Depression in older persons who are chronically ill

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This study explores the severity of depression in older persons who are chronically ill. The study was an attempt to determine if there is a significant relationship between four independent variables—family support, social support, marital status, and gender. The study was conducted while respondents were hospitalized at Clayton General Hospital. The research concluded that most older chronically ill persons were not depressed or were only mildly depressed. Significant factors were gender. Females reported more incidence of depression than males and single respondents reported higher incidences of depression than married persons. Suggestions for identifying depression in older persons were indicated and implications for social work practice for working with this unique population were discussed.
DEPRESSION IN OLDER PERSONS WHO ARE CHRONICALLY ILL

A THESIS
SUBMITTED TO THE FACULTY OF
CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
ROXANNE TURNER
SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
1990
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CHAPTER ONE
INTRODUCTION

Depression is a rather common term used in describing one's mood. The following words or phrases are used in describing depression: "Down in the dumps," "Under the weather," and "Having the blues." The dictionary describes depression as a mental disorder of psychotic proportions characterized by sadness, retardation or motor and certain vegetative processes, feelings of inadequacy and self-depreciation, and often by suicidal attempts. (Webster's Third New International Dictionary, 1976.) This research will focus on people over 60.

Depression can range in varying degrees and intensity. There are three main types of depression that are most common. Whitehead (1974) classifies depression as follows: "Mild mood disorders, reactive and neurotic depressions and severe depression. Mild mood disorders can be characterized by feelings of unhappiness possibly related to financial difficulties, losses of friends or relatives. This type of depression usually doesn't last long and the individual usually isn't seen by a mental health practitioner. Most people have experienced this type of depression at some point in their life.

Reactive depression is related to an outside event that occurs. "The sufferer complains of feeling unhappy, has
difficulty in getting to sleep and may feel worse under specific conditions" (Whitehead, 1974, p. 265).

"Severe depression is typified by subjective feelings of great misery, mental and physical slowing, sleep disturbance, loss of appetite and weight, constipation, loss of interest, and the ability to concentrate, morbid thoughts, delusional beliefs and agitations" (Whitehead, 1974, p. 27).

This research will attempt to look at all three types of depression and their relationship to the chronically ill elderly. "Medical illness is not pleasant to endure at any age, and for the older adult it is even more difficult. Although most older people are not sick, the prevalence of chronic illness is great" (Billig, 1987, p. 11). Most elderly suffer health problems that are chronic in nature, such as arthritis, heart disease and respiratory problems. Chronic illness is generally long lasting and varies in degree of disability. Billig suggest that chronic illness may play an important part in the development of depression in the chronically ill elderly. "Hip fractures, cataracts, and the surgery required to treat them are stressors that many elderly people endure, but they may serve as focal points for the onset of depression" (Billig). It would seem that if depression was likely in chronically ill older persons then a lot of attention would be given to diagnosing and treatment of depression in older persons. However, depression in older people often gets overlooked or not
taken seriously by health care providers. Depression is often regarded as being a normal part of the aging process and something that should be accepted by the elderly. Even if they are recognized as being depressed, the diagnosis may be dismissed as unimportant or seen as a natural consequence of being old and therefore something that should be accepted by the patient" (Murphy, 1985).

Elderly who are chronically ill usually suffer from an illness which is related to some degree of physical pain. The elderly who are depressed and chronically ill should not have to suffer mental pain as well as physical pain. The chronically ill elderly deserve to live quality lives and should not accept depression as a natural consequence of being old. Physicians and other caregivers of the elderly need to be able to identify depression and formulate appropriate plans of treatment for the elderly with chronic illness as well as those elderly who have no chronic disease. Major depression or dysthymic disorders are not normal responses to aging or chronic or terminal medical illness. They are additional clinical entities that respond to aggressive treatment (Dreyfus, 1988).
Statement of the Problem

Studies report a 10% incidence of depression in the elderly community, with a range of 20% to 50% on the hospitalized elderly. Depression that is not diagnosed and treated can result in morbidity and mortality (Dreyfus, 1988, p.27).

The researcher felt that depression in older persons is often overlooked or not taken seriously by physicians and other health care professionals working with the elderly. The goals of this research were to try to identify the problem of depression in older persons with chronic illness and explore possible options for interventions to use specifically for older persons with chronic illness. Current resources for meeting the mental health needs of older persons appear to be scarce and inaccessible to older persons with physical limitations. Mental health resources for older persons were expanded on in preceding chapters of this research.

Variables that were used in this research are social support, family support, gender and marital status. This research will attempt to answer the following questions: (1) Does depression exist in the chronically ill elderly? (2) What impact does family support have on the degree of depression in the chronically ill elderly? (3) What impact does social support have on the chronically ill elderly? (4) Is marital status a factor in the
degree of depression in older persons? (5) Are chronically ill females more depressed than chronically ill males in later life?

