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SELF-STIGMA FOR THE TIME OF PASSING — AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCE OF OLDER WOMEN STRUGGLING WITH DEPRESSION IN THE COURSE OF MOOD DISORDERS

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ageing
autostigmatization
depression

Summary

Objectives: Self-stigma associated with mental disorders can be an additional cause of suffering for those affected. Our intention was to extend the assumption made in the literature that the phenomenon of self-stigma is accompanied by only negative consequences. We made an attempt to describe and understand the ways of experiencing oneself and relationships with others in the context of suffering from depression, and we also reflected on the multitude of possible meanings of self-stigma.
Method: Based on the data collected during individual interviews with six women aged 60+, hospitalized due to the severity of an episode of depression in the course of mood disorders, we conducted an interpretative phenomenological analysis.
Results: We have identified three meanings that preoccupation with an illness may have and described them in the areas of: (1) Dealing with depression as an important aspect of identity; (2) Depression as one of the aspects around which thinking about the future is structured; (3) Depression as a regulator of interpersonal relations.
Conclusions: Self-stigma was manifested in the respondents in the form of a severe devaluation of themselves and the experience of being overwhelmed with critical thoughts about themselves. It seems, however, that the recurring perception of oneself through the prism of the illness could also fulfil some protective functions: filling the void left by former roles; protecting against confrontation with passing and creating opportunities for contact with others. On the basis of the obtained results, we presented suggestions for the psychoeducation of older people struggling with depression: encouraging them to create narratives about their past, enabling contact with peers affected by similar concerns, abandoning attempts to encourage changes in the way of experiencing oneself and revising self-narration.

Introduction

Difficulties resulting from the confrontation with transience and its manifestations, such as separation or mourning, reappear in all phases of life [1], but during the stage of aging they may be recalled in a new way. Losses often accumulate (widowhood, illness and death of important family members, loss of health) [2]. In addition, the ever-closer end of life encourages you to look back – when you try to see what has passed, there is an opportunity to put the experienced moments together into a coherent whole [3]. The creation of this emergent pattern sometimes gives a feeling of completion, a finished play – as if old age revealed the message of the "show" [4, p. 17]. However, the moment of turning back can also be the starting point for growing despair, for reliving the pain – this time compounded by the finding that there is no time to start over. Erikson [3], the author of the theory of psychosocial stages of life, called these two aspects of the conflict characteristic of the stage of old age integrity and despair. As Bugajska [5] reminds us, these two phenomena are not mutually exclusive, but are rather poles of the continuum of experiences. Wisdom is the force that can arise from confronting both joyful and dramatic states. The researcher modifies Erikson's theory by proposing to add one more life phase to the construct that would precede the last one described above. This would make it possible to nuance the stage of old age, which today may last several decades. The penultimate phase would be the period of retirement, which forces one to respond to major changes in the area of daily tasks and social roles. The antinomy characteristic of this phase of life would be commitment – resignation, and the force arising from their confrontation would be the courage necessary to face the progressive changes resulting from aging.

Success in resolving the crises characteristic of the phases described depends, *inter alia*, on the socio-cultural context[1], on the current possibilities, on the way in which crises in previous life phases were developed, and on the ability to define one's own identity. In this context, it is worth recalling Śleszyński's considerations [10] – he points to the phenomenon of too strong identification with the performed role (*e.g.* employee, guardian), which, while fulfilling a protective, structuring function, can also significantly limit the formation of one's own identity. In such a situation, the death of a loved one, a child's marriage, or a change in life status often precede a mental breakdown, forcing people to resign from "identifying with the role, while there is no new identification" [10, p. 66]. One of the possible consequences of this confrontation with changes that appear too painful and difficult to bear is melancholy.

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[1] According to Cruikshank [6], the category of old age considered in the public debate is extremely monolithic, provokes prejudices, and separates part of society from the rest. Moody [7], writing about the common phenomenon of denial of old age and passing away in public debate, shares an interesting observation that statistically in the US there are more members of the American Academy of Anti-Aging Medicine than qualified geriatric doctors. On the other hand, in Poland, Szarota [8] describes the emerging pro-senior pedagogy, pointing to many unexplored areas of the life of older people: "the beliefs and perceptions of old people about old people, *i.e.* carriers of certain beliefs and attitudes, are rarely analyzed". Meanwhile, as Levy notes [9], negative stereotypes about old age are formed long before reaching this developmental phase, and after entering it, they reduce efforts to maintain the will to live (*e.g.* seek treatment).Therefore, taking into account the impact of social discourse on the development of difficulties in meeting the challenges of aging is an extremely important topic that requires a separate study.

