of sources: medical messages, media, implicit social messages, and individual experiences. A schema is a conceptual structure that specifies "default" relationships between concepts in a domain (D'Andrade & Strauss, 1992). Central to the theory of schemas is their motivational properties. The idea of culture as the motivational force behind human action—the intermediary between meaning and human behavior—has been useful to understand help-seeking behavior for diabetes (Chowdhury, Helman, & Greenhal, 2000; Garro, 2000; Loewe & Freeman, 2000), AIDS (Baer et al., 1999), breast cancer (Coreil, Wilke, & Pintado, 2004), and cervical cancer (Chavez, Hubbell, McMullin, Martinez, & Mishra, 1995). Researchers refer to this motivational force as valence or salience; that is, what motivates a person to act in a certain way (for example, to seek depression treatment from a health care provider). Schemas are thus tools that allow researchers to map and theorize the strength and frequency of mental pathways that influence individuals' decision making and behavior. When processing new information or in making decisions, individuals actively construct knowledge along the lines of schemas informed by past experience rather than passive recall of isolated bits of information (D'Andrade & Strauss, 1992).

Because culture is shared and socially transmitted (D'Andrade, 1995), people with similar life experiences or exposure to similar social contexts are likely to have some degree of overlap among their schemas for a given domain. Along with other cognitive anthropologists (D'Andrade & Strauss, 1992; Quinn & Strauss, 1989), we are terming this overlap across individuals' schemas a cultural model. Recurring themes, metaphors, and constructs used by members of a group can be signposts for the kinds of ideas they share (Quinn, 2006). To define a cultural cohort with regard to depression, we focus here on a particular group of older adults: those who have been identified by their physicians as being depressed. We follow previous researchers in viewing our sample of older adults as constituting a cultural group with ideas about depression and its treatment that are shared and socially transmitted (Ayalong, 2004).

Study Aims

Our aim in this article was to identify commonly held beliefs and perceptions about depression among older adults and ways that they perceived their ideas about depression to differ from those held by doctors. We aimed to understand the emic, or insider, perspective on depression so that interventions directed toward older adults are congruent with their beliefs and experiences of depression. In this article, we explore how older primary care patients define depression and how they perceive their ideas about depression to differ or relate to those held by doctors. By understanding the emic perspective on depression, we can prepare to develop interventions directed toward older adults that are congruent with their understandings and experiences of depression.

Method

Study Overview

Data for this article come from a larger study, the Spectrum study, whose goal was to characterize the range of depression in older primary care patients. The study included two phases. The quantitative phase, Spectrum I, was designed to describe depression in late life that might not meet standard criteria for major depression by using standard survey measures

(Barg et al., 2006; Bogner et al., 2004; Gallo, Bogner, Straton, et al., 2005). In Spectrum I, we recruited patients aged 65 and older from primary care practices in Baltimore, Maryland ($n = 355$; sample described in detail in Bogner et al., 2004; Gallo, Bogner, Straton, et al., 2005). At the index visit, the physician rated the patient's level of depression on a 4-point Likert-type scale (*none, mild, moderate, and severe*; Bogner, Ford, & Gallo, 2006; Gallo, Bogner, Morales, & Ford, 2005).

The qualitative phase, Spectrum II, was designed to give participants an opportunity to express their views about depression and to integrate participants' views with the structured responses they gave to the fixed-answer questions in Spectrum I (Barg et al., 2006). Participants for Spectrum II were identified from the pool of older adults who participated in Spectrum I and who agreed to be contacted and interviewed again. Permission to re-contact and interview Spectrum I participants was granted by the University of Pennsylvania Institutional Review Board. A Certificate of Confidentiality was obtained from the Department of Health and Human Services as an additional confidentiality safeguard. In all, 102 persons from the Spectrum I study participated in individual semistructured interviews in Spectrum II. Of these 102 participants, physicians identified 29 as having mild depression, 19 as having moderate depression, and none as having severe depression.

Study Sample

To study a group of older adults likely to have had experience with discussing depression in the medical setting, in this article we focused on the 19 participants in the Spectrum II interviews who were identified as moderately depressed by their physicians. We reasoned that patients recognized as moderately depressed by their doctor, in contrast to patients identified as not depressed or mildly depressed, would be more likely to have experience with medically recognized depressive symptoms and to have encountered clinical ideas about depression through discussion with their physicians (see sample characteristics in results).

Interview Procedures

During Spectrum I, we assessed age, gender, ethnicity, and level of educational attainment (Gallo, Bogner, Straton, et al., 2005). To measure depressive symptoms, we used the Centers for Epidemiologic Studies Depression (CES-D) scale (Comstock & Helsing, 1976; Radloff, 1977). Participants were asked if they had ever had counseling or taken medication for depression. Participants were classified as currently taking an antidepressant if an antidepressant medication was among their medications recorded by interviewers.

