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Examination of the Impact of Living Arrangements and Marital Status on Depression
among Older Adult Male Veterans: AN HONORS THESIS

College of St. Benedict/ St. John's University

In Partial Fulfillment of the Requirement

for All College Honors and Distinction

in the ¹Department of Nursing

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Abstract

Project Title: Examination of the Impact of Living Arrangements and Marital Status on Depression among Older Adult Male Veterans

Background: As the older adult population grows, depression rates are also on the rise. This is especially evident among American veterans, who experience a depression incidence close to 30%, making it one of the most common diagnoses treated within the Veterans Health Administration (Hankin, Spiro, Miller et al, as cited in Cully, Zimmer, Khan & Petersen, 2008).

Objective: The purpose of this study is to identify key demographic variables associated with depression among older male veterans. The results could help improve patterns of care, hopefully improving the management of depression.

Method: This retrospective descriptive study uses existing medical record data to identify patterns of factors commonly occurring in veterans with depression. Demographic variables, depression screening scores, and patterns of International Statistical Classification of Diseases and Related Health Problems 9th Revision (ICD9 codes) are analyzed for patterns that can improve care.

Results: Descriptive findings and relevant correlations are reported with recommendations to improve care for adult older adult male veterans diagnosed with depression.

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Introduction

The older adult population is a large portion of the population of the United States, and will continue to grow in the coming years as the “baby-boomer” generation ages. According to the United States Census Bureau, 13.3% of the U.S. population was sixty-five and older in 2011. Many members of the older adult population are also veterans. According to the US Census Bureau, there were 21.8 million veterans in our nation in 2010, 20.2 million of them men (US Census Bureau, 2010). This study investigates the relationship between depression, marital status and living arrangements, in a sample of older adult veterans. The data analyzed for this research is from the medical records of veterans sixty-five years and older. In order to be medically diagnosed with depression, one must meet specific criteria. Major Depressive Disorder (MDD) is generally diagnosed as a result of a persistent low mood and lack of a positive affect. One must also meet at least 4 additional MDD criteria symptoms for at least two weeks.

This study is important for maximizing the quality of care for the veteran population. Recognition of factors and measures that create improvements in depression status as veterans grow older has the potential to improve their health and well-being and reduce health care costs.

Review of the Literature

In order to be diagnosed with Major Depressive Disorder (MDD), one generally manifests a persistent low mood and lack of positive affect, along with various other symptoms. One must also manifest 4 additional MDD diagnosis criteria symptoms for at least two weeks. Examples of additional symptoms include weight or appetite changes, insomnia, decreased concentration, decreased energy and feelings of worthlessness. See Appendix A for further details of MDD diagnoses (VA, 2009).

Cully, Zimmer, Khan and Petersen (2008) found that less than fifty percent of patients with newly diagnosed depression received quality care. The most likely reason for delayed follow-up care for depression is due to the vast size of the VHA health care system.

Older adults with a history of anxiety or depression were more likely to participate in treatment because of their previous experience (Garrido, Kane, Kane and Kaas, 2009). These researchers also confirmed that the more experience people have with medical care, the more likely they are to recognize personal health care needs because they are more knowledgeable of and comfortable with their health care needs. The large sample size (n=1339) lends strength to this study.

Zhang and Li (2011) analyzed the impact of social support systems within the older adult population. Relationships between gender and depressive symptoms and marital status and depressive symptoms were explored. Based on previous research, Zhang and Li state that the rates and severity of depression were higher among widowed people compared to their own pre-bereavement levels and to their married counterparts. Additionally, Zhang and Li found that the lack of social support is one of the most critical factors affecting depression in elderly people. Depression levels were significantly higher in the elderly who were widowed than those who

were married. Furthermore, a spouse is considered the most important source of family support, providing emotional and material support. With the loss of a spouse, the older adult loses one of the most influential people in his or her life which can lead to stronger and more lasting bereavement.

