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Narratives of Lived Experiences of Older Persons with Depression in Macau

Wen Zeng

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing, The University of Auckland, 2009
Abstract

This study aims to document and interpret the lived experiences of older persons with depression in Macau; to identify the principal influences on depression among older persons in Macau; and to construct an explanatory framework based on the medical and socioeconomic factors related to depression as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression among older persons in Macau.

A mixed methods research design, using both quantitative and qualitative approaches, was employed to interpret the lived experiences of these older persons. Using a purposive sampling approach, the final study involved 31 older persons with depression, and seven caregivers; all consented to participate. A range of standardised, validated scales including the MSQ, GDS-15, BI, Lawton IADL, LSNS, SF-36QOL, and instruments to collect demographic data, were employed to determine eligibility to participate and to quantify a variety of psychosocial factors that may be associated with the lives of these older persons. Questions raised by these quantitative results were then reflected on through in-depth interview, that generated data collected using an open-ended interview guide to identify the life events, issues and common thinking patterns in older persons that relate to depression in Macau.

These lived experiences clustered into four broad dominant categories. The first dominant category, negative thinking, consisted of the themes of feeling useless, hopelessness, sadness, and helplessness. The second dominant category, physical limitations and complaints, covered the themes of limited mobility, dependence on others, chronic joint pain, problems with sleep, poor appetite, poor memory, complex medication regimens, and difficulties in getting to hospital. The third dominant category, present living conditions and social support, consisted of the themes of being poor, being illiterate, injustice, being widowed, living alone, conflict with adult children, being neglected by children, being looked down upon by others, and lack of social contact. The final dominant category, the lives they have lived, included the themes of hard labour with low reward, being fatherless, having a bad marriage, and trauma from wars and revolutions.
Three meta-categories are drawn from the dominant categories and themes reflected across the findings; physical/material meta-category, social/family meta-category, and mental suffering meta-category. These three meta-categories illuminate the complex phenomenon of depression among these older persons in Macau. The associated explanatory framework models the relationships between the three meta-categories. Each interacts with the others, consequently one meta-category both causes and also results from others. The three meta-categories capture their life-long hardship and bio-psycho-social-cultural disability, which lay at the root of their negative thinking. The consequences and impacts of their negative thinking appear to feed and sustain depression among the older persons.

Findings from this study offer a deeper understanding of the nature and meaning of the negative feelings experienced by this depressed population in Macau. Through its fully grounded interpretative research approach, the present study has advanced previous research describing depression among Chinese older person by allowing a wider and more complete picture to be produced. Furthermore, these findings help to inform future health service development for older persons and the future development of interventions for older persons with depression in Macau, and in other Chinese contexts.
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Glossary of Terms and Abbreviations

BI
Reduced Item Barthel Index

GDS-15
The Geriatric Depression Scale-15

Lawton IADL
The Lawton Instrument of Activities of Daily Living Questionnaire

LSNS
Lubben Social Network Scale

MOP
Macau Pataca, Macau’s official currency, MOP 8=USD 1

MSQ
Mental Status Questionnaire

Older Persons
This is a term favoured in the definition of persons aged 65 years and over and in this thesis is used interchangeably with: elderly, old folks, elderly folks, senior.

SF-36QOL
The 36-item Short-form Health Survey of Quality of Life
Chapter 1

Introduction and Context of the Study

Background and Significance of Research Problem

Macau is an advanced Chinese city with a population of 502,113. As a result of developments in society, science and healthcare, the life expectancy at birth of the inhabitants had been extended from 76.6 years in 1996 to 81.1 years in 2006. The percentage of the population who were aged 65 years and over was also increasing. In 2006, there were 35,355 older persons aged 65 years and over; they accounted for 7.0 percent of the Macau population (Macau Statistics and Census Bureau, 2007a) and this was projected to rise (Macau Statistics and Census Bureau, 2007b). The speed of population ageing was unprecedented within Asia. For example, the People’s Republic of China had the proportion of the population of older persons aged 65 and over which was 7.0 percent in 2000 and was estimated to rise to 13.5 percent by the end of 2026, followed by Singapore with 6.8 percent in 2000 and this figure was projected to accelerate to 12.5 percent by the end of 2026 (United Nations, 2002).

As being described below, older age had been associated with depression. In Macau, the incidence of depression among 662 older persons in the community was found to be 12.37 percent (Ning, 2001). A further large-scale study identified that the incidence of depression among 2039 community-dwelling older persons was 10.4 percent (Macau Social Welfare Bureau, 2006). Yet, another study found that the incidence of depression was 53.1 percent for 367 older persons in day centres care (D. D. Li, Li, Liu, Qiu, & Zeng, 2003). These depression rates of Macau’s older persons, particularly the latter, appeared high, but these must be compared to that of 10 percent to 15 percent of the population over 65 in UK (Ebersole & Hess, 2001), 15 percent to 20 percent of older persons in USA (Stuart & Laraia, 1998), 26 percent of 162 Chinese elderly migrants living in community in Auckland (Abbott, Wong, Giles, Young, & Au, 2003), and 19.1 percent among 1087 representative community older persons in Hong Kong (K. Chou & I. Chi, 2005a). Depression had been described as the commonest and the most
reversible mental health problem in old age (Chen & Jiang, 2000; Ebersole & Hess, 2001; Lueckenotte, 2000). Overall it was clear that depression was a significant problem experienced by large proportions of the older population, especially in Macau. Consequently, improving mental health was an area targeted in the health policy initiatives, ‘Healthy City’ (Macau Health Bureau, 2004) and more recently the ‘Quality of Life of Macau Resident’ initiative (Macau Government, 2005). Within Macau’s healthcare system, nurses had responsibility for taking care of older persons with depression in various settings including hospitals, day centres for the elderly, and residents in community. Timely identification and effective management of depression might help to accelerate recovery and improve quality of life of these older persons (Feng, Jia, Hu, Wang, & Ji, 2004; Mayall, Oathamshaw, Lovell, & Pusey, 2004; Solnek & Seiter, 2002; Waller & Griffin, 1984; Waterreus, Blanchard, & Mann, 1994).

Associated with advancing age were both physical and psychological problems (L. Yin, 2000). Many of the emotional and physical aspects of ageing, such as physical disablement and dissatisfaction with life, were found to contribute to an increased prevalence of depression (Copeland et al., 1999). In addition, strong links had been noted between depression and the number of deficits in an older person’s social support, regardless of life events (Prince, Harwood, Blizard, Thomas, & Mann, 1997). Depression was a serious negative emotion. It was characterised as a dysphoric mood disorder, which resulted in the withdrawal of life interest, lack of motivation, loss of vital energy and feelings of hopelessness (Stuart & Laraia, 1998). Indeed, if left untreated, depression could result in high rates of morbidity and mortality (Anderson, 2001), due to natural causes and suicide: “depression is the most important psychiatric condition associated with successful and attempted suicide in old age” (Anderson, 2001, p. 13). In China, the suicide rate of older persons with depression reported as high, at 60 percent, with an associated high mortality rate at 15 percent (Chen & Jiang, 2000). Depression therefore threatened the older person’s life but, unfortunately, in primary health care it was frequently under-detected and usually untreated (Wong et al., 2006). A London study (Anderson, 2001) noted the higher uptake of services utilised by depressed older persons, found to be nearly three times that of healthy older persons. With its high cost on morbidity, mortality and services, depression amongst older persons was a risk that appeared to remain unaddressed, despite its position as the most common mental health illness amongst older persons.
Numerous initiatives had been developed to promote preventive and protective measures for depression in older persons (Alexopoulos, Raue, & Arean, 2003; Arean & Cook, 2002; Laidlaw, 2001; Lynch, Morse, & Mendelson, 2003; Mather, Rodriguez, & Guthrie, 2002; Reynolds, Frank, & Perel, 1999; Serrano, Latorre, & Gatz, 2004). Although the conclusions drawn from such work were invaluable, minimal data had been obtained about the effectiveness of depression-associated interventions in Chinese populations, and this included older persons with depression in Macau. Originally, the present study intended to develop and trial interventions for older persons with depression in Macau. Being a key research team member involving in a large-scale investigation of a proportionately stratified sample of 2039 older persons in Macau 2004, the researcher found the depression rate in Macau’s older persons was high at 10.4 percent using Geriatric Depression Scale-15 (GDS-15) with cut-off point of eight. However, the investigation presented only a score to indicate depression, thus facilitating comparison and statistical aggregation of the data, but did not capture the depth of understanding of the participants and situations studied. These results raised the question: why did these older persons score so negatively? In response to a lack of information about, and understanding of, Macau’s older persons’ lives contributing to and sustaining dysphoria that any intervention would need to take account of, it became clear that a number of questions needed to be answered to provide data that could then be used to develop culturally appropriate interventions. These questions included: What were the lived experiences of older persons with depression in Macau? What were the principal influences on depression among older persons in Macau? How could this information be used to inform health care, and nursing services, in particular to help prevent, detect and protect older persons from depression in Macau? These and other questions informed the development of the research design.

**Aims and Objectives of the Study**

This study aims to document and interpret the lived experiences of older persons with depression in Macau, in order to identify the principal influences on depression among older persons in Macau, and from these, construct an explanatory framework related to depression. The results gained from this original piece of work offer a significant contribution to the existing body of knowledge by furthering our understanding of the contextual factors associated with these real-life experiences of Chinese older persons.
with depression, in Macau and similar societies. This information, valuable in its own right, will then serve as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression among older persons in Macau. These findings will also help to inform future health service development for older persons and enable comparisons with other countries/regions to be made.

**Introduction to Macau**

In order to contextualise this study, it was important that information about the location of the research was provided.

**Autonomous Territory of Macau and its People**

Located in the Pearl River Delta of the southeastern coast of Mainland China, Macau is 60 kms away from the Hong Kong Special Administrative Region (see Figure 1.1). The territory consists of the Macau Peninsula, Taipa Island and Coloane Island and the total area is 29.2 km² (see Figure 1.2). The Macau Peninsula is connected to Taipa Island by three bridges and the two islands are connected by land reclamation. The climate of Macau is, in general, subtropical to temperate. It is humid and rainy in spring and summer, whereas in autumn and winter the relative humidity and rainfall drop. The typhoon season is from May to October, with the highest frequency from July to September. Macau’s population is mostly composed of migrants from the region of the Pearl River Delta; 78.5 percent of the inhabitants has been born in the People’s Republic of China (Pina-Cabral, 2004). Macau has similar cultural and geographical environments to Hong Kong with a total area of 1,104 km² and a population of approximately 6.92 millions in 2007. Macau’s geographic location and political history made it a main point of departure of the Chinese diaspora. At the end of the Qing dynasty period (1840~1911), Macau was the point of departure for the majority of coolies, the indentured labourers destined for the plantations and mines of the Southeast Asia and South America. The role of Macau as a stepping-stone for the Chinese diaspora was not limited to the coolie trade. Many intellectuals passed through Macau on their way out of China during the troubled years of the collapse of the Qing regime. Subsequently too, the Civil War in China that followed the end of the Pacific War and the first decade of the Chinese Communist Party regime saw large numbers of people
Figure 1.1 Geographical Location of Macau

(Adapted from: Macau Cartography and Cadastre Bureau, 2008)
Figure 1.2 Map of Macau

(Adapted from: Macau Cartography and Cadastre Bureau, 2008)
passing through the territory. Those who felt dissatisfied with the new Chinese regime were often able to escape via Macau due to the relative informality of the administrative arrangements. From 1949 to 1976, there was a steady inflow of migrants, many of them political refugees, who arrived in the territory in the most dire of conditions (Fei, 1996).

In the 1950s, however, many people made the reverse journey. Ethnic Chinese of Southeast Asia, who were being subjected to political and ethnic persecution in Indonesia, Malaysia, Burma, and Cambodia, returned to China via Macau. Those migrants who came from Southeast Asia constituted an important sub-group of the Territory’s Chinese elite in the 1980s and 1990s. After the political changes associated with the open-door policy in mainland China under Premier Deng Xiaoping in 1978, the numbers of returnees increased but then most migrants were motivated by economic considerations (Pina-Cabral, 2004).

**From Colony to Autonomy**

Formerly a Portuguese colony, Macau has been a Special Administrative Region of the People’s Republic of China since 20th December 1999. Its high degree of autonomy has allowed life to continue without great upheavals both during and after the transition. Macau retains its current political, economic and social system, unchanged for 50 years, under the Macau Basic Law. The Chinese government has affirmed its confidence in Macau’s future prosperity and stability, and this will help to guarantee the success of its “One country, two systems” policy. Since reunification with China, Macau has entered a cycle of prosperity and high development, which it had not seen before in modern times (Macau Government, 2008a).

In 1513, Portugal was the first European nation to reach China by sea. The Portuguese leased Macau from the Ming dynasty and settled down on the peninsula of Macau in 1557. Macau was granted the privileges of a Portuguese city by the Portugal Government in 1586 and given the title “City of the Name of God of Macau in China”, because of its growing importance, both in commercial and religious matters. In 1759, China closed all ports apart from Canton to foreign trade. This measure inaugurated Macau’s “Golden Era”, which lasted until the end of the Opium War in 1842, when the Qing dynasty had to agree to the opening of the so-called “treaty ports” (Fei, 1996).
Macau experienced its colonial period from 1846, after the Opium War, to 1987. The Portuguese authorities in Macau no longer respectfully and submissively obeyed the Chinese government’s decrees, and the Qing government could no longer control the situation in Macau. Macau attempted to renegotiate its position after Hong Kong was founded in 1843 in the midst of the Opium War. However, the Chinese leadership wanted to keep Macau under Portuguese administration but in such a manner that they could dictate the terms of the local policies. Such a situation continued until 1987 when the Chinese-Portuguese Joint Declaration was signed that established the terms of the transition. Macau stepped into a transition period from 1987 to 1999 and the Chinese and Portuguese authorities started collaborating closely to organise a smooth transition (Pina-Cabral, 2004).

Since the beginning of the colonial period, Macau’s life had been punctuated by the flaring up of incidents. In May 1922, Portuguese troops killed and wounded a large number of Chinese workers and urban inhabitants. After the massacre, Dr. Sun Yat-sen’s regime, leading the Xin Hai Revolution in 1911 to break the imperial dynasty system that had lasted for more than 2000 years in China, started the national movement to abolish all unequal treaties and notified that the treaty between China and Portugal had expired and become null and void. However, the Nationalist Party Government lacked the determination to retrieve Macau immediately; the Preliminary Treaty of Peking was signed on December 19, 1928, but Macau was not mentioned (Fei, 1996); In July 1937, the Japanese launched a large scale armed invasion with the aim to wipe out China. The Japanese captured Canton and Hong Kong in December 1941, leaving Macau an isolated “island” in the vast “sea” occupied by the Japanese army from southern Guangdong to Southeast Asia. With sea communications cut off, rice was in short supply and firewood costly. For Macau’s inhabitants, life was very hard, and many poor people were underfed, barely eking out a living. Throughout 1942, Macau suffered from serious famine. Many poor people were reduced to begging and died of hunger and illness in the streets. Macau entered a period of agitation lasting three years and eight months until September 1945 (Hsu, 2000).

**Impact of China’s Political Events**

Many other major political events that happened on the mainland China impacted on the inhabitants of Macau (Hsu, 2000), as being demonstrated in the stories of the study.
participants in later chapters of the thesis. The Civil War took place between the Chinese Communist Party and the Nationalist Party from 1945 to 1949. In the early phase of the Civil War, the Nationalist Party troops reaped victories at every encounter. On the other hand, the Chinese Communist Party foresaw many difficult days ahead before a final victory. Mid-1947 seemed to mark a turning point in the fighting. The previously victorious Nationalist Party military machine began to lose ground, partly because of increased assignment of soldiers to garrison duties in reconquered areas, with a corresponding reduction in the actual fighting force. In contrast, the Chinese Communist Party army had been expanding steadily (Hsu, 2000).

The People’s Republic of China was established on October 1, 1949 with the Chinese Communist Party conquest of mainland China. In June 1950, The Chinese Communist Party promulgated the Agrarian Reform Law, which called for the abolition of the land ownership system of feudal exploitation and the confiscation of landowners’ holdings and farm implements for redistribution to landless peasants. Both landlords and rich peasants suffered grievous losses and many were summarily shot after a brief public trial. The gentry, formerly the dominant elite and the backbone of the traditional society, was destroyed (Fei, 1996).

In February 1958, the National People’s Congress announced a “Great Leap Forward” movement. To achieve this phenomenal development goal, everyone was urged to participate in industrial production, regardless of his/her background, and to become a proletarian. By the Autumn of 1958, approximately 600,000 backyard furnaces had sprung up all over the country. Yet, much of the quality was sacrificed for quantity; three million of the 11 million tons of steel produced in 1958 was pronounced unfit for industrial use—backyard furnaces simply did not perform the same function as the giant steel mill (Hsu, 2000).

The Great Proletarian Cultural Revolution, from 1966 to 1976, ushered in a decade of turmoil and civil strife that drove the country to utter chaos and to the brink of bankruptcy. The party had been decimated and many of its leaders purged or dismissed. Industrial and agricultural productions suffered severe setbacks, and the disruption in education caused the loss of a generation of trained manpower. Poignantly, the Cultural Revolution turned out to be anti-cultural, anti-intellectual, and anti-scientific, for knowledge was considered the source of reactionary and bourgeois thought and action.
Countless officials and individuals were wrongfully accused of anti-revolutionary activities and imprisoned or driven to suicide (Fei, 1996).

