**Older Persons' Lived Experiences of Depression and Self-Management**

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**Abstract**

Mental ill-health such as depression in the elderly is a complex issue that is influenced by the life-world perspective of older persons. Their self-management ability should be strengthened based on an understanding of their situation, perspectives and vulnerability. The aim of this study was to explore and increase understanding of old persons' lived experiences of depression and self-management using an interpretative explorative design. Understanding was developed by means of hermeneutic interpretation. One theme; Relationships and togetherness, and four sub-themes emerged; *A sense of carrying a shoulder bag, Walking on eggshells, Holding the reins* and *Estrangement – a loss of togetherness.* A collaborative approach can be important for empowering older persons through self-development and management. While the findings of the present study cannot be considered conclusive or definitive, they nevertheless contribute new knowledge of older persons' lived experiences of depression in everyday life.

**INTRODUCTION**

Mental health is a state of well-being in which the individual becomes aware of her/his abilities, can cope with the normal stresses of life, works productively and fruitfully, thus contributing to her/his community (World Health Organisation, 2001, p.1). According to Feely *et al.* (2007), there are different interpretations of mental health integrated in each individual's lived experience as she/he progresses through life. Mental ill-health could, for example as Feely *et al.* (2007, p. 23) suggested be defined; 'in the context of each person's experience of living in their internal and external world during a period of personal despair or when his or her autonomy is temporarily impaired'. Mental ill-health such as depression is a multifaceted phenomenon that has at its roots in the realities of persons' lived experiences that can be multidimensional in nature (Feely & Long, 2009). The label 'depressed' or 'depressive' can imply social sanctions often associated with fear and lack of understanding on the part of society (Feely & Long, 2009).

By the year 2020, depression is predicted to reach 2nd largest cause of injury and disease in the world for all ages and both sexes (WHO 2004). Late-life depression is common in primary care settings, affecting at least 5% to 10% of older persons (Blazer, 2003), although it remains under-detected in older persons who live in their own home (Brown *et al.*, 2007; Gellis, 2010). This might be related to the stigma (Porter, 1998) attached to depression that causes many persons to ignore the fact that they are ill and thus avoid seeking treatment (WHO, 2012). It is important to consider different perspectives on depression when interpreting patients' lived experiences of being depressed. Studies of gender, different cultures and societies have described depression in different ways (Herrick & Brown, 1999; Raguran, 1996; Mills, 2000; Schreiber *et al.*, 2000; Wolpert, 2001; Ó'Baíolláin, 2002; Karasz, 2004; Ó'Fithcheallaigh, 2005a, b; Beauboeuf-Lafontant, 2007). In Asia, depression is described as a

culturally stigmatizing phenomenon expressed through somatisation and emotional distress (Raguram, 1996), while in America it is viewed as an illness that affects middle-class white women (Beauboeuf-Lafontant, 2007). Karasz (2004) compared conceptual models of depression in two cultural groups in the USA, one of which comprised 36 immigrants from South Asia (SA) and the other 37 immigrants from Europe (EA). The SA group emphasized self-management and referral strategies. In contrast, the EA group suggested biological explanations such as "hormonal imbalance" and "neurological problems". Elderly Afro-American women consider depression in old age a normative reaction to the stress of living a long life in poverty and poor working conditions (Mills, 2000). In England, Wolpert (2001) found that depression is very difficult to understand and thus considered a sign of weakness. In Ireland, experiences of depression among the Irish-speaking communities in the Gaeltacht areas are similar to those of the English speaking population, but are described differently (Ó' Baíolláin, 2002; Ó' Fithcheallaigh, 2005a, b). The Irish word for depression is *an galar dubhach*, which means the illness of darkness (MacMatúma & Ó Corráin, 2002).

The medical model of depression has been dominant in Western society (Rapaport *et al*., 2002; Simon *et al*., 2002). In this paradigm, the person's story is used in the diagnostic process to identify symptoms of depression (Casey & Long, 2002; Moyle, 2003). Traditional diagnostic measures of depression such as the American Psychiatric Association (2000) consider apathy a symptom. However, even within this paradigm the perception of depressive symptoms such as apathy seems to be changing, as today it has been suggested that apathy is a neuropsychiatric condition (Levy *et al*., 1998; Njomboro & Deb, 2012). For many years physicians have employed patient-friendly strategies to avoid or moderate the stigma of mental illness by attributing the symptoms to physical causes (Porter, 1998). Nevertheless, its failures frequently highlighted in professional guidance (Sounders, 2008). Some decades ago Mishler (l984) stated that the use of medical language 'interrupts the voice of the life-world'

(as experienced by patients), resulting in a dissonance between true understanding of the meaning of the symptoms presented and perceptions of the impact of the illness. The author used the concept of 'voice' to distinguish between the perspectives of the 'voice of medicine' and the 'voice of the life world' (Mishler, l984, p. 14).

