The Lived Experience of Depression in Elderly African American Women

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**Objectives.** This article focuses on the lived experience of depression in 20 elderly African American women.

**Methods.** Data on depression emerged from research that qualitatively explored experiences of depression, sadness, and suffering in 120 community-dwelling persons aged 80 and older, stratified by gender, ethnicity, and self-reported health.

**Results.** We placed women’s narratives under three general themes: Depression was (a) linked with diminishment of personal strength, (b) related to sadness and suffering, and (c) preventable or resolvable through personal responsibility. Brief accounts illustrate how themes emerged in women’s discussion of depression.

**Discussion.** African American women created a language for depression that was rooted in their personal and cultural history and presented in vivid vignettes through their life stories. Their belief systems and the language they used to describe depression are integral aspects of the lived experience of depression.

Recent work on the experience of depression as a cultural phenomenon and lived experience has shown that African American (AA) women view depression as an illness affecting “feminine, middle-class white women” (Beaubois-Lafontant, 2007, p. 31; hooks, 1981). AA women are said to suppress depressive symptoms with qualities deemed culturally appropriate, such as faith, silence, and strength (Schreiber, Noerager & Wilson, 2000). And although an individual’s ability to imbue meaning to negative events is significant in countering those events (Mathews, 1997), little is known about the meaning that AA women take from or find in the lived experience of depression.

This article focuses on the lived experience of depression in 20 AA women who participated in research exploring experiences of depression, sadness, and suffering in elderly persons aged 80 and older. Our qualitative research methods invited women to narratively construct these sometimes inchoate experiences. We therefore situate the experience of depression within their life narratives.

We address the following questions in this article: What is the meaning of depression to a group of elderly AA women? And, how is it experienced and expressed?

**Background**

Historical events, such as the Great Depression and the World Wars, influenced individual and cohort development for elders who were raised during this period. The catastrophes of the larger world seeped into the smaller worlds of individuals to engender a mindset and morality distinctive to this generation. Likewise, the cultural construction of gendered experience and its structural embeddedness, constraint, disparities, and creation of appropriate roles formed gender-based attitudes and behaviors in this generation of women (Schreiber & Hartrick, 2002; Stewart, 1835/1988).

History and location have also contextualized the social construction of race. Many AA women who were born in the southern United States between World War I and the Great Depression migrated to northeastern cities, such as Philadelphia, after the Second World War, along with family and extended family, to find employment (K. Davis, Grant, & Rowland, 1992). AA women’s choices of jobs or mates were set in cultural stone determined by gender and race. Racism and sexism affected the income and social class AA women occupied and led to the increased social jeopardy of classism (Cannon, 1995). Among this cohort of elders, AA women were the most disadvantaged in terms of income status and social mobility (Black & Rubinstein, 2000). Mills (2000) reported that for older AA women, a lifetime of discrimination, poverty, and hostile living and working conditions makes depression in old age a normative reaction to the stress of living a long life.

Yet recent research has suggested that culturally specific expectations placed on AA women to be strong in body, mind, and spirit (Beaubois-Lafontant, 2007) tend to refute, negate, or trivialize depression (Schreiber et al., 2000). A discourse of strength labels depressive symptoms a luxury AA women cannot afford or stigmatizes depression as a moral wrong (R. Davis, 1998). The aforementioned research focused on middle-aged and younger AA women, whose internalization of this discourse may actually precipitate depressive symptoms (Brooks-Bertram, 1996; Schreiber, 2001).

Does a culturally specific expectation of silence and strength concerning depression in AA women extend into old age? Local culture usually shapes the experience and expression of negative events, such as depression, at any age (deVries, 1996). For example, a shared background of disadvantage may be constructed in part, on thriving despite adversity (R. Davis, 1998). And although the mandate for physical strength may be lessened for AA women older than 80 (our respondents), AA women’s bulwark of self-definition may resonate to AA heroines such as Sojourner Truth, who typified emotional, physical, and spiritual strength throughout the life course (Painter, 1996). Through messages from oral and literary traditions, religious beliefs, and
daily circumstances in which caring for others is a primary job for AA women, silence and strength regarding depression seem to remain an expectation, if not a cultural ideal (Beal, 1969).

