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The Relationship Between Depression and Loss, Support System, and Perceived Health of the Elderly

Eleanor M. Foehner

THE RELATIONSHIPS BETWEEN DEPRESSION AND LOSS, SUPPORT SYSTEM, AND PERCEIVED HEALTH OF THE ELDERLY

Eleanor M. Foehner, B.A.

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Abstract

Adults between the ages of 65 and 90 were the subjects of a study to explore the relationship between depression and the variables of personal loss, support system, and perceived physical health. Thirty-four subjects completed a self-administered depression scale (the Geriatric Depression Scale) and a personal information sheet. The relationships between depression and perceived personal health was significant, as was the relationship between depression and the support system. The relationship between depression and loss was not significant. As one's perceived health became better, depression decreased. Likewise, as one's support system increased, depression decreased. Whether or not someone had experienced a recent loss had no relationship with depressive symptomatology. Other significant findings indicated that there was also a relationship between depression and satisfaction of living arrangements. The greater the satisfaction, the less pronounced the depression.

COMMITTEE IN CHARGE OF CANDIDACY:

Professor Patrick Openlander, Ph.D.
Chairperson and Advisor

Professor James D. Evans, Ph.D.

Professor Raphael Becvar, Ph.D.

Dedication

This work is dedicated to my family and friends who have patiently supported and encouraged me through all the difficult times as I struggled to obtain my degree. In particular, my parents and sister, who understood the missed holidays and my husband who understood the missed meals and to my children who understood the missed attention. Special thanks to Doris my supervisor, without whose encouragement I may not have completed my studies; and also my thanks to Brooks, who remained a faithful and comforting friend.

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CHAPTER I

INTRODUCTION

It has been estimated that by the year 2010 34.3 million people will be over 65 years old and 6.8 million people will be over the age of 85. That is an increase of more than two times the number of people in that age group as recorded by the United States census completed in 1983. It was further noted in that census that the group aged 65 and older had already grown especially rapidly, up 65% from 1962 to 1982. Although the older population, as a whole, is healthier than is stereotypically assumed, by the age of 85 over half report being limited or unable to carry out a major activity because of chronic illness. (U.S. Bureau of the Census, 1983.)

Because of this expanding population, a growing awareness of the needs of the chronically ill elderly and a commitment to meet these needs are essential. More specifically, mental health issues concerning this population group need to be addressed.

According to one study, mental health problems have been regarded as the largest single cause of chronic disability in the elderly, with depression accounting for half of all hospital admissions (Zarit,

1980). Because developmental issues change over time as the individual interacts with the environment, they can play a role in the emergence of mental illness at specific life phases. Developmental events of later adulthood such as retirement, loss of a spouse, change of residence, and declining physical abilities represent experiences that may necessitate restructuring one's life.

If one is unable to develop appropriate resources to cope with changing developmental issues, some form of mental illness or depression may be the result. Of the psychosocial precipitators of depression, stress factors or perceived stress have played major roles in depressive symptomatology. "Depression occurs when an event disrupts a role that had been primary in providing the basis for a person's sense of self and there are no alternatives that allow that sense of self to be maintained," (Oatley & Bolton, 1985).

In one study it was suggested, after a review of major investigations regarding depression, that, with a few exceptions, depressed subjects have experienced more stressful life events before the onset of the disorder than nondepressed persons in the same time period (Lloyd, 1980). In another study, (Blazer, 1980) it was determined that of the five factors having etiological significance in psychiatric disorders among

the elderly, three can be viewed as related to developmental tasks of later adulthood: environmental change, loss of social supports, and changes in physical status.

Other researchers have identified correlates and predictors of emotional well-being in older adults that can be interpreted as developmental issues of older adulthood, yet not exclusive to that age group. Factors such as viewing life as worthwhile and expanding one's life space (Adams, 1971); having a sense of financial security and satisfaction with one's life-style (Medley, 1976; Morgan, 1982); acquiring a positive perception about one's body and health (Baur & Okun, 1983; Larson, 1978); and engaging in self-expression and achieving a satisfying use of one's time (Lawton, Kleban & diCarlo, 1984) are important if an older adult is to feel emotionally good about his or herself.

"Quality of life" is a term used loosely to indicate general well-being. Among the indicators of a good quality of life are health, sufficient funds, absence of psychological distress, and availability of supportive family and friends (Staats & Stassen, 1987).

If the quality of life of older citizens is to be a major concern for our society, the factors that contribute to a good quality of life need to be studied

separately, as well as in relation to other personal factors or demographic variables. One indicator, absence of psychological distress or depression has been studied in terms of age and sex differences for certain population groups, in a general sense. (Himmelfarb, 1984; Kivela & Pahkala 1986; Krause, 1986). There have been vast amounts of literature on depression in relation to younger population groups. However, there have been few, if any studies, that have explored the relationship of demographic variables to depression in the elderly population with the expressed purpose focusing on improving quality of life for this country's older adults.