Liang, Brown, Krause, Ofstedal and Bennett (2005) explored the relationship between marital status, living arrangements and depression. Living arrangements tend to be very highly associated with the psychological status and overall functioning of unmarried older adults. This association is not nearly as high for married older adults. Unmarried older adults are more likely to reside with children or other loved ones compared to married older adults. Overall, unmarried older adults tend to have less support in their lives as they grow older than that of married older adults, especially in the areas of mental and physical health support.

Following are examples that indicate that being in a marital relationship is one of the best ways to experience successful aging. Married people tend to be more accountable to each other for their own health and monitor their own health behaviors and those of their partner. Married people usually have a higher income and can therefore afford better health care, healthier food and a safer home. Spouses can provide effective emotional support for each other on a daily basis which can help deduce health problems that relate to poor overall health. This study showed the association between living arrangements and marital status. Marriage generally means that one is living with a spouse, while an unmarried person is much more likely than a married person to live alone. A few exceptions to this statement are if a spouse is in a long-term care facility or is unable to manage care of the spouse for another reason. Another conclusion from this data is that those who are married can better cope with poor health and uphold current living conditions than the unmarried (Liang et al., 2005).

Ferri, James & Pruchno (2009) also researched social support in the older adult population, but in a different manner. They studied older adults' views of successful aging. The most significant factors include: activity/exercise, physical health, social relationships, and psychological/ cognitive health. Within the sample, 27% of participants had depression scores within a clinically significant range. One drawback to this study was a small sample size; another was that the amount of missing data for total Center for Epidemiological Studies Depression Scale (CES-D) score may have impacted analysis. The researchers recommend further research on the relationship between depressive symptoms and a subjective assessment of successful aging in depressed and non-depressed older adults. Overall, the primary finding from this study is that perception of health status is more strongly related to successful aging than actual physical health status (Ferri, James & Pruchno, 2009).

Research Questions

Within the older adult male veteran population:

- What is the relationship between marital status and depression screening scores?
- What is the relationship between living arrangements and depression screening scores?

Study Design and Methods

Since the present study is a segment of a larger one, (Twohy, Meijer, McCue, 2011), a bit of information about the larger study can aid the reader's understanding. The study design was a repeated measure, retrospective descriptive study. Arrangements were made for data collection with the director of research at the St. Cloud VAHCS, the Decision Support System (DSS), the

primary investigator (required to be a VA employee), and faculty co-investigators. Beginning December 31, 2007, 1200 inpatient and outpatient records were screened for the inclusion criteria (ICD-9 codes for depression, alcohol use/abuse, and falls). On initial extraction, there were 98 inpatient cases and 645 outpatient cases. Since the study call protocol called for 200 outpatients, PAWS-20 random sample generator was used to reduce the outpatient group to 200. Preliminary data were downloaded to excel files, cleaned, formatted, and then de-identified creating a preliminary database for analysis.

A number of protections are required for accessing personal health information (PHI) of veterans receiving health services from the VAHCS. The primary and co-investigators participated in the extensive research training required by the VAHCS. ‘Request to review the research proposal’ and ‘application for initial review of medical records-only research’ were submitted and approved by the St. Cloud VAHCS Research and Development (R&D) Committee and affiliate Institutional Review Board (IRB). Careful consideration was taken by the R&D and IRB to review the study for the welfare and protection of human subjects. The proposal was expedited by IRB, as the data were all retrospective and the study was considered minimal risk. Waiver of requirement for informed consent and HIPAA authorization was granted due to the retrospective nature of the study. The primary and co-investigators followed the requirements of human subjects’ protection throughout the research project. The student co-investigators did not have access to files containing raw data; they did have access to output files following analysis.

All data files were stored in a secured, password-protected folder, with the assigned security group on a shared research drive at the St. Cloud VAHCS. The director of research, the primary and faculty co-investigators accessed these files. The drive was inaccessible from off-

site locations. All data was de-identified prior to analyses. Analyses were conducted using IBM/SPSS Statistics (Version 21.0). Analysis methods included frequencies, Chi-square for categorical variables, and t-tests for continuous variables. Table 1 depicts the variables studied.

