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Depression, Coping Mechanisms, Help-Seeking Behaviors, and the Perceptions of Purpose in Life of Older Adults

Cheryl Jones
Utah State University

DEPRESSION, COPING MECHANISMS, HELP-SEEKING BEHAVIORS, AND THE PERCEPTIONS OF PURPOSE IN LIFE OF OLDER ADULTS

by

Cheryl Jones

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ABSTRACT

Qualitative Perspective on Depression, Coping Mechanisms, Help-Seeking Behaviors, and The perceptions of Purpose in Life of Older Adults

by

Cheryl Jones, Master of Science

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Major Professor: Dr. Kathleen W. Piercy
Major Professor: Dr. Maria C. Norton
Department: Family, Consumer, and Human Development

Depression in older adults and their methods of coping were examined using a mixed methods approach. The data were from the Quality of Life Study (QLS), an ancillary study of the NIH-funded Cache County Study on Memory Health and Aging (CCSMHA). Forty-two individuals completed a qualitative interview, the Center for Epidemiological Studies—Depression scale (CES-D), Revised Ways of Coping measure, and Diagnostic Interview Schedule (DIS).

The sample faced many life challenges and sought help from spouses first, then other family members, and then friends, clergy, and physicians. Blames Others and Wishful Thinking were significantly associated with depression and Religious Coping was significantly associated with no depression. The majority of participants who referenced reframing and religion as coping strategies in their interviews did not have

depression as measured by the CESD and DIS. Belief in a purpose to life appeared to be important for no depression.

(173 pages)

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Cheryl Jones

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CHAPTER I

INTRODUCTION

Depression in older adults is a growing concern among researchers and practitioners alike. Currently, it is estimated that 15%-20% of older adults suffer from significant depressive symptoms (Gallo & Lebowitz, 1999; Pollock & Reynolds, 2000), with 1.4% of women, 0.4% of men, and 1% of the overall population who suffer from the diagnostic criteria for major depression found in the The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV; Serby & Yu, 2003). Prevalence of depression in older individuals is almost twice as high in women as men (Sonnenberg, Beekman, Deeg, & van Tilburg, 2000).

There are known problems with underdiagnoses (Friedhoff, 1994) and undertreatment (Mulsant & Ganguli, 1999) of depression among elderly persons. This may be due to a wide array of factors including negative stigma and perceptions that sadness in late life is normative. For example, a large epidemiologic study of the incidence of geriatric depression demonstrated that older adults who may be reluctant to endorse depression history in the context of a symptom inventory may disclose depression history when interviewed about medication use, substantially affecting incidence rates (Norton et al., 2006). Further, elder depression can be expressed in ways other than sadness, such as hopelessness and anhedonia, or loss of interest (Gallo & Rabins, 1999; Gallo, Rabins, Lyketsos, Tien, & Anthony, 1997). This may mean that depression in older adults may be a more extensive problem than heretofore thought by

researchers. Depression rates are high in older adults, especially considering it is often underreported, and therefore needs to be explored in more depth.

The problems confronting older adults may increase their risk for depression (Blazer, Hughes, & George, 1987; Kraaij & de Wilde, 2001). Negative life events older adults experience include death of significant others, severe illness of self, severe illness of significant others, negative socioeconomic circumstances, sexual abuse, physical abuse, emotional abuse and neglect, crime, disaster and war events, relational stress, and problem behavior of significant others. However, coping strategies are an important factor in decreasing the risk for depression that may result from events that occur in late life (Kraaij, Pruymboom, & Garnefski, 2001).

Social support is important to older adults' health by providing emotional support, physical assistance, and protection from the risk factors of isolation (Rowe & Kahn, 1998). Elderly individuals seek help from family, friends, physicians, clergy, and from self-help mechanisms such as prayer (Husaini, Moore, & Cain, 1994).

Elderly individuals who find meaning or purpose in life report better general health than older adults who are unable to find meaning in life (Krause & Shaw, 2003). Older adults who have a sense of meaning in life stemming from religious beliefs tend to report higher satisfaction in life, self-esteem, and optimism (Krause, 2003). Older adults' perceptions of the purpose of their last years of life may be an indirect indicator of depression.

Statement of the Problem

Most people will live to old age. It is the last stage and experience of living.

There are many problems that older adults face and how they cope with these problems may directly result in happiness or depression. Depression in older adults is a concern because it is often co-morbid with other medical problems, physical and cognitive impairments, and disability. It is also tied to poor quality of life, loneliness, higher mortality, and increased demands from caregivers and service institutions (Charney et al., 2003; Palsson & Skoog, 1997). Those who report depressive symptoms with or without sadness tend to be more at risk for inability to perform activities of daily living, lower quality of life, cognitive impairment, death, and suicide (Blazer, Hybels, & Pieper, 2001; Charney et al., 2003; Friedhoff, 1994; Gallo et al., 1997). By understanding the problems that older adults face, along with appropriate coping strategies, researchers may learn how to reduce depression risk in later life.

Very little research has examined coping strategies and depression in the elderly population from a qualitative perspective. A phenomenological study of late life depression may help increase understanding of how people cope with challenges in late life through an examination of their own explanations and stories. Moreover, research that focuses on help provided to older adults often focuses on the caregivers and resources available, with very little research exploring older adults' beliefs about seeking help and how and why they seek help.

Given these differences in the current literature on elder depression, the present research helps expand knowledge of geriatric depression, help-seeking behaviors, coping strategies, and older adults' perceptions of the purpose of their last years of life.

Theoretical Framework

The identification of coping strategies in this sample was guided by the Stress, Appraisal, and Coping model developed by Lazarus and Folkman (1984). Coping can consist of thoughts or behaviors that are used to reduce the stress caused by life challenges (Folkman & Moskowitz, 2004). The stress, appraisal, and coping theory views stress as a consequence of the ongoing interaction of the individual and environment. The emphasis is on the perceived meaning of the event, rather than its actual consequences. Through cognitive appraisal, one decides whether stimuli are potentially stressful and then whether, and how they can be coped with. This theory might be helpful in explaining how elderly individuals cope with life events, seek help, and evaluate purpose in life.

Purpose of the Study

The purpose of this research is to investigate the problems of late life and how older adults can best cope with them to reduce their risk of depression. This study was designed to directly explore the phenomenon of depression of older adults. This research identifies coping strategies used to deal with perceived life challenges and evaluate the degree of association between these coping strategies and depression. It explores help-seeking beliefs and about how help is sought. Finally, it addresses older adults' perceptions of the meaning and purpose of the rest of their lives, and how such purpose might have an association with depression risk.

The present research study incorporated quantitative as well as qualitative methods of data collection and analysis, using data from the Quality of Life Study (QLS), an ancillary study of the NIH-funded Cache County Utah Study on Memory Health and Aging (CCSMHA). The latter is a longitudinal study of dementia and mild cognitive impairment and putative antecedent risk and protective factors, including depression, medical, and pharmacological history (Breitner et al., 1999). QLS was funded through Utah State University's community university research initiative program. The QLS study was funded through Utah State University's Office for Vice President of Research under the Community University Research Initiative Program. In Cache County, 4.4% of older women and 2.7% of older men met criteria for major depression at the baseline interview conducted in 1995 (Steffens et al., 2000).

CHAPTER II

REVIEW OF THE LITERATURE

Geriatric Depression

The National Administration on Aging projects that in 2030, 20% of the population in the United States will be comprised of older adults (aged 65 years and older). This, along with current prevalence rates for geriatric depression, means that depression in later life is a rising concern. Understanding the factors that affect or alleviate depression may have future applications in public arenas. Depression is fairly prevalent in older adults (Alexopoulos, 2000; Gallo & Lebowitz, 1999), especially in women (Sonnenberg et al., 2000). It is estimated that 15 to 20% of older adults have depressive symptoms (Gallo & Lebowitz; Pollock & Reynolds, 2000). Depression is often co-morbid with other medical ailments (Alexopoulos, Meyers, Young, Silbersweig, & Charlson, 1997; Charney et al., 2003), and may be a predictor of dementia (Jorm, 2001; Schneider, Reynolds, Lebowitz, & Friedhoff, 1994). Depression has a negative impact on quality of life (Gallo & Lebowitz), and is associated with a higher mortality rate (Palsson, Ostling, & Skoog, 2001) as well as the highest risk of suicide throughout the life cycle (Heisel, 2004; Lebowitz et al., 1997). Lastly, depression results in added health care costs and loss of productivity (Goldman, Nielsen, & Champion, 1999).

What Is Geriatric Depression?

Depression in the general population can either fall into the category of depressed mood, which is characterized by some minor depressive symptoms, or it can be expressed

in major depression, a clinical disorder. The symptoms of a depressed mood and major depression can be expressed by emotional, cognitive, somatic, behavioral, and other manifestations (DSM-IV, American Psychological Association, 1994). Emotional symptoms can include sadness, fear, and anger. Sadness from a depressed mood is often expressed in individuals who are gloomy, dejected, and despondent. Cognitive symptoms that depressed individuals experience may include slowed thinking processes and abilities, lack of concentration, and high distractibility. Often, depressed people have a hard time concentrating because they are preoccupied with feelings of worthlessness, hopelessness, and guilt. They may fall into a depressive cycle, in which they focus their attention on the negative aspects of themselves (Beck, 1967). The somatic symptoms of depression, which are physical problems without a medical cause, include disturbances in sleep patterns, fatigue, bodily pains, and appetite changes. Finally, behavioral symptoms can include slowed movement and speech. Depression is often co-morbid, meaning that it often occurs along with other disorders, such as anxiety (Jorm, 2000).

Major depression is expressed by having one of or both a depressed mood (sadness) and a loss of interest (DSM-IV, American Psychological Association, 1994). In addition, the individual must experience four of the following symptoms for at least 2 weeks: worthlessness or guilt, inability to concentrate, fatigue, slowed motor abilities, problems sleeping, changes in appetite or weight, and thoughts about death or suicide. Minor depression is expressed by one of the core symptoms listed earlier along with one to three of the addition symptoms. Depression may also be present if the subject receives a score of 16+ on the CES-D or is taking antidepressant medications, even if they do not meet the DSM-IV criteria.

Depression tends to be expressed differently in older adults than in other age groups (Gallo & Rabins, 1999; Lebowitz et al., 1997; Schneider et al., 1994). Older adults may often exhibit depression that does not meet the DSM-IV criteria for major depression. They may deny feeling sad, but show other characteristics of depression. For example, an older adult may have only feelings of hopelessness and worthlessness and admit to thoughts about suicide. Clinical clues to diagnosis of depression in the elderly include, but are not limited to, unexplained somatic symptoms, hopelessness and associated suicide idealization, anxiety (including worry and nervous tension), anhedonia (the loss of feeling or an inability to derive pleasure from life), slowed movements and speech, stooped posture, and a lack of interest in personal care, producing a failure to follow medical or dietary therapy. Two thirds of people who have depression complain of physical pain and may not report psychological symptoms because of stigma (Stewart, 2003).

Depression in older adults that does not meet the full criteria for major depression may still have problematic effects. Gallo and Rabins (1997) found that older adults who reported depressive symptoms without reporting sadness were at greater risk for death, were unable to perform daily activities, had psychological distress, and experienced greater cognitive impairment than those who do not report any depressive symptoms.

Prevalence and Severity of Depression in Older Adults

Studies that have looked at the prevalence of depressive symptoms and major depression have come to various conclusions depending on their methodology, diagnostic criteria, and sample characteristics. Prevalence refers to the proportion of a certain

population that meets the requirements for either major depression or the expression of depressive symptoms.

Prevalence rates in community settings range from 1% to 19% of older adults with major depression and 2%-23% of older adults with depressive symptoms (Gallo & Lebowitz, 1999). The Epidemiologic Catchment Area (ECA; Blazer et al., 1987) study found a 1% - 2% prevalence of severe forms of depression in adults older than 65 years. Another study looked at 1,304 adults over 60 years old and found that 27% reported depressive symptoms and 0.8% reported major depression. A study in Finland reported major depression in men at 2.6% and women 4.5%, and the total percentage suffering from depressive symptoms was 22.4% for men and 29.7% for women (Kivela, Pahkela, & Laippala, 1988). In Cache County, major depression was estimated at 4.4% in women and 2.7% in men and an estimated lifetime prevalence of major depression at 20.4% in women and 9.6% in men (Steffens et al., 2000).

Depression is more common among elderly persons in medical institutions, ranging from 17% - 37% of patients having depressive symptoms, and 30% of those having major depression (Alexopoulos, 2000). Twelve percent of older adults treated in long-term care settings have major depression and 30% have depressive symptoms (Alexopoulos). Elderly individuals with a disability, such as vision impairment, are also at a higher risk of depression (Horowitz, Reinhardt, Boerner, & Travis, 2003).

Late life depression and other variables surrounding its prevalence are not well understood. There appears to be a decline in depressive symptoms as people reach old age, yet they suffer from increased physical illnesses, multiple losses, and other age-related risk factors for depression (Ernst & Angst, 1995). Old age may also increase

vulnerability to depression because bereavement and other psychological losses, somatic diseases, and institutionalization become more common with increasing age (Palsson & Skoog, 1997). It is possible that depression does not decline with old age, but appears to decline. This may be due to diagnostic criteria, depression disguised by somatic symptoms, placement in institutions, negative stigma with depression, possibly fewer, but more severe cases, or possibly that many do not meet the requirements for major depression, but show depressive symptoms (Ernst & Angst). Another explanation may be the increased mortality risk among depressed older adults, reducing the members in the population (Blazer et al., 2001; Rozzini, Frisoni, Sabatini, & Trabucchi, 2002; Schulz, Martire, Beach, & Scheier, 2000).

Risk Factors for Geriatric Depression

A meta-analysis of previous research was conducted that reported on the significant risk factors for depression among older adults in the community was conducted (Cole & Dendukuri, 2003). Significant risk factors for depression were the presence of a disability, new medical illness, poor health status, prior depression, poor self-perceived health, bereavement, sleep disturbance, and female gender.

A qualitative study (Hedelin & Strandmark, 2001) looked at five older women who met the criteria for depression and who considered themselves to be depressed to obtain a viewpoint of their experiences. The women were asked to talk about their past and present experiences. The women attributed their depression to some sort of traumatic event that "gave rise to feelings of worthlessness, inferiority, incompetence, insecurity, and loss of self-respect" (Hedelin & Strandmark, p. 407). The women also became more

sensitive and vulnerable to internal and external stressors throughout their depressive episodes. They appeared to be trapped in a cycle of hopelessness and guilt. This is one of only a few qualitative study investigating depression in older adults published in major journals to date.

Concerns about Geriatric Depression

Depression in older adults is a concern because it is often co-morbid with other medical problems, physical and cognitive impairments, and disability. This is a concern both because of greater suffering of older adults with depression and because of greater difficulty in detecting/diagnosing depression. It is also tied to poor quality of life, loneliness, higher mortality, and increased demands from caregivers and service institutions (Charney et al., 2003; Palsson & Skoog, 1997). Cerebrovascular disease may predict or perpetuate depression (Alexopoulos et al., 1997). Depression has also been found to double the risk for subsequent dementia (Jorm, 2001).

Depression presents multifaceted problems for older adults. Frontal lobe cognitive impairments have been found in depressed individuals when compared to non-depressed individuals and to themselves after recovery. The depressed individuals showed deficits on visuospatial recognition memory, attentional shifting of both processing and motor speed, and task planning (Beats, Sahakian, & Levy, 1996). Gallo and colleagues (1997) found that elderly individuals who did not meet the full criteria for depression and were without sadness were still at risk for functional impairments. People with depression are often the victims of the same attitudes and inadequate healthcare and social barriers that

people with psychotic disorders often experience (McNair, Highet, Hickie, & Davenport, 2002).

Suicide rates are much higher in old age than any other time (Heisel, 2004). Up to 90% of those who carried out suicide had a depressive disorder at the time (Raymond, 2002). Suicide may also be a reaction to the inability to cope with some of the changes that occur with old age such as isolation and illness (Bauer et al., 1997). Other possible factors that increase risk for suicide include decreases in cognitive functioning, a sense of hopelessness, and perceived lack of meaning or purpose in life (Heisel, Flett, & Besser, 2002).

Life Events Effect on Depression

Older adults who meet the DSM-IV criteria for major depression are more likely to report negative life events (Blazer et al., 1987). Depressive symptoms in older adults are often a reaction to the life events they may experience. In a study of 194 elderly individuals, depressed mood was found to be related to self-reports of childhood problems such as negative socio-economic circumstances as well as emotional abuse and neglect. Adulthood and late adulthood problems such as negative socio-economic circumstances, sexual abuse, emotional abuse and neglect, relational stress, and problem behavior of significant others also contribute to depressed mood (Kraaij & de Wilde, 2001). Thus, it is important to explore the negative life events of older adults to assess depression because negative life events are risk factors for depression.

Stressful events are also associated with later depression (Kessler, 1997). Specifically, stressful life events seem to play a critical role in the reoccurrence of major

depression. They have not been clearly shown to have an effect on the onset of depression, however. In contrast, positive life changes, such as events or changes that build hope, increase security, and provide relief from current stressors, are associated with depression remission. Women benefit more from positive life change than men do. Other factors that contribute to the remission of depression are high self esteem, social support, and effective coping strategies (Oldehinkel, Ormel, & Neeleman, 2000).

Coping Mechanisms in Older Adults

The concept of coping has been classified in many different ways. Coping usually can be split into two categories: (a) coping styles or "dispositions" that people typically use in their interactions with their environment, and (b) cognitive and behavioral coping responses that people use to handle stressful events (Moos, Holahan, & Beutler, 2003). Coping style dispositions usually emphasize a more personality based and habitual nature, whereas coping responses emphasize various reactions that are modified to fit the situation.

Coping mechanisms are commonly broken down into three categories: problem-focused coping, emotion-focused coping, and avoidance-oriented coping, and each of these coping categories can be further broken down in to person-oriented coping, which is an internal coping method using cognitive or emotional methods; and task-oriented coping, which is an external method using outward behaviors (Parker & Endler, 1996). Problem focused coping involves behavior and actions by the person intended to solve or lessen the problem. Emotion-focused coping is a cognitive process used to alleviate emotional stress. Avoidance-oriented coping involves avoiding stressful stimuli to

alleviate the stress. Person-oriented coping is a cognitive/emotional process focused on changing the perception of problems. Task-oriented coping is a behavioral process focused on specific tasks used to solve a problem.

For most people, later life presents more health related problems than any other time period. Cognitive coping is an important way to deal with these as well as other changes that late life presents. Coping dispositions and strategies are important in alleviating the symptoms of depression after negative life events (Garnesfski, Kraaij, & Spinhoven, 2001). Older adults with more depressive symptoms are reported to use acceptance, rumination, and catastrophizing more than other coping strategies. Those with fewer depressive symptoms used positive reappraisal the most often (Kraaij, Pruymboom, & Garnefski, 2002).

Coping strategies can be negative or positive. A person in a stressful situation may use a coping strategy to help alleviate the stress, but depending on the strategies used, consequences may be negative or positive. Negative consequences refer to those consequences that are ineffective in protecting against depressive symptoms, and positive consequences refer to and those that are effective in protecting against depressive symptoms.

Task-oriented coping is usually an effective way to cope with stress, while emotion-focused coping is usually not an effective way to cope with stress in order to prevent depression (Kraaji, Garnefski, & Maes, 2002). Emotion-focused coping is also associated with poor life satisfaction and little happiness. On the other hand, task-oriented coping and avoidance are associated with greater happiness (Jones, Rapport, Hanks, Lichtenberg, & Telmet, 2003).

Older adults who suffer from age related impairments often use less effective coping strategies than those who do not suffer from impairments. A study of 28 cognitively impaired older adults suggested that they used fewer problem focused coping and emotion focused coping techniques than the 42 anxious/depressed and 25 control participants. They also used less positive reinterpretation and more behavioral disengagement than the other groups (Fisher, Segal, & Coolidge, 2003). Individuals who are relatively healthy are more likely than unhealthy individuals to use humor as a coping strategy (Celso, Ebener, & Burkhead, 2003), although, its use did not have a significant impact on life satisfaction.

Religion is often used by adults as a coping mechanism (Koenig, 1990; Pargament, Smith, Koenig, & Perez, 1998). Religion, as a way of coping, changes from adulthood to late adulthood, with younger adults placing more emphasis on the purpose and goals of their life, and older adults placing more emphasis on the need to be satisfied with their past (Eggars, 2000). Religious coping is related to social support, but is also independently related to the outcome of depression (Hayden, Kwang-Soo, & Douglas, 2003), that is, that social support was an important part of religion, but when social support was removed as a coping factor, depression was alleviated by religious coping alone, outside of social support. Therefore, researchers concluded that religion plays an important part reducing the risk for depression.

Religious practice can be either a positive or a negative way of coping. Positive aspects include religious forgiveness, seeking spiritual support, collaborative religious coping, spiritual connection, religious purification, and benevolent religious reappraisal. Negative aspects include spiritual discontent, punishing God reappraisals, interpersonal

religious discontent, demonic reappraisal, and reappraisal of God's powers. Particular religions and denominations were not separated for comparison. Positive aspects of religious coping are more widely used (Pargament et al., 1998). In a study of religious involvement and depression in Cache County, frequent church attendance strongly predicted lower prevalence of major depression in women but not in men, even after controlling for social support, demographic, and health variables (Norton et al., 2006).