The Chinese Communist Party conference of December 1978 (Third Plenum, Eleventh Central Committee) was a major landmark in the political and economic life in mainland China and adopted the new open-door policy. There was growing prosperity in the countryside and substantial improvement in the farmers’ standard of living. Urban life had become more colourful, open, and relaxed, and commercial and scientific exchanges with foreign countries grew by leaps and bounds. Ten years into the reforms, China’s economic indicators continued to skyrocket and showed no sign of slackening, but there were ominous signs of ideological confusion, economic imbalance, social unrest, and moral degradation (Hsu, 2000).

**The Culture of Macau’s People**

Reflecting Macau’s political history, social life in Macau structured itself around two linguistic universes: The Cantonese and the Portuguese. There was a clear boundary line between the Chinese and the Portuguese; people associated within their own circles and very seldom stepped outside of them (Duan, 1997). A large majority of the population (95.6 percent in 2006) spoke one of the Chinese languages, and of these 85.7 percent were Cantonese speakers. Portuguese was important as a language of administration, but not as a domestic language.

The great majority of the population was regularly involved in one form or another of ritual and religious practice, in particular, the Buddhist/Taoist rituals that were characteristic of Chinese popular religion and, as such, an integral part of the life of the Chinese population. Much of Chinese ritual activity could be viewed in terms of various forms of exchange between people and categories of spirits. Those who declared themselves ‘Buddhist’ or ‘Taoist’ were declaring more than the simple generalised allegiance to a religious ‘faith’ and its life cycle rituals. Such declarations were associated with the sort of ground-level Buddhist and Taoist communities that were proliferating in Macau during the 1990s, as a reaction to Portuguese’s leaving. These constituted small centres that were marginally associated to one or another of the large Buddhist monasteries and Taoist temples that were visited by the population on a regular basis. That Buddhist and Taoist beliefs persisted through Portuguese
colonisation for more than four hundred years reflected the culturally liberal stance of Portuguese rulers, allowing the Chinese to keep their own faith and customs (Saraiva, 1994). Dozens of Taoist and Buddhist temples were still kept intact. Confucianism, Taoism and Buddhism still preserved their own characteristics just as they had on the mainland. Religious rituals and festival celebrations and ceremonies still retained distinctive Chinese traditional features. The repeated destruction inflicted by people on the mainland, such as the great damage done to the temples by the disasters of war and the ten-year holocaust of the Cultural Revolution brought a great number of temples to the ground, and some sacrificial and celebration rites were lost. In comparison, Chinese traditional culture in Macau was richer (Duan, 1997). Many traditional practices were still intact in Macau, for example, there were many small altars on the ground dedicated to the God of the Earth, and household rites using incense to bring prosperity to the family were often performed at night (Han, 1997).

**Present Day Macau**

**Political System**

The Government of the People’s Republic of China resumed sovereignty over Macau on 20th December 1999 when the Macau Special Administrative Region was established in accordance with Article 31 of the Constitution of the People’s Republic of China. Similar to Hong Kong that was handed over on 1st July 1997, in harmony with the principle of “One country, two systems” policy, the previous capitalist system and way of life is to remain unchanged for 50 years. The principle of “Macau people ruling Macau” means that the people of Macau themselves exercise governance of Macau, with the executive body and the legislature of the Macau Special Administrative Region comprised of local residents of Macau. According to Macau Basic Law, the definition of Macau people refers to the permanent residents of Macau, including Chinese, Portuguese and other people who meet the qualifications stipulated in the Macau Basic Law. “A high degree of autonomy” means that the National People’s Congress (NPC) of China authorises Macau to exercise its autonomy in line with the Macau Basic Law, and the Central People’s Government will not interfere in the affairs that fall within the scope of autonomy of Macau. The autonomy to be exercised by Macau includes the administrative power, legislative power and independent judicial power, which included the power of final adjudication (Macau Government, 2008a).
Main Economic Activities

Macau pursues an open economic policy. Export has been a key industry in Macau for decades. While the manufacturing industry is striving to meet the challenge of a new era, export of services becomes more and more important in Macau’s economy. Macau is one of two international free ports in China, the other being Hong Kong. Goods, capital, foreign exchange and people flow freely in and out of Macau. Economic policy in Macau has focused primarily on protecting and streamlining its free market economic system. It has cultivated a world-recognised, free and open, fair and orderly market environment. In April 2007, the World Trade Organization (WTO) released a review of trade policies of Macau to recognise Macau’s economic achievements and its optimistic prospects for future development, and reaffirmed the openness of its economy (Macau Government, 2008a).

Macau’s economy is largely based on the leisure industries, particularly those activities that are associated with gambling as practised in casinos. With a history dating back to the mid 19th century, gambling is one of Macau's oldest industries. Entering the 21st century, the gambling industry has developed a very close relationship with the tourism industry, becoming one of the pillars of Macau's economy. It has also earned Macau the appellate "Monte Carlo of the Orient". It has been estimated that roughly three-quarters of the tourism industry was geared to serving gamblers. Approximately one-third of the declared legal profits of casinos were paid to the government as tax, constituting around 40 percent of the income of the Administration and 27 percent of the Gross Domestic Product (GDP). Indeed, in the 1980s and 1990s the main economic activity of the Territory was gambling. Subsequent renegotiations of the gambling contract have been of central importance to the development of Macau. The Government of the Macau Special Administrative Region decided to liberalise the gambling industry in 2001 to introduce competition in the industry, increase employment and consolidate Macau’s position as a gaming centre in the region. The gambling and tourism sector continued to prosper amid a favourable external environment. In the second quarter of 2008, the gross revenue of the gaming sector amounted to MOP (Macau Pataca, Macau's official currency) 29.17 billion (USD 3.65 billion). The sector contributed MOP 24.24 billion (USD 3.03 billion) in direct tax to the Macau government in the first seven months of 2008. The gambling and tourism sector propelled Macau's GDP to reach MOP 44.17 billion (USD 5.52 billion) in the first quarter of 2008, with a real growth of 31.6 percent.
over the same period of the previous year. In 2007, the per-capita GDP of Macau hit MOP 292,200, which was equivalent to USD 36,525 (Macau Government, 2008a). The total labour force was 337,400 and the labour force participation rate was 70.7 percent in 2008. The median monthly employment earning of residents amounted to MOP 10,000 (USD 1250). However, older persons who were 65 years old and over accounted for only 1.4 percent of the Macau employed population in 2008 (Macau Statistics and Census Bureau, 2008).

**Older Persons in Macau**

Since the early 1980s population ageing has become a global issue. While the majority of the world’s population of older persons resided in the developed countries, compared with other regions the Asian and Pacific region was home to the largest net number of older persons. Worldwide, the number of people aged 60 and over would increase from 600 million in 2000 to almost 2000 million in 2050 (United Nations, 2002). In 2000, China had the largest population aged 60 years and over; in absolute numbers, nearly 130 million older persons. While it took developed countries (such as France, UK, USA) 80 to 150 years to double their population of older persons from 7 percent to 14 percent, in China, it was projected that it would take only 27 years, from 2000 to 2027, for the proportion of the population aged 60 and over to double from 10 percent to 20 percent (United Nations, 2002). In Macau, older persons aged 60 and above were projected to rise steadily to 9.0 percent by the end of 2016, 12.0 percent by the end of 2021, 16.0 percent by the end of 2026, and 19.0 percent by the end of 2031. The proportion of the old-olds aged 75 and over among the population of older persons was also increasing. The percentage of people aged 75 and over of the population of older persons was expected to increase from 23 percent in 2000 to 38 percent in 2050 (Macau Statistics and Census Bureau, 2007b). In 1994, Macau Government approved the Basic Political Law of Family, which explicitly required families to take responsibility for old-age support. The law stipulated that children had the obligation to support their parents and prohibited abuse or abandonment (Macau Government, 1994). Unfortunately, many of these older persons were often without substantial personal resources. Few of them had participated in any pension schemes, and so they suffered if state and family resources were not available. Moreover, there was a continuing gender gap in life expectancy in the region, with females consistently outliving males, meaning many of the old-olds
aged 75 and over were women. Poverty amongst older women was potentially a major problem; they were often widowed, without adequate means of support, were less educated, had poorer health and worse financial situation when compared to men. This implied that, just as in other countries, many older women in Macau would live alone and in poverty in the last stages of their lives (United Nations, 2002).

**Social Services for Older Persons in Macau**

**Social Services Development Periods in Macau**

The social service for older persons in Macau could be divided into the following three development periods (Macau Social Welfare Bureau, 2006):

Phase I (before 1982): at that time, the services for older persons were primarily financial aid, material supply and refuge. Except for few nursing homes, there were scarcely any other social facilities established for older persons. The beneficiaries of these services were chiefly the needy older ones.

Phase II (1983-1999): social services for older persons developed rapidly during these 16 years. Besides the ever-increasing number of facilities, the scope of services also kept extending. The added services included: the Social Security Fund Policy; free primary and specialty health care; low-rent public housing policy for older persons; the Seniors Academy to assist life-long learning; and the social welfare services based on home and community. Recreational centres for the elderly, day centres for the elderly, day-care centres for the elderly, community dining halls, home helpers, services for the elderly living alone, homes for the elderly and nursing homes for the elderly were also offered. Furthermore, there was also provision for hospice and palliative care for older persons with terminal cancer.

Phase III (1999 to the present): since the restoration of Macau to the People’s Republic of China on 20th December 1999, social services for the elderly had been identified as a preferential priority in the administrative domain of the Macau Government. The social service policy for the elderly included financial support, support for positive living, support for those living at home, social housing and residential care, and medical services. The services were not limited to the needy older persons but made available to all the older persons of Macau. These social services were detailed in the next section.
Present Social Services for Older Persons in Macau

At the time of the present study, the following social services were, in theory, provided for older persons in Macau (Macau Social Welfare Bureau, 2006). However, since the Basic Political Law of Family still pertains, many of the following social services were in reality not available to many older persons.

1. Financial support:

- Old Age Subsidy, from Macau Social Welfare Bureau, was a direct financial assistance to older persons who were in severely impoverished circumstances.

- Old Age Supplementary Subsidy, from Macau Social Welfare Bureau, was a supplementary subsidy for the special needs of the beneficiary who received the Old Age Subsidy to overcome times of difficulties.

- Old Age Pension, from Macau Social Security Fund, was a financial assistance to support their basic life needs of the older persons after they retired.

- Old Age Social Assistance, from Macau Social Security Fund, was an assistance to older persons who had not any right to receive the Old Age Pension but lacked the means of maintaining the fundamental livelihood.

- Subsidy for Senior Citizens, from Macau Social Welfare Bureau since 1st August 2005, was given to advocate the merit of respect for the older persons and show the care for the older persons of Macau.

The type, eligibility and amount of financial support for older persons in Macau are detailed in Table 1.1.
Table 1.1 Financial Support for Older Persons in Macau*

<table>
<thead>
<tr>
<th>Name of support</th>
<th>Eligibility</th>
<th>Amount</th>
</tr>
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</table>
| Old Age Subsidy from Social Welfare Bureau           | -Macau residents aged 65 and over  
-Having stayed in Macau continuously for five to seven years  
-Lacking any means of livelihood or self support  
-No any assistance from Social Welfare Bureau or Social Security Fund | MOP 1650 (USD 206) per month |
| Old Age Supplementary Subsidy from Social Welfare Bureau | -A supplementary subsidy for special needs of the beneficiary of old age subsidy  
-Family with members of disabled or chronic diseases | MOP 850 (USD 106) per month |
| Old Age Pension from Social Security Fund            | -Macau residents aged 65 and over  
-Having stayed in Macau continuously for at least seven years  
-Have contributed at least 60 months of instalment for the Social Security Fund | MOP 1150 (USD 144) per month |
| Old Age Social Assistance from Social Security Fund  | -Macau residents aged 65 and over  
-Having stayed in Macau continuously for at least seven years  
-No right of receiving Old Age Pension  
-Lacking means of maintaining fundamental livelihood | MOP 750 (USD 94) per month |
| Subsidy for Senior Citizens from Social Welfare Bureau# | Macau permanent residents aged 65 and over                                           | MOP 1200 (USD 150) per year |

# Since 1st August 2005

* Adapted from: Macau Social Welfare Bureau, 2006
Chapter 1 Introduction and Context of the Study

2. Support for positive living:

- Recreational centres for the elderly: the centres offered social contact, recreational and educational activities and other social services to enrich their daily life of the older persons. At present, there were 24 such recreational centres for the elderly in Macau.

- Care for older persons network: this project provided the elderly living alone care and support while helping them to get in touch with social activities. Besides the regular visits by the volunteers and the staff members to offer assistance to quench their different needs, arrangements of tours, visits, social gathering, seminars etc. were all designed for the benefit of the older persons.

- Seniors Academy: the Seniors Academy of the Macau Polytechnic Institute offered courses (computer, history, arts, music, health education, Traditional Chinese Medicine) for older persons. Furthermore, they also organised activities including massage, Chen’s Tai Chi, Chinese traditional opera, Geomancy, swimming, and table tennis. The applicant for Seniors Academy must be capable in reading and writing Chinese and pay for registration fee at MOP 50 and tuition fee at MOP 120 per course. Most participants of the present study were exclusive because of their illiteracy and impoverishment.

- Senior Citizen Card Project: this project started on 2nd January 1997 encouraged respect for the elderly and offer them special privileges. The card holders were entitled to enjoy certain price reduction, free services or special prices in deals with the public or private businesses participated in the project.

- Dining halls: these offered inexpensive or even free meal for older persons.

3. Support for those living at home: social support services for community-dwelling older persons with intention to support and promote their living with their family:

- Day centres for the elderly: at present, there were seven day centres for the elderly. These day centres for the elderly provided, besides all the activities of the recreational centres, community support provisions of meals, clothes washing, bath showers, and hair-cutting etc.

- Day-care centres for the elderly: the aim was to provide general nursing care,
Chapter 1 Introduction and Context of the Study

rehabilitation services and social activities for the feeble and fragile elderly folk who required assistance and nursing care to meet their daily needs. These also helped to share the care pressures of their families. At present, there were two day-care centres for the elderly.

- Home help: this service was available for the older persons who were unable to take care of themselves and had no one to help them out. The services included personal hygiene, meal delivery, house cleaning, clothes washing, and shopping. At present, there were four home help teams.

- Home-visiting by the health centres: at present, health professionals from the eight health centres run by the Macau Health Bureau visited the older persons to provide primary health care for those who needed it.

- Rehabilitation escort transport: this was a service to offer transportation to those who had difficulty in moving about or were not in the position of taking public transport. At present there were two organisations in Macau installed with rehabilitation bus or charitable ambulance.

- Safety bell service: this 24 hours emergency domestic service had been established specifically for the older persons in the community who were living alone, with chronic illness, or disabled. This was a high-paid service, which functioned through a home instalment of an emergency calling signal fitted into the home, which allowed the user to contact with an agent if needed to lessen the danger of having unsupported and unaided situation.

4. Social housing and residential care:

- “Social Housing for the Elderly”: this project was for the elderly folk who were staying in poor living conditions and those single or couple senior persons living alone who needed special care. After being approved by the Macau Housing Bureau, the daily care was provided which includes 24-hour urgent supportive service, cleaning, laundry, meals and other social services. Currently there were five of these housing blocks for the elderly.

- Homes for the elderly: at present, there were eight homes for the elderly. These homes offered dormitory services, living care, health care, social activities and other social services for those who had no family or relative or any other means
Chapter 1 Introduction and Context of the Study

of support.

- Nursing home for the elderly: the first nursing home for the elderly for the sick and feeble aged folk was established in November 1999.

5. Medical Services: Macau offered older persons a number of different ways to obtain medical or healthcare services. The main streams could be grouped into governmental and non-governmental types. The medical services offered by the government included primary health care delivered from the health centres and the specialty health services provided by the Hospital Centre S. Januario. The non-governmental services were subdivided into government-subsidised institutes such as Kiang Wu Hospital, Operarios-Sede Clinic, Tung Sin Tong Clinic and all other private clinics. Of these, the services offered by Tung Sin Tong Clinic, the health centres, and the Hospital Centre S. Januario were free of charge for all the older persons of Macau, while other institutes were ‘pay-for-service’ with different service charges. The main services offered by the health centres to Macau residents were: adult health care, dental health care, health education, home visit, emergency service, and environment and food hygiene supervision. Except for emergency cases, the specialty departments of Hospital Centre S. Januario accepted only the patients transferred from health centres. Older persons might choose the required medical service according to their own situation (Macau Health Bureau, 2006).

In summary, these social services and medical services for older persons in Macau provided a safety net to support them in the final stage of their life. However, in practice a majority of older persons were unable to access these services and support as will emerged in the findings of this study. In 2004, the rate of beneficiary for the old age pension was only 22.7 percent among a proportionate stratified sample of 2039 Macau’s older persons (Macau Social Welfare Bureau, 2006) and this had only increased to 36.3 percent in 2007 (Macau Government, 2008b). Minimal data had been obtained about the impact of these social and medical services on older persons in Macau, and in view of the high incidence of depression among Macau’s older persons (D. D. Li et al., 2003; Macau Social Welfare Bureau, 2006; Ning, 2001), how older persons’ health and wellbeing were affected by the social and medical services needed to be investigated to provide data that informed future services development in Macau.