There are few empirical qualitative studies of the lived experiences of mental ill-health including depression. Hedelin and Strandmark (2001) described depression as a complex issue based on the life-world perspective of older persons. Holm and Severinsson (2013) reported a comprehensive literature synthesis of older persons' narratives about what they need in order to survive when suffering from depressive ill-health. The themes that emerged from the analysis were; The need for courage, strength and self-reliance, The meaning of responsibility and Wearing a mask of normalcy to hide the shame. Forsman's (2012) research revealed that limited social networks are associated with depression and psychological distress in later life. According to Yeung *et al*. (2010)*,* self-management of depression is a way of shifting more responsibility to the patient. In order to manage successfully, it is essential that patients have an in-depth understanding of their illness (Yeung *et al.*, 2010). Thus, self-management programmes have been developed in the health care sector. Evidence-based interventions for the care and treatment of depression include cognitive approaches (Rokke *et al.*, 1999). Self-management should be expanded to include the life-world perspective in order to understand the older persons' situation, views and vulnerability. Such a perspective can strengthen mental health and introduce an existential approach into mental health nursing. Hedelin and Jonsson (2003, p. 317) stated that 'if we really want to understand what depression means we also have to focus on the meaning of mental health'. However, the present authors want to understand the lived experiences of mental ill-health such as depression and its relation to self-management. This study is part of a larger research project carried out in Norway (Holm & Severinsson, 2012b; Severinsson, 2012).

**Aim**

The aim of this study was to explore and increase understanding of old persons' lived

experiences of depression and self-management using an interpretative explorative design.

## DESIGN AND METHOD

An explorative design and hermeneutic approach with focus on understanding older persons

in the context of depression were combined with a self-management perspective. The overall

goal of a hermeneutic approach in health care is the provision of high-quality care, which

means that one must continue to explore what Gadamer (2004) called 'lived experiences'

using intuition and empathy, thus creating hope and future possibilities (Holm & Severinsson,

2012a). In line with Gadamer's (2004) philosophical hermeneutics, the methodological

approach is both an underlying philosophy and a specific mode of interpretative reading of

narrative texts. In this study the authors explore older persons' (60 years and over) lived

experiences of depression.

Focusing on experiences of self-management among individuals suffering from depression

requires a certain pre-understanding of the topic on the part of the authors (*cf.* Gadamer,

2004).

The authors' pre-understanding is based on theoretical and practical knowledge gained from

their professional experience as psychiatric nurses, supervisors and researchers. The pre-

understanding of working as psychiatric nurses was brought into the open, which allowed it to

be reflected upon during the research process.  The fourth author has a background in

intensive care and is not familiar with the context of psychiatric care. However, all authors

have experience of formulating analytical texts.

**Participants**

Twenty-nine persons were recruited by nurse managers in the communities and mental health care services on the West Coast and in the South-Eastern part of Norway. The inclusion criteria were persons diagnosed with a depressive or mood disorder, able to understand and speak the Norwegian language, resident in a community in Norway, referred to community health care during the previous six months and over 60 years of age.

**Interviews**

Semi-structured interviews (Polit & Beck, 2010) were conducted and each interview lasted one to two hours. All were audio-taped and later transcribed verbatim. The interview took the form of a dialogue (Gadamer, 2004) with the informant, who chose the place for the meeting; a private office, a mental health clinic or her/his own home. The first and second authors (A.L.H. and A.L.) encouraged the participants to engage in a dialogue about their experiences of depression and how the illness influenced daily life with focus on self-management; "*Can you please tell me how you manage everyday life*?" The authors tried to interpret the participants' bodily expressions and non-verbal language to ascertain whether they were capable of discussing lived experiences. Sometimes the topic was too sensitive and they struggled to find the right words. Some explained how they experienced situations that influenced their daily life with significant others such as feeling humiliated and lacking strength. The interviewers had to be careful about their choice of words and in some cases improvise in an attempt to make the participants feel safe enough to talk about their situation, as some aroused feelings that were difficult to express.