Help-Seeking Behaviors

Very little research has looked specifically at help-seeking behaviors in general and for depression, especially among older adults. Research addressing this topic often focuses on what types of help is available to older adults, but not older adult's beliefs and perceptions about seeking help.

Seeking help or social support is often considered one aspect of older adults' coping mechanisms. Elders that perceive they have good social support are less depressed and those that have stressful or bad relationships are often more depressed than the general population (Cummings & Cockerham, 2004).

Older adults seem to withdraw from society in old age (Cartensen, 1995). Two previous theories suggested that it might be that society pushes out older adults or that because older adults are nearing death, they become more self-aware and withdraw from society. Cartensen, after conducting extensive research, proposed a socioemotional selectivity theory. This theory suggests that older adults' social involvement follows the life-cycle approach. Specifically, adults become better at emotion regulation as they age,

but become less willing to associate with unfamiliar people, and thus they seek help from fewer people with whom they have more intimate relationships.

In one study, older and younger adults were given various reasoning tasks. Older adults did not seek help as often as younger adults even when they missed more problems (Alea & Cunningham, 2003). These research studies may suggest that older adults seek help less than younger adults, particularly from people that are unfamiliar.

The illness behavior model (George, 2001) suggests that individuals who have symptoms of illness move through two phases: the appraisal phase in which they acknowledge the symptoms as a health problem and the illness phase in which they seek help for the problem. Older adults only report one third of their symptoms to physicians, and, depression may be one the symptoms not reported.

There is some evidence that praying and seeking religious help and talking to others about problems may be a coping mechanism that alleviates depression in the general population (Wang & Patten, 2002). Older adults with depressive symptoms use more mental health professional resources that older adults without depressive symptoms. Mental health services are used less than family doctors and clergy. Older women seek slightly more help from clergy, prayer, and family or friends than do older men (Husaini et al., 1994).

Meaning and Purpose of the Rest of Life

Meaning-based coping strategies are positively associated with positive psychological well-being (Schanowitz, 2004). There is a strong associated between

having a purpose and meaning in life and positive well-being (Zika & Chamberlain, 1992). Older adults who have a sense of meaning enjoy better health than older adults who do not find meaning in life (Krause & Shaw, 2003). Older adults who derive a sense of meaning in life from religion tend to have higher levels of life satisfaction, self-esteem, and optimism (Krause, 2003). Family relationships, pleasure, and health are the strongest predictors of meaning in older adults lives (Depaola & Ebersole, 1995).

Older adults who have little or no depression express more meaning and purpose in life and vice versa (Gerwood, 1996). There appears to be a reciprocal relationship between the two and this needs further investigation. Hopelessness, failure in life, and loneliness are attributes that predict both depression and less perceived purpose in life.

Theoretical Framework

The identification of coping strategies in this sample was navigated by the Stress, Appraisal, and Coping model developed by Lazarus and Folkman (1984). Coping can consist of thoughts or behaviors that are used to reduce the stress caused by life challenges (Folkman & Moskowitz, 2004). Lazarus and Folkman's transactional model is commonly used to examine the effects of stressful events and how people cope with them. This model examines the interaction that occurs between persons and their environment. When events occur, the persons appraise the situation and determine if it exceeds their resources and is therefore stressful. The person then tries to cope with the stressful events by using either cognitive or behavioral strategies. These strategies are used to eliminate the stress or minimize its consequences. Therefore, coping is a sequence of events and decision making in which older adults make evaluations and

assumptions, choose ways to cope, evaluate the effectiveness of the strategy, and make modifications when necessary. The model of coping presented in this theory will help explore how older adults react to and cope with stressful life events which may or may not result in depression.

By using this model as the theoretical framework, it is predicted that qualitative interviews with elderly will reveal an array of coping styles and thought processes that encompass both behavioral and emotion/cognitive-focused approaches. Further, the literature on coping styles and depression would predict that subjects endorsing problem-focused or positive-reappraisal types of coping will report less depression than subjects who report use of more emotion-focused coping strategies.

Summary of Literature

Depression in older adults is increasingly becoming a public concern. Depression can be categorized as having depressive symptoms or meeting the criteria for major depression, which also include dysthymia, which is a pervasive sadness lasting two or more years. Depression might be represented without sadness in older adults. Older adults suffer from many physical illnesses, multiple losses, and other age-related risk factors for depression. Older adults with depression are also likely to report a high number of negative life events. Positive coping strategies have been found to reduce the symptoms of depression. Very little research has looked specifically at help-seeking behaviors, which are often considered coping mechanisms. Having a purpose in life is associated with positive well-being. The stress, appraisal, and coping theory views stress

and consequently depression as a product of the ongoing interaction of the individual and environment.

Importance of a Mixed Methods Approach

Depression in older adults varies in characteristics and some older adults are hesitant to disclose depression (Mulsant & Ganguli, 1999). Medications to treat physical illnesses may also have depressive effects (Blazer, Moody-Ayers, Craft-Morgan, & Burchett, 2002). With regards to accuracy of assessment methods for late-life depression, Howe, Bath, and Goudie (2000) showed that the sensitivity and specificity of a depression screening method depends on context, and may need repeated assessment in different contexts. Specifically, depression varies by the social context and the individual's personal beliefs (Jadhav, Weiss, & Littlewood, 2001). It is important to use a qualitative approach and compare it with standard quantitative measures to gain a better understanding of depression. This will give researchers a better understanding of depression because the open ended interviews will add expanded knowledge about the content areas outside of survey questions.

Very little research has looked at depression in older adults from a qualitative viewpoint. Agar (2003) called for a qualitative method because of its broader focus and the need to identify specific contexts. He felt that examining a person's own stories was needed to understand the nature of illness. In order to more thoroughly meet the objectives of this study, it is important to use both qualitative and quantitative data to reach a broader understanding of depression and its contexts in the aging population.

Research Questions and Objectives

This research addresses depression and its relation to coping strategies, perceived meaning of life, and help-seeking behaviors in older adults. The primary objective of this study is to get a better and broader understanding of depression and related factors in elderly persons. This study explores and identifies the coping strategies that appear to be the most effective at alleviating depression or reducing depression risk. It also identifies how comfortable older adults are about seeking help from others, and how they seek that help. Lastly, it looks at the relationship between older adults' perception of their meaning and purpose in life, and how this is associated with depression.

Research Questions:

1. How do older adults cope with perceived life challenges?

2. What are older adults' beliefs about seeking help from others to cope with life's challenges? How do they seek help? From whom do they seek help?

3. Which coping strategies are associated with self reports of depression?

4. Are older adults' beliefs about the meaning and purpose of the rest of their life associated with depression?

CHAPTER III

METHODS

Introduction

This research utilized both qualitative and quantitative data from selected individuals in a community setting to learn more about depression in older adults and how it relates to coping styles, help-seeking behaviors, and their perceived meaning and purpose in life. The sample consisted of selected individuals from the Cache County Study of Memory Health and Aging who previously showed some sign of depression. Qualitative and quantitative information were gathered about the person's living situation, life challenges, coping mechanisms, purpose of life, and depression. The qualitative interview data were analyzed for themes surrounding coping, help-seeking behaviors, purpose in life, and depression. Additionally, quantitative data were analyzed to assess depression levels and the extent to which depression is correlated with various ways of coping in the elderly participants.

Population and Sample

Participants for this sample were elderly members of the community in Cache County, Utah who previously participated in the NIH-funded Cache County Study on Memory Health and Aging (CCSMHA, NIA AG 11-380). The present research study used data from the Quality of Life Study (QLS), an ancillary study of the CCSMHA (Dr. Maria Norton, principal investigator). The Memory Study is an ongoing epidemiological study of dementia examining individuals who were 65 or older and permanent residents

of the county on January 1, 1995. It uses a panel design with longitudinal study including only those who enrolled at the baseline interview. The older adults in this population exceed the norms of life expectancy, especially in males, whose median life expectancy are the highest in the United States, and exceeds national norms by almost 10 years (Manton, Stallard, & Tolley, 1991). The participation rate of the first wave of CCSMHA was 90% of the elderly community totaling 5,092 residents (Breitner et al., 1999). Such high levels of participation dramatically reduce non-responder bias (Norton, Breitner, Welsh, & Wyse, 1994).

The participants who were selected for the QLS study were all evaluated to be non-demented at their most recent CCSMHA visit, via a multi-stage dementia ascertainment protocol described elsewhere (Breitner et al., 1999). To be eligible for the QLS study, individuals had to have reported some indications of depression at their most recent screening interview in the CCSMHA in 2002-2003. Eligibility criteria were a report of commencement of antidepressant use "for depression" in the preceding interval between interviews without endorsement of depressive symptoms; endorsement of depressive symptoms but not treatment, or endorsement of both. Individuals assigned a diagnosis of dementia by the CCSMHA were excluded, leaving 322 eligible individuals. These individuals were stratified according to: (a) gender, (b) age (< 80 years) versus older (≥ 80 years), and (c) cognitive status (normal versus mild cognitive impairment), also from the CCSMHA dementia ascertainment protocol. Thus, each of the 322 eligible individuals were classified into one of 24 strata defined by combinations of these variables (3 depression history levels x 2 genders x 2 age groups x 2 cognitive status groups). Two participants in each stratum were selected to complete all QLS study

interviews and questionnaires. When sampled individuals were deceased, had permanently moved out of the area, or refused to be interviewed, resampling within strata was used. The goal was to interview a total of 48 individuals, with two from each stratum. Out of the 322 eligible participants, two hundred and five had previously reported no depressive symptoms, but said yes to use of antidepressant medications "for depression," 52 had reported yes to depression and no to antidepressant use, and 65 had reported yes to both.

Eighty-four individuals were randomly selected from the eligible pool with only two potential participants contacted within each stratum initially, and the plan to select additional subjects within each stratum from the eligible pool whenever fewer than two participated. From this initial group of 84 individuals, 43 did not participate for the following reasons: two had permanently withdrawn from the CCSMHA, one refused QLS participation, 19 were deceased, and two had permanently moved out of the area. Another 19 were still in the midst of completion of assessment visits with the CCSMHA, so in the interest of not overburdening them with too many research interviews over a relatively short time interval, they were not contacted. Forty-two individuals were contacted and completed the first interview and 40 of those completed the second interview as well. Table 1 shows initial depression screening, cognitive status, and gender of the 84 eligible participants for the study.

Procedures

Participants were contacted initially by a letter (see Appendix A) that provided a description of the study. The letter prepared the participants for an in-depth interview that

Table 1

Depression, MCI, and Gender of Selected Sample

Depression group			Cognitive status		Total
			Cognitively normal	Mild cognitive impairment	
Yes to dep	Gender	Male	2	3	5
No to meds		Female	3	5	8
	Total		5	8	13
No to dep	Gender	Male	2	6	8
Yes to meds		Female	4	4	8
	Total		6	10	16
Yes to dep	Gender	Male	2	3	5
Yes to meds		Female	3	5	8
	Total		5	8	13

would ask about their quality of life and well-being. The letter gave them advance notice that an interviewer would arrive at their door sometime in the following weeks to schedule an interview. Two letters at a time were mailed out for each stratum with additional letters mailed out if one or both did not respond positively for an interview. Some strata had no additional individuals available to recruit from the available pool of 322 potential participants. Interviews were conducted at the participant's home after informed consent forms were signed. The informed consent (see Appendix B) was read

aloud to the participant and the interviewer answered any questions about the interviews and the study.

Interviewers were trained to be sensitive to the participant's emotional state and if the participant indicated suicidal ideation, a triage protocol was used that was developed and supervised by the study's consulting psychiatrist, Dr. Curt Canning of Logan. This protocol was established to clearly describe criteria that the interviewers would use to determine whether or not to refer the case to Dr. Canning (and the study's principal investigator). All such referrals to Dr. Canning would then be followed by a clinical determination by Dr. Canning of any needed medical follow-up (no such referrals were necessary in all of the completed fieldwork).

The data were collected through two different interviews. The qualitative interview was administered first so that the items from the quantitative interview would not bias participants as they responded to the open-ended qualitative questions. A six-item cognitive screening instrument was administered and individuals scoring 4 or more out of 6 were deemed to be capable of providing informed consent (Callahan, Unverzagt, Hui, Perkins, & Hendrie, 2002). All of the participants passed the screener, in part because all individuals with dementia were previously excluded.

The qualitative interview requested in-depth information about participants living situations, life events, coping mechanisms, mood, and relationships with their primary care doctor. These interviews typically lasted about 45 minutes to an hour and a half. After obtaining consent, the vast majority allowed this interview to be audio taped. The interviewers allowed the participants the option of taking a short break during the

interview or to split the interview into two visits for participants who became tired or uncomfortable.

The second interview was quantitative with two parts, one conducted orally and another via a self-administered questionnaire that included a cognitive screening test, an inventory of activities of daily living, an inventory of current medications, a measure of religious coping, a short personality inventory, two depression inventories, and a measure of coping strategies utilized. The USU Institutional Review Board approved the informed consent, the study design, and protocol before data collection commenced.

Measures and Instruments

In order to answer the research questions, the measures used for data collection included the Center for Epidemiologic Studies—Depression (CES-D) scale, the Diagnostic Interview Schedule (DIS), the Revised Ways of Coping Check List (RWCCL) scales and a detailed qualitative interview. The DIS was administered through an oral interview and the CES-D and RWCCL were given through a self-administered questionnaire. The researchers felt there was an advantage in having depression assessed by both oral interview and self-administered questionnaire, believing that there might be differences in the willingness to disclose by data collection method.

Center for Epidemiologic Studies Depression Scale (CES-D)

Depression in the older adults of this study was measured by the CES-D on a self-administered questionnaire (see Appendix C). It was developed by Lenore S. Radloff (1977) from a pool of previously validated depression inventories. The CES-D measures

(1977) from a pool of previously validated depression inventories. The CES-D measures depression by a self-report scale developed for use in the community. It has four valid subscales: (a) depressed affect (i.e., feeling sad), (b) positive affect (i.e., being happy), (c) somatic complaints and inhibition (i.e., eating or sleep disturbances), and (d) interpersonal problems (i.e., people dislike me). Twenty items were used with each item scored on a four-point Likert scale from 0-3, with 0 indicating "Not at all or less than one day last week," to 3, indicating "Nearly every day for two weeks." Participants provided these responses to such questions as, "I did not like myself" or "I was tired all the time." The range of total scores possible is from 0 to 60 with higher scores indicating greater distress. Scores of 16 or greater are suggestive of clinically significant depressive symptoms (Radloff, 1977).

The CES-D has very high internal consistency (coefficient alpha level of .85 in the general population) and high test-retest reliability ($r = .54$). Convergent validity was established by high positive correlation ($r = .83$) with the Symptom Checklist 90-Revised (SCL-90) while divergent validity was established by high negative correlation with the Bradburn Positive Affect scale. In a community sample, 21% scored above the cutoff point for clinical depressive symptoms, compared with 70% of the clinical sample who scored above the cutoff. The CES-D also had high concurrent validity with other variables, such as with the older person's need for services, traumatic life events. Finally older adults improved on CESD score after treatment, showing that correct identification of depression had been made (Radloff, 1977). The CESD is mainly used in community or medical settings (Clark, Mahoney, Clark, & Eriksen, 2002). A total symptom count of

CES-D symptoms and a dichotomous cutoff of above versus below a score of 16 will be created to indicate clinically significant depressive symptoms.

Diagnostic Interview Schedule (DIS)

The present study utilized another depression instrument: the Diagnostic Interview Schedule (DIS) in the oral interview (see Appendix D). The National Institute of Mental Health developed this questionnaire (Robins, Helzer, Ratcliff, & Seyfried, 1982). It was used in earlier interviews for the CCSMHA. The DIS uses the DSM-IV clinical criteria for diagnosis of depression as a basis for evaluating depression. The DIS is designed to elicit diagnostic elements including symptoms, their severity, frequency, distribution over time, and whether they are due to physical illness, drug or alcohol use, or the presence of another psychiatric disorder. Major depression, minor depression, and no depression are determined by nine symptoms: sadness, loss of interest, appetite or weight disturbance, sleep disturbance, agitation or slowing down, fatigue or loss of energy, inappropriate guilt, thoughts of death or suicide, and poor concentration.

In initial testing, the DIS was judged by a psychiatrist using the scale in an independent interview, his clinical judgment after the interview, and his opinion after the interview and a free question period (Robins et al., 1982). The Kappa concordance was .63, which tested the agreement between lay interviewers and the psychiatrist's diagnosis for depression. Eighty percent of lay interviewers who diagnosed participants with depression confirmed the psychiatrist's previous evaluations. Eighty-four percent of lay interviewers who judged that the participants did not have depression confirmed the evaluations made by the psychiatrists. Eighty-two percent of psychiatrists confirmed the diagnosis made by the lay interviewers.

In the present study, the DIS was used only to assess current depression using DSM-IV symptoms described earlier. Using the Memory Study's modification to the DIS, participants were allowed to "skip out" of the remaining depression questions if they did not endorse one of three "gateway" questions: two weeks or more of sadness, loss of interest, or irritability. As such, diagnosed categories do not precisely follow DSM-IV criteria. Endorsement of a total of five or more symptoms endorsed were coded as "major depression" and one to four symptoms were coded as endorsing "depressive symptoms," and those denying all three screening questions were coded as "not depressed."

Revised Ways of Coping Checklist

The coping strategies of the participants in this study were measured by the Revised Ways of Coping Checklist (RWCCL; Vitaliano, 1991) in the self-administered questionnaire (see Appendix E). The RWCCL is a 57-item questionnaire that assesses several types of coping strategies, including wishful thinking, seeks social support, blames self, problem-focused coping, blames others, religious involvement, counting blessing, and avoidance. The RWCCL was developed for use with the general population. Participants are asked to think about a major problem and then answer the questions according to how they have dealt with this issue. Responses are provided on a 4-point Likert scale with 0 never used, 1 rarely used, 2 sometimes used, 3 regularly used (with separate coding for refusal to answer, and not applicable). Sample questions include "blamed myself" and "kept feelings to myself."

The RWCCL was found to be reliable and valid (Vitaliano, Russo, Carr, Maiuro, & Becker, 1985). The measure was tested on three groups: medical students, spouses of

Alzheimer's patients, and psychiatric outpatients. The internal consistency reliability mean alpha for the medical students was .82. The mean alpha for the spouses of Alzheimer's patients and psychiatric outpatients was .83. In terms of construct validity, depression appeared to result from wishful thinking coping strategies. Depression appeared to be prevented from use of problem-focused strategies. The scoring system provided by Vitaliano and associates were used to compute scale scores for each of the six ways of coping.

Qualitative Interview

A qualitative interview was used to ask the participants questions that would allow them to elaborate in their own words about the topics needed to answer the research questions (see Appendix E). The questions addressed life changes, ways in which participants cope with their life changes, their mood, and help-seeking behaviors.

Analysis Plan

The data were analyzed using a mixed methods approach. Analysis of the research questions used both qualitative textual data and quantitative numeric data to answer the questions. The data collected from questionnaires were compared with the themes found in the qualitative data and vice versa where appropriate. Both processes are different and were synthesized to best answer the research questions.

Through the qualitative process, textual data from the interview transcriptions were analyzed using a five-stage process for long interviews (McCracken, 1988). During the first stage, interview transcripts were read twice. The first reading focused on the general

understanding of content, and the second reading was meant to identify themes related to the respondents' experiences with life changes, coping strategies, help-seeking behaviors, purpose in life, and depression. In the second stage, observations and codes were categorized (see Appendix G). In the third stage, these codes were refined to ascertain patterns and connections among them. The fourth stage is used to inspect the patterns and connections in order to recognize themes that emerge from the interviews. During this process, two researchers (Cheryl Jones and Dr. Kathy Piercy) analyzed each other's interpretations of the data to establish inter-observer reliability. Any differences in interpretation were discussed and resolved at this stage. Finally, in the last stage of analysis, the data from the emerging themes, patterns, and codes were integrated to produce final themes. Two researchers, in this process as well, analyzed each others' interpretations, discussed, and resolve discrepancies. The computer software QSR NUD*IST Version 6 (Qualitative Solutions and Research, 1995) was used for data management and analysis of the in-depth interview responses.

The measures RWCCL, DIS, and CES-D, were analyzed to gain a quantitative assessment of the participants' depression and coping strategies. The methods by which the qualitative and quantitative data were applied to each question is described below.

1. How do older adults cope with perceived life challenges? Qualitative and quantitative approaches were used to effectively answer this question and provide methods triangulation. The RWCCL was used to characterize the extent to which participants reported use of each subscale/dimension of coping, summarized with descriptive statistics. The qualitative interview was employed to identify the various ways that older adults cope with life changes. The textual data was broken down into small "data bits" (Dye, Shatz, Rosenberg, & Coleman, 2000) and then sorted into categories of

coping mechanisms. Throughout the entire process, these categories underwent refinement until they were placed into overarching themes. Any discrepancies between the quantitative and qualitative responses were discussed.