Chapter 1 Introduction and Context of the Study

Structure of the Thesis

The background and context of the study were set out in the first three chapters. The introduction and context of older persons with depression in Macau had been described in this chapter, outlining the brief socio-political history of Macau, the culture of Macau’s people, and present day state of political system and economic activities in Macau, in particular, the social services and medical services for older persons in Macau. The literature to provide the knowledge context of the study was reported in Chapter 2, presenting the rates of depression among older persons, theories on aetiology of depression among older persons, symptoms and signs, screening and diagnostic tools, and treatment of depression among older persons, and highlighting the studies that had explored depression as a social and cultural construct in Chinese older persons. The mixed methods of both quantitative and qualitative approaches used in conducting the study were described in Chapter 3, along with a discussion on theoretical framework of the study, mixed methods research design, instruments used, the participants, procedures of quantitative and qualitative data collection and analysis, and ethical issues related to conducting a triangulation and cultural research among older persons with depression in Macau.

The next five chapters addressed the dominant findings and discussion of the lived experiences of older persons with depression in Macau, which consisted of quantitative and qualitative data. To set the findings in context, Chapter 4 provided an introduction to, and overview of, the following four chapters that reported and discussed in detail each of the dominant categories to emerge in the study. Chapter 5 contributed to the study with description and discussion of negative thinking of feeling uselessness, hopelessness, sadness, and helplessness. Chapter 6 described and analysed the way in which physical limitations and complaints contributed to the negative thinking patterns of the participants. Furthermore, accounts of present living conditions and social support of these participants were the focuses of Chapter 7, accounted that further illuminated the issues behind their negative thinking patterns. Finally, Chapter 8 reported in-depth of the link between the lives they have lived in the past and negative thinking, lives characterised by hard labour with low reward, being fatherless, having a bad marriage, and trauma from wars and revolutions.
In the context of collecting quantitative data and narratives of the participants, a holistic understanding of depression in older persons in Macau emerged. The meaning of this phenomenon embedded in Chinese culture was unfolded in Chapter 9. The explanatory framework based on the medical and socioeconomic factors led naturally into interpretations of lived experiences, and explanations of depression given by older persons, especially Chinese older persons in Macau. Such explanations conformed neither to traditionally-held Chinese explanatory models, nor to those dominant in the western culture. Rather, the Chinese older persons with depression in Macau engaged in a process of drawing on physical/material meta-category, social/family meta-category, and mental suffering meta-category, in their search to explain their negative thinking, which led to their depression. The explanatory framework offered an alternative perspective for understanding the depression among Chinese older persons.

The thesis concluded in Chapter 10 by summarising the mixed methods research design, the relationships among the four dominant categories (negative thinking, physical limitations and complaints, present living conditions and social support, and the lives they have lived) and the explanatory framework which modeled the relationships among the three meta-categories (physical/material meta-category, social/family meta-category, and mental suffering meta-category), to understand depression in older persons in Macau. Further recommendations arising from the study for health services, nursing and future research agenda concluded the thesis.

**Summary**

The introduction and context of the study provided in this chapter outlined the issue of population ageing and high incidence of depression among older persons in Macau, who had lived through dramatic sociocultural changes and political events including Portuguese colonisation, the Pacific War (Japanese invasion of China), the Civil War between the Chinese Communist Party and the Nationalist Party, the Great Leap Forward movement, and the Cultural Revolution in China. The issues reviewed in this chapter, had raised a number of questions that guided the research reported in this thesis.
Chapter 2

Depression among Older Persons: A Review of the Literature

Introduction

In the light of increasing number of persons aged 65 years and over, in Macau and other countries, surviving into old and very old age, and the high prevalence of depression among older persons, often under-recognised and under-treated, attention must turn to better understanding the phenomenon of depression in older age. In order to establish the present state of relevant knowledge, published research was now reviewed. Reflecting on the biomedical basis of research, much of the literature had an epidemiological, aetiological or therapeutic focus and had been conducted in western contexts.

This review of the literature sought to provide an overview on the subject of depression in older persons, especially Chinese older persons, and to provide the knowledge context of the research. It critiqued both the different origins of depression in older persons and depression as a social and cultural construct in Chinese older persons, and highlighted the studies that have explored symptoms and signs, screening and diagnostic tools, and treatment of depression in older persons. The review was comprehensively divided into four sections: Part I explored literature pertaining to different origins of depression among older persons; Part II reviewed studies relating to symptoms and signs, screening and diagnostic tools of depression among older persons; Part III considered the treatment of depression; and finally, Part IV discussed depression as a social and cultural construct in Chinese older persons.

Part I: Rates of Depression among Older Persons

Depression had been described as the commonest and the most reversible mental health problem in old age, affecting 10 percent to 15 percent of the population over 65 in the UK, which seemed significantly higher than the incidence in general adult population
Chapter 2 Depression among Older Persons: A Review of the Literature

(Ebersole & Hess, 2001; Lueckenotte, 2000). Depression was also cited as being the commonest psychological problem among Chinese older persons (Chen & Jiang, 2000), with the prevalence of depression among Chinese elderly occurring at a higher rate than the larger population (Feng et al., 2004). Broader current estimates indicated that 15 percent to 20 percent of older persons in USA experienced depression (Stuart & Laraia, 1998), whilst the prevalence of depression increased among older persons in long-term care facilities; the incidence of depression in this population ranged from 30 percent to 50 percent (D. D. Li et al., 2003). The increased dependency that older persons might experience could lead to feelings of hopelessness, helplessness, a lowered sense of self-control, and decreased self-esteem and self-worth (Copeland et al., 1999; D. D. Li et al., 2003). Furthermore, changes that interfered with daily functioning might exacerbate depression (K. Chou & I. Chi, 2005a).

The incidence rate of depression among the Chinese populations across the world appeared to be variable. It was found to be 45.7 percent among a probability sample of 407 immigrant Chinese older persons in USA (Mui & Kang, 2006). In New Zealand, 26 percent of 162 Chinese elderly migrants living in community in Auckland showed symptoms of depression (Abbott et al., 2003). In Canada, there were almost one-quarter of 1537 elderly Chinese immigrants reported as having depression (Lai, 2004). In Chinese societies the prevalence of depression was also found to be high: 43.4 percent in 150 elders randomly selected in Taiwan (Y. Tsai, Chung, Wong, & Huang, 2005), 30.9 percent among 972 older persons in Hong Kong (Woo, Ho, & Lau, 1994); and 19.1 percent among 1087 representative community older persons in Hong Kong (K. Chou & I. Chi, 2005a). Differences in prevalence might reflect different instruments used and different cut-off points; for example Chou & Chi (2005a) used eight as the cut-off point for the Geriatric Depression Scale-15 (GDS-15) while Mui & Kang (2006) used the Geriatric Depression Scale-30 (GDS-30) with cut-off point of 11 and Tsai et al. (2005) used a modified, seven-item version of the Center for Epidemiologic Studies Depression Scale (CES-Dm). In Macau, the incidence of depression among 662 older persons in the community was found to be 12.37 percent by Ning (2001) using the Center for Epidemiologic Studies Depression Scale (CES-D) with cut-off point of 16. A further large-scale study identified that the incidence of depression among community-dwelling older persons was 10.4 percent (Macau Social Welfare Bureau, 2006) using Geriatric Depression Scale-15 (GDS-15) with cut-off point of eight. Another study
found that the incidence of depression was 53.1 percent for the older persons in day centres using GDS-30 with cut-off point of 11 (D. D. Li et al., 2003).

**Aetiology of Depression**

A number of factors had been found to be associated with depression. Biological changes with ageing and genetic predisposition (C. Walker, 2008), health problems and physical disabilities (Rovner & Casten, 2002), cognitive and behavioural perspectives and losses (A. T. Beck, 1976; Whybrow, 1997), and socioeconomic status (Payne, 2006; Wilton, 2003) were all factors that had been found to contribute significantly to the development of depression in older persons. Depressive symptoms in an older person were complex and might arise from several intersecting situations and conditions which included: biologic changes due to age, sleep cycle changes, neurotransmitter reduction, and alteration in neuroendocrine substances (E. S. Brown, Varghese, & McEwan, 2004; Penza, Heim, & Nemeroff, 2003). All of these contributed to a predisposition toward depression. Older persons were thought to be more vulnerable to depression because of the reduced production of mood-controlling neurotransmitters (E. S. Brown et al., 2004). The helplessness of observing one’s slowly deteriorating physical capacities was also depressing.

Beck (1976), a pioneer in depression research, believed that there was a host of possible predisposing factors, such as biological factors including hereditary predisposition, physical diseases leading to persistent neurochemical abnormalities, and developmental traumas, that led to specific vulnerabilities. In addition there were psychological factors such as inadequate personal experiences or sense of personal identity to provide appropriate coping mechanisms, counterproductive cognitive patterns, unrealistic goals, unreasonable values, assumptions, and imperatives absorbed from significant others. Beck’s views appeared to still have relevancy over two decades later.

Similarly, there was a host of possible precipitating factors. Some examples of these were: physical diseases and/or toxic substances, severe external stress (e.g., a series of losses of close relatives), chronic insidious external stress (e.g., continuous, subtle disapproval from significant others), and specific external stress impinging on a specific emotional vulnerability (e.g., a loss of an ability or attribute considered by the person to be the only mechanism for obtaining social supplies or attaining his goals).
Chapter 2 Depression among Older Persons: A Review of the Literature

The Origins of Depression in Older Persons

While theories on depression related to the general population were applicable to older persons, the elderly were vulnerable for a range of reasons. Depression was a disorder that affected thoughts, emotions and the physical body, encompassing all aspects of the human experience. Just as there were a number of theoretical schools in mental health, so there were a number of different ways to construct the disorder as outlined below. It was important to highlight at the outset that the ‘cognitive school’ had been prominent in recent years. Some of the problems experienced during depression included decreased lingual complexity, paucity of thought, reduced motivation, memory and concentration issues as well as a selective bias toward negative autobiographical events. Depression was often considered to be characterized by an ‘inaccurate’ cognitive style among other elements (Kuyken & Brewin, 1999). It was thought that many depressed older people had negative cognitive styles, negative ways of thinking and retrieving knowledge and memories, and all these negative cognitive styles were associated with a more chronic course of depression. Self-blame and self-criticism were cognitions common to many depressives. This was also true of intrusive negative memories. Most depressed older people experienced highly specific intrusive memories concerning illness, death in the family, episodes of personal illness and assaults, relationship problems and rows (Kuyken & Brewin, 1999). It was believed that the onset of depression could trigger certain internal information-holding structures called schemas. These schemas represented specific information in the brain and it had been considered that the onset of depression could trigger a ‘self-as-worthless’ schema and this might then maintain the depression while the episode worsened (Kuyken & Brewin, 1999).

In recent years, late life depression was often found to be associated with biological changes (Mondimore, 2006). As with all mental illnesses, biological explanations and implications had been eagerly sought from the scientific world, and this included both health professionals hoping to use their knowledge to better understand the biochemical basis of the illness, and patient groups seeking to move the responsibility for the illness to biological complications beyond the patient’s control. There had been much debate over recent years with regard to compartmentalizing aspects that were mental and those that were biological. Depression was, first and foremost, a biopsychosocial disorder and, as such, all three elements were crucial in its genesis, natural history and treatment.
Biologic Origins of Depression in Older Persons

Mental illnesses had strong biological elements because fundamental concepts of the experience of depression were represented using the biological apparatus inside the brain. Much of this apparatus and the way it worked were still largely undiscovered in the early twenty-first century but what we did know was that the different constituents of the brain and the body were intimately linked with. Depression was represented not only by apathy, despair, hopelessness and sadness but also by those physical problems of sleep difficulties, weight fluctuations, psychomotor retardation and somatic complaints.

A number of factors, including stress, genetic predisposition, social networks and life experience, interacted to determine vulnerability to mood. In particular, the physiology of stress had received attention with regard to depression. Nusair and Abou-Saleh (1997) concluded that the number of synaptic connections between neurons decreased while ageing. There was considerable evidence for changes in brain structure with ageing. Brain volume decreased with ageing but cerebral spinal fluid volume increased (Miller, Spencer, McEwen, & Stein, 1993). Davidson et al (1980) found significant elevated platelet monoamine oxidase (MAO) activity, which might further reduce central nervous system’s norepinephrine activity, in the older persons with depression. The limbic brain was a command post that received information from different parts of the body. It responded by regulating the body’s physiological balance and maintaining homeostasis (internal biological stability). It essentially processed information in order to ensure our survival. When something stressful occurred, processes in the brain activated what was known as the hypothalamic pituitary axis (HPA). Age was positively associated with basal plasma cortisol concentration (Mondimore, 2006). The hypothalamus, a constituent of this HPA, would act via the pituitary gland with the result that abnormally high levels of a stress hormone called cortisol was circulated around the body. This abnormal secretion could be beneficial in coping with immediate stressors but prolonged secretion could lead to problems with the immune system and depression. This endocrine arousal could be driven by feelings of chronic uncertainty and helplessness and the usually precise hypothalamic regulation of cortisol was impaired in many people with depression. Indeed, high levels of cortisol were related to more severe depressions (E. S. Brown et al., 2004).
Exposure of the HPA to stress led to decreased glucocorticoid receptor density in the hippocampus and the prefrontal cortex, an important area of the brain involved in planning and complex cognitive behaviours. This was possibly due to the chronic over secretion of cortisol, which was important because decreased hippocampal volume had been found in depression (Penza et al., 2003). Regarding these lower hippocampal volumes in patients with depression, studies suggested that this volume reduction might happen early in the course of depression or even preceded the onset of the disorder. An age-related decrease in the activity and density of noradrenergic neurons in the central nervous system might play a key role in the increased basal level of cortisol of older persons and thus, in turn, accounted for the association between age and plasma cortisol responding to yohimbine and alpha-2 antagonist (Nusair & Abou-Saleh, 1997). Furthermore, Miller et al (1993) announced that the thyroid-stimulating hormone (TSH) response to thyroid-releasing hormone (TRH) had been found to decrease in older men with increasing age. Hypothyroidism alone could cause all the symptoms of depression (Mondimore, 2006). Patients could experience slowed thinking, a decreased energy level, and memory problems in addition to depressed mood which, sometimes, was of a suicidal proportion. Therefore some impairment in the thyroid axis, analogous to that described as the HPA axis, might present.

The role of certain genes had also been explored in the recent medical literature, and a functional difference in a gene known as the 5 HTT gene was found to moderate the influence of stressful life events on depression. People with one variant of this gene appeared with more depressive symptoms, diagnosable depression and suicidal ideation in comparison to those with another variant. This had been taken as evidence for a gene/environment interaction where people with the unhealthier gene variant would be more likely to develop depression in the presence of stressful or difficult life events (C. Walker, 2008).

**Physiologic Origins of Depression in Older Persons**

One source of stress of particular importance among the elderly was medical illness and its associated functional limitations. Medical illness was closely associated with depression, contributing to both the emergence and persistence of depressive symptoms (Kocsis, 1998; Lyness, King, Cox, Yoediono, & Caine, 1999). Medical illness and consequent physical disabilities frequently robbed individuals of the ability to pursue
goals and engage in preferred activities (Rovner & Casten, 2002; Vali & Walkup, 1998). Among elders with physical disability and/or visual impairment, the loss of usual activities such as watching TV, reading, driving, walking, exercise, engaging in hobbies, and physical activities or routines were commonly reported (Rovner & Casten, 2002). Such changes constituted a major loss, leading to demoralisation, low self-esteem, and diminished self-efficacy (Bandura, 1982; Rovner & Casten, 2002). Further, these changes often took place in close proximity with other major life events (such as retirement, interpersonal loss, and reduced income) that might also diminish individual autonomy and compound vulnerability to depressive syndromes. The association between poor health and depression appeared to be stronger for men and for those aged 75 and over than for women and younger old people (aged 65-74 years). Poor health, loss of mobility and depression were linked with loneliness and social isolation (Cattan, 2002). Subjective measures of ill-health like pain, or self-rating of overall healthiness and well-being, were more strongly related to depression than were more objective measures of illness or disability like the number of chronic diseases or the degree of functional limitation (Beekman, Kriegsman, & Deeg, 1995). Nearly a third of older people with four or more medical problems were depressed, compared with 1 in 20 of those without a significant illness (Kennedy, Kelman, & Thomas, 1990), and the frequency of depression occurring among patients with poor physical health attending their general practitioner was twice that of healthy older people (S. Evans & Katona, 1993). Perceived health status and osteoarthritis were significant predictors of depression among Taiwanese institutionalised older persons (Y. Tsai et al., 2005). Eating problems and sleep problems were found to be significant predictors of depression in older adult (Cuijpers, Beekman, Smit, & Deeg, 2006).

