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Research Brief



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Hardiness and Depression in the Institutionalized Elderly

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IN THE YEAR 2020, there are likely to be about 43 million elderly Americans, approximately 2.5 million of whom will be in long-term care facilities (LTCFs) (Khachaturian, 1984). Recent studies indicate that there are high prevalence rates of depression in LTCFs. There has been a tendency to view depression as a result of biological, genetic, or social influences. There is a dearth of information on the institutionalized elderly and their personality characteristics, their views, and their attitudes. How these factors affect depression is unknown.

Kobasa (1979) proposed that persons who experience high degrees of stress and who do not become ill have a personality characteristic, which was termed "hardiness" by the investigator. According to Kobasa, the hardy person is characterized by commitment, control, and challenge, three factors that deter the development of depression (Kobasa, Maddi, & Courington, 1981).

To address the concerns about the broad use of the term "hardiness" in relation to health, Pollock (1986) proposed the health-related hardiness construct. There are two major differences between this construct and the general understanding of hardiness. First, the three characteristics of hardiness have been defined from the perspective of health. Second, the presence rather than the absence of these characteristics is measured (Pollock & Duffy, 1990). Health-related control is defined as the sense of mastery or self-confidence needed to appropriately appraise and interpret health stressors. Commitment involves the motivation and

competence to effectively cope with the threat of a health stressor. Finally, challenge refers to the re-appraisal of a health stressor as potentially beneficial and as an opportunity for growth (Pollock, 1989).

Three recent studies have discussed the effect of hardiness on adaptation to health problems. Lee (1983) found that those adults who possessed the hardiness characteristic remained active and adjusted to the difficulties of living with cancer. Contrada (1985) determined that those high in hardiness had a lower diastolic pressure than those low in hardiness during a sensorimotor task. Solomon, Temoshok, O'Leary, and Zich (1987) noted that lower hardiness scores were significantly related to higher lymphocyte counts in acquired immune deficiency syndrome patients. The relationship of hardiness and depression has not been explored. The purpose of this study was to examine the relationship between hardiness and depression in the institutionalized elderly.

METHODS

Sample

A computerized list of 472 residents in a skilled nursing facility (SNF) within a LTCF was generated. Nursing staff were asked to eliminate from the list those residents who were unable to communicate or tolerate a 1-hour interview, had a diagnosis of a major affective disorder, or were currently on antidepressants. A sample of 90 residents agreed to participate in the study.

Although the sample was from only one institution, it was multiracial and consisted of 31 Blacks (34.4%), 49 Whites (54.4%), and 10 Hispanics (11.1%). The sample consisted of 46 women (51.1%) and 44 men (48.9%). The sample ranged in age from 65 to 92 years, with a mean age of 73.3 years. A mean number of medical diagnoses was 3.8 ($SD = 1.2$) and the average length of stay at the institution was 41.3 months.

Instruments

In this study, the ZUNG-SDS, a 20-item screening inventory of the participant's depressive symptomatology, was used (Zung, 1972). In numerous studies, the ZUNG-SDS has proven reliable in the chronically ill elderly with Cronbach alpha coefficients ranging from .59 to .81 (Foster, Cataldo, & Boksay, 1991). The Cronbach alpha coefficient obtained in this study was .80.

The original version of the Health-Related Hardiness Scale (HRHS) (Pollock, 1984) was used in this study. The HRHS was developed to assess the hardiness characteristic in the chronically ill. Pollock's (1986) analysis indicated a better reliability for the total HRHS (alpha coefficient .80) than Kobasa's Hardiness Scale (alpha coefficient .65). The Cronbach alpha coefficient for the present study was .72. The HRHS rating is obtained by summing the scores of the three subscales; a low score indicates a high level of hardiness.

RESULTS

The total sample ($N = 90$) had an average depression score of 50.5, with scores ranging from 32 to 77. Okimoto and Barnes (1982) recommend a marginal score of 60 to indicate depression in elderly medical patients.

The mean hardiness score was 117.50, with scores ranging from 60 to 210. The lowest possible score is 40, and a lower score indicates a higher level of hardiness. Neither hardiness nor depression were significantly correlated with any of the demographic variables. A moderately strong Pearson product-moment correlation coefficient of .40 ($p < .001$) was found between depression and hardiness.

DISCUSSION

The findings of this study indicate that an inverse relationship between hardiness and depression in the institutionalized elderly does exist. This study suggests that knowledge about hardiness and its effect on psychological well-being may assist in the prediction of an individual's vulnerability to depression. This knowledge can impact on the assessment, planning, intervention, and evaluation in the nursing care of the elderly in LTCFs.

Once clients have been assessed as hardy, it can be understood that they enter into the LTCF with

the belief still intact that both their desire for wellness and their actions can and will affect their health status. They present with a spirit of independence and are more likely to comply with self-care regimens. However, it has been found that staff tend to view independence and the need for control as undesirable traits in patients. It is considered too complicated and time consuming to consider individual preferences (Storlie, 1984). The institutionalized elderly have been systematically infantilized and prohibited from exercising control by being denied the ability to choose. Clients are told what and where to eat, their clothes are chosen for them, they are denied requests to be alone, and they are stripped of personal items. The older person in a long-term care facility is given a diagnosis and then told what we, as health care professionals, will do about it. They are instructed to comply and are patronized with remarks such as "good girl" and given pats on the head (Dolinsky, 1984). This approach does not enhance or build on the inherent strength of the hardy client. Rather, it will reinforce the belief of the client with the absence of the hardy characteristic that "no matter what I do, I will be sick."

With the identification of the health-related hardiness characteristic, nursing care can be planned to support or build the client's need for control and involvement. An effort can be made to actively include the client in developing health goals and planning recovery regimens. One's ability to act on one's own behalf is interconnected with self-esteem and self-concept (Lekan-Rutledge, 1988). Only through collaboration with the client, the family, and the health care professionals can acceptable and realistic goals be set. Nurses must develop insight into how professional coercion may guide the decision-making process. With the knowledge of the relationship between hardiness and depression, client self-determination should be incorporated into the planning process.

Given the numbers of older persons in LTCFs, the incidence of depression, and the fact that nurses are often the primary caregivers in LTCFs, it is imperative that nurses strengthen their assessment skills to identify the patient who is vulnerable to depression. The findings of this study suggest that low levels of health-related hardiness may be one aspect of vulnerability to depression. This implies the possibility that assessing a client for the hardiness characteristic, and planning care accord-

ingly, may affect the incidence of depression in the chronically ill older person.

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