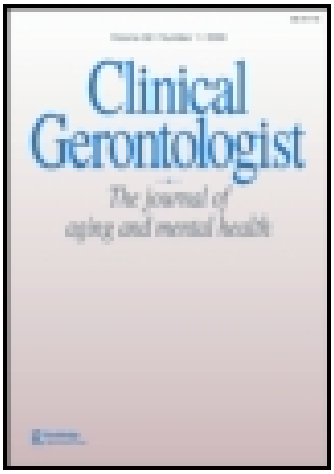

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Coping with Symptoms of Depression: A Descriptive Survey of Community-Dwelling Elders

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This study describes the manifestation of depression among community-dwelling elders, addressing symptoms experienced, coping strategies used, and the relative effectiveness of each strategy as perceived by the elders themselves. A modified version of the Center for Epidemiological Studies Depression Scale (CES-D) was administered to a random sample of 91 elders living in the community. The most common symptoms reported were sleep disturbance and lack of energy. The absence of pleasure, while relatively uncommon, posed a significant challenge to seniors' coping abilities. Among the coping strategies examined, respondents reported using diversion or distraction most often, followed by problem-solving and persistence. In this sample, most reported coping effectively with the symptoms they experienced. They reported that problem solving was the most effective coping strategy, and the few who relied on spiritual approaches also cited high effectiveness.

KEYWORDS community, coping, depression, effectiveness, resilience

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INTRODUCTION

Coping, seen here as ". . . things people do to avoid being harmed by life strains" (Perlin & Schooler, 1978), is central to well-being in later life. Drawing from the model introduced by Folkman and Lazarus (1988), the process of coping is seen here as a learned behavioral response to stressors. With the growth of the aged population has come rising interest in the processes of stress and coping in later life. The importance of coping was illustrated in one seminal study of the experiences of relocated elders Lieberman & Tobin (1983). Results of this work suggested that the coping strategies used were even more important than the stressors experienced in determining survival and well-being.

Yet studies of age-related changes in coping responses have produced contradictory findings. Folkman and colleagues (1987) conducted a cross-sectional study of diverse age groups and concluded that "age differences in coping . . . were striking and consistent" (p. 182) with older adults using more passive, emotion-focused approaches while younger people used more problem-solving and interpersonal coping strategies. Other researchers have suggested that older adults use similar levels of problem-solving and less escapism or avoidant coping (Felton & Revenson, 1987; Irion & Blanchard-Fields, 1987). Similarly, Aldwin (1991) reported that older adults made less use of escapist coping.

The relationship between coping and emotional distress has been addressed in the growing body of research on late-life psychiatric disorders, particularly depression. Much of this work involves cross-sectional study of clinical samples to describe factors associated with emotional distress. For instance, Remjeet and colleagues (2005) examined the role of gender, age, depression, and coping in 112 patients with inflammatory polyarthritis (Ramjeet et al., 2005). Passive coping strategies and younger age were associated with higher rates of depressive symptoms (Ramjeet et al., 2005). Foster and Gallagher (1986) compared the coping strategies used by 32 depressed and 32 nondepressed elders in response to a major life event and to the experience of feeling down or depressed. Their results suggested greater use of avoidance and emotional discharge among those who were depressed. They also reported that the depressed tended to rate their coping as less effective. Similar findings were obtained in the United Kingdom, when Berry and colleagues compared a group of 48 older psychiatric patients with 25 older volunteers who were not patients (Berry et al., 2006). Respondents with diagnosed psychiatric disorders rated their coping as less effective, despite using more problem-focused coping strategies.

Based on these and related findings, many have concluded that emotion-focused or passive coping strategies are maladaptive while "proactive" coping and problem solving are adaptive (Greenglass, Fiksenbaum, &

Eaton, 2006). For instance, Ho (2007) evaluated the effectiveness of a counseling program for depressed elders in the community in part based on the extent to which participants reported less use of "negative" coping (detachment, passivity and resignation, and concealment) and increased use of "positive" coping approaches (positive orientation, active self-care, and seeking social support). Of course, an observed association between certain coping strategies and higher levels of depressive symptoms does not necessarily imply that the coping strategies are negative or ineffective. Relatively few studies have asked elders about the effectiveness of specific coping responses or conducted the longitudinal research necessary to establish causality with a measure of confidence.