Table 1. Variables Studied			
Inclusion Criteria	Exclusion Criteria	Demographic Variables	Outcome Variables
-Random sample of veterans, age ≥ 65 years old -inpatient (VAHCS hospital, LTC or assisted living) at the beginning of the study -outpatient (community-dwelling) at the beginning of the study -Diagnosed with Depression (multiple ICD-9 codes 296.2, 296.24, 296.3, 296.32, 296.33, 296.34, 296.5, 296.52, 296.53, 296.54, 296.6, 296.62, 296.64, 296.7, 296.8, 309, 309.28, 311)	-Veterans < 65 years old -Female	-Age -Gender -Combat Experience (yes/no) -Service Connected (yes/no) <i>Covariates:</i> <ul style="list-style-type: none"> - other ICD-9 codes - Depression scores - Living arrangements - Marital status -Data gathered every Dec. 31 in 2007, 2008, 2009, 2010	-Change in severity of illness -Change in inpatient/outpatient status -Change in living arrangements -Change in marital status

Sample

The sample utilized for this study was derived from the larger study's preliminary dataset. The sample size for the present study is 39 veterans diagnosed with at least one depressive disorder.

Results

Tables 1 through 8 provide demographic information on the sample of 39 older adult veterans. These tables show the limited data available for analysis as there was a fair amount of data missing from veterans' charts. Table 2 presents the Age category frequencies. The majority of the veterans in the sample fall in the lower two age categories.

Age	Frequency	Valid Percent
65-70	9	23.1
71-75	12	30.8
76-80	7	17.9
81-85	6	15.4
85 and older	5	12.8
Total	39	100.0

Table 3 depicts the marital status of the veterans in the sample of 39. Most veterans are or were married. The largest group is that of Married people, followed by Widowed, then Divorced, and finally Never Married.

	Frequency	Valid Percent
Divorced	10	25.6
Married	14	35.9
Never Married	4	10.3
Widowed	11	28.2
Total	39	100.0

Living arrangement data was only available for twelve to fourteen of the veterans in the sample. Among these 14 veterans, a majority have some sort of caregiver who lives with them, though the sample is too small to draw any conclusions. See Table 4 for details.

	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
1-GEC ¹ Caregiver lives with patient	8	20.5	8	20.5	7	17.9	7	17.9
2-GEC Caregiver does not live with patient	2	5.1	4	10.3	3	7.7	4	10.3
3-CCHT NIC lives with spouse only	1	2.6	1	2.6	1	2.6	1	2.6
4-CCHT NIC lives alone	0	0	1	2.6	1	2.6	1	2.6
5-Homeless	1	2.6					1	2.6
Total	12	30.8	14	35.9	12	30.8	14	35.9
System Missing	27	69.2	25	64.1	27	69.2	25	64.1
Total	39	100.0		100.0	39	100.0	39	100

Very little data exists in the sample for depression screenings. Even though the VA's protocol is to screen for depression annually, in 2008, only four of the 39 patients had valid data. In 2009, ten patients had valid data and in 2010, eleven people had accessible screening data. See Table 5.

¹ GEC Geriatric Extended Care

	2008		2009		2010	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
NEG	4	10.3	7	17.9	9	23.1
POS	0	0	3	7.7	2	5.1
Total	4	10.3	10	25.6	11	28.2
Missing	35	89.7	29	74.4	28	71.8
Total	39	100.0	39	100.0	39	100.0

Cross Tabulations

Chi Square tests were run on living arrangements and depression screening scores by age category and marital status. Only significant results are presented in the Table 7.

Living Arrangements 2009	Marital				Total
	DIVORCED	MARRIED	NEVER MARRIED	WIDOWED	
1-GEC Caregiver lives with patient	0	5	0	2	7
2-GEC Caregiver does not live with patient	1	2	0	0	3
3-CCHT NIC lives with spouse only	0	0	0	1	1
4-CCHT NIC lives alone	0	0	1	0	1
Total	1	7	1	3	12

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.694 ^a	9	.028
Likelihood Ratio	13.608	9	.137
N of Valid Cases	12		

a. 16 cells (100.0%) have expected count less than 5. The minimum expected count is .08.

