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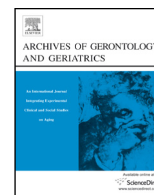

Are coping strategies and locus of control orientation associated with health-related quality of life in older adults with and without depression?

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ABSTRACT

The aim of this study was to investigate relationships between coping and health related quality of life (HRQoL) in older adults (aged ≥60 years) with and without depression. This cross-sectional study included 144 depressed inpatients from seven psychogeriatric hospital units in Norway and 106 community-living older adults without depression. HRQoL was measured using Euro Qol Group's EQ-5D Index and visual analog scale (EQ-VAS). Two aspects of coping were of primary interest for HRQoL: locus of control (LOC) and ways of coping (WOC). Measures of depressive symptoms, cognitive functioning, instrumental activities of daily living, and general physical health were included as covariates. In linear regression analyses adjusted for age, stronger external LOC was associated with poorer HRQoL in both depressed and non-depressed older adults. In the fully-specified regression models for both groups, the association between stronger external LOC and poorer HRQoL remained significant for the EQ-VAS score but not the EQ-5D Index. WOC was not associated with HRQoL in either group. Total amount of explained variance in fully-specified models was considerably lower in the sample of depressed, hospitalized older adults (17.1% and 15.5% for EQ-5D index and EQ-VAS, respectively), than in the sample of non-depressed, community-based older adults (45.8% and 48.9% for EQ-5D Index and EQ-VAS, respectively). One aspect of coping (LOC orientation) was associated with HRQoL in both depressed and non-depressed older adult samples, and therefore may be an important target for intervention for both groups. Differences in the amount of variance explained in models for the two groups warrant further research.

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1. Introduction

Health-related quality of life (HRQoL) relates to the perceived effects of health on each individual's ability to live a fulfilling life (Bowling, 1995; The_WHOgroup, 1995). This multidimensional construct, which including physical, psychological, and social aspects of life (Bowling, 1995; Rapley, 2003) has been identified both in the U.S. and globally as a priority public health goal for older adults (Health aging, 2015; Power, Quinn, & Schmidt, 2005; Winkler, Matschinger, & Angermeyer, 2006). HRQoL emerges from how each person perceives and acts upon life changes; as such, it varies according to individual physical and mental health status as

Abbreviations: EQ-5D Index, Summary index of the Euro Qol Group EQ-5D descriptive system; EQ-VAS, Euro Qol Group Visual Analog Scale score; GMHR, General Medical Health Rating; HRQoL, health-related quality of life; I-ADL, Instrumental activities of daily living; LBC, Locus of Control of Behaviour; LOC, locus of control; MADRS, Montgomery–Aasberg Depression Rating Scale; MMSE-NR, Mini-Mental-State Exam-Norwegian Revised Version; WOC, ways of coping.

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well as by sociodemographic and psychosocial characteristics, including coping (Wilson & Cleary, 1995).

Coping is a multifaceted process. Two key dimensions of coping include locus of control (LOC) orientation, and coping strategies or ways of coping (Folkman, 1984; Skinner, 1995; Rotter, 1966). LOC orientation represents the degree to which an individual perceives external factors (powerful others, chance, luck, or coincidence) as being responsible for outcomes in his or her life. High external LOC orientation has been related to demotivation and negative health outcomes (Skinner, 1995; Miller, Seligman, & Kurlander, 1975; Wallston & Wallston, 1978) and poorer HRQoL (Brown et al., 2015; Birmele, Le Gall, Sautenet, Aguerre, & Camus, 2012) in young people and mixed-age samples of adults. However, we have not identified previous studies that have specifically examined the relationship between LOC orientation and HRQoL within samples of older adults.

Coping strategies, also referred to as 'ways of coping' (WOC), comprise a second key dimension of coping. WOC include ways of thinking and acting directed to either (1) alter a perceived stressful situation (problem-focused strategies), or (2) regulate emotional responses linked to the stressful situation (emotion-focused strategies) (Folkman, 1984; Folkman & Lazarus, 1980; de Ridder & Kerssens, 2003). Use of coping strategies is known to affect health outcomes including HRQoL in adults (Lazarus & Folkman, 1984a; Del-Pino-Casado, Frias-Osuna, & Palomino-Moral, 2011; Folkman & Lazarus, 1988), but research on WOC in older adults has focused primarily on age-related differences in coping strategies rather than on health outcomes. Older adults use problem-solving strategies less frequently than their younger counterparts (Aldwin, 2011; Aldwin, 1991; Meeks, Carstensen, Tamsky, Wright, & Pellegrini, 1989). Furthermore, older adults can deploy emotion-focused strategies very effectively, because maturity and sophistication of emotional regulation increase with age (Vaillant, 1977; Diehl, Coyle, & Labouvie-Vief, 1996), while reliance on hostile emotion-focused strategies decreases (Aldwin, 1991). To our knowledge, however, the relationship between WOC and HRQoL has not yet been investigated in older adults.

