



Research paper

Trajectories of depressive symptoms in community-dwelling older adults: A six-month longitudinal study with monthly assessment

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ABSTRACT

Background: This study aimed to examine six-month trajectories of depressive symptoms and their predictors for community-dwelling older adults. Innovations included monthly assessments, examination of non-linear trajectories, and inclusion of coping styles as predictors.

Method: Data were derived from a six-month longitudinal study of 144 community-dwelling older adults with depressive symptoms (Short-Geriatric Depression Scale [S-GDS] ≥ 5) with seven waves of data. Descriptive analyses and individual growth curve modeling were conducted.

Results: The majority of participants changed symptom levels over time; most participants with severe symptoms at baseline remained at least mildly depressed at six months. Younger participants were more depressed at baseline and improved slightly more than older participants. Those who used more active and emotional support coping had faster improvement and maintained gains, whereas those who used less of these coping styles demonstrated worse symptoms over the six-month follow-up period.

Limitations: The most significant limitations are the convenience sampling methods and relatively small sample size, although the large number of assessments (7 waves) increases precision of the statistical methods used.

Conclusions: Findings suggest that it may be beneficial to target interventions to older adults with more severe depressive symptoms and who display low levels of active and emotional support coping. Behavioral interventions that improve these coping styles may help depressed older adults recover and maintain treatment gains over time.

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1. Introduction

The longitudinal course of depressive symptoms varies across older adults, although they are persistent for many and associated with harmful outcomes. Major depressive disorder (MDD) is often chronic for older adults (Mackenzie et al., 2014); likewise, of those with milder depressive symptoms, 8–10% will convert to MDD in a given year, and the vast majority (median = 73% across epidemiological studies) will remain symptomatic (Meeks et al., 2011). Both MDD and milder depressive symptoms are risk factors for morbidity, mortality (Cuijpers et al., 2013), and increased healthcare costs (Meeks et al., 2011; Unützer et al., 2009).

Longitudinal, epidemiological research with older adults who report depressive symptoms at baseline has identified a variety of trajectories and their predictors. Many older adults will experience a persistent or chronic course, with estimates ranging from 23% to

34% across studies. Many others (17–37%) will experience a fluctuating trajectory, with symptoms waxing and waning over time (Beekman et al., 2002; Gallagher et al., 2013; Geerlings et al., 2000; Lippa et al., 2012). Older adults are more likely to remain depressed over time than to improve if they have more severe depressive symptoms or a more chronic history of depression (Beekman et al., 2002; Gallagher et al., 2013; Lippa et al., 2012), worse physical health (Andreescu et al., 2008; Geerlings et al., 2000; Kuchibhatla et al., 2012; Mackenzie et al., 2014), more functional limitations (Andreescu et al., 2008; Beekman et al., 2002; Gallagher et al., 2013; Geerlings et al., 2000), experience more stressful life events (Gallagher et al., 2013; Kuchibhatla et al., 2012), and have less social support (Beekman et al., 2002). Some studies found that women are more likely to remain depressed than men (Andreescu et al., 2008; Gallagher et al., 2013), although not all studies find a gender relationship (Geerlings et al., 2000). Chronic and fluctuating courses have even been linked to mortality (approximately 70% and 75% survival rates over 3 years, respectively, vs 90% survival rate for those who had improved or

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were not depressed initially; Geerlings et al., 2002).

These findings are derived from population-based, longitudinal studies with two to eight waves of data spanning up to 25 years. These studies tended to either examine linear trends in depressive symptoms (e.g., remain stable, worsen, improve; Andreescu et al., 2008; Kuchibhatla et al., 2012) or categorize participants into groups based on cutoff scores or diagnoses (e.g., persist, remit, recur, intermittent; Beekman et al., 2002; Gallagher et al., 2013; Geerlings et al., 2000; Luppá et al., 2012; Mackenzie et al., 2014). Although this research provides valuable information about the long-term course of depressive symptoms and risk factors for persistence, a study design with multiple waves in a shorter period of time allows us to investigate fluctuations and non-linear trends in a time frame that might be amenable to intervention.

Our research team conducted a six-month longitudinal study with community-dwelling older adults who had mild to severe depressive symptoms at baseline, with seven waves of data collected over monthly intervals (N=144; Gum et al., 2011). In prior analyses, 31% of the variability in depressive symptoms over the course of the study was accounted for by month-to-month fluctuations within persons (Dautovich et al., 2014), suggesting the possibility of a variety of linear and non-linear trajectories. We also assessed a potential predictor of trajectories – coping styles. A substantial body of research documents that people are more likely to experience depressive symptoms and distress if they respond to stressful situations by using coping strategies such as avoidance and disengagement, as opposed to active, engaged coping styles such as problem-solving, seeking social support (instrumental and emotional), and managing emotions (Carver and Connor-Smith, 2010). Although no longitudinal studies were identified that examined whether coping predicted depression trajectories, one study of primary care patients (mixed ages) found that those with low mastery were more likely than those with higher mastery to experience recurrence of depression over a 12-year follow-up period (Patten et al., 2010).