One exception was a 1986 study that examined coping effectiveness in 80 men aged 26 to 90 years and 71 women aged 21 to 78 years (McCrae & Costa, 1986). The participants were asked to rate the effectiveness of each coping response they used. The coping strategies ranked most effective were problem solving and one emotion-oriented strategy, expression of feelings. The coping strategies ranked least effective were other emotion-oriented strategies including hostile reactions, self-blame, wishful thinking and passivity. The authors suggested that coping strategies ranked more effective contributed to psychological well-being.

In one of the few longitudinal studies conducted on this topic researchers in The Netherlands examined the impact of cognitive coping strategies on the symptoms of depression (Kraaij, Pruymboom & Garnefski, 2002). They conducted a self-report survey of a random sample of 99 community-based people aged 67 and older at two time intervals spaced by 2.5 years. When negative life events and prior depressive symptoms were controlled, positive reappraisal was associated with fewer depressive symptoms, while acceptance was associated with more symptoms.

In this study we sought to describe how older adults living in the community experienced and coped with the symptoms of depression. Rather than offer forced choices to describe coping responses, we invited participants to use their own words in an open-ended format. Thus we hoped to develop a more nuanced understanding of elders' coping strategies. We also hoped to build on the McCrae & Costa (1986) study, shedding light on the perceived effectiveness of the coping strategies used by these older adults.

METHODS

Participants

Respondents were randomly selected from the voter registry in a Western metropolitan area in the U.S. The selection process began at the precinct level, with the random selection of 17 voting precincts. Twenty voters aged

65 years and over were randomly selected in each precinct. These potential respondents were mailed an invitation letter and a return post card. A total of 340 invitation letters were mailed. Of these 39% (131) were not delivered because of incorrect addresses. A week after the mailing we made follow-up phone calls to those whose letters had not been returned. The overall participation rate of 48% resulted in 100 respondents. Among these, nine were eliminated due to cognitive difficulties.

Within the resulting sample of 91, the mean CES-D score was 10.4, with a range from 0 to 37. Twenty-five respondents (27%) scored above 16 on the CES-D, which indicated clinically significant depressive symptomatology. Just over half of the sample (59%) was female. Most (95%) identified themselves as Caucasians. The mean age was 74.5 years, with a range from 65 to 91 years. The modal income level reported was $20,000 to $29,000 per year. All had finished Junior High or Middle School, and the vast majority (95%) completed high school. Another 32% completed at least some college. Most (58%) respondents were married; 16% were divorced; and 23% reported they had been widowed.

Setting

Interviews were conducted either in the participants' homes or in public spaces. Two interviews were conducted in the public library. Minimal requirements included an electrical outlet for the tape recorder and comfortable chairs for the interviewer and interviewee. Interviewers made every effort to minimize distractions and interruptions.

Human Subjects Procedures

The study was approved by the University of Utah Institutional Review Board. All ethical principles regarding human subjects in research were followed including: a) informed consent, b) assessment of risks and benefits, and c) fair recruitment procedures in the selection of research subjects. Separate consent forms were signed for the screening and in-depth interviews. Respondents received a "thank you gift" of $20 for their time.

Rigor

Rigor in data collection was addressed through careful adherence to training and interview procedures, and identification of interviewers' underlying assumptions. Weekly sessions with the research team involved discussion of interview experiences, emerging insights, and assumptions. Additionally, training focused on self-awareness of the interviewers so they understood how their own attitudes might influence participants' responses.

Instruments

All interviews began with the collection of general demographic information including age, gender, race, religion, education level, marital status, and income level. Cognitive impairment and depressive symptoms were then addressed, followed by coping effectiveness.

Cognitive Impairment

Cognitive impairment was measured with the MMSE, in which participants answer eleven questions that tested orientation, recall, attention, calculation, ability to copy a figure, and ability to follow verbal and written commands (Folstein, Folstein & McHugh, 1975). Nine participants (of the original sample of 100) who scored at or below the established cut-off of 24 were eliminated from further participation in the study (Folstein et al., 1975).