Various theories had been advanced to describe the interactions between physiological and psychosocial factors in patients suffering from both medical illnesses and depressive symptoms. The interaction between depression and medical illness appeared to be bidirectional. Depression increased the risk for medical illness, and illness pathology in turn increased the risk for depression (MacMahon & Lip, 2002). Medical illness, as Lyness and colleagues (1996) had noted, was “the most consistently identified factor associated with the presence of late life depression and is the most powerful predictor of poor depressive outcome” (Lyness et al., 1996, p. 198). Conversely, depression was a major risk for onset or progression of a range of medical
illnesses. When medical illness was complicated with depression, the risk of morbidity and mortality were increased (Koenig & Kuchibhatla, 1999). Furthermore, there was a complex interplay between medical and psychiatric factors. Medical illnesses could increase depression both directly, through neurohumoral effects, and indirectly, through impaired role functioning and resultant demoralisation. Depression, similarly, could aggravate medical illnesses through both direct and indirect routes. The risk of depression as measured one week after myocardial infarction, for example, was increased by about 24 percent in one study. Another study, examining patients hospitalised for congestive heart failure, identified severe depression in 85 percent of participants (Zuccala, Cocchi, & Carbonin, 1995). Acceptance of ill health as a normative aspect of ageing and illness, resulting in adoption of a “sick role,” could contribute further to a condition of “excessive disability.” The outcome could be a positive feedback loop or “reciprocal spiraling” (Bruce, 2001), a mechanism in which depression and medical illness mutually exacerbated with each other, ultimately producing greater dysfunction than that would be accounted for by either component of illness alone (Lenze et al., 2001). Many older adults dismissed depressive symptoms, which they were more likely to attribute to their known medical illnesses. Others might underreport depressive symptoms as a result of a negative attitude towards psychiatric illness.

**Psychologic Origins of Depression in Older Persons**

In common with many other mental disorders, theories of the causality of mood disorders could be placed within psychological, social and biological perspectives. The psychological perspective traced the cause of mental disorders to past events, often remoted to the sufferer, which impinged on current emotions and cognitions, whereas the social perspective tended to focus on the impact of interpersonal and social events external to the sufferer. These two perspectives employed the mind–body dualism of Descartes and leaned heavily on psychological constructs to explain the origin of depression. The psychiatric literature was replete with discussions of the psychologic aetiology and psychodynamics of depression in age (A. T. Beck, 1976).

The psychodynamic perspectives had traditionally focused on depression as the result of aggression or anger turned inward towards the self. This anger had been directed at a loved one who had thwarted the person’s need for love and support. Because the person
had internalised the love object in his attempt to prevent a traumatic loss, he became the target of his own anger (Whybrow, 1997). Ayalon and Young (2003) noted that depression in older adults might result from frustration and their sense of loss of control over the environment and a need to respond positively to accommodate environmental stimuli, especially what appeared to be helpful gestures from the environment. Monopoli, Vaccaro, Christmann, and Badgett (2000) also suggested that loss of self-esteem was the central psychological problem of depression in older persons. When the older person looked back on his or her life course, which was viewed as not as worthwhile as it should be, self-esteem decreased, thus increasing despair. This despair would then take in the form of depressive symptoms. However, this theory failed to provide an account of current forces outside the individual, and recent developments in the psychoanalytic tradition had allowed a more active interchange between the mind and the environment. Adult losses, of which separations were the most frequent and potent, were postulated to revive a childhood loss and hence led to psychopathology (Monopoli et al., 2000).

Cognitive theories focused on the way people processed information and became popular in the second half of the twentieth century. Prominent cognitive theories included those of Aaron Beck, a mental health professional who created the concept of the negative cognitive triad. Beck et al (1979) proposed that the cognitive triad consisted of three major patterns that induced the patient to regard himself/herself, his/her future, and his/her experiences in an idiosyncratic manner. The first component centred on the patient’s negative view of himself/herself. He/she viewed himself/herself as defective, inadequate, diseased, or deprived. He/she often attributed his/her unpleasant experiences to a psychological, moral, or physical defect in himself/herself. He/she tended to underestimate or criticize himself/herself because of their defects. Finally, he/she believed he/she lacked the attributes that he/she considered necessary to attain happiness and contentment. The second component of the triad consisted of the patient’s tendency to interpret his/her ongoing experiences in a negative way. He/she viewed his/her world as making exorbitant demands on him/her and/or presenting insuperable obstacles to reach his/her life goals. He/she misinterpreted or overinterpreted his/her interactions as representing defect or deprivation. The patient negatively construed situations even when more plausible, positive interpretations were apparent. The third component of the triad consisted of a negative view of the future.
The depressed patient anticipated that his/her current difficulties or suffering would continue indefinitely. He/she foresaw unremitting hardship, frustration, and deprivation. When he/she considered undertaking a specific task in the immediate future, he/she predicted that he/she would fail. Depressed people were said to have a negative view towards the world, a negative view of themselves and a negative view of the future, and these people would commit ‘cognitive errors or distortions’ based on these three sets of beliefs. These errors were thought to maintain an outlook on life that perpetuated depression. Once the older person developed the negative triad about the self, the world, and the future, and developed schema that structured cognitive functioning into an enduring component, which in turn became formalised, then usual life events led to depressive symptoms. This was because interpretations of those events were typically negative and idiosyncratic to the older person. In addition, autonomous depressive symptoms could lead to negative interpretations of the environment and similar idiosyncratic contexts. Beck (1976) postulated that negative mental structures, called schemas, existed in a latent form and could act as predisposing factors to depression. Helplessness and hopelessness were seen as core experiences of depressed people (A. T. Beck et al., 1979).

The other signs and symptoms of the depressive syndrome might be viewed as consequences of the activation of the negative cognitive patterns. Motivational symptoms (for example, paralysis of the will, escape and avoidance of wishes) could be understood as consequences of negative cognitions. “Paralysis of the will” might result from the patient’s pessimism and hopelessness. If he/she expected a negative outcome, he/she would not commit himself/herself to a goal or undertaking. Suicidal wishes could be explained as an extreme expression of the desire to escape from what appeared to be insoluble problems or an unbearable situation. The depressed person might see himself as a worthless burden and consequently believed that everyone, including himself, would be better off if he were dead. Not only did cognitive aspects contribute to depression, the cognitive aspect of depression might also explain the physical symptoms of depression. Apathy and low energy might be the consequences of the patient’s belief that he was doomed to failure in all his experiences (A. T. Beck, Steer, & Garbin, 1988).

Behavioural models of depression focused on the characteristics of people’s immediate environment such as events of an interpersonal or situational nature. The theory of learned helplessness was one such theory. Based largely on animal experiments, the
theory of learned helplessness stated that a lack of assertiveness, passivity and resignation to fate were learned from the past where the person was unable to discover a behaviour that terminated aversive events. Thus helplessness was traced back to the personal biography of the patients. Evolutionary theory was one strand of a more biological, reductionist approach to mental health and had also been used as a framework to explain depression (and, indeed, almost every other facet of human culture). Evolutionary theory stated that depression was actually an evolutionary adaptation whose function was to inhibit aggressive behaviour to rivals and superiors when one did not have the resources to effectively challenge them. It acted as a kind of self-check mechanism to stop individuals competing and fighting for resources that they could not realistically have access to and thus set up a dominance hierarchy without resorting to violence. Evidence from studies of primates had been used to support this view and humans were thought to share this yielding mechanism when competing for food or mates. It was self protective as it signaled that the individual did not represent a threat. That said, while there might or might not be some merit in this explanation, there were grave doubts about the success of evolutionary psychologists who tried to explain to severely depressed patients that their current state served as an adaptation. Just because a given illness was widespread within a species did not necessarily mean that it had an evolutionary origin (Whybrow, 1997).

Social Origins of Depression in Older Persons

Depression and social support might be linked (Harris, Cook, Victor, DeWilde, & Beighton, 2006). Proximal stressors in the social environment that might contribute to the onset and continuance of depression in older adults had been divided into life events, chronic stress, and daily hassles (George, 1993). Life events were those identifiable, discrete changes in life patterns that disrupted the elder’s usual behaviour and threatened or challenged his or her well being. Such life events as bereavement, moving house, social alienation, employment difficulties, the breakdown of a relationship and suffering a long-term or debilitating illness had been considered to be causes of depression (Priest, Vize, Roberts, Roberts, & Tylee, 1996; Spence, Najman, Bor, O'Callaghan, & Williams, 2002). Indeed, the strongest relationship between life events and the onset of depression had been shown to be between threatening and undesirable events and depression onset (Putnam, 2000). Longer duration of depression appeared to
be associated with marital difficulties or widowhood, with a shorter duration of illness associated with lifetime trauma (C. Brown, Schulberg, & Prigerson, 2000). Chronic stress included those long-term conditions that challenged or threatened the elder’s well-being, such as ongoing financial deprivation and interpersonal difficulties (Krause, 1987). Daily hassles were the ordinary but stressful events and transactions between the person and the physical or social environment (Kubzansky et al., 2005). Examples of daily hassles included household responsibility, home maintenance, and unpleasant interactions with neighbours.

Social networks provided tangible health assistance as well as reinforcing healthy modes of behaviour. It had been shown to be significantly associated with depression in particular (Putnam, 2000). Social support had a direct effect on depression symptoms. Social engagement was independently associated with depressive symptoms (Glass, De Leon, Bassuk, & Berkman, 2006). Higher rates of depression had been found in people who reported feelings of isolation over the previous twelve months as a result of the difficulties related to life, cost and availability of transport, paid work, issues related to care for children and being unable to socialize with friends and family (Payne, 2006). The size of a person’s social network was important, with larger social networks being associated with better mental health (Stansfeld, Fuhrer, Shipley, & Marmot, 1999). The size of a person’s primary group (the social support network) was significantly smaller in psychiatric outpatients than community controls (Brugha et al., 2004). Over the years some of the leading theorists on suicide, like Emile Durkheim and Roy Baumeister (1990), had reiterated the importance of poor social integration as a precipitating factor in both depression and suicide. Social support was profoundly important with regard to coping with everyday challenges and strong interpersonal ties protecting people from becoming distressed. Social interaction was not the same as social support and strong, supportive relationships were often needed to reduce feelings of helplessness and low self regard, to reduce the impact of what could often seem like crushing life events. The feeling of not being isolated, of experiencing a rich support network, could be of great help for many people as they moved through difficult times (House, Landis, & Umberson, 1988).

There was a considerable and growing body of literature showing that poverty and economic deprivation were associated with an increased prevalence of mental disorders, including depression (Boardman, Hodgson, Lewis, & Allen, 1997; P. R. Roy-Byrne,
Ruso, Cowley, & Katon, 2003), with depressed groups suffering from greater economic deprivation than healthy controls (E. Lin & Parikh, 1999). Depression had been shown to be associated with low material standards of living within all occupational strata, and Weich and Lewis (1998) claimed that a poor material standard of living accounted for nearly 25 percent of prevalent cases of common mental disorder. It had been shown that poverty not only predicted current risk of depression but also predicted depression in the future. Data from the New Haven Epidemiologic Catchment Area study showed that poverty at first contact predicted a doubling of the risk of a further depressive episode (G. W. Brown & Moran, 1997). Financial strain seemed to be the critical mediator behind the greater depression associated with unemployment (Price, Choi, & Vinokur, 2002). Moreover, the experience of being in debt to one or more companies in the last year made someone significantly more likely to suffer poor mental health. It had been suggested that the profound fear of eviction and impending homelessness associated with falling into mortgage arrears had led to nearly 80 percent of such people suffering from mental disorder (Payne, 2006).

Poverty and the development and maintenance of social networks were related. A lack of income could seriously impinge upon the possibilities for social network development and integration (Wilton, 2003) and such a lack of social integration that resulted from being unable to finance sociality would lead to greater isolation and feelings of alienation. If an older person could not afford to visiting malls, shops, pay for their own phonecards or mobile phones and could not afford the clothing by which to subjectively make oneself respectable, then such community and family ties could easily drift. Feeling like a third class citizen, since one was unable to exist at the same consuming level as members of your social circle, could lead to a distancing from those around, and such considerations were more common than many people might realise. Both social capital and social support influenced mental health status, and there was considerable evidence to suggest that having less social support with which to cope with the increased stresses and strains created by urban living was fundamental to mental health disorders including depression. Reduced housing quality and greater social isolation were profound problems that increased the risk for developing depression and decreased the likelihood of recovering from depression and these factors were rather endemic in urban environments.
Other studies indicated that children from poorer families had poorer academic achievement, nutritional status and social development than more advantaged children (Petterson & Albers, 2001). They tended to have more mental health problems generally, with higher rates of depression specifically, than children of wealthy families. Those children with an early history of persistent poverty had higher levels of depression over the five years that they were examined, regardless of their subsequent experience of poverty (McLeod & Shanahan, 1996). Simply addressed, it appeared that early economic disadvantage had long term effects on mental health. This long term effect of consistent poverty during the first five years of a child’s life also influenced the child’s depression during adolescence and this effect was independent from the mental health status of the child’s mother (Spence et al., 2002). Family interaction, especially criticism, had a more imposing effect on psychological symptoms. Emotional support had a stronger effect on psychological symptoms than did instrumental support (Kawachi & Berkman, 2001). Satisfaction with family assistance turned out to be significantly correlated with the level of depression (Kim-Goh, 2006).

As with all psychological theories, each of the above conceptualisations had elements that intuitively rang true when discussing some given aspect of depression but no theory alone was able to provide a completely convincing account of the full psychological, social and biological elements of the disorder.

**Part II: Symptoms and Signs of Depression**

Turning from a discussion of the origins of depression across the age spectrum, the focus now was on depression in older persons and specifically, how depression was manifested, as reported in the literature. Symptoms of depression included changes in physical, psychological, or social functioning, subjectively reported, that might be indicative of maladaptation. Signs of depression, on the other hand, were objective indications that maladaptation is present. Symptoms and signs of depression in late life were determined not only by reports and observable evidence of distress within the individual but also observations that the personal environmental interactions were disturbed. The chief complaint made by the depressed older person concerned physical health, difficulty in family and social relationships, dissatisfaction with economic circumstances, and so on, highlighted in the following literature.
Emotional Symptoms

Emotional symptoms of depression were those changes in the person’s feelings that accompany depression. The most common characteristic symptoms described by depressed persons were affects, e.g. sadness, decreased life satisfaction, loss of interest, and feelings of hopelessness (Blazer, 2002a).

Blazer (1993) found depressed older persons, in both clinical and community samples with equivalent severity of depression and no complicating comorbidity, were no less likely to respond that they were sad, “blue”, or down in the dumps during a depressive episode than persons in mid-life. Consequently, decreased life satisfaction was a pervasive emotional symptom among the depressed. The symptom was common and was usually associated with external factors, such as poor health, or widowhood (Gallo, Rabins, & Anthony, 1999).

Loss of interest, however, was a common symptom of depression in later life. Negative feelings toward the self were frequently found among the elderly (Beck, 1993), whilst feelings of helplessness, hopelessness, and uselessness were experienced by older persons suffering from depression. Demoralised and discouraged older persons complained of a sense of hopelessness and helplessness about the future and might reflect the difficulties that they faced in their lives (Blazer, 1993). The depressed older persons might withdraw from social activities, which in turn led to boredom and loneliness (Isaacowitz & Seligman, 2001).

Severe depression was often accompanied by complete paralysis of will, leading to almost total immobility associated with passive resistance to intervention by others. Many depressed older persons withdrew from more demanding activities and appeared to be attracted to less demanding activities in terms of degree of responsibility or initiative required. This was, in part, secondary to residual physical disabilities, but motivational difficulty was also a frequent cause of inability to initiate activity (Gallo, Rabins, Lyketsos, Tien, & Anthony, 1997).

Cognitive Symptoms

Beck et al (1979) emphasised the importance of cognitive symptoms and depression. Thoughts of a depressed older person might reflect distortions or unrealistic
conceptualisations that deviated from logical thinking about the self and the social environment, which in turn led to a depressed affect. Unwarranted pessimism about the future was common in the depressed older persons. Rumination about present and past problems was characteristic of depressed older persons. Rumination might be accompanied by delusions of uselessness. Delusions of unforgivable behaviour or self-blame and criticisms were related to the egocentric notions of causality frequently seen in the elderly (A. T. Beck et al., 1979). Symptoms ranged from suspiciousness and irritability to frank delusions.

**Physical Symptoms**

Physical symptoms were frequently associated with depression in late life. Kraaji, Arensma, and Spinhoren (2002) found that, in primary care settings, somatic symptoms were common among older persons suffering depression. The most common somatic symptoms were sleep problems, fatigue, dizziness, and appetite changes. Blazer (2002a) suggested that the frequency and severity of somatic symptoms increased with the severity of depression among the elderly. Goodwin, Black, and Satish (1999) found severe localised pain to be an occasional symptom of depression in the elderly. Schnittker (2005) found chronic pain to be a more frequent complaint in the depressed elderly than in controls, whilst sleep difficulties were also common complaints (Black, Goodwin, & Markides, 1998). Changes in sleep habits normally accompanied ageing, and these complaints might reflect a lack of understanding and tolerance of the normal physiological changes, rather than symptoms induced by depression. Although Ayalon and Young (2003) found numerous somatic symptoms in the depressed elderly, they found that somatic symptoms contributed less to depression than lack of hope, decreased activity, difficulty in doing things, feelings of uselessness, and problems in decision making.

**Signs of Depression**

In recent years, signs of depression had received less emphasis than symptoms. Weight loss had been found to be more common in the elderly depressed than in depressed persons younger than 60 years (Blazer, 2002a). Older depressed patients also often required enemas or manual evacuations for constipation. Parker et al. (1998) suggested psychomotor retardation, nonreactivity, distinct quality of mood, and nonvariability of
mood featured as the most distinguishing signs of depression. Parker et al. also emphasised the importance of observable signs, which could be as reliable as self-reported symptoms. Observable signs might be especially relevant to older persons who might not volunteer their symptoms as easily, or who might be so depressed that they were incapable of responding accurately to an interview.