Like gender and race, the social construction of old age is framed by place in historical time. Bryant, Corbett, and Kutner (2001) reported that “aging black females” held a realistic assessment of being controlled by “external forces” and were thus at a high risk of depression because they are society’s most disadvantaged group in terms of socioeconomic status and health. Yet to admit the “weakness” or moral wrong of depression may dishonor AA traditions that teach personal strength as a resolution to depression while creating tension between what one feels and believes she “should” feel (Schreiber, 2001).

Like ethnicity, gender, and old age, narrative is another social construction, built by interviewer and respondent, to facilitate a type of life review (Reissman, 1997). AA women find meaning for difficulties, a euphemism connoting depressive symptoms, by incorporating an interpretation of these difficulties into their narratives (Black, White, & Hannum, 2006). In research on depression, Banks (2007) reported that AA elders insisted that before they could answer researchers’ questions they must tell the researcher “who [I] am and where [I’m] coming from.” In other words, the researcher must view each elder as unique in place and time, with an intricate context, rather than as having an “essence” independent of individuals’ experience (Pinker, 2002). We based our research on three frameworks that reflect social constructivist theory: the first is phenomenology and the sociology of knowledge, which focuses on how people create a personal meaning system to understand everyday life. Of particular significance is the biographical perspective on meaning, which sees elders as creating and interpreting meaning on the basis of their biography. Essentially, one can understand little about meaning in elders’ lives without reference to biography (Rubinstein, 1992).

The second framework relates to conceptualizations from cultural anthropology (Geertz, 1973), which sees meaning making and interpretation as key human actions. The elder is the creator of a meaningful world of “lived experience” and is best able to explain his or her world. Anthropology has a tradition of thick descriptive and analytical accounts that report individuals’ lived experiences.

The third framework is drawn from AA religious studies and the psychology of religion, which are strongly cultural and show religious belief and personal spirituality as cultural lenses through which individuals view life situations and restructure negative events (Black, 2006). AA religious studies have demonstrated the significance of oral narratives dating back to the time of slavery. Experiences of degradation in captivity ultimately became stories of strength, faith, and deliverance by God (Pinn, 1995; Stewart, 1835/1988).

A bottom-up theoretical framework fits well with the bottom-up nature of our research. That is, we explored the nature of depression through context, which in this case was through a descriptive and analytical exploration into an individual’s experience of depression that was situated within the story of her life. The framework was particularly relevant to the subjective experience of the person. It showed how a lived experience, such as depression, was interpreted by an individual and translated into a narrative informed by her culture and ethnicity (Lawrence, 2006).

**METHODS**

**Data Collection**

This article emerges from data collected from research funded by the National Institute on Aging (The Experience of Suffering in Later Life, Robert Rubinstein, principal investigator). In the original study, 120 respondents were stratified by gender, ethnicity, and self-reported health (men/women, AA/European American/Jewish American, excellent/good or fair/poor). The 20 women whose accounts of depression form the basis for this article comprised the two cells for AA women respondents: 10 women who described themselves as in excellent/good health and 10 who described themselves as in fair/poor health. Data for this study were collected through formal ethnographic interviews and informal conversation (Reissman, 1997) and were processed through audiorecording and transcription for analysis or detailed in analyzable field notes. We culled the cases that follow from both processes.

For all respondents, private interviews took place in their homes and lasted approximately 2 hr each in three sessions, for a total of approximately 6 hr. Each respondent signed a letter of informed consent, consistent with Thomas Jefferson University institutional review board guidelines.

The main tool of the study was the interview schedule, which included open-ended questions that spanned three sessions. The first interview began with a request to hear the “life story.” One function of the life story is to provide an interpretive context in which to situate questions that follow (Bruner, 1999; Reissman, 1997).

The second interview asked specific questions about depression. It tapped into respondents’ internal worlds and the beliefs and values that shape elders’ processes of experiencing, interpreting, and expressing depression.