2. What are older adults' beliefs about seeking help? How do they seek help? This question was answered mostly through qualitative data analysis. The textual data followed a similar process of categorizing data bits, and refining to establish themes about older adults' beliefs about seeking help from others and how they seek help, in what situations they may seek help, or what they consider to be help. In addition, the "seeks social support" portion of the quantitative RWCCL measure will be analyzed.

3. Which coping strategies are associated with self reports of depression? To answer this question, quantitative and qualitative coping strategies identified earlier were compared with the CES-D and DIS assessment of depression levels. The RWCCL provided information about the use of various coping subscales that was correlated with reported levels of depression. The qualitative categories and themes were compared to levels of depression to investigate possible relationships between them.

4. Do older adults' beliefs about the meaning and purpose of the rest of their life have an association with depression? To answer this question, both CES-D and DIS measures of depression were calculated to obtain a rating of the older adult's depression level. The qualitative data were analyzed to produce categories of older adults' perceptions of their purpose in life which were then refined into overarching negative, positive, neutral, and avoidant themes. Those themes were then compared with depression levels.

CHAPTER IV

RESULTS

Data from in-depth interviews and depression and coping measures of 42 older adults in the Cache County community were analyzed to gain a greater understanding of the problems and challenges that older adults face, their self reports of depression, coping mechanisms, help-seeking behaviors, perceived purpose in life, and some possible protective factors against depression in old age.

Background

This section explores depression as manifested in the CESD and DIS quantitative depression measures as well as the qualitative experiences of depression. In addition, the life challenges reported by the participants in the qualitative interviews are presented. Information about depression and life challenges is not offered to answer the research questions, but to provide background information for the variables examined.

The participants who completed the qualitative interview ranged from 74 to 91 years of age with a mean age of 80.9 years ($SD = 4.9$). Twenty-one were younger than 80 years of age (48.8%) and 21 were 80 years or older (51.2%); 18 were male (41.9%) and 25 were female (58.1%); 36 were members of The Church of Jesus Christ of Latter-day Saints (Mormon) (85.7%), two were Protestant (4.8%), one was another religion (2.4%), and two were not affiliated with any religion (4.8%). All of the participants were Caucasian. There were 25 who were married (55.8%), 17 who were widowed (41.9%), and 1 who was divorced (2.3%). The majority of males in this sample were married

(77%) and the majority of females were widowed (64%). This difference was statically significant using a chi-square ($\chi^2 = 11.38$, df = 1, $r = .001$), even though males and females were roughly the same age. Fifty-seven percent of the participants scored above 90 on the 3MS and all of the participants scored above 70, meaning that none of the participants in this sample were severely cognitively impaired. Using independent samples s, mean cognitive scores on the 3MS did not differ significantly between age groups ($t = -0.32$, df = 35, $p = 0.76$), genders ($t = -1.05$, df = 35, $p = 0.30$), or marital status ($t = -0.29$, df = 35, $p = 0.78$).

Depression

Two quantitative measures were used to assess depression in study participants of this study: the CES-D and the DIS. The qualitative interview assessed depression (see Table 2). Roughly 25% of the participants in this study met the criteria for depression on either the CESD ($n = 14$) and/or DIS ($n = 10$) and over 50% of the participants endorsed depressive symptoms in the qualitative interview ($n = 23$). Twenty-nine participants (69.0%) endorsed depression on at least one of these three measures or interview question.

Only one participant manifested minor depression (which is calculated by current sadness or loss of interest but with fewer than five total symptoms), therefore researchers decided to combine minor and major depression in the DIS result to a single manifestation of depression.

The qualitative analysis as part of this research explored how depression was manifested in older adults. The most common manifestations of depression described by

Table 2

Consistency in Reports of Depression from Three Data Sources (n = 40)

CES-D depression positive (score ≥16)	DIS depression positive [a]	Qualitative depression endorsement [b]	N (% of total)
NO	NO	NO	11 (27.5%)
NO	NO	YES	11 (27.5%)
NO	YES	NO	1 (02.5%)
NO	YES	YES	3 (07.5%)
YES	NO	NO	5 (12.5%)
YES	NO	YES	3 (07.5%)
YES	YES	NO	0 (00.0%)
YES	YES	YES	6 (15.0%)

[a] Positive DIS response was scored when participants endorsed either sadness or loss of interest. Most also endorsed 5 or more of the following: appetite or weight disturbance, sleep disturbance, agitation or slowing down, fatigue or loss of energy, inappropriate guilt, thoughts of death or suicide, and poor concentration.

[b] Positive Qualitative responses were scored when participants endorsed one or more depressive symptoms including sadness, lack of interest, anxiety, suicide, and other symptoms.

the participants were emotional symptoms, including sadness and loss of interest in activities once enjoyed. The participants also experienced cognitive, somatic, and behavioral symptoms, anxiety, and suicidal ideation related to depression. These categories were developed based on the American Psychological Association's grouping of depressive symptoms. Anxiety and suicidal ideation were included as depressive

symptoms because they are often comorbid with depression. Participants who endorsed the above symptoms of depression in the qualitative interviews were coded as "yes" for depression and these variables were added to the SPSS data file to be analyzed with the demographics and quantitative measures.

Depression endorsement from the three different sources the CESD, DIS, and qualitative interview showed some disparity in this sample. Table 2 shows the number of subjects in each of eight possible categories according to endorsement (versus non-endorsement) of depression from the three data sources. The most common pattern was no depression on all three measures and no depression on the CESD and DIS but endorsement of depression in the qualitative interview. Fifteen percent of the sample had depression on all three measures. Seventy-three percent of this sample indicated depression on at least one of the three analytic sources of depression. Sixty percent of the participants who scored positive on the DIS for depression also scored positive on the CESD for depression, whereas, only 43% percent who scored positive on the CESD for depression also scored positive on the DIS. A Pearson correlation test was computed and the two measures were associated at trend level (near to, but not meeting a significance level of 0.05; $r = 3.66$, df = 1, $p = .056$). Association between the CESD scores and qualitative endorsement of depressive symptoms was not significant ($r = .406$ df = 1 $p = .524$). Interestingly, the DIS and qualitative endorsement of depression were highly significantly correlated ($r = .576$, df = 1 $p = .016$).

A cross-tabulation was conducted for each of the demographic variables and a composite measure of the response pattern across the three depression measures (see Tables 3-5). The cross-tabulation used only the cutoff scores for depression and may give

a clear picture of depression in the various demographic groups participating in this study because it eliminates the outlier scores that would skew the results. The composite measure combines the two quantitative measures into one variable and, when combined with the qualitative measure, characterizes four groups, which were tested for association with the three demographic variables. Chi-square tests of independence between the depression response pattern variable and the demographic variable were conducted, with an a priori alpha level of .05 to signify statistical significance. None of the demographic variables were significantly associated with depression response pattern.

Qualitative data indicated that emotional symptoms of depression in the participants included feelings of hopelessness, worthlessness, sadness, fear, anger, and a loss of interest and pleasure in life. Twenty-seven participants identified emotional symptoms of depression; of those, twenty identified feelings of sadness and eighteen identified lack of interest and pleasure in life. A male participant explained his experience with depression: "It just comes and goes, and it is rather gradual. At least the getting out of it seems to be gradual. Sometimes the onset seems very sudden, you get up feeling good, and suddenly you do not feel good, you feel depressed." A female participant commented, "Sometimes I cry and you know and stuff, but I feel I am okay. Then I feel bad when I say that. I feel mad and I feel sad, and everything else, and you are tired, and you are depressed with everything, you know?"

The participants often mentioned a loss of interest and pleasure in life. A 75-year-old woman experienced this after the loss of her husband and son. She said, "I just don't enjoy things as much as I used to. They are constantly on my mind." A 79-year-

Table 3

Depression Response Pattern and Gender

Endorsed depression in quantitative [a]	Endorsed depression in qualitative	Males	Females	Chi-square, *df*, *p*-value
YES	YES	4	8	$\chi^2 = 2.18$
YES	NO	3	3	$df = 3$
NO	YES	6	5	$p = .535$
NO	NO	3	8	

[a] Endorsement included those scoring ≥ 16 on the CESD or were positive for depression on the DIS.

Table 4

Depression Response Pattern and Marital Status

Endorsed depression in quantitative [a]	Endorsed depression in qualitative	Married	Unmarried (widowed=17) (divorced=1)	Chi-square, *df*, *p*-value
YES	YES	5	7	$\chi^2 = 5.2$
YES	NO	2	4	$df = 3$
NO	YES	9	2	$p = .158$
NO	NO	6	5	

[a] Endorsement included those scoring ≥ 16 on the CESD or were positive for depression on the DIS.

old married man said, "There are a lot of things that I do not do, that I used to do… because I have lost the interest in them and the desire."

Depression can also be manifested in ways other than emotional symptoms. Cognitive symptoms may include slowed thinking processes and abilities, lack of

Table 5

Depression Response Pattern and Age

Endorsed depression in quantitative [a]	Endorsed depression in qualitative	Under 80 years	Over 80 years	Chi-square, *df*, *p*-value
YES	YES	6	6	$\chi^2 = 2.21$
YES	NO	2	4	$df = 3$
NO	YES	7	4	$p = .530$
NO	NO	4	7	

[a] Endorsement included those scoring ≥ 16 on the CESD or were positive for depression on the DIS.

concentration, high distractibility, and focusing attention on the negative aspects of oneself. None of the participants described these symptoms in relation to depression, although many experienced memory problems.

Somatic symptoms are often physical problems related to depression, which include disturbances in sleep patterns, fatigue, bodily pains, and appetite changes. Some of the participants experienced sleep problems related to depression or anxiety. A 76-year-old married man who endorsed depression on all the measures explained,

> And I have complications, and I am tired all of the time. I just want to sleep. I could sleep 24 hours a day. But I am not depressed, they are thinking I am depressed, but I am not depressed to the point that I'd want to take my own life, but, I just (paused) the things I can not do. I cannot fix anything or anything like that. That gets me down.

The participant appears to have a misconception about depression because he equated being depressed with being suicidal. He did not believe he had depression, but on all the measures of depression, he endorsed a large number of depressive symptoms.

Behavioral manifestations of depression may include slowed movement and speech. The same severely depressed male participant described the problem as,

> I can not do two things at the same time. Like my wife, she tries to remember not to ask me any questions while I am getting in the car or out of the car, because I have to stop to answer her. And if I am doing something, that is the only thing that I can do. I cannot think about anything else, or talk about something I am not doing at the same time.

Behavioral symptoms may also include eating problems or withdrawing from activities. An 86-year-old widowed female who reported depression in the CESD and qualitative interview said, "I have withdrawn. I love my family and get out with them, and my church and community, but socially otherwise with other people, no. I have withdrawn."

Anxiety is often comorbid with depressive symptoms and is manifested by anxious thoughts and behaviors. The widow above related an experience of a potential break-in to her home. She said, "I think that has made me fearful of being alone, almost to the point of being paranoid, sometimes." Another widowed woman denied depression and said, "But I have had anxiety most of the time. I worry about everything, especially money because I do not have it."

Suicidal ideation often results from the depression symptoms mentioned earlier. Some participants admitted to wishing they were dead or thinking about committing

suicide. Eleven participants admitted to thoughts of suicide or not believing life was worth living, although, based on the suicidal ideation protocol supervised by Dr. Canning, none of these participants met criteria for referral (e.g., thoughts were from distant past, were fleeting, no plan). Of those eleven, seven scored positive for depression on the DIS or CESD inventories. The same severely depressed 76-year-old man mentioned above said, "I got rid of all of my guns, to make sure that I would not sit down and find the easy way out. And it was reloading my guns. But once in a while I will entertain a thought how I could end my life. But it does not stay with me long."

Some of these participants felt they were needed by family members and friends and pushed away suicidal thoughts. The depressed man who got rid of his guns commented, "Well, a few years back as I was contemplating suicide, and I mentioned it to my wife, and she talked me out of it, and made me promise not to do it. So I am more or less here right now to keep my word." A married woman stated, "Well I considered getting rid of myself a time or two, but then I thought it over, and thought what it would do to my family and my husband, and everybody that knew my family and I just kept thinking what it would do to them."

Many of the participants did not have suicidal thoughts, but rather just felt that life was not worth living. A widowed female participant responded to a question about whether or not life was worth living with,

> Yes, yes, yes. I felt it just the other day. What is there to life, when you just sit there all of the time? I wanted to live, but I am old, and I know I will not live for another 100 years. If I am just going to sit here, and not have anything to do with relatives, why it would be better to be dead than alive.

Roughly 25% of the sample was depressed as measured by the two quantitative measures of depression. Over 50% of the participants endorsed depressive symptoms in the qualitative interview. The entire sample had previously indicated depression, anti-depressant use, or both. Therefore, they were able to give rich details about the experience of depression. The participants reported feelings of sadness, lack of interest, withdrawal, anxiety, and suicide ideation. Sadness resulted from events and challenges such as loss, but also was described as an onset unrelated to events. Lack of interest and withdrawal from society and activities were closely related with each other. Other symptoms such as cognitive, somatic, and behavioral symptoms were not mentioned often in relation to depression, although they were mentioned when asked about life challenges.

Life Challenges

It is important to understand the challenges that older adults face to truly understand what they have to cope with in their lives. This section will explore the life challenges older adults in this sample experienced using qualitative analysis. The participants provided rich detail about their living situations, which drew a clear picture of the problems confronting these older persons. Several overarching themes emerged after analyzing the data. These included loss, health problems, daily life, memory changes, financial changes, and family problems.

Loss. Loss of loved ones is a challenge in life that is likely to occur more often in old age due to the aging of friends and family members. Our participants identified struggling with the loss of people close to them, particularly family members and

spouses, to be one of the hardest challenges of later life. Many of the older adults in this sample dealt with the challenge of losing a spouse. One participant commented, "Well, I think undoubtedly losing my wife and having to live alone, is the more outstanding change." In this sample, far more women were widowed than men. They also identified significant losses in general more then men throughout the interviews. An 81-year-old woman commented, "The biggest change has been [my husband's] passing. And oh, I miss him, I miss him terribly. But I have tried to fill my life with other things."

Furthermore, several older adults in this study had lost a child, which may have felt untimely for them and thereby seemed to cause additional pain. One woman said,

> The worst to deal with was the loss of our son. I mean that was so hard because it was so sudden. You know, it was hard to lose my parents, and it was hard to lose a brother, but neither one of them compared to losing my son.

The participants also described the loss of siblings and friends that had provided them with social and emotional support. A 79-year-old widowed woman commented, "I lost my twin brother, and that was almost as hard as losing my husband because we were very close."

Loneliness was a challenge that appeared to result from loss. As one widow put it, "It is hard to be alone. This is the hardest part, I think, of life." Being able to cope with loss and loneliness is important. Participants referenced self-reliance most often as a way to work through a loss. A widowed man commented,

> Well, I lost my younger son five years ago. Then I lost my wife two years ago. And the loss of them was really difficult on me. . . I have a hard time dealing with it. But it is something, I guess, that I'm going to have to deal with.

Health problems. Significant changes in health are prevalent among older persons. Many of the elderly individuals in this sample have faced a wide range of physical problems such as heart disease, stroke, diabetes, severe arthritis, and serious operations. Some suffer from chronic pain or hearing or vision loss. These health problems can be painful, limit the ability or desire to participate in activities, and result in anxiety and depression. A 74-year old widow explained, "Take your eyes away, and it kind of takes away your independence." A 76-year-old married man commented,

> I had a bypass about eight years ago, and since that time, I have been somewhat depressed, and I think that is probably the next one. I don't really care to do a lot of things that I used to do. I used to go in the fifth wheel, and we used to go fishing and all these things, and I don't have that desire any more.

It was common for participants in this sample to experience multiple health problems. A particularly good example came from a widow, who said,

> Well, two years ago, I was real bad in January. I kept passing out, and they took me to the hospital, and I was very dehydrated, terribly. And my stomach was bleeding. I don't have an ulcer, but the lining of my stomach bleeds when I eat certain foods. And they had to pump my stomach out because I was throwing up blood. And then that's when they done the colonoscopy and found the cancer. They operated and took that out. And then, like I say, my heart kept stopping, and so they put a pacemaker in. That was all about two years ago in January.

Changes in daily life. Changes in daily life often occur due to the experience of aging, lifestyle changes, and also as a result of health problems. Many older adults in this

sample have retired and live differently than they did in their earlier years, and some were not coping well with this change. A male participant put it this way,

> Well, I think probably the most significant [challenge] is once I retired... I had goals. Go to college, go to graduate school, finish a Ph.D., get a job, advance in the job, and those kinds of things. When I retired in 1970 that was cut off, there were not any more goals.

The health problems they experience affect their daily life: limiting many of the normal day-to-day tasks they used to be able to perform quickly. After describing some health problems, an 80-year-old widower said,

> Health problems like that actually slowed my pleasure down. There are a lot of things that I used to just love to do that I can no longer do... My biggest problem is trying to find something that I can do that is within my capabilities. I like to work. I've always liked to work. I've enjoyed working. And now, all of the things that I used to do are beyond my capabilities.

Heath problems and life style changes also have an effect on their desire to participate in activities that once brought them joy. A married male said, "I have not the energy to do what you used to do and the desire to do things. If I do not do it today, Ill do it tomorrow. Just not like I used to be."

Losing the ability to drive was a very significant and consistent negative life style change for older adults. Many of the participants who discussed losing their car did not want to lose the ability to drive and were angry at family and friends that insisted upon it. An 86-year-old divorced participant described losing her car:

> It has been painful for me. It has made me feel lonelier. I'm not able to cope because I have nothing to cope with. I can't run out and get in my car and go someplace if I feel like it. I can't get to my grandchildren… that car had become very dear to me. It is like a death in the family.

Memory changes. The older adults in this study referenced changes in their memory as major life challenges. As measured by the Modified Mini-Mental State (3MS), half of the participants in this study showed some mild impairment in their cognitive ability. Older adults were frustrated that they could not remember or mentally process things that used to be simple when they were younger. One married participant explained his frustration: "I don't read any more because… I read over something, and I'll have about a page, and I don't remember what I read to begin with." Participants most commonly referenced forgetting people's names as the most significant memory change. A 76-year-old married man said,

> I have noticed [memory changes] quite a bunch. My grandkids come up here, and I have a hard time remembering all of their names. I feel bad. That's the reason, that's one of the reasons I was going to tell you, taking this test. There is something about—maybe its pride? I don't know what it is, but to not be able to do some of the things that you used to do. Memory wise, I used to teach in the church…. and I got so I couldn't remember names. I still love to teach, but I found it a handicap, so I'm not doing that any more.

Financial changes. In addition to all these challenges, some older adults in our sample experienced financial challenges. Many live on a fixed income. Several of the participants in this study traveled or participated in other activities when they were

younger and expressed frustration that they could no longer do them due to financial restrictions. A 77-year-old married man commented,

> Well, my wife and I used to travel extensively… since the monetary things and problems have come up, that's a thing of the past. Nothing. I'm not interested in going to Europe with the present situation. Even if I had the money, I wouldn't. But I would probably do a little bit of traveling. But since the monetary problems have arose, it is impossible. It hasn't caused a crisis, but it has been a little bit of a concern.

A 76-year-old married man commented, "Well, we are living on a fixed income. Yeah, I used to repair TV and that kind of went under. Before I was not doing too good. Yeah, we are kind of struggling, financially."

Family problems. The last challenge that older adults noted was dealing with family and marital problems. A married man expressed his frustration with his wife,

> I have always had a good outlook on things, and think of things the best. My wife, she is the negative side. She is just negative everything all day long. And you know, it gets me. I cannot stand it some days. So I say, do not you ever think I do anything right?

A divorced female participant was a caregiver to some of her co-residing grandchildren, and she told the interviewer,

> I was so happy, you know, to go along, then I began to get fatigued… So I knew that I needed to move and move to a small enough place that wouldn't allow anybody else to come and live with me.

After relaying many of the problems her family was dealing with such as family sexual abuse, prenatal drug abuse, and divorce in the family, she added,

> You see all of these things? So what do you do, you can't always hide your head under a pillow and say, "ooh, I wish this hadn't have happened." There have been so many [problems], that I think I have learned to cope so it is just one more thing. You've got to go through it, so we will get through this one also.

There are many problems that people face throughout their entire lifetime. Most of the challenges participants identified in the interviews occurred throughout the lifespan. Yet, they seemed to occur most often and more severely in old age, thus making the participants more at risk for depression. The challenges identified were loss, health problems, daily life, memory changes, financial changes, and family problems.

Research Question Number One:

How Do Older Adults Cope with Perceived Life Challenges?

Coping was measured using the Revised Ways of Coping Checklist (Vitaliano, 1991). The Revised RWCCL was comprised of eight subscales, with a variable number of items in each subscale. The measure was shown to be reasonably reliable, with a Cronbach alpha of 0.80 for Problem Focused Copy, 0.77 for Seeks Social Support, 0.71 for Blames Self, 0.74 for Wishful Thinking, 0.67 for Avoidance, 0.61 for Blames Others, 0.48 for Counts Blessings, and 0.65 for Religious Coping. The mean alpha in this study was 0.68. The mean alpha in previous research was 0.82 and 0.83 (Vitaliano et al., 1985).

