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Social Engagement: Depressogenic

Factors in the Elderly

by
Joell P. Worster

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree in the Graduate Division
of Rowan University
May 1998

Approved by

Professor

Date Approved 5-5-98

ABSTRACT

Joell P. Worster

Social Engagement: Depressogenic
Factors in the Elderly

1998

Dr. Roberta Dihoff

School Psychology

The purpose of this study was to examine whether those elderly nursing home residents who maintained social engagement would be less depressed than those elderly nursing home residents who did not maintain social engagement. The study consisted of 21 residents who resided in a nursing home. All subjects were given the Geriatric Depression Scale and asked to respond to the 30 questions by yes or no. A Mann Whitney Test was performed on the depression scores from the results of the Geriatric Depression Scale. The results were significant with the prediction of the study. Those elderly residents in the nursing home who maintained social engagement were less depressed than those elderly nursing home residents who did not maintain social engagement.

MINI-ABSTRACT

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The purpose of this study was to examine whether those elderly nursing home residents who maintained social engagement would be less depressed than those elderly nursing home residents who did not maintain social engagement. The results of the study indicated that those elderly nursing home residents who maintained social engagement were less depressed than those elderly nursing home residents who did not maintain social engagement.

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Chapter 1: The Problem

Need

The U.S. Bureau of the Census (1991) revealed that the population of those over the age of 65 has risen from 20 million in 1970 to 29.4 million in 1986. It is predicted that by 2010 those 65 years and older will be 15 % of the population (Beckham and Leber, 1995, p. 494). As the elderly population increases so will the placement of elderly in residential care units and nursing homes. Thus, it is important to investigate depression. Depression is a common illness among the elderly. Of the elderly population, 15% exhibit symptoms of depression (Reynolds III, 1995). Presently, the institutionalized and the physically ill are growing rapidly. Today 1.5 million elderly live in nursing homes and of those in residential care units 15% of the population suffer from major depressive disorder (Beckman and Leber, p. 495). There is no question that later life depression is a significant and growing problem. There is a need to research aspects which will provide the elderly with a continued sense of meaning and purpose to combat feelings of loss (i.e. physical, mental and social) as an individual ages. As the elderly are placed into residential care units and nursing homes the question becomes, how will the elderly be provided with the idea that their life continues to have meaning and purpose?

Purpose

The purpose of this research is to examine whether there are differences among levels of depression with respect to the elderly that are institutionalized and maintain social engagement and the elderly that are institutionalized that do not maintain social engagement. This research will focus specifically on a sample of elderly people who reside in a nursing home. Another focus will examine the level of participation in activities and frequency of physical contact with family and significant others. The purpose for studying these variables of depression is that according to the DMSIV, one of the five symptoms of depression is depressed mood or loss of interest or pleasure in nearly all activities (Ahed and Takeshita, 1996). One article relating to the elderly states that the hallmarks of depression are persistent depressed mood, feelings of pessimism or hopelessness and diminished interest in daily activities (Reynolds III, Small, Stein, and Teri, 1994).

Hypothesis

The elderly in nursing homes who maintain social engagement will score less depressed on the Geriatric Depression Scale.

Theory

In order to understand depression, it is helpful to review some psychological theories that attempt to define depression in general. Psychological theories have divided depression into two parts. Some view depression as primarily a mood disturbance, an affective disorder. Others suggest that depression is primarily a cognitive disorder, a disturbance in thought process.

In 1911, Abraham described depression in terms of the psychoanalytic theory, comparing depression with normal grief or mourning. Abraham suggested that the difference between grief and depression is that the mourner is consciously concerned with the loss of a person, but the depressed person is dominated by feelings of loss, guilt and low self-esteem. Freud in 1917 in his paper *Mourning and Melancholia* also examined the difference between grief and depression. According to Freud, depression was marked by loss of self-esteem. Both Abraham and Freud relate depression to several difficulties in childhood. Depression results from fixation of emotional development at the oral stage. This is marked by dependency on sources of direct oral satisfaction but also great dependency on people and events to supply emotional gratification (Mendels, 1970, chap. 5).

Other views are suggested by Bibring and Arieti. In 1953, Edward Bibring emphasized that the loss of self-esteem is the crucial element in depression. He placed great emphasis on “ego psychology”, a conscious response to events. Arieti in 1959 emphasized the mother-child relationship. Arieti, suggested that a child responds by

developing a willingness to accept everything that he or she is offered; being receptive to the mother's influences. This leads to the development of a personality characterized by features of extroversion, conformity, acceptance of surrounding value systems and a degree of dependence (Mendels, 1970, chap. 5).

Beck offers a slightly different perspective. In 1964, Beck suggested that depression is a primary disturbance in thinking that causes the development of the disturbed mood state. Beck proposed that everyone has a schema. A schema is defined as a pattern or framework of thought that an individual uses to approach and experience life. The nature and specific characteristics of this schema determine the individual responses (Mendels, 1970, chap. 5).

For the specific purposes of this study it is worthwhile to examine one of Erik Erikson's psychosocial developmental stages that describes the psychosocial development of the elderly. Then it is important to examine what current research has said about the increase of the elderly population and depression among this population. Erickson's last developmental stage is termed integrity vs. despair. The older adult tries to make sense out of their lives, either seeing life as a meaningful whole or despairing at goals never achieved and questions never answered. An individual must adjust to the changes of the body and to new demands in life while maintaining a sense of self. For the elderly this is best done by affirming their individuality as well as recognizing their ties with others, not only with family and friends, but also with the human race as a

whole. To reach the point of integrity, is to affirm our own unique life as worthwhile. If integrity is not reached it will lead to despair, resulting in symptoms of depression.

Demographic shifts are taking place rapidly in the U.S. resulting in the “graying” of America. Occurring within the growing geriatric segment of the population is a relatively greater increase in the proportion of “very old “ individuals (Reynolds III, 1995). Depression among the elderly is a significant problem and one that we can expect to grow. Depression seems to be as chronic in the elderly as in the young population. Depression warrants careful attention because the elderly have the highest suicide rate in America at 25% (Mann, 1996).

Marked by persistent sadness, difficulty in sleeping , physical illness, effects of polypharmacy or dementia , depression may go unrecognized, misdiagnosed and untreated. Depression is also noted to go undetected and untreated in the elderly because health professionals have a low expectancy for a high quality of life for this age group and they view depression in the elderly as typical.