Purpose/Significance of the Study

The objectives of this study are the following: (1) to examine the degree of depression in the chronically ill elderly, (2) to examine the causal factors of depression in older persons with chronic illness, (3) to formulate ways to identify depression in chronically ill elderly, (4) to educate physicians and caregivers of the elderly to the problem of depression, and (5) to put together treatment modalities that meet the unique needs of the chronically ill elderly.

The researcher chose to do this thesis on depression and the elderly because she is concerned with the mental health needs of the elderly with chronic illness. "It is estimated that eight million elderly in the United States live in conditions conducive to the development of mental illness" (National Council on Aging, 1978).

It seems that the State of Georgia provides for the basic physical needs of the aged. Programs like Meals on Wheels, Food Stamps, Medicare and Home Health all contribute to the physical health of the elderly. However, there appears to be a lack of services to meet the mental health needs of the elderly. "Because
depression is more prevalent in the elderly population than in any other group, it represents a major mental, medical, and social problem that may potentially touch us all" (Billig, 1987, p.4). Mental health needs of older persons are just as important as physical needs and the resources necessary to address those needs. Advances in medical technology have enabled older persons to live longer; however medical technology has not given much attention to the quality of life for older persons. Now that life spans have been expanded, it is time to look at the quality and satisfaction of life in the aged.

"Depression can be so severe that it is a common precursor to suicide, a major cause of death in the aged" (Chenitz, 1979). "Theodore Lidz (1968) calls the increasing size of the aged population one of the major social problems of contemporary society. Above all, this group will place increasing demands on health professionals to care for their members who are suffering from chronic conditions and depression" (Stewart, 1976, p.5). With the increasing number of elderly in our society, social workers need to be aware of the unique problems and needs of this group. Hopefully, this research will help social workers gain an insight to the issues of depression in the chronically ill elderly and possibly into the modalities for treatment for this group.

This research may also be used as a guideline for legislators to prompt them to allocate funds to provide increased mental
health services which are easily accessible to the chronically ill elderly.

Statement of Hypothesis

There was no significant relationship in depression scores in regard to family support, social support, gender and marital status in older persons who are chronically ill.
Most research that has been conducted on the aged has included variables such as social factors, income, physical health, sex, and organic brain problems. One major study which provided a wide variety of issues concerning the elderly was the Duke Longitudinal Study. This study observed individuals 60 years old and older, and observed them for 20 years or until death. The results of this study are as follows: "The proportion of people rated depressed remained remarkably constant at approximately 20-25%. These data demonstrate that depression is exceedingly common in well-functioning elderly people living in the community" (Gianturco and Busse, 1978, p.5). This study concluded that there were sex differences in relation to depression. "Repeated episodes of depression in women is significantly associated with their financial state whereas in men, physical function is the most significant variable. The finding that there is an association between depression and the older person's health status is not a new observation" (Gianturco and Busse, 1978, p.7).

Feinson (1987) evaluated fifteen community studies which were designed to test the psychological impairment of older adults. The studies concluded that females showed higher trends of clinical depression and major depressive episodes than males.
One possible explanation for the finding that physical function is associated with increasing depression in males, may be that loss of physical strength in males may lead to loss of self-esteem, which leads to depression. In 1974, Nowlin performed a similar study over a ten year period of time. Nowlin specifically analyzed the relationship between depression and health in the aged. He speculated that "poor health with its attended discomforts may invoke the feeling state of depression."

The previous studies suggest that physical health may be a strong component in the development of depression in older persons. It is interesting to note that the Duke study also found depression to be common in well-functioning older persons.

In a more recent study, Murphy (1982), compared elderly depressed subjects and elderly subjects who were not depressed. He found "an association between severe life events, major social difficulties, poor physical health and the onset of depression" (Hanley and Baik, 1984, p.216). Another more recent study involved examining a self-report inventory of 246 older adults ages 60-80. What these researchers found was congruent with previous studies. "Disability exerts a more harmful effect on psychological adjustment than any life stressor for adults" (Zautra, Guarannaccia, and Reich, 1987, p.518).

In the past, there appears to have been a lack of research that did not specifically concentrate on the relationship between
physical illness and depression in older persons. There currently appears to be researchers who are gaining interest in the relationship between depression and physical health in the elderly. "Several recent studies have suggested that among the elderly with acute and chronic medical problems, the prevalence of depression ranges from 15% to 45%" (Rapp, Walsh, Parisi, and Wallace, 1987, p.509).

This thesis is different from past research in that its primary focus was on chronic illness and the elderly. The results of the most recent study concludes that health problems combined with lack of social support had an impact on the development of depression in older persons. "Phifer and Murrell (1986) confirmed that loss events were associated with the onset of depression but pointed to health problems and minimal sources of social support as having an even greater depression-inducing effects in this group" (Carson, Butcher & Coleman, 1988, p.298).