Kristeva [11] refers to the phenomenon of female depression in this context – in the period of early and middle adulthood, it is sometimes hidden behind activity, diligence and action. These strategies can fulfil their protective function for years, until the body begins to weaken, and when you reach retirement age, you must give up your previous job.

The difficulty of the situation of many elderly people suffering from mental disorders, *e.g.* depression, was captured by Nock *et al.* [12], who noticed that people over 70, regardless of gender, almost all over the world constitute the age group most at risk of suicide, and mental illness in this population is the strongest risk factor for taking one's own life. Gatz and Fiske [13] emphasize the high prevalence of self-destructive behaviours among older women suffering from depression.

Age and illness-related concerns may be additionally reinforced by public stigma – it includes stereotypes and prejudices (*e.g.* "depression is the result of laziness") and discriminatory behaviour (such as condescending treatment, attempts to limit personal rights) [14]. One of the consequences of stigmatizing the elderly suffering from affective disorders is the lack of success in treatment [15]. The reason may be *e.g.* avoiding psychological or psychiatric help by people who potentially need it for fear of being excluded and stigmatized by society. Recovery may be additionally hampered by pressure from relatives who, encouraging the ill person to "pull themselves together" or "take care of something," increase the feeling of loneliness, misunderstanding, and hopelessness [16].

The stigma does not have to come from others but can also be directed towards oneself. This construct was called personal stigma and, according to Brohan *et al.* [17], it has three components. Perceived stigma refers to the way in which – according to the ill person – society perceives the stigmatized group to which they belong. Experienced stigma is about how an ill person experiences actual discrimination and exclusion from other people. Self-stigma, on the other hand, is a stigma internalized by an ill person, expressed in a sense of shame, guilt, inferiority, and a desire to keep the illness secret [14].

As indicated by Werner *et al.* [18] the personal stigma of elderly people suffering from mental disorders is a serious and common problem, which is at the same time neglected in the literature. The number of qualitative in-depth studies exploring the component of the phenomenon that we are interested in – self-stigma, is particularly small. Holm *et al.* [19] note that one of its serious manifestations is questioning and doubting the reality of one's health problems other than mental illness. Tanaka [20] notes that elderly people suffering from depression may sometimes experience regret, guilt, and pessimism related to it. The above-mentioned concerns include the inability to come to terms with lower efficiency and lack of strength that would allow helping others.

Yanos *et al.* [21] reviewed the interventions used in the case of people affected by mental illness manifesting self-stigma. What connects the proposed techniques is the desire to reduce the phenomenon and, as a result of this change, improve the quality of life of the ill person. This approach is consistent with the unequivocal recognition of self-stigma as a maladaptive strategy resulting from the internalization of stereotypes present in society, which should be combated or modified [22–24]. However, the literature does not ask the question of whether and what adaptive function can be present in the form of self-stigma. Attempts to answer the question about the function of stigmatization appear only in the context of its public displays – *e.g.* Kurzban and Leary [25] or Gilbert [26] assume that prejudice against people whose behaviour differs from the norm recognized by the majority may be a manifestation of protection against potential external threats. Existential psychologists, *e.g.* May [27] or Opoczyńska-Morasiewicz [28] notice that creating a distance between us (people like us) and those who are different from us, is one of the forms of coping with the fear of what is foreign (Greek *xenos*). Xenophobia has a similar function; in this case, the fear is transformed into hostility towards the other.

According to the existential thought in which our research has its origin, each symptom of mental life is a form of being, the subjective and historical way of inhabiting the world [29]. Thus, self-stigma – while being a part of someone's life – can express something, answer something, deny something. Noticing it, we may ask: why must it be so? At the root of this question is the recognition (*Er-messen*) of self-stigma as a significant manifestation of life. It is possible that only on the basis of such recognition, which will be not about "not noticing something abnormal in pain, suffering, or illness, but something natural, inseparable from life" [30, p. 24], may other forms of being appear – the less painful ones. It seems certain, however, that by recognizing the value of self-stigma, we can prevent the effects of thoughtless interventions aimed at those affected by it. We decided to undertake the task of describing and understanding the ways of experiencing ourselves and relationships with others in the context of suffering from depression. Our goal was to outline the possible meanings of self-stigma.