**Screening and Diagnostic Tools**

The components of screening and diagnostic workup for an elderly person with depression included history, symptoms, physical examination, and mental status examination (Blazer, 1993). The high probability that older persons with depression would experience a concurrent medical problem or history of medical difficulties, made the distinction of depression symptoms in the medically ill difficult. One of the major difficulties in diagnosing late life depression was making the distinction between depression and organic mental disorders. For this purpose, Blazer argued the need to obtain an accurate chronological history of onset, duration, and fluctuation of symptoms over time.

Physical examination appeared to help establish a therapeutic relationship with the older person and showed concern about the physical complaints that were frequently expressed by depressed elders. Careful evaluation of the endocrine system (especially the thyroid gland), neurological deficits (especially frontal lobe signs), cardiac dysfunction, and signs of an occult malignancy was essential (Blazer, 2002a).

The mental status examination of the depressive person, especially the elderly, was central to the diagnostic workup. Mood was the feeling state that underlies affect and was sustained over a period of time. Previous studies have found that mood was usually depressed and was sustained during interviews in depressed elders (A. T. Beck et al., 1979; Greenberger & Padesky, 1995). Therefore a thorough evaluation of the content and process of cognition was essential for the depressed elder. Thinking was the goal-directed flow of ideas, symbols, and associations that was initiated in response to a problem or task and that led to a reality-oriented conclusion (Newman, 1989). Newman went on to say that disturbances of thinking might present as problems with the structure of associations, the speed of associations, and the content of thought. The depressed older person might have beliefs that generally could not be corrected by
reasoning, and which were inconsistent with objective information obtained from family members about his/her abilities and social resources. Disturbances of memory and intelligence were commonly elicited during the mental status examination of the depressed older person. Disturbances of recall could also be tested directly; the most common test involved questioning about orientation to time, place, person, and situation. Recent memory might be assessed by asking the older person to recall certain events during the past 12 to 24 hours, such as what he or she ate during the most recent meal. Intelligence, the ability to constructively understand, recall, mobilise, and integrated previous learning when meeting new situations (Newman, 1989), should also be tested and include ability to abstract, the ability to perform simple arithmetic calculations, the fund of knowledge, and tests unrelated to previous experience.

**Psychological Testing**

The use of psychological tests for the evaluation of depressed older persons was commonplace. Varying estimates in the prevalence and incidence of depression in the elderly might be due to the approaches used to determine and measure depression (Newman, 1989). Clinical assessments and associated tools, used by mental health professionals specifically trained in detecting and diagnosing mental disorders, included the Structured Clinical Interview (SCID) based on criteria from the DSM-IV and the depression module of the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule (DIS) (First, Spitzer, Gibbon, & Williams, 1995; Newman, 1989; L. N. Robins, Helzer, Groughan, & Ratcliff, 1981). A major feature of clinical assessments was reliance on the clinician’s ability to probe further into the informant’s responses and to provide an accurate interpretation in order to determine presence of a mental disorder, its type and severity, and appropriate course of treatment. Non-clinical assessments involved tools used by non-clinicians and researchers to estimate depression and depressive symptoms in a study sample. Non-clinical assessments included the CIDI-Depression Module (L. Robins et al., 1988), the Geriatric Depression Scale (GDS) (Yesavage et al., 1983), the Center for Epidemiological Studies in Depression Scale (CES-D) (Murrel, Himmelfarb, & Wright, 1983; Radloff, 1977), the Self-rating Depression Scale (SDS) (Zung, 1965), and the Beck Depression Inventory (A. T. Beck et al., 1988). Non-clinical assessments were designed specifically to
eliminate or minimise the need for the untrained interviewer to make an interpretive decision regarding depression status of the informant.

**The Mental Status Questionnaire (MSQ)**

The Mental Status Questionnaire (MSQ) had a long history of use in clinical settings since its development in USA and was a concise measure of orientation and memory, drawn partly from standard mental-status examinations. The tool had been modified in the USA by Pfeiffer (1975). It had been widely used in community and clinical populations. It had been successfully used with older persons living at home in the USA by Feher (1991) and had been judged to be a useful measure in institutional settings (Bowling, 1995). Bowling (Bowling, 1997) reported it could be easily administered to 90 percent of geriatric inpatients. As an indication of the ease of administration, they indicated that half the questions could be asked without the patient’s knowing he/she was being tested, and the other half could follow after brief explanation: ‘How is your memory, I would like to test it?’ They reported that it rarely provoked anxiety or embarrassment. It could be given without causing fatigue in the very ill. Lazarus (1966) reported that the MSQ had a high association with psychiatrists’ evaluations of the presence and degree of chronic brain syndrome and reliability to be satisfactory. Bowling (1997) concluded that the MSQ was a powerful measure for detecting and quantifying mental impairment.

**The Geriatric Depression Scale-15 (GDS-15)**

The Geriatric Depression Scale-15 (GDS-15) was developed in response to the recognition that depression scales developed on younger persons or the general population might not be most ideal for use in the elderly population. Example of items used in the general adult population that were unhelpful in older adults include, somatic complaints of depression that were confounded with the general physiological effects of ageing, and issues surrounding hope and suicide that were difficult to interpret for people approaching the end of their lives. The GDS was constructed in older population in USA and to construct the GDS, 30 items were chosen from an initial pool of 100 items on the basis of corrected item-total correlations. None of the initial items tapping somatic problems and suicide thoughts were selected due to their lower item-total correlations. All items were answered on a yes-no basis to suit the information-
processing capacity of older persons in general (Brink et al., 1982; Yesavage et al., 1983).

Subsequently, the 15 items which had the highest correlations with the number of depressive symptoms assessed clinically in the validation sample, were further chosen from the 30-item pool to form the GDS-15 (Sheikh & Yesavage, 1986). Evidence suggested that the GDS was applicable to the very old (De Craen, Heeren, & Gussekloo, 2003) as well as elderly persons with mild-to-moderate cognitive impairment (E. P. Feher, Larrabee, & Crook, 1992).

**The 36-item Short-Form Health Survey of Quality of Life (SF-36QOL)**

The 36-Item Short Form Health Survey (SF-36QOL) developed by Ware et al. (1993) in USA was gaining international popularity and had been widely used for. The SF-36QOL usually took about 5–10 minutes to complete, although elders might require up to 15 minutes (McDowell & Newell, 1996). Some literature recommended elders did not self-complete the SF-36QOL due to their cognitive and physical difficulties (Lyons, Perry, & Littlepage, 1994; S. G. Parker et al., 1998). Not all instruments were suitable for both self-administration and telephone interview, but the SF-36QOL was developed to be consistent in either mode (McDowell & Newell, 1996; Mchorney, Ware, Lu, & Sherbourne, 1994). The SF-36QOL was composed of eight scales, each of which had 2–10 items. The internal consistency reliability of the scales in the English language SF-36 (Cronbach alpha) had generally exceeded 0.80 in studies (Mchorney et al., 1994; Ware, Kosinski, & Keller, 1994) and construct validity had been established by comparison with other health surveys (Ware et al., 1994). Scores on the SF-36QOL scales were transformed to a 0–100 scale, with higher scores indicating better health status.

**Part III: Treatments of Depression**

There were a plethora of evidence-based therapies for depression, in approaching psychological disorders, it was important to take a holistic view, as disorders were most often multifactorial in nature. This holistic, multifactorial, and biopsychosocial perspective was the cornerstone of nursing philosophy making certain therapies more appropriate for use in nursing (Wellbery, 2003). Older persons with depressive mood had a range of treatment options separately or in combination and could be broadly categorised as being medical, psychological and lifestyle changes/ alternative therapies.
Chapter 2 Depression among Older Persons: A Review of the Literature

Medical treatments included antidepressant medication (Wilson, Mottram, & Sivanranthan, 2004), electroconvulsive therapy (Vander, Stek, Hoogendijk, & Beekman, 2003, 2004), oestrogen therapy (Carranza-Lira & Valentino-Figueroa, 1999), testosterone therapy (Perry, Yates, & Williams, 2002), and transcranial magnetic stimulation (Jorge, Robinson, & Teateno, 2004).

Psychological treatments included cognitive therapy (Arean & Cook, 2002; Laidlaw, 2001), dialectical behaviour therapy (Lynch et al., 2003), interpersonal therapy (Reynolds et al., 1999), problem-solving therapy (Alexopoulos et al., 2003; Arean, Perri, & M., 1993), psychodynamic psychotherapy (Arean & Cook, 2002), reminiscence and life review (Bohlmeijer, Smit, & Cuijpers, 2003; Serrano et al., 2004), bibliotherapy (McKendree-Smith, Floyd, & Scogin, 2003).


Most treatments that were found to be effective for older adults overlapped with those that were currently recommended for adults in general. Given the different aetiological pathways and the different presentation of depression in older persons, it was important that the full ranges of possible treatments were evaluated for use by this population. Reminiscence/life review and testosterone therapy were treatments specifically formulated for older persons, and others might be found to be especially effective in this age group. In the case of late-onset vascular depression, trials of treatments for cerebrovascular disease might be worthwhile. Testing of older persons needed to be broadened to potentially include these possible treatments, particularly in view of the public’s more favourable attitudes to some non-standard treatments (Arean, Gum, Tang, & Unutzer, 2007).

**Pharmacotherapy**

Pharmacotherapy was often used exclusively to treat depressive mood for numerous reasons. Primary care providers often used medication alone to treat depression, for reasons including perceived ease of administration and cost considerations. The medicalisation of depression had made the disorder more legitimate and acceptable, a far cry from the stigma in decades and centuries past. This approach, however, negated
the very premise of psychological disorders. It was still not clear whether alterations in brain chemistry preceded or induced reductions in mood or whether altered brain chemistry was an outcome of stressful events that lowered mood. There was evidence that most cases of depression were preceded by stressful life events, providing support for latter explanation (E. S. Brown et al., 2004). It was most likely that depression and stress were interactive and mutually reinforcing: stress decreases mood, which decreased select neurotransmitters, which left the individual more vulnerable to stress, etc (Van & Riksen, 2004).

Antidepressant medications were very effective. Tricyclic antidepressants were considered the gold standard of antidepressant therapy in terms of their effectiveness, but their extensive side effect profiles made them a second-tier consideration. Selective serotonin reuptake inhibitors (SSRIs) were considered first-line therapy because they had good effectiveness and a desirable side effect profile. Finally, monoamine oxidase inhibitors (MAOIs) were a tertiary-line treatment reserved for severely depressed individuals who had exhausted other pharmacological options because they had the potential for life-threatening food and drug interactions (Wellbery, 2003).

Although antidepressant drugs seemed to be less expensive than psychological treatment, not all depressed people responded to these medications. The best estimates, based on a review of numerous controlled studies of the chemotherapy of depression, indicated that only about 60 percent to 65 percent showed a definite improvement as a result of treatment with a common tricyclic drug (C. T. Beck, 1993). Hence, methods must be developed to help the 35 percent to 40 percent of the depressed people who did not respond to such therapy.

**Cognitive Behaviour Therapy and Depression**

Cognitive Behaviour Therapy (CBT) was unique among psychological treatment of depressions for several reasons. First, CBT was a brief therapy with the typical course of therapy lasting 12-20 weeks as a reasonable trial (Chabrol, 2005; Tuerk, 2005; D. A. Walker, 2004; Woods & Clare, 2008). Second, CBT was a collaborative effort in which both the client and therapist assumed an active role. The collaborative approach increased the client’s sense of efficacy and countered negative attributions about self, world, and future. The therapist might be active when providing psychological...
education on the model or the nature of depression. Because a major goal of therapy was for the individual to acquire the ability to independently address cognitions and behaviors, the client must demonstrate an increased ability to set the direction, focus, and pace throughout the course of therapy. By their very nature, schema could not be eliminated, but they could be restructured. Similarly, automatic thoughts were not eliminated, but monitored and evaluated. The therapist used a broad range of cognitive and behavioural techniques to promote coping skill acquisition, which translated into improvements in cognition, behaviour, and affect. Young, et al. (1998) suggested that “the most effective cognitive therapists are especially skilled at seeing events from their patients’ perspective,” which they labelled as “accurate empathy” (p. 274).

Nonspecific factors were also important contributions to CBT, as they were to all therapeutic models (Woods & Clare, 2008). These included warmth and empathy. The ability to quickly establish therapeutic rapport was integral to successful therapy. Overall, the primary targets of CBT for depression were both the negative automatic thoughts that maintained the depression and the schema (assumptions and beliefs) that were believed to predispose the person to depression in the first place (Blackburn, 1990). The major focus was to help clients to become aware of, evaluate, and restructure the ways in which they derived the meaning of their experiences (Chang, 1999). Clients were encouraged to experiment with new ways of responding, both cognitively and behaviourally. Although cognition was a major focus of therapy, therapists also utilised a broad range of behavioural approaches, to meet both cognitive and behavioural ends (S. M. Freeman & Freeman, 2005). The therapist aimed to demystify the process of therapy via psychological education and skills-building practice. Ultimately, the goal was for clients to internalise the therapy process so that they could continue to reap the benefits of therapy beyond the official bounds of the session.

**Cognitive Behaviour Therapy in Group Model**

The history of group psychotherapy, beginning with Freud, spanned the 20th century (Steuer & Hammen, 2005). Group CBT was an economical way to deliver treatment. The rationale for including group CBT in treatment programs rested in part on nonspecific operational principles such as universality, support, and peer feedback shared with group therapies (Chabrol, 2005). Moreover, group CBT had the advantage
of being a short-term, problem-oriented approach that was an integral part of cognitive behaviour therapy.

The idea of treating people in groups had continued as the main paradigms of therapy had changed. Groups were developed for humanistic therapies, gestalt therapy, and transactional analysis. When behaviour therapy was developed in the early sixties there were many successful attempts to do systematic desensitisation in groups (Lazarus, 1966). The same was true of cognitive therapy. Two landmarks in the development of Cognitive Therapy were the publication of the first major outcome study in 1976 (A. T. Beck, 1976), and the publication of a treatment manual (A. T. Beck et al., 1979). CBT had since become the dominant form of psychotherapy in most of the Western world, and was the framework used for most of the empirically validated treatments. It was not long after the publication of Cognitive Therapy of Depression (A. T. Beck et al., 1979) that Cognitive Therapy with Couples and Groups (S. D. Rose, 1989) was published.

**Therapy Based on a Combined Interventions**

Studies had shown that group and individual psychotherapies were equivalent in efficacy (S. D. Rose, 1999). Group CBT provided additional benefits for the depressed elderly including cost-effectiveness, decreased social isolation, and increased social support (Chabrol, 2005). Since the elderly presented with issues of loss and isolation, it appeared that a group modality might be more advantageous than individual psychotherapy. An added benefit of improved social support afforded by group CBT might play a key role in decreasing mortality in the elderly.

Apparently, the group format itself contributed to the improvement in each of the groups. Arean and Cook (2002) had argued that groups offered positive aspects that individual therapy did not, including increased social contact and support, decreased inactivity and isolation, and less stigma attached to treatment, all of which might be highly salient to older persons. Other hypothesised benefits of group treatment were vicarious learning, modelling, social reinforcement, and moral support (Vollmer & Blanchard, 1998).

Many people who might be drug responsive either refused to take the medication because of personal objections or developed side effects that caused them to terminate taking the drug. It was possible that in the long run the reliance on chemotherapy might
indirectly undermine the patient’s utilisation of his own psychological methods of coping with depression. The patient could learn from his/her psychological treatment experience. Thus, such a person might be expected to cope with subsequent depressions more effectively, to abort incipient depressions, and potentially to prevent subsequent depressions. Individuals receiving cognitive therapy in addition to pharmacotherapy had significantly lower relapse rates (McKendree-Smith, 2000). Moreover, cognitive therapy had been shown to be as effective as pharmacotherapy (Kraaij, Pruymboom, & Garnefski, 2002) and to have more lasting effects than pharmacotherapy alone (D. A. Walker, 2004). In contrast, individuals receiving pharmacotherapy alone often wished to discontinue the medication at some point for various reasons, and there was no residual protection from future depression. Cognitive therapy, on the other hand, did not have adverse effects, and gains made belong to the patient, not the pill.

**Cognitive Behaviour Therapy and Older Persons**

Much of the literature applied to depressive illness generally and much less was known about the treatment of depression in the elderly. Numerous authors agreed that there was a paucity of research on all aspects of depression in the elderly, including prevalence, assessment, and treatment (L. W. Thompson & Gallagher, 1986; D. A. Walker, 2004). The reasons for avoiding this segment of the population were unclear but might include stigma and stereotypes (D. Thompson, 2000). Complicating the picture was the observation that the elderly were not always forthright about their emotional symptoms. They might believe that psychological disorders were signs of weakness, and there was considerable stigma associated with mental health care (Leszcz, Feigenbaum, Sadavoy, & Robinson, 2005). The elderly might underreport their symptoms or misattribute their symptoms to some other disorder.

Very few studies had compared the efficacy of psychotherapy versus pharmacotherapy in the depressed elderly (L. W. Thompson, Gallagher, & Breckenridge, 2001). Several studies had concluded that various forms of psychotherapy with the elderly were more effective than placebo-control or no treatment (L. W. Thompson et al., 2001). Other studies had demonstrated the superiority of the CBT model over other forms of psychotherapy with the elderly (Chabrol, 2005). There had been mixed reviews of the equivalency of effect sizes between CBT and pharmacotherapy in the elderly (L. W. Thompson et al., 2001). Some studies supported the assertion that CBT resulted in more
enduring gains than pharmacotherapy due to active skill acquisition versus being a passive recipient of care (Leszcz et al., 2005).

