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"Pull Yourself Up by Your Bootstraps": A Response to Depression in Older Adults

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Abstract

Although depression is one of the most common problems among adults in primary care settings, many do not seek or adhere to the treatment regimens suggested by their providers. Understanding the cultural model surrounding depression and its treatment in older adults might provide insight into the development of more effective strategies for addressing the problem in the clinical setting. In this study, the authors conducted semistructured interviews with adults over age 65. Personal responsibility for the management of depression emerged as a pervasive approach to dealing with depression. Older adults used orientational and movement metaphors to describe the process of moving out of depression. They viewed initiation and follow-through of this process as the sole responsibility of the depressed individual. This attitude might be rooted in the cultural experiences of this particular cohort of older adults and has implications for their use of physical and mental health services for depression.

Keywords

depression; aged; cultural models

Depression is one of the most common problems among older adults in primary care settings (deGruy, 1996). However, many older persons who might benefit from an intervention for depression never fully engage in the treatment recommended by their physicians. This resistance might result from differing concepts about depression held by the physician and the patient. Patient behavior is often a logical extension of the beliefs they hold about the illness and what to do about it (Good, 1992). This study is an effort to understand beliefs about depression and depression treatment held by older adults that might affect their willingness to participate in depression treatment suggested by their primary care doctors.

In our work, we use the idea of a cultural model to understand the notions held by older adults about depression and its treatment (Garro, 2000). Cultural models are “taken-for-granted” presuppositions about the way the world works (Holland & Quinn, 1987). A cultural model for an illness such as depression consists of largely unspoken attitudes, stances, and beliefs about the illness and the way it should be treated that are shared among a group of people. Cultural models about illness often are a subset of more general cultural models about ways to function as a bona fide member of a group (D'Andrade & Strauss, 1992). For example, one study demonstrated how a cultural model about breast cancer among first-generation Korean American women reflected in a particular sense the more abstract and general cultural model of The Good Mother in Korean culture (Suh, 2004). Cultural models have been used 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).

A cultural model of illness is derived from mental associations, called schemas, among sets of information formed from individual experience (D'Andrade & Strauss, 1992). When someone perceives a cue about depression (e.g., feeling “down in the dumps,” hearing a story about a friend who is depressed, viewing a segment on *Oprah* [Winfrey, 2006] about depression), features of that person's individual depression schema might become activated. Specific features of the depression schema can be particularly strong because of an emotion that is associated with that memory (e.g., remembering a relative with depression) (Mellers et al., 2001). Even though an individual might not know all the details about what it is like to be depressed, the depression schema helps fill in gaps in the information provided by the original cue by offering a commonsense template for the phenomenological experience of depression. In this way, a cultural model for depression can serve as a heuristic device for reasoning about what type of action might be necessary to address the depression.

Schemas become components of a cultural model when they are shared among members of a group such as older adults. Older adults who have similar experiences (the Great Depression, World War II, loss of function due to aging, deaths of family members and friends) might share similar schemas about depression and its treatment. An understanding of the cultural model for depression treatment held by older adults furnishes insight into the “things everybody knows,” or the commonsense assumptions that can either facilitate or hinder acceptance of treatment that is offered in the medical setting. Individual models of illness define each person's understanding of what constitutes the condition, what causes the condition, what happens to people with the condition, and what to do about the condition. To tap cultural models of depression, we conducted in-depth interviews with older persons identified from primary care settings to discuss their ideas and experiences with depression and its treatment.

In this article, we describe the prominent concept of personal responsibility that emerged as part of the cultural model for depression among older adults. This includes the idea that the management of depression, although difficult, is a matter of “picking oneself up by the bootstraps.” It might be grounded in the cultural value that self-indulgence is a weakness. For individuals who ascribe to the “bootstraps” concept, physicians can play an important but ancillary role in the management of depression. This perception about the appropriate management of depression has important implications for whether older adults discuss depression with their doctors and for the types of treatments that older adults deem to be appropriate for depression.

Method

This article is based on semistructured, open-ended interviews with 71 persons aged 65 years and older following their participation in a year-long study of depression in late life called the Spectrum Study (Bogner et al., 2004). During the year, we collected structured survey data related to participants' psychological, cognitive, and physical status. These quantitative data allowed us to sample individuals purposively for qualitative interviews from the pool of eligible persons based on features such as their depression and anxiety scores, family history of depression, age, gender, and physical status. The Spectrum Study and the subsequent qualitative interviews were approved by the University of Pennsylvania Institutional Review Board. All participants signed informed consent statements.

