Mental Health Needs of Older Persons: Identifying At-Risk Populations

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Abstract:

The Multiple Affect Adjective Checklist was used to measureeffects of anxiety, depression, and hostility in a sample of 65 older persons. The three variables were analyzed to determine the differences among study participants on the bases of age, sex, race, and marital status. Statistically significant differences resulted when the anxiety scale was analyzed on the bases of age and marital status; when the depression scale was analyzed on the hoses of age, sex, and marital status; and when the hostility scale was analyzed on the hoses of age, race and marital status. The authors examine the implications of the data for manta/ health counselors working in community settings and discuss several readily identifiable at-risk subgroups of older persons.

Article:

Recent increases in the older population are well documented; in fact, persons aged 60 and above now comprise more than 10% of the nation's population (Harris & Associates, 1975). A variety of descriptions of problems faced by these people, as well as frequent statements of their unmet needs, may be found in current popular and scientific literature (Butler, 1975). One consequence of this situation is the increasing incidence of mental health concerns in the aged (Butler & Lewis, 1977). It has been estimated that at least 25% of today's elderly could benefit from mental health care, yet only 2% to 4% receive outpatient care in any given year (Kramer, Taube, & Redick, 1975). This same group makes up 22% of annual mental hospital admissions.

Preventive mental health care in a community setting is obviously both socially and emotionally preferable to post hoc institutional support. Our community based resources are limited. We are faced, therefore, with the mandate to focus our resources on services for persons with the most acute needs. Identification of these "at-risk" persons is thus a high priority within our current mental-health-service delivery systems.

One means of identifying those needing mental health care involves the individual assessment of psychiatric disorders. This can be a very time consuming process. Another, and more readily accessible means of identifying potential at-risk target populations correlates various traits with the existence of emotional disturbance. Anyone possessing these traits could then be indentified and singled out for assessment.

There is some indication that levels of emotion or affect, may vary within groups of older persons (i.e., those over age 60), depending on their life circumstances (Butler & Lewis, 1977). Furthermore, the existence of highly negative emotional states, such as high anxiety, extreme depression, or hostility, may signify both the need and potential for intervention. Given the current limited array of mental health resources, some identification of high risk subgroups of older persons is imperative if we are to focus our resources on services for those with the greatest needs.

The identification of pathological emotional conditions in older persons is frequently difficult. We are simply lacking a definition of what "normal" emotions in the aged may be (Gurland, 1975). We must look within the elderly population itself for definitions, which will be comparative in nature, rather than absolute. For example, the identification of high anxiety in groups of widowed as opposed to married older persons, would suggest that we emphasize provision of outreach anti counseling services for the former.

The variety of studies reported in the literature reveal the numerous stresses to which older persons are exposed. These stresses and life circumstances may affect older persons in different ways, predisposing; them to evidence affects which are clinically measurable and treatable. For example, some authors, notably Youmans (1977), have suggested the existence of tangible differences among older persons classified as "young-old" (60-74) and "old-old" (75 +). The inevitable realities el physical decline and progressive, cumulative losses become increasingly stressful with advancing age, and negative emotional consequences often result as resources diminish for meeting one's basic needs. It thus appears that the "old old" may experience more negative: emotions when contrasted with the "young-old."

Further, life expectancies vary between men (67) and women (74) (Butler & Lewis, 1977). Older women can, therefore, expect statistically to outlive their spouses. This expectation may contribute to anticipatory anxiety in older women. The death of a spouse, with it concomitant personal and social consequences, has been found to contribute to depression in older individuals (Lopata, 1970), and older women are more frequently affected by this specific loss than are older men. At age 60 there are 146 women for every 100 men in our population (Barrow & Smith, 1979).