Working with the elderly population might require the therapist to move beyond the traditional office setting of therapy (S. M. Freeman & Freeman, 2005). The therapist might hold formal group sessions in a designated therapy room or closed area, such as a reserved family meeting room or library, or might meet in the privacy of a resident’s room.

Due to the high prevalence of acute and chronic medical conditions in the elderly, it was imperative that the nurse developed a working alliance with the client’s primary care provider (S. M. Freeman & Freeman, 2005). Because of the historical stigma associated with mental health care, the amount of time spent preparing the client for therapy might need to be increased (L. W. Thompson et al., 2001). Open discussion of the beliefs and myths related to mental illness and its treatments was recommended (L. W. Thompson & Gallagher, 1986). The nurse should avoid jargon; reframing technical terms into more acceptable layman’s terms was essential (S. M. Freeman & Freeman, 2005).

It was particularly important to set measurable, realistic, and time-limited treatment goals with all patients. Since many elderly were not familiar with the process of psychotherapy, it was even more imperative that comprehensive goal setting took place with the elderly (S. M. Freeman & Freeman, 2005). Making outcomes measurable allowed clients to recognise in much the same way as practitioners did. Successes in therapy usually resulted in increased motivation for further change. The framework of therapy should be modified when working with the elderly. Due to the normal cognitive changes of ageing, the pace of information delivery should generally be slower, and repetition of information from session to session should occur (Blackburn, 1990).

To promote a collaborative approach that detered regression and dependency, the nurse should encourage the elderly client to keep a record of therapy sessions and important learning points if at all possible. Modifications to specific cognitive techniques needed to be employed when working with the depressed elderly. The daily thought record should be simplified to include no more than three columns (event, thought, and emotion) until the client demonstrated proficiency (L. W. Thompson et al., 2001). In the
beginning, the nurse might need to generate scenarios as example for clients until they grasped the concept (S. M. Freeman & Freeman, 2005).

Modifications to specific behavioural techniques also needed to be employed with working with the depressed elderly. Homework usually included incorporating one or more of the items into one’s daily routine. Thompson et al (2001) recommended creating a visual graph of the client’s mood monitoring form in order to make the connection more concrete. Activity scheduling and graded task assignments were especially helpful with this population, as social isolation, regression, and dependency are common (Kraaij, Pruymboom et al., 2002). Social skills training, pen pals, and group modalities also worked to decrease isolation (Kraaij, Pruymboom et al., 2002).

The termination process should be adjusted when working with elderly clients. Thompson et al (2001) recommended the creation of a relapse “survival guide” that included specifically tailored CBT interventions for each client. Specific symptoms of relapse could be mapped so the client or his or her family or caregiver could identify early warning signs of depressive relapse. Depression in older persons tended to be associated with a more chronic and relapsing course; therefore maintenance was recommended (Leszcz et al., 2005). Freeman (2005) suggested booster sessions at three, six, and twelve months.

**Part IV: Depression among Chinese Older Persons**

The previous section presented an overview of depression as a disorder from medical and psychological perspectives. The emphasis now shifted to providing and using a cultural perspective to define and determine depression status among the Chinese population. The idea of culture was central to the exploration of interpretations of depression since culture shaped how one interpreted and responded to the implicit rules governing any cultural entity (Kleinman & Good, 1985; Stoppard, 2000). According to social constructionist arguments, culture provided the store of knowledge, the touchstone through which individuals interpreted and made sense of their life worlds (R. Ray, 2000). In many parts of Chinese society, the expression of depression was physical rather than psychological. Hsu (2000) argued that the Chinese usually regarded interpersonal problems (especially family problems) and financial difficulties as the most serious sources of stress, and they usually regarded intrapsychic problems as
relatively less stressful. Many depressed Chinese people did not report feeling sad, but rather expressed boredom, discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue. The pattern of somatisation might further complicate the concept of depression, which, according to biomedicine, could be an emotion, a symptom, or a disease. The Chinese characters for "depression" were employed in medical settings but were not in popular usage (Kleinman, 2004).

**Traditional Chinese Medicine**

Traditional Chinese medicine was considered one of the longest established traditional medical systems in the world. It had a history spanning several thousand years and was still officially recognised and clinically practiced in contemporary China (Tseng, 1999). The underpinning theory took the view that the human body, like the cosmos, could be divided fundamentally into a positive force (Yang) and a negative force (Yin), which were complementary to each other. In the cosmos, the sun symbolised the positive force, whereas the moon was the negative. Among living beings, the male symbolised Yang and the female, Yin. The concept of positive and negative forces applied not only to physiology, but also to psychopathology and its associated treatments. If the two forces were balanced and in harmony, good health was maintained; if not, illness would result. For example, excited insanity was the result of excessive positive force, whereas “falling sickness” (i.e., epilepsy) was caused by excessive negative force. In treatment, reduction of the positive force was considered necessary for excited insanity, whereas supplementing the positive force was needed for falling sickness attacks. Yin and Yang were thus interpreted as the dual forces operating in the nature, as well as in human beings, and emphasise the principle of balance.

Without the knowledge and techniques for examining the body physiologically, as was done in modern times, everything occurring in the body and mind was interpreted as an expression of the visceral organs, the parts of the human body existing in the trunk, which could be observed easily. The heart was thought to house the superior mind, the liver to control the spiritual soul, the lungs the animal soul, the spleen ideas and intelligence, and the kidney vitality and will. When vital air was concentrated on the heart, joy was created; on the lungs, sorrow; on the liver, anger; on the spleen, worry; and on the kidney, fear. Thus, it was considered that various emotions were stirred through the visceral organs. In accordance with this medical knowledge, in daily life,
many organ-related sayings were used by the common people, such as "elevated liver fire," "losing spleen spirit," "hasty heart," or "exhausted kidney," to denote becoming angry and irritated, losing one's temper, being anxious, or generally fatigued, respectively. This also reflected a holistic view of body and mind and the common acceptance of somatic presentation of emotion. This paralleled modern psychosomatic approaches and sharply contrasted the dual concepts of psychic and somatic in contemporary western psychiatry.

Because traditional medicine had been practiced for so long in China, its concepts and knowledge not only influenced clinicians, but also patients and society generally. In other words, traditional medicine did not merely function as one kind of medical system influencing the pattern of professional practice, but was also deeply embedded as a part of the culture itself. From a sociocultural perspective, it had a strong impact on the illness-behaviour of patients, including their help seeking behaviour. Kleinman (2004) had described several general trends that might be observed from a psychiatric perspective:

- Patients are very likely to have a holistic orientation and are not used to making a dichotomatized distinction between body and mind.
- Patients, even though clearly aware of their psychological state or emotional problems, may use somatic and organ-oriented concepts and terms to describe their emotional states.
- Patients, following traditional medical practices, may expect their doctors to inquire about their somatic symptoms, to perform a physical examination, and to even take their pulse, but will feel unfamiliar and uncomfortable if they inquire about their social history or personal and family lives.
- Patients usually expect the physicians to prescribe medicines as remedies for their illnesses. Western medicine is generally considered effective, but too strong, with side effects, and even harmful to the body; herb medicine, however, is welcomed because it is perceived as more gentle, with the primary aim of balancing vitality and restoring strength.
- Based on the Yin and Yang theory, patients may inquire as to what kind of food, either hot or cold, should be consumed, and whether it is necessary to take a
tonic to regain their strength. These issues are influenced by traditional medical concepts of illness and treatment.

These expectations offered quite a contrast to the western approach, which emphasised the resolution of problems, conquering the difficulties, and removing obstacles. Emphasising an individual's responsibility to cope with his situation could sometimes become a burden for the patient and his family. An alternative approach needed to be considered for certain patients and their families.

**Chinese Cultural Patterning of Depression and Somatisation**

Kleinman (1980) stated that depression occurred as universal psychobiological states, but that they were cognised before they took on the form of perceived, felt, labelled, and valued experiences recognised as emotions. The Chinese learned to employ culturally constituted cognitive coping mechanisms for managing depressive experience. Culture had its major influence on depression, therefore, through the influence of beliefs and norms on cognition. In Chinese culture, suppression, lack of differentiation, minimisation, displacement, and somatic substitution were the dominant mechanisms employed by individuals (Kleinman, 1980).

During their primary socialisation, Chinese learned that their own personal affects, especially strong and negative ones, should not be openly expressed (Hsu, 2000). Revealing their own feelings might result in shame for themselves and their families. The family was frequently thought of as a circle whose perfect roundness symbolised the ideal of harmonious integration of all individual members (Fei, 1996). In Chinese culture, tremendous stigma was attached to depression (Kleinman, 1980). Shame fell on those affected and on their families. Misfortune, including sickness, affected both. When personally upset, one endured disturbed feelings, and excessive expression of emotion upset the harmonious functioning of the body and caused disease. When physical complaints accompanied psychological complaints, family members attended only to the former. In such situations, the individual learned a much more sophisticated set of terms and beliefs for somatic distress than for psychological distress. Family members, friends, and teachers did not apply negative terms to physical complaints to the same extent as they did to psychological complaints. Chinese learned that others would rarely challenge the legitimacy of their physical sicknesses and medical sick roles.
But psychological excuses lacked social legitimacy and might reflect the stigmatised domain of mental illness (Hsu, 2000).

Differences in the quality of depression resulted from their cognitive processing, and not from their psychobiological substrate. The somatic idiom for cognising and expressing depressive feelings among Chinese constituted that affect was a vegetative experience (Kleinman, 1980). The Chinese minimised the intensity of depressive feelings and the like by keeping them undifferentiated, which helped both to distance them and to focus concern elsewhere. The coping strategies were, first, minimisation or denial, an active process of suppressing the intensity and sequelae of depression by minimising their significance. Second, dissociation, which included a whole range of coping practices by which depression was separated from consciousness, cognition, behaviour, or the specific stimuli provoking it. The dissociated depression was expressed in isolation, most usually in a culturally sanctioned way, and thirdly, somatisation, which was the substitution of somatic preoccupation for depression in the form of complaints of physical symptoms and even illness.

Social and cultural factors shaped affect principally through cognitive processes. Somatisation was the substitution of somatic preoccupation for dysphoric affect in the form of complaints of physical symptoms and even illness. Chinese popular sickness categories labeled depression as a somatic problem. Those labels shaped the quality of the experience of depression in Chinese culture into a bodily or vegetative experience (Kleinman, 1980). To cover minor psychiatric disorders under the more respectable mantle of physical disorder, the Chinese term of neurasthenia was used to convey the same vague idea of organic pathology that the term connoted in English. The picture was of an ailment involving non-specific signs and symptoms associated with a “weakness” of the nerves and a general “weakness” of the body produced by the weakness of the nerves. Chinese culture defined the somatic complaints as the primary illness problem (Kleinman, 1980). The great majority of Chinese reported physiological symptoms, generated by the high level of depression, as affecting the autonomic nervous system and the structures it innervated. Cultural, along with personal, meanings influence which kinds of stimuli were perceived as stressful. Cultural beliefs and experience helped determine which symptoms were most threatening and bothersome (Kleinman, 1982).
Chinese with depression had been reported to have suffered from physical symptoms, such as, insomnia, weakness, dizziness, chronic pains, all of which could be attributed to the autonomic nervous system correlates of depression (Kleinman & Good, 1985). These illnesses represented the patterning of the underlying disease by cultural determinants the yield characteristic types of somatisation. The Chinese character for depression included the heart radical enclosed within a doorway radical (Kleinman, 1980). Their hearts were “locked in,” “closed off,” or “suffocating behind a door.” They pointed to their chests to locate the feeling there. To them, depression meant this physical sensation and its associated psychological state. The metaphors communicated how they felt in physical imagery in which the affect was inferred. The physical imagery, rather than the affect, was most real. The idiom made the experience primarily somatic. Chinese patients who were psychologically depressed thus complained that they felt something “depressing” into their chests or “pressing down” on their heads. Accordingly, it was quite common for physical complaints to be used to describe psychological as well as physiological states and as such were understood by adults (Kleinman, 1980).

Summary

Although an extensive body of research pointed to the presence, misdiagnosis and underdiagnosis of depression in older persons, especially Chinese older persons, it was important to understand the different origins, a social and cultural construct, and consequences of depression in older persons.

Origins of depression included biological, physical, psychological, and social. Biological origins included changes in brain structure and function, and cortisol level with ageing. Physical origins included functional limitations, loss of mobility, and medical illness. Psychological origins included changes in cognitive, behavioural, and psychodynamic aspects. Social origins included limited social network, negative life events, poverty, and poor family relationships. The consequences of depression were manifested in symptoms and signs, detected using screening and diagnostic tools, and reflecting the variety of theories on origins of depression, treatments of depression were wide-ranging. Depression as experienced and expressed by Chinese older persons reflected somatisation of distress, arising from traditional Chinese medicine and presents a social and cultural construct embedded in Chinese culture.
Chapter 2 Depression among Older Persons: A Review of the Literature

The background information provided a starting point for the current study. Although the conclusions drawn from such work were invaluable, they highlighted the lack of information about and understanding of the contributing factors for depression that are specific to Macau’s older persons. A number of questions did need to be answered to provide data that could then be used to develop culturally appropriate interventions. These questions included: What are the lived experiences of older persons with depression in Macau? What are the principal influences on depression among older persons in Macau? How can this information be used to inform health care, and nursing services in particular, to help prevent, detect and protect older persons from depression in Macau? These questions influenced the design of the present study, fully described in Chapter 3.
Chapter 3 Methodology and Methods

Introduction

The literature on depression and its treatment, both generally and in relation to older persons specifically, reviewed in the previous chapter, was extensive and yet there was a dearth of research on depression among Macau’s Chinese older persons. The literature reviewed highlighted that a number of questions did need to be investigated to provide data that could then be used to develop culturally appropriate interventions for older persons with depression in Macau, a special administrative region of China that exercises a high degree of autonomy and features the exchanges between Chinese traditional culture and western culture over more than four hundred years. These questions included: What were the lived experiences of older persons with depression in Macau? What were the principal factors influencing on depression among older persons in Macau? How could this information be used to inform health care, and nursing services in particular, to help prevent, detect and protect older persons from depression in Macau?

To answer these questions, a general qualitative research orientation using in-depth interviews, with minimal structure, for both the older persons with depression and their caregivers, was deemed to be the most appropriate. Data collected from different sources were subsequently used, including person triangulation to cross-validate data for the purpose of confirmation (Knafl & Breitmayer, 1991). As advocated by Clamp and Gough (1999) and Feher (1991), different sources of data were included within this study to obtain diverse material that would provide a more complete picture of the topic under investigation. To supplement the qualitative data, a number of standardised, validated scales, including the Mental Status Questionnaire (MSQ), the Geriatric Depression Scale-15 (GDS-15), the Reduced Item Barthel Index (BI), the Lawton Instrument of Activities of Daily Living Questionnaire (IADL), the Lubben Social Network Scale (LSNS), the 36-item Short-Form Health Survey of Quality of Life (SF-36QOL), and demographic data were used. The purposes of the quantitative tools were two-fold; to determine eligibility of older persons to participate, and to quantify a
variety of psychosocial factors that might be associated with the experiences of older persons with depression in Macau that could then be compared with data from other similar populations in previous studies. The methodology and methods employed were described in detail in this chapter.

**Aims and Objectives**

This study aims to document and interpret the lived experiences of older persons with depression, to identify the principal influences on depression among older persons in Macau, and to construct an explanatory framework based on the medical and socioeconomic factors related to depression as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression among older persons in Macau. The results make a significant contribution to the existing body of knowledge by furthering our understanding of the contextual factors associated with these real-life experiences of Chinese older persons with depression, initially in Macau but also in similar societies. They will be used to inform the future development of interventions for depressed older persons, particularly in Chinese societies and to help to inform future health service development in Macau and enable comparisons with other countries/regions to be made.

**Theoretical Framework: A Mixed Methods Research Strategy**

Deliberations over design alternatives and choice of methods led directly to consideration of the relative strengths and weaknesses of qualitative and quantitative data. Qualitative methods facilitated study of issues in depth and detail. Approaching fieldwork without being constrained by predetermined categories of analysis contributed to the depth, openness, and detail of qualitative inquiries. Quantitative methods, on the other hand, required the use of standardised measures so that the varying perspectives and experiences of people could be fitted into a limited number of predetermined response categories to which numbers were assigned (Patton, 2002).

The advantage of a quantitative approach was that it was possible to measure the reactions of a larger number people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data. This gave a broad, generalisable set of findings presented succinctly and parsimoniously. By contrast, qualitative methods
typically produced a wealth of detailed information about a much smaller number of people and cases. This increased the depth of understanding of the cases and situations studied, but reduced generalisability (Patton, 2002).

The decision to use a mixed methods approach, involving both quantitative and qualitative methods as employed in this study, allowed for the merits of each approach to be maximised. Significant rates of depression in Macau’s Chinese older persons were identified in a large-scale survey (Macau Social Welfare Bureau, 2006), and therefore depression as a phenomenon was worthy of investigation in its own light. However, that study did not advance our understanding as to why depression rates were at those levels. As the review of literature demonstrated, there was insufficient knowledge available on the predisposition of this population to depression to develop clinical interventions and policy. Hence, in the present study, the lived experiences of older persons with depression in Macau were examined quantitatively using a range of standardised, validated scales and then reflected on by drawing on the qualitative data.