Statement of Purpose

The purpose of this study will be to make a comparison of specific demographic variables to the prevalence of depressive symptomotology in adults 65 years of age and older. Any correlations noted will be studied and used to address some of the mental health issues of the elderly relative to quality of life.

CHAPTER II

REVIEW OF LITERATURE

The recognition both that the population is aging and that the mental health needs of the elderly are often under served has increased interest in and concern about the mental health of older persons. Although the research varies considerably, according to several studies, (Berkman, 1971; Gurland, 1976; & Zung, 1967) the highest rate of depressive symptoms are found in the oldest age groups, above 65 years. The elderly population is expanding at a rapid rate. Concern for the mental health of our older population should be a concern for all of us, particularly as we look at quality of life in our older years and expense to the community as a whole. Of the various severe emotional and mental illness which occur in the elderly it is believed that depressive disorders are most common. (Gurland, 1976)

Factors Contributing to Depression

In order to mitigate or eliminate depressive symtomatologies and before looking at older adults specifically, information regarding contributing factors to depression should be taken into account.

In one such study, Warheidt (1979), collected data on the relationships between life events, coping resources and depressive symptomatology. Five hundred seventeen subjects were interviewed on two separate occasions, three years apart. Respondents with high life-event scores as measured by the Scale of Life Events were determined to have high stress levels and had significantly more depressive symptomatology than those with low scores. Those with personal, familial, and interpersonal resources (stronger support systems) had significantly less depressive symptomatology than those without such resources. The findings suggested that high stress levels, as measured by the Events of Life Scale increase the possibility of depressive symptoms.

O'Neil, Lancee, and Freeman (1986), interested in psychosocial factors as they relate to depression, studied four factors, family history of psychiatric illness; early loss of a nurturing relationship; stressful life events; and low social support, in this regard. The experimental group consisted of 160 university students diagnosed as depressed and receiving psychiatric services. Two hundred six randomly selected students from the general university population were chosen for the control group. Depression was measured by the Beck Depression Inventory. Family history of

psychiatric illness, stressful life events, and lack of confidant all had a significant, direct correlation to the occurrence of depressive symptoms. Early loss was not associated with depression, according to the findings in this particular study.

Other studies have suggested that life event stressors are risk factors for depression. In one such study, Aneshensel and Stone (1982) hypothesized that crisis events and ongoing problems in such areas as work, marriage, personal losses, and finances were associated with the incidence of depression. A large community sample (N = 1000) of Los Angeles County adults were interviewed and given the Center for Epidemiologic Studies-Depression Scale, a 20-item scale used to measure prevalence of depressive symptomatologies.

The independent variables, stress and social support, were significantly related to the levels of depression, as measured by the Depression Scale. Social support, as measured by an objective measure of close relationships and subjective measure of perceived social support, was inversely related to degree of depression. Depression decreased as the number of relationships and perceived support increased. Stress was measured objectively by number of discrete life-event losses and subjectively by a perceived strain index. (This encompassed issues of financial, marital, and

work-related sources.)

Depression increased as the number of losses and perceived strain increased. Conclusions drawn from this investigation suggested that the effects of stress on depressive symptomatology were similar regardless of low or high levels of support. The presence of support is beneficial in an end in itself; its absence is itself a source of stress.

Numerous studies have paved the way for additional research with regard to stress and depressive symptomatology. Oatley and Bolton (1985) conducted a study based on a theory that depression occurs with events that disrupt roles for which people lack alternative sources of self-definition. It is thought that for most people the most severe and typical stresses are psychosocial disruptions. These can include such events as a death of a loved one, retirement from a job, a divorce, a relocation, or an illness, for example. Although some depressive symptoms are physiological in nature and may include neurochemical depletions, they also take on significance in a person's inability to maintain an ordinary social life. By using a comparison of 12 studies on depression, Oatley and Bolton were able to present a single theory of depression combining the results of all of the studies. They identified depression as the

despair of a severe loss or disappointment from which there seems to be no escape. They believed by changing the circumstances, the methods of relating to an event or person, or by assuming a new or different role, the pattern or depression could then be altered.

From a related developmental approach, a longitudinal study (Reed, 1986), was conducted with 28 clinically depressed and 28 mentally healthy older adults (55 to 83 years of age) matched on sex, age, and, years of education. Developmental resources and depression were measured on three occasions for both groups using a measurement for developmental resources, the Developmental Resources of Later Adulthood Scale (DRLA) and a measurement for depression, the Center for Epidemiological Studies-Depression Scale (CESD).