We conducted open-ended, semistructured interviews with 71 older adults. The general purpose of the interviews was to explore how older persons and their families experience depression in late life and how they integrate symptoms of depression with medical conditions (Barg et al., in press). Saturation for the theme of personal responsibility was achieved after 29 interviews. Because we continued to conduct interviews to investigate other themes, we identified 28 additional examples of the theme among remaining interviews. In total, 83% of the 71 interviews contained a variant of the personal responsibility theme.

Semistructured interviews took place in the respondents' homes in the Baltimore metropolitan area. The interviews consisted of a series of open-ended questions designed to elucidate the older person's explanatory model of depression (Kleinman, 1980). Interviews were recorded and transcribed using standard transcription guidelines (McLellan, MacQueen, & Neidig, 2003). Each interview transcript was first read by a research assistant who eliminated identifying information, corrected obvious errors in transcription (such as typographical errors), and formatted the document for entry into the software used to manage text data (QSR N6.0). The transcript was then broadly coded by two team members (JS and BK). The coders assigned segments of the text to one of four codes corresponding with the explanatory model framework (Kleinman, 1980): (a) What causes depression? (b) What is depression like? (c) What should be done to address depression? (d) How will the depression turn out? Coding done by the initial two coders was merged to apply both versions of broad coding to the documents. Portions of the transcripts were then distributed to eight team members, who were each assigned one of the original four questions to “fine code.” In other words, each coder created subcodes that emerged “in vivo” from the text to divide the predetermined broad codes further and label the text with subthemes. The eight coding schemes were merged to apply all fine coding to the original document.

At weekly team meetings, all coders gathered to discuss individual cases. A case summary was prepared from each transcript to alert the team to the overall flavor of the transcript and to identify an overview of that individual's ideas about the etiology, description, management, and outcome of depression. The remainder of the meeting time was dedicated to discussing the case and the themes that emerged from the transcript.

Findings

Participant Characteristics

We analyzed the transcripts of 71 study participants. Fifty-two respondents were women, and 30 were African American. Thirty-six stated that they were depressed, whereas 33% were considered depressed using the CES-D (Devins, Orme, Costello, & Yitzchak, 1988; Radloff, 1977) a standardized depression screening tool. The mean age of the sample was 76 years. Eighty-three percent of the respondents expressed a version of the theme of personal

responsibility discussed in this article. Expression of this theme was not related to gender, marital status, ethnicity, age, or depression status.

Personal Responsibility for Managing Depression

In discussing cases and coding, we identified the concept of individual responsibility in managing depression as a consistent theme in the interviews. Participants frequently used the phrase "pulling yourself up by your bootstraps," reflecting the general notion that individuals must take personal responsibility for their condition and initiate change to relieve themselves of the symptoms of depression. The term *individual responsibility* denotes control by the individual to initiate change toward improving health and well-being, and alleviating depression. The theme arose in response to a variety of questions and scenarios within the semistructured interview. For example, when asked where to look for help with depression, one respondent said, "It is left with us as individuals. My grandmother said: 'God's not going to come down here and do it for you; you gotta do it for yourself, boy.'" Respondents also stated that taking personal responsibility bolstered the effectiveness of other common treatment options.

> Medication can help pull her up so that she can do it, but I honestly think that a person's got to be responsible for their own peace of mind, their own outlook and—you know, I feel sorry for people who can't. I mean, it's an awful situation. But that's why I say OK, go with the medication, but the medication is only to help break that habit of being depressed.

We present three variations in the way the concept of individual responsibility was expressed: (a) pulling up by your bootstraps, or upward motion; (b) taking action through a forward motion, and (c) a reframing of attitude through circular motion. We will describe how each of these forms of expression relates to the perception of the type of effort that is required to manage depression.

Bootstrap, or Upward Motion

The most common expressions of personal responsibility incorporate an effortful, upward, pulling motion. We have called this theme of upward motion bootstraps, as it was often expressed via the common idiom "pulling oneself up by the bootstraps." This expression, by definition, conveys the general sense of taking personal responsibility but also incorporates an effortful upward motion required to extract oneself from the depths of depression. The idiom was used in response to questions about what people should do about depression or when feeling down in the dumps. "You have to pull yourself up by your bootstraps, as my mother always said." Bootstraps, then, expresses an effort that is self-directed, upward, and strong, and pulls the individual up and out of the negative context of depression. One man noted that medication might help if the depression is a result of a chemical imbalance, but if not, "Guess what? You've got to pull yourself up by the bootstraps and pray yourself up by the bootstraps." Although others did not use the specific idiom of bootstraps, they drew on similar sentiments. "You're not supposed to be laying around feeling sorry for yourself…. Get up and do something about it." Another woman stated, "Sometimes the help comes from within the person … medication can help … [but] I honestly think that a person's got to be responsible for their own peace of mind, their own outlook."