Spectrum II consisted of semistructured interviews (interview guide available upon request¹). Interviews began with vignettes designed to elicit older adults' views on depression without using the word *depression* (for example, in one vignette "depression" is glossed as "the blues" or "being down"). After the vignettes, respondents were asked a series of open-ended questions, including, "What do you think doctors mean when they use the word 'depressed'?" "When you use the word 'depressed,' do you use it with the same meaning?"; and "Have you ever thought of yourself as someone who is depressed?" as well as questions about what causes depression, what depression is like, and what to do about depression. Interviewers were trained to probe into related topics raised by respondents. All interviews were conducted in the respondents' homes by one of four professional interviewers who were trained and supervised by project investigators. Interviews were digitally recorded and transcribed with identifying information such as the names of individuals or places removed during the transcription process.

Analytic Strategy

Analysis for this article occurred in two phases. All analysis of transcripts employed the constant comparative method, moving iteratively between codes and text to derive themes (Glaser & Strauss, 1967; Malterud, 2001; Wittink, Barg, & Gallo, 2006). Originally developed for use in the grounded theory methodology of Glaser and Strauss (1967), this strategy involves taking one piece of data (e.g., one theme) and comparing it with all others that might be similar or different to develop conceptualizations of the possible relations between various pieces of data. For the first phase of coding, a multidisciplinary team discussed and created broad codes for each transcript in weekly team meetings (details are provided elsewhere [see Barg et al., 2006]). During broad coding, team members identified four main topics within the transcripts: (a) What is the cause of depression? (b) What is it like to be depressed? (c) What should you do for depression? and (d) How will the depression turn out? To assess reliability of the team coding, an independent reviewer broadly coded 10 randomly selected transcripts. This assessment of intercoder reliability showed that 90% of the time the study team and the independent reviewer agreed upon codes assigned to the text. In other words, the team coding was unlikely to miss material elsewhere in the transcripts that was relevant to the broad codes.

For this article, we began with the aim of exploring how older adults understood depression and, therefore, focused our attention on sections broadly coded under “What is it like to be depressed?” After an initial reading of these sections, we realized that participants used the word *depression* in a variety of ways. Therefore, three of the authors (MW, BD, and CB) looked for contrasts older adults made between types of depression. Through team meetings and discussion, we found that the primary contrast emerging (and underlying the specific contrasts we had coded) was between a clinical and lay notion of depression. We therefore returned to the original transcripts to locate responses to the questions, “What do you think doctors mean when they use the word ‘depressed’?” and “When you use the word ‘depressed,’ do you use it with the same meaning?” and added these sections to our analysis when they were not already included in the “what is depression like” broad coding. We reread these sections paying special attention to how participants (a) described what doctors mean by depression, (b) described what they (the participants) mean, and (c) characterized the relationship between their doctor’s and their own notion of depression. For this detailed analysis we looked at themes across cases (characterizing participants’ view of doctors’ definitions, their own, and differences) and also looked within cases to explore how individuals related clinical and personal definitions of depression.

Results

Sample Characteristics

Of 19 participants whose physicians thought they were moderately depressed, 13 (68%) were women, 6 (32%) self-identified as African American, and 6 (32%) reported having attained less than a high school education. The mean age of the sample was 78.2 years (standard deviation = 6.7). The mean CES-D score was 22.4 (standard deviation = 14.5), indicating a significant degree of depressive symptoms. Seventeen participants (89%) reported having ever been prescribed and taken antidepressant medication, 9 (60%) reported ever receiving counseling for depression, and 15 (79%) reported currently taking an antidepressant.

Medical Definitions and Patient Experiences

Though participants were familiar with the term *depression*, they often made distinctions among types of depression, or indicated that the term failed to encompass the full complexity of their own experiences. For example, some participants indicated distinctions by using alternate terms such as *the blues* or *clinical depression*. In other cases, respondents suggested

subtle differences in how they and their physicians used the single word. One respondent summarized what he perceived to be the difficulty of a multiply nuanced term *depression*:

I'll say "clinically depressed" as the disease and I say people are "depressed" when they have the blues. So yeah, that's part of the problem with the language, I think, is the—that depression means different things to different people. It makes for confusion.

The principal contrast that emerged was between a medical definition of depression used by doctors and individuals' understandings and experiences with depression.