From a phenomenological point of view, research set out to question the way we experienced the world, in order to know more about the world in which we lived as human beings. We wanted to know what factors were most essential to being (Van Manen, 1997b). Phenomenology was the study of the lifeworld as it was immediately experienced pre-reflectively, rather than as conceptualised, categorised, or reflected on (Husserl, 1970). Phenomenology aimed at gaining a deeper understanding of the nature or meaning of our everyday experiences and asked for the very essences of a phenomenon; hence, it was the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experiences. A universal or essence might only be intuited or grasped through a study of the particulars or instances as they were encountered in lived experience (Van Manen, 1997b). Phenomenology claimed to be scientific in a broad sense, since it was a systematic, explicit, self-critical, and intersubjective study of its subject matter, our lived experience. It was systematic in that it used specially practised modes of questioning, reflecting, focusing, and intuiting. Phenomenology was explicit in that it attempted to articulate, through the content and form of text, the structures of meaning embedded in lived experience; it was a search for what it meant to be human and had been called a poetising activity (Van Manen, 1997b).
Phenomenology was a research approach or methodology as well as a philosophy or way of thinking. It was a system of interpretation that helped us perceive and conceive ourselves, our contacts and interchanges with others, and everything else in the realm of our experience. The goal of phenomenology was to explicate the structure or essence of the lived experience of a phenomenon in the search for the unity of meaning which was the identification of the essence of a phenomenon, and its accurate description through the everyday lived experience (Van Manen, 1997b).

Phenomenology was, on the one hand, description of the lived-through quality of lived experience, and on the other hand, description of meaning of the expressions of lived experience. Heidegger (1962) said that the meaning of phenomenological description as a method lay in interpretation and that the phenomenology was a hermeneutic in the primordial signification of this word, where it designated this business of interpreting.

Three different schools of phenomenological philosophy had resulted in approaches that had been used comprehensively in social science research (Cohen & Omery, 1994). The first was eidetic or descriptive phenomenology, guided by the work of Husserl (Maggs-Rapport, 2001). The strategy of bracketing, the suspension of all biases and beliefs regarding the phenomenon being researched prior to collecting data about it, was an effort to maintain ‘objectivity’ in the phenomenological method (Koch & Harrington, 1998). The second school of phenomenology, hermeneutics, had as its aim the interpretation of phenomena to uncover hidden meanings, and was guided by the work of Heidegger. The primary difference between Husserlian and Heideggerian approaches was that while Husserl advocated ‘bracketing’, Heidegger suggested that presuppositions were not to be eliminated or suspended (M. A. Ray, 1994). For Heidegger, it was not possible to bracket one’s being-in-the-world, and hermeneutics presupposed prior understanding on the part of the researcher (Polit & Beck, 2006). The third school was guided by the Dutch school (including scholars such as Van Manen) and was a combination of characteristics of descriptive and interpretive phenomenology (Cohen & Omery, 1994). Van Manen combined the descriptive phenomenology of Husserl, with an emphasis on the study of the world before reflection and also argued that it was scientific and simultaneously asserts that it involved interpretation and used the terms “description” to include both interpretive (hermeneutic) as well as the descriptive phenomenological element (Dowling, 2007).
Van Manen’s (1984) phenomenological method, a dynamic interplay among six research activities, offered an appropriate scientific and rigorous method and for this reason was used in this study:

1. Turning to a phenomenon, which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualise it;
3. Reflecting on the essential themes that characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented relation to the phenomenon;
6. Balancing the research context by considering parts and whole.

The decision to use this phenomenological method was a complex one that was grounded in the understanding that the approach selected must be the best one to answer the research questions. Nursing’s philosophical beliefs about humans and the holistic nature of professional nursing provided further direction and guidance. Nursing encouraged detailed attention to the care of people as individuals and grounds its practice in a holistic belief system guiding nurses to care for the mind, body and spirit. This holistic perspective helped to form the foundation for phenomenological inquiry, which brought everyday knowledge to conscious awareness for understanding and interpretation (Wilde, 2002) and attempted to interpret human experience in its context (Boyd, 1993). Because phenomenological inquiry required that the integrated whole be explored, it was therefore a suitable method for this.

“Turning to the nature of lived experience” (Van Manen, 1997b, p. 30) required that the researcher attended to his own experiences and presuppositions, in this case an extensive knowledge base that developed through involvement with the care of older persons and community over fifteen years of teaching and practice expertise, related to the phenomenon. “Investigation” (Van Manen, 1997b, p. 30) entailed conducting audio-taped face-to-face interviews with participants. Van Manen’s phenomenological method had been successfully applied in different domains study, such as the education domain (C. T. Beck, 1993), and nursing practice domain (Bottorff, 1990; Lauterbach, 2001; Morse, 1994; Parsons, 1997; Ring, 1997; Wilde, 2002, 2003). For instance, Fielden
Chapter 3 Methodology and Methods

(2003) utilised Van Manen’s phenomenology to explore and interpret the lived experience of family members after losing a close family member to a suicidal death. Moreover, Hassouneh-Phillips (2003) explored lived spirituality among abused American Muslim women by utilising the work of Van Manen. In addition, Brett (2004) utilised the work of Van Manen which she indicated brought “structure” (p. 14) to the study and “informed analysis through phenomenological reflection” (p. 14) in her study exploring how parents of profoundly handicapped children experience support in their lives. Finally, Jongudomkarn and West (2004) utilised Van Manen’s work for data analysis in their case study strategy for data collection and a phenomenological approach for data analysis.

Van Manen (1997b) suggested analytical techniques helped to elicit concepts related to space, body, time and relations with others. In reflecting on lived experience, the researcher analysed the thematic aspects of that experience. Accordingly, themes could be uncovered or isolated from participants’ descriptions of an experience by three different means: (1) the holistic approach: the researcher viewed the text as a whole and tried to capture its meanings; (2) the selective or highlighting approach: the researcher underlined, highlighted, or pulled out statements or phrases that seemed essential to the experience under study; and (3) the detailed or line-by-line approach: the researcher analysed every sentence. Once the themes had been identified, they became the objects of reflecting and interpreting through follow-up interview with participants. Through this process, the essential themes were discovered.

In summary, the principles of Van Manen’s phenomenological approach were deemed suitable for interpreting the phenomenon of depression among a sample of older persons who lived in Macau, to learn more about how these older persons feel about, understand, and interpret their lives. This approach therefore informed the design of the study and choice of methods.

**Research Design: Methodological Triangulation**

By the nature of the study and the data envisaged to arise from it, a mixed method design, using both qualitative and quantitative approaches, was employed in the study, reflecting methodological and data triangulation. The combination of qualitative and quantitative approaches in a single study had been extensively debated because the two
main theoretical perspectives reflect a dichotomy in research. The positivist perspective used a deductive process to test theory and tried to establish the relationship among variables. Knowledge was gained through traditional objective forms of measurement with the aim of predicting events. On the other hand, a qualitative perspective relied on inductive methods to understand the meaning of phenomena in a naturalist setting (Thrumond, 2001). It aimed to generate theory.

Triangulation was a challenging approach when employed to integrate the differences of two or more data sources, methodological approaches, theoretical perspectives, investigators and data analysis; however, its advantage was that it could compensate the weaknesses of single strategy and contribute towards completeness or confirmation of findings (Onwuegbuzie & Johnson, 2004). Triangulation had a long history in research. Campbell and Fiske (1959) used more than one quantitative method to measure a psychological trait and introduced the term “triangulation techniques”. Denzin (1978) employed the term “triangulation”, borrowed from navigation and military strategy, to argue for the use of mixed methods to more robustly study a phenomenon. The primary assumption of triangulation was that any bias inherent in particular data sources, investigators, and methods would be neutralised when used in conjunction with other data sources, investigators, theories, and methods (Jick, 1979). A combined method study was one in which the researcher used multiple methods of data collection and analysis.

Nursing was also a profession with different philosophical bases, as well as diverse and complex practice, and was constantly changing in its scope, nature, knowledge, skills and professional perspective. So it was appropriate that nursing research should reflect this non-linear and coherent reality of nursing (Rampogus, 2005). These research approaches might be drawn from “within methods” designs, such as different sources of qualitative data. Alternatively, it could be “between methods” drawing on quantitative and qualitative data collection procedures and having the potential to overcome the inadequacies of each paradigm (Denzin, 1989). Denzin (1989) further stated that triangulation allowed a wider and more complete picture to emerge that that presented by single methods work alone, producing a fully grounded interpretative research approach. Triangulation, therefore, using different data collection methods to add to understanding to gain different perspectives from data, could give a fuller picture that further enhanced the rigour of the research (K. E. Rose & Webb, 1997). Furthermore,
Thurmond (2001) argued that triangulation could increase the ability to interpret findings. Therefore, in this study, triangulation of “between methods” was subsequently utilised to generate qualitative data from older persons with depression, and their caregivers, and quantitative data from the older persons using a range of standardised, validated scales.

The theoretical and methodological influences on the research design of the study are illustrated in Figure 3.1.
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Figure 3.1 Theoretical and Methodological Influences on Research Design of Study

Phenomenon of interest

Lived experiences of older persons with depression in Macau

Procedures

Narratives generated through qualitative interview

Quantitative data generated through standardised instruments

Research design

Mixed methods design reflecting triangulation of data

Philosophical basis

Naturalistic inquiry → general qualitative inductive approach reflecting phenomenological perspective (Van Manen)

Biomedical & health sciences perspectives

Influences on research design

Research questions

The researcher

Nursing as a practice discipline
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**Instruments**

**The Researcher as Principal Instrument**

The researcher as a person was critical for the quality of the qualitative inquiry. When interviewing, the importance of the researcher was magnified because the interviewer was the main instrument for obtaining knowledge. The integrity of the researcher-his knowledge, experience, honesty, and fairness-was seen as a decisive factor (Willig & Stainton-Rogers, 2008). Consequently, the researcher undertook the investigation with personal characteristics that would influence the choice of research method, data collection, and the interpretative analytical stage. An extensive knowledge base, developed through involvement with the care of the elderly and community over fifteen years of teaching and practice, gave the researcher a solid foundation from which to conduct this study.

The skills and the qualities possessed by the researcher were very important and had a direct impact on the quality and quantity of the data (Morse, 1994). The quality of the information, generated by the data collecting method, depended mostly on the ability of the researcher to establish rapport, trust and generally be seen as a person with whom it is easy and safe to talk (Fog, 2004). Furthermore, the researcher and the interviewees were all seen as factors that influence the quality of the study. Patton (2002) reported that the quality of the information obtained during an interview was largely dependent on the interviewer. In the present study, the researcher as principal instrument interviewed with participants in collecting their stories, or narratives, that were expected to illuminate the high rates of depression among Macau’s older population.

Subjectivity should be recognised as an influencing factor but should not necessarily be seen as one that limited the quality of the study. The interpretation of the information in the analysis phase was dependent on the quality of the researcher, in that, the researcher’s insight, knowledge and powers of perceptions and sensitivity would influence the final result. The researcher could only report what he has been told. Morse (1994) indicated that the purpose of qualitative study was not to determine objectively what actually happened, but rather to objectively report the perceptions of each of the participants.
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An open-ended interview guide with ten prompt questions (see Appendix 1) was developed, based on literature to facilitate the in-depth interview that was conducted by the researcher, to identify the life events, issues and common thoughts reported by the older persons and their care-givers. The first question “How do you feel about your life at present?” was a general question to help the participant to express his/her overall thinking of present life. Then, there were two questions that aimed at eliciting descriptions of experiences of his/her physical problems and impacts of the treatments. Following that was an opinion question asking the participant opinions about his/her family relationship and social network. The participant was also asked his/her plan for the future. One more question was used to help the participant to express the issues with the most severe impact of his/her daily life. Two questions were specifically designed to invite the participant to reflect on and talk about his/her past lives. The final question was a back up question which helped the participant say anything that had not been asked.

Quantitative Data Collection

To supplement the qualitative data, and to determine eligibility to participate, a range of standardised and validated measures were used to generate quantitative data. These included: the Mental Status Questionnaire (MSQ), The Geriatric Depression Scale-15 (GDS-15), the Reduced Item Barthel Index (BI), the Lawton Instrument of Activities of Daily Living Questionnaire (Lawton IADL), the Lubben Social Network Scale (LSNS), the 36-item Short-Form Health Survey of Quality of Life (SF-36QOL), and demographic data. Each of these instruments was now discussed in detail.

The Mental Status Questionnaire (MSQ)

The Mental Status Questionnaire (MSQ) was used to determine the general cognitive state of the older person and specifically to screen for any memory impairment in the older person. It was generally considered that individuals with a MSQ of less than six had a memory deficit that was of clinical significance.

The MSQ had been validated in China (T. Y. Li et al., 2001), in Hong Kong (Ngan, Leung, Kwan, & Yeung, 1996) and in Macau (Macau Social Welfare Bureau, 2006). For the purpose of the investigation, and for the reasons given, subjects with a MSQ of less than six, indicating memory impairment, were excluded from this study.
The Geriatric Depression Scale-15 (GDS-15)

The Geriatric Depression Scale-15 (GDS-15) was perhaps the most widely used instrument for assessing depression in elderly persons and for diagnostic screening in clinical and community setting (Osborn et al., 2002) and was therefore used in the present study to determine the presence of depression. The GDS-15 had been validated in China (A. C. M. Chan, 1996; H. B. Lee et al., 1993) as well as in other cultural groups, such as Japanese and Korean (Mui, Burnette, & Chen, 2001). Furthermore, the GDS-15 had also been validated in Macau (Macau Social Welfare Bureau, 2006).

The higher the GDS-15 score indicated the more severe the depression. Brink et al (1982) and Sheikh and Yesavage (1983) suggested a threshold of 11 for the GDS-30 and six for the GDS-15 as indicative of clinically significant depression. In their validation study in Hong Kong’s Chinese older persons, Chiu et al (1994) and Lee et al (1993) recommended cut-offs of 15 (GDS-30) and eight (GDS-15) instead. With similar cultural and population environments to Hong Kong, the present study in Macau used cut-off point of eight for the GDS-15 as an inclusion criterion. The presence of depression was a criterion as the purpose of the study was to illuminate the phenomenon of depression.

The Reduced Item Barthel Index (BI)

The Reduced Item Barthel Index (BI) was developed in USA for use with long-term hospital patients with neuromuscular or musculoskeletal disorders (OSullivan & Schmitz, 1994). More recently, the tool had been employed as a means to evaluate treatment outcomes. The scale covered the following dimensions: feeding, mobility from bed to chair, on/off toilet, climbing up/down stairs, continence and washing and dressing. Not included in the scale were the more elective activities such as shopping, use of telephone and housework.

Numerous studies had concluded that the validity and the reliability of the tool were acceptable. The BI had been validated in China (T. Y. Li et al., 2001), in Hong Kong (Ngan et al., 1996) and in Macau (Macau Social Welfare Bureau, 2006). Therefore, the BI was utilised in this study to evaluate the capability of activities of daily living of older persons with depression in Macau.
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The Lawton Instrument of Activities of Daily Living Questionnaire (Lawton IADL)

Hanne et al (Hanne, Karen, Kirsten, & Birgitte, 2002) suggested that when the BI was supplemented with a broader measure as in the Lawton IADL questionnaire a more complete interpretation of functional ability could emerge and so this was employed as well in the current study.

The Lawton IADL was developed in USA (Lawton & Brody, 1969) to assess the capability of instrumental self-maintenance of community-dwelling people (OSullivan & Schmitz, 1994). The Lawton IADL included many items related to mobility and ‘elective mobility’. The questionnaire contained 20-items grouped into four uni-dimensional Guttman-scaled subscales including mobility, kitchen, domestic and leisure abilities. The subscales could be summed to provide an overall score. Each item was scored through a four-point response choice: ‘3’ representing ‘independent function’, ‘2’ representing ‘alone with difficulty’, ‘1’, ‘with help’ and ‘0’, ‘unable’. The questionnaire was developed to be interviewer administered or delivered via mail and subjects were asked whether they undertook the activity, as opposed to asking whether they could do it, thus assessing the level of activity, rather than capability.

Test/retest reliability of the questionnaire was good. The Lawton IADL had been validated in China (T. Y. Li et al., 2001), in Hong Kong (Ngan et al., 1996) and in Macau (Macau Social Welfare Bureau, 2006). The Lawton IADL had been shown to be sensitive to clinically important changes and was used in the present study to investigate the level of instrument activities of daily living of the participants.

The Lubben Social Network Scale (LSNS)

The Lubben Social Network Scale (LSNS), an abbreviated social support network scale, could readily be incorporated into a geriatric assessment battery allowing clinicians to gather social health information in a systematic manner in a relatively short period of time (Lubben, 1988). The systematic use of such a scale facilitated a more accurate description of aspects of social network and social support that might require tailored intervention. Additionally, global scales that quantified an older person’s social environment might also be useful for monitoring systematic changes over time. Expanded use of social support network measurement tools in geriatric practice would
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enhance community care and appropriate referral to such programs as respite care, peer support or counselling (Ceria et al., 2001). The use of such assessment tools might also increase attention of the elderly person to his or her own social health (Lubben, 1988). An older person might be encouraged by the nature of inquiry contained in these scales to evaluate or identify (on their own) areas of weakness in social network or areas of strength or potential resources. The LSNS could be used as a health promotion screener to identify cases of social isolation or loneliness that might otherwise go undetected. A good measure of one’s social support network would prove useful as an initial indicator of risk for isolation and loneliness (Lubben, Weiler, & Chi, 1989; Mor-Barak & Miller, 1991).