In summary, previous research has explored relationships of both LOC orientation and WOC to HRQoL in some adult populations, but there is a lack of empirical knowledge about the association between either dimension of coping and HRQoL in older adults (Aldwin, 2011). This study aims to address this gap by examining relationships of LOC orientation and WOC with HRQoL in samples comprised entirely of older adults.

Chronic comorbid conditions (both physical and mental), which are known to be conceptually and empirically related to both coping and HRQoL are highly prevalent among older adults (Eriksson & Lindstrom, 2006; Eriksson & Lindstrom, 2007; Bjorklof, Engedal, Selbaek, Kouwenhoven, & Helvik, 2013; Sivertsen, Bjørkløf, Engedal, Selbæk, & Helvik, 2015). Depression is the most common mood disorder in late life; population-based studies suggest that 4 to 10% of older adults in community settings suffer from a major depressive disorder (Kessler et al., 2010; Luppa et al., 2012). Depression and depressive symptoms are known to adversely affect HRQoL in older adults (Sivertsen et al., 2015). While previous studies have examined relationships of depression (or depressive symptoms) with different aspects of coping and quality of life in older adults (Rolke, Bakke, & Gallefoss, 2008; Brink, Persson, & Karlson, 2009; Vogel et al., 2012; Dezutter, Wiesmann, Apers, & Luyckx, 2013; Henoch, Axelsson, & Bergman, 2010; Klein, Turvey, & Pies, 2007; Dantas, Motzer, & Ciol, 2002; Huang, Hsu, & Chen, 2012; Zielinska-Wieczkowska, Ciemnoczolowski, Kedziora-Kornatowska, & Muszalik, 2012; Yoon & Lee, 2006; Drageset, Espehaug, & Kirkevold, 2012; Giglio, Rodriguez-Blazquez, de Pedro-Cuesta, & Forjaz, 2015; Yoon & Lee, 2006), none have explored how LOC orientation and/or WOC are related to HRQoL in this age group. We therefore chose to investigate potential relationships between coping and HRQoL in two very different samples: older adults hospitalized with depression, and community-dwelling non-depressed older adults. This study aims to advance our understanding of the relationships between LOC orientation and use of coping strategies and HRQoL among older adults with and without depression.

2. Method

This study used a cross-sectional design to investigate associations between two dimensions of coping (external LOC orientation and use of coping strategies) and health related quality of life in two groups of older adults: psychogeriatric in-patients diagnosed with depression and community-dwelling older adults without depression.

2.1. Recruitment of participants with depression

Patients (aged $\geq$60 years) admitted to one of seven geriatric psychiatry hospital units in Norway between December 1, 2009 and December 30, 2011 with an ICD-10 (World Health Organization, 1992) diagnosis of depression or depressive disorder were evaluated for inclusion in the study sample of depressed older adults. For all potential participants, evaluation of inclusion and exclusion criteria and diagnostic assessments were performed by psychiatrists and psychologists experienced in geriatric psychiatry. Previous and current episodes of depression, together with other mental health problems and family history of mental health problems were also recorded.

Exclusion criteria were: severe cognitive impairment defined by a score $\leq$11 on the Mini-Mental State Examination-Norwegian Revised Version (MMSE-NR) (Folstein & McHugh, 1975; Strobel & Engedal, 2008); severe aphasia, having a life-threatening medical condition, and inability to complete the questionnaires used to assess LOC orientation, coping strategies and HRQoL. In all, 160 were included in the study sample. Due to incomplete data, 16 sample members were excluded from the analyses; thus, 144 inpatients were included in this study. The persons excluded due to incomplete data did not differ in mean age, mean MMSE-NR, or gender distribution from those participating.

2.2. Recruitment of non-depressed participants

Adults aged $\geq$60 years who lived in community settings were recruited for participation in the study through advertisement in the local newspaper, home nursing agencies, senior centers, and voluntary organizations. Potential participants were screened for symptoms of depression and cognitive impairment by trained students of nursing, psychology and medicine, and diagnostic evaluations were performed by an experienced psychologist in geriatric psychiatry and an experienced physician. All history of mental health problems was recorded. Exclusion criteria included: current depressive episode or depressive disorder according to ICD-10 (World Health Organization, 1992); current symptoms of any other psychiatric disorder; any cognitive impairment, as defined by a score of $<$27 on the MMSE-NR; severe aphasia; having a life-threatening medical condition; inability to complete the study questionnaires; and inability to understand the purpose of the study or to provide informed consent. In all, 215 older adults volunteered to participate in the study. After initial screening, 47 were excluded because of a MMSE-NR score below 27 points and 56 persons were excluded because of a current ICD-10 depressive episode. Six persons were excluded due to incomplete data; thus, 106 older persons constituted the sample

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