Life expectancies also differ when older persons are grouped according to race. Black elderly persons have a lower life expectancy than White elderly. They also suffer from relatively greater economic deprivation (Harris & Associates, 1975), while enduring the same social stigma of ageism and the added burden of racism (Butler, 1975). Their position of double jeopardy, resulting from being both old and Black, is increased to triple jeopardy, as a result of also being poor (Hill, 1971). The same circumstances face Chicano and other minority elderly (Barron, 1963). These accentuated life stresses may be seen as contributing to greater anxiety and depression in older persons who are members of ethnic minorities. Further, Barron (1963) suggested that older Blacks may respond to their life circumstances with typical minority group reactions such as hostility.

This study was undertaken to examine the possible differential and emotional effects that the stresses of age may create in the various subgroups of elderly persons described above. Specifically, we have hypothesized that clinically measurable affects of anxiety, depression, and hostility would be significantly greater for older persons in the following four categories: (a) the "old-old" as opposed to the "young-old"; (b) females, as compared to males; (c) widowed or single elderly persons, as compared to those who are married; and (d) Black as compared to White elderly. This information was viewed as potentially useful for community based mental health workers seeking to identify older persons most in need of appropriate and timely counseling intervention.

PROCEDURES

Instrumentation

The In-General form of the Multiple Affect Adjective Checklist (MAACL) (Zuckerman & Lubin, 1965) was chosen as an acceptable self-report measure of clinical affects of anxiety (A), depression (D), and hostility (H). Subscale reliabilities range from .17 to .92 for different groups of participants, with a mean of .72 as reported in the checklist manual. Intercorrelations among the scales are reported to be as high as their reliabilities. Extensive validation studies, also reported in the manual, attest to the validity of the three scales. Additionally, a set of local norms for the three scales have been established for a group of older persons (Myers & Loesch, 1981).

Administration and Subjects

The MAACL was administered to 65 older persons who were participating in meetings of independent senior citizens clubs in both rural and urban areas. They were chosen on the basis of accessibility for group administrations and potential for self-administration of the checklist. Selected demographic characteristics of the resulting sample are shown in Table 1. The data base included 21 males, 17 of whom were White, and 44 females, 35 of whom were White. In all, the sample included 52 White and 13 Black elderly. Married participants numbered 24, and 41 were widowed or single. A breakdown of ages resulted in 48 being classified as "young-old" and 17 "old-old".

DATA ANALYSIS

Means and standard deviations were computed for each of the designated groups of older persons. A one-way analysis of variance was completed for each of the four major variables using each of the three MAACL scales. The data analyses were computed using the Statistical Package for the Social Sciences (Nie, Hull, Jenkins, Steinbrenner, & Bent. 1975). An alpha level of .05 was chosen to evaluate statistical significance.

TABLE 1

Demographic Characteristics of the Sample

Characteristic		*n*	%
Age:	60-75	48	74
	75+	17	16
Sex:	Males	21	32
	Females	44	68
Race:	White	52	80
	Black	13	20
Marital Status:	Married	24	37
	Single or Widowed	41	63
Residency City Size:	0-2,500	43	66
	Over 250,000	23	34
Employment Status:	Retired	50	80
	In-labor market	13	20
Education:	Less than high school	23	35
	High school	20	31
	Some college	22	34
Income:	0-$5,000	42	65
	$5,000-$10,000	21	32
	$10,000-$15,000	2	3

TABLE 2

Means, Standard Deviations and *F* Ratios for MAACL Scales

		MAACL Scales								
		Anxiety			Depression			Hostility		
Characteristic	*N*	$\bar{X}$	*S.D.*	*F*	$\bar{X}$	*S.D.*	*F*	$\bar{X}$	*S.D.*	*F*
Age:										
60-74	48	7.72	3.3	4.53*	15.52	7.0	2.96*	8.44	4.3	1.54*
75+	17	9.82	4.1		19.23	10.0		9.88	3.7	
Sex:										
Males	21	6.95	3.3	3.53	13.19	7.5	5.71*	8.60	4.2	0.05
Females	44	8.58	3.1		17.36	6.1		8.86	4.2	
Race:										
White	52	7.89	3.5	0.93	15.42	7.1	2.00	8.25	4.4	4.21*
Black	13	8.84	1.9		18.39	5.3		10.84	2.5	
Marital Status:										
Single/widow	24	9.15	3.8	6.98*	18.76	8.4	10.05*	9.68	4.0	5.18*
Married	41	6.78	2.5		12.67	5.7		7.33	4.0	