The third interview centered on issues of religion/spirituality, dying and death, and thoughts about the future. It included questions about life lessons learned and advice elders would offer future generations.

All interviews were conversational and interactive. The interviewer asked the initial question and obtained a response. Responses were reframed as additional lines of questioning; interviewers probed answers to most questions with tailored, follow-up questions. Respondents’ answers to tailor-made questions were important; they provided in-depth descriptions of the lived experience of depression. The interviewer introduced the word depression.

Following is a sampling of questions that have particular relevance for this article:

1. Can you tell me about an incident, event, or time in your life when you were suffering?
2. Can you tell me about the saddest times in your life?
3. Can you tell me about a time when you were depressed?
4. How is depression the same as sadness? How is it different?
5. How is depression the same as suffering? How is it different?
6. How do you resolve depression?

Data Analysis

Qualitative data analysis began with the transcription of the first interview and was ongoing throughout data collection (Gubrium, 1989). The inventory of women’s narratives occurred in two general parts (Denzin & Lincoln, 2001). The first author and three coders (interviewers for the original project) made a general assessment of the data after audiotapes were transcribed. The large level of data analysis started from a general set of guiding questions, such as: What is in the data? How are ideas relevant to this study repeated inter- and intra-individually? The first question (What is in the data?) produced the largest level of coding categorization as general topics.

In the next stage, refined coding, narratives were sorted with detail; the first author developed codes that generated analytical insight into transcripts. She abstracted coding categories from experiences and meanings inherent in each transcript (Mischler, 1986); other categories were developed from fieldwork or post hoc reflection. Themes and patterns developed from ongoing work as well as post hoc insights and inferences by first author and interviewers. Themes and patterns concerned specific subject matters (e.g., loneliness) or processes (e.g., a respondent’s belief that depression is alleviated by activity). Each complete transcript was the focus of narrative and thematic analysis. The goal of our approach was particularly appropriate when eliciting data about respondents’ construction of depression within the framework of the life narrative.

RESULTS

Suffering was the focus of our original study and the referent construct to which we compared and contrasted depression and sadness. Constructs of depression, sadness, and suffering were explored separately and together in interviews. Although some respondents differentiated depression from sadness and suffering, some thought the three constructs were similar in source and manifestation (Black & Rubinstein, 2004). We explore this association/distinction later in the article.

The social construction of depression is built on North American as well as AA views about the self as stalwartly individualistic. One woman defined depression as “when you’re down on yourself.” She described a resolution: “You have to get out of it [depression] yourself; doctors can’t help you. You have to fight your way out.”

AA women’s narratives showed that depressive symptoms “should” be countered by personal strength (Schreiber et al., 2000). Mrs. C, an 85-year-old widow, exemplified this when asked if she had ever been depressed:

You can’t give in to your feelings. You have to go on in spite of it. I come from a family of strong women. You had very little, so you did what had to be done. If it meant you worked in somebody’s kitchen, you did it. It was a way of life.

Three themes of depression.—AA women’s lived experiences of depression were based on current situations as well as the contexts of their entire lives. In this article, we categorize their experiences into three interrelated themes. Depression was (a) linked to the diminishment of strength resulting from the difficulties of a long life, (b) related to sadness and suffering because all three were precipitated by the same or similar event, and (c) preventable or resolvable by personal responsibility.

Theme 1: Depression is linked to a diminishment of personal strength.—This theme shows how an individual culturally and narratively constructs depression in the context of her personal and communal history and current situation. Women spoke of depression as a lived experience that is characterized by (a) a perception that emotional, mental, or physical strength is waning due to the difficulties that occur throughout a long life; and (b) a sense of responsibility to combat depression with the strength that remains. The following narrative accounts exemplify Theme 1.

Mrs. B was an 81-year-old widow who lived alone in a senior apartment. She considered her health “poor” because arthritis made it difficult for her to walk more than a few steps or stand long enough to fix a meal. She described a history of serious ailments:

I’m a cancer survivor. I had a triple bypass. All that takes its toll on your body. My knees are giving out. And my lower back. My life is not like I would like for it to be or like it once was. I keep going to doctors and they still can’t seem to hit the spot.