Counts blessings was the most commonly used coping method, consistent with high levels of religious involvement in this population (Norton et al., 2006). Blames

Table 6

Reported Use of Coping Strategies

	Minimum	Maximum	Mean	Standard Deviation
Count blessings	1.17	3.00	2.45	.428
Religious	0.00	3.00	2.00	.688
Problem focus	0.80	2.56	1.87	.485
Seeks social support	0.00	3.00	1.62	.651
Wishful thinking	0.00	2.75	1.55	.608
Blames self	0.00	3.00	1.45	.871
Avoidance	0.50	2.30	1.38	.481
Blame others	0.00	2.80	0.86	.659

Note. the mean score is based on the responses provided on a Likert scale with 0 indicating never used, 1 indication rarely used, 2 indicating sometimes used, 3 indicating regularly used.

others was the least used (see Table 6 for subscale average scores). Counts Blessings had the least variability in the sample, while Blames Self had the most. The four positive coping styles (problem focused, seeks help, counts blessings, and religion) all yielded higher mean scores than did the negative coping subscales.

Instead of using a simple sum of items within each subscale to calculate a score for each coping style, a new set of variables was created. This was done to address the problem of missing data so that each new variable had the same metric for each participant. For each coping style, the maximum possible total score among the non-missing responses was computed for each subject. This was then divided into the actual

total score on all non-missing responses, which resulted in a new variable, which was the "percent of maximum score among non-missing responses" for each coping style.

Coping mechanisms varied slightly by gender, martial status, age, and cognitive ability (see Table 7). Male and female participants did not vary much in reported used of certain coping mechanisms. Female participants used more religious coping, counts blessings, avoidance, wishful thinking, seeks help, and problem-focused methods than male participants. Male participants used blames self and blames others more than females participants. Widowed participants sought social support more often those who were not widowed, and also used religious and counts blessing coping mechanisms more frequently than their married counterparts. Participants that were younger than 80 years old also sought help more than those that were 80 or older. The older participants also used problem-focused behaviors more than the younger participants.

The identification of coping mechanisms in the qualitative data was guided by previous coping research and the Stress, Appraisal, and Coping model developed by Lazarus and Folkman (1984). Coping can consist of thoughts or behaviors that are used to reduce the stress caused by life challenges (Folkman & Moskowitz, 2004). In this sample, the participants referenced Help-Seeking, Religion, Reframing, "Dealing With It," Wishful Thinking, Problem Focused, Activities, Medication, and other methods to cope with stressful life events.

Help-seeking

Many of the older adults referenced seeking help as a way to cope with life challenges. They sought help from family members, spouses, friends, church leaders, and

Table 7

RWCCL Coping Mechanism Means (on Likert Scale from 0-3) for Demographics: Gender, Marital Status, and Age

	Prob. focus	Seeks social support	Blame self	Wishful thinking	Avoid-ance	Blame others	Counts blessing	Religion
female								
Mean	1.905	1.658	1.361	1.559	1.482	0.818	2.522	2.066
N	24	24	24	24	24	24	23	24
SD	0.504	0.646	0.932	0.453	0.489	0.612	0.392	0.637
male								
Mean	1.802	1.561	1.595	1.533	1.228	0.931	2.333	1.889
N	15	15	14	15	15	15	15	15
SD	0.463	0.676	0.764	0.815	0.440	0.744	0.467	0.773
married								
Mean	1.925	1.486	1.714	1.633	1.385	0.935	2.302	1.857
N	21	21	21	21	21	21	21	21
SD	0.401	0.593	0.709	0.610	0.449	0.597	0.443	0.688
widowed								
Mean	1.796	1.778	1.118	1.452	1.383	.776	2.628	2.157
N	18	18	17	18	18	18	17	18
SD	.5720	.6965	.9570	.6066	.5297	.7315	.3396	.6703

(table continues)

	Prob. focus	Seeks social support	Blame self	Wishful thinking	Avoidance	Blame others	Counts blessing	Religion
Under 80 years								
Mean	1.959	1.820	1.315	1.600	1.350	0.900	2.465	2.194
N	18	18	18	18	18	18	18	18
SD	0.484	0.442	0.700	0.595	0.441	0.552	0.310	0.549
Over 80 years								
Mean	1.785	1.450	1.567	1.506	1.414	0.829	2.432	1.825
N	21	21	20	21	21	21	20	21
SD	0.484	0.757	1.004	0.629	0.522	0.750	0.519	0.759
Total								
Mean	1.865	1.621	1.447	1.549	1.384	0.862	2.447	1.996
N	39	39	38	39	39	39	38	39
SD	0.485	0.651	0.871	0.608	0.481	0.659	0.428	0.688

from their physicians. Participants sought help from spouses first, and then family, and then finally from friends, church leaders and physicians. Twenty-four of the participants referenced negative beliefs about seeking help and 21 referenced positive beliefs. Some of the participants mentioned both positive and negative beliefs throughout the interviews, but yet most were consistent about their belief model. They sought help for both instrumental and emotional reasons. Research question number two will address this coping strategy in more depth.

Religion

Thirty-two participants mentioned using religion as a way to cope with life challenges. It was used in various ways. The most common ways were for spirituality, a support system (church), activities/responsibility, and an eternal perspective.

Spirituality in this reference refers to the use of meditation and/or prayer as a cognitive mechanism to cope with life's challenges. In this sample, spirituality was used much more often than the other methods of religious coping. A married female participant described the importance of prayer to her by saying, "I just live from day to day with prayer. I just could not get through a day if I did not believe in the power of prayer."

Some of the participants used religion to cope with life's challenges by using the support group created by the members of the congregation. As one 88-year-old married male stated, "I go to church all the time. To be truthful, I do not go to those completely for what I learn or get. I go because I'm here alone so much, that I enjoy the company."

Religious involvement often included activities and responsibilities that often helped people cope with life challenges. This included attending and participating in church classes and activities as well as the responsibilities they had (e.g., Sunday School Teacher). A married woman said,

> You can keep busy doing for the church. I mean, we still hold, my husband goes home teaching, I'm a visitor teaching, and we are over the home canning part of the ward. And then there, I lost my good old neighbor that lived just across the street from me. But while she was alive I, you know, I tried to do a lot for her and

> take things, you know meals, and food to her, and just, I mean I've always just loved to help somebody else.

Having an eternal perspective or believing that there is life beyond our own helped some of the participants cope with life's challenges, particularly with the loss of a beloved one. A married woman who had experienced the loss of her son recently said, "Knowing that I will see my son… I mean that is what just keeps me going." It also appeared to give more meaning and purpose to life. A married man commented, "All these problems and trials you have in life. Do not ask me why. The Lord knows, but I do not. We are sent here for a purpose. I think that is just to see what we can endure and how we react to certain things."

Reframing

Twenty-four of the participants were able to reframe their problems, meaning they attempted to think of a life challenge as positive. Some did this by looking at the positive aspects that resulted from a bad situation, including sympathy and learning experience. An 83-year-old widow commented,

> Every experience that I thought was negative has turned out to be positive, had good results. Sometimes it would take a while to see what it was, but it was always. It has always been there. Whether it was a divorce, or death, or whatever.

Some participants reframed their situation by comparing it with someone who had experienced a situation worse than their own. The married woman who lost her son said, "There are so many people so much worse off than we are. That is what sort of keeps me

getting through each day. If I have a down day and get thinking of him, you know." Others put their situation into perspective by acknowledging their age or circumstances and being grateful that they still could do some things. A married male participant, when asked how his life challenges had affected his enjoyment of life, responded, "Well, naturally they have affected it, but it is to be expected. I do not expect to be able to do the things that I did when I was younger, and so the fact that I can get around and live alone, I am satisfied."

"Just Deal With it"

Twenty-three participants used a personal cognitive coping mechanism to just "deal with" challenges and rely on themselves. This theme is similar to reframing, but the situation is not conceptualized as a positive one; instead, participants reported learning to "deal with" or "move on" because they do not perceive solutions to their problems and feel that there is nothing else that they can do. It was simply put by a woman in this study who said, "Just hang in there." A female participant said, "I guess to say there is not much you can do about it. Just grit your teeth and keep on going."

Half of the participants mentioned having this outlook in coping with problems. A female participant explained, "I just decided there is no point in knocking yourself out and being unhappy all of the time, because there is nothing you can do about it." A married man said, when asked about life challenges, "Well, you have to put them behind you and go on. That is all I can say. There is nothing you can do about it. You just have to do the best you can." Lastly, after discussing a medical problem, a 76-year-old married female participant said,

> Oh, it is just something that I have to do. So, and I can not seem to change it. I have tried about everything… Well, you know, what is the alternative? So you just try to do the best with what we have, and I do not mean that to be Pollyannish at all, but you know, I could cry all day and retreat to my bedroom, but that would not make me happy. So, I just make the best of it.

Wishful Thinking

Wishful thinking is a cognitive coping method in which nine participants in this study evaluated the situation and rather than try and reframe or "deal with it," wished that the situation could be better. Six were female and three were male. This method of coping appears to be a negative way to handle a life challenge (Vitaliano et al., 1985). A female participant expressed her frustration about her situation by noting,

> I used to do a lot of golfing and bowling and things like that, which I can not do at all now. And it makes you wonder why you have to go through the things you do…. I wish I could go bowling. I wish I could go golfing, I wish I could do the fun things that I used to do.

A 75-year-old married woman said,

> Well, I still like to get out and I always was a social person. But it seems like as you get older, and you see the younger ones going and they know all their kids and their kid's kids, and even my daughter, she is 20 years younger than me. When you get older, you feel like you are all kind of by yourself. You know. I sure wish I was about your age.

Problem Focused

The problem-focused method of coping is a behavioral method of coping with a bad situation. Four participants mentioned a specific behavior that they used to solve a certain problem. When the participants were asked about coping, very little responded with problem-focused coping, although, many mentioned "just dealing with it." The participants in this study evaluated the situation and then used an outward behavior to change it into something better. An 80-year-old married man said it this way:

> If I have a problem, I want to solve it now. I don't want it to ride. I realize the longer you let a problem ride, the worse it gets. Just like poop, the more you stir it, the more it stinks you know. Get it, get it done, and get away from it. Life is too damn short.

Another female participant mentioned seeking help, but in a problem-focused manner,

> Yeah, I think so. I think I've made, even though I still cry once in a while. I have learned to know what's the matter. I know what's the matter, and I can do something about it. Before I knew what was wrong, I was in a terrible state. But then I got some help and it helped me.

Activities

Involvement and participation in activities or hobbies were often referenced as a way to cope with life challenges. The activities that the participants engaged in were diverse, including social activities, service, hobbies, work, exercise, and entertainment. These activities consistently appeared to be used as a way to stay active and/or as a

distraction from life's challenges. A married man commented, "Keeping busy and having an interest in something. You have got to keep going. That's the bottom line. You have just got to keep going."

Social activities were a common way for older adults to cope with life challenges. The participants socialized with family and friends to share meals, play games, and travel. Some of the participants referenced service and helping others as a way to cope with life challenges. A widowed participant explained, "Oh, I love reaching out to others and helping people. In fact, there is a couple in our ward that is alone, and each one has a boy. And I give boxes of food to them, and help buy boxes of food for my cousins; they are just having a struggle. And I love to help people."

Hobbies were the most common activities mentioned by the participants. The hobbies often brought enjoyment and fulfillment into their lives. Work was also mentioned often as a coping mechanism and closely related to hobbies. A married male participant described the waterfall in his yard,

> People like it, and I like it. And like I say, sometimes wonder if it is worth it or not, if you did not have all the limbs and the leaves blown into that. Then of course the pump gets clogged up if you cannot get the leaves out, so it is a constant job out there. But you do need to be doing something, and I guess I might as well be doing that as sitting here at this table thinking or feeling sorry for myself or something. But I do feel better when I do that.

Exercise was a coping mechanism for a few of the older adults in this sample. A widowed woman who walks an entire mile on a tread mill everyday explained exercise by saying, "it relaxes you." Some of the older adults in this sample also used

entertainment as a way to cope with life challenges. The participants enjoyed watching television, music, and reading books. The same widowed woman said, "Oh yeah, [music] relaxes you. I'm a worrier. I worry a lot about everything." After being prompted about coping, a 76-year old married woman replied with saying, "I think television, because it takes my mind into a different realm."

Medication

Many of the participants in this sample used medication to cope with life challenges. The participants often used medication to help cope with physical pain, problems sleeping, and depression. A woman said, "Well I have this medication that I take for my diverticulitis. I have taken Prozac off and on. I'm not on it right now. But I've taken it for you know. I have a little bit of depression." A male survivor of World War II said,

> Well, quite generally, I feel really good. But occasionally, I will get flashbacks of when we got hit. Sometimes it gets pretty discouraging, especially when it hits you in the night time, and you get these dreams. So the last, I guess the last year, the lady doctor down at the VA put me on Zoloft. And you see, I do not see any difference, except I do not have bad dreams at night. It has helped me. It has helped me cope with my life, and other than that, I feel good about myself.

A widowed woman, when asked about medications, said, "Yeah, antidepressants. And then I take one at night so I can sleep. Usually I lay awake until two or three o'clock in the morning. But I get along fine, now."

Summary

In the quantitative measures, counts blessings was the most commonly used coping method. Blames others was the least used in this sample. During the interviews, the participants referenced help-seeking, religion, reframing, "dealing with it," wishful thinking, problem focused, activities, medication, and other methods to cope with stressful life events. The coping mechanisms identified were both behavioral and cognitive/emotional in their approach. Help-seeking and religious coping involved both emotional and instrumental (behavioral) needs. "Dealing with it" and wishful thinking were both cognitive coping processes. Problem focused and activities were both behavioral methods of coping. Emotional methods of coping ($n = 38$) were used slightly more than behavioral methods of coping ($n = 33$). The majority of the participants reported a combination of both behavioral and emotional methods of coping.

Research Question Number Two

What Are Older Adults' Beliefs About Seeking Help From Others to Cope with Life's Challenges? How Do They Seek Help? From Whom Do They Seek Help?

This section will look at the positive and/or negative beliefs the participants had about seeking help, as well as how they sought help, their perceptions of the understanding and availability of those they sought help from, and from whom they sought help. Seeking help is considered a coping method in this study. Participants were asked direct questions about their beliefs about seeking help and their perceptions of the understanding and availability of friends and family. In the WCCL, seeking help in the form of seeks social support was the fourth most commonly used coping mechanism by

the participants.

Beliefs about Seeking Help

Twenty-one participants referenced positive beliefs about turning to others for help, and twenty-four mentioned negative beliefs. Positive beliefs included the participants' willingness to ask others for help and positive feelings about receiving help from others.

A married female participant said, "I certainly know that you can not get through this alone. You know, whatever you would have. And I guess that is why my family means so much to me. Because I just know that if I need the help, or ever need anything that they are there to do it."

Negative beliefs included feelings of self-reliance and independence instead of asking for help from others. Some of the participants even expressed distrust and anger towards family members and friends, thus reducing their willingness to ask for help from them. A female participant commented, "Well, I can handle my own problems. I have very good neighbors and friends, but I try to handle most of my problems alone. I turn to my son of course, but then, you know, he is not very close, you know. We are close, but not close." An 88-year-old male participant said,

> Well, I do not have any desire to expect help from others, if I can do it. I am not, according to my family, I am not supposed to mow the lawn. And I have neighbors and friends that see me sometimes and they will come and offer to do it. And I said no, if I can do it, I want to do it.

Who Participants Sought Help From

Thirty-six of the participants sought help from family members, which included spouses, siblings, and children. Nineteen participants looked for help from friends, 11 from clergy or church leaders, and 11 from physicians.

Family was a key source of help and comfort for many of the participants. Children often provided instrumental help and spouses often provided emotional help. After being asked who he would turn to for help, a participant responded, "My wife. It would be my wife. That is who I would talk to her about. I would burden her with it." An 85-year-old widowed male commented, "My family all really look out for me, to help me, and I really appreciate that. I feel like if I did not have my family, I do not know what kind of a life this would be. I would hate to see it."

Friends and neighbors also played an importation role in the participants life. A female participant said,

> [Friends] are the only ones really that I can say, "Gee, I feel sick. Or Oh, I feel rotten." And they understand without it being a downer for them. And I do n0t like to talk about myself and my problems because they are on-going and who wants to hear that all of the time. I do not even want to live it all the time, let alone hear about it all the time. But I do have two special friends that have been good to me.

Clergy and church members were often mentioned as sources of help from the participants. The majority of the participants were Latter-day Saints. Each Latter-day Saint belongs to a ward that includes neighbors who attend church together. The ward is governed by a bishop and underneath, a priesthood leader who teaches and assists the

men of the ward and a Relief Society leader who teaches and assists the women. A female participant said, "The leaders in my church I could turn to for help. In fact, the Relief Society president helped me a great deal when I broke my leg. She was very considerate and helpful." The LDS church also instructs every member to be either a "home teacher" if you are a man or "visiting teacher" if you are a woman. Home teachers and visiting teachers visit and help the same church members every month. This system was also mentioned as a good source of help. A married male participant said,

> We have a home teacher that comes once a month and every so often I ask him to give me a blessing, because I am down or low… I had so much pain. But whatever I took, it would not touch, or would not cure it. So I got him by himself, and we went by ourselves and he gave me a blessing. And I came out of it then and in a short time and was ready. I did not join in with everything they were doing, but it was at Christmas time, but I was conscious to the fact of what was going on, and the fun we were having.

Some of the participants talked to their physicians or family doctors about their problems. An 80-year-old married male participant said that seeking help from, "my own family would not bother me at all. If I did. But as far as reaching out to somebody, maybe a doctor, yes, but as far as neighbors, friends, or somebody like that?" A female participant said,

> My doctor has been really good about that. If I have things that are just over-powering me, I will say, have you got a minute, because I have something I need to tell you. And so he will listen to me, and he will talk to me, and he will give me fatherly advice, even though. But he is so cute about it, and he makes you feel

> like your problems are almost his, and that he will be happy to help you. So I unload to him. And then he decides whether to increase my Lexipro or take me off of it, or just what to do, you know.

Help-Seeking Perceptions

Participants sought help from family, friends, and doctors for emotional and instrumental needs. The majority of the participants felt that their family and friends were available when they needed them and about half of the participants felt that they understood what was going on.

Emotional needs included talking to people about their situation and asking for comfort and support. A 79-year-old widowed female participant gained comfort from a friend,

> Well I have anxiety and sadness. But I try not to do it. I talk to my girl friend every day. She lost her husband two days before, or two months before I did. And we talk a lot. We grew up together out in Benson. There was a house between us. And we have always been good friends. And I confide in her a lot and she does me.

Instrumental needs included requesting help from others for specific tasks that they could potentially provide assistance with. A widowed male who received instrumental help said, "I have two daughters that usually come here on Wednesday to go through my house, but they probably wont be here until the afternoon."

Some of the participants sought help from others in indirect ways. A woman explained, "I do not exactly seek help, but I find that if I mingle with other people, then I

kind of forget about my problems. But that is probably the solution. I never go ask anybody." A male participant said,

> We do not have any friends who have any fewer problems than we do, so if we have difficulties, physical difficulties, memory things, then we all laugh about them when we are with friends. And maybe that is therapeutic.

Eighteen participants felt that family and friends were available to help them. A female participant said, "Well, they would do anything I think that I needed." Another female said,

> My brothers come almost immediately, and then my family and kids come in at least once or twice. My daughter comes up from Springville at least once a month to help me. And then they come in once or twice a year, my family, the other ones come in, and try to catch up on all the needy things that need to be repaired in the house.

Three participants felt that friends or family were not available if they were to need them. A widowed woman who lived in an assisted living center said,

> Oh friends might help, but family will not. Like I said, my family does not come around. One of them, my sister called me one day last week and I thought she might be coming, but she did not. She has never come yet.

The participants were asked if they felt family and friends understood their situations and challenges. Fifteen of the participants said yes, 14 said no, and 8 either had mixed feelings or said that there were some family members that understood, and others that did not understand. A 79-year-old married male participant said,

> I think they understand, especially the one here. She understands what we are going through and the others, they come on weekends, and Sundays. They got a family and it is hard for them to do much for me, because of the distance. But the one here is real understanding.

In contrast, a widowed female participant said, "I think they try to understand, but I do not think they really realize how it is to be blind. But they are very caring and very helpful." Another female participant said, "Sometimes I think they understand, and sometimes I think nobody understands."

Summary

Participants were fairly divided on their positive versus negative beliefs about seeking help. Those that felt positively were willing to ask others for help and felt comfortable receiving help from others. Those that felt negatively expressed feelings of self-reliance and independence. Participants sought help from family members, friends, clergy or church leaders, and physicians. Family was a key source of help and comfort for many of the participants. Participants sought help for instrumental and emotional needs. The majority of the participants felt that friends were available and understanding of their situation.

Research Question Number Three:

Which Coping Strategies Are Associated with Self Reports of Depression?

In this section, the CESD and the RWCCL coping scores were correlated and an independent samples *t* test between the DIS result and the RWCCL scores was

conducted. Finally, this section compared qualitative experiences and quantified results of depression with coping strategies identified by the participants to better understand depression and coping from a different angle.