Subjects

Six women over sixty took part in the study. They were treated at a stationary unit at the General Psychiatric Ward at the University Hospital by two researchers (one employed there permanently as a psychologist and therapist, the other completing an internship during psychotherapeutic training. They were both acquainted with patients during their therapeutic sessions, therapy, group classes and individual meetings). From among 20 seniors that were treated during the research period, eight women were invited to be interviewed. They were treated due to the deterioration of health accompanying an episode of depression, in the course of mood disorders such as unipolar disorder, bipolar disorder, and organic mood disorders[2].

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[2] The respondents share the experience of mental suffering present in deep depressive states, which was the cause of hospitalization – although the women received different diagnoses in the area of affective disorders, their attention is focused on this aspect of the illness – perhaps sadness, fatigue, and discouragement present in depression are more palpable as the cause of suffering than the manic state, or the deterioration of cognitive functioning typical of the neurodegenerative process. Moreover, it is precisely on these depressive symptoms that the respondents focus their attention particularly strongly, also in the context of self-blame and shame (this tendency, present during the interviews, was noticed by the authors long before the research, during the therapeutic processes and other activities for the elderly people affected by mental disorders).

The interview invitation included a description of the course of the study (the information that it would take the form of an individual interview lasting about an hour, during which the researcher would ask for “sharing the history of life and mental breakdowns or crises, known as mental illness”); information that the collected data will be used to create a manuscript that will be published in a scientific journal. The invited people were also informed about the voluntary nature of participation in the study and the possibility of withdrawing from it at any time and assured of confidentiality (change of names to pseudonyms, deletion of details such as city names, dates, family configurations). Two people refused to participate in the study.

Below, we present short biographies of the respondents – it is an attempt to outline the context in which the words spoken by our interlocutors can be heard and understood by the reader.

Beata is 71 years old, has been retired for several years and has two adult children. She used to be supported by her parents when she was looking after the first child. After she gave birth to her second child, her husband began to abuse alcohol, and Beata was diagnosed with depression for the first time. Since her husband’s death, she has been hospitalized several times due to a significantly depressed mood.

Irena is 62 years old and works in a bookstore. She has grown up children and one brother – the other brother died a few years ago. The school years were full of studying, sports, and friendships. She began suffering from bipolar disorder more than 20 years ago, when the nature of her husband’s work forced the spouses to separate frequently. Mental health deteriorated again a few years ago after her husband died.

Wanda is 75 years old, she has been retired for several years. She has two sisters and a son who is currently moving to his own home with his family. She grew up in the countryside and looked after their farm. For over 20 years, until her retirement, she worked at school. A year after her husband’s death, Wanda was first diagnosed with depression.

Kinga is 60 years old, lives with her husband, daughter and granddaughter. Her second daughter lives with her family. She has younger siblings, with whom she grew up in the countryside, when her parents took care of their farm. She started suffering from depression several years ago, right after she became somatically ill.

Jadwiga is 71 years old, lives with her husband and has one daughter. She had her first episode of depression a year ago, right after her critically ill husband was rushed to hospital. The husband’s hospitalization was the couple’s first separation in years. Currently, her husband often visits Jadwiga in the hospital and spends time with her on leave.

Maria is 63 years old, lives with her husband, has adult daughters and is expecting a granddaughter. For many years, she worked as a teacher. She has a close relationship with her two sisters. She was diagnosed with bipolar disorder over 40 years ago, right after she broke up with her then-boyfriend.

Method

The study was approved by the ethics committee of the Institute of Psychology of the Jagiellonian University and the management of the University Hospital in Krakow. The respondents, after reading the instructions and signing the consent to participate in the study and recording its course, began participating in a partially structured individual interview lasting 45 minutes on average. The interview guide contained the following questions as a starting point for the stories of the respondents.

1. Please share your life story;
2. Please describe the situation or the meeting during which you did not think that you were ill;
3. Describe the situation or the meeting during which you recalled being ill.