Mrs. B named the present as “the worst time in life.” After leaving “a beautiful apartment and many friends” in Chicago to be near her only son in Philadelphia, she realized he is “very busy” and “hardly ever visits.” She wondered about her purpose in life. “When I pray I ask God, ‘What am I here for?’ That’s what I’d like to know. I ask God, please tell me what you want me to do in this life.”

Mrs. B’s query to God may highlight the existential questions individuals ask in the latter stage of life. Or it may reveal her disappointment with the outcomes of recent decisions, such as moving from her home city or searching for “good” doctors. When asked whether she had ever been depressed, she answered, “I’m depressed now because I’m not able to do things I used to do.” For Mrs. B, the word depression connoted physical limitations and loneliness. When asked how depression is alleviated, she replied:

I guess if I had somebody to talk to or share my problems with. Sometimes I feel ashamed because I feel that God is blessing me each day. So I ask God, ‘What are you trying to tell me? What am I doing that’s not right? What should I be doing?’

Mrs. B’s comment suggests that if she were grateful for daily blessings, asked God the “right” questions, or heard God’s answers more clearly, she would find a path out of depression. When asked what she sees when she looks in the mirror, she replied:

Well, a little old lady who can’t hardly walk, who has a cane and holding on to the wall. And going to the grocery store and being glad to have a cart to lay on. And having people look at you and feeling sorry for you.

This self-reflective picture reveals Mrs. B’s image of herself as an object of pity, and that empathy comes only from...
strangers. Yet, although she acknowledged she has little physical strength, she assumed moral and spiritual responsibility to improve her situation by feeling “grateful” and persistent prayer.

Mrs. G was an 82-year-old divorcee who lived alone in the house she had bought more than 50 years ago and in which she had raised two sons. She described her health as “good.” When asked whether she had ever been depressed, she replied, “Memories can lead to depression.” She reported that her father did not want “another daughter,” she felt “inferior” to her “talented” sister, and classmates teased her about “White-colored skin.” A college education was reserved for her brothers, and she was passed over for jobs because of “being Black.”

I see the trials we’ve had because of society, and women not having opportunities. Certain things we were taught not to expect. If you’re not expecting things, you’re not going to ask for them. So you saved yourself a lot of disappointment. For my age I know I’m blessed. When I look at it that way, I’m not sorry for myself.

Mrs. G reported that depression comes from recalling lost opportunities and paths not taken, even though she had little say over whether these opportunities or paths were open to her.

Mrs. G described herself as “generally happy,” then added, “except I have to watch myself.” When asked if she had ever been depressed, she replied:

I’ve not been depressed enough that it would make a difference. That’s why I’m active with my church and the senior center. I don’t cry, uh, much. I feel blue about being alone, but then I’ll do something. I get around people. Luckily nothing broke me down yet. But it’s up to me to make things pleasant.

Mrs. G’s responsibility was to decide which memories to recall and whether loneliness “breaks her down.” Like most women in this group, her response to “feeling blue” was to “work at it.”

Ms. T, who was 81 years old, took boarders into her small row home for extra income. As the only single woman in the group who had never borne children, Ms. T described herself as a “loner.” She reported that remaining “alone in life” shows inner strength. Despite being “hardly able to walk” due to arthritis, she described her health as “good” because “other people is worse off than me.” She saw herself as an example of why people should be quiet about [any type of] pain. That’s why I stay away from people because most of the time I’m full of pain. It’s bad enough you have to suffer with it, but to have other people know about it?

This comment highlights her theme, salient throughout the interview, of extreme guardedness. This theme took root when she was in the service. As an AA woman stationed at various U.S. bases during World War II, she had constructed a protective shell through silence. “Anything come out here [points to mouth] they can turn it around and say you said something else. But they can’t get you for what you think.”

Serving in the military also affected her health:

Oh, Arthur [arthritis]. I picked him up in the service. And he never comes alone, he comes with his relatives, rheumatism and sciatica [laughter]. I don’t want to be doped up. Because you can go out in the street and fall or a car hit you. Next thing they think you’re on dope. Or booze.