In summary, our goal was to extend prior longitudinal research on depressive symptom trajectories in older adults, by examining: a) monthly fluctuations and non-linear trends within an intermediate time frame; and b) coping styles as predictors of trajectories, along with predictors identified in previous studies. We hypothesized that participants would be more likely to show improvements in depressive symptoms over time (versus a more stable, chronic trajectory) if they did not meet criteria for a major depressive episode (an indicator of severity); did not perceive a mental health problem or need for treatment (also an indicator of severity); had less disability; and used more engaged, active coping styles (i.e., more active coping, less behavioral disengagement, more emotional support coping, and more instrumental support coping). We also included other covariates but did not have specific hypotheses based on prior theory or research (age, gender, race/ethnicity, stressful life events). We did not expect stressful life events to differentiate among trajectories, given prior analyses from our dataset that found stressful life events to predict depressive symptoms concurrently but not a month later (Dautovich et al., 2014). Moreover, we did not have specific hypotheses regarding predictors of fluctuating trajectories, based on the paucity of research examining non-linear trends.

2. Methods

2.1. Sample

Data for the current study were derived from a six-month longitudinal, convenience sample of 144 community-dwelling older adults with depressive symptoms (Gum et al., 2011).

Participants met the following inclusion/exclusion criteria: a) age ≥ 65 ; b) English-speaking; c) score of ≥ 5 on the Short-Geriatric Depression Scale (S-GDS) (Sheikh and Yesavage, 1986); d) score ≥ 3 on a six-item cognitive screen (Callahan et al., 2002), displayed no signs of substance misuse (i.e., not ≥ 3 drinks/week, ≥ 2 drinks/day, or any illicit substance use); and f) not engaged in specialty mental health services (i.e., psychotherapy, psychotropic medication prescribed by a psychiatrist) at baseline. Participants were recruited from a variety of community-based, health, and social service settings in six regions of Florida. Please see Gum et al. (2011) for details.

2.2. Measures

2.2.1. Depressive symptoms: the outcome variable

Depressive symptoms were measured by the Short Geriatric Depression Scale (S-GDS; Sheikh and Yesavage, 1986), a 15-item scale, items are answered using a yes/no format. Possible scores for this instrument are 0–15, with higher scores indicating more depressive symptoms. A continuous scale was used in the analysis. For descriptive purposes, S-GDS scores ranging from 0 to 4 were categorized as not depressed, 5–9 were categorized as mild to moderate depressive symptoms, and scores of 10–15 were categorized as severe depressive symptoms.

2.2.2. Demographic information

Participants self-reported demographics. The current analysis included age (determined by birth date and entered as a continuous variable), race (dichotomized into White Non-Hispanic and Other), and marital status (categorized as married/widowed/other).

2.2.3. Depression severity: current major depressive episode

The presence or absence of a current major depressive episode was assessed using the Structured Clinical Interview for DSM Disorders (SCID)-IV Depression Module (First et al., 1995). All interviewers' assessments were reviewed by the project coordinator and/or principal investigator (second author, a licensed psychologist). Other SCID modules were not assessed to minimize participant burden. This measure was included to control for the presence of a major depressive episode and examine independent associations of other variables with the outcome variable.

2.2.4. Depression severity perceived current problem

Participants were asked, "Are you currently experiencing an emotional or mental problem?" (yes/no).

2.2.5. Disability World Health Organization Disability Assessment Schedule II (WHODAS-II)

The WHODAS-II is a 12-item scale (WHO, 2000) that measures six domains: communication, mobility, self-care, getting along with others, life activities, and participation in society. Possible scores range from 0 to 100, with higher scores indicating greater disability.

2.2.6. Stressful life events: Geriatric Adverse Life Events Scale (GALES)

The GALES (Devanand et al., 2002) was developed and validated to assess stressful life events for older adults and includes 26 major life events (e.g., retirement, new illness, and death of spouse). The score reflects the number of events that occurred in the past year (range 0–26).

2.2.7. Coping styles: brief COPE inventory subscales

This instrument (Carver, 1997) was developed to assess a broad range of coping responses. The current study assessed four subscales from the larger instrument, which contains 14 subscales

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