Depression

The Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) is a 20-item self-report scale that measures depressive symptoms across four domains: depressed affect, positive affect, somatic symptoms and retarded activity, and interpersonal relations (Radloff, 1977). Frequency of symptoms in the preceding week is reported on a four point scale that ranges from 0 (rarely) to 3 (most or all of the time (Sheehan, Fifield, Reisine, & Tennen, 1995). Answers are summed, with potential scores ranging from 0 to 60. A score of 16 or above indicates significant depressive symptoms (Radloff, 1977). The CES-D has been shown to have a test-retest reliability of .81 (Davidson, Feldman, & Crawford, 1994).

The CES-D was modified for this study by the addition of two questions related to coping. Each time a respondent indicated that a symptom was experienced he or she was asked: 1) How do you cope with this? Up to two discrete verbatim responses were recorded. Then the respondent was asked, 2) How effective has this been for you? Responses were recorded using a 5-point Likert scale that ranged from "makes the situation worse" (0) to "always solves the problem completely" (5).

Data Analysis

Interviews were recorded and transcribed and then coping responses were subjected to iterative thematic analysis by two members of the project team (a professor and a gerontology student). All interviews were first read separately and the coders independently developed their proposed coding

schemes. These were then discussed and refined until a consensus scheme was developed. This scheme was used to independently code random samples of 10 interviews. Areas of disagreement were discussed, and the coding scheme was revised. This process was repeated until an acceptable level of agreement (80%) was achieved in independent coding of a random sample of interviews. Then the remaining interviews were coded by one coder and any questions resolved through discussion. NVivo 7 software (Welsh, 2002) was used for cross-referencing and examining associations between records.

The resulting coding scheme for coping responses included six categories: "doing" (activity not related to solving the problem); "thinking" (cognitive responses—either avoiding or focusing on the symptom/problem); "solving" (planful activity focused on the symptom/problem); "retreating" (waiting or withdrawing from the symptom/problem); "feeling" (emotion-focused activity, often ventilating) and "praying" (spiritual or religious activity). A seventh category was established for "other" responses that did not fit into any other category. Two of the categories, doing and thinking, were divided into subcategories. In the doing category these included diversion, socializing, and pushing through. Thinking subcategories distinguished between cognitive activity directed away from the symptom or problem and thoughts that focused on the symptom or problem. In some cases respondents used more than one type of coping response. These cases were coded as having "multiple" approaches, and distinguished from those in which a respondent used only one response. These categories and illustrative examples are presented in Table 1.

TABLE 1 Coding Categories for Coping Responses

Primary category	Subcategories	Illustrative quote
"Doing"	A. Hobby or diversion	"Keep busy reading, cook, gardening, knitting" (20)
	B. Socializing	"Call family or friends" (72)
	C. Persist	"Tough it out." (67)
"Thinking"	A. Focusing Away from the problem	"Try to get it out of my mind." (48)
	B. Focusing On the problem	"Thinking things through, realizing I can't do anything about my son's problems" (52)
	C. Other Thinking Response	"Compare myself to others." (22)
"Solving"		"Look at alternatives, then do it." (1)
"Retreating"		"Wait for a better day." (12)
"Feeling"		"Sit and sulk, feel sorry for myself" (13)
"Praying"		"Turning to a higher power." (11)
"Other"		"I don't know what to do when I feel this way." (15)
Multiple Approaches		"Read, visit friends [attend] church service." (3)

RESULTS

Depressive Symptoms

The most common symptoms that respondents reported involved somatic complaints. The four symptoms in this subscale were reported by an average of 40% of respondents. Of these the most common, reported by 60% of the sample was sleep disturbance. On average, 21% of respondents reported experiencing the four symptoms in the absence of positive affect subscale. The four symptoms in the interpersonal complaints subscale were experienced by 24% of respondents, on average. On average, 29% of respondents reported experiencing each of the eight symptoms in the negative affect subscale These results are summarized in Table 2.