If she took pain relievers, strangers might think she was drugged or drunk, or she might be forced to seek help from her siblings, with whom she had little contact. Because she could not control what others think of her, she preferred solitude: “It’s best to be able to do what you can for yourself as long as you can. You can’t rely on others. As you get older people drop you. Friends drop you, even family.”

When asked if she had ever been depressed, she considered: What’s depressed? How do you know you’re depressed? Does someone define that word for you and tell you that’s what you’re going through? With suffering you know the difference when you’re feeling good. I don’t think I’ve ever been deep down in depression whatever that is. That’s sadder than sad.

Like all women in this group, Ms. T did not define depression biomedically or clinically. For her, it was an extreme emotion that existed on the periphery of her experience.

Theme 1 shows that women conceptualized depression as a depletion of personal strength that resulted from, among other things, illness, loneliness, and bad memories. Yet, they also believed it was their responsibility to reclaim strength by using the personal characteristics, opportunities, and talents that had been given to them for that purpose.

Theme 2: Depression is related to sadness and suffering.—Our project asked respondents to conceptualize sadness and suffering and their relation to depression. As lived experiences, all three concepts were culturally and socially constructed from the warp and woof of women’s lives. Several AA women described depression as being related to sadness and suffering because all three were triggered by the same event or state of being, such as lifelong poverty.

For example, Mrs. E, an 86-year-old widow, lived alone in a subsidized apartment filled with her own artwork. She described her health as “poor” because of difficulty “getting around.” Sadness, depression, and suffering centered on her inability in youth and adulthood to achieve a “better life” because of poverty. When asked to define suffering, she replied:

We didn’t have money to go to school when we were coming up. We had to work on the farm. And we didn’t have the proper food, like milk. See, you must eat to support your body and be strong in your head. If you don’t have that strength, things like suffering might get the best of you.

When asked what a picture of suffering would show, she replied:

Getting old. Somebody asking for help with their hands up. I know I can’t do as much as I used to. That kind of getting to me. It makes me pray harder. I say, “Please give me strength to overcome this matter. I don’t want to fall short.”

Mrs. E equated suffering with old age and poverty because both had weakened her ability to manage day-to-day health and financial problems. When asked about the saddest period of life, she said, “I didn’t get no education. It’s really sad when you look at it. I just sometimes think what could have been is not. It didn’t happen.”
Mrs. E defined sadness as that which “could have been” and “never was.” Because of poverty she had not achieved a “good education” and artistic success. When asked if she had ever been depressed, she said, “Maybe I’m depressed and don’t know it. People depressed, they act different. They don’t want to be bothered. Depression is hard to get out of. It become a sickness if you’re not strong enough to fight it.” Although Mrs. E, like Ms. T, was uncertain about whether she was depressed, both women knew that depression results from a lack of strength.

For women in this group, events of depression, sadness, and suffering were also triggered by poor relationships and early experiences of grief. Mrs. H, an 85-year-old divorcée who lived alone in a senior facility, described her health as “good,” despite problems related to diabetes, such as neuropathy. For her, depression was a reaction to poor relationships she had with important others. She described her unhappy marriage as “one of convenience.” Regarding her middle-aged daughter, she said, “She’s my first born but I don’t understand her at all and that’s heavy on my heart, real, real, heavy. I shouldn’t allow her to have that strong a hold on me.” When asked about the differences among depression, sadness and suffering, Mrs. H replied:

They’re about the same. Sadness is when somebody you love dies. Suffering is when your heart is not broken, but bent, and there’s not much you can do about it. Depression is the worse. You can go to someone with those other two problems but depression, wow! And you can’t talk it out because it would take a long time.

When asked what she imagines depression to be like, she replied:

You’re in a closed dark room with demons and there is no way out. If you would scream no one would hear you. In the more extreme case you were in there by yourself. You didn’t have anyone to put your arms around.