The results indicated that the mentally healthy group scored significantly higher scores on the developmental resources scale and significantly lower scores on the CESD as compared to the depressed group. What this suggests is that mental health in later life may be related to developmental resources. The findings indicated that depressed older adults scored consistently lower on developmental resources than did the mentally healthy group over three measurement periods.

Age, Sex, and Depression

Since the current study focuses on the elderly population, and it has already been suggested that there are differences in regard to depression and stress levels at varying ages, it would be beneficial to explore these variations more closely. In one study, Zung (1967) attempted to clarify some of these age factors. He concluded, from his study of 169 geriatric patients, that the elderly have a higher baseline with respect to depressive complaints, and any evaluation of geriatric patients should take this into consideration. He believed that his findings corroborated previous ones that suggested that major reasons for feelings of depression in the elderly are frequently related to apathy, disinterest, feelings of inferiority, and loss of self-esteem. One problem with his results in this particular study is that 100 of the 169 individuals studied resided in a retirement home. Using nursing home patients as a sample to be generalized to the entire population is perhaps an erroneous assumption and an issue that needs to be addressed further.

In 1986, Kivela and her associate, Kimmo Pahkala, completed a study with regard to depression in the elderly Finnish population. In the study, the Zung Self rating Depression Scale (SDS) was administered to 1358 elderly adults. As already suggested, depression among

the elderly is at an elevated level normally compared with the general population. With this in mind, it was further suggested that there are differences in depression levels between the young-old and the old-old populations as well.

In this particular study, the primary factors of depression for young-old men and women (60-74 years of age) and old-old men (75 plus years of age) were loss of self-esteem. For old-old women (75 years and older) the primary factor was agitated mood with somatic symptoms. It was found that, overall, although the reliability of the SDS was high, sex and age differences need to be accounted for. (Kivela & Pahkala, 1986)

Other significant research has been conducted in regards to relating depressive symptoms with age and sex variables. As demonstrated in one study conducted by Hemmelfarb (1984), mental health was curvilinearly related to age with higher depression symptom scores obtained in both the 55-59 year age groups and 85-89 year age groups. Sex differences as related to marital status suggested that there were higher depression symptom scores among males who were ever married and among females who were in either the widowed or married categories.

For the study, 2,051 respondents of ages 55 years and older were included in the sample. The trait

anxiety inventory was administered to all respondents. The Center for Epidemiologic Studies Depression-Scale and General Well-being Scale, measuring subjective well-being and distress were also used as dependent variables, as well as age, sex, perceived physical health, locus of control, life events, and social support.

In the analysis, females reported higher frequency levels of depressive symptomatology than did males. However, when partitioned by marital status, only married and widowed females reported higher levels than their male counterparts. As further suggested by the study, perceived health was the single best predictor of mental health and had the strongest relationship with mental health even when other variables were statistically controlled.

In another study, Krause (1986) found that from surveying a group of 351 older adults, women were generally more depressed than men. His study included a random sample of noninstitutionalized adults who were 65 years of age and older. He believed that the results of the study showed that women experienced a greater vulnerability to chronic life stresses, in particular chronic financial strains.

Overall, what these data suggest are that the interactions among the factors examined can become quite

complicated. Because of the strong influence of perceived physical health, however, this particular study suggests implications for the mental health of the elderly. As a result of the study, the age-physical health relationship for the elderly is such that poor mental health is not an inevitable consequence of poor physical health for the elderly. Instead, what this study may suggest, at least for some elderly, is that how they regard their physical health could reduce some problems of mental health, if more positive attitudes are encouraged.

Measurements of Depression

In attempting to measure and quantify factors of stress and depression to be used to study the elderly, one can review the studies involving the use of various depression scales. Perhaps one of the most notable scales, the Depression Inventory, was one of the earliest measurements used to study depression.

In 1960, Beck et al. conducted a study in which he devised a Depression Scale to quantitatively measure intensity of depression. The Depression Inventory was administered to 226 clinic and hospitalized psychiatric patients. It was replicated using 183 of the initial patients after a seven month time span and results were matched with independent clinical ratings with regard to

depth of depression by psychiatrists.

As a result, Beck demonstrated that the inventory was able to discriminate among groups of patients with varying degrees of depression. He concluded it was a useful tool for research study of depression and assisted with psychiatric diagnosis on a quantitative basis.

In later studies, Zung (1964), designed a self-rating depression scale which he believed was shorter, simpler, and more effective than Beck's scale. It was self-administered and more accurate. In designing the scale he studied 56 subjects admitted to a psychiatric hospital for depressive disorders. The scale included 20 items and testing was administered prior to and following treatment for depression.