Directionality is a key feature in this concept. Overcoming feelings of depression involves moving from a lower to a higher state. "Guess you get lonely to a certain point but … you gotta have the willpower to dig yourself out." The notion of pulling or getting up or digging out is associated with hard work and a certain difficulty in achieving results. Several people commented on the fact that this "pulling up" is difficult and requires perseverance and a great deal of effort. The person must take action in an upward, pulling direction that requires force.

> When you get around people more it helps take some of the depression, makes you feel better than just sitting, you know, staring at the walls. You get more down in the dumps…. Sometimes, when I try to force myself to do a little something, it makes me feel, you know, (better) to be able to move around a little more. Sometimes, I have to force myself and other times … I just don't care.

Forward Motion

Personal responsibility is also expressed as forward motion. Expressions of horizontal motion are less demanding than the vertical motion of bootstraps. One woman spoke about advising a friend: "I said, 'go to the doctor and get out every—get out of this house.'" Another woman said,

> How can I get out of this house when I feel bad? I said, "Just drag yourself out." I said, "You got to make yourself. You just can't sit around and not make yourself do these things. You've got to make yourself." … I don't sit in the house that I can't—that I get sad, real sad. I have to take my bath, put some clothes on, and get out of the house.

A third woman was even more pragmatic. "If I start feeling low or something worrying me, I get up and go out and do something, take care of it. That's it. Doesn't affect me."

The context in which this expression is used is to leave the depression or sadness behind by moving forward, away from the depression or out of a depressing environment. Akin to the bootstraps theme, this movement must be initiated and sustained by the person. Forward or horizontal movement was recommended to improve the person's condition, to lessen the degree of depression, or to prevent its onset. When asked, "How does depression interfere with your day?" one woman stated, "Well it doesn't interfere with it because if I feel myself becoming depressed I get out of here." With the same emphasis on self-motivation and motion, another woman said, "We go out, or again, I take myself out. I push myself to go out. Luckily I still drive."

Changing Attitude Motion

A third theme that concerned self-regulation was in reference to changing attitudes. Here, the focus is more cognitive. The motion is internal and circular and is an attempt to restructure or reinforce the pathways within the mind to change actively the way one thinks. This theme refers to individual responsibility or personal responsibility that involves recognizing what might be wrong with a particular outlook or attitude and then changing that attitude or outlook, moving the mind onto something else or into the right state. As compared with the bootstraps notion of pulling up and out of a situation, those who endorsed the attitude change refer to a self-generated treatment that suggests reframing one's outlook, for example, by "getting in the right mind." The person's self-reflection is the critical point. These opinions must be initiated by the individual or with the assistance of another (non-professional) person. Many interviews include statements concerning the influence of the person's attitude on their mental outlook: If your attitude is negative, depression will follow. Like the other two categories, changing the state of mind requires significant effort. One gentleman noted,

> It's all left to us as individuals so if you cannot get my mind right you'll labor in vain … So he doesn't have the right attitude either, OK. He's got to have a positive attitude, period.

Another person stated,

> My idea is it should be, you should look at whatever it is as positively as you can … not sometimes but all the times and you should make yourself do it even if you don't

> —say at times you may not want to do it but you must make yourself do it as far as I'm concerned…. It can be avoided if you just don't let everything worry you. If you got something—if you got yourself a, something to do and get your mind off of that and do, something like that can be avoided but if you just set around and think about this, that, and the other thing, next thing you know, you keep … and things start worrying you.

Many persons spoke of moving the mind off of depression, “I find something else to do to get my mind off of it. Others described the need to change attitude to feel better: “You know, a depressed person doesn't go on, in my opinion. So you have to pick yourself up and don't think those things … that make you feel that way.”

