Psychological Assessment Tools for Older People with Depression: A Literature Review

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Depression was found to be the most common psychological problem among older people (Chen, 2000; Ebersole & Hess, 2001; Lueckenotte, 2000). Many of the emotional and physical aspects of ageing increase the prevalence of depression, such as: gender, physical disablement and dissatisfaction with life (Copeland et al., 1999). Depression has been accounted of the commonest and the most reversible mental health problem in old age and affects 10~15% of the population over 65 in the United Kingdom. There were strong links between the number of deficits in an older person's social support, regardless of life events and depression (Prince, Harwood, Blizard, Thomas, & Mann, 1997). In Macau, the incidence of older people with depression in community was found to be 12.37% in Ning's study (2001) using Centre for Epidemiological Studies Depression Scale (CES-D) with cut-off point of 16. Another study by Li (2003) found that it was 53.1% for the older people in elderly day centres using GDS-30 with cut-off point of 11. In the Macau Government health statistics (2006) the incidence was 10.4% using GDS-15 with cut-off point of 8.

Depression is a serious negative emotion. It is a dysphoric mood and withdrawal of life interest, lack of motivation, loss of vital energy and feelings of hopelessness. Indeed, if left untreated, depression can result in high morbidity and mortality rates (Anderson, 2001). Depression carries an increased risk of death, both from natural causes and from suicide and "depression is the most important psychiatric condition associated with successful and attempted suicide in old age" (Anderson, 2001, p. 13). The suicide rate is high at 60% and the mortality rate is high at 15% (Chen, 2000). It threatens the older people's life, but in primary care it is frequently under-detected and usually untreated (Orrell, Scurfield, Cloke, & Renshaw, 2000). The reasons included: the widespread belief that depression is normal or expected with ageing, conscious under reporting or denial of symptoms by patients due to shame or stigma, and symptoms of depression in late life may be atypical (Blazer, 1993). Therefore, the comprehensive psychological assessment for older people with depression will pose considerable challenges and incur substantial debate. This article reviews the use of three common psychological assessment tools including the Geriatric Depression Scale (GDS-15), the 36-item Short-Form Health Survey of Quality of Life (SF-36QoL) and the Lubben Social Network Scale (LSNS) for older people with depression through current literatures.

1. The Geriatric Depression Scale (GDS-15)

The Geriatric Depression Scale (GDS) is perhaps the most widely used instrument for assessing depression in elderly persons and for diagnostic screening in clinical and community setting (Liu et al., 1997; Osborn et al., 2002). The GDS was developed in response to the recognition that depression scales developed on younger or the general population which might not be the most ideal for use in the elderly population. For example, somatic complaints of depression are confounded with the general physiological effects of ageing, and issues surrounding hope and suicide are difficult to interpret for people approaching the end of their lives. To construct the GDS, 30 items were chosen from an initial pool of 100 items on the basis of corrected item-total correlations. None of the initial items tapping somatic problems and suicide thoughts were selected due to their lower item-total correlations. All items were answered on a yes/no basis to suit the information-processing capacity of older people in general (Brink et al., 1982; Yesavage et al., 1983).

Later on, 15 items, which had the highest correlations with the number of depressive symptoms assessed clinically in the validation sample, were further chosen from the 30-item pool to form the GDS-15 (Sheikh and Yesavage, 1986). The full GDS and its 15-item version have been translated and validated in Chinese elderly populations (Chan, 1996; Chiu et al.,

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1994; Lee et al., 1993) as well as in other cultural groups (Mui, Burnette, and Chen, 2001). Evidence suggests that the GDS is applicable to the very old people (De Craen, Heeren, and Gussekloo, 2003) as well as the elderly persons with mild-to-moderate cognitive impairment (Feher, Larrabee, and Crook, 1992).

Brink et al. (1982) and Sheikh and Yesavage (1986) suggested a threshold of 11 points for the GDS-30 and 6 points for the GDS-15 as indicative of clinically significant depression. In their validation study in Hong Kong's Chinese elderly, Chiu, et al. (1994) and Lee et al. (1993) recommended the cut-offs point of 15 (GDS-30) and 8 (GDS-15) instead.

2. The 36-item Short-Form Health Survey of Quality of Life (SF-36QoL)

The definitions of quality of life have changed according to the study and perceptions of the individual. For older people, quality of life refers not just to health and well being but encompasses social support, relationships with family and lifestyle (Farquhar, 1995). Similarly, Dwyer, Gray and Renwick (2000) identified six factors which indicated a positive quality of life including adequate income, good health, social contacts, sense of security, self-management and a respected position within the community. These six factors were closely related to the older people with high self-esteem and a positive outlook. Positive quality of life of the older people and particularly the independence is supported by current health policy and initiatives as an integral part of ageing.