Zung (1964) concluded that the test was a valid quantitative measure of depression. He correlated sleep disturbance with depression, which he determined to be the most outstanding symptom of depressive disorders. There appeared to be a high correlation of patients for presence of depressive disorders, self-rating depression indices and EEG responses to auditory stimulation during sleep.

In 1982, a new depression scale was developed and validated for older adults, specifically. It has been felt that previously used scales have not addressed the

issues specific to the elderly population. For instance, somatic disturbances which are common symptoms of depression are also common in non-depressed elderly. (Coleman et al., 1981) and are uncommon in younger persons not suffering from depression. Normal decline in sexual function and the aches and pains associated with arthritis in normal aged might be symptomatic of depression in young persons.

Questions asked on some of the available depression scales may not be relevant for the elderly. The format of the scale may be too difficult and confusing.

The Geriatric Depression Scale (GDS) was designed to be used specifically for older adults. Validation of the 30 item scale was made in a study of 100 senior citizens, 40 normal elderly persons and 60 depressed elderly individuals. The depressed elderly were subsequently divided into mildly and severe groups on the basis of whether they met the Research Diagnostic Criteria (RDC) for a major affective disorder. By doing this, a mild depressive group (N=26) and a severe depressive group (N=34) were formed.

All subjects were given 30-60 minute interviews, in which they were given the HRD-S and two self rating scales, the SDS and GDS. As a result, the GDS was shown to be a reliable and valid measure of geriatric depression. A high degree of internal consistency was

found for the scale, and total scores for the GDS were reliable over a one-week interval. The correlation of validity between the GDS and the SDS, the correlation between the GDS and HRS-D, and the correlation between the SDS and HRS-D were statistically reliable at or beyond the .001 level.

In another study, the GDS was compared with both the Center for Epidemiological Studies Depression Scale (CES-D), the Hamilton Rating Scale for Depression (HRS-D), and the Depression Adjective Check List (DACL). Each scale discriminated between depressed and nondepressed subjects.

In the most recent revision of the GDS (Sheikh & Yesavage, 1986) a shorter form was developed to reduce the time an elderly person would require to do the questionnaire by selecting 15 items from the 30 question GDS that have the highest correlation with depressive symptoms in validation studies.

The questionnaire, arranged in a 15-item, one-page yes/no format (GDS Short Form) was compared with the 30 item long form for purposes of validation. Thirty five subjects were included in the study. The subjects consisted of 18 normal elderly from the community and 17 older adults in a variety of treatment settings with complaints of depression. The latter group met the DSM-III criteria for either a major depression or a

dysthymic disorder. All subjects were over 55 years of age, and the subjects included both males and females.

The subjects were all given both the Long and Short Forms of the GDS for self-rating of depression symptomatology. Both were successful in differentiating depressed from nondepressed subjects with a high correlation ($r=.84$, $p < .001$).

Overall, it is felt from the results of this study that the Short Form of the GDS provides an accurate screening device for elderly individuals. It is easy to administer, takes little time to complete, and is especially suited for the older population.

Hypothesis

For this particular study, it has been hypothesized that for the elderly, there is a significant positive correlation between depressive symptomatologies, as measured by the short form of the GDS, and personal losses. Also, that there is a significant negative correlation between depressive symptomatologies, measured by the same means, and support system and perceived physical health, respectively.

CHAPTER III

METHOD

Subjects

The subjects in this study consisted of 12 men and 22 women between the ages of 65 and 90, who were selected randomly from the files of the Missouri Division of Aging. Of the 150 individuals who were initially contacted by mail, 38 responded. Ten questionnaires were returned by the post office as being "undeliverable". Six were returned uncompleted. Of the 38 returned and completed, 4 questionnaires were unusable because of either incomplete or incorrectly completed forms. The remaining 34 questionnaires were used in the study. Thus, the effective return rate in this survey was 23%.

Research Investigator

The research investigator was a master's level student enrolled in a counseling psychology program. No special training was necessary to complete the study.

Primary Instrument Used--
The Geriatric Depression Scale (GDS)

The Geriatric Depression Scale has been

specifically designed for measuring depression symptomatology in the elderly. In its long form, it is a 30-item questionnaire. A short form consisting of 15 questions has also been developed.

In its original development, 100 questions were selected by a team of clinicians involved in geriatric psychiatry. All questions were believed to have the potential for distinguishing elderly depressives from normal individuals.

Yesavage, Brink, Lum, Heersema, Aday, and Rose, (1982) administered the self-rating form to 47 subjects over 55 years of age, in two separate groups. One group consisted of normal elderly individuals living in the community without a history of or complaints of depression. The other group consisted of male and female subjects hospitalized for depression.

Data analysis identified 30 questions from the 100 item questionnaire that correlated best with the total score and would be most likely to measure depression. These 30 questions were selected for inclusion of the GDS.