Depression is not a natural part of aging. It should however, be emphasized that it is treatable in the elderly population. There is a need for greater recognition of this disease and rejection that depression is “normal” with aging. Treatment of depression in the elderly can improve their motivation and provide them with a sense of purpose. It has been said that the best treatment for depression is a combination of antidepressants and brief focused psychotherapy. Antidepressants are effective when they are administered in appropriate doses and for a sufficient amount of time (Christensen,

1995). It is also suggested that staying socially connected and physically fit is a means of preventing depression.

Factors affecting depression include declining health, increase in medical problems and increased disability that accompanies aging. Social factors such as isolation and spousal loss can predispose the elderly to depression. The strain and negative events in life lead to depression and effect the psychological stability of the elderly (Dunkle, Haug, and Roberts, 1994). Because the elderly experience more life changes and disabilities such as, retirement , social isolation, living alone, bereavement, multiple medical illness and deteriorating physical health they are at risk for depression. There is much need for improving the quality of life for the elderly. As the population continues to grow so will the rate of depression and there is a need to recognize the illness and a need to find solutions to combat the illness especially for those individuals who are institutionalized.

Definitions

Depression: A mood disorder characterized by severe or prolonged feelings of hopelessness, despair, low self-esteem, worthlessness, guilt, withdrawal from others, loss of sleep, appetite, and sexual desire.

Elderly: Individuals 65 years of age or older.

Nursing Home: An institution that provides care 24 hours a day to individuals who have had a physical and or mental decline.

Social engagement: A resident who participates in activities on a daily bases and has contact with family or significant others at least 3 times a week while residing in a nursing home.

Assumptions

It is assumed that there will be no significant difference in scores based on the subjects level of decline, cognitive levels and medical condition. It is assumed that the subjects will answer the questions on the scale honesty. It is also assumed that there will be no difference in the scores with individuals who require more time to answer the questions or need the questions repeated and those individuals who do not require additional time.

Limitations

The study is limited to one nursing home and in South Jersey. Another limitation would be the sample size which is somewhat small for making generalizations to the population.

Overview

The relevant research related to the elderly and depression will be reviewed in Chapter 2. The research will assist in the understanding depression in the elderly and factors that predispose them to depression.

In chapter 3, a description of the sample population will be given. The design of the study will be described. A detailed description of the measure to be used, the study's procedure and the method of analysis will be presented. The hypothesis will be restated.

The results will be interpreted and all of the analyzed data will be presented in Chapter 4, as well as a discussion of the results of the hypothesis. In addition, results not related to the hypothesis will also be reported in this chapter.

In chapter 5, the summary and conclusions will be presented and the implications for further research.

Chapter 2: Review of Literature

Introduction

A significant amount of research has been done investigating the diagnosis, etiology and treatment of depression. This review of research will investigate etiology of depression and variables that correlate to depression in the elderly. The variables that will be examined include; loss of function, loneliness, life satisfaction, social skills, activity participation, and social support. The review of literature pertaining to the variables will focus first on the general elderly population and then more specifically on the elderly in the nursing home. Then there will be a review of literature regarding quality of life in the nursing home, healthy aging and interventions for depression in the nursing home all of which are important factors to decrease depression.

Social gerontologist have been concerned with the emotional well-being of older persons virtually since the inception of the discipline. Emotional well-being refers to a state of mind inclusive to feelings of happiness, contentment and satisfaction with one's life (Lee and Ishii-Kuntz, 1987). Poor health and disability have negative effects on mental well-being. Depression has been associated to disease and disability. Given

rising life expectancy and the experiences of the very old, resources to improve their well-being require attention (Roberts, Dunkle, and Haug, 1994).

Etiology of Depression

The risk factors for depression are the same in all adult ages. They include female gender, lack of social support, a family history of depression, chronic medical illness, alcohol abuse and stressful life events especially the loss of a spouse (Reynolds III, 1996). Reynolds III (1995) also states the presence of sad mood during most of the day is the hallmark of depression. This sad mood is often expressed as markedly diminished pleasure or interest in most all activities of daily living.

Butler and Lewis (1995) in their review of several case studies describe the symptoms of depression. Depression in older adults is sometimes an understandable responses to loss, whether physical or emotional. Mourning is a natural part of life at any age but in later years it is a frequent companion. Issues of death and dying may become central to the lives of older people, as they lose family and friends with the passage of time. There may be feelings of increased guilt, impairment of daily functioning and a sense of worthlessness. The depressed person can be more limited physically and socially than persons with chronic medical conditions. Depression has also been more strongly associated with daily strains than life events (Roberts, Dunkle, and Haug, 1994).

Etiology of Depression in the Nursing Home Resident

Several studies have examined some variables which correlate to depression of residents in a nursing home. Depression is particularly burdensome in residents of nursing homes, most of whom are already physically and psychiatrically disabled (Masand, 1995). Depression has been diagnosed as the leading cause of disabilities among geriatric patients residing in long term care facilities. Masand also states that several reasons may account for higher rates of depression among long term care residents, greater loss of autonomy and social support. Ahmed and Takeshate (1996) also conclude that depressive symptoms and clinical depression are common in this age group, and nursing home residents showing a higher prevalence of depression than those in the community.

Factors Correlated with Depression

In the Harvard Health Letter (1995), it is stated that social isolation, sadness and loss of function are problems that many people face as they grow old. Loss is an inevitable part of old age but loss of function can be a major precipitant to depression (Garnett, 1995). Reynolds III (1995) makes reference in his research that declining health, increased prevalence of medical problems and disability are important factors for depression as well as social factors such as social isolation, and spousal loss.

Loss of Function

Several studies have investigated loss of function in older adults and the effects it has on depression. Individuals who had high levels of functional impairment, older people and women who had high levels of functional impairment reported higher levels of depression symptomatology (Antonucci, Fuhrer, and Dartiques, 1997). It was found that older adults with high functional impairment are at risk of onset of depression (Zeiss, Lewinsohn, Rohde, and Seeley, 1996).