*$p < .05$

RESULTS

The resulting means, standard deviations, and F ratios for each analysis are shown in Table 2. The "old-old" participants achieved higher mean scores than did the "young-old" on all three MAACL scales. These differences were all statistically significant.

Although female participants scored higher than males on all three scales, the only significant difference occurred for the Depression scale scores. Blacks scored higher than Whites on all three scales, however, the only significant difference occurred for the Hostility scale analysis.

On all three scales, single and widowed persons scored higher than those married. Each of these differences was statistically significant.

DISCUSSION

Results of this study provide support for some, but not all, of the authors' hypotheses. Interpretation of the results must consider the possibility that the achieved scores may have been subject to sampling error. The sample, though not totally representative of the older population in general, contains adequate numbers of participants in each category to permit valid comparisons. Furthermore, the number and magnitude of the observed differences among the groups, lend credence to the above hypotheses.

One hypothesis not supported by the study was that *A*, D, and H would all be significantly greater for older persons in each of the four designated categories. This hypothesis was based in large part on the high subscale intercorrelations reported by the authors of the MAACL (Zuckerman & Lubin, 1965). In this case, the results indicated that clinically measurable affects of anxiety, depression, and hostility do not always appear, as it were, in concert. When working with groups of older people, therefore, it appears important for helpers to distinguish if any or all of these affects are present. Treatment for each condition may be different, depending on the individual's life circumstances, resources, and other factors.

The hypothesis that all three affects would be measurably greater for certain groups was actually supported in only two of the four categories, age and marital status. The possibility that these two categories were related was not studied; however, there is a strong likelihood that a greater proportion of "old-old" clients than "young-old" were single or widowed. The two categories are treated separately for discussion purposes.

The conclusion drawn from literature cited in the introduction, which suggested that decline and loss become increasingly stressful with advancing age, is essentially supported by the results of this study. While it may seem obvious that often the "old-old" experience greater losses than those classified as "young-old", it is significant that they also endure the negative emotional consequences of these losses to a greater extent than do their younger counterparts.

Older persons in general are survivors, and they have survived a long time, with or without mental health care. But because of the multiple stresses associated with aging, counseling needs may intensify in the later years. It is entirely possible that needs for counseling may actually arise in later years for persons who previously had little or no difficulty in coping with life stresses. Frequently, this is because previously adequate methods of coping with situational difficulties are inadequate means of coping with the new, multiple, and complex problems that can occur in late life. These problems occur at a time when physical and emotional resources to meet them are diminishing.

Counselors working with all ages of older adults should be aware of the increasing incidence of mental health problems in the "old-old" and thus be sensitive to the reality factors contributing to such problems. The entire gamut of negative emotions is potentially present in the most aged population, hence the potential for counseling intervention is great.

Given that social withdrawal and isolation tend to increase with advancing age, it becomes important for counselors to consider outreach activities when providing services to "old-old" persons. Nontraditional settings and service approaches, even in-home services, may be required if existing mental health needs are to be adequately met. The current trend of housing mental health counselors in places where older persons congregate, such as senior centers, nutrition sites, and housing complexes, is certainly a step in the right direction. Similarly, recommendations for increased emphasis on outreach to single and widowed older persons may be drawn from the data presented in this study. The contention that single and widowed older persons may have greater needs for counseling is not new. It is important to note, however, that this group of older persons scored much higher than the married subjects on all three MAACL scales. These results not only support the

literature, they also lend credence to the MAACL as a valid instrument for use with older persons, particularly as an aid to selection for mental health counseling. Such aids are vitally needed where resources are limited.