Based on the audio recording made during the interview, transcripts were made. Three researchers analyzed the collected data using the IPA method – interpretative phenomenological analysis [31]. This method is idiographic, *i.e.* it is characterized by a concentration on individual experiences of specific people, after which one can move on to a nomothetic description, *i.e.* showing common and differentiating threads present in the statements of the respondents. Small groups of respondents are preferred, which is conducive to a thorough and detailed analysis of the statements of specific people. Using the method based on phenomenological thought made it possible to explore the experienced world (*Lebenswelt*) of the respondents: not what it is, but what it appears to be in the acts of intentionally focusing on its objects. At the same time, the second key aspect of the method, *i.e.* its grounding in the hermeneutic tradition, means that the researcher makes a "translation" from what is said to what is heard and thought – that is, from the perceptual and relational level to the level of meaning [32].

In the beginning, we read the transcripts several times in order to get acquainted with the entirety of the interviews and arrive at a general understanding. With time, using NVivo [33], we started adding our own notes in the margins. Then, during subsequent readings of the text, we created codes – in a "bottom-up" manner, directly resulting from the given fragments of the statement. When rereading, when necessary, we assigned these generated codes to subsequent fragments of the text. Then we grouped the created codes together, finally formulating themes based on them showing the contexts in which self-stigma manifests itself in the respondents. Text analysis was characterized by frequent returning to its earlier stages and modifying the resulting constellations of codes and topics under the influence of perceived new meanings of fragments of the respondents' statements.

Discussion of the results

As a result of the analysis of the collected data, we identified three areas of experiencing oneself and relationships with others in the context of struggling with depression in the course of mood disorders: "Struggling with depression as an important aspect of identity;"

"Depression as one of the aspects around which thinking about the future is organized" and "Depression as a regulator of interpersonal relations".

1. Struggling with depression as an important aspect of identity
   All respondents express anger towards themselves for not being able to fulfil life roles in which they used to feel so well. Wanda recalls her energy and dedication to work as a teacher, and notices an unbearable contrast with the current lack of independence.

   > *I have worked in school for over 20 years. You had to be really agile and resolute, you had to have eyes around your head. I was healthy. […] Now I have a fear of leaving the house, I have various other breakdowns, it is just difficult for me.*

   All respondents also emphasize the contrast between the place they occupied in the family system in the past and the place they occupy now – three of them present illness as a factor that destroyed the idyll. Kinga is pleased to describe her part in creating a safe home, warm relationships with her relatives, and after a while adds that the recurrence of her illness had a negative impact on the atmosphere in the family.

   > *Everything was good for me – from cleaning to cooking, to washing, to shopping, to everything. And today I can't handle it anymore. I always took the initiative. Our home has always been such an oasis of joy and laughter. The moment I fell ill… The whole family is simply shaken by my illness. I used to comfort others, today I need to be comforted. It makes my daughters and grandchildren suffer because I am not able to sacrifice myself as much as I used to when I was healthy. I don't like myself in this state.*

   Maria also describes her involvement in building loving relationships among the household members until an episode of illness occurred.

   > *When I am healthy, we talk nicely to each other. I say "dear husband, Basia, never Baśka, Gosia, not Gosia." I love my grandchildren very much.*

   Barbara, going back to the period before her illness, draws attention to her social activity, which was an important element of her identity, and to the joy derived from contact with friends. All this disappeared when the illness appeared.

   > *Earlier, I was going to the University of the Third Age or with a friend for some Nordic Walking. And then I stopped going anywhere, I stopped being in touch with my neighbours. Yes, with anyone, I didn't even want to go to the store, so as not to meet anyone.*

   Although Irena and Barbara keep thinking about returning to previously liked activities and roles with great liveliness, similarly to the rest of the respondents, they refer to the difficulty of thinking about themselves in isolation from the fact that they are suffering from depression. The illness, its symptoms, treatment, and consequences became the main topic of reflection. Jadwiga even talks about the physical experience of being overwhelmed with thoughts.

> *Well, I just can't get that thought out of my head. About illness and illness, even now. It seems to me that everyone is looking at me and seeing this illness. It's still in my head, my head is so full. I cannot get rid of the thought that there is an illness.*

Similarly, Krystyna, when asked about situations in which she does not think about being ill, is unable to recall such a moment.