TABLE 2 Symptoms of Depression

CESD subscale	Item	Percent experiencing symptom	Modal coping response*	Percent not coping effectively
Somatic Complaints	Poor appetite	24	3	13
	Everything was an effort	47	1	22
	Sleep was restless	60	1	27
	Could not "get going"	54	3	12
Subscale mean		40		19
Positive Affect (reverse coded)	Felt just as good as others	14	6	18
	Hopeful about future	30	7	27
	Happy	23	1	40
	Enjoyed life	16	1	29
Subscale mean		21		29
Interpersonal Complaints	People were unfriendly	16	5	29
	Talked less	36	2	24
	Felt lonely	35	1	21
	Felt people disliked me	7	3	17
Subscale mean		24		23
Negative Affect	Bothered by things	38	1	16
	Couldn't shake off blues	35	1	25
	Felt sad	35	1	28
	Trouble keeping mind on things	42	3/5	18
	Felt Depressed	36	1	16
	Crying spells	11	8	44
	Life a failure	18	2	20
	Felt Fearful	16	8	18
Subscale mean		29		23

*1 = Diversion; 2 = Doing something social; 3 = Pushing through; 4 = Doing something to solve the problem; 5 = Retreating from the problem; 6 = Cognitive avoidance; 7 = Thinking about the problem; 8 = Emotion-focused approach; 9 = Spiritual approach; 10 = Multiple approaches.

Also presented in Table 2 was the most common or modal coping response used in response to each symptom. Diversion was by far the most common coping approach reported, as it was the modal response to nine of the CES-D symptoms. The second most common response was persisting or pushing through, which was used most often in four of the symptoms. Retreating and emotion-focused coping responses were modal for two symptoms each. Problem-solving and spiritual approaches did not emerge as the modal response to any of the symptoms reported.

Finally, Table 2 presents the proportion of those having the symptom who reported limited success (at best) in resolving the problem. These might be considered the symptoms that pose the greatest challenge to seniors' coping abilities. Limited effectiveness was indicated when respondents rated their effectiveness at a 2 or worse, with 2 being "helps sometimes or solves part of the problem." Two symptoms: absence of happiness and crying spells had the highest proportion reporting limited coping effectiveness. While only 11% of the sample experienced crying spells, nearly half (44%) of those who did reported they did not cope effectively. Nearly a quarter of the sample (23%) reported that they did not experience happiness very often, and 40% of those who did reported less effective coping.

When the CES-D subscales were compared, more respondents reported ineffective coping with the absence of positive affect than with the other CES-D sub-scales. On the four items in the positive affect subscale an average of 29% of respondents reported low levels of coping effectiveness. This compares with 23% for the eight items in the negative affect subscale, 23% for the four items in the interpersonal subscale, and 19% for the four items in the somatic subscale.

Coping Responses

To examine coping strategies more carefully, we computed a measure for each participant that reflected the proportionate use of each strategy. The measure was calculated by dividing the number of times each strategy was used by the number of symptoms experienced. Frequencies for this measure are presented in Table 3. Respondents indicated that they were proportionately most likely to use diversion as a coping response to CES-D symptoms. On average, they reported using this response for over a third (39%) of the symptoms they experienced. Although it did not surface as the modal response for any symptom, problem-solving was the next most common response reported overall. On average, respondents reported use of problem solving in nearly a quarter (24%) of the symptoms they experienced. The third most commonly applied strategy was persisting or pushing though. Respondents indicated use of this strategy in an average of 20% of their symptoms.

TABLE 3 Proportionate Use and Effectiveness of Coping Responses

Primary category	Subcategories	Mean proportion	Mean effectiveness of coping response
"Doing"	D. Hobby or diversion	39%	3.44
	E. Socializing	15%	3.45
	F. Persist	20%	3.40
"Thinking"	D. Focusing Away from the problem	12%	3.16
	E. Focusing On the problem	9%	3.33
"Solving"		24%	3.77
"Retreating"		14%	3.21
"Feeling"		3%	1.30
"Praying"		7%	3.69
"Other"		4%	1.4
Multiple Approaches		15%	

DISCUSSION

This study describes how older adults cope with depressive symptoms in their own words, adding an important element to the literature on coping and aging, and providing insight into how older adults experience and manage depression. The majority or respondents in this study report that they cope effectively with any depressive symptoms they encountered. Further, results suggest that:

- The lack of pleasure might be a significant focus for clinical intervention. While these symptoms were not common among community-dwelling elders, they were most likely to challenge to elders' coping abilities.
- Somatic symptoms of depression, on the other hand, are relatively common and seem to pose less of a challenge to coping.
- Elders report here that, while they seldom apply it, problem-solving is an effective coping strategy. Diversion or distraction is used more frequently, to good effect. We suggest this reflects the often-uncontrollable nature of the "vicissitudes of age."