The underlying causes of high anxiety, depression, and hostility will vary with the individual, as will the particular treatment selected. The overwhelming importance of the data on marital status is to alert the mental health counselor to the strong likelihood that single or widowed older persons are in the "at-risk" category for provision of counseling and support services. Hopefully, needed services can be provided in a community setting.

In contrast to results for the age and marital status dimensions, neither sex nor race analyses yielded consistent results for all three MAACL scales. The hypothesis that older women would score significantly higher than men on all three scales was supported only for the measure of depression. Some of the reasons for increased depression among older females were suggested earlier. The results of this study lend support to the contention that greater needs for counseling exist for older adult females, and that counselors should be alert to symptoms of depression in the older adult females with whom they work.

The hypotheses concerning elderly Blacks were supported only in the hostility category, although scores for these participants on all three measures were higher than for their White counterparts. Perhaps the greater hostility evidenced is a function of the multiple jeopardy situation in which older Blacks often are placed by virtue of being old, minority group members, and often poor. The problems are frequently societal, and deep rooted. Counselors can help by developing a sensitivity to the life circumstances of Black elderly and by seeking resources to help overcome at least some of their existing problems. A thorough knowledge of community resources will enable the counselor to refer older Black clients to available community agencies for assistance. The counselor can also enter the role of advocate and work to change negative community and societal attitudes toward the elderly and Black elderly in particular.

RECOMMENDATIONS FOR FURTHER RESEARCH

It is clear from the preceding discussion that some basic differences do exist among certain subgroups of the older population. Again, the size of the sample and possibility of sampling error both suggest that caution should be used, in drawing conclusions from the data. Replication of the current research, using a larger sample, could lead to more definite conclusions.

Further research on the subgroups delineated for inclusion in this study would be valuable. For example, the finding that marital status was a significant variable could be further examined. More information about the within-group variance could be important. Research efforts might be directed toward a study of possible differences between persons recently widowed and those widowed for greater periods of time. Differences between these groups of persons would have important implications for counseling interventions, including crisis techniques. Such research would require a much larger sample of widowed older persons than was available in this study.

More detailed information on within-groups variance for the other subgroups could be found using larger samples of various age, sex, and racial composition, with attention given to subgroups within those three categories. In particular, the inclusion of study participants representing a variety of ethnic minorities would be useful. Data resulting from cross-cultural comparisons could reveal whether the emotional concomitants of aging are stable across minority subcultures. If not, further research or discussion of minority-group life circumstances and history could help to explain any differences.

The inclusion of large samples would also permit multiple analyses of variance, in contrast to the one-way ANOVAs accomplished in the current study. The possible interactions between age, sex, race, and marital status could be explored. These analyses could reveal, for example, whether there are significant interactions between variables such as race and sex. Perhaps older White females are more or less prone to depression than

are older Black females; we do not know. Large samples and multiple ANOVAs would provide this type of information.

The importance of further research on the mental health needs of older persons cannot be overestimated. This study has provided some beginning data to help counselors recognize older individuals who show the greatest potential need for mental health care. Additional research, as described above, could help to further define the "at-risk" population and help us better allocate our scarce mental health resources.

Summary and Conclusions

The major impact of this study is to draw attention to certain groups of older persons who are "at-risk" and both more vulnerable to the stresses of aging in American society and potentially more in need of counseling services. As long as mental health resources remain limited, we will need to target services toward those persons most in need. While the reasons underlying the existence of negative emotional conditions deserve further study, we may conclude from this research effort that the "old-old" and single and widowed aged persons fall into the very high-risk category for provision of counseling services. Older women and older Blacks may also be prone to experience a greater incidence of negative emotional states.

Mental health counselors working in the community may encounter large numbers of elderly persons. The presence of the characteristics mentioned here may serve as indicating that therapeutic intervention may be needed. Additional research on mental health concerns is required if our profession is to effect positive change in the lives of many older persons.

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