> *It's hard for me to remember the last time I didn't think about the illness, I keep it in mind all the time.*

Irena talks about the importance of the topic of depression in her contacts with other patients – support and encouragement accumulate around it. All respondents, except for Maria, share similar reflections.

> *Here, in the ward, I talked to people who are in a similar situation. We supported each other, we advised each other. We said that some people are bothered by it, while others wonder why it is still there ...*

It seems that in the face of the disappearance or significant limitation of the ability to actively engage in various areas of everyday functioning, depression has become one of the most important aspects of life with which the respondents identify themselves.

2. Depression as one of the aspects around which thinking about the future is organized
   The respondents, fantasizing about the future, seem to balance between an overwhelming fear of suffering and loneliness, and hope for recovery, sometimes equated to full recovery (at the time of the study, only Jadwiga was preoccupied only with pessimistic thoughts about the future).

At times, Kinga seems to expect herself to return to the same state she was in before she fell ill – this is not surprising given that once she did return. These thoughts, however, are accompanied by the fear that it will not be possible again.

> *Maybe a little longer and this black hole in front of me will also move back and I will take on my duties as I did before. I once recovered from this illness for years, I returned to work after the first episode, because I still worked for so many years. But I still fear the future, how will I cope, when I get out of here. Will I jump into my duties as I did before my illness?*

Similarly, Wanda looks forward to the day when she will recover and will enjoy the same activities as before.

> *Then I think that someday I will also feel better, that I will be able to sit at home and do the chores. And I have a lot of them, cooking, cleaning, shopping.*

However, these thoughts about the future that awaits Wanda after the end of treatment in the hospital are also accompanied by fear of what is independent of the illness – the lack of the daily presence of loved ones.

> *I wonder how I will handle it when I get home. Because they have built homes for themselves up, they will move out, and I will be left alone. My son will be visiting me, because he lives very near, 5 minutes from my home. But he works, so he'll be at his home every day.*

Maria remembers the times when she had the strength and motivation to help others and fantasizes that this strength will come back to her.

> *I am used to working. I was very ambitious, I worked with seriously ill children. I worked a lot, I was so active. Now I have a very severe depression, and I would like to be healthy and help others.*

However, she also mentions sadness that seems to be naturally associated with loneliness.

> *My daughter has built a beautiful house for herself, I will have to drive up to her, and it is on such a big hill. And I can't go uphill. When they leave, I feel so sad, empty.*

Beata remembers the times when, despite recurring mental crises, she managed to cope.

> *I was constantly on the move, I was constantly working, taking my medications and always on the move until retirement. Yes, it is possible that if I was healthy and I worked, I would feel differently, because there would be always something going on. I need some activities to keep myself busy.*

The respondents sometimes also arrive at the idea of accepting that the future may be heterogeneous and have various shades. Irena hopes to return home, but takes into account the possibility that the period after leaving the hospital will require a lot of effort.

> *Now it's going to be such a difficult time as I'm going home, but I'll face it. I am alone, my husband is gone, so I have to take care of the apartment myself.*

Kinga ends the conversation with a reflection on how to look at oneself softer.

> *Maybe you just have to accept the illness, if there is no way to eliminate it, and learn to live with it – compromise. Everything had to be perfect, everything. Apparently my psyche did not withstand this rigour anymore and I just broke down. It is easier to let go of what I cannot do.*

3. Depression as a regulator of interpersonal relations
   Although the respondents blame themselves for the negative impact of the illness on the well-being of the family, identification with depression seems to create a space

for all the women to notice the care shown by their relatives. Wanda happily gives examples of their interest in her well-being.

> *My granddaughter visited me. It was very nice, she surprised me. In general, when they call, they are cordially interested, they ask "are you better?", "How often do you feel better there?"*

In Beata's case, deterioration caused by depression was an incentive to stay with her family for several weeks.

> *I was so depressed, I slept during Christmas almost all the time. In the afternoon, I got up, my daughter took me home, my son arrived with my grandchildren and that's how we spent Christmas. And she said she wouldn't let me out of the house until I was able to get up and take the bus by myself.*

For most of the respondents experiencing depression became (only Maria does not mention this) also a platform for contact with peers. Beata thinks that the presence of other patients is a reason for a significant improvement in her well-being.