Even though the previous research strongly suggests a positive relationship between physical health and depression in the elderly, there have been some studies that have looked at variables such as family support and found different conclusions. In the National Depression Survey which was done in 1968, it was suggested that depression peaks between age 40-60 and then decreases.

There has been considerable evidence relating lack of social
support to depression in the elderly. "Support from both family and friends has been associated with less depression" (Smallegan, 1989, p.45). This thesis will observe family support among the chronically ill elderly which was unique from other research that has been done.

In doing research for this thesis, another problem seems to be consistent with regard to depression in the chronically ill elderly. Individuals who are depressed often go undetected by physicians and family members "because even moderate depressive symptoms are distressing to the person experiencing them. Recognition of the condition with subsequent treatment or support would be useful. Unfortunately, depressive symptoms are often ignored because physicians may be inattentive to the mental and behavioral problems of older people" (Smallegan, 1989, p.45).

Most older persons rely on their family physician for overall care and if the family physician is overlooking a depressive disorder then the elderly aren't living the quality lives that they should be. Many depressed elderly will not be recognized as being depressed, and therefore their overall care is likely to be less than optimal" (Frengley, 1987, p.29). Perhaps physicians don't feel that the depression is severe enough to warrant treatment or maybe they are just ignorant to the fact that it exists. Another problem in diagnosing depression is that it often gets misdiagnosed with dementia. "Consequently, diagnosticians
who exclude depression in their list of potential diagnoses in the elderly patient, either because they are unaware of its prevalence or because they consider it to be normal characteristic or senescence, are bound to misdiagnose depression as either organic brain syndrome or some other know or unknown chronic physical ailment" (Stewart, 1985, p.15).

In conclusion, the literature suggests that chronic illness is definitely a factor in the development of depression in older persons. Some researchers suggest that family support may hinder incidences of depression in older persons with chronic illness.

This study was different from other studies that have been done in that it was completed in a short time frame. This study was current for 1990 and involved individuals who were hospitalized. Many of the previous studies focus on individuals in the community. Gaining an understanding of depression and being able to identify it will lay groundwork for treatment modalities for Social Work practice.

Theoretical Framework

Theories on depression can be traced back to Sigmund Freud (1940s) who postulated that depression was primarily caused by biological factors. However, "He finally sided with Karl Abraham, who argued that depression was a psychological illness that
developed in people with an excessive need for nurturing, approval, and emotional support" (Young, 1988, p.301).

In the 1960s theories regarding depression in the elderly suggest that the elderly suffer many losses and have stressors that are unique to that age group. "Sixty to eighty percent of depression in the elderly is precipitated by incisive events, almost all losses. Losses of all kinds are suffered on a scale that few have experienced before" (Stewart, 1985, p.61). The elderly experience a variety of losses that may occur in a short period of time. The aging process causes loss of physical vigor and stamina, loss of senses such as sight, smell and taste. The elderly also experience a variety of social losses which include loss of income, peers and spouse.

Bowlby (1983) contributed to the theory of object loss. "He hypothesized that depression in adult life is related to losses which revive memories of poorly managed losses in infancy" (Murphy, 1986, p.75). The object loss theory is interesting in that it suggest that the roots of depression are established early in life and may make some individuals more than others vulnerable in establishing depression. Other theories that blend in with Bowlby's are Beck's notion of hopelessness and helplessness. Beck (1967) suggests a cognitive triad of negative conceptions of self, negative interpretation of one's experiences and a negative view of the future are characterized by ways of thinking which leads to
Beck also believes that individuals may be predestined to depression because of negative views. In 1970, Seligman expanded on the theory of "learned helplessness." Seligman (1975) theorized that when losses occur which include loss of income, peers and spouse they come to believe that outcomes are independent of their behavior and congruently they reduce their attempt to influence the environment" (Murphy, 1985, p. 85). What this means is that individuals tend to give up when they are faced with uncontrollable events, hence, a sense of "learned helplessness" is instilled in them. This theory can be applied to the elderly who experience many losses such as loss of control, declining physical ability and other losses which have previously been mentioned.

Another theory that is worth mentioning is that of coping and adaptation. Kerman and Maclean (1984, 1976) consider depression to be an adaptation failure rather than a psychological problem. "Unsuccessful adaptation at a time of developmental crisis which also occurs in old age according to Erickson, can lead to emotional disturbances, which often take the form of depressive reactions" (Levin, 1963). The chronically ill elderly may not be able to use coping mechanisms that they previously used; chronic illness now limits their functioning, therefore, they have the proclivity to become depressed.
An interesting approach to theories relating to depression in the elderly are those that suggest that biological factors underlie depression. The amine hypotheses of affective disorders states that depression is associated with a functional deficit of one or more brain neurotransmitters amines at specific central synapses" (Stewart, 1985, p.93).