What Older Adults Think Doctors Mean by the Word *Depression*

Many of the older persons we interviewed felt that physicians hold a different definition of depression as compared with nonphysicians. For example, when asked what she thought doctors mean when they use the word *depression*, one woman responded,

It's not the same meaning that the person might think when they say "depressed." They [doctors] mean they are down, they are sad, they are low, they don't want to be bothered, they don't want to eat, don't have to eat. They don't want to be around people really, like I said, not happy.

Older adults said doctors defined depression using an authoritative list of symptoms that could be observed or elicited. Participants might have encountered the diagnostic signs that doctors use, either from direct experience or something they had learned from how depression in the medical realm is discussed elsewhere:

I guess doctors mean you've lost interest in practically everything—you don't feel like eating, your sex life, you know that's gone. You don't want to mingle with people, you're withdrawn, you want to stay in the corner something to yourself.

Most of the older adults referred to doctors generally, though some made explicit reference to psychiatrists: "If you say 'depression' to a psychiatrist they immediately know symptoms, it evokes in them a whole array of symptoms and they know what it is, they know it's not just the blues." Participants talked about this collection of symptoms doctors used to define depression as existing in the abstract—the symptom list existed as a general rule across people and did not necessarily match any one individual's exact symptoms of depression: "Lack of interest, loss of appetite. Now in my case, loss of appetite is not one but generally speaking I would say that it could be."

Participants described this symptom list as known and applied by doctors alone. Many participants described an opaque process by which physicians were able to infer or identify depression—to *see* depression—that was invisible to the patient. Some respondents gave a lot of credence to doctors' expertise in recognizing a set of seemingly unrelated outward signs and "putting them all together" to diagnose depression. When asked what was wrong with a person described in a scenario, one respondent said,

I don't know, I'm not a doctor. It could be any number of things. I haven't had much experience with that so I'm not really sure. I'm not a doctor.

In stories about their own experiences with depression, several respondents said that they did not realize they were suffering from depression until the doctor diagnosed their problem as depression: "Yeah, because I didn't know what it was until I went to the doctor." Others suggested that although they knew that something was "off," the doctor's diagnosis helped them to understand what this feeling they were having really was: "I guess when I was going through this depression ... I didn't know what the trouble really was ... but I wasn't myself." For these participants, doctors had an almost magical ability to diagnose; participants implied

that doctors had access to special knowledge that was inaccessible to and not fully understood by their patients. Participants who discussed having experience with mental health professionals, in particular, emphasized the importance of the physician's role in determining depression: "So I found out, I mean, I figured he [the doctor] put it all together and called it depression." Similarly, another respondent said,

Well I think before the doctor would use the word depressed he would talk to the patient and pick up on things that he or she tells the doctor that indicate depression to a professional like a doctor. It could be so many of the things—lack of interest, loss of appetite, a feeling of unhappiness—very many things and then the doctor would try to put it all together and come up with some help.

Although many participants described this as a sort of three-step process—identify symptoms, put them together into a diagnosis, provide a treatment—for some participants any aspect could be the defining feature of what the doctor meant. For instance, when the doctor uses the word *depression*, they mean "they need Prozac," said one woman. Notably, the links among symptoms, diagnosis, and treatment were justified by the doctor's authority, that is, by being defined as leading to one another. Patients did not describe explanations linking these pieces, only that they co-occurred in what the doctor knew and did.

What Older Adults Say Depression Means to Them

Participants suggested that knowledge about symptoms, diagnosis, and clinical treatment were primarily the purview of doctors, but almost all participants added that the outward signs used in diagnosis were not enough to define depression. Patients were experts on their own experiences of what depression feels like, and these experiences generated a separate set of ideas about depression. One woman who said doctors think of a "list of symptoms" when they mean depression, herself described a depressed person in the following way:

Alone—even though they might have a big family they still could be lonely for something. Lack of attention or lack of love from them would depress them, unhappy, feeling that they're not a part of whatever is going on in their families. You know it might be where a mother had more siblings and they think that the mother cares more for one than me.

The respondent provides a personal and contextual account of the etiology of depression from the hypothetical depressed person's unique point of view. Words like *lonely*, *unhappy*, and *lack of attention/love* illustrate a fundamental anchoring of depression to social relations (or lack of them) and personal feelings and can be contrasted with a series of outward context-free physical symptoms to be "read" or seen by doctors.