> *Everything helps me here – the surroundings, I wake up and I'm not alone. I will speak to this lady, to this one. I read books, newspapers, and go for walks. Everything has changed for me in the hospital. I am not alone.*

Conclusions

Integrating one's identity in the face of all the changes that take place during aging is a serious challenge for the elderly [34]. As Śleszyński notes [10], this integration may be particularly threatened in a situation where it is no longer possible to fulfil the social role with which a given person has identified so far. It seems that our interlocutors were in such a difficult position. The analysis of their experiences allowed us to distinguish three areas of their concerns. The first area, "Struggling with depression as an important aspect of identity," shows the growing void that appeared once they have lost the roles and activities performed so far. Depression and its treatment, in turn, are at the centre of all thoughts and actions. The women report that they are completely absorbed in this topic, it seems that they even identify with the illness. Perhaps it is so in response to the loss of the ability to fulfil one's marital, parental and professional roles. From such a point of view, identification with the illness would paradoxically protect against disintegration, disappearance in the face of irreversible changes.

What draws attention is the idealization of their past by the surveyed women. According to many of them, being ill has disturbed the harmonious course of life. Our interlocutors contrast their current unsatisfactory condition with the numerous advantages or skills which, in their opinion, characterized them in the past and would still have characterized them if it were not for the illness. The past – although in the case of some women marked by first episodes of depression – appears in the memories as a period in which one had the strength to face everything. Such idealization may, according to Varchevker [35], protect against getting too close to the painful aspects of reality that are hard to come to terms with – its changeability and transience. Perhaps it is so in the case of our interlocutors.

As can be seen in the second area, "Depression as one of the aspects around which thinking about the future is organized," the respondents sometimes carefully develop in their minds a vision of returning to independent everyday functioning, in which good and bad moments can be expected. Other times, the future fills them with fear and uncertainty, and illness appears as the main cause of unfavourable changes. It is then that fantasies arise that if you manage to recover, it will be possible to return to the ways things were before falling ill. Such a subconscious way of thinking could allow maintaining the vision of oneself unchanged by the consequences of the passing time – resilience and resourcefulness are separated from the current state only by the diagnostic limit. Of course, this has many consequences. On the one hand, immersion in thinking about the illness may, paradoxically, bring relief – there is a cure for it, which brings hope for the reversibility of the course of events and a return to youth. If the past has not offered sufficiently strong support and stability that could be internalized in a symbolic form [11], there may be a desire to come back to it literally in reality – to be young again. Unfortunately, while using the imagination to reach the previous stages of life may provide relief and constitute a support for development, it may also be used to withdraw and block the possibility of reaching the next stage of development [35, 36]. The denial of transience and the related denial of losses and unfulfilled intentions can lead to avoiding life or even feeling sorry for it. Self-stigma, protecting against confrontation with a passing reality, can paradoxically be understood as a form of taking one's own life.

The third area outlined on the basis of the analysis of the statements of our interlocutors "Depression as a regulator of interpersonal relations" refers to interpersonal relations in the context of suffering from depression. The company of others makes everyday life not only bearable, but sometimes even pleasant, bringing both joy and reflection on worries. Self-stigma can be understood here as a kind of cry – the illness becomes the axis around which contact with loved ones begins to accumulate. Focusing attention on the illness, which is common and affects people of all ages (which is sometimes unnoticed by the younger ones, who avoid facing the reality that is beyond their control) gives hope to get the attention of others. And it happens so – the family provides support, is interested in changes in mood, does not abandon. Paradoxically, the loneliness imposed by old age, visible in the area of ""Depression as one of the aspects around which thinking about the future is organized" becomes a less acute problem at such times. This inverse relationship also becomes apparent in the context of hospitalization. The stories told by most of the respondents reveal the healing role of contact with other patients. The peer group gives the opportunity to reveal difficult experiences related to losing vitality. Worries, fears, and anxieties specific to a given period of life may be shared with others who are also at this stage of life [37].