**Hermeneutic interpretation**

According to Lincoln and Guba (l985), a key assumption in hermeneutic analysis is that meanings can only be understood in the context in which they occur. The hermeneutic interpretation encompassed two levels and a meta-principle known as the hermeneutic circle was employed. At the first level, understanding was increased by reading the text several times and moving from the parts to the whole and back again in an iterative manner.

The second level of analysis provided a deeper understanding of the meaning of depression and its relation with self-management on a higher level of abstraction by searching for more general meaning patterns. According to Ricoeur (l976) and Porter and Robinson (2011, p. 121), literary works have a 'surplus of meaning', or 'hidden meanings' as suggested by Gadamer (1999), which goes beyond pure linguistics and means an approach intended to deepen the essence of the findings by relating them to theories. Finally, the authors discussed interpretations in order to clarify their meaning and validate them, achieve consensus and expand their individual understanding of the lived experiences reported by the older persons.

**Trustworthiness**

There are a range of methods available for analysing narrative texts. In a hermeneutic approach the researchers and the participants are interrelated and interact with each other, thus the interpretation of the text is seen as a process. Trustworthiness refers to confidence in the interpretation and analysis of the data (*cf.* Polit & Beck, 2010). The research team discussed the theme and sub-themes that emerged. During the interpretation, they attempted to render the participants' experiences as exactly and truly as possible (Denzin & Lincoln, 2008). Citing the participants' own words was one way that can help the reader to judge whether or not the interpretation of the participants' experiences is credible. One of the authors (E.L)

made the first interpretation of the text, while the others posed critical questions, thereby

enhancing the credibility of the findings. Miles and Huberman (1994) suggested that

qualitative researchers should use metaphors when communicating research findings. Within

a hermeneutic approach, language can be both subject and medium and Wiklund (2010)

pointed out that the world of the human being is a world of metaphors. Carpenter (2008)

defined a metaphor as a figure of speech, replacing one idea or object with another to suggest

an analogous relationship. Carpenter (2008) emphasised that using metaphors should not

become a self-serving attempt at creativity that supersedes subject and substance. In this

study, the metaphors were used to capture the meaning of old depressed persons' daily

experiences of living with their illness and reflecting on self-management. The choice of

metaphors can be subjective, where the risk of "taken-for-granted" assumptions is present.

This can mean that the data do not fit, thus becoming a source of injustice and suppression of

vulnerable research populations (*cf.* Carpenter, 2008). The metaphors used in this study have

been critically and carefully discussed by the research team to minimise these risks.

**Ethical considerations**

The Ethical Guidelines for Nursing Research in the Nordic Countries (2003) were adhered to.

Approval for the study was granted by The Regional Ethics Committee of Western Norway

(No. 2010/2242). The first and second authors (A.L.H and A.L.) conducted the interviews in a

sensitive manner so as not to increase the older persons' feeling of being overwhelmed by

their lived experiences of depression. They tried to interpret the older persons' expressions

and non-verbal signs to ascertain whether they were capable of discussing their experiences or

if the topic was too sensitive (*cf.* Liamputtong, 2007). The older persons were provided with

detailed written information and signed a consent form. They were assured that their name

and identity would not be disclosed and that they had the right to withdraw at any time. All

data were stored in a locked and fireproof filing cabinet.

**FINDINGS**

One theme; Relationships and togetherness, and four sub-themes; A sense of carrying a shoulder bag, Walking on eggshells, Holding the reins and Estrangement - a loss of togetherness, emerged from the hermeneutic interpretation.

**Relationships and togetherness**

The participants revealed that relationships are important for mental health, but patterns of relationship and their meaning change over the course of life. Relationships can be extremely important, as exemplified by one participant: "my husband and children mean everything to me", and more advanced age does not change the worries of parenthood or about siblings and other family members.

*A sense of carrying a shoulder bag*

The meaning of the lived experience of depression seemed to be associated with a great deal of relational baggage such as *carrying a heavy shoulder bag*, as explained by the following participant:

> The worst thing was that my mother in law was very jealous of me. There were many intrigues, which took different forms, resulting in conflict. My son was left out in the cold because my mother in law preferred my husband's sister's sons.