Loneliness

Several studies examine the effects of loneliness in old age and the onset of depression. There is a clear consensus on the negative impact of loneliness later in life. The seriousness is demonstrated in its association with other emotionally debilitating conditions such as depression, grief, and anxiety (Creecy, Berg, and Wright, 1985). In a study done by Berg, Mellstrom, Perrson, and Svanborg (1981), they identified loss of spouse to be the single most important factor contributing to loneliness later in life. It is also concluded in another study that the strongest antecedents of loneliness of both sexes are health and interactions with friends (Lee and Ishii-Kuntz, 1987).

In order to combat loneliness and reduce the risk for the onset of depression Lee and Ishii-Kuntz (1987) point to the importance of interactions with family, friends, and participation in voluntary associations. Their study concludes that friendship is an important contribution to physical, social and psychological well-being. Interactions with friends and neighbors and participation in voluntary associations were each

significantly correlated to lower loneliness and increased morale. Interactions with family although small a correlation, was significant with respect to decreased loneliness.

Life Satisfaction

In one particular study, two elements are correlated with life satisfaction, religion and location. Increased religiosity is not a complete explanation of the relationship between age and satisfaction but it does explain a consistent part. It is also concluded from the study that time spent in the present residence and the adaptation process that ensues is related to age and satisfaction (Herzog and Rogers, 1981).

In a study conducted by Commerford and Reznikoff (1996) they too stressed the importance of religion to the nursing home resident. Public religious activity was significantly correlated with decreased depression and increased self esteem of the nursing home resident. It also concludes that the two potential resources remaining for the nursing home resident is religion and social support. The data strongly indicated that religion was an important factor in the lives of the nursing home resident.

Social Skills

Another important factor related to depression is the decline of social skills as an individual ages. A study was done to determine whether social skills do in fact deteriorate with advanced age and whether these deteriorating social skills are associated with lower self esteem and a number of other psychosocial problems such as depression. The study concludes that among the elderly who are fairly mobile, reasonably educated,

do not have social skill deficits or psychological problems do not have low self esteem or suffer from depression. Those with social skill deficits show lower self esteem and are at risk for the onset of depression (Sergin, 1994).

Activity Participation

A factor that needs to be reviewed for the purpose of this study is the activity participation of the older adult and effects it has on loneliness, self esteem, morale and more specifically depression. Studies relating to this issue have investigated the Activity Theory. A bulk of studies seem to support the notion that the more socially active individuals score higher on morale measures than less socially active individuals. Individuals who perceive their health better, believe in internal control, who are married and who lead more socially active lives show a stronger will to live (Brown, Perman, and Dobbs, 1981).

The following studies conclude that activity participation correlates to increased self esteem, morale, and decreased depression. Activities that generate positive feedback from others confirming a person's role as a coworker, friend, spouse, parent or relative has a greater effect on self esteem than the sheer number of activities (Reitzes, Mutan, and Verrill, 1995). They concluded that activities enable individuals to confirm valued identifies which is likely to generate support for self esteem and well-being. Participation in group activities has a direct impact on loneliness. Activities that include kin and non-kin foster social integration (Creecy, Berg, and Wright, 1985). Participation in voluntary association has a significant effect on morale (Lee and Ishii-Kuntz, 1987).

Roberts, Dunkle, and Haug (1994) correlated those with higher self esteem to lower depression.

This study will attempt to take these generalizations from the community to the nursing home to show the importance of activity participation in this population to increase self esteem, morale, and decrease loneliness which will result in residents being less depressed.

Social Support

Social isolation can be defined as being or feeling detached from a social network or community. Dungan and Kivett (1994) have found factors contributing to social isolation. Factors contributing to social isolation include instability of residence, infrequent contact with friends, children, siblings, and lack of participation in social groups. Others have found that quality of relations with family members rather than frequency of interactions, that is what is most important to the elderly (Lee and Ishii-Kuntz, 1987). Wan and Weissert (1981) conclude that married couples had more sources of social support than non-married and those who lived alone were less likely to have social support networks than those living with others preventing placement in a nursing home. The availability of siblings, other relatives, and friends as social support was associated with high levels of physical and mental functioning. Supportive social relations may operate at least in part by replenishing feelings of control and self worth (Krause and Borawski-Clark, 1994). Blazer (1982) examined the three separate parameters of social support; perceived support, frequency of social interaction and roles

and available attachments and morality status of the elderly. These parameters were important to decrease morality in the elderly community sample. In conclusion, a final study found people with larger networks were less likely to be depressed and people with only friends in their network reported higher levels of depressive symptomatology (Antonucci, Fuhrer, and Dartiques, 1997).

Becoming a nursing home resident involves a major disruption of a person's social world, altering relationships with family and friends. In a study by Commerford and Reznikoff (1996) they conclude that perceives social support from family was positively related to self esteem of nursing home residents. Roberts, Dunkle, and Haug, (1994) significantly correlated greater social support with lower depression. The social support from family helped people to feel better about them selves and less depressed. Furthermore, they conclude that family ties rather than friendships may be significant predictors of psychological adjustment in nursing home populations (Commerford and Reznikoff, 1996).

Quality of Life in the Nursing Home

What constitutes quality of live for nursing home residents? Several studies have included aspects that promote quality of life for residents in the nursing home environment. Harel (1981) concludes quality of care in nursing homes is reflected in part by a residents' perception of how much their social needs are gratified and how much personal space and responsibility they enjoy. These aspects of social climate are positively correlated to residents' satisfaction with treatment and life satisfaction.

According to the Institute of Medicine and the Nursing Home Reform Act social engagement is a critical component of quality of life and is an appropriate goal of nursing home care (Mor, et al., 1995). They further state that the capacity to respond to social overtures from others and to initiate meaningful social involvement is an important aspect of human functioning. Thus from their study it can be stated that one focus in the nursing home should be on the residents engagement in the social world around them and target social and recreational programs appropriate to their level of functioning, that offer them meaningful involvement in their environment to increase satisfaction and quality of life.

Healthy Aging

Psychiatrist Carmella Cremen's believes that exercise and remaining social active are good ways to starve off mild depression. This can bring about a good sense of well-being (Garnett, 1995). In an additional study, the factors which correlated to healthy aging included level of activity, such as participation in church or being aware of the political issues; ability to change and rebound from difficult situations; how the subjects viewed themselves physically and mentally and frequency of contact with family and friends (Krach, 1995).

Interventions for Depression in the Nursing Home

Depression is commonly underdiagnosed and untreatable in the nursing home.