Recommendations for practice

The willingness and readiness of older people to share stories about their lives, visible in the area of "“Depression as a regulator of interpersonal relations,” has already been observed by many researchers (*e.g.* Bańbura and Opoczyńsa-Morasiewicz; Draaisma; Merrill and Fivush; Tokarska) [38–41]. When designing interventions against self-stigma, it is worth taking advantage of this natural path to introspection and expression. Tokarska points out the great importance of creating a space for older people to remember the past and reflect on their own experiences [41]. Narrating your life in the presence of attentive listeners can bring you relief and joy, and ultimately open you to contact with what was difficult, painful and so far not regretted in the past. Perhaps on this basis will arise readiness to see what Frankl [42] describes as “deeds done, loves lived, and finally suffering that [one] has endured with courage and dignity [...] used opportunities, fulfilled meanings, realized values” [42, pp. 147-148]. As a result of such a view of the past, there may also be a space for fantasizing about the future with greater flexibility and openness to various perspectives – this gives hope for future life that can be infused with meaning and significance [41].

Attempts at presenting one’s life as a narrative may also help to strengthen one’s sense of identity, which, as Dyga and Opoczyńska-Morasiewicz [43] recall, is “a process, not an achieved state” [43, p. 19]. Connecting one’s past experiences and integrating them with current experiences and ideas about the future may strengthen the feeling that despite changes, losses, recurring episodes of illness, “you remain yourself” – as Quinodoz [34, p. 45] put it – “despite not being the same person all the time.”

The results presented in the area of "“Depression as a regulator of interpersonal relations” suggest that for some people, group meetings may be particularly valuable. For others, however, thinking about social interactions may cause fear of rejection or the loss of important aspects of their own identity [44]. The fear of not being seen, recognized, and appreciated can dominate the desire to share life stories with others. In such a situation, individual contact with a psychologist, therapist or physician who is listening to the stories about the past, present, and future life may be sufficient.

Experts face the challenge of refraining from imposing what “should” replace strategies such as self-stigma. As Yalom and Leszcz [45] propose, in the face of the inevitable a therapist may just be there – that is, accept the gift of speech from another person. Instead of trying to turn self-stigma into affirmative thoughts, he may recognize the desires and hopes behind the former. This recognition should go hand in hand with supporting efforts to integrate all instances of ourselves.

Limitations and indication of areas for further reflection

Further exploration of the issue we have studied may be of great importance for creating adequate forms of assistance. It is worth broadening the understanding of the phenomenon of self-stigma accompanying elderly people affected by mental disorders, what strengthens it, what weakens it, and above all what its significance is. When designing further studies, it is certainly worth considering the following reflections on the limitations of our research to date.

The course of the study could have been influenced by the large age difference between the respondents and the researchers. Talking about illness, loss and old age may have been a bit more difficult in the company of young women who were not patients. One should not exclude the role of feelings such as shame, which could hinder the process of freely speaking. At the same time, the age difference may appear as an advantage and hope for the surveyed women – that the younger generation is interested in their voice, that order has been "restored" when a young woman listens to the older woman to learn something herself. Moreover, the interviewed women were patients of both the therapeutic group and occupational therapy conducted by two researchers. Such a situation seemed to have a calming effect on the respondents: they talked to people they knew, whom they could trust – our experience and observations of numerous studies at the University Hospital indicate that patients prefer to talk to people they know.

The above-mentioned relationship of the two authors and professional experience in psychoeducational and psychotherapeutic work, grounded in psychoanalytic and existential thought, certainly influenced the analysis of the obtained data and the formulation of conclusions and recommendations based on it. However, the very basis of the chosen method of analysis is the assumption that the statements of the respondents are translated by researchers into the written word, and then paraphrased in interpretation. This specific interpretation is an attempt to reflect on, to make sense of, so it does not have the status of a conclusion "it is so", but rather: "it may be so" in the light of the premises which include not only the data provided in the study, but also the knowledge that the researcher conducting the study cannot forget.

Summary

The self-stigma manifested by the examined women seems to have many meanings. It protects them against confrontation with transience, gives hope for the future, and brings them closer to other people. It fills the void that grows bigger with age. So, in our opinion, it is not only behaviour that is hard to bear, but also a message that is directed at those who experience its consequences. Recognition of self-stigma as a significant form of behaviour may favour careful communication with the affected seniors. Seen from this perspective, they appear as people trying to maintain integrity in the face of the challenges posed by passing away. Recognizing self-stigma as a significant and, consequently, a valuable form of adaptation creates the ground for finding less costly ways of experiencing the inevitable.

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