Biological theories which are related to depression in old age are new and much more research is needed on them. Some theorists also believe that genetic factors play a part in understanding depression; however, more research is needed in that area. Relating the above theories to chronic illness and the elderly, one may conclude that the loss of physical health may lead to fear of loss of independence which may lead to stress and possible depression. Coupled with other losses such as income, friend, spouse, etc., the researcher tends to believe that there is a high incidence of depression in the elderly with chronic illness.
CHAPTER THREE

METHODOLOGY

Research Design

This was a correlational study to examine the degree of depression in older persons who are chronically ill. A correlational study can be defined as an interdependence between mathematical variables, especially in statistics (Webster's Third Dictionary). This correlational study will measure variables such as family support, social support, marital status and gender in people over 60 years old.

Chi-square was the statistical test used to measure the variables in this study. A crossbreak table was used to measure two or more groups with qualitative values. The crossbreak table was chosen to measure the degrees of depression and to measure categorical differences in regards to gender, and marital status.

Sampling

Convenience sampling was used for this research. This is the most cost effective and time efficient manner to perform this type of research. The sample was taken from 34 individuals who were hospitalized at Clayton General Hospital. The subjects were
divided by sex—eighteen males and sixteen females. Being an employee at this hospital, the researcher had access to all the face sheets on all admissions. Face sheets list identifying information such as age, sex, admitting diagnosis, and marital status. The face sheet will enable the researcher to identify individuals over 60, sex, and marital status. The research will sort face sheets male/female and choose every other sheet to attempt the study. The researcher will go to the individual, discuss the study, request permission, and then if the patient agrees, examine the chart. The patient's medical chart must include one diagnosis of chronic illness. Individuals must not have a diagnosis of senile dementia or organic brain syndrome. After determining chronic illness, the Geriatric Depression Scale was administered to the individual. To determine family support and social support the researcher will use a Likert type scale designed by the researcher. Individuals who are admitted to Clayton General Hospital reside primarily in Clayton County, Georgia. Clayton County is a suburb of metropolitan Atlanta.

Data Collection Procedure

The Geriatric Depression Scale was used to measure depression in the subjects. This scale is a 30-item tool which was exclusively designed to assess depression in older persons. The
questionnaire consists of 30 yes/no questions, and measures varying degrees of depression. Higher scores indicate higher levels of depression: 0 to 10, normal; 11 to 20, mild depression; 21 to 30, moderate to severe. Brink and colleagues reported a reliability coefficient of .82 for the scale (Nelson, 1989).

Tesher (1986) validated the GDS among elderly New Hampshire residents. Tesher's sample of 51 residents yielded a test reliability of .94 (Nelson, 1989). This instrument was chosen because the Geriatric Depression Scale is current and designed to specifically study depression in older persons. It is also simple and can be administered very quickly.

Although one could apply existing general psychiatric depression scales to this population, the aged present unique problems for clinicians and researchers interested in the study and treatment of depression (Brink, Rose, & Tum, 1982, p.37).

"A Geriatric Depression Scale should not only be applicable for screening depression in physically health elderly but should also be useful with the physically ill, and acognitively impaired. There is some evidence that the G.D.S. may fulfill this criterion. Using data from a study by Gallagher et al (1981), we found that the G.D.S. differentiated depressed from nondepressed elderly in a sample of subjects who all suffered from physical illness." (Validation and Screening of a G.D.S., p.46).
Data Analysis

The SPSSX batch system was used to measure the following: (1) A correlation analysis is conducted to determine any relationship between age, gender, social support, family support, and degree of depression. (2) Crossbreak tables were used to test the significance of relationships between depression, marital status, family support, social support, and gender.
In this chapter, the results will be presented by stating the null hypothesis and the statistical method used which either accepts or rejects the hypothesis. To answer the question, "Does depression exist in older persons with chronic illness?", cross tabulation was used. The results were 53% (or 18) indicated no depression, 41% (or 14) of respondents indicated mild depression, and 6% (or 2) of the respondents indicated severe depression. Therefore the largest percentage of older persons with chronic illness indicated no depression.

The Null Hypothesis

There is no relationship between social support and depression scores as tested by using cross tabulation. The results of this statistical analysis are as follows: $x^2 = 3.45$, $df = 2$, $p > 0.05$. Thus we would accept the null hypothesis that there is no significant relationship between depression scores and social support. Of those who reported having good family support 64% (or 22) were still mildly depressed. (See Table 5.1.)
Null hypothesis: There is no relationship between respondents' depression scores and family support. To test this hypothesis, a cross tabulation was performed using SPSSX batch system. The results of this statistical analysis shows chi square, $x^2 = 1.03$; degrees of freedom, df = 2; and the level of significance, $p < 0.05$. Thus we would accept the null hypothesis that there is no significant relationship between family support and depression scores. Of the respondents 79% indicated high levels of family support and also indicated mild depression.
The null hypothesis stating there is no relationship between gender and depression scores is tested by using cross tabulation. The study reported that females (71%, or 10) showed a higher evidence of mild depression than males (29%, or 4). The only group which showed evidence of severe depression were males (11%, or 2). We reject the null hypothesis because there is a significant difference in depression scores when using gender as a variable. (See Table 5.3).