Depression is explained away by saying it is an understandable consequence of the losses they have suffered and their current condition in life (Masand, 1995).

Residents may be more likely to remain active or socially engaged if they feel they can exercise some control over their environment. Participation in the organizational structure may strengthen relationships among residents (Timko and Moos, 1990).

Providing environmental stability and maintaining a structured daily routine can help reduce the patients fear and agitation. Having familiar persons and mementos in the environment can help reduce the anxiety often experienced by the patient with

Alzheimer's disease and depression (Lundquist, Bernes, and Olsen, 1997). A more comfortable facility may provide more resources with which residents can initiate activities, engage in social interaction and make productive use of their time. Physical features that enhance pleasantness, opportunities for activity and space facilitate interpersonal support and self direction (Timko and Moos, 1990). O'Conner and

Vallerard (1994) conclude that seniors who engage in every behaviors for their own inherent pleasure, or because they choose to perform actions for their own good, show better psychological adjustment to the nursing home. Providing a pleasant environment, consistent daily routine, allowing residents to exercise some control, space to engage in social interactions and initiate activities can be associated with greater psychological adjustment in the nursing home.

Summary

In summary, there is a significant amount of research on late life depression. The bulk of the research shows a correlation among loss of function, mainly physical, loneliness specifically related to loss of spouse, life satisfaction as it relates to religion and location, social skill deficits.

For the purpose of this study research was reviewed on the elements of activity participation and social support. Most research on activity participation focused on the Activity Theory. The supported theory is, the more socially active individuals score higher on morale measures than less socially active individuals. Current research also supports that activity participation increases self esteem, morale and decreases depression in the elderly.

A significant amount of research has been reviewed on social support, such as interactions with family and friends. The bulk of the research supports the notion that the quality of interaction with family and friends increases mental and physical functioning, self esteem, morale, decreases loneliness and depression. Some research on social support did include the nursing home population. Social support from families was associated with increased self esteem, less depression and a predictor of psychological adjustment to the nursing home.

A further investigation was done to explain the need for nursing home residents to have quality of life. Providing residents with quality of life will reduce depression. Social engagement is a critical component as well as to target social and recreational

programs appropriate to their level of functioning and offer them meaningful involvement in their environment. These increases satisfaction and quality of life.

In conclusion, it is important to mention what constitutes healthy aging and interventions that can be done to reduce depression in the nursing home. Activity level, the ability to change and rebound from difficult situations, how individuals view themselves physically and mentally, and frequency of contact with family and friends are the important components of healthy aging.

In the nursing home several factors can be manipulated to decrease depression. The environment is one important component. The environment needs to be pleasant and provide space for residents to engage in social interactions and initiate activities. Providing residents an opportunity to exercise control and a consistent daily routine are other important factors. These factors can all promote psychological adjustment to the nursing home thus decreasing depression.

Although a significant amount of research has been done on depression in the elderly and its correlation to activity participation and social support with regards to elderly in the community. Little research has been done on these variables and how they correlate to the nursing home population. More research should be done correlating these variables on this population as these may be the only resources remaining to the elderly in nursing homes.

Chapter 3: Design of Study

Restatement of Hypothesis

The elderly in nursing homes who maintain social engagement will score less depressed on the Geriatric Depression Scale.

Null Hypothesis

There will be no difference in the scores of depression for those elderly in nursing homes who maintain social engagement and those who do not.

Variables

The independent variable in this study was whether or not the subjects maintained social engagement. The dependent variable in this study was the actual score on the Geriatric Depression Scale.

Sample

The sample population utilized was 21 elderly adults between the ages of 67 and 91; with the mean age 87.9. 90% were females and 10% were males. 100% of the

subjects were Caucasian. Subjects included in the study have resided in the nursing home for at least six months or more. All subjects resided in a 120 bed nursing home in southern New Jersey. All subjects consented to participate in the study. Subjects were selected solely on the bases of their cognitive ability to answer the questions on the Geriatric Depression Scale. A subject was excluded from the study if they met only one criteria for social engagement; activity participation or physical contact with family or significant others. A subject was also excluded if they were receiving an antidepressant.

Measures

To measure depression, the Geriatric Depression Scale was used. The Geriatric Depression Scale was developed for use in the elderly population. It was designed to differentiate non-depressed, mildly depressed and moderate to severely depressed subjects. The scale consist of 30 questions with psychological content and less on somatic items, which older people often indicate difficulties or complaints in the absence of depressed mood (Coleman, Philip and Mule, 1995).

In a preliminary study the Geriatric Depression Scale (GDS-30) was compared to the Zung Self Rating Scale (SDS) and the Hamilton Rating Scale for Depression (HRS-D). The Geriatric Depression Scale when compared showed a high overall internal consistency, that all items measure the same underlying construct. Chornbach's alpha was utilized to provide the over all internal consistency of the scales. The GDS-30 had a correlation of 0.94, SDS 0.87 and HRS-D 0.90. Convergent validity among the three scales was found to be 0.84 between the GDS-30 and SDS, 0.83 between the GDS-30 and

HRS-D and 0.80 between the SDS and HRS-D. The study also found that the SDS discriminated less effectively between the normal, mildly depressed and severely depressed subjects than the GDS-30 and HRS-D (Yesavage, et al., 1983).

The GDS-30 was also able to correctly classify depressed individuals and to classify nondepressed individuals as such. The GDS-30 has a sensitivity rate of 84% and a specificity rate of 95% (Yesavage, et al., 1983).

When the three scales were compared for reliability, the GDS-30 showed a greater split-half reliability at 0.94 with the SDS at 0.81 and HRS-D at 0.94. Test-retest reliability was calculated for the GDS-30 and it showed a correlation of 0.85. The GDS-30 proves to be a valid and reliable measure for depression in the elderly population (Yesavage, et al., 1983).

The questions on the scale are to be answered in a yes/no format and the scale can be orally administered. One point is counted for each depressive answer as indicated by the scoring instructions. The normal range is 0-10; mild depression ranges from 11-20; and 21-30 indicates moderate to severe depression. Appendix A contains a sample of the Geriatric Depression Scale.