Mrs. H’s demons “come to light” when she is alone. The poignancy of this description reflects her perceived lack of strength in relationships with important others, loneliness, and being “blind” to an exit from either the relationships or the loneliness. In our research, “no way out” was a common response to questions concerning individuals’ most extreme negative experiences.

Theme 2 shows that respondents constructed experiences of depression, sadness, and suffering from their unique biographies and cultural histories and described them with metaphors that precisely expressed both the commonality and singularity of their experiences. Theme 2 also shows the significance of current context in women’s descriptions of depression, sadness, and suffering.

**Theme 3:** Depression is prevented or resolved by personal responsibility. —For our AA female respondents, depression demanded a response geared toward resolution. The response must be aligned with beliefs women had about themselves. The primary means women used to prevent or resolve depression was religious belief. For believers, religious adherence was a framework for explaining the meaning of life events. Faith convinced respondents that negative situations would improve, or they would have strength to bear them. Accounts of religious belief in respondents’ narratives were described as an active decision to accommodate the diminishment of strength that occurs in old age by partnering with God. For this group of women, strength through faith emerged as an AA cultural construct (Townes, 1997). It was operationalized as internal and external empowerment formed through an intimate union with the ultimate source of power—God (Black 1999a, 1999b).

For example, Mrs. W, an 80-year-old widow who lived alone in the home where she and her husband raised four children, had endured several illnesses in the past decade, such as diabetes, arthritis, and a tumor on her vocal cords. Despite this, she believed that she was and would remain in “good” health:

When I was in for my throat [vocal cord tumor], one lady say, “Oh, you got cancer of the throat like me.” Another lady said, “I know I got cancer.” I said, “I know I haven’t got it. I refuse to get it because I didn’t do anything to get it.” I went in there with that positive thinking. The doctor said everything was all right. I say, of course. Because I’m not giving myself something that I didn’t deserve to get. I refuse to have it. I don’t need it. And I don’t want it.

Mrs. W’s remarks illustrate similar responses made by AA women supporting claims to good health as blessings for a righteous life. According to Mrs. W, illness and unhappiness revealed a lack of faith. “If I’m angry or mad or sad about something, then I don’t trust him [God] enough.”

Mrs. W reported that whenever she encounters difficulties, she prays. God then sends angels in the form of human beings, who offer concrete and practical assistance. She explained:

I was in the hospital when I got my knees done [knee replacement]. That next morning I wet the bed. I got very depressed about that situation. I said, “I can go home [die]. I’m ready” I couldn’t take it. Not being able to do on my own. I had done it for so long. Then a young man come in, picked me up and put me on the commode. Just like that. Well, God know you got your pride. Then I got washed up and the bed changed. Then back to that bed. I said, “Oh, thank you, God, you sent me an angel.”

Mrs. W believed she had received help without asking because of her long-standing relationship with God. When asked, she described the elusive nature of depression:

Mrs. W: After my husband went [died], I didn’t realize the shape I was in. I forgot how to drive. I forgot how to go anywhere, do anything. The children cooked, cleaned, and washed. I’m just sitting. My grandchildren come in and say, “That’s not grandma.” I just feel nothing. I didn’t think about nothing. It wasn’t suffering. With suffering you feel it. But you don’t know you’re depressed. I didn’t know it. You going to work, you going to church, you coming back, but you like a robot. I’d get up in the morning and sit. Wasn’t nothing hurting me. I’m sitting around like a visitor. This girl belonged to our church. She said to my son, “Your mother need a psychiatrist.”

**Interviewer:** What happened?

Mrs. W: I go in the garden. Just the idea of it [smiling]. Going down there, digging in that ground which I never did in my whole life. But I enjoyed doing it. I said, “I got food coming up.” It was a miracle to see stuff growing. I get up early every morning and go to the garden. It wasn’t that far. It helped get me back on track. And I started coming back.

An important part of Mrs. W’s life story consisted of cooking for, feeding, and cleaning up after her family. The act of
planting and harvesting fruits and vegetables in a community garden highlights a personalized remedy for depression.