<table>
<thead>
<tr>
<th>Depression</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>66% (12)</td>
<td>33% (6)</td>
</tr>
<tr>
<td>Mild</td>
<td>29% (4)</td>
<td>71% (10)</td>
</tr>
<tr>
<td>Severe</td>
<td>100% (2)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

\[x^2 = 6.48; \text{ df} = 2; \ p < 0.05\]
Significance = 0.039 (less than 0.05). The only persons who responded to severe depression were males.

Null hypothesis: There is no significant relationship between marital status and depression scores. This hypothesis is tested by using cross tabulation. The results of this statistical analysis is as follows: \(x^2 = 0.68\), \(\text{df} = 2\), \(p < 0.05\). Therefore we can accept this null hypothesis. (See Table 5.4.)
Table 5.4
MARITAL STATUS

<table>
<thead>
<tr>
<th>Depression</th>
<th>Single</th>
<th>Married</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Mild</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Severe</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

$[x^2 = 0.2; \text{ df } = 2; \text{ } p < 0.05]$
CHAPTER FIVE

SUMMARY

Conclusion

This study examined depression in older persons with chronic illness using social support, family support, marital status, and gender as variables. The research was an attempt to expand the writer's knowledge of depression in older adults and to provide an informative paper for professions who work directly with the elderly population. This research was also an attempt to gain knowledge of clinical skills and enhance counseling skills in working with a group. The researcher has worked with the chronically ill elderly in a social work capacity for the past six years, previously in the community and currently in a hospital setting.

In working with this group there appeared to be a large number of persons who were depressed and virtually no resources easily accessible to them. Physicians working with this group rarely recommended or referred their patients for mental health intervention.

The results of this study were surprising to the researcher. Most of the respondents reported no depression or mild depression on the instrument.

In this study it was hypothesized that there was no
significant relationship in depression scores in regard to family support, social support, gender, and marital status in older persons who are chronically ill. This hypothesis was accepted using social support and family support variables based on the cross tabulation as shown in table 5.1 and 5.2. The hypothesis was rejected using variables gender and marital status which was shown in table 5.3 and 5.4.

The literature on the relationship between social support and depression in older persons does not support these findings. The literature suggests that the lack of social support was an important factor in the development of depression in older persons (Smallegan, 1989).

In this study respondents with high social support still reported being mildly depressed. See table 5.1. A possible explanation for this may be that since all respondents were hospitalized, social support systems may have been greater than usual. Friends and church members may have called or visited the respondent while hospitalized, which may have been a long time since previously visited, prompting high scores on the social support inventory. The social support inventory may have looked very different if it had been administered to the same respondent in their home.

The variable family support also had no significant relationship in older persons with chronic illness. The
literature indicated that support from family and friends has been associated with less depression (Smallegan, 1989). This study found that persons with high family support still reported mild depression. See cross tabulation table 5.2. The researcher again feels that the respondents being hospitalized may have accounted for consistently high scores on the family support scale. The respondents may receive much more attention from family members while hospitalized. It would be interesting to wait four to six months and administer the social support and family support scale to the same respondents in their home and compare the results.

When gender was used as a variable in this study it showed that a higher percentage of females, 71%, were mildly depressed compared to 29% of males. These findings are in agreement with previous findings that did indicate gender differences.

What is evident in previous findings is that depression in older women is associated with income, while depression in older males is associated with physical health (Gianturco & Busse, 1978). This study revealed that 71% of women respondents were significantly more depressed than 29% male respondents. The Commonwealth Fund Commission reports that by the year 2020, of the 2 million poor elderly living alone, 1.5 million will be women (Glasse & Leonard, 1988). Since income was not a variable used in this study, one suggestion for future studies would be to use income as a variable and administer the same questionnaire to the
same respondents.

The variable marital status indicates that single persons are slightly more depressed than married persons, but no significance relationship is evident between single and married.

Limitations to the Study

One limitation of this study was the time frame. The data was collected from September 1989 to March 1990. The sample (34) was also very limited because of the time frame. A two year period and a large sample may have produced very different results. Another limitation was the study was strictly done in a hospital. The hospital is a controlled environment where patients' basic needs are met as well as frequent interactions with medical staff and other patients. An interesting comparison would have been to administer the questionnaire to older persons who are chronically ill in the community. Also, older persons with no physical problems could have been included to provide a comparison population.

The use of a Likert type instrument may have showed different results and different degrees of depression. An interesting comparison would be to administer a Likert type depression scale and compare results. This would also be a good way to test reliability and validity of the Geriatric Depression Scale.
CHAPTER SIX
IMPLICATIONS FOR SOCIAL WORK PRACTICE

Depression Assessment

This research indicates that 52% of the chronically ill persons who responded were not depressed, 41% of respondents reported being mildly depressed, and only 6% reported being severely depressed. Although, the majority of respondents indicated no depression and mild depression, the researcher believes that chronic depression does exist and warrants intervention from social work practitioners.