Social engagement has been measured in terms of the amount of activity participation of the subjects and the amount of physical contact with family or significant others. A subject was considered to participate in activities if they attended at least one activity daily over a 7 day observation period. A subject was considered to have physical contact with family or significant others if they had contact with these individuals at least

3 times in the seven day observation period. The amount of time spent with these individuals was not included in the study.

Design

The study was designed to correlate social engagement and less depression among the elderly in the nursing home population. It has been designed to show that the elderly who maintain social engagement; activity participation and physical contact with family or significant others while residing in the nursing home will be less depressed than those residents who do not maintain social engagement.

The Geriatric Depression Scale provided a score of normal depression; mild depression and moderate to severe depression. Each subject was then assigned to a group consisting of those who met the criteria for social engagement and those who did not meet the criteria for social engagement. The study is a between subjects design. Due to the limited size of the sample a non-parametric statistical measure was used. The Mann-Whitney was used to show if there was a significant correlation among social engagement and being less depressed among elderly residents in the nursing home population.

Procedure

Permission was obtained by the Executive Director to conduct the study at the nursing home. The study was conducted over a one week period. The week to conduct the study was selected at random. The day prior to the beginning of the one week period,

the researcher met with the two RN Unit Coordinators to review those residents who were cognitively able to answer the questions on the Geriatric Depression Scale.

Once a list of residents was established the researcher met with the Activities Director to develop a checklist for the purposes of data collection. The residents in the study were placed on a list and the activities staff was instructed to place a check next to the names of those residents who attended at least one activity daily over the 7 day observation period.

All subjects were given a consent form to sign before the researcher administered the Geriatric Depression Scale. Appendix B contains a copy of the consent form. All subjects were debriefed on their participation in the study. Along with the consent form the subjects were asked their age, race, gender, length of stay in the nursing home and if they were receiving antidepressants. All information was verified by the RN Unit Coordinator.

Subjects were administered the Geriatric Depression Scale orally by the researcher. The administration took place in the privacy of their rooms at the nursing home. The Geriatric Depression was administered to each subject over the one week period. The Geriatric Depression Scale took on the average approximately 30 minutes to administer to each subject.

Once the Geriatric Depression Scale was completed the researcher viewed the visitor's sign in log. Data was recorded on the amount of physical contact each subject had over the one week period with family or significant others. The researcher also obtained the data on activity participation collected by the activities staff.

Chapter 4: Analysis of Results

Restatement of Hypothesis

The hypothesis was that there would be a difference in the scores obtained by the elderly nursing home residents who maintain social engagement and those elderly nursing home residents who do not maintain social engagement on the Geriatric Depression Scale. It was predicted that the elderly in nursing homes who maintain social engagement would score less depressed on the Geriatric Depression Scale. The null hypothesis was rejected in this study. There was, in fact, a significant difference in the scores.

Interpretation of Results

The mean ranks and sum of ranks for depression from the scores of the Geriatric Depression Scale are shown in Table 4.1. The social engagement group scored a mean of 8.10 on the Geriatric Depression Scale which indicated, normal depression for the group. The non-social engagement group scored a mean of 13.64 on the Geriatric Depression Scale which indicated, mild depression for the group.

Table 4.1

Mean Ranks and Sum of Ranks for Depression From the Scores of the Geriatric Depression Scale

Group	Number of Cases	Mean Ranks	Sum of Ranks
Social Engagement	10	8.10	81.00
Non- Social Engagement	11	13.64	150.00

There was a significant difference among the depression scores of the social engagement and non-social engagement groups. The Mann Whitney Test revealed a significant difference between the scores. The scores were statistically significant at (.030, $p < .05$).

The measures of central tendency for depression from the scores of the Geriatric Depression Scale are shown in Table 4.2. The median and mode for the social engagement group was 4.00, which indicated normal depression. The median and mode for the non-social engagement group was 11.00, which indicated mild depression.

Table 4.2

Measures of Central Tendency for Depression From the Scores of the Geriatric Depression Scale

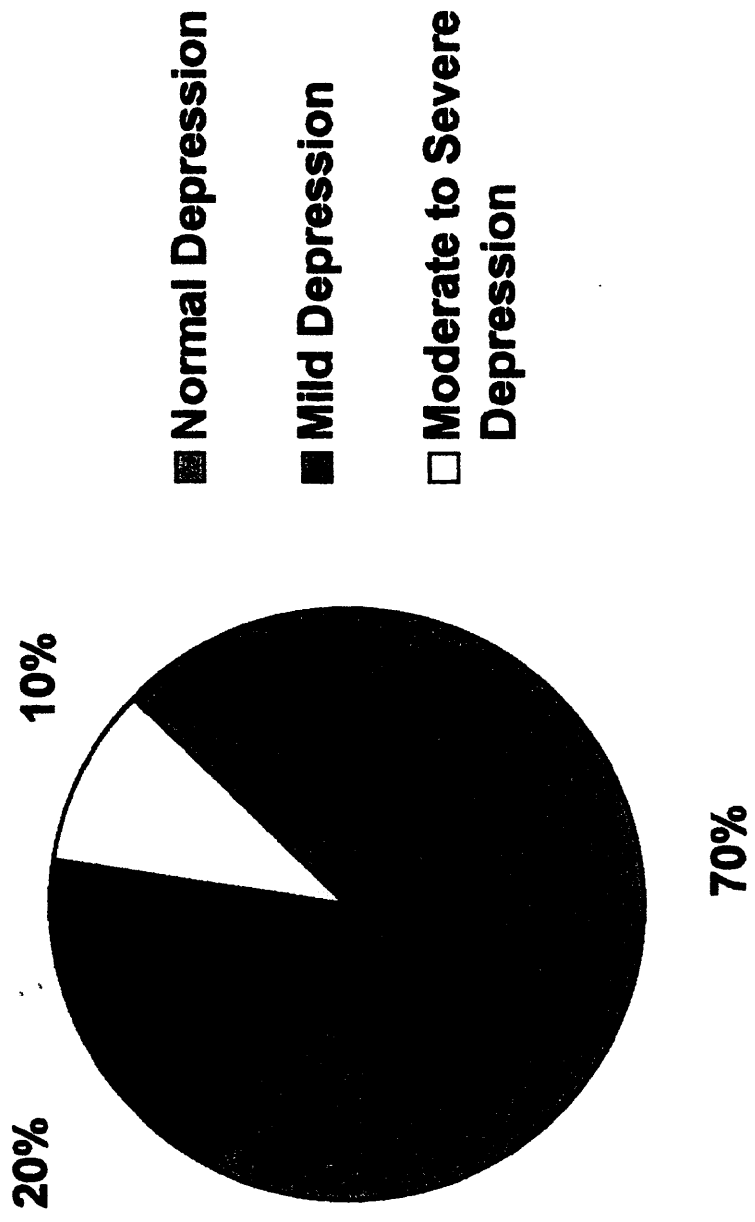
Group	Mean	Median	Mode
Social Engagement	8.10	4.00	4.00
Non-Social Engagement	13.64	11.00	11.00