Lack of Pleasure

The absence of positive affect, while relatively uncommon, appears to challenge respondents' coping resources. For instance, 40% of those who reported a lack of happiness indicated that they did not cope effectively with the experience. Similarly, 29% of those who seldom enjoyed life reported coping unsuccessfully. Seen within a constellation of other

symptoms, the absence of positive affect may not be especially alarming. Nonetheless, clinicians may be advised to attend to the absence of positive affect, as it appears particularly difficult for elders to cope with.

Studies of happiness *per se* may be relevant to the treatment of depression. Practitioners may be informed by the views of Margaret Gullan-Whur, who suggested that "the attitudes most likely to ensure happiness in later life are flexibility, self-respect, persevering with a personal project, and knowing the difference between illness and ageing" (Gullan-Whur, 2002; p. 19). This is consistent with Lewinsohn's conceptualization of depression as reinforcement deprivation (Lewsinsohn, 1992), which underscores the merits of therapeutic approaches such as behavior activation that is designed to increase the number of pleasant experiences. Behavioral activation has proven effective with elders who suffer from depression (Culjpers, van Straten, & Warmerdam, 2006; Yon & Scogin, 2009).

Somatic Symptoms

In this study somatic symptoms appear to be both relatively common and relatively manageable. Other studies have reported that somatic symptoms of depression are common among older adults (i.e., Berkman et al., 1986; Gatz & Margo-Lea, 1990; Hertzog et al., 1990). To this, we would add the observation that in this study most people with these problems reported coping with them effectively.

Problem-Solving vs. Distraction

Respondents indicated that, while they did not apply it as often as other approaches, problem-solving was the most effective strategy they used to cope with the symptoms of depression. This is similar to findings reported by McCrae & Costa (1986). Of course, problem-solving can only be applied to problems that can be solved. Many of the vicissitudes of age are not of this type, which may explain why problem solving was less commonly applied by our sample than diversion or distraction.

Some consider distraction or diversion a negative coping strategy. (Abe, Kashiwagi & Tsuneto, 2003). While hobbies or diversions may not solve the underlying problem, respondents in this study reported the strategy was moderately effective. The mean score of 3.44 indicated that it "sometimes solves the problem completely." Building on Paul Baltes' model of "Selection, Optimization, and Compensation," the theory of socioemotional selectivity suggests that older adults learn to direct their attention away from experiences that cause negative emotions (Baltes & Baltes, 1990; Carstensen, Isaacowitz, & Charles, 1999). Diversion may represent an adaptive strategy for coping with symptoms the respondent believes cannot be "solved."

In this study relatively few respondents used spiritual or religious approaches to cope with depressive symptoms. But those who did rated the effectiveness of these methods quite high. This is consistent with findings reported by Bosworth and colleagues, who observed that when social support was controlled, religious coping was associated with lower scores on depression (Bosworth et al., 2003). It may also reflect the importance of positive re-appraisal observed in the Dutch study (Kraaij, Pruymboom, & Garnefski, 2002). For some, prayer may convert an uncontrollable and potentially damaging stressor into a matter than can be handily managed with help from the almighty.

Limitations

The study has limitations that dictate caution in the interpretation of results. The random sample was drawn from voter registries, so cannot be considered representative of community-dwelling older adults who are not registered to vote. The sample is also fairly small, so results must be seen as indicative of potential areas of research and not as estimates of population characteristics. Further, while the CES-D is an effective screening tool for depressive symptoms, it does not offer a definitive clinical diagnosis. Some respondents described here may not meet DSM or related criteria for the disorder. That said the results provide an intriguing look at how depression is experienced and managed by older adults in the community.

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