Yesavage et al., (1982) also chose two groups of geriatric subjects for the validation phase. Forty elderly subjects without any history of mental illness were chosen for the one group. Sixty elderly subjects under treatment for depression were chosen for the second group of subjects. The subjects within the latter

group were further differentiated in mild and severe depression groups based on the Research Diagnostic Criteria (RDC) for a major affective disorder. Twenty-six subjects met the criteria for mild depression. The remainder were included in the severe group.

Four measures of internal consistency were computed for the three depression scales used in the study. The GDS was compared with the Hamilton Rating Scale for Depression (HRS-D) and the Zung Self-Rating Depression Scale (SDS).

The overall measure of internal consistency for the GDS was a computed value of 0.94 for the alpha coefficient. The computed values of the alpha coefficient for the SDS and HRS-D were 0.89 and 0.90, respectively. (Yesavage et al., 1982)

The split-half reliability for the GDS, SDS, and HRS-D were found to be 0.94, 0.81, and 0.82, respectively. Test-rest reliability was measured for the GDS by having 20 subjects complete the questionnaire twice, one week apart. A correlation of 0.85 was obtained. (Yesavage et al., 1982)

Research on the GDS further suggested the test to have adequate validity. Construct validity was proven highly significant for the GDS as a measure of depression, as well as the SDS and HRS-D.

> Given previous findings indicating that SDS (Zung, 1965 Hedlund and Vieweg, 1979) and HRS-D (Carroll et al., 1973; Hamilton, 1960, 1967; Biggs et al., 1978; Knesevich et al., 1977) are valid measures of depression, positive correlations between these measures and the GDS would provide evidence for the scales' convergent validity. The obtained correlation between the GDS and the SDS was found to be 0.84 while a correlation of 0.83 was found between GDS and the HRS-D. The correlation between the SDS and the HRS-D was 0.80. All of these correlations were statistically reliable at or beyond the 0.001 level. (Yesavage, Brink, Rose, Lum, Huang, Adey, & Leirer, 1983)

A shorter form of the GDS was developed and proven to be valid and reliable measure of depression in a study conducted by Sheikh and Yesavage (1986). Fifteen questions were selected from the GDS which had the highest correlation with depressive symptoms in previous validation studies. These questions were arranged in a 15-item, one page, yes/no format (GDS, Short Form) similar to the longer version of the GDS. Of the 15 items that were included in the questionnaire, 10 indicated the presence of depression when answered positively, while the remainder (Nos. 1, 5, 7, 11, 13,) indicated depression when answered negatively.

In the validation study, the Long Form of the GDS was compared to the Short Form of the GDS. Thirty-five elderly subjects were included in the study. The subjects consisted of 18 normal elderly from the community, and 17 elderly patients in various treatment settings who had complaints of depression.

The latter group of elderly met the DSM-III criteria of either a major depression or a dysthymic disorder. Both male and female subjects were included and all were above the age of 55 years. Both the long version and short version of the GDS were given to all subjects. Both forms were successful in differentiating depressed from non-depressed subjects with a high correlation ($r = .84$, $p < .001$).

Procedure

A systematic random sampling technique was used to select 150 individuals from the files of the Division of Aging as possible subjects for a study on depression and the elderly. All individuals resided independently within the community.

The 50th person was chosen at random from the files as the first possible subject for the study. Every 40th person was selected thereafter until 150 names were chosen.

If an individual did not fall into the age group

being studied, then that person was not considered for the study and the next person in the sequence was chosen by the selection process until 150 potential subjects were selected.

All the potential subjects who were selected for inclusion in the study were mailed a two-page questionnaire. The questionnaire consisted of the short form of the GDS (see Appendix A) and a demographic information page (Appendix B). A cover letter (Appendix C) and a stamped, return envelope were mailed to each of the potential subjects along with the two-page questionnaire.

The cover letter included the date for the forms to be returned, which was two weeks from the date they were mailed to the subjects. A space for the subjects to request the results of the study was provided in the cover letter.

Protestants, 12 Catholics, one Jew, and 4 uncommitted subjects in terms of religious preference. Fifteen subjects were widowed. Ten subjects were married. Three were divorced. Five were single. One subject claimed the status of being separated.

The statistical tests used to evaluate the data were the Pearson product-moment correlation coefficient and the t test for independent samples. The .05 level of significance was used for all the tests. The .01 level of significance was also used for one of the tests.

The resulting relationships hypothesized in the study were mixed. Although there was a moderately significant correlation between depression in the elderly, as measured by the GDS and support system, there was a strong correlation between depression in the elderly and perceived personal health. There was no significant correlation between depressed elderly and personal losses as measured by this study. The specific statistics are presented below.