The continuous scale of the CESD was correlated with the Revised Ways of Coping Checklist (RWCCL) to determine which coping methods were associated with depression. The results follow the findings of previous research, adding to the reliability and validity of the measures in this sample (see Table 8). Problem Focused Coping, $r(42) = -.25$ $p = .126$; Seeks Social Support, $r(42) = -.07$ $p = .684$; Counts Blessings $r(42) = -.30$ $p = .064$; and Religious Coping, $r(42) = -.13$ $p = .418$, were all negatively associated with depression, meaning that depression scores were lower in people who used these coping strategies. However, these results did not achieve statistical significance, which means that the probability of obtaining them is possibly due to chance. Wishful Thinking, $r(42) = .38$ $p = .019$, and Blames Others, $r(42)=.39$ $p= .014$, were all significantly associated with depression in a positive direction, meaning that depression scores tended to be higher in people who reported these coping strategies. Blames Self, $r(42) = .28$ $p = .095$, and Avoidance, $r(42) = .24$ $p =.134$, were also positively associated with depression but did not reach statistical significance at an alpha level of 0.05.

An independent samples t test was run to compare the RWCCL group's mean score with the DIS dichotomy of yes or no to depression to evaluate whether depressed individuals use significantly different levels of the various coping strategies than non-depressed individuals. Of all the RWCCL subscales, only religious coping was significantly different between depressed and non-depressed individuals at an alpha level

Table 8

CESD Continuous Scale Correlation with RWCCL Coping Strategies

WCCL strategies	Test	Result
Problem focused	Pearson correlation	-.249
	Sig. (2-tailed)	.126
Seeks help	Pearson correlation	-.067
	Sig. (2-tailed)	.684
Blames self	Pearson correlation	.275
	Sig. (2-tailed)	.095
Wishful thinking	Pearson correlation	.375*
	Sig. (2-tailed)	.019
Avoidance	Pearson correlation	.244
	Sig. (2-tailed)	.134
Blame others	Pearson correlation	.391*
	Sig. (2-tailed)	.014
Count blessings	Pearson correlation	-.304
	Sig. (2-tailed)	.064
Religious coping	Pearson correlation	-.133
	Sig. (2-tailed)	.418

* Correlation is significant at the 0.05 level (2-tailed).

of .05 t = -2.035, df. = 37, p = .049, see Table 9. Specifically, more use of religious coping was associated with less depression in this sample.

Table 9

Significance of RWCCL Subscales

	t value	*df*	*p* Value
Problem focused	-0.52	37	.607
Seeks help	-1.70	37	.097
Blames others	0.89	36	.382
Wishful thinking	-0.293	37	.771
Avoidance	-.686	37	.497
Blames others	1.415	37	.165
Counts blessings	-.775	36	.443
Religious	-2.035	37	.049*

The relation between coping strategies and depression in the qualitative analysis was explored by conducting a Boolean Matrix in QSR N6 between the CESD, DIS, and qualitative endorsement of depression and the coping strategy themes reported in Research Question Number One (see Table 10). Reframing showed the largest difference in the quantitative measures, with the vast majority of participants who referenced reframing in their interviews not reporting depression as measured by the CESD and DIS.

In summary, about 25% of the participants were depressed according to self-reports from the CESD and DIS. About half of the participants referenced symptoms of depression in the qualitative interviews. Problem Focused Coping, Seeks Help, Counts Blessings, and Religious Coping appeared to be protective against depression as shown

Table 10

CESD, DIS, and Qualitative Depression Results in a Boolean Matrix with Participants Self-identified Coping Strategies

Coping	DIS No	DIS Yes	CESD No	CESD Yes	Qual No	Qual Yes
Help-seeking positive	14	6	14	6	10	11
Help-seeking negative	19	3	13	9	11	12
Religion	25	5	19	11	14	17
Reframing	18	4	18	4	11	12
Activities	20	6	16	10	10	17
"Just deal with it"	17	3	14	6	9	12
Medication	11	2	8	5	3	11
Problem focused	4	0	4	0	0	4
Wishful thinking	5	2	6	1	3	5

Note. Quantities represent number of participants who identified each coping strategy and endorsed depression or no depression in each depression measure. Totals will not equal the total number of participants because not all of the participants mentioned each coping strategy.

by a correlation between the CESD and RWCCL. On the other hand, Blames Self, Wishful Thinking, Avoidance, and Blames Others appeared to be negative methods of coping. Participants who scored negative for depression on the DIS and CESD represented a greater majority of those who referenced coping strategies during the qualitative interviews than those who scored within a depressed range. Further analysis is explored in the next chapter.

Research Question Number Four:

What Are Older Adults' Perceptions of The Meaning and Purpose in Life?

As part of the qualitative interview, participants were asked how they viewed the meaning and purpose of the rest of their life. The participants' responses to the question were categorized in three separate categories: positive, negative, and neutral. Respondents who did not provide information related to the question asked were coded as "not applicable." Nineteen of the participants responded in a positive way, nine in a negative way, seven in a neutral way, and four did not answer the question.

The researcher determined the placement of each response to the question into each category of purpose in life based on a coding scheme she developed. Only the responses to the particular question about meaning and purpose in life were used for this research question and they were coded separately from the rest of the transcripts. Participants that responded with optimistic views, with desire to or actual work on a project, continuing faith and commitment to "endure to the end," and/or a legacy of heritage were coded as having a positive purpose in life. The researcher felt that these responses reflected a positive purpose in life because the participant noted a desire to continue to live and live happily.

Participants that responded with fear of the future, loneliness, responsibility, or with a statement of no purpose were coded as having a negative purpose in life. The researcher felt that these responses reflected a negative purpose in life because the participant noted no desire or obligation to continue to live, and thus did not have a good viewpoint about the rest of their life. A negative purpose in life and no purpose in life

were different, but similar in that they both denoted a lack of desire to live and so they were grouped together. That lack of desire to live did not necessarily mean suicidal thoughts, but rather an indifference or negativity towards life. A negative purpose was indicated when the participant cited something that made the rest of life negative, such as fear. No purpose was indicated by comments that life once held a purpose, such as work or education, but no longer does.

A neutral comment was indicated by the participant talking about the rest of life, but no indication of negative or positive purpose to life. Responses that were completely unrelated to the topic were coded as "not applicable."

Positive Meaning and Purpose

Participants who were categorized as having a positive meaning and purpose in life were optimistic about life, were working on a project or hobby, passing on their heritage, and living a good life. Participants that were optimistic enjoyed life, were thankful, and looked forward to the future. A woman in this group commented, "Well, I am granted each day. And hopefully I can learn something that day. I think as long as you keep trying to learn and grow, that you will achieve what you are supposed to."

Some of the participants had a project or a hobby that gave them purpose in life. For example, a woman responded, "Oh, I have always wanted to write something from the time I was young. I have not gotten around to it, and different days, I think if I get caught up, I am going to start writing."

Other participants found meaning in passing on their heritage and teaching their children and grandchildren. A married male participant explained, "I think I am trying to

do is tell the grandkids about my experiences and stuff, and we got books and picture books and things here that tells about their [heritage]."

Finally, many participants referenced a religious-related belief to continue to live a good life in the hopes to be rewarded later. An 89-year-old widowed woman said, "Well, I feel like if I can still live my life and do as well as I have done in the past, maybe there is a good chance of going someplace besides hell."

Negative Meaning and Purpose

Participants were assigned to the category of negative if they did not see a purpose to life, if they only continued to live out of responsibility to others, were fearful, or felt alone. A widowed female participant who felt lonely said,

> You feel like you are – like nobody needs you. I think that is the biggest problem with old age. You are not needed. And its just can not be helped. It is life. Your family goes on and has their family. But I am not needed. And I see people in the morning, going to work, and I think, "Oh, I wish I had somewhere I had to go." Because I think that is what is good for you. Something you have to do, whether you want to or not. It is good for you. And when you get so old, you physically can not do it, but mentally you want to. I worked in the temple for a few years and thoroughly enjoyed that. But I have a bad back, and I just could not do the standing that it takes. And that was very hard to have to quit, because that really filled a need in my life. And everybody needs that. Like I say, somewhere you have to be.

Three of the participants did not believe that there was a purpose to life for themselves, but continued to live for family members. A male participant said, "Well the purpose of my life now is just to keep going. My wife says she wants me around, and so I am doing it more or less for her." Fear and loneliness were also a problem in a few of the participants. In response to the question, an 88-year-old married man responded, "Well. I think of it negatively, but I should not. Because I am alone, and because I can not do any more than I do, and I am the age I am. I think, I do not think, I wonder how long it will last. How much longer I have got to live this way."

Participants were categorized as neutral if they, as a woman put it, "Just take it as it comes" or talked about the rest of their life, but did not identify a positive or negative purpose to it. For example, a female participant responded to the question with, "Just the same thing. The same entertainment probably. The same family parties and family birthdays, and go out quite a bit and just a continuation of what we have been doing, I guess."

Depression and Purpose in Life

The purpose in life categories were imported into SPSS statistical software to be analyzed. A box plot was created using the purpose of life categories of positive, negative or neutral and the continuous CESD result (see figure 1). The participants with positive responses had a range with less depression, whereas the participants with negative or neutral responses had a range with more depression, though there was also some overlap.

The CESD and DIS quantitative depression measures and the qualitative interview endorsement of depression were combined into a four-level depression variable indicating whether quantitative, qualitative, both, or neither depression endorsements

were reported. This composite multinomial depression variable was cross-tabulated with the trichotomy of purpose in life (categorized positive, negative, and neutral) and a chi-square test of independence was conducted (see Table 11). A larger portion of the respondents that were positive about their purpose in life did not have depression and more of the respondents that were negative about their purpose in life, did have depression. The neutral responses had the most variation between the three depression results. Purpose in life and the qualitative endorsement of depression were the closest to being significant ($\chi^2 = .4.99$ $df = 3$ $p = .173$). The association between purpose in life and the quantitative depression measures CESD ($\chi^2 = .5.88$ $df = 3$ $p = .889$) and DIS ($\chi^2 = .4.18$ $df = 3$ $p = .243$) were not significant.

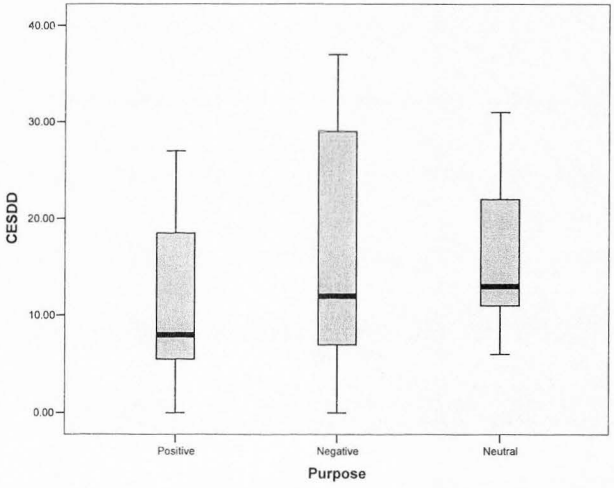

Figure 1. Purpose in life and depression from CES-D.

Table 11

Crosstabs Between Purpose in Life and DIS, CESD, and Qualitative Endorsement of Depression

Endorsed depression in quantitative	Endorsed depression in qualitative	Yes purpose in life	No purpose in life	Neutral purpose in life
YES	YES	4	4	2
YES	NO	3	2	0
NO	YES	5	2	3
NO	NO	7	2	0

Most of the participants that were married reported a positive purpose (positive = 12; negative = 1; neutral= 4; N/A = 3), whereas most of the participants without a spouse had a negative or neutral response (positive = 6; negative = 7; neutral = 3; N/A = 0). Female participants were slightly more positive about their purpose in life (positive = 11; negative = 6; neutral = 5; N/A = 0) than men (positive = 8; negative = 2; neutral = 2; N/A = 3). Interestingly, the participants older than 80 years were also slightly more positive (positive = 12; negative = 4; neutral= 1; N/A = 2) than those that were younger (positive = 7; negative = 4; neutral = 6; N/A = 1).

Summary

The participants' response to the question "How do you view the meaning or purpose of the rest of your life?" was categorized in three separate themes including: positive, negative, and neutral. The respondents who were optimistic, involved, passed on their heritage, and felt they lived a good life tended to report less depression while those

who reported thoughts and feelings of responsibility to others, fear, or loneliness tended to report more depression. Participants that were married reported a positive purpose in life more so than those who were not.

CHAPTER V

DISCUSSION

The purpose of this study was to collect in-depth information about depression and coping mechanisms in older adults through open-ended questions and well-validated measures. Qualitative interviews and quantitative measures of depression and coping were utilized. Previous research investigating depression and coping in older adults have failed to take a mixed methods approach. By studying depression and coping using a mixed methods approach, we are better able to understand the experience of older adults, as well as how they conceptualize depression. Understanding the results of this study can help a wide arena of researchers and individuals working with older adults. The Stress, Appraisal, and Coping model developed by Lazarus and Folkman (1984) provided the theoretical framework for this analysis. Four research questions were created to gain a complex understanding of coping and depression in older adults.

1. How do older adults cope with perceived life challenges?
2. What are older adults beliefs about seeking help from others to cope with lifes challenges? How do they seek help? Who do they seek help from?
3. Which coping strategies are associated with self reports of depression?
4. Are older adults beliefs about the meaning and purpose of the rest of their life associated with depression?

Analysis of the qualitative data showed that the sample most often experienced challenges such as loss, health problems, old age, family problems, and changes in daily life, memory, and financial situations. Participants also reported that they coped with life

challenges by using both emotional and behavioral coping methods, including seeking help, religion, reframing, "dealing with it," wishful thinking, problem focused coping, activities, and medication.

In terms of seeking help, participants were about evenly divided, with 21 who mentioned positive beliefs and 24 who mentioned negative beliefs. The participants sought help for emotional and instrumental needs, and some sought help indirectly. Most participants sought help from family members, which included spouses, siblings, and children. Others looked to friends, clergy or church leaders, and physicians.

Problem Focused Coping, Seeks Help, Counts Blessings, and particularly Religious Coping appeared to be protective against depression as shown by an analysis of the relationship between the RWCCL subscales and the DIS and CESD. Blames others and Wishful Thinking were associated with increased depression. Reframing and Religion appeared to be the most effective coping mechanisms identified in the qualitative interviews.

Most of the participants felt positive about the purpose and meaning of their lives. Respondents who felt positive about their purpose in life had less depression than participants who manifested depression on either the CESD or DIS, and vice versa.

Discussion of Results

RQ 1: Coping with Life Challenges

The purpose of the first research question was to investigate the ways in which older adults cope with life's challenges. To better understand how they cope, the challenges they faced were identified. People face challenges throughout their entire

lifetime. Yet, they seem to occur most often and more severely in old age, thus making the participants at greater risk for depression. For example, Kraaij and de Wilde (2001) found that the experience of negative life events such as death of significant others, personal illness, relational stress, and problem behavior of significant others increases with age. Participants in this study reported similar challenges of loss, health problems, memory changes, and family problems. In particular, multiple health problems and loss appeared to be the hardest challenges with which to cope.

Coping can usually be split into two categories, either coping "dispositions" or cognitive and behavioral coping "responses" (Eksi, 2004; Moos et al., 2003). Coping style dispositions usually emphasize a personality-based and habitual nature to coping, whereas coping responses emphasize various reactions that are modified to fit the situation. The Stress, Appraisal, and Coping model developed by Lazarus and Folkman (1984) views coping as a response to situation that is appraised as threatening. The researcher's evaluation of coping mechanisms in these data was guided by this view point. Coping can consist of *thoughts/emotions* or *behaviors* that are used to reduce the stress caused by life challenges.

Coping strategies can be positive and/or negative. A person in a stressful situation may use a coping strategy to help alleviate the stress, but depending on the strategies used, it may have negative consequences or positive consequences. Negative consequences refer to ineffectiveness in protecting against depressive symptoms and positive consequences refer to effectiveness in protecting against depressive symptoms. The coping strategies used by the participants throughout this section will attempt to determine whether or not the strategies used were positive or negative.

Prevalence of coping. In the qualitative interviews, the coping mechanisms in order of most reported, were Religion, Activities, Reframing, "Dealing With It," Help-Seeking, Medication, other methods, Wishful Thinking, and Problem Focused. The analysis of the data viewed participants' coping as either a cognitive/emotional or behavioral response to challenges. Help-seeking and religious coping involved the use of both emotional/cognitive and/or behavioral coping responses. "Dealing with it" and wishful thinking were both considered cognitive coping processes. Problem focused coping and activities were both considered behavioral methods of coping. In order of most commonly reported on the RWCCL survey, the participants used Count Blessings, Religious, Problem Focused, Seeks Social Support, Wishful thinking, Blames self, Avoidance, and Blame Others.

Coping and demographics. In the RWCCL data, coping strategies used varied slightly by gender, martial status, age, and cognitive ability. Male and female participants were similar in reported use of certain coping mechanisms, although women reported positive coping methods at higher rates than men. Overall reported higher means on the RWCCL subscales than men for every subscale except blames self and blames others. These findings support previous research that shows women reported higher means than men in every case of all coping strategies (Vitaliano et al., 1985).

The widowed participants had a much higher mean score for seeks social support than those who were married, contrary to the findings of Vitaliano and colleagues (1985), who found no relationship between coping and marital status. The finding in the current study may be explained by a greater need to seek help outside of the home among a sample of widows all of whom were age 75 or older. Women sought help more often than

men, which also is evident in Vitaliano's work, and in the current study sample, more female participants were widowed than men.

Participants who were widowed also used religious and counts blessing coping strategies more than their married counterparts. Women are three times more likely to lose a spouse than men (Michael, Crowther, Schmid, & Allen, 2003). Previous research has shown that older widows use religious coping as well as spiritual beliefs and behaviors to adjust positively to the loss of a spouse (Michael et al.). Previous research and the quantitative analysis in this research suggest that religious beliefs and practices are important in recovery from the loss of a spouse. The responses in the qualitative data also suggest that religion is an important coping method in dealing with the loss of a loved one.

Participants who were younger than 80 years old also sought help more frequently than those who were older. This is surprising because one would believe that the older adults would seek help more than their young-old counterparts because of increased health problems and other age-related challenges that become more prevalent with age. However, some research has shown that younger individuals seek help more often than older individuals (Alea & Cunningham, 2003). Prior studies addressing age differences in seeking help have grouped participants by generation; yet, this research suggests that it may apply within generations as well.

Religious coping. Religion was a rich source of emotional satisfaction, social access, and instrumental help for many of the participants. Religion appeared to be the most used coping mechanism across all categories of participants in this study. The majority of the participants belonged to The Church of Jesus Christ of Latter-day Saints

(also known as the Mormon Church). Involvement of members in the Mormon Church extends beyond just attending church. For most members of the Mormon Church, as was found for many of the participants as well, church membership affects virtually every part of their daily life and interactions.

Latter-day Saints believe in personal revelation (Kendrick, 1999). Others have found that prayer appears to be an important and highly used coping method in research (Husaini et al., 1994). Many of the participants in this study believed that a major aspect of their ability to cope with life challenges was through receiving comfort and answers to problems through prayer. In addition, many of the participants coped with their life challenges through a belief in an eternal perspective.

The Mormon faith includes a strong and unique belief in the afterlife (Benson, 1992) namely, that people are immortal beings, having existed in a previous life and will continue to live forever. The actions of Latter-day Saints are judged in the afterlife and therefore Latter-day Saints are encouraged to remain good and faithful to the very end of their lives (Hales, 1998). Families are sealed together forever; therefore, Latter-day Saints are comforted to know they will see loved ones again. These beliefs are likely a significant reason that having an eternal perspective helped the participants cope with the loss of loved ones, particularly family members.

Religion was also a source of behavioral coping thorough social support, instrumental help, and religious activities. In addition to attending church services, the Mormon Church has a network of "visiting teachers" (women) and "home teachers" (men). Each person in the church is called to act as one of these teachers and visit with a certain number of the same individuals or families each month. Thus, acting as a visiting

teacher or home teacher and receiving help from them were mentioned as a way of coping for some of the participants. Others mentioned acting as teachers in their church services. Even participants who could not attend church spoke of receiving blessings and of visiting teachers.

Counting blessings is a positive coping method taught by many religions, including the Mormon Church (Monson, 1992). It is an emotional coping method in which the participant focuses on the good things or "blessings" in their life or reframes negative events into blessings. Counts blessings was reported the most often on the RWCCL measure.

Cognitive/emotional coping. One of the cognitive coping methods participants referenced was the concept of just "dealing with" life challenges. Many of them spoke about tackling problems without trying to solve them or reframe them into something positive. This does not mean that the participants did not actually use problem-focused, reframing, or other coping methods, but that when asked how they cope with life challenges, they responded with "I just deal with it." It may also be that participants were unable to recall the specific cognitive and behavior actions used to cope with the situation (Folkman & Moskowitz, 2004), and in retrospect they believed they just "dealt with it." Or perhaps older adults do cope with challenges with this cognitive approach, without enacting any specific behaviors. Further research is needed to understand how this strategy operates in the lives of older adults.