Personal Responsibility and Cultural Models

Our sample represents a possible cultural cohort from which we can derive a cultural model related to treatment for depression centered on shared experiences. The notions of picking oneself up by the bootstraps, moving forward, and forcing oneself to think differently can reflect a cultural value among this cohort that rejects self-indulgence and self-pity. The individuals in our study were born between 1912 and 1938. This was long before Medicare or Medicaid programs (established in the mid-1960s) supported health care for older or financially needy Americans. Health insurance as a significant employee benefit did not emerge until the World War II era or beyond (McLellan et al., 2003). Thus, many, if not most, of the respondents' families paid out of pocket for health care during their formative years. This shared experience is reflected in respondents' descriptions of self-care during their childhood.

> I guess it has something to do with background 'cause I think all of us are the same way. We don't run to doctors. When we were kids, we didn't have the money to run to the doctors with eleven kids but we—and we're not used to bad health and we're not … geared to complaining about it. When we were little, if you got sick and you weren't feeling good and you got cranky my mother would say, “Listen here, mister, just 'cause you're sick, the rest of the world doesn't have to be miserable along with you. If you can't be decent, go up to your own room and stay there.

For many respondents, at least in retrospect, hard times bred an essential pragmatism. One woman, describing the harmony among her many siblings, stated that they had to get along; their mother wouldn't let them fight. This pragmatism is accompanied by a sense of wistfulness about the past, taking care of oneself, and taking care of “one's own.”

> A long time ago people took care of their family … I lived with my grandfather all my life when I was growing up and he died right in his home…. But I guess that don't happen no more … very seldom.

Discussion

Older adults in our study described a cultural model for the role of individual responsibility for the management of depression. Variations on the model concerned pulling oneself up and out of depression, moving forward and beyond the depression, reframing one's attitude, and recommending that others move up or forward, or change direction. Depression was viewed as feeling “stuck,” mired, and not making progress. The way to manage depression must be through individual responsibility, action and hard work. However due to the very nature of depression, this agency is required at a time when self-respect and initiative might be at a low point.

Our results reflect the literature surrounding metaphors and depression. Lakoff and Johnson (1999) have described metaphors as mapping devices that allow one to make inferences from

a source domain to a target domain, preserving many of the features across the domains. Social scientists have described the pervasive use of orientational metaphors in Western culture and the common use of the up-down scale in referring to depression (Shore, 1996). In Western culture, health, happiness, self-control, and status are considered "up," whereas their opposites are considered "down." Participants in our study drew heavily on these metaphors and therefore illustrated the necessity for individuals to pull themselves up from a down feeling of depression to feel healthier and happier. In other cases, older adults used horizontal motion to describe the notion of escaping depression by moving forward. Finally, some described the notion of moving the mind away from or off of depression and into a more positive state of mind. These attitudes might be rooted in the sociohistorical events that shaped the experiences of this particular cohort of older adults.

Respondents were not in denial of depression as a condition but believed deeply that the impetus for change must come from within. Essentially, they are not ignoring or denying the depression, but they are underemphasizing the need for outside medical or psychotherapeutic help. The schemas for depression that comprise the cultural models of older adults can influence how patients respond when medication or psychotherapy is suggested.

This study tapped the lived experience of older adults: a person-centered perspective. Before discussing the implications of these findings, we need to acknowledge the limitations. First, the sample consists of persons who were willing to be screened for depression, and participated in an in-home assessment and follow-up study. These individuals might have particular characteristics, such as independence, that made it more likely to endorse a strategy of personal responsibility for illness than others who did not participate. Second, respondents might have discussed personal responsibility as a response to depression because it was thought to be a socially desirable behavior. We have no reason to believe this was a strong reason for the responses we obtained. Third, we interviewed participants in their homes, and it is possible that had the respondents been interviewed at the doctor's office they might have been more likely to suggest medical or professional interventions.

Our findings have practice implications for the primary care provider in the management of depression. We have identified a possible cultural model for depression management shared among older adults. The cultural model functions as a heuristic device for help seeking for problems with depression. In the "personal responsibility" cultural model, the older adult places emphasis on the role that he or she must play in the healing process and moves absolute control away from the provider. Indeed, the data presented here suggest that older adults allocate an important but ancillary role to their health care providers in the management of depression. To increase the likelihood that older adults will discuss depression symptoms or consider interventions for depression, primary care providers should incorporate an understanding of the role for personal responsibility in their discussions with patients and an appreciation for the effort involved. Older adults' acceptance of interventions for depression and adherence to treatment recommendations are more likely if the provider's model for treatment is congruent with the values and beliefs inherent in the Bootstraps cultural model.

In future research, we intend to explore the link among schemas about treatment for depression and actual use of services, satisfaction with care, and accepted treatment modalities to improve interventions targeting depression in older adults.

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