When the above respondent was asked to describe what a hypothetical depressed person might be like, the account is colored by her personal experiences and social relationships in a way that the abstracted list of physical symptoms alone are not. Similarly, another respondent made the distinction between outward signs and internal experiences by saying that doctors are likely to define depression as "not functioning like you should," whereas for her, depression is associated with a feeling of being "very sad." Internal feeling was an important aspect of the meaning of depression for these older adults. In the following quote, the term *unloved* suggests an unexplored reason for why a depressed person might exhibit certain outward signs:

Well, I feel as though when you depressed most people that are depressed really they feel unloved—that's the main thing or they feel unwanted or they feel as though that they useless and like "well I can't—I'm no more use to you any more so you just let me go."

Indeed, the need to describe an underlying cause of depressed signs or symptoms was a common thread among these older adults. For some, grief or bereavement triggering depressive symptoms was an important component of depressive experiences that older adults felt was overlooked by clinical definitions of depression: “No, [I use the term depression in a different way]. I mean if there’s been a death in the family and you feel depressed then afterwards.”

The respondents often had clear ideas about causes of depression that they felt were omitted by the doctor’s definition of depression:

Well, I use [the word *depression*] the same way [as my doctor], but I don’t know how you make that [diagnosis] but I know how I got it, you know? Being depressed is problems. I think about something that stays with me a long time and I can’t get rid of it....

Whereas this man describes being unsure of how someone can be identified or diagnosed as depressed, his experience makes it clear to him the causes of his depression: problems in life that he continues to think about. Another man described visiting the doctor when he was upset:

Well, I went to him that morning because I was nervous and you feel—you feel bad. Well, you can’t write that—you’re bad. You don’t feel good ... you don’t feel good, that’s the general thing because a lot of things be happening when—you know? Then when you get them all together, then you say depression.

This respondent sees depression as a diagnosis provided by the doctor, offering a clinical mode of categorizing a particular genre of suffering; however, the term might elide the complex of experiences, events, or feelings that combine to make a person feel “bad.”

Accommodating Clinical and Experiential Components of the Cultural Model

Whereas most participants talked about their doctor (or doctors) abstractly having the authority to define the symptoms constituting depression and to pronounce someone as “depressed,” respondents felt that this notion of depression was incomplete. They added to their doctors’ indices for depression by drawing on stories and terms that were more experiential, personal, and social in nature. Just as the “putting it all together” and treatment aspects of the perceived clinical modus operandi were identified as belonging solely to the doctors in medical context, older adults maintained other ideas about depression that belonged to them (what they said *they* meant by depression), and these were substantiated and rooted in very different sources of knowledge. Whereas the validity of the clinical definition for depression appears to lie in the authority attributed to doctors and the clinical context, the older adults’ notions of depression gained salience because they were based in experience and social knowledge.

Discussion

Our results make it clear that to grasp how older adults in this sample define or conceptualize depression, we must examine how they discuss and assess knowledge drawn from multiple sources—namely, the clinical encounter and life experience. Whereas older adults felt that doctors value “seeing” as a primary and conclusive mode of diagnosing depression and use lists of symptoms to authoritatively name someone as “depressed,” they also suggested that their own “feeling” is an important mode of knowing, that life events and relationships contribute to depression’s etiology, and that there are multiple ways of “being depressed.”

Before discussing our results further, we would like to review limitations. First, participants were recruited from primary care practices and thus might have been more inclined to think of depression in medical terms. On the other hand, participants were interviewed in their homes by nonmedical personnel who were trained to investigate the participants’ perceptions by encouraging personal narratives and probing into topics important to the participants. Second,

we did not follow up our open-ended questions with survey questions, which could be used to assess the degree to which patients feel they agree or disagree with their understandings of how doctors define depression. Nevertheless, this study provided us with unique insights into the multiplicity of concepts referenced by the word *depressed*, unavailable through survey measures. Finally, we recognize that by only focusing on participants who were identified by their physicians as having moderate depression, we might have a limited view of the heterogeneity of older adults' beliefs about depression and how they might differ from their perceptions of how physicians view depression. It is plausible that older persons whose physicians feel they have either mild or no depression might have very different ways of contrasting their views on depression with their physician's as compared to older persons who might have discussed depression with their physician. Physicians might be less likely to diagnose depression in older adults who have different cultural models of depression than their physicians. However, even among those who are recognized as depressed, few engage in or continue with treatment. Previous studies have suggested that elements of cultural models of depression might be associated with current and past treatment seeking, medication adherence, and coping strategies (Brown et al., 2001). By focusing on how the experience of depression differs from the medical concept of depression among individuals recognized as depressed, we hope to shed some light on potential reasons for this apparent lack of engagement or adherence to medical treatments for depression among older adults.