Social work practice with older persons requires an accurate assessment in order to distinguish depression from other problems that may affect the elderly. Dementia is often confused with depression in the elderly and a thorough neurological exam should be performed to rule out the onset of early dementia. Social workers can utilize Differentiating Dementia and Depression in the Elderly to assist with the assessment. (Appendix E.) The Geriatric Depression Scale (see Appendix D) in conjunction with Symptoms of Depression and Nursing Care Problems in the Elderly (Appendix H) may be used to diagnose depression in chronically ill elderly.
Therapies for Older Persons

When depression is diagnosed there are several therapies that may be utilized. Medical Social Workers who have the opportunity to work with older persons on a daily basis can use Cognitive Behavioral Techniques. The Cognitive Behavioral model includes a broad umbrella of cognitive and behavioral treatment techniques. The focus is on here and now problems with the therapist and patient functioning as collaborators (Dreyfus, 1986). A weekly activity schedule (see Appendix F) can be used to list all daily activities and record how much enjoyment they obtain from each one. Being able to visualize on paper what the patient can do and still enjoys doing combats feelings of helplessness and reaffirms that they are still productive and can enjoy daily activities.

Another part of Cognitive Behavior Therapy offers ways to modify negative automatic thoughts. (See Appendix G.) Having patients look at the activity schedule can be one way to combat overgeneralizations and negative thoughts such as, "I never enjoy myself," or "I can't do anything any more" (Dreyfus, 1986).

Life Review and Reminiscence therapies are often used in working with the depressed elderly with physical limitations. Regarding Life Review and Reminiscence, Dreyfus (1984) states, "Most studies of the approach have focused on global effects such as maintaining self-esteem, a positive adjustment to aging, and
combatting depression." Life review is a process in which the elderly person not only remembers the past but analyzes and reconstructs past life events with the goal of personality reorganization. Lewis and Butler (1974) describe three steps for Life Review therapy to be effective: a) recording a detailed history, b) careful observation by the therapist, and c) systematic evaluation of memories. Social workers can encourage patients to talk about their past by asking direct and simple questions such as, "Where did you grow up?", "What was your occupation?", or "What did you do for a living?", "What was life like growing up in 1930s, 1940s, or 1950s?" Social workers can also ask family and friends to bring in scrapbooks and photos to motivate patients to discuss past life experiences.

Expressive Therapy can also be useful in working with older adults who are chronically ill. Expressive Therapy can satisfy the individual's psychosocial needs by helping the person work through his "rite of passage" dealing with significant and confidential issues and problems. It also helps the individual find enjoyment in life (Weiss, 1988). This type of therapy may be used with individuals who have trouble with verbal communications, such as those suffering from strokes or other head related injuries.
Older Women and Depression Policy Implications

This research did indicate a significant relationship between moderate depression and chronically ill older females. In working with older females who are depressed, Lagonda (1988) suggests that multidimensional interventions are used that address both external perceived events and internal biophysiological processes. The patient takes control of the planning and implementation of the contract agreed upon by herself and the worker. Also any biological dysfunctions must be addressed. For example, older females often have thyroid difficulties and hormone imbalances which can be diagnosed and treated by physicians. Support groups primarily for older women and the use of Cognitive Behavior Therapy may be helpful in treatment of women who are depressed.

The literature suggests that changes in income are often associated with depression in older females. This can have policy implications for social workers in terms of advocating for upgraded laws within the Social Security System. Women who never worked outside the home should have a monetary amount equal to men who worked outside of the home; so, when they retire, the retirement income is the same as their male counterparts.
There appears to be a lack of community services available to meet the unique needs of chronically ill elderly. Community mental health centers are inaccessible to many older persons who are chronically ill because of lack of transportation, and the sliding fee scale may be too costly for the elderly who are on fixed incomes with high medical bills. Transportation services in Clayton County must be made two weeks in advance and the wheelchair van is only available for medical appointment.

One solution to the above problems would be for mental health clinicians to make home visits to the chronically ill and homebound elderly. The sliding fee scale needs to be flexible to assure that older persons are not denied mental health services based on their inability to afford them. Model programs should include transportation as a therapeutic intervention that provides access to day activity programs and day trips, thus increasing involvement outside the home if possible.

Older persons also need to be primarily involved in the policy and program implementation of mental health programs available to them. Older persons who are chronically ill experience a loss of control over their physical abilities.

Active involvement of older persons in planning their own programs enables them to have a sense of control and fosters
feelings of integrity and worth. "Nonetheless, their remain gaps in our attempts to provide services to the elderly. One such area, very critical to their well-being, is mental health services to the aged. The present scarcity of community mental health services for the elderly is in part an outgrowth of the failure to include them during initial stages of community health centers" (Burton, 1986, p.35).