Such past events gave rise to almost endless worry and a permanently troubled conscience, irrespective of how long ago they had occurred. The burden was interpreted as a *sense of*

*carrying a shoulder bag* that seemed to have the power to influence the older persons'

existence as if the negative events had taken place only yesterday. An essential component of

the older persons' shoulder bag was worries about their children; their sorrows, problems and

how they managed their life. When narrating about longing for more contact with their

children and grandchildren, the participants revealed troublesome elements in many of these

relations. They described a gnawing feeling of not being allowed to be a part of their

children's life, of not having done enough, not having given them sufficient security or

perhaps having done everything wrong. Almost half a century later some still carried a burden

of guilt and shame about not being a good enough parent. Over time, the relational baggage

became exhausting, sometimes covering life like a dark blanket and experienced as a burden.

> Today I struggle with memories from the past and suffer a lot from guilt. My sleep is
>
> disturbed by pain and dreams. The children are always with me in these dreams. I
>
> escape with them into huge stone houses without windows or furniture.  It's awful.

*Walking on eggshells*

The meaning of the lived experience of *walking on eggshells* revealed that it was necessary to

be continually careful, not make a fuss and never say too much. However, one could fail,

which implied more discrepancy and disagreement. We sensed deep disappointment behind

the following quotation:

> I do not experience myself as a human being, more like a patient!

> It's as if you are nothing when you meet him. You feel like air.

Non-supportive relationships were characterised by obligation, while supportive relationships

were based on commitment, involvement and understanding. This *togetherness* was often

created by normal conversation. In essence it was mutually beneficial, as it expressed trust and commitment as opposed to obligation.

> I can talk with him [psychiatrist] and he does not try to give me medication all the time. We talk about daily life and he has taken an interest in our family the whole time. I trust him and the psychiatric nurse a lot.

In addition, some supportive relationships are characterised by contradictions and ambivalence. Being unwell and dependent on help that is not provided unconditionally but is seen as a duty can make it difficult to maintain self-esteem. This can weaken older persons' sense of value, dignity and self-confidence in social contexts, in addition to giving rise to thoughts about how other people perceive them. A reciprocal relationship as well as availability and compliance were understood as truly meaningful in easing the depressed mood and promoting health, dignity and well-being. There were many such positive experiences. The narratives revealed that a dilemma was the diversity in perspectives and expectations that in many respects lacked mutual assumptions. This could mean that while the person tried to cope with depressive ill-health the professionals' focus was on the effect of the medication. When analysing how to nurture relationship, an expectation of support in terms of talking and 'being there' emerged, togetherness based on spontaneous conversation, as stated above. Several of the participants described feeling lonely, not only as a result of lacking close family ties or living alone, but due to their inability to participate in community activities. They expressed that their feeling was accompanied by withdrawal, sadness or anxiety. One participant stated that it helps to have someone "who really cares about me". They longed to be cared for and to receive supportive encouragement despite many disappointments that almost destroyed their trust in others. The lived experiences of depression is associated with an underlying shame; one is not quite the same as one's neighbour, leading to a feeling of fear and loneliness that is almost impossible to imagine.

*Holding the reins*

The narratives revealed a strong desire to make decisions about what is best, set boundaries and be 'in charge and hold the reins' in daily life. The nature of self-management and the strategies employed by older persons who suffer from depression can be metaphorically compared to the relationship between a coach driver and horse. The question is: Who is the master? Like a coach driver, the individual tries to "hold the reins" and remain master. In essence, this can be understood as the Self being a Person; not accepting being a victim with no power over one's circumstances and health.

> I worried a lot all my life. But I have the ability to put my problems behind me.
> For example, I force myself to go to the day-centre as I must get to know people.
> I have the strength and resources to want to do something. The psychiatrist wanted to try a new medicine, but I said 'No, thanks'. I had enough of trying new medications. I stopped attending that psychiatrist.

An important aspect of holding the reins is the search for alternative ways to manage one's life. It is connected to one's future, i.e. expectations associated with everyday life, instead of trepidation or inertia. Personal dignity and integrity seem to be of existential significance for daily self-management. Therefore, the meaning of holding the *reins* is having a self and experience being a person and not only a victim. There is a great deal of courage evident in the narratives, demonstrating outstanding perseverance as demonstrated by the following quotation:

> Wake up about five o'clock in the morning and go for a walk. Afterwards I feel peace for a while and am able to eat my breakfast.

The everyday life of older persons living with long-term mental ill health such as depression is like *a permanent battle* in which one is in a disadvantaged position. Existential meaninglessness is an invisible enemy who cannot be allowed to take control.