Depressed Elderly and Support System

The question "How many family members or close friends do you do things with?," as included on the second page demographic/informational of the survey (see Appendix B), determined the support system for the

CHAPTER IV

RESULTS

Subject Demographics

Included in the study of 34 subjects were 12 males and 22 females. Statistically this accounts for a population consisting of 35% male and 65% female subjects. Of the males studied, 58% were white. The remainder were black. The average age for male subjects was 73 years. Forty-one percent of the male subjects were Catholic. Protestants were represented by 41%, as well. The remainder were uncommitted as to religion. Represented were 3 married, 3 widowed, 3 single, and 2 divorced males, as well as one separated man.

The average age for female subjects was 75 years. There were 18 white and 4 black females in the study, accounting for a representation of 86% white females. Eleven women were of the protestant faith. Eight were Catholic. One woman was Jewish. Two women professed no religion affiliation. Of the 22 women represented, 12 were widows, 7 were married, 2 were single, and one was divorced.

Overall, of the 34 subjects included in the study, the average age was 74 years. Twenty-five whites were represented, as compared to 9 blacks. There were 16

elderly subjects studied. Due to 2 ambiguous answers given in the study, only 32 subjects were able to be compared with the 15 item depression scale. The proportion of variance in Depression accounted for by support system was .138. The inverse correlation was significant at the .05 level, r (30) = -.371.

Perceived Health and Depression

Perceived health was measured by subjects' responses to the question, "How would you rate your personal health on a scale of 1-5?," 1=poor and 5=excellent (See Appendix B). For the 34 subjects who responded, the data resulted in a significant negative correlation between perceived health and depression, (r(32) = -.470. p <.01). The proportion of variance in depression accounted for by perceived health was .221.

Personal Losses and Depression

Personal losses were measured by subjects' responses to the question, "Have you experienced any personal losses within the past three months?", as found on the second page, demographic information part of the survey (see Appendix B). Thirty-four subjects responded to this question. Their yes/no answers were compared to depression symptomatology, as measured by the GDS. The proportion of variance in depression accounted for by

loss was found to be .109. ($r(32) = .330$). The results were only marginally significant, at best, at the .06 level.

Table one shows the means, variances, and standard deviations for each of the comparisons made in the study.

Table 1

Means, Variances, and Standard-deviations of Variables Used in the Study

Variables	N	M	V	SD
Loss	34	.176	.150	.387
Perceived Health	34	2.235	1.519	1.232
Support System	32	6.656	41.394	6.434
Depression	34	5.176	18.150	4.260
	32	4.938	17.738	4.212

CHAPTER V

DISCUSSION

This study explored the relationship between specific demographic variables and depression in elderly adults, residing independently within the community. Specifically, the psychosocial factors used as independent variables in the study included personal support system, perceived physical health, and personal losses. A positive correlation was found between individual support system and perceived physical health when compared to depressive symptomatology in elderly adults, supporting the hypothesis that both of these factors were significant. Recent personal losses were not significantly related to elderly adults showing depressive symptoms.

Support System

As shown by this study, there appears to be a moderately high correlation between support system and depression. This is congruent with other studies involving correlations between depression and support systems. Brown (1975) identified the presence of a "confidant" as a crucial protective factor that modified the impact of stressful life events and reduced the risk for depression in working women. Other

investigators (Lin et al., 1979) found that social support has a direct effect on depression.

O'Neil, Lancee, and Freeman (1986) conducted a study involving university students, in which family history of psychiatric illness, stressful life events, and lack of a confidant all had significant, independent direct effects on the occurrence of depressive symptoms. "The lack of confidant has already been shown to be a risk factor that appears to apply across all other age groups." (O'Neil et al., 1986, p.22.)

This is also consistent with Ameshensel and Stones' findings (1982), which indicated that "social support may itself be important in ameliorating depressive symptoms. Moreover, assuming that lack of perceived or actual social support is not just a manifestation of depression itself, our findings support the corollary that the lack of social support contributes to the creation of depressive symptoms."

Other aspects of the relationship between a support system or social network and depressive symptoms can be noted. One consideration is how the support system correlates with and influences the depressive symptoms. This may become very complicated as, suggested by one study, a distinction between positive versus negative aspects of social networks need to be accounted for in relating them to depression.

A strong support system may not be a totally positive influence on an individual, according to findings of Pagel, Erdly, and Becker (1987). Instead, they concluded from their study that "the influence of upsetting, negative network interactions may be seen in indicators of negative affect such as depression.... whereas network helpfulness may influence overall subjective well-being through its relation with positive affect." (p. 802)

Other findings related to support systems and depression show different factors as influencing the relationship, a relationship that might not be a direct one in and of itself. Ameshensel and Stone (1982) conducted a study in which they tested the buffering model of social support as it relates to depression. In forming an alternative concept for the role of social support in the etiology of depression, the study suggested, they believed, a more tenable alternative than the buffering model.