In addition to the above there needs to be an expansion of the current home delivered services for the elderly. Medicare should provide activity therapists at home to do expressive therapy, reminiscence or life review therapy, or other activities that the elderly may enjoy. Other in-home services that should be expanded are friendly visitors and telephone reassurance programs.

Finally, social workers need to educate physicians, health care practitioners, and legislators as to the problem of depression and treatment modalities for the chronically ill elderly by inservices and seminars.


Appendix A

RELEASE OF INFORMATION

I, ___________________________, give permission to Roxanne Turner, BSW to review my medical record as a part of her graduate school thesis for Clark-Atlanta University School of Social Work. I understand that the study is concerned about chronic illness and depression. I further agree to complete the attached questionnaire. I understand that no personal identifying data will be used in this study.

Name _________________________

Date _________________________

Witness _________________________
Appendix B

FAMILY SUPPORT

1. I can depend on my family.
   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

2. My family is a real source of comfort to me.
   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

3. I can rely on my family if I need assistance with household tasks.
   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

4. My family is a great joy to me.
   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

5. I feel that members of my family really care about me.
   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree
Appendix C

SOCIAL SUPPORT

1. I have a neighbor I can count on if I need assistance.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

2. I have a friend or neighbor who frequently visits or calls.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

3. Would you say you are in social clubs?

[ ] Very active [ ] Fairly active

[ ] Not very active [ ] Not active at all

4. I can count on assistance from my church if needed.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

5. I attend church

[ ] As often as possible [ ] once a week [ ] seldom [ ] never
Appendix D

GERIATRIC DEPRESSION SCALE

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

YES NO

1. Are you basically satisfied with your life?.............[ ] [ ]
2. Have you dropped many of
   your activities and interests?.......................... [ ] [ ]
3. Do you feel that your life is empty?.................... [ ] [ ]
4. Do you often get bored?................................. [ ] [ ]
5. Are you hopeful about the future?...................... [ ] [ ]
6. Are you bothered by thoughts
   you can't get out of your head?......................... [ ] [ ]
7. Are you in good spirits most of the time?...............[ ] [ ]
8. Are you afraid that something bad
   is going to happen to you?............................. [ ] [ ]
9. Do you feel happy most of the time?.................... [ ] [ ]
10. Do you often feel helpless?.......................... [ ] [ ]
11. Do you often get restless and fidgety?............... [ ] [ ]
12. Do you prefer to stay at home,
    rather than going out and doing new things?........ [ ] [ ]
13. Do you frequently worry about the future?......... [ ] [ ]
14. Do you feel you have more problems
    with memory than most?............................. [ ] [ ]
15. Do you think it is wonderful to be alive now?...... [ ] [ ]
16. Do you often feel downhearted and blue?........... [ ] [ ]
17. Do you feel pretty worthless the way you are now? [ ] [ ]
18. Do you worry a lot about the past?.................. [ ] [ ]
19. Do you find life very exciting?...................... [ ] [ ]
20. It is hard for you to get started on new projects? [ ] [ ]
21. Do you feel full of energy?......................... [ ] [ ]
22. Do you feel that your situation is hopeless?....... [ ] [ ]
23. Do you think that most people
    are better off than you are?....................... [ ] [ ]
24. Do you frequently get upset over little things?... [ ] [ ]
25. Do you frequently feel like crying?................ [ ] [ ]
26. Do you have trouble concentrating?................ [ ] [ ]
27. Do you enjoy getting up in the morning?........... [ ] [ ]
28. Do you prefer to avoid social gatherings?......... [ ] [ ]
29. Is it easy for you to make decisions?............... [ ] [ ]
30. Is your mind as clear as it used to be?............ [ ] [ ]
# Appendix E

## Differentiating Dementia and Depression in the Elderly

<table>
<thead>
<tr>
<th>Factors</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Progressive loss recent and remote</td>
<td>Not impaired but complains of deficits</td>
</tr>
<tr>
<td>Orientation</td>
<td>Disoriented as disease progresses</td>
<td>Oriented X3</td>
</tr>
<tr>
<td>Learning Capacity</td>
<td>Impaired</td>
<td>Usually intact, may have decreased constriction</td>
</tr>
<tr>
<td>Affect</td>
<td>Shallow with episodic anxiety or depression</td>
<td>Irritable, Constricted</td>
</tr>
<tr>
<td>Delusions, hallucinations</td>
<td>Common</td>
<td>Uncommon except in delusional depression</td>
</tr>
<tr>
<td>Behavior</td>
<td>Episodes of agitation</td>
<td>Withdrawal or consistently agitated</td>
</tr>
<tr>
<td>Onset</td>
<td>Gradual</td>
<td>Rapid</td>
</tr>
<tr>
<td>Symptom level</td>
<td>Worse at night</td>
<td>Stable symptoms level</td>
</tr>
<tr>
<td>Precursors</td>
<td>No clear precursor</td>
<td>May have history of loss or stress</td>
</tr>
<tr>
<td>Progress of Illness</td>
<td>Gradual, progressive or stepwise decline</td>
<td>Not progressive but may affect level of functioning</td>
</tr>
<tr>
<td>EEG</td>
<td>Slow wave activity</td>
<td>No changes</td>
</tr>
<tr>
<td>Mental Status results</td>
<td>Frequent errors</td>
<td>I don't know answers, minimal errors</td>
</tr>
<tr>
<td>Neuropsychological tests</td>
<td>Global deficits</td>
<td>Normal aging patterns (slow response)</td>
</tr>
<tr>
<td>Face hand test</td>
<td>Errors after 4th trial</td>
<td>No errors after 4th trial</td>
</tr>
<tr>
<td>Response to treatment</td>
<td>Little change in level of functioning</td>
<td>Dramatic improvement with antidepressants</td>
</tr>
</tbody>
</table>
## Appendix F