Mrs. R, an 84-year-old widow, lived with her youngest son in the large row home her husband had built more than 60 years ago. Like Mrs. W, she described her health as “good” despite an inability to walk because of sciatica. Unlike Mrs. E, mentioned in Theme 2, she named “old age” as the best time of life because she had achieved her goals after her 60th birthday, such as getting a GED, nursing and child care certificates, and an associate’s degree at a community college. When asked if she had ever been depressed, she answered:

When my sister died, I didn’t think I could get over that. I lost control of my immune system. Medication didn’t do the pain no good. I was holding her hand when she died, and it looked like something left me. And that pain came uncontrollable, and I haven’t had control since about 2 years ago. See I think I lost control cause there were 16 of us—6 of us lived here in Philadelphia—and all of them are dead now but me. When the one before last died, I lost control of my sciatic pain.

This interesting take on the “cause” of depression highlights Mrs. R’s belief about the origins of physical and mental illness and disease. Although her health succumbed to overwhelming grief, she remained able to care for herself. She described a friend who was bedridden and for whom “[her] heart aches.” She said: I asked my God, ‘Don’t let me lay down and somebody got to feed me and bathe me.’

Faith and independence meet in Mrs. R’s prayer. Her faith in God was the bridge between her fear that she would “end up helpless,” and her conviction that this would “never happen.”

Theme 3 witnesses a refrain heard in centuries-old narratives of AA peoples and current interviews with our respondents. It was their responsibility to counter depression or any of life’s “difficulties” with faith in God and, for the most part, in themselves.

DISCUSSION

In this article we viewed depression as a cultural phenomenon placed in a framework of meaning constructed by AA women from cultural systems rooted in North American society and AA tradition. Both systems sometimes demanded extraordinary measures of personal strength (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Painter, 1996).

Our respondents were part of an age cohort of AA and European American elders that endured deprivations due to the World Wars and the Great Depression. As women, they experienced a lack of opportunities because of gender in terms of jobs, social mobility, and roles seen as “inappropriate” for women. For these AA women living in North America in the first half of the twentieth century, laws and conventions further blocked possibilities for movement between jobs and social classes. In this sense, gender and ethnic disparities and restraints were historical antecedents of depression (Cannon, 1984; Mills, 2000). Yet our respondents were members of an age, ethnic, and gender group who, for the most part, did not discuss depression as an illness and had not been asked to describe the content and quality of their “difficulties.” Our study welcomed and valued their unique and enduring voices.

Although historical context provides a backdrop for individual experience, women in this group, for the most part, located both the experience and resolution of depression in their smaller world. They connected memories of abuse, grief, poor relationships, and poverty to depression. They also rooted accounts of depression in current contexts of loneliness. Women expressed the meaning of depression, as well as its resolution, through metaphors and vivid vignettes. They created a language for depression that was neither clinical nor biomedical, nor compartmentalized as an illness or experience distinct from other aspects of their lives (Schreiber & Hartrick, 2002). They saw depressive symptoms as part of life, similar to the sadness and suffering that “affects everyone at some point in life” (Black, 2006, p. 13), and more often as one grows older.

Implications, limitation, and future research.—In this article, we present a contextual picture of depression for a particular group of people—elderly AA women living in an urban area in the northeastern United States. We do not intend this article to be a general model for the lived experience of depression, but a representation of this group’s mindset, language, and use of metaphors when they answered the question “Have you ever been depressed?” and related follow-up questions. We suggest that the women interviewed based their descriptions of depression on their expectations about life and a reading of how their lives met or exceeded expectations. In women’s narratives, historical circumstances regarding class, gender, and race meshed with individual experiences and current context to create a language about depression that represents this age, ethnic, and gender cohort.

The language that succeeding generations might use to define, describe, or seek treatment for depression may be different. We hope that future research will investigate whether the use of faith and strength to interpret and treat depression persists with the young-old cohort or into the next generation—the offspring of our respondents.

We suggest that an individual’s subjective take on depression through narrative is irreducible; it is the “last stop” in understanding the content and quality of depression as a lived experience. We also suggest that health care professionals can be aided by knowledge about depression offered by the experts—in this case, the elderly AA women who narrated their experiences.

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