Figure 4.1, represents the percentage of subjects classified as normal, mild, or moderate to severely depressed in the social engagement group. Figure 4.2, represents the percentage of subjects classified as normal, mild, or moderate to severely depressed for the non-social engagement group. Classifications were based on the raw scores of the two groups on the Geriatric Depression Scale. Subjects were labeled with normal depression if the raw score was between 0-10. Subjects were labeled mildly depressed if the raw scores were between 11-20 and subjects were labeled moderate to severely depressed if the raw scores were between 21-30 on the Geriatric Depression Scale.

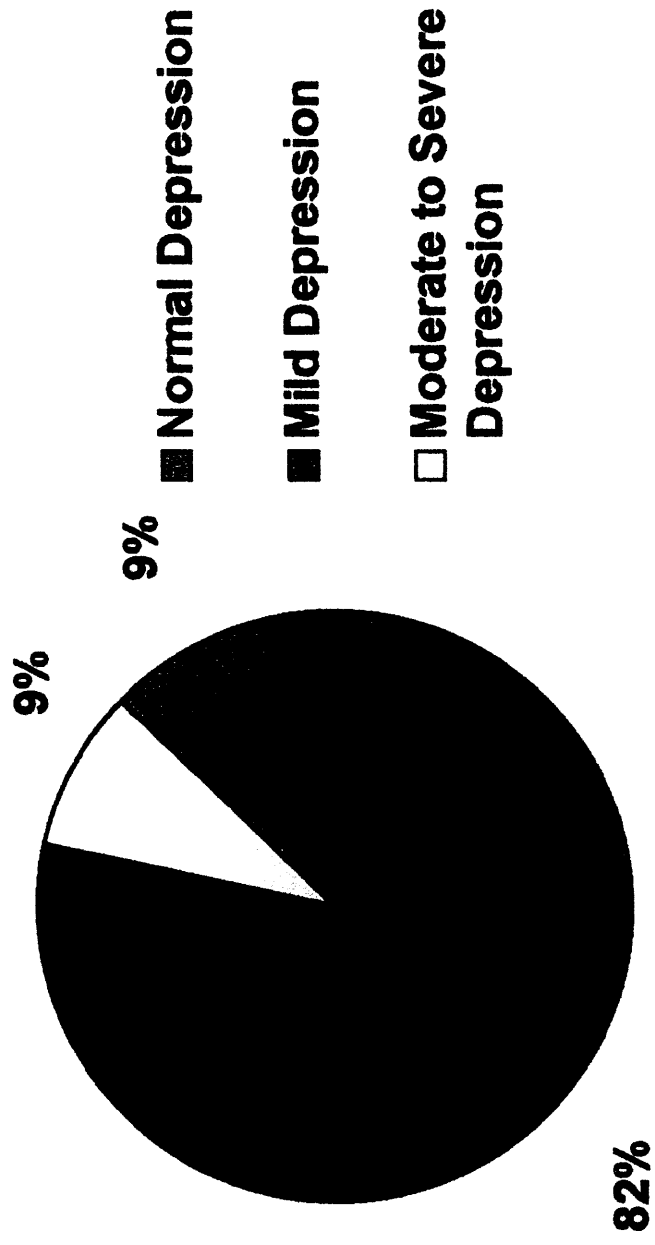
Further data was obtained on the subjects age and length of stay in the nursing home. Figure 4.3, represents the mean age for both the social engagement and non-social engagement group. Figure 4.4, represents the mean length of stay for both the social engagement and non-social engagement group. The mean age for the social engagement group was 84.1 and the mean age for the non-social engagement group was 83.5. The groups were relatively similar in age. The mean length of stay for the social engagement

group was 18 months and the mean length of stay for the non-social engagement group was 15 months. The groups were relatively similar in the amount of time they have resided in the nursing home.