While perceived health is an important indicator of quality of life, studies have shown that anxiety and depression are also important determinants (Sullivan, Kempen, Van Sonderen, & Ormel, 2000). Poor quality of life could be countered by positive social networks, which are proven to be effective buffers of stress or anxiety, while loneliness and depression can potentially be avoided. The quality of social support in particular, appears to play a large part in an older person's perception of life satisfaction. Positive social support can benefit a person during times of stress and take on a buffering effect but it can also enhance an activity if shared with another person, like taking a walk or cooking for another person (Sommer, 1990). This can impart an older person with a pleasurable or positive experience and additionally can provide a 'therapeutic effect, counterbalancing negative events and experiences' (Sommer, 1990, p. 46). Alternatively, a lack of social support can inhibit an older person's opportunity to participate in activities, as many activities lack the pleasure or intensity without another person (Sommer, 1990). Furthermore, a reluctance to take part in the community can have detrimental effects to a person's health, well-being and life satisfaction.

Quality of life is greatly affected by social support and positive social networks. They are the important predictors of good physical and mental health, life satisfaction, and reduced risk of institutionalization among older adults (Potts, 1997).

The 36-Item Short Form health Survey (SF-36) developed by (Ware, Snow, Kosinski, & Gandek, 1993) in the United States is gaining international popularity. It consists of 36 items that grouped under 11 questions. The scores of the 36 items are summated into eight multi-item scales: physical functioning (PF), limitations due to physical health problems (role-physical; RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), limitations due to emotional health problems (role-emotional; RE), and metal health (MH) and one single-item scale on health transition. The SF-36 usually takes about 5 to10 minutes to complete, although older people may require up to 15 minutes (McDowell & Newell, 1996). Not all instruments are suitable for both self-administration and telephone interview, but the SF-36 was developed to be consistent in either mode (McDowell & Newell, 1996; McHorney, Kosinski, & Ware, 1994). The SF-36 is composed of eight scales, each of which has 2 to 10 items. The internal consistency reliability of the scales in the English version SF-36 (Cronbach alpha) has generally exceeded .80 in studies (McHorney, Ware, Lu, & Sherbourne, 1994) and construct validity has been established by comparison with other health surveys (Ware, Kosinski, & Keller, 1994). Scores on the SF-36 scales are transformed to a 0 to 100 scale, with higher scores indicating better health status.

The SF-36QoL has been translated and tested in

more than 40 countries and normed in 12 countries. Ren et al. (1998) developed and tested a Chinese version of the SF-36QoL on Chinese Americans and Lam et al. (1998, 1999, 2003) developed, tested and normed a Chinese (HK) version of SF-36QoL on Chinese living in Hong Kong. The SF-36QoL Chinese version has also been tested and normed in mainland China (Li et al., 2001; Liu et al., 2001).

3. Lubben Social Network Scale (LSNS)

Indicators of an older adult's social health should be as much a part of the geriatric assessment protocols as are mental and physical health markers. An abbreviated social support network scale can readily be incorporated into a geriatric assessment battery allowing clinicians to gather social health information in a systematic manner and in a relatively short period of time. From this, they can readily share this knowledge with other team members in quantifiable, measurable terms. Also, the systematic use of such scale facilitates a more accurate description of aspects of social network and social support that may require tailored interventions. Additionally, global scales that quantify an older person's social environment might also be useful for monitoring systematic changes over time. Expanded use of social support network measurement tools in geriatric practice will enhance community care and appropriate referral to such programs as respite care, peer support or counselling.

The use of such assessment tools may also increase attention of the elderly person to his/her own social health. An older person might be encouraged by the nature of inquiry contained in these scales to evaluate or identify (on their own) areas of weakness in social network or areas of strength or potential resources. Short assessment tools can be used as health promotion screeners to identify cases of social isolation or loneliness. A good assessment of one's social support network will prove useful as an initial indicator of risk for isolation and loneliness that might otherwise go undetected.

To address the need for a relatively brief measure kin and non-kin social ties, the LSNS-Revised is presented.

The LSNS has been used in a wide array of studies since it was first reported a decade ago (Ceria, et al., 2001; Chou & Chi, 1999; Martire, Schulz, Mittelmark & Newsom, 1999; Lubben & Gironda, 1997; Okwumabua, Baker, Wong & Pilgrim, 1997; Mor-Barak, 1997; Dorfman, et al., 1995; Luggen & Rini, 1995; Rubenstein, L. et al., 1994; Rubenstein et al., 1994; Hurwicz & Berkanovic, 1993; Potts, et al., 1992; Mor-Barak & Miller, 1991; Mor-Borak & Miller, 1991; Lubben, Weiler, & Chi, 1989; Lubben, 1988). It has been used in both research and practice settings. It has been translated into several languages including Chinese, Korean, Japanese, and Spanish; for use in cross-cultural and cross-national comparative studies. Recently, Lubben and associates (Lubben, Gironda & Lee, in press) published the revision of the original LSNS (LSNS-R), a twelve item measure of social ties, that offers enhanced administrative and psychometric properties over the original LSNS.

4. Conclusion

Based on the research that used psychological assessment tools in older people with depression, it is clear that GDS, SF-36, and LSNS are the well validated instruments in various geriatric populations. It is important to apply comprehensive tools to assess older people with depression. The comprehensive assessment tools can help to detect the depression of older people. Also the three assessment tools can be used to identify different aspects of psychological changes of older people with depression and reflect the effect of interventions.

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