### WEEKLY ACTIVITY SCHEDULE

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-10</td>
<td>Take a shower</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>S=2</td>
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<tr>
<td>10-11</td>
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<tr>
<td>11-12</td>
<td>Talks on phone E=3</td>
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<td>12-1</td>
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<td>1-2</td>
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<td>2-3</td>
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<tr>
<td>3-4</td>
<td>Play Bingo E=4</td>
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<tr>
<td>4-5</td>
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<td>5-6</td>
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<tr>
<td>6-7</td>
<td>Do needlework S=3</td>
<td></td>
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</tr>
<tr>
<td>7-8</td>
<td>Watch TV E=2</td>
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<tr>
<td>8-12</td>
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</tr>
</tbody>
</table>

E=Enjoyment  1=very little  
S=Satisfactory  5=a lot
### Appendix G

**Cognitive Interventions for Loss of Motivation**

<table>
<thead>
<tr>
<th>Depression Symptom</th>
<th>Negative Automatic Thoughts</th>
<th>Disturbed Thinking Pattern</th>
<th>Nursing Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation for self-care, e.g., refuses to wash self, wants staff to do total ADLS</td>
<td>&quot;I can't wash myself, I'm too weak.&quot; &quot;What's the use?&quot; &quot;No one cares about me; just leave me alone.&quot;</td>
<td>Overgeneralization—making broad conclusions based on one example—ignoring all data to the contrary, frequent use of never, can't, no one</td>
<td>Help patient to challenge overgeneralization. Look for evidence that there may be another interpretation of the data. Plan an experiment to test the data, e.g., what are patient's thoughts after washing hands and face?</td>
</tr>
</tbody>
</table>
### Appendix H

**SYMPTOMS OF DEPRESSION AND NURSING CARE PROBLEMS IN THE ELDERLY**

<table>
<thead>
<tr>
<th>Symptoms of Depression</th>
<th>Behavior</th>
<th>Sample Negative Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease of energy, motivation and interest</td>
<td>Decreased self-care ability: a) refuses to do tasks requiring physical exertion; b) asks staff to do total care when not medically indicated; c) not interested in diversionary activities—social withdrawal.</td>
<td>I'll never be able to do these exercises. I'm too sick to wash myself. Leave me alone, I don't want to do anything but rest.</td>
</tr>
<tr>
<td>Frequent somatic complaints</td>
<td>Frequently rings call bell. Numerous physical complaints that don't resolve with usual nursing measures.</td>
<td>No one ever comes when I call. If they would just cure my back trouble I would be fine.</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>Refuses food and fluids or takes inadequate nutrition, may need TPN or tube feeding.</td>
<td>I'm just not hungry. Leave me alone. What's the use of eating, I'll never get well.</td>
</tr>
<tr>
<td>Perceived cognitive deficits</td>
<td>Complains of being forgetful. Loses familiar objects, but does well on mental stats exam of recent memory, poor on concentration—gives &quot;I don't know&quot; answers.</td>
<td>I'm losing my mind. I must be senile, now they will put me in a home. My mind is a blank.</td>
</tr>
<tr>
<td>Critical and envious of others</td>
<td>Complains about poor care. Criticizes staff and family. In multiple bed room patient constantly calls you when you are trying to care for other roommates.</td>
<td>Nobody cares about me anymore. I would never treat my parents like this.</td>
</tr>
</tbody>
</table>

(continued)
Appendix H (continued)

| Decreased concentration and indecisiveness | Can't keep their mind on what you are saying, especially patient teaching. Has difficulty making decisions, eg—"When would you like your bath?" "I don't know. I don't care." |
| Loss of self-esteem and decreased sense of lifelong accomplishments | Patient ignores appearance—doesn't brush hair, teeth. Patient has no positive feelings about his/her life—hobbies, job, marriage. |
| | I can't stand all these questions. I wish I were home. I can't remember what the nurse told me—so many words. |
| | I'm a failure. My life was a waste. What's the use of trying any more? I'll never feel well again. |