In the buffering model, support is a moderator of stress. Stress is significantly correlated to the incidence of depression. Brown and Harris (1982) studies this model and concluded that support does create a buffering effect for depression.

Contrary to the buffering model, Aneshensel and Stone found that stress was found to have a "positive

association with depressive symptomatology among those individuals reporting high, as well as low, levels of social support. Support did not significantly alter the relationship between stress and depression." (p. 1394)

Personal Health

How people view their physical health or well being seems to be highly significant in relation to their mental health, according to the study conducted. This has been supported in previous studies, as well.

In his study of mental health in adults over 55 years of age, Himmelfarb (1984) found that "physical health was the single best predictor of mental health and had the strongest relationship with mental health."

In another study (Lubin et al., 1988), demographic variables, depressive affects, and health were compared in an extensive study including 1,543 adults. Results showed that there were highly significant correlations between self-ratings of health and affect variables. People who were less depressed and more positive rated their health as being better than their more depressed and more negative counterparts.

Loss

The results of recent personal loss when compared to degree of depression were not statistically

significant in this particular study. It is possible that some deficiencies in the research accounted for these results.

One possibility for the insignificant results regarding this variable was the format of the measure for loss that was used. The question, "Have you experienced a personal loss within the past three months?" might be more effective if it distinguished varying gradients of loss by significance to the individuals, rather than using a yes/no format. This would allow more subtle distinctions for measuring the factor of loss.

The time frame in which the loss occurred was also restrictive. Since the grieving process after a loss varies from individual to individual, it could be possible that grieving could be delayed for years or even absent in some cases. (Badal, 1988) Since the symptoms of grief and depression can be very similar in nature, it could be difficult without knowing someone's history to make a distinction between one or the other. "When grieving is delayed, it may not be recognized as a reaction to the original loss...Frequently, the patient's depression began with a significant loss, but in other cases there may be only an indirect relationship between the current depression and a previous loss." (Rush, 1986) It could be possible that

a loss experienced within the past three months, as questioned in the survey for purposes of this study, might not be grieved at this time. Also, a person who had experienced a loss years previously might currently be starting the grieving process. This grieving process could possibly be mistaken for depression, as a result of scores on the GDS.

Furthermore, the confounding factors of support system was not taken into consideration when looking at these findings. Particularly considering a recently experienced loss, it is possible that a positive support system would reduce the presence of depression symptomatologies. This is the time period when close friends and support networks seem to respond to individuals more intensely. As a result, this would tend possibly to ameliorate the depression symtomatology. After a time lapse from the initial onset of the loss, a support system may decrease or the realization of the actual loss, not thought about earlier because of involvement with busy reactions to the initial crisis, may impact an individual. They would tend to be more depressed at a later period of time.

Although the data for two of the three hypotheses studies were significant, there are apparently numerous other factors that could be related to depressive

symptomatology of the elderly. One factor, living satisfaction, was addressed on the demographic informational sheet in the form of a 5-point gradient for satisfaction with living situation. In comparing the subjects' responses with the depression scale, a significant negative correlation found. $r(32) = -.508$, $p < .01$.

Perhaps what can be suggested from the results of this study is that depressive symtomatology in the elderly correlates with a variety of factors and encompasses varied interrelationships among life developments, coping resources, and psychosocial factors. Warheit (1979) concluded from his research that subjects with personal, familial, and interpersonal resources had significantly less depressive symptomatology than those without such resources. He believed that the findings "demonstrate the complex interrelatedness of life events, coping resources, and depressive symptomatology" (p. 409).

In a more recent study involving older adults (Reed, 1986), developmental resources were correlated with depressive symptomatology. Developmental resources, as broadly defined by Reed, includes an individual's ability to free one's self of less useful operations and to acquire more effective resources to be used in adjusting to one's life-context. A mental illness such

as depression can occur during various developmental events or crisis in one's life if developmental resources are not available or used. In Reed's results, the conclusion that mental health in later adulthood is linked to developmental resources was a significant finding.

An alternative way of conceptualizing the idea of developmental resources and their significance as related to depression can be seen. In an intensive study conducted by Oatley and Bolton (1985) with regards to depression, they concluded that "depression occurs with events that disrupt roles by which people define their worth, if these people lack alternative sources of self definition" (p. 372).

Methodological Limitations

Part of the weakness of the present study was the limited number in the sample. The smaller the sample the less likely the results will represent the population being targeted (Evans, 1985). Perhaps with a larger sample from a more diverse population the results would have differed. Many elderly and senior citizens are unknown to the Division of Aging and were not included in the study.