*Estrangement – a loss of togetherness*

Being depressed can imply a lack of self-management*,* a sense of estrangement and thus a loss of togetherness, which sometimes leads to apathy. In addition, it is not always easy to be with other people. One believes that others can see the problem and that the depression is written on one's face. Shielding is an expression of self-protection against pain, but also a concrete withdrawal from relationships that might not be working as desired. One stops *wrestling,* withdraws from the struggle, eats and sleeps either too much or too little, has no routines, is passive and often has suicidal thoughts. All of these symptoms are understood as meaninglessness, characterized by isolation, loneliness and shielding, which implies loss of an existential life context. When supportive togetherness is lacking, poor or simply obscured, a sense of strangeness occurs. In the long term, this can mean becoming estranged from family and friends. One's existence becomes similar to that of a prisoner, sitting alone most of the time:  The loss of ability to hold the reins casts a shadow over the older person's daily life, she/he may start to identify her/himself as 'a person who does not fit in' and feel like a prisoner:

> I experience myself as a prisoner because I don't know how to get out of here. I can
> see no way out. It is as if I have been put aside, forgotten and no one cares. I'm alone
> most of the time, staring idly at my watch.

Usually, this suffering is kept secret as the elderly persons want to conceal this shameful struggle from others*,* even when in reality they silently wish for the opposite.

**DISCUSSION**

The aim of this study was to explore and increase understanding of old persons' lived experiences of depression and self-management using an interpretative explorative design. The findings revealed that *Relationships and togetherness* constituted a kind of support that did not imply a solution to their problem(s) but a person to person relationship and togetherness in terms of endowing life with meaning. Relational baggage can be described metaphorically as carrying a difficult life history in *a shoulder bag*. The experience seems to be 'beyond words' and metaphors help the older persons to express the inexpressible (Buchanan-Barker & Barker, 2005). When suffering from mental ill-health such as depression, togetherness appears to enable communication on common ground. A cultural hermeneutics of togetherness can be seen as lived mutuality in a world of coexisting differences that are in both opposition and harmony, as proposed by Wu (1998). In real life there is 'absolute inseparability of the living body and life itself' (Gadamer, 1999, p. 71). Mutual respect arises from the reality that one is fundamentally related to the other. Mutual respect is respect for difference (e.g. power, knowledge, beliefs and values, experience, attitudes) and not easy to achieve. However, mutuality was experienced as a form of background music related to mental health and depression (Hedelin & Jonsson, 2003). Research has revealed that support from others can serve as a buffer against the development of depression and facilitate recovery, thus preventing isolation and withdrawal (Blazer 2003; Romanov *et al.*, 2003; Ahlström *et al.*, 2009). Peer support groups have been described as one way to obtain mutual respect (Hogan *et al.*, 2002; Eysenbach *et al.*, 2004). Davison *et al.* (2000) demonstrated that persons with stigmatizing conditions are more likely to seek support groups than those with less 'embarrassing' conditions.

*Walking on eggshells* can be seen as a strategy to create balance in daily life. Not surprisingly, the meaning can be considered as the art of balance. Periods of depressive ill-health can result in deep loneliness and isolation that affect one's relationships in complex ways. This mental health problem can be seen as chronic, which implies enduring, leading to loss of the potential for a satisfying life. In the light of health potential, "chronic" means that the health problem is a long-term phenomenon, which is not an automatic reason for giving up. In fact, health or ill-health is never static. It is described in the literature as a movement and a process related to the existential loneliness of one's being (Lindström, 1995; Eriksson, 1996), ontologically as a mystery (Gadamer, 2003) and of significance for one's dignity (Rizzo Parse, 2010). This highlights the fact that one of the core elements of human reality is a desire to make sense of one's life − not just to solve problems. This shifts some of the focus from ill-health and illness to the human being, giving a person time and space to feel grief and be sad as described by Lassenius (2005) and Holm (2009). Believing that personal growth continues in old age (Rizzo Parse, 2010) can strengthen human potential and optimism.