The only significant chi-square data is the association between Living arrangements in 2009 and Marital status (Chi = 18.694, p=0.028). All other chi-square tests are non-significant or there was too few data points to calculate the statistic.

Table 8 presents a summary of the diagnostic codes for the cases in the sample.

Diagnoses	2007	2008	2009	2010
Major Effective Depressive Disorders	9	12	13	13
Bipolar Disorders	5	6	5	8
Adjustment Disorders	4	3	6	4
Depressive Disorders, unspecified	25	22	26	22
Total	43	43	50	47

These numbers correspond to the number of the ICD-9 codes found within the sample of 39 people; many had more than one of the diagnoses leading to totals that exceed the number of cases (39). See the table of ICD-9 codes in Appendix B for definitions of specific diagnostic codes. Depressive Disorders, Unspecified (code 311.0) was the most common diagnosis, as it encompasses all those diagnosed with a depressive disorder that do not meet the criteria of the other diagnoses.

The first research question was: What is the relationship between marital status and depression screening scores? This was answered in a minimal way from the research data, and more maximally from the research done by others. Due to lack of data for depression screening scores, difficulty arose in recognizing the results of the relationship between marital status and depression screening scores. However, according to Zhang and Li (2011), there is a correlation.

The second research question is: What is the relationship between living arrangements and depression screening scores? This has a similar answer as above. Due to lack of data for depression screening scores, it was difficult to yield effective results. Overall, the results yielded from the current data were minimal, due to a lack of depression screening scores.

Discussion

According to research findings, the most effective non-pharmacological way to minimize depression in the older adult population is to live with a spouse, consequential to being married. Married people tend to be more accountable to each other for their own health and monitor their own health behaviors and those of their partner. Married people usually have a higher income and can therefore afford better health care, healthier food and a safer home (Liang, et al., 2005).

Spouses can provide effective emotional support for each other on a daily basis which can help deduce health problems that relate to poor overall health (Liang, et al., 2005). This study showed an association between living arrangements and marital status in one year, though the number of cases for which both variables were present was less than one-third of the sample. Marriage generally means that one is living with a spouse, while an unmarried person is much more likely than a married person to live alone. Liang, et al (2005) discovered that those who are married can better cope with poor health and uphold current living conditions than the unmarried (Liang et al., 2005).

As referenced earlier, Liang, Brown, Krause, Ofstedal and Bennett (2005) explored the relationship between marital status, living arrangements and depression. Overall, unmarried older adults tend to have less support in their lives as they grow older than that of married older adults, especially in the areas of mental and physical health support. Unmarried older adults have

the most positive psychological outcomes when residing with children or other loved ones than those who live alone.

Limitations

Many limitations were present in this study. The most serious limitation was the inability to easily extract data from the clinical record. Sometimes, the screening scores were electronically extracted by DSS, while other times, extraction required manual entry into the clinical reminders for each case, each of four years. Even then, some screening data could not be found. It is likely that some depression screenings were not conducted for various reasons, including patient non-compliance, lack of follow-up appointments scheduled or classified as a “no show”, and potential lack of education/learning regarding the significance of follow-up screening to maximize care. Also it appears that screening is not done if the patient is in the hospital.

Due to the lack of follow-up screening data for depressive disorders among this sample, it was nearly impossible to recognize any changes in the status of patients’ depression over the four year timeframe. Additionally, one is unable to discern the effectiveness of any life changes, such as living arrangements or marital status. Theoretically, all older adults ought to be screened annually for depression, whether they are diagnosed with a depressive disorder or not (this needs a citation or removal). Doing so would raise awareness of changes in the presence and severity of depressive disorders and how to provide effective care (see Appendix A for criteria diagnosing Major Depressive Disorders).

The narrow demographics of this sample make it difficult to reach any generalizations for other segments of the older adult population. The small sample size and missing data limit the usefulness of the findings.