Several questions of believed significance were omitted in the demographic section of the survey. In

particular, whether a person had a history of mental illness or whether there was history in the person's family was not addressed. Such a seemingly minor issue as transportation is very important for senior adults. No longer being able to drive or being without dependable transportation could influence depressive symptomatologies. This variable was not addressed in the study.

Depression can be chronic or situational in nature. In this particular study, the distinctions would not be addressed due to the limited measures used. As previously mentioned, by omitting familial data regarding any history of depression, important information was not available for comparative purposes in the study.

Another possible deficiency of the short form of the GDS could be the form itself. Although the simplified yes/no format made the questionnaire easy to understand, it did not allow for any individual variations or gradients in responding to the questions.

Overall, the factors related to depressive symptomatology with the elderly are quite complex. In additional to developmental and psychosocial issues, neurochemical factors, resulting from various sources could have an impact on depressive symptoms. This complexity of the variables that relate to depressive

symptomatology makes studies in this area difficult. Losses, support systems, changing life situations, health factors, financial concerns are just a partial list of the confounding of issues when researching this topic. Biological, psychological, as well as social variables are all involved in the etiology of depression. Future studies appear to be needed in areas of prevention and minimization of depression for the elderly so that maintenance of a healthy, contented, and productive or meaningful quality of life can be attainable for all older adults.

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APPENDICES

Appendix A

Mood Scale

Name _____ Date _____

MOOD SCALE
(short form)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? .....YES / NO
2. Have you dropped many of your activities and interests? .....YES / NO
3. Do you feel that your life is empty? .....YES / NO
4. Do you often get bored? .....YES / NO
5. Are you in good spirits most of the time? .....YES / NO
6. Are you afraid that something bad is going to happen to you? .....YES / NO
7. Do you feel happy most of the time? .....YES / NO
8. Do you often feel helpless? .....YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? .....YES / NO
10. Do you feel you have more problems with memory than most? .....YES / NO
11. Do you think it is wonderful to be alive now? .....YES / NO
12. Do you feel pretty worthless the way you are now? .....YES / NO
13. Do you feel full of energy? .....YES / NO
14. Do you feel that your situation is hopeless? .....YES / NO
15. Do you think that most people are better off than you are? .....YES / NO

Appendix B

Demographic-Data Form

AGE_____

RELIGION_____

ANCESTRAL ORIGIN_____

MARITAL STATUS: (CIRCLE ONE) SINGLE___, MARRIED___, DIVORCED___, SEPARATED___, WIDOWED___?

FOR HOW LONG HAVE YOU HELD THIS STATUS?_____

HOW LONG HAVE YOU LIVED AT YOUR CURRENT ADDRESS?_____

HOW WOULD YOU RATE YOUR SATISFACTION WITH YOUR CURRENT LIVING ARRANGEMENTS? (CIRCLE ONE) 1-NOT SATISFIED, 2-SOMEWHAT SATISFIED, 3-SATISFIED, 4-MORE THAN SATISFIED, 5-VERY SATISFIED.

HAVE YOU EXPERIENCED ANY PERSONAL LOSSES WITHIN THE PAST 3 MONTHS?_____
IF YES, EXPLAIN WHAT KIND OF LOS IT WAS._____

_____

DO YOU HAVE ANY IMMEDIATE FAMILY MEMBERS OR CLOSE FRIENDS WITH WHOM YOU DO THINGS WITH?_____

HOW WOULD YOU RATE YOUR PERSONAL HEALTH ON A SCALE OF 1-5? (CIRCLE ONE) 1-POOR, 2-FAIR, 3-AVERAGE, 4-VERY GOOD, 5-EXCELLENT.

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING (prescription or non-prescription), ON A REGULAR BASIS?

LIST IF KNOWN	MEDICATION	PURPOSE
	1)_____	_____
	2)_____	_____
	3)_____	_____
	4)_____	_____

Appendix C

Questionnaire Cover Letter

Eleanor M. Foehner
1863 Buckington Dr.
Chesterfield, MO 63017

Dear Sir/Madam:

I am a student in the master's program in Counseling Psychology at Lindenwood College. As part of the requirements for this program I am conducting a research project. My research project consists of a study of individuals between the ages of 70-90. I would very much appreciate your participation by answering the attached two pages of questions. asking for information about yourself.

Your participation is completely voluntary and confidential. The reporting of results will include no names or identifying information of individuals. All information will be used only for the purposes of the study.

When you have answered the questions in the study, please return the information in the self-addressed stamped envelope provided. The information needs to be returned by . If you decide not to participate in the research project at any time subsequent to receiving these forms, please return the forms without completing them.

The results of the survey will be shared with all participants who indicate they wish to know the results. Please complete the section below if you wish to be notified of the results, and return this section with the forms that you have completed.

NAME

STREET

CITY STATE ZIP

Sincerely,

Eleanor M. Foehner