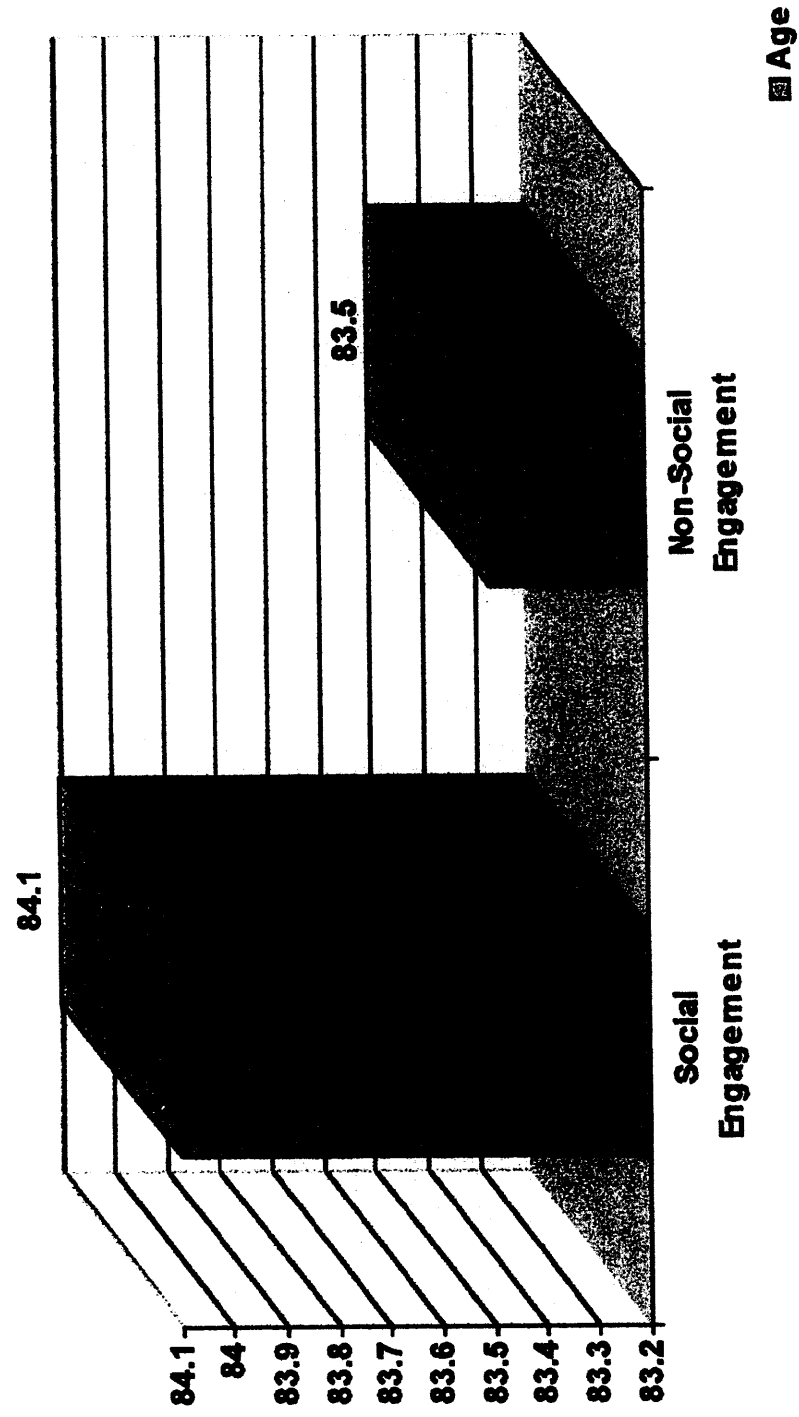
Classification Percentages Social Engagement Group



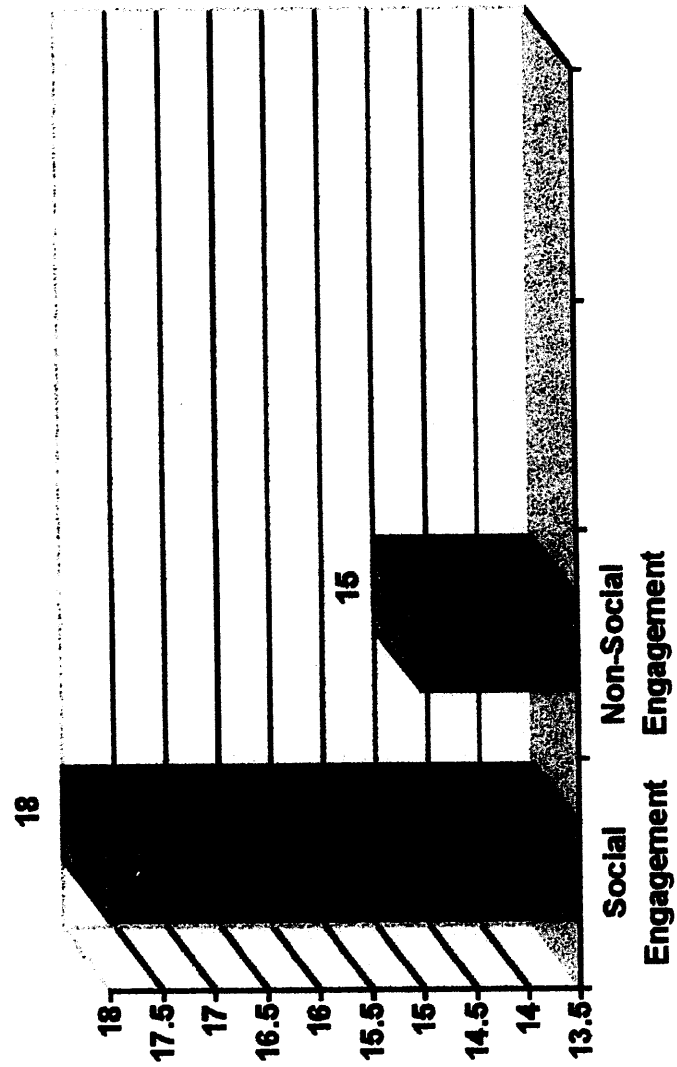
Classification Percentages Non-Social Engagement Group



Mean Age



Mean Length of Stay (Months)



■ Length of Stay (Months)

Chapter 5: Summary and Conclusion

Summary

The U.S. Bureau of the census in 1991 revealed that the population of those over the age of 65 has risen from 20 million in 1970 to 29.4 million in 1986. It has been predicted that by 2010 the elderly will be 15% of the population. As the elderly population increases so will the placement of elderly in residential care units and nursing homes.

One significant factor that can have an effect on the elderly as they age is depression. Depression is as chronic in the elderly as in the young population. Depression warrants careful attention as the elderly have the highest suicide rates in America. There is no question that later life depression is a significant and growing problem as the elderly population continues to grow.

Depression in the elderly has been marked by persistent sadness, difficulty in sleeping, physical illness, effects of polypharmacy or dementia. In the elderly, depression may go undetected and untreated as health professionals have a low expectancy for a high quality of life for this age group and view depression in the elderly

as typical. However, depression has been viewed as not a natural part of aging. It has been emphasized as treatable in the elderly population. There has been a greater need for recognition of the disease and rejection that depression is “normal” with aging.

Treatment of depression can improve their motivation and provide them with a sense of purpose. Not only are antidepressants a way of combating depression but so is staying socially connected and physically fit.

As the population continues to grow so will the rate of depression and there is a need to recognize the illness and a need to find solutions to combat the illness especially for those who have been institutionalized. This study examined the effects of maintaining social engagement on depression in the nursing home population.

One measure designed as a screening instrument for depression specifically for the elderly population is the Geriatric Depression Scale. It was designed to differentiate non-depressed, mildly depressed and severely depressed subjects. Subjects are given the scale orally or in written form and are asked to answer yes/no to the thirty questions. Subjects are then given a rating of either normal, mild or moderate to severe depression.