Conclusion

There are more older adults in our world today than ever before. Due to better health status, people are living longer. Additionally, many of these people in our nation are veterans, some of whom suffer from mental health disorders, including depression. Other research documents many demographic factors that affect the rates of depression among older adult populations, especially marital status and living arrangements. Other research articles cited in support the value of marital status; marital status is an important factor for persons with depression. According to Desai, Rosenhock and Craig (2006), screening for depression is underutilized. Therefore, depression is often undertreated. The fact that so few of the veterans in this study received depression screenings, though they were all diagnosed with depression, reinforces the conclusion of Desai, Rosenbock and Craig (2006) that depression screenings are underutilized.

While other studies (Liang et al., 2005; Zhang and Li, 2011) have noted that marital support is one of the most effective ways to decrease the likelihood of an increased depression score as one ages, this was not born out in this investigation.

Recommendations

For further research of this sort, it would be beneficial to have a much larger sample size, in addition to less complicated methods for extracting patient clinical record data. The demographics available were limited, e.g. education, socioeconomic status, were unavailable yet these variables are associated with many health patterns. The consistency of screening for depression should be greatly increased.

Further research is needed to clearly identify the cluster of factors that can minimize depression in older adults. In addition, clinical practice ought to make a clear and consistent effort to maximize the data available for clinical decision-making and quality improvement efforts.

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Appendix A: Diagnosis of Major Depressive Disorder (MDD)

	MDD diagnosis is based on the following list of symptoms, and requires the presence of symptom 1, 2, or both; and at least 5 of 9 symptoms overall; these symptoms must persist for at least 2 weeks
1.	Depressed mood nearly every day for most of the day, based on self-report or observation of others
2.	Marked reduction or loss of interest or pleasure in all, or nearly all, activities for most of the day, nearly every day
3.	Significant non-dieting weight loss or weight gain (> 5% change in body weight)
4.	Insomnia or hypersomnia nearly every day
5.	Psychomotor agitation or retardation (should be observable by others)
6.	Fatigue/loss of energy nearly every day
7.	Feelings of worthlessness or excessive/inappropriate guilt (possibly delusional) nearly every day
8.	Diminished cognitive function (reduced ability to think or concentrate, or indecisiveness) nearly every day
9.	Recurrent thoughts of death and/or suicide, suicide planning, or a suicide attempt

From the American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM), 4th ed, Text Revision. Washington, DC: American Psychiatric Association; 2000 as cited in the VA's Major Depressive Disorder Protocol (2009)

Appendix B: Diagnostic Codes and Definitions

296.2	Major Depressive Affective Disorder, Single Episode, Unspecified Degree
296.24	Major Depressive Affective Disorder, Single Episode, Severe Degree, Specified As With Psychotic Behavior
296.3	Major Depressive Affective Disorder, Recurrent Episode, Unspecified Degree
296.32	Major Depressive Affective Disorder, Recurrent Episode, Moderate Degree
296.33	Major Depressive Affective Disorder, Recurrent Episode, Severe Degree, Without Mention Of Psychotic Behavior
296.34	Major Depressive Affective Disorder, Recurrent Episode, Severe Degree, Specified As With Psychotic Behavior
296.5	Bipolar I Disorder, Most Recent Episode (Or Current) Depressed, Unspecified
296.52	Bipolar I Disorder, Most Recent Episode (Or Current) Depressed, Moderate
296.53	Bipolar I Disorder, Most Recent Episode (Or Current) Depressed, Severe, Without Mention Of Psychotic Behavior
296.54	Bipolar I Disorder, Most Recent Episode (Or Current) Depressed, Severe, Specified As With Psychotic Behavior
296.6	Bipolar I Disorder, Most Recent Episode (Or Current) Mixed, Unspecified
296.62	Bipolar I Disorder, Most Recent Episode (Or Current) Mixed, Moderate
296.64	Bipolar I Disorder, Most Recent Episode (Or Current) Mixed, Severe, Specified As With Psychotic Behavior
296.7	Bipolar I Disorder, Most Recent Episode (Or Current) Unspecified
296.8	Bipolar Disorder, Unspecified
309	Adjustment Disorder With Depressed Mood
309.28	Adjustment Disorder With Mixed Anxiety And Depressed Mood
311.0	Depressive Disorder unspecified

PROJECT TITLE: Examination of the Impact of Living Arrangements and Marital Status on
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