As shown in both the qualitative data and quantitative measures, participants did not make heavy use of wishful thinking. Such thinking is usually thought of as a negative or destructive way to cope with challenges (Vitaliano et al., 1985). Those who

reported it tended to wish they were younger, could do the things they used to, or had fewer struggles.

Behavioral coping. Problem-focused coping was reported to be used more in the quantitative data than in qualitative data. The participants rarely described actions that they used to solve a problem when asked how they cope with life challenges. Yet, in other parts of the interviews they described problem-focused behavior. Future interviews should possibly probe for more detailed information about behavioral actions. For example, the persons who replied with, "just deal with it" may have, in actuality, engaged in problem-focused behavior. Or they may have reframed the situation.

Activities seemed to be an important coping mechanism for some of the participants. They engaged in a large variety of activities, including social activities, service, hobbies, work, exercise and entertainment. Focusing on enjoyable activities might be considered an effective way to cope with life challenges because it brings joy and happiness into the lives of older adults. Very little existing literature has explored the use of activities as a coping method; however, some literature has explored leisure as a method of coping with negative life events. It is used to distract from negative life events, to produce optimism, and to preserve a sense of self (Kleiber, Hutchinson, & Williams, 2002). This is similar to how the participants in this study felt about having hobbies and involvement in recreation as a way to cope.

Conclusion. The researchers for this study know more detail about coping strategies after analyzing the interviews. Religion was an important coping avenue for this study's participants. It involved emotional, cognitive, and behavioral methods. Other

cognitive methods such as wishful thinking and "dealing with it" were used. Behavioral methods such as problem focused and activities were also used.

RQ 2: Help-Seeking

The second research question explored the beliefs of older adults about seeking help from family, friends, and church leaders. In addition, this study explored how they seek help and from whom they seek help. The participants were questioned thoroughly about help-seeking beliefs and behaviors. Seeking help and social support are among the coping methods used by the participants.

Participants were distributed about evenly based on their positive versus negative beliefs about seeking help. Their responses about seeking help were consistent during the interviews, with just a few mentioning both positive and negative beliefs in the same interview. Those that felt positively were willing to ask others for help and comfortable receiving help from others. Those that felt negatively were self-reliant and independent. Participants who had positive beliefs about seeking help were less likely to score in the depressed range of the CESD and DIS. More women had positive beliefs about seeking help than men, even though more of the participants as a whole had negative beliefs about seeking help.

Participants who had a strong support system, usually family, appeared to be happier and have a better outlook in life. Patrick, Cottrell, and Barnes (2001) also found that men have increased happiness when they were more satisfied with family support. For women, satisfaction with emotional support from family was associated with lower levels of sadness, and friend's emotional support enhanced their happiness.

In this research, family is a vital support system for older adults. The care of older adults by others is not as effective or cherished by older adults in this sample than that of the family. Friends, church members and leaders, and physicians still take a second stage to the family. Yet, in existing literature, friends are more often cited as confidants than family by many older adults. After conducting extensive research, Cartensen (1995) proposed socioemotional selectivity theory. This theory suggests that older adults social involvement follows a life-cycle approach. Specifically, adults become better at emotion regulation as they age, but become less desirous of associating with unfamiliar people and acquiring information as they age. This might help explain why participants in this sample prefer to seek help from family members rather than physicians or other non-family members.

Children and grandchildren who were heavily involved in the participants lives brought a lot of joy and satisfaction to these participants. On the other hand, participants who did not have a good relationship with their posterity often struggled with it as a life challenge.

In terms of other types of social support, previous research has found that mental health services were used less by older adults as compared to help from clergy, friends/relatives, or praying frequently. This difference was higher among the females than males (Husaini et al., 1994). In addition, these researchers found that female white older adults sought help from their spouses or families more than friends and distant relatives. However, in their study, white males sought help from relatives and friends more than their spouse or family. This pattern of results is different from the findings of the current research. Male participants in this study sought help from their wives far more

than women did from their husbands. The women in this sample sought help from their children and other family members far more than did men. This is most likely because the majority of female participants were widowed and the majority of the male participants in this study were married. These findings suggest that turning to a spouse for help may be the first route for many older adults, but without spouses, they turn to their family members. Family appeared to the first route the participants took in seeking help (spouses, children, or siblings). Friends, church members and leaders, and physicians appeared to take a back seat to family, although some participants said they would rather talk to their physicians than friends and church members. This trend follows closely with the hierarchical compensatory model which states that kin, particularly spouse and children, are of primary importance, followed by friends and neighbors and formal organizations in a well-ordered hierarchical selection process (Cantor, 1979).

The fact that the majority of the sample were members of The Church of Jesus Christ of Latter-day Saints (LDS or Mormons) might help provide insight into the importance the participants placed on the family (Hinckley, 1995). In addition, Marjorie Cantor (1992) developed what is called a hierarchical compensatory model to explain how older persons in need of help often turn first to family and friends, but when they are unavailable, they turn to neighbors, informal supporters, and if necessary, to home health workers and other professionals. This model fits the experiences of the current study participants as well.

Family was a key source of help and comfort for many of the participants. Participants sought help for instrumental and emotional needs. Spouses played an important role in emotional support, whereas, children seemed to be important in both

emotional and instrumental help. Scholarly literature usually focuses on the thoughts and strains of caregivers and family members taking care of older adults. But very little research exists that addresses the perceptions of the older adult. The majority of the participants felt that family and friends were available and understanding of their situation, although fewer saw their family members as understanding than available. Other research has found that elders who perceive they have good social support are protected from depression (Cummings & Cockerham, 2004).

In conclusion, this research suggests that family is a vital support system for older adults. Participants who have lost their spouses seek help from others more than those who have not, particularly from family members. Married participants turned to their spouses more often than others, including other family members. The majority of those who lost a spouse were women, and those who had not were men. This pattern is similar in older adults across the country.

RQ 3: Coping and Depression

The purpose of the third research question was to explore which coping strategies identified in the first research question were associated with depression using both qualitative and quantitative analysis. Fifteen percent of the sample had reported depression on all three measures. Seventy-three percent of this population indicated depression on at least one of the three ways of measuring depression. The entire sample indicated depression of some sort in the past, and many described depression in the qualitative interview; therefore, this sample gave rich data about the experience of depression. The participants reported feelings of sadness, lack of interest, withdrawal,

anxiety, and suicidal ideation. Sadness resulted from events and challenges such as loss, but also was described as an onset unrelated to events. Lack of interest in activities and withdrawal from society were closely related to each other. Other symptoms such as cognitive, somatic, and behavioral symptoms were not mentioned often in relation to depression, although they were mentioned when asked about life challenges.

Older adults may often exhibit depression that does not meet the criteria for the DSM-IV (Gallo & Rabins, 1999). They may deny feeling sad, but show other characteristics of depression. For example, they may exhibit somatic complaints and have a sense of hopelessness, or have anxiety or a loss of the ability to feel pleasure. Other indicators of depression might be slowness of movement and lack of interest in personal care. Older adults may not meet the number of symptoms required by the DSM-IV, but still have significant depression. For example, someone may just have feelings of hopelessness and worthlessness and admit to thoughts about suicide. Current study participants exhibited all of these manifestations of depression. Feelings of sadness endorsed by the participants made up less than half of the total depressive symptoms endorsed by the participants. Eleven of the participants endorsed thoughts about suicide, and many of those never reported being sad in the interviews.

Depression endorsement from the three different sources, the CESD, DIS, and qualitative interview, showed some disparity in relation to each other. The DIS and CESD quantitative tests approached significance, while the CESD and qualitative endorsement of depressive symptoms were not significantly correlated. Interestingly, the DIS depression measure and qualitative endorsement of depression were highly significantly associated. This is likely due to the qualitative interviews being coded as

"endorsing depression" when participants endorsed any of the depressive symptoms from the DSM-IV criteria for depression, which is how the DIS diagnoses depression.

In order of most commonly used on the WCCL, the participants used Counts Blessings, Religious, Problem Focused, Seeks Social Support, Wishful thinking, Blames self, Avoidance, and Blame Others. Depression literature suggests that emotion/cognitive-focused coping methods such as wishful thinking, blames self or blames others are more highly correlated with depression than the positive methods such as problem solving, counts blessings, religion, and seeks social support (Vitaliano et al., 1985). The four most used coping strategies were ones cited in previous research as the most effective strategies for reducing depression risk. This may seem contrary to most published literature given that the respondents, most of whom endorse at least one indicator of depression, endorsed, on average, more positive than negative coping methods. However, the participants in the present study followed the same pattern as extant literature in that those with higher depression scores also indicated more "negative" coping methods, and participants with no depression indicated more "positive" coping methods.

Problem Focused Coping, Seeks Social Support, Counts Blessings, and Religious Coping appeared to be protective against depression as shown by a correlation between the CESD and WCCL. On the other hand, Blames Self, Wishful Thinking, Avoidance, and Blames Others appeared to be negative methods of coping. However, Blames Others and Wishful Thinking were the only coping methods that were significantly correlated with the CESD. Religious coping was the only method significantly correlated with a lack of depression using the DIS depression measure. The lack of statistical significance

in the relationship between depression and coping strategies might be due to a small sample size the majority of whom were depressed. Nevertheless, it is interesting to note that religious coping was correlated with less depression in this sample.

Religious coping was used the most by the participants. In the qualitative and quantitative data, it was associated with less depression in the participants. Having an eternal perspective as noted in the qualitative data, however, did not however translate into less depression. This may be because of its association with the loss of loved ones, which was associated with higher rates of depression.

The use of behavioral instead of emotional coping mechanisms or vice versa did not appear to have a different impact on depression (as measured with the CESD and DIS). On the other hand, more participants that mentioned reframing, religion, "just dealing with it," positive beliefs about help-seeking, and problem-focused coping did not report depression, whereas that gap between participants with depression and without became slimmer when participants mentioned wishful thinking, medication, and a negative belief about seeking help.

Coping through activities appeared to be the least effective way to cope, with close to the same number of depressed versus non-depressed persons using this method This might mean that the particular methods used to cope are more important than classifying coping styles as cognitive/emotional vs. behavioral. As discussed earlier, activities can be used to distract persons from negative life events, and some research indicates that involvement in activities might be an indication of avoidant coping behavior (Folkman & Moskowitz, 2004). In addition, Cummings and Cockerham (1982) found that the number of social activities in which people participated was not

significantly correlated with depression, while perceived social support, satisfaction with others and living situation were predictive of psychological well-being.

Therefore, when activities were removed from the behavioral category, there were twice as many non-depressed participants using behavioral coping methods than depressed participants. The remaining behavioral methods included problem-focused behaviors, instrumental help seeking, and religious social support. This would support existing research that shows behavioral problem-focused coping is more effective than cognitive/emotional coping and avoidance (Folkman & Moskowitz, 2004). This may be a good indication that some of the activities mentioned by participants were indeed an avoidance method of coping, or simply a way to pass time.

In conclusion, there are a variety of coping methods to deal with challenges that are either behavioral or emotional/cognitive. Behavioral coping methods appear to be more effective than emotional/cognitive and avoidant methods. Yet, the specific mechanisms used appear to be the most important factor when looking at its impact on the ability to cope. Problem Focused Coping, Reframing, Seeks Help, Counts Blessings, and Religious Coping appear to be effective strategies, while Activities, "Just Deal with it," Blames Self, Wishful Thinking, Avoidance, and Blames Others appeared to be negative methods of coping.

RQ 4: Meaning and Purpose in Life

The purpose of the fourth research question was to determine if there was an association between the participants' views of the purpose of the rest of their lives and depression. Little research has looked at the direct relationship between depression and

purpose in life, although there has been research that found an association between having a purpose and meaning in life and positive well-being (Zika & Chamberlain, 1992). In the current research, the respondents who were optimistic, involved, passed on their heritage, and felt they lived a good life tended to report less depression while those who reported thoughts and feelings of responsibility to others, fear, or loneliness tended to report more depression. This finding held with both the qualitative and quantitative endorsement of depression.

This study used cross sectional data. Therefore, direction of causality in these relationships is unknown. We do not know if those that are depressed are less likely to see a purpose in life, or if those that do not see a life purpose become depressed. There does appear to be an association, and having no purpose in life could be indicator of depression. Additionally, helping older adults see a purpose in life may be a good way to alleviate depression. In existing literature, Heisel and colleagues (2004) found that purpose in life mediated the relation between satisfaction with life and suicide ideation and moderated the relation between depression and suicide ideation.

Interestingly, a participant's neutral response to the meaning and purpose in life was the most indicative of depression. In this study, a great majority of the participants who talked about the rest of their life, but did not identify a positive or negative purpose to it, endorsed depressive symptoms in the qualitative interviews.

Researchers coded the participants responses as either positive or negative based on judgments of the participants meaning. Although the researchers used specific characteristics and criteria, labeling the responses was based on the researcher's perception of the participant's meaning. Participants who were coded with a positive

response were optimistic about their future, engaged in activities, and felt it important to pass their wisdom onto others. As suggested earlier, involvement in activities was not effective at reducing depression. But, it appeared to have a good influence on the participants' beliefs about the purpose of the rest of their lives.

The vast majority of the married participants had a positive purpose in life, whereas more people that did not have a spouse believed there was no purpose in life. One might believe that this finding could be explained by the fact that the majority of the married participants were male and younger. Because research has shown that men have lower rates of depression, and younger old adults are often healthier and have more time to live, they may possess a stronger belief in the purpose of their life than women or the oldest old. Yet, the same strong contrast did not exist for gender or age. In fact more people above age eighty had a positive outlook on life than those younger than eighty. Therefore it is possible to suggest that having a spouse has huge impact on an older adult's viewpoint on the meaning and purpose of the rest of their life. Indeed, existing research shows that family relationships, pleasure, and health are the strongest predictors of meaning in older adults lives (Depaola & Ebersole, 1995). Other research (Robak & Griffen, 2000) indicates a strong positive relationship between purpose in life and happiness, and a negative correlation between purpose in life and depression as a result of a death. In addition, women reported a greater degree of depression from the death of a loved one. Those who have recovered from the death of a loved one have greater purpose in life and happiness.

In conclusion, this research suggests that depression is associated with older adults' beliefs about the meaning and purpose in life. Participants who felt they had a

purpose in life were less likely to report depression. Because of this, researchers might want to look at their subjects beliefs about their meaning and purpose in life when looking at depression.

Strengths and Limitations

Strengths

This study was greatly needed to reach a better understanding of depression and its contexts in the aging population. Very little research in the past has looked at depression in older adults from a qualitative perspective. The researchers used a mixed methods approach to create methods triangulation. Mixed methods approaches not only expand the data collection and analysis possibilities, they also provide the opportunity to use and combine multiple research traditions, theories, methods, and materials. This gives the investigator additional perspectives and insights that are beyond the scope of any single data collection technique or theory. In this study, the mixed methods approach was used to create methods triangulation. Data triangulation uses two methods (qualitative and quantitative) to test the consistency, cross-validate, or confirm findings obtained through different instruments (Creswell, 1994).

The mixed method approach to research on depression greatly adds to a vast amount of past research that has been mostly quantitative. The addition of the qualitative interview has brought insight into the experience of old age through dialogue. Readers can gain a greater understanding of depression, coping, and meaning near the end of life by getting glimpses of participants' stories.

Folkman and Moskowitz (2004) believed that the best solution to exploring coping is the use of a mixed methods approach. They discussed literature that suggests that survey data and qualitative data overlap, but are not equivalent. By using mixed methods, researchers were able to identify the stressors through narrative that can be used with the quantitative measure. It also allows researchers to uncover ways of coping that are not included on standard coping measures.

The qualitative data uncovered coping methods or processes not represented in inventories. This included the use of activities, reframing, and just "dealing with it" is a unique response that many participants referred to throughout the interview. The participants discussed coping, stressful events, and emotional outcomes all within the same interview. This may have allowed answers to be more related to each other than can be captured in standardized measures.

In addition, because stigma may have an effect on disclosure of depression, it is important to explore multiple ways of covering it. Depression in elderly adults is unlike depression in younger individuals. Furthermore, some older adults are hesitant to disclose depression (Mulsant & Ganguli, 1999). Negative social stigma is one the common explanations for not disclosing depression (McNair et al., 2002). The use of a qualitative interview in this study helped the researchers understand the participants' own beliefs and their social context. Methods used in this study provided an enhanced understanding of depression in older adults beyond survey questions that may have failed to capture personal experiences of depression, and how older adults cope, seek help, and perceive the purpose of their life. Additionally, the quantitative results for depression and coping

were consistent with previous research, adding to the ability of these data to be relevant to other older adults experiencing depression.

Limitations

In qualitative data, interviewers and researchers inevitably influence data simply because of the social interactions with their subjects or by their interpretation of the data. In this study, the researchers limited bias as much as possible for this study by maintaining a professional distance during the interviews and coding the data based on criteria that were formulated from existing research. Additionally, two coders provided a way of checking and refining interpretation of data. Thus, this reduced the possibility that researchers misinterpreted or negatively influenced data analysis.

Folkman and Moskowitz (2004) cited variations and inability to recall and changes in coping based on different stressful situations as possible problems with collecting survey data. The participant's responses to both qualitative and quantitative questions involved using recall, which may not fully capture what coping methods were used at the time the challenge was presented. On the other hand, Folkman and Moskowitz said it was possible that by discussing the event after it occurred, reflection about the coping methods used may better determine the outcome of depression or no depression.

The results from this study cannot theoretically compare depressed with non-depressed individuals because the participants had all indicated depression or antidepressant use for depression in the past. Therefore, the comparisons made between participants are purely cross-sectional and do not show causality. The limited sample

size, high population of Latter-day Saints in Utah, all Caucasian, and qualitative method approach makes it difficult to be generalizability.

This research was guided by the cognitive or behavioral coping response model developed by Lazarus and Folkman (1984). The in depth interviews did not ask for coping responses to particular experiences. Although many participants talked about coping within the context of particular situation or challenge, because it was not formally asked with all the participants, the researchers cannot accurately make conclusions about which strategies are more or less effective in certain situations.

The findings in this research are not generalizable to all older adults with depression. Qualitative results are not usually considered generalizable, but are often transferable. This means that although the results from this small selective sample are not generalizable to the population at large, they may help explain or understand cases similar to the participants in this study. This research is somewhat limited in its ability to be transferable because the majority of the sample was Mormon. Understanding the influence of religion in this group may be different than in other religious groups. However, some findings may be applied to older adults who are deeply religious and very involved in their religion.

Implications and Future Directions

This research has produced additional insight into the experiences of old age. The information gained from this research will help future practitioners, policy makers, and researchers working with older adults. By understanding the relationships among depression, coping and help-seeking, and meaning in life, practitioners, policy makers,

and researchers will gain greater insight into the experience of old age and, thus, be better able to assist older adults who are struggling with problems of old age.

Practice

In future implementation, practitioners in the field should focus on older adults' specific coping mechanisms, rather than whether or not they are using behavioral versus cognitive methods. The distinction between a behavioral or cognitive approach appears less important than the specific coping mechanism they use. Problem Focused Coping, Reframing, Seeks Help, Counts Blessings, and Religious Coping should be reinforced coping strategies, whereas Activities, "Just Deal with it," Blames Self, Wishful Thinking, Avoidance, and Blames Others should be deemphasized.

It is projected that as the baby boomer population beings to age, its members will want to continue their community involvement more so than previous generations (Freedman, 2002). By promoting volunteer opportunities customized to older adults, both older adults and their communities will benefit (Johnson, Cobb, Parel, Bouvier, & Fauss, 2004). It is important that the activities in which older adults become involved are meant to increase their purpose in life and not to distract them from life challenges because such avoidant behavior is ineffective in reducing depression risk. Many of the participants felt their purpose in life derived from family goals. Therefore, it is important that older adults are able to make positive contributions to their posterity.

The belief that there is meaning and purpose to life is a crucial part of happiness. Meaning and purpose in the sample came from social involvement, activities or hobbies that gave them a cause, optimism, and passing on their heritage. Therefore, practitioners

can help people to have a meaning and purpose in life by supporting and encouraging persons to adopt these characteristics. The loss of a spouse appeared to have the largest impact on purpose in life. Because previous research (Robak & Griffen, 2000) has shown that people who have recovered from the death of a loved one have more purpose and meaning in life, practitioners should work to assist older adults in recovery from the loss of their spouse.

Policy

Older adults face challenges such as loss, health problems, old age, family problems, and changes in daily life, memory, and financial situations. Problems in old age are substantial and can lead to depression in some of the older population. More attention should be brought to this topic in policy as our population continues to get older. Policy makers should be aware of the challenges older adults face when creating policy about health care and other issues that challenge older adults, particularly mental health policies, based on this research.

Family members and friends should be educated about old age because they will be the first people to whom older adults turn. Older adults who have lost their spouse seek help from others more than those who have not, particularly from family members. Therefore, it is crucial that families are aware of challenges, coping strategies, and resources available to older adults.

Research

Emphasis in research should focus on specific coping mechanisms, rather than whether or not persons are using behavioral versus cognitive methods. Most research

concludes that behavioral methods of coping are more effective than cognitive methods. Yet, this research shows that some activities (behavioral) are not very effective and reframing (cognitive) is highly effective. Therefore, the specific method of coping should be explored in greater detail.