*Holding the reins* can be a way of controlling one's life. Thus self-management may provide meaningful support for older persons' self-determination. The meaning of self-management can vary as it forms part of each person's personal values throughout life. When trying to hold the reins, one needs a trustworthy person who *listens* and to whom one can *tell* what it is like carrying on day by day with this "companion" i.e. depression, someone who can confirm and strengthen one's self-worth and identity. Stickley and Freshwater (2006) stated that nurses need to reflect on the patient's vulnerability and their longing to be confirmed, trusted and listened to, which has been proposed as a tool for improving nurses' awareness of their own role in the dialogue. Barker (2011) highlighted self-determination as the most significant human right. It is the core of self-management and an existential dimension of being in the world as well as related to freedom and dignity. Self-management

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can be associated with the health process as a "journeying task of making sense of life itself" (Barker, 2011, p 332).  In most desperate situations it is possible to increase an old depressed person's strength by enhancing her/his self-determination and dignity. Research has revealed that in order to achieve self-management, the focus must shift from didactic education to encouragement and support. This approach is relatively new and underdeveloped in primary care settings (Wagner *et al*., 2001; Holm & Severinsson, 2012b).

*Estrangement* can be described as an existential lack of self-management and understood as emotional pain and suffering where the realisation of one's existential aloneness becomes visible and alienates the older person from her/himself. There seems to be a sort of invisible blanket between the world and the person. A feeling of loneliness can be a step up from a sense of estrangement. Research has indicated that persons who find themselves in such a state may require help from mental health professionals to prevent passivity and apathy (*cf.* Yeung *et al*., 2010). Nurses must change from a traditional authoritative role to form partnerships with their patients, who are responsible for modifying their lifestyles and improving their health (Holman & Lorig, 2000). Redman (2005) holds that self-management leads to an unreasonable shift of responsibility. Old depressed persons' may lack control and is unable to assume responsibility. Such expectations can be experienced as a violation, leading to suffering, emotional pain, indolence and lifelessness. Over time a state of apathy occurs, which affects the old depressed persons' possibility to assume self-management responsibility.

**Implications for practice, education and future research**

Mental health practitioners require a greater understanding of self-management to enhance older depressed persons' well-being and life satisfaction. Mental health nursing should view depression as a phenomenon that has its roots in the realities of a person's lived experiences. Reflecting over the ontological freedom of every human being implies being sensitive to old persons' lived experiences of depression and their everyday needs where the opportunity to express themselves can reduce their pain and suffering. Models should be designed within the discipline of mental health nursing that respect each individual and facilitate care pathways that can be of benefit to the older persons. Care planning should focus on how life crises impact on different persons' lives. This could make nursing interventions more context oriented and better able to meet the needs of every human being, including her/his belief system and spirituality (*cf.* Feely *et al.*, 2007). Hopefully the old persons' everyday life will be provided with a health service that is more relevant to their actual needs and perceived reality. Such a care approach in mental health practice can increase the feeling of being a real human being and decrease the burden of stigma (WHO, 2012). Self-management as described by Wagner *et al.* (2001) in the chronic care model (CCM) represents a shift away from the traditional medical model by changing the way of working in primary care. Several studies have revealed how problems arise because the working methods were inadequate to for supporting self-management (Macdonald *et al.*, 2008; Holm & Severinsson, 2012b). Koch *et al.* (2004) concluded that professionals must gain a new understanding of self-management that includes respect for the expertise that a person brings to the management of her/his condition.

The discipline of mental health nursing would benefit from a higher level of education, training and support to increase the professionals' ability to handle dilemmas experienced by

older persons lived experiences of depression. Organisational factors such as management

involvement are described as crucial (Kälvemark Sporrong *et al.*, 2007). A current problem in

mental health nursing seems to some degree to be the organisational system level that shifts

too much responsibility to health care professionals and patients (Redman, 2005).  Redman

(2005) outlined the responsibility to obtain patient agreement on planned goals, which is

based on the notion that older persons are moral agents with their own values. Thus nurses

and health care providers must engage in a discourse about the use of different self-

management strategies.  Despite the fact that according to Yeung *et al.* (2010) the intention

behind self-management is for patients to gain an in-depth understanding of their illnesses,

these authors did not discuss older persons' lived experiences of mental ill-health such as

depression. A collaborative approach can be important for empowering older persons by

means of self-development and self-management.  While the findings of the present study

cannot be considered conclusive or definitive, they nevertheless contribute new knowledge of

self-development in everyday life of old persons lived experiences of depression.

**CONCLUSION**

Reflection and discussion can help to facilitate openness to integrating the principles of self-

management into care plans for older depressed persons. The barriers to self-management can

be eliminated by team collaboration and the presence of a nurse manager to coordinate the

care.  To achieve this aim, the organization of mental health care must be redesigned by

developing functional team leadership. It is important to listen carefully to team members'

concerns and scepticism about the development of mental health care and include self-

management principles based on the lived experiences of old persons.

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