To test the hypothesis that those elderly nursing home residents who maintained social engagement would score less depressed on the Geriatric Depression Scale, the scale was given to 21 elderly nursing home residents. The results were significant to the predication and found the elderly residents in the nursing who maintained social engagement were less depressed then the group of elderly residents who did not maintain social engagement.

Conclusions

The purpose of this study was to examine whether those elderly home residents who maintained social engagement were less depressed than those elderly nursing home residents who did not maintain social engagement when asked to complete the Geriatric Depression Scale. Specifically, the hypothesis was that those elderly nursing home residents who maintained social engagement would score less depressed on the Geriatric Depression Scale.

The results indicated that there was a significant difference in the scores of depression between the two groups of subjects. The significant results of this study was as follows:

1. Nursing home residents that maintained social engagement were less depressed than nursing home residents who did not maintain social engagement.

Discussion

Past research has identified variables that correlate to depression, in the elderly adults. These variables examined included loss of function, loneliness, life satisfaction, social skills, activity participation and social support. This study examined maintaining social engagement which included both activity participation and social support.

As the study predicted, those elderly nursing home residents who maintained social engagement were less depressed than those elderly nursing home residents who did not maintain social engagement. The significant finding coincided with past research

that indicated that activities generate positive feedback from others that confirms a person's role, activities enable individuals to confirm valued identities which is likely to generate support for self-esteem and well-being (Reutzes, Mutan and Verrill, 1995), and participation in associations has a significant impact on morale (Lee and Ishii-Kuntz, 1987).

This study also coincides with studies that have examined social support. The qualities of interaction with family members is most important to the elderly. Supportive social relations operate at least in part by replenishing feelings of control and self-worth (Krause and Borawski-Clark, 1994). In the nursing home population, support from family was positively correlated to self-esteem (Reznikoff, 1996). The social support from family helped people feel better about themselves and less depressed (Roberts, Dunkle, and Haug, 1994). They also concluded that family ties rather than friendships are significant predictors of psychological adjustment in the nursing home populations.

Though the study was significant, some aspects that raised question and concern was generalizing to the general population because of the limited sample size. The sample size was limited due to need to control for cognitive functioning, drug use and the consideration of the amount of time that the residents resided at the nursing home.

Due to the fact that the a large number of residents residing in nursing homes have cognitive deficits, the amount of subjects was limited to those individuals who had the cognitive functioning to answer the Geriatric Depression Scale. Several residents that reside in the nursing were also taking antidepressants. To measure social engagement and not the effects of medications these residents were excluded from the study. Lastly,

subjects were excluded from the study if they spent less than six months at the nursing home, assuming that these subjects would be less adjusted than those that had resided in the nursing home six months or longer.

Implications for Future Research

As mentioned in Chapter 2, research has been done investigating the diagnosis, etiology and treatment of depression. The research has examined the variables of loss of function, loneliness, life satisfaction, social skills, activity participation, and social support in relation to depression in the elderly population.

Unfortunately, most of the research of the population has focused on the elderly who continue to reside in the community. There is a limited amount of research in these areas on residents who are residing in the nursing homes. The research has focused to a large extent to the issue of quality of life with regard to the nursing home population. Part of quality of life for nursing home residents involves activity participation and social support. Little research has been done on these variables and how they correlate with depression in the nursing home population. More research should be done correlating these variables on this population as these may be the only resources remaining to the elderly in nursing homes.

Finally, as the population of the elderly is on the rise, thus increasing the number of elderly being placed in nursing homes, more research is needed on this population. Not only should the research include issues of quality of life, it needs to include treatment and ways to combat depression for these residents by expanding on the areas of

healthy aging, well-being, and maintaining independence all of which correlate to decreased depression in the elderly.

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APPENDIX A

GERIATRIC DEPRESSION SCALE

for other translations and updated research, consult our website:

<http://www-leland.stanford.edu/~yesavage/gds.html>

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

Administration: These items may be administered in written format, but oral presentation is preferred for medical patients. If written format is used, the answer sheet must have printed YES/NO after each question, and the subject is instructed to circle the better response. If administered orally, the examiner may have to repeat the question in order to get a response that is more clearly a yes or no.

Scoring: Count 1 point for each depressive answer. The normal range is 0-10; mild depression ranges from 11-20; and 21-30 indicates moderate to severe depression.

APPENDIX B

CONSENT FORM

I Agree to participate in the following interview, to complete the Geriatric Depression Scale and have additional data regarding my activity participation and family interaction collected.

I am aware that the current study is being conducted as part of a Graduate Thesis. I give permission to the researcher to use the results of the scale and the additional data collected in the study. I also give permission to the researcher to share the results of my scale with the professional staff of Victoria Manor Nursing Center, if the results indicate the need for professional consultation on my behalf.

I am aware that at anytime I may end my participation in this study.

Signature

APPENDIX C

Clinical Gerontologist

... the journal of aging and mental health

EDITOR:
T.L. Brink, PhD
1103 Church Street
Redlands, CA 92374

Dear Colleague:

Enclosed are copies of the scales you requested, complete with scoring/administration instructions, and even an annotated bibliography. (Sorry, I do not have more reprints of the articles cited in that bibliography). I hereby grant permission to use in your clinical work and research, to duplicate and disseminate these scales among your colleagues and students. Although the Geriatric Depression Scale was developed for use with the aged, it seems to be just as valid and reliable with other age groups. Its lack of somatic items makes it especially appropriate for patients with medical problems, and its simple yes/no format makes it ideal for oral administration. In doing research with the G.D.S., I have three suggestions:

- 1) Do not alter the guidelines for scoring/administration.
- 2) If you will be trying to show a treatment effect, start out with a clinically depressed sample.
- 3) If your sample size is small, use non-parametric statistics (e.g., Fisher Exact, Mann-Whitney, Sign Test, Friedman, Kolmogorov-Smirnov).

Let me take this opportunity to describe the journal that I edit. Clinical Gerontologist, now in its second decade, is for psychiatrists, psychologists, social workers, geriatricians, nurses, and other counselors. CG covers topics such as dementia, depression, assessment, psychotherapy, caregivers, psychopharmacology, and cognitive-behavior therapy. What distinguishes CG from some other journals in this field is an uncompromising commitment to practitioner relevance. If you are not yet a subscriber to CG, just contact the Haworth Press at 10 Alice Street, Binghamton, NY 13904-1580, or call them at 1-800-3-HAWORTH.

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