Additional research is needed to explore the coping process involved in dealing with particular events and their outcomes. Looking at the event, the coping strategy selected, the available resources, and resulting experience or lack of depression through a qualitative viewpoint would help to discover which coping strategies are more or less effective in certain situations. It is important to continue this additional research through a qualitative approach.

Participants who felt they had a purpose in life were less likely to report depression. Additionally, people who were married felt there was meaning and purpose in life. Unfortunately, researchers or practitioners have little ability to control these aspects of people's lives. Future research should look at the consequences of losing a spouse beyond the possible result of depression and loneliness.

Conclusion

This research contributes to the academic community, policy, and practice field. The greater understanding gained here and the stories told will inform practitioners, policy makers, and researchers of the intimate and intertwined experiences of challenges, coping and depression in later life. With the aging population, increased knowledge and understanding is greatly needed to better serve our community and society.

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APPENDICES

Appendix A. Participant Contact Letter

QUALITY OF LIFE STUDY

LETTER OF INTRODUCTION

[DATE]

Dear Mr./Mrs [LAST NAME]:

On behalf of all the Cache County Memory Study researchers who are dedicated to the study of healthy aging, we thank you for your continued participation in the study. Thanks to your generosity in willingness to be interviewed, we have been able to make important contributions to the understanding of Alzheimer's Disease and other memory and health problems in late life, as well as healthy aging.

At this time, we are conducting a study with a small randomly-chosen group of Memory Study participants and we would like to include you. The purpose of this study, called the Quality of Life Study, is to explore the process of aging from the older adult's point of view. We hope to better understand how people adjust to life changes and cope with life events and the experience of getting older. In addition, this study will help us to improve on the questions we ask in future research. Unlike most of the previous Memory Study interviews, where you had to pick from specific responses to answer the questions, this interview is more "open-ended" allowing you to elaborate on any question *as you see fit.*

Within the next few weeks, a Memory Study interviewer will contact you at home to explain this study and give you a chance to ask questions about it. If you are willing to participate, we will arrange a time and place to conduct two interviews at your convenience. To thank you for your time and interest, you will receive $25 upon completion of each interview.

It is our hope that you will continue your valuable involvement with the study and that you will find this interview a rewarding experience. If you have any questions, please feel free to call Dr. Maria Norton at 797-1599 or Dr. Kathy Piercy at 797-2387. We very much appreciate your help and look forward to talking with you soon.

Sincerely,

Maria C. Norton, Ph.D.
Principal Investigator
Quality of Life Study

Kathy Piercy, Ph.D.
Co-Investigator
Quality of Life Study

Appendix B. Consent Form

Utah State
UNIVERSITY

Center for Epidemiologic Studies
4450 Old Main
Logan UT 84322-4450
Tel: (435) 797-8108
Fax: (435) 797-2771

INFORMED CONSENT
The Cache County Memory Study
Principal Investigator: Maria C. Norton, Ph.D.
Project Title: Quality of Life Study

IRB Approval Terminates 8/03/05
IRB Password Protected per True M. Rubal, IRB Administrator

Project Title: The Quality of Life Study
Principal Investigator: Maria C. Norton, Ph.D.

Introduction and Purpose of the Study
We are conducting a study with a small group of participants in the Cache County Memory Study. The purpose of this study, called the Quality of Life Study, is to explore the process of aging from the older adult's point of view. We hope to better understand how people adjust to life changes and cope with life events and the experience of getting older. In addition, this study will help us improve on the questions we include in future Memory Study interviews

Procedures
Fifty participants of the Cache County Memory Study will be randomly selected and invited to participate in the Quality of Life Study. Interviews will take place on two occasions. The first interview will take about an hour to an hour and a half and will include questions about various life changes you may have experienced, their effects on your quality of life and the ways in which you cope with them. These questions allow you to offer detailed answers and elaborate on any question as you see fit. This interview will be audio taped to help us remember everything you say so that we can better understand your answers. The tapes will be erased six months after the project is completed. The second interview will take about an hour and will include a brief memory test and additional questions about mood, concentration, and coping skills.

Benefits
For the researchers, this project will provide important insights about how older adults adjust to life's challenges. As a participant, the process of completing the interview will give you the opportunity to reflect on all that you've accomplished and how well you have handled the many changes that occur with aging. Many participants comment on how much they enjoy this type of interview, as it helps them to see these changes in a lifelong perspective and to appreciate some of their meanings and life's lessons learned.

Confidentiality
All information you supply will remain confidential. Study records that identify you will be kept confidential as required by law. Federal Privacy Regulations provide safeguards

for privacy, security, and authorized access. Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in study records disclosed outside of Utah State University, unless at your separate request. No publications resulting from the study will disclose any information that could identify you personally. A strict confidentiality policy is in place for all study staff and collaborators and all of them have signed an Agreement of Confidentiality. Study records and audiotapes are stored in locked file cabinets and secured in locked offices or facilities. Audiotapes will be destroyed six months after the conclusion of the study.

Risks

There are no significant risks anticipated in this study. There is the possibility of emotional discomfort in answering some questions, however, interviewers have been trained to be sensitive to your emotions and to minimize any discomfort. You are free to stop the interview at any time. Also, you may refuse to answer any specific questions that you feel uncomfortable answering. There is an extremely low risk for loss of confidentiality due to the safeguards mentioned above.

Explanation and Offer to Answer Questions

If you have any questions about the study you can contact Dr. Maria Norton, Principal Investigator, at (435) 797-1599, Dr. Kathy Piercy, Co-Investigator, at (435) 797-2387, or the Institutional Review Board of Utah State University at (435) 797-1180.

Costs

There will be no cost to you for participating in this research.

Payment

You will be paid $25 for completion of each of the interviews, for a total of $50.

Voluntary Participation

Your participation in this study is voluntary and you may stop your participation or withdraw from the study at any time without consequence. If you agree now to participate, you can still refuse to answer any individual questions. Doing so will not affect your or your relatives' relationship with Utah State University.

IRB Approval Statement

The Institutional Review Board (IRB) for the protection of human subjects at Utah State University has reviewed and approved this research project.

Copy of Consent

You have been given two copies of this Informed Consent. Please sign both copies and keep one for yourself.

Investigator Statement

This research project has been reviewed and approved by the Institutional Review Board for the protection of human subjects at Utah State University. I certify that the information contained in this form is correct and that we have provided trained staff to explain the nature and purpose, possible risks and benefits associated with taking part in this research study and to answer any questions that may arise.

Maria C. Norton, Ph.D.

(Name of Principal Investigator) (Signature of Principal Investigator) (Date)

Consent

I have read the information provided above and hereby consent to participate in the Quality of Life Study. I have been given an opportunity to ask questions and I understand the risks and benefits associated with my participation. I understand that I have the right to refuse any parts of the interviews or to stop my participation at any time.

(PRINT - Name of Participant) (Signature of Participant) (Date)

(PRINT- Name of Witness/Responsible Party)(Signature of Responsible Party) (Date)

(PRINT- Name of Staff Member) (Signature of Staff Member) (Date)

Appendix C. Center for Etiological Studies Depression (CES-D) scale

Below is a list of the ways you might have felt or behaved. Please circle the number to tell me how often you have felt this way in the past week or so.

	Last week				Last 2 Weeks
	Not at all or less than 1 day	1 to 2 days	3 to 4 days	5 to 7 days	Nearly every day for 2 weeks
My appetite was poor	0	1	2	3	4
I could not shake off the "blues."	0	1	2	3	4
I had trouble keeping my mind on what I was doing.	0	1	2	3	4
I felt depressed.	0	1	2	3	4
My sleep was restless.	0	1	2	3	4
I felt sad.	0	1	2	3	4
I could not get going.	0	1	2	3	4
Nothing made me happy.	0	1	2	3	4
I felt like a bad person.	0	1	2	3	4
I lost interest in my usual activities.	0	1	2	3	4
I slept much more than usual.	0	1	2	3	4
I felt like I was moving too slowly.	0	1	2	3	4
I felt fidgety.	0	1	2	3	4
I wished I were dead.	0	1	2	3	4
I wanted to hurt myself.	0	1	2	3	4
I was tired all the time.	0	1	2	3	4
I did not like myself.	0	1	2	3	4
I lost a lot of weight without trying to.	0	1	2	3	4
I had a lot of trouble getting to sleep.	0	1	2	3	4
I could not focus on the important things.	0	1	2	3	4

Appendix D. Diagnostic Interview Schedule (DIS)

1.	Over the past year, have you had a period of two weeks or more when, nearly every day, you felt sad, blue or depressed?	YES NO RF DK
2.	Over the past year, have you had a period of two weeks or more when, nearly every day, you lost all interest and pleasure in things that you usually cared about or enjoyed?	YES NO RF DK
3.	Over the past year, have you had a period of two weeks or more when, nearly every day, you felt unusually cross or irritable?	YES NO RF DK
#1 INTERVIEWER CHECKPOINT: DOES 1, 2, OR 3= YES?		YES (CONTINUE) NO (GO TO SECTION E)
4.	How many episodes of two weeks or more of this sort of sadness, loss of interest, or irritability have you had over the past year?	***EPISODES*** ⌊⌊⌋
5.	At present, are you still experiencing this sort of sadness, loss of interest, or irritability?	YES NO (GO TO D22) RF (GO TO D22) DK (GO TO D22)
6.	When did this episode begin?	DATE ⌊⌊⌋ MM YY
7.	Did this episode occur just after someone close to you died or left you?	YES NO RF

		DK .....
8.	Have people told you recently that you look sad or down, during the past two weeks?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
9.	Has your appetite recently decreased or increased?	***INCREASED*** ..... ***1*** ***DECREASED*** ..... ***2*** BOTH INCR. & DECR ..... 3 NO CHANGE ..... 4 **RF** ..... **7** DK 8
10.	Have you recently lost or gained weight?	GAINED ..... 1 LOST ..... 2 BOTH GAINED & LOST ..... 3 NO CHANGE (GO TO D11) ..... 4 **RF (GO TO D11)** ..... **7** DK (GO TO D11) 8
	a. How much?	LBS. ..... ⌊⌊⌊
11.	Have you recently had difficulty sleeping, or have you been sleeping too much?	DIFFICULTY SLEEPING ..... 1 SLEEPING TOO MUCH ..... 2 BOTH PROBLEMS ..... 3 NEITHER PROBLEM ..... 4 RF ..... 7 DK 8
12.	Still reflecting on the past two weeks, have you recently felt either slowed down, or restless and fidgety?	SLOWED DOWN ..... 1 RESTLESS & FIDGETY ..... 2 BOTH PROBLEMS ..... 3 NEITHER PROBLEM ..... 4 RF ..... 7 DK 8
13.	Have you recently had low energy, felt tired out, or fatigued?	YES ..... 1 ***NO*** ..... ***0*** RF ..... 7 DK 8

14.	Do you have feelings of guilt or worthlessness?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
15.	Do you have unusual trouble concentrating, thinking, or making decisions?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
16.	Have you been thinking about death?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
17.	Have you been thinking about suicide?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
18.	Have you told a doctor about your current depression, loss of interest and pleasure, or irritability?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
19.	Are you currently receiving treatment for depressed mood, clinical depression, or the symptoms we just talked about? Treatment could include counseling, medication, or shock treatment.	YES ..... 1 NO (GO TO D21) ..... 0 RF (GO TO D21) ..... 7 DK (GO TO D21) 8

20.	What type of treatment?		YES	NO	RF	DK
		COUNSELING IF YES, SPECIFY OCCUPATION _____	1	0	7	8
	COUNSELOR: _____ (E.G. PSYCHOLOGIST, BISHOP, SOCIAL	MEDICATIONS	1	0	7	8
		ELECTRIC SHOCK	1	0	7	8

WORKER)	HOSPITALIZED	1	0	7	8
	OTHER _____	1	0	7	8

21.	Have you been hospitalized for this current episode of depressed mood or clinical depression for any of the symptoms we just discussed?	YES..... NO (GO TO #2 INT. CHECKPOINT)..... RF (GO TO #2 INT. CHECKPOINT)..... DK (GO TO #2 INT. CHECKPOINT).....
	a. (IF HOSPITALIZED) Where was that? (HOSPITAL NAME, CITY, STATE? HOSPITAL NAME: _____ CITY, STATE:_____ _	
	b. What were the dates of your hospitalization?	ADMIT DATE ☐☐ ☐☐☐☐ MM YY
		DISCHARGE DATE ☐☐ ☐☐☐☐ MM YY
#2 INTERVIEWER CHECKPOINT		IF D17 =YES, GO TO SUICIDAL PROTOCOL P. 25 IF D17=NO, CONTINUE

#3 INTERVIEWER CHECKPOINT: DID S. REPORT ANOTHER EPISODE OF DEPRESSION?		YES (CONTINUE)..... NO (GO TO SECTION E).....
22.	When did (<u>your most recent/last</u>) episode begin in which nearly every day for 2 weeks or more, you felt sad, blue, or depressed, lost all interest and pleasure in things or felt irritable?	DATE ☐☐ ☐☐☐☐ MM YY ☐☐☐☐

23.	How long did this episode last?	# WEEKS.....
24.	Did this episode occur just after someone close to you died or left you?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
25.	During this (most recent/last) episode, did people tell you that you looked sad or "down"?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
26.	During your (most recent/last) episode, was your appetite decreased or increased?	INCREASED ..... 1 DECREASED ..... 2 BOTH INCR & DECR ..... 3 NO CHANGE ..... 4 RF ..... 7 DK 8
27.	During your (most recent/last) episode, did you lose or gain weight?	GAINED ..... 1 LOST ..... 2 BOTH GAINED AND LOST 3 NO CHANGE (GO TO D28) 4 RF (GO TO D28) ..... 7 DK (GO TO D28) 8
	a. How much?	LBS. .....
28.	During your (most recent/last) episode, did you have difficulty sleeping or did you sleep too much?	DIFFICULTY SLEEPING ... 1 SLEEPING TOO MUCH ..... 2 BOTH PROBLEMS..... 3 NEITHER PROBLEM..... 4 RF ..... 7 DK 8
29.	During your (most recent/last) episode, did you feel either slowed down, or restless and fidgety?	SLOWED DOWN ..... 1 RESTLESS AND FIDGETY 2 BOTH PROBLEMS..... 3 NEITHER PROBLEM..... 4 RF ..... 7 DK 8

30.	During your (most recent/last) episode, did you experience low energy, feel tired out, or fatigued?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
31.	During your (most recent/last) episode, did you feel worthless or guilty?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
32.	During your (most recent/last) episode, did you have trouble concentrating, thinking, or making decisions?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
33.	During your (most recent/last) episode, did you have thoughts about death?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
34.	During your (most recent/last) episode, did you have thoughts about suicide?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
35.	Did you tell a doctor about your (most recent/last) episode of depression, loss of interest and pleasure, or irritability?	YES ..... 1 NO ..... 0 RF ..... 7 DK 8
36.	Did you receive treatment for this (most recent/last) episode of depressed mood, clinical depression, or for any of the symptoms we just talked about? Treatment could include counseling, medication, shock treatment, or hospitalization.	YES ..... 1 NO (GO TO D38) ..... 0 RF (GO TO D38) ..... 7 DK (GO TO D38) 8

37.	***What type of treatment?***		YES	NO	RF	DK
		COUNSELING IF YES, SPECIFY OCCUPATION____	1	0	7	8
COUNSELOR:		_____				

_____	MEDICATIONS	1	0	7	8
_ (E.G. PSYCHOLOGIST, BISHOP, SOCIAL WORKER)	ELECTRIC SHOCK	1	0	7	8
	HOSPITALIZED	1	0	7	8
	OTHER _____	1	0	7	8

38.	Were you hospitalized for this (most recent/last) episode of depressed mood or clinical depression for any of the symptoms we just discussed?	YES ..... NO (GO TO E)..... RF (GO TO E) ..... DK (GO TO E).....
	a. (IF HOSPITALIZED) Where was that? (HOSPITAL NAME, CITY, STATE?) HOSPITAL NAME: _____ CITY, STATE:_____ _	
	b. What were the dates of your hospitalization?	ADMIT DATE ..... ⌊⌊⌋⌋ MM YY ⌊⌊⌋⌋⌊⌊⌋⌋
		DISCHARGE DATE ..... ⌊⌊⌋⌋ MM YY ⌊⌊⌋⌋⌊⌊⌋⌋

Appendix E. Ways of Coping Check List (WCCL)

Everyone has an issue or problem in his/her life that he or she has to deal with. We are interested in what that issue is to you. Please list your major problem.

The following items below represent ways that you may have dealt with the major problem you listed above. We are interested in the degree to which you have used each of the following thoughts or behaviors in order to deal with this problem. Please circle one answer for each item.

0 = Never Used; 1 = Rarely Used; 2 = Sometimes Used; 3 = Regularly Used; NA = Non-Applicable

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
1. Bargained or compromised to get something positive from situation.	0	1	2	3	7	999
2. Counted my blessings.	0	1	2	3	7	999
3. Blamed myself.	0	1	2	3	7	999
4. Concentrated on something good that could come out of the whole thing.	0	1	2	3	7	999
5. Kept my	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
feelings to myself.						
6. Figured out whom to blame.	0	1	2	3	7	999
7. Hoped a miracle would happen.	0	1	2	3	7	999
8. Asked someone I respected for advice and followed it.	0	1	2	3	7	999
9. Prayed about it.	0	1	2	3	7	999
10. Talked to someone about how I was feeling.	0	1	2	3	7	999
11. Stood my ground and fought for what I wanted	0	1	2	3	7	999
12. Refused to believe	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
that it had happened.						
13. Criticized or lectured myself.	0	1	2	3	7	999
14. Took it out on others.	0	1	2	3	7	999
15. Came up with a couple of different solutions to my problem.	0	1	2	3	7	999
16. Wished I were a stronger person—more optimistic and forceful.	0	1	2	3	7	999
17. Accepted my strong feelings, but didn't let them interfere with other things	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
too much.						
18. Focused on the good things in my life.	0	1	2	3	7	999
19. Wished that I could change the way that I felt.	0	1	2	3	7	999
20. Changed something about myself so that I could deal with the situation better.	0	1	2	3	7	999
21. Accepted sympathy and understanding from someone.	0	1	2	3	7	999
22. Got mad at the people or things that caused	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
the problem.						
23. Slept more than usual.	0	1	2	3	7	999
24. Spoke to my clergyman about it.	0	1	2	3	7	999
25. Realized I brought the problem on myself.	0	1	2	3	7	999
26. Felt bad that I couldn't avoid the problem.	0	1	2	3	7	999
27. I knew what had to be done, so I doubled my efforts and tried harder to make things work.	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
28. Thought that others were unfair to me.	0	1	2	3	7	999
29. Daydreamed or imagined a better time or place than the one I was in.	0	1	2	3	7	999
30. Tried to forget the whole thing.	0	1	2	3	7	999
31. Got professional help and did what they recommended.	0	1	2	3	7	999
32. Changed or grew as a person in a good way.	0	1	2	3	7	999
33. Blamed others.	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
34. Went on as if nothing had happened.	0	1	2	3	7	999
35. Accepted the next best thing to what I wanted.	0	1	2	3	7	999
36. Told myself things could be worse.	0	1	2	3	7	999
37. Talked to someone who could do something concrete about the problem.	0	1	2	3	7	999
38. Tried to make myself feel better by eating, drinking, smoking, taking medications, etc.	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
39. Tried not to act too hastily or follow my own hunch.	0	1	2	3	7	999
40. Changed something so things would turn out right.	0	1	2	3	7	999
41. Avoided being with people in general.	0	1	2	3	7	999
42. Thought how much better off I am than others.	0	1	2	3	7	999
43. Had fantasies or wishes about how things might turn out.	0	1	2	3	7	999
44. Just took things one-step at a time.	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
45. Wished the situation would go away or somehow be finished.	0	1	2	3	7	999
46. Kept others from knowing how bad things were.	0	1	2	3	7	999
47. Found out what other person was responsible.	0	1	2	3	7	999
48. Thought about fantastic or unreal things (like the perfect revenge or finding a million dollars).	0	1	2	3	7	999
49. Came out of the experienc	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
e better than I went in.						
50. Told myself how much I have already accomplished.	0	1	2	3	7	999
51. Wished that I could change what had happened.	0	1	2	3	7	999
52. Made a plan of action and followed it.	0	1	2	3	7	999
53. Talked to someone to find out about the situation.	0	1	2	3	7	999
54. Avoided my problem.	0	1	2	3	7	999
55. Relied on faith to	0	1	2	3	7	999

THOUGHTS/ BEHAVIORS	NEVER	RARELY	SOME-TIMES	REGU-LARLY	REFUSED	NOT APPLIC-ABLE
get me through.						
56. Compared myself to others who are less fortunate.	0	1	2	3	7	999
57. Tried not to burn my bridges behind me, but left things open somewhat.	0	1	2	3	7	999

	NOT INVOLVED	NOT VERY INVOLVED	SOMEWHAT INVOLVED	VERY INVOLVED
58. To what extent is your religion involved in understanding or dealing with stressful situations in any way?	0	1	2	3

Appendix F. Qualitative Interview

INSTRUCTIONS:

As part of the Memory Study, we are conducting a smaller related study that seeks to better understand the process of aging and how people adjust to life changes and cope with life events and the experience of getting older. We want to see, not from a medical point of view, but from a 'life experience' point of view, what we can learn about these things so we will conduct this interview more like a conversation than a formal interview. Please answer the following questions as fully as possible. Let me know if there is anything that I ask that is unclear or confusing to you. Do you have any questions before we begin?