Based on the fundamental assumption that cultural models affect and motivate the behavior of individuals and groups (D'Andrade & Strauss, 1992; Holland & Quinn, 1987), we found it useful to describe a cultural model of depression among this group of older adults. The utility of a cultural models framework to this study lies in its emphasis on the way that individuals incorporate new or seemingly incommensurate kinds of knowledge into their view of depression. Traditional framings of noncompliant or nonadhering patients often suggest that the patient is ignorant of or antagonistic to clinical definitions of depression and clinically sanctioned treatments for the condition. However, in piecing together older adults' ideas about depression, we note that instead of rejecting medical knowledge wholesale, these individuals complemented it with their own knowledge and fit it into their way of knowing about depression. Rather than being passive or static entities on which clinicians of biomedicine write their diagnoses, the elderly adults at once absorb and modify (or make relevant) the discourses and diagnoses of biomedicine. These discourses and diagnoses are filtered through a sensate and dynamic embodied self (Csordas, 1994; Lyon & Barbalet, 1995).

By shedding light on how older adults view their own illness experiences or engage with depression, we challenge the medicalization of depression and the privileging of seeing over feeling, or sensation over emotion. The notion or entity of depression only exists at the crossroads of life experience and medical diagnosis; depression is always felt and filtered through a lively, unique, and constantly changing body but identified and labeled as depression through a list of abstract symptoms and a clinically validated diagnostic process. The individual schemas of depression among the older adults in our sample have a number of common elements and often incorporate clinical, biomedical notions of depression. In short, older adults added the clinical definition of depression into their own individual experiences of depression located in an embodied self and its everyday context.

The cultural models informing behavior, social relations, and decision making are substantiated by a myriad of sources, including both "expert validation and cultural authority" as well as experiential evidence (Holland & Quinn, 1987). Whereas older adults might take their doctor's notion of the definition of depression seriously, they also draw from their own experiences to construct a cultural model for depression that might have important implications for treatment-seeking behavior or compliance. People might even hold multiple components or explanations that might appear contradictory, merging multiple theories or applying one theory to account

for one practice and another theory for another practice (Holland & Quinn, 1987; Kempton, 1987). Our findings support the suggestion of Darghouth and colleagues that people are particularly likely to maintain multiple explanations and beliefs if no single model fully accounts for the entire experience (Darghouth, Pedersen, Bibeau, & Rousseau, 2006).

We suggest that when the clinical definition excludes important aspects of experience or does not successfully or fully solve the problem, older adults draw from other knowledge bases to try to understand, ascribe meaning to, describe, cope with, and address their distress. Although participants view the doctor's and their own definitions as both explaining one thing (depression), it appeared that different aspects of what depression is were explained by different sources. Specifically, whereas participants often indicated that doctors have authority in knowing about the observable symptoms and suitable medical treatments of depression, broader experiential and cultural wisdom held authority when it came to the causes (linked to sociocultural context), experience, and meaning (individual, moral, social) of depression. When older adults make decisions about what to do when they feel sad, or whether to take medicine for depression, each of these elements constituting an individual's schema of depression has the potential to be activated and inform behavior.

The valence or salience of the connections or activation pathways will depend on context, among other things. Because of the social establishment of physicians' dominance in the clinical context, clinician models are likely to hold sway at the time point when depression is diagnosed and labeled. However, once the patient leaves the doctor's office, he or she once again becomes a person in a broader social context, where multiple other nonclinician models might circulate and be incorporated to varying degrees. In other words, whereas clinical diagnosis might be particularly critical when someone first consults a physician earlier in the help-seeking process, at the time of treatment decision making, the experiential component might be more salient to older adults. Having the physician put the symptoms together to name a diagnosis of depression and perhaps even having an effective treatment is not the whole story for these older adults. Putting emphasis on their experiences and how depression is individually embodied is what makes the diagnosis of depression and any potential suggestions for treatment salient or relevant to any one individual.

Conclusion

Our findings have several implications for further investigation. If a treatment only addresses symptoms of depression without addressing notions about the etiology of depression held by an older adult, the treatment might be rejected, even though the diagnosis of depression is accepted. Similarly, if older adults notice that clinicians are not focused on the social experiences of having depression, they might be less inclined to discuss symptoms that might be the source of significant distress. Based on their work looking at cultural models of depression among ethnically diverse groups of older adults, Lawrence et al. (2006) have suggested that physicians would be more likely to engage their older patients in a discussion about depression if they were to take into account social causes and consequences of depression. As Paul McHugh (2005) has noted, the field of psychiatry has used a system of classification that is appearance driven and aids in identification but in contrast to most of medicine does not take etiology into account when defining a disorder. To make depression treatments more acceptable to older adults in primary care, it might be critical to explicitly incorporate older adults' understandings of what causes depression and address the cause along with the symptoms.

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