INTERVIEW:

1. First, please tell us a little bit about yourself and your life as it is right now.

Probes: Tell me about your family. Tell me about your hobbies, how you spend your time in a typical day.

2. What are the significant life changes that you have experienced over the past couple decades?

Probes: Bereavement [have you lost anyone close to you?]
Health changes [have there been any significant changes in your health]
Functional decline [are you less able to do some of the things you used to do, such as exercise, get around on your own, drive, etc.?]
Other probes: chronic pain, financial changes, cognitive changes

3. How have these life changes affected your enjoyment of life? Which changes were particularly difficult to deal with? To what extent has any of these life changes affected your ability to carry out day-to-day activities, such as housework, shopping, managing your finances?

4. When you think of how active you used to be, what impact have these experiences had on your ability to live your life to the fullest? What impact has there been on your interest and ability to get out socially with friends and family?

5. Who or what do you turn to for help in coping with life challenges?

Probes: How about family members, friends, religion, meditation, spiritual counselor, exercise, entertainment, pets?

6. How helpful are family and friends when you need them? To what extent do you feel that they really understand what you're going through?

7. As you think about these life changes, are there any benefits or personal growth opportunities for you that have resulted from these experiences? What would they be?

8. How do you view the meaning or purpose of the rest of your life?

The next questions focus more on the recent past and the present.

9. How would you describe your mood or emotions in the past few weeks?

10. To what extent, if any, have you or your family noticed that you seem less interested in things that you used to enjoy doing?

NOTE: If subject reports some loss of interest, ask Questions 11 and 12. If he/she reports no loss of interest, then skip to Question 13.

11. Have you pulled away from any of your regular activities because of lack of interest or motivation? How have you and your family dealt with these changes?

12. Have you thought about talking to your doctor or some other professional about these changes in your interest in activities or your motivation to do them?

13. What are your beliefs about seeking help from others for feelings of sadness, anxiety, lack of interest, or the like? How likely is it that you would reach out to others if/when you feel this way? From whom would you feel comfortable seeking help? Is there any one person who you prefer to talk to about these matters?

Probes: Name them by their relationship to you, i.e. brother, spouse, doctor, church leader, close friend.

14. When you've experienced these types of feelings in the past, how have important people in your life reacted to you? What seem to be their attitudes towards emotional distress? Towards seeking help for feelings of distress or sadness?

15. To what extent have the physical/social/thought changes you've described been the result of the life events and trials you've mentioned? Are there other reasons we haven't discussed that have contributed to these changes?

16. What other aspects of your life, if any, help you cope with life's challenges?

17. Can you describe the ways in which religion, or spirituality help you cope?

Probe: query both private [prayer, scripture study] and public [attending services, serving on church committees] religious activities

18. Have you felt in the last week, even for a fleeting moment, that life is not worth living? Note: If person responds "Yes," follow Suicidality Protocol on Page 7 of this booklet.

19. Tell me a little bit about your relationship with your primary care physician.

Probes: How often do you see him/her?
To what extent do you feel comfortable discussing a new medical problem with him/her?
To what extent can/could you talk with him/her about your mood or feelings of anxiousness or sadness?
If you are unable to talk with your primary care doctor about your mood or feelings, please explain why.

20. Have you actually talked to him/her about these things? How did he/she respond? Was s/he helpful? To what extent did the doctor give you enough time/attention to talk about these issues? Is there anyone else in the doctor's office with whom you could talk about these things? If you haven't talked with your physician about these issues, what do you think s/he would say? Would there be any suggestions or treatments you think he'd be able to offer? In your opinion, how likely is it that these treatments would be helpful?

21. We've talked about some of the struggles and trials you've had because of life changes. What are some of the happy experiences you've had in your life that you can reflect back on and receive joy thinking about or are still doing? Are there any new activities that you've taken up recently that you enjoy?

Probe: if person doesn't mention anything positive, remind him/her of the accomplishments revealed in the above questions such as raising a family, career successes, etc.

22. You've made it through many life challenges. Do you have anything you'd like to share that is a formula for a living a good life?

23. Is there any issue related to these questions that you would like to tell us more about, perhaps something we didn't mention or ask, or something that you would like to add that would help us better to understand your situation?

Appendix G. Qualitative Coding Scheme

Qualitative Coping Scheme

****

(1) /demographics

*** Description:

demographic info on participants

This node codes 0 documents.

****

(1 1) /demographics/gender

*** Description:

male or female participant

This node codes 0 documents.

****

(1 1 1) /demographics/gender/male

*** Description:

male participant

This node codes 34 documents.

****

(1 1 2) /demographics/gender/female

*** Description:

Participant is female.

This node codes 47 documents.

****

(1 2) /demographics/age

*** Description:

age by 5 year increments

This node codes 0 documents.

****

(1 2 1) /demographics/age/below 80

*** Description:

respondent is less than 80 years old

This node codes 40 documents.

****

(1 2 2) /demographics/age/80 and above

*** Description:

respondent is age 80 or older

This node codes 41 documents.

****

(1 3) /demographics/marital status
*** Marital status of participant
This node codes 0 documents.
****
(1 3 1) /demographics/marital status/married
*** Participant is currently married
This node codes 46 documents.
****
(1 3 2) /demographics/marital status/widowed
*** Participant is currently widowed
This node codes 33 documents.
****
(1 3 3) /demographics/marital status/divorced
*** Participant is currently divorced
This node codes 2 documents.
****
(1 4) /demographics/DepScore
*** Combined CESD and DIS scores imported.
This node codes 0 documents.
****
(1 4 1) /demographics/DepScore/YES
*** Combined CESD and DIS scores imported. Participants that indicated depression in one or both were coded as Yes for depression.
This node codes 18 documents.
****
(1 4 2) /demographics/DepScore/NO
*** Combined CESD and DIS scores imported. Participants that indicated no depression on both measures.
This node codes 21 documents.
****
(1 5) /demographics/Qual Depression
*** Qualitative endorsement of or no depression.
This node codes 0 documents.
****
(1 5 1) /demographics/Qual Depression/YES
*** Those that indicated at least one depressive symptom throughout the interviews.
This node codes 23 documents.

****
(1 5 2) /demographics/Qual Depression/NO
*** Participants that did not report any depressive symptoms throughout the interviews.
This node codes 17 documents.
****
(1 6) /demographics/CESD
*** Imported CESD results
This node codes 1 document.
****
(1 6 1) /demographics/CESD/YES
*** Participants that scored above 16 on the CESD scale
This node codes 14 documents.
****
(1 6 2) /demographics/CESD/NO
*** Participants that scored below 16 on the CESD scale
This node codes 25 documents.
****
(1 7) /demographics/DIS
*** Imported DIS results
This node codes 0 documents.
****
(1 7 1) /demographics/DIS/YES
*** Participants that endorsed either sadness or lack of interested and then also at least 5 other depressive symptoms.
This node codes 10 documents.
****
(1 7 2) /demographics/DIS/NO
*** Those that did not meet the criteria for major or minor depression.
This node codes 29 documents.
****
(2) /Life Challenges
*** What are the challenges that older adults experience with old age?
This node codes 0 documents.
****
(2 1) /Life Challenges/Loss
*** Loss of close individual(s) through death or other problem.

This node codes 36 documents.
****
(2 1 1) /Life Challenges/Loss/lonliness
*** Those that felt lonely due to the loss of someone special
This node codes 3 documents.
****
(2 2) /Life Challenges/Health
*** Significant health problems that older adults find hard to deal with.
This node codes 37 documents.
****
(2 2 1) /Life Challenges/Health/Pain
*** Those the felt pain as a result of health problems
This node codes 4 documents.
****
(2 2 2) /Life Challenges/Health/Loss of autonomy
*** Those that lost their sense of autonomy as a result of health problems
This node codes 5 documents.
****
(2 2 3) /Life Challenges/Health/Anxiety and depression
*** Participants that became anxious or depressed because of health problems
This node codes 2 documents.
****
(2 2 5) /Life Challenges/Health/Multiple Health Problems
*** Those that suffered multiple health problems.
This node codes 12 documents.
****
(2 2 6) /Life Challenges/Health/Optimistic about Health
*** Those that felt optimistic that they would get better.
This node codes 2 documents.
****
(2 3) /Life Challenges/Daily life
*** Ease of daily life. How able they are in carrying out day-to-day activities. Inability to do certain things that used to bring joy.
This node codes 36 documents.
****
(2 3 6) /Life Challenges/Daily life/Retirement

*** Retirement caused problems in daily life.
Cut from node (2 6). The effect retirement has/had on their life.
This node codes 6 documents.
****

(2 4) /Life Challenges/Memory Changes
*** How much memory loss they have experienced and problems that may arise because of it.
This node codes 25 documents.
****

(2 5) /Life Challenges/Financial Changes
*** The problems they experience due to their financial situation.
This node codes 21 documents.
****

(2 7) /Life Challenges/Old Age
*** Older adults who struggle with aging in and of itself.
This node codes 6 documents.
****

(2 8) /Life Challenges/Family Problems
*** Participants that expressed concern over problems in their family
This node codes 10 documents.
****

(3) /Mood/Depression
*** What are the symptoms, occurrence and causes of depression?
This node codes 0 documents.
****

(3 1) /Mood/Depression/Depressive Symptoms
*** How do older adults experience depression in old age.
This node codes 0 documents.
****

(3 1 1) /Mood/Depression/Depressive Symptoms/Emotional
*** Includes feelings of hopelessness, worthlessness, sadness, fear, and anger. Expressed by individuals who are gloomy, dejected, and despondent. Anhedonia, which is a loss of pleasure from life.
This node codes 27 documents.
****

(3 1 1 1) /Mood/Depression/Depressive Symptoms/Emotional/Feelings
*** Sadness endorsed by the participant

This node codes 20 documents.

****

(3 1 1 2) /Mood/Depression/Depressive Symptoms/Emotional/Loss of Interest

*** Participants that suffered a loss of interest in things that used to bring pleasure

This node codes 18 documents.

****

(3 1 2) /Mood/Depression/Depressive Symptoms/Cognitive

*** Experience may include slowed thinking processes and abilities, lack of concentration, and high distractibility. They may focus their attention on the negative aspects of themselves

This node codes 0 documents.

****

(3 1 3) /Mood/Depression/Depressive Symptoms/Somatic

*** Physical problems without a medical cause, include disturbances in sleep patterns, fatigue, bodily pains, and appetite changes.

This node codes 2 documents.

****

(3 1 4) /Mood/Depression/Depressive Symptoms/Behavioral

*** Behavioral manifestations of depression. Includes slowed movement and speech.

This node codes 4 documents.

****

(3 1 5) /Mood/Depression/Depressive Symptoms/Anxiety

*** Anxious thoughts and behaviors. Comorbid with depression.

This node codes 4 documents.

****

(3 1 6) /Mood/Depression/Depressive Symptoms/Suicide Ideation

*** They admit to thoughts about suicide.

This node codes 11 documents.

****

(3 2) /Mood/Depression/Time Frame

*** Experience of mood or depression in the past and in the present.

This node codes 0 documents.

****

(3 2 1) /Mood/Depression/Time Frame/Past

*** Expression of depressive symptoms in the past.

This node codes 2 documents.

****

****

(3 2 1 1) /Mood/Depression/Time Frame/Past/Yes
*** Expression of depressive symptoms in the past.

This node codes 11 documents.
****

****

(3 2 1 2) /Mood/Depression/Time Frame/Past/No
*** No Expression of depressive symptoms in the past.
This node codes 2 documents.
****

****

(3 2 2) /Mood/Depression/Time Frame/Present
*** Current expression of depressive symptoms.
This node codes 6 documents.
****

****

(3 2 2 1) /Mood/Depression/Time Frame/Present/Yes
*** Expression of depressive symptoms in the present
This node codes 18 documents.
****

****

(3 2 2 2) /Mood/Depression/Time Frame/Present/No
*** No Expression of depressive symptoms in the present
This node codes 12 documents.
****

****

(3 4) /Mood/Depression/Depression
*** All depressive coding together
This node codes 36 documents.
****

****

(4) /Coping
*** How do older adults cope with perceived life challenges?
This node codes 0 documents.
****

****

(4 1) /Coping/Help-Seeking
*** What are older adults' beliefs about seeking help from others to cope with life's challenges? How do they seek help?
This node codes 0 documents.
****

****

(4 1 1) /Coping/Help-Seeking/Beliefs
*** Do they have positive or negative views about seeking help in general?

This node codes 0 documents.
****
****

(4 1 1 1) /Coping/Help-Seeking/Beliefs/Positive B
*** Older adults who are comfortable with and want to get help from others.
This node codes 21 documents.
****
****

(4 1 1 2) /Coping/Help-Seeking/Beliefs/Negative B
*** Those who do not want to get help from others and want handle problems on their own.
This node codes 24 documents.
****
****

(4 1 2) /Coping/Help-Seeking/From Whom
*** Who do older adults seek help from?
This node codes 0 documents.
****
****

(4 1 2 1) /Coping/Help-Seeking/From Whom/Family
*** Participants seek help from family
This node codes 36 documents.
****
****

(4 1 2 1 1) /Coping/Help-Seeking/From Whom/Family/Children
*** Participants seek help from children
This node codes 20 documents.
****
****

(4 1 2 1 2) /Coping/Help-Seeking/From Whom/Family/Spouse
*** Participants seek help from spouse
This node codes 12 documents.
****
****

(4 1 2 1 3) /Coping/Help-Seeking/From Whom/Family/Other Family
*** Participants seek help from siblings and other family members
This node codes 9 documents.
****
****

(4 1 2 2) /Coping/Help-Seeking/From Whom/Friends
*** Participants seek help from friends
This node codes 19 documents.
****
****

(4 1 2 3) /Coping/Help-Seeking/From Whom/Clergy/Church

*** Participants seek help from clergy
This node codes 11 documents.
****
(4 1 2 4) /Coping/Help-Seeking/From Whom/Physician
*** Participants seek help from physicians
This node codes 11 documents.
****
(4 1 3) /Coping/Help-Seeking/How/Why
*** How do older adults seek help? And why do they seek help?
This node codes 0 documents.
****
(4 1 3 1) /Coping/Help-Seeking/How/Why/Instrumental
*** Those who seek help for goods or help with a particular problem.
This node codes 3 documents.
****
(4 1 3 2) /Coping/Help-Seeking/How/Why/Emotional
*** Those who seek help to express emotions to get comfort.
This node codes 9 documents.
****
(4 1 3 3) /Coping/Help-Seeking/How/Why/Indirectly Seek Help
*** Participants that engage in interactions to indirectly get help
This node codes 3 documents.
****
(4 1 4) /Coping/Help-Seeking/Understanding
*** The extent to which older adults feel that others understand what they go through.
This node codes 0 documents.
****
(4 1 4 1) /Coping/Help-Seeking/Understanding/Yes
*** Those who felt others understand what they go through.
This node codes 15 documents.
****
(4 1 4 2) /Coping/Help-Seeking/Understanding/No
*** Those who did not feel others understand what they go through.
This node codes 14 documents.
****
(4 1 4 3) /Coping/Help-Seeking/Understanding/Both

*** Some understand, some don't.
This node codes 8 documents.
****
****

(4 1 5) /Coping/Help-Seeking/Availability
*** Extent to which family and friends are there when they need them.

This node codes 1 document.
****
****

(4 1 5 1) /Coping/Help-Seeking/Availability/Yes
*** Those who felt family and friends are there when they need them.
This node codes 18 documents.
****
****

(4 1 5 2) /Coping/Help-Seeking/Availability/No
*** Those who did not feel family and friends are there when they need them.
This node codes 3 documents.
****
****

(4 2) /Coping/Religion
*** The ways that older adults use religion to cope with life challenges.
This node codes 32 documents.
****
****

(4 2 1) /Coping/Religion/Spirituality/Meditation
*** Those that use meditation, spirituality and prayer through religion to cope.
This node codes 26 documents.
****
****

(4 2 2) /Coping/Religion/Support System
*** Those that use a support system from religion, clergy, visiting teachers, etc.
This node codes 4 documents.
****
****

(4 2 3) /Coping/Religion/Eternal Perspective
*** Those that coped by putting things into an eternal perspective
This node codes 5 documents.
****
****

(4 2 4) /Coping/Religion/Activities/Responsibility
*** Those that coped through the activities and responsibility they had at church
This node codes 7 documents.
****
****

(4 3) /Coping/Reframing
*** Positive perspective on life challenges as a way to cope.
This node codes 24 documents.
****
(4 4) /Coping/Activities
*** Being involved and participating in activities or hobbies as a way to cope with life challenges.
This node codes 27 documents.
****
(4 4 1) /Coping/Activities/Social Activities
*** Social support outside of looking for for help. Recreational activities with other people.
This node codes 8 documents.
****
(4 4 2) /Coping/Activities/Work
*** Involvement in work
This node codes 6 documents.
****
(4 4 3) /Coping/Activities/Hobbies
*** Involvement in activities
This node codes 18 documents.
****
(4 4 4) /Coping/Activities/Service
*** Involvement in services and volunteer work
This node codes 10 documents.
****
(4 4 5) /Coping/Activities/Exercise
*** Using exercise as a way to cope.
This node codes 5 documents.
****
(4 4 6) /Coping/Activities/Entertainment
*** Using entertainment as a way to cope
This node codes 5 documents.
****
(4 5) /Coping/"Just Deal With It"
*** The idea that challenges should "just be dealt with" at a personal level. Includes meditation and cognitive coping strategies.

This node codes 23 documents.
****
(4 6) /Coping/Medication
*** Medications prescribed for depression and/or anxiety.
This node codes 15 documents.
****
(4 8) /Coping/Other
*** Exercise, Food, Alcohol, or Pets.
This node codes 15 documents.
****
(4 8 1) /Coping/Other/Pets
*** Those that gain comfort from pets
This node codes 4 documents.
****
(4 8 2) /Coping/Other/Food/Alcohol
*** Those that used food or alcohol for coping
This node codes 7 documents.
****
(4 9) /Coping/Problem Focused
*** Those that engaged in behaviors for coping
This node codes 4 documents.
****
(4 10) /Coping/Wishful Thinking
*** Those that wished things were different from how they are currently
This node codes 9 documents.
****
(5) /Purpose of Life
*** Older adults' beliefs about the meaning and purpose of the rest of their life.
This node codes 0 documents.
****
(5 1) /Purpose of Life/Positive
*** Positive and goal-oriented views on the purpose of the rest of their life.
This node codes 19 documents.
****
(5 1 1) /Purpose of Life/Positive/Project
*** A project that the older adult wants to finish before they die. (Ex. geneology, life

history)
This node codes 4 documents.
****
****
(5 1 2) /Purpose of Life/Positive/Optimistic
*** Things will be good. Thankful for Life.
This node codes 6 documents.
****
****
(5 1 3) /Purpose of Life/Positive/Endure
*** Continue to live a good life. Includes the religious idea of "enduring to the end" and being rewarded later.
This node codes 6 documents.
****
****
(5 1 4) /Purpose of Life/Positive/Heritage
*** Those that were positive because they enjoyed passing on their heritage
This node codes 3 documents.
****
****
(5 2) /Purpose of Life/Negative
*** Negative and unfocused views on the purpose of the rest of their life.
This node codes 9 documents.
****
****
(5 2 1) /Purpose of Life/Negative/Fear
*** Fear of death or losing physical or mental abilities
This node codes 1 document.
****
****
(5 2 2) /Purpose of Life/Negative/Alone
*** Older Adult feels alone.
This node codes 1 document.
****
****
(5 2 3) /Purpose of Life/Negative/responsibility
*** The participant personally does not want to live, but lingers due to some responsibility.
This node codes 3 documents.
****
****
(5 2 4) /Purpose of Life/Negative/other
*** Other negative reasons
This node codes 1 document.
****

****

(5 2 5) /Purpose of Life/Negative/No purpose
*** They have no purpose
This node codes 4 documents.
****

(5 3) /Purpose of Life/Neutral
*** Neutral beliefs about the meaning and purpose of the rest of their life.
This node codes 7 documents.
****

(5 4) /Purpose of Life/N/A
*** Older adults who did not give a meaning or purpose to their life or avoided the question.
This node codes 4 documents.
****

(6) /Mechanisms
*** This codes the overarching approaches to coping, compiled from previous coping mechanisms.
This node codes 26 documents.
****

(6 1) /Mechanisms/Emotion-Focused
*** Mechanisms that were cognitive or emotional approaches
This node codes 38 documents.
****

(6 2) /Mechanisms/Problem Focused
*** Mechanisms that were behavioral approaches
This node codes 21 documents.
****

(6 3) /Mechanisms/Avoidance
*** Mechanisms that were avoidant approaches, included activities.
This node codes 27 documents.