The LSNS had been used in a wide array of studies since it was first reported a decade ago (Ceria et al., 2001; K. L. Chou & Chi, 2001b; Hurwicz & Berkanovic, 1993; Lubben, 1988; Martire, Schulz, Mittelmark, & Newsom, 1999; Mor-Barak & Miller, 1991; Okwumabua, Baker, Wong, & Pilgrim, 1997; Potts, 1997; Rubinstein, Lubben, & Mintzer, 1994). It had been used in both research and practice settings and it had been translated into several languages; including Chinese, Korean, Japanese, and Spanish; for use in cross-cultural and cross-national comparative studies. The LSNS covered aspects of family networks, friendship networks, confidant relationships and helping others of older person. The total LSNS scores could range from 0 to 50, with higher scores indicating better social network and social support. It was suggested that a score below 20 indicated an extreme risk for limited social networks (Lubben, 1988). Furthermore, the LSNS had also been validated in Hong Kong (K. L. Chou & Chi, 2001a) and in Macau (Macau Social Welfare Bureau, 2006). Therefore, the LSNS was utilised in this study to assess the social network and social support of the older persons with depression.

The 36-item Short-Form Health Survey of Quality of Life (SF-36QOL)

The 36-Item Short Form Health Survey of Quality of Life (SF-36QOL) consisted of 36 items grouped under 11 questions. The scores for the 36 items were summated into eight multi-item scales: physical functioning (PF), limitations due to physical health problems (role-physical; RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), limitations due to emotional health problems (role-emotional; RE), and mental health (MH) and one single-item scale on health transition.
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The SF-36QOL had been translated and tested in more than 40 countries and validated in 12 countries, including Chinese Americans (Ren, Amick, Zhou, & Gandek, 1998), Chinese living in Hong Kong (Lam, 2003; Lam, Gandek, & Ren, 1998; Lam, Lauder, Lam, & Gandek, 1999), and Chinese in the mainland (J. Li, Liu, Li, He, & Li, 2001; Liu et al., 2001). The SF-36QOL was therefore used in the present study to measure the mental states and physical conditions of older persons with depression in Macau.

Demographic Data

In order to generate a descriptive profile of the participants, and allow the researcher to become acquainted with the lives of the participants, that would then inform the subsequent interview, demographic data were collected. This information was requested in such a way as to make participants comfortable with the interviewer and to pave the way for the qualitative interview. Furthermore, Chinese older persons were used to being questioned about their personal details, e.g. in social services or day centres and so to be questioned in this way was expected. The range of demographic information was collected including: Age, gender, marriage status, highest educational level attained, income source, and living circumstance. The collection of this data facilitated comparison of the study population with the general population of older persons in Macau.

The participants

The study was conducted in Macau between 14\textsuperscript{th} January 2007 and 8\textsuperscript{th} August 2007 in Cantonese language, the mother tongue of the participants and the researcher. The study sample was recruited from older persons in Macau using a purposive sampling method and guided by the following inclusion criteria.

Inclusion Criteria

The study adopted the following inclusion criteria for participants:

1. Macau resident aged 65 years and over;

2. Presence of depression (based on a GDS-15 score of eight or more, indicates depression), having had no suicide attempt, and no pre-existing and nonaffective
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psychiatric disorder;

3. No or minimal cognitive impairment. Participant was included if he/she had a MSQ score of six or more (below six indicates memory impairment).

Inclusion criteria for the caregiver were that he/she was the significant family member who took care of the daily life of the older person with depression and was referred by the older person. The caregiver was also required to have a MSQ score of six or over.

**Recruitment and Selection**

Participants and caregivers were recruited using purposive sampling (Patton, 2002), an approach that ensures selection of characteristics of the key groups of interest and captures major variations. Selection was influenced by what Patton (2002) described as ‘information-rich cases’, to facilitate in-depth study of phenomena and identification of the important issues in the research.

To access participants, managers of day centres/recreational centres for the elderly, where a majority of older persons spent some of their days, were contacted by the researcher to identify older persons believed to be depressed. The researcher first screened the older person for eligibility then, once confirmed, each older person was given written and verbal information about the study, and asked by the researcher if they would like to participate in the study. Participants continued to be enrolled until repetition of the salient points (themes) was reached; this was the point at which saturation was deemed achieved (J. Green & Thorogood, 2004; Lincoln & Guba, 1985).

In total 53 older persons were referred as being potentially suitable for inclusion in the study. All of them attended one of the eight day centres/recreational centres for the elderly in Macau that respectively represented the developed district and the developing district in Macau. Twenty-two older persons were excluded from the study because the GDS-15 score was less than eight in the case of 21 (below eight indicates they are not depressed), and in the case of one person, the MSQ score was less than six (below six indicates memory impairment). The final study sample therefore consisted of 31 older persons with depression and seven caregivers. Data collected using the GDS-15 and MSQ for the 22 persons not eligible to participate were destroyed; the data collected for
the 31 eligible persons who consented to participate became part of the data set for subsequent analysis.

**Ethical Approval**

As with any research, the ethical considerations associated with the study aimed to protect the participants from any harm (Hansen, 2006). Older persons with depression were considered to be vulnerable to exploitation associated with their participation in the research. Therefore, the researcher had a duty of care to ensure that the risk of physical or psychological harm to participants from the research was minimised (The University of Auckland, 2006).

A participant was considered unlikely to experience any physical harm from their involvement in this study, but it was acknowledged when designing the study that talking about the experiences could be emotionally distressing. The following provision was made in the event if distress occurred: there would be a break to allow the participant to take some rest and a cup of tea or assistance if this was needed. The support worker was an experienced psychiatric nurse available and could be access by telephone.

A second ethical consideration was the benefit arising from the study. Participation would have the potentially immediate benefit of providing the participant with an opportunity to recall their experiences and identify where care could possibly be enhanced.

Permission was sought from both the Research Ethics Committee of Kiang Wu Nursing College of Macau (0225-KC/LO/2006, see Appendix 7) and The University of Auckland Human Participants Ethics Committee (2006/435, see Appendix 8) prior to undertaking the study. Permission to access the older persons referred by the day centres/recreational centres for the elderly was gained from the managers of the centres (see Appendix 9). A consent form (see Appendix 10) with information about the study was distributed to each person deemed eligible for inclusion into the study, and if consent was given then consent form was signed or finger stamped, in the case of illiterate persons, by participants or oral permission was tape-recorded by participants. The researcher agreed to retain the consent forms, which would be stored separately from the data for six years after completion of the study.
In addition to providing a participant information sheet (see Appendix 12), the researcher spent at least ten minutes with each participant to explain the purpose of the interviews, and the assessments, what they would entail and how long each would take. The participants were assured that only the researcher and supervisors would access data only for the purposes of the study. The researcher respected the confidentiality of personal information and emphasised that in all data collected, participants would be introduced by pseudonym, and if the information a participant provided was reported or published, this would be done in a way that did not identify the participant as its source. The participants were also told that the data would be securely stored by the researcher for six years and then destroyed. The researcher also emphasised to the participants that they could withdraw from the study at any time and in such instances, their data would not be included in the analysis. None chose to withdraw; however some participants’ caregivers did decline to be interviewed when approached.

**Procedures**

Before the in-depth interview commenced, the standardised and validated measures detailed above, BI, Lawton IADL, LSNS, SF-36QOL, were used to collect quantitative indicators about the older person, a process that took approximately 30 minutes. These data were requested in such a way as to make participants comfortable with the researcher and to pave the way for the qualitative interview, by allowing the researcher to become acquainted with the lives of the participants. Then, using the open-ended interview guide with the prompt questions described above, the researcher conducted an in-depth interview to identify the life events, issues and common thoughts in older persons that related to depression.

**Pilot Study**

A pilot study was undertaken to review the feasibility and acceptability of the data collection methods before proceeding with the full study and to review the combination in practice of qualitative and quantitative approaches to interpret the lived experiences of older persons with depression in Macau. For the purposes of piloting the research strategy, eight older persons who met the inclusion criteria, aged 70 to 82, were attending one of three day centres/recreational centres for the elderly. After discussions with the researcher, the participants were given a choice of being interviewed either in a
private room at day centres/recreational centres for the elderly (seven chose this option) or in their own home (one chose this option). Giving choice enabled the participant to feel comfortable and at ease in a familiar environment that they preferred, thus the quality of interview was facilitated. Visiting the participant’s home gave the researcher the added opportunity to observe the living environment of the participant.

Having completed data collection on the eight older persons, the researcher reflected on pre-determined objectives as detailed above. A second follow-up interview was arranged by the researcher to talk and discuss the preliminary analysis with the participant and to allow the participant to clarify, add or alter anything said in the interview, as well as to give feedback on the transcribed interview.

The pilot study demonstrated that the combination of qualitative and quantitative approaches was appropriate to facilitate the description and interpretation of the lived experiences of older persons with depression in Macau, and that the process was acceptable to, and did not cause undue distress to, the participants. The pilot study fulfilled two functions: it showed that the prompt questions and the interview process employed generated the data desired and demonstrated that the combination of instruments and interview was not excessive for the older persons. The pilot study provided valuable insight into the acceptability to participants and the logistics of undertaking the study. The quality of the data was deemed suitable so that the experiences of these participants were included in the total data set for this study.

**In-depth Interviews**

Having completed quantitative data collection through use of standardised instruments, the researcher conducted the in-depth interviews with the participants at another time and place preferred by them. The in-depth interviews were conducted in a private room at either the participant’s home (17 chose this option) or the day centres/recreational centres for the elderly (14 chose this option). A familiar environment ensured the participant was comfortable and at ease, thus facilitating the quality of data collected. The researcher also had the opportunity to observe the living environment of the participant while visiting his/her own home.

A follow-up interview was arranged by the researcher with the participant at another time and place to talk and discuss the preliminary analysis with the participant and to
allow the participant to clarify, add or alter anything said in the in-depth interview, as well as to give feedback on the transcribed interview.

The caregivers were invited to be interviewed in the follow-up interviews, not to speak for (on behalf of) the older persons, but asked for their perspectives on the lives of the older persons they were caring for. Some participants’ caregivers declined to be interviewed when approached, citing they were too busy or it was not their business. Finally, seven caregivers consented to participate in the interviews.

The participant selection and data collection process of the study is illustrated in Figure 3.2.
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Figure 3.2 Participant Selection & Data Collection Process

Contact 1

53 older persons referred by day centres

Screening by researcher using MSQ, GDS & criteria

31 participants selected

Quantitative data through BI, IADL, LSNS, SF-36QOL

Contact 2

Narratives collected through qualitative interviews

Caregivers invited to be interviewed

Contact 3

Follow-up interviews with participant older persons

7 caregivers interviewed

Figure 3.2 Participant Selection & Data Collection Process
Quantitative Data Analysis

Quantitative data were collected using MSQ, GDS-15, BI, Lawton IADL, LSNS, SF-36QOL, and demographic data, firstly for the purposes of establishing eligibility to participate, and secondly to quantify a variety of psychosocial factors that could be compared with other older populations through descriptive statistics and inferential statistics to establish the relationships between dominant categories and themes.

Quantitative data analyses were conducted to give meaning to the data. The rationale for the specific statistical techniques used to analyse the data is based on the type of measures used and the nature of the data. All quantitative data were entered into the SPSS for Windows 15.0 where all statistical analyses were executed.

The quantitative data were analysed in two stages beginning with descriptive statistical analyses producing measures of mean, standard deviation, median and range; frequency, and percentage. Variations in the means were calculated on age, GDS-15, SF-36QOL, and LSNS. The second stage involved utilisation of inferential bivariate statistical analysis techniques. Nominal data initially coded to facilitate in the preliminary statistical investigations were then measured against demographic data (gender, marriage status, highest educational level attained, living circumstance, and income source), BI, IADL, Physical disorders, and LSNS. Thus, to this end, inferential statistical analyses were used to facilitate the statistical interpretation of the data, reported in detail below.

The \( t \)-test explores the level of difference between two group means that have been generated from interval level or ratio level data. Significance was determined at \( p<0.05 \), indicating the probability that the result could have been produced by chance was less than five percent, in accordance with most nursing research (Polit & Beck, 2006). \( t \)-tests were used here to see if the means of the following variables of the 31 participants differed significantly from comparable populations:

- GDS-15 with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)
- Eight scales of SF-36QOL with Hong Kong total population norm and Hong Kong general population of older persons norm (Lam et al., 1999)
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- LSNS with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

- GDS-15 between Group A who had experienced hardship from early in life and Group B who were not so hard

The non-parametric equivalent to the t-test, the Wilcoxon signed ranks test generates a z score and is used to determine the level of statistical significance of a difference in proportions of two variables (Feinstein, 2002). In this study it was employed to discover the level of difference of the following variables between the 31 participants and comparable populations:

- Demographic data: Gender with the general population of older persons in Macau, created following the Macau Census 2006 (Macau Statistics and Census Bureau, 2007a)

- IADL with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

- LSNS with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

Goodness-of-fit test was applied to a single categorical variable to see if the distribution among categories fitted a theoretical expectation (Vogt, 1999). Thus it is used to contrast observed and expected values. Goodness-of-fit tests were chosen to find if there were significant differences between the following variables, the 31 participants and comparable populations:

- Demographic data: Marriage status, highest educational level attained with the general population of older persons in Macau, created following the Macau Census 2006 (Macau Statistics and Census Bureau, 2007a)

- Demographic data: Living circumstance, income source with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

- BI with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

- Physical disorders with the general population of older persons in Macau 2004
Pearson’s product moment correlation test is a parametric test used to determine the existence of a relationship between interval or ratio level data and to show the degree of linear relationship between two variables, generating a $r$ value (Polit & Beck, 2006). Thus Pearson’s $r$ was selected to identify the relationships between GDS-15 scores and the following variables of the 31 participants and comparable populations:

- BI with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)
- IADL with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)
- Eight scales of SF-36QOL with Hong Kong total population norm and Hong Kong general population of older persons norm (Lam et al., 1999)
- LSNS with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006)

Mann-Whitney $U$ test, a nonparametric test for non-normal distribution of critical variables, was used to test the statistical significance of differences between two groups, where the independent variable is nominal level and the dependent variable is ordinal level in nature (Polit & Beck, 2004). It was used to test the significant differences of the following variables between Group A and Group B:

- BI between Group A who had experienced hardship from early in life and Group B who were not so hard
- Two scales of SF-36QOL (General Health and Mental Health) between Group A who had experienced hardship from early in life and Group B who were not so hard

As mentioned previously, Table 3.1 summarises the descriptive statistical analyses and inferential statistical analyses for the quantitative data of the participants.
Table 3.1 Analysis Methods for Quantitative Data of the Participants

<table>
<thead>
<tr>
<th>Analysis methods</th>
<th>Variables</th>
</tr>
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<td>Mean, median, standard deviation, and range</td>
<td>Age, GDS-15, eight scales of SF-36QOL, LSNS</td>
</tr>
<tr>
<td>Frequency and percentage</td>
<td>- Gender (male/female), marriage status (never married/married/divorced/widowed), highest educational level attained (illiterate/primary school/middle school/university), living circumstance (alone/with spouse/with family), income source (nil/pension/subsidy)</td>
</tr>
<tr>
<td></td>
<td>- BI: 0~, 56~, 100</td>
</tr>
<tr>
<td></td>
<td>- IADL: ~24, 24</td>
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<tr>
<td></td>
<td>- Physical disorders: Code; co-morbidities</td>
</tr>
<tr>
<td></td>
<td>- LSNS: <del>20, 20</del></td>
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<tr>
<td>$t$-tests</td>
<td>- GDS-15 with the general population of older persons in Macau 2004</td>
</tr>
<tr>
<td></td>
<td>- Eight scales of SF-36QOL with Hong Kong total population and general population of older persons</td>
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<td></td>
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<td></td>
<td>- GDS-15 between Group A who had experienced hardship from early in life and Group B who were not so hard</td>
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<tr>
<td>$z$-tests</td>
<td>- Gender with the general population of older persons in Macau</td>
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<td></td>
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<td>Goodness-of-fit tests</td>
<td>- Marriage status, highest educational level attained with the general population of older persons in Macau</td>
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<td></td>
<td>- Living circumstance, income source with the general population of older persons in Macau 2004</td>
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<td></td>
<td>- BI with the general population of older persons in Macau 2004</td>
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<tr>
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<td>GDS-15 and BI, IADL, eight scales of SF-36QOL, LSNS</td>
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<td>Mann-Whitney $U$ tests</td>
<td>- BI between Group A who had experienced hardship from early in life and Group B who were not so hard</td>
</tr>
<tr>
<td></td>
<td>- Two scales of SF-36QOL (General Health and Mental Health) between Group A who had experienced hardship from early in life and Group B who were not so hard</td>
</tr>
</tbody>
</table>
**Narrative Method**

Within the inductive qualitative research approach used, informed by a phenomenological theoretical framework, the narrative method was selected to guide the interviews (Riessman, 2008). Narrative method was deemed the method of choice to illuminate the lived experience of depression among older persons. The method privileged the stories the participant told to shed light on depression, truly a holistic and whole of life approach: How did the experience of depression affect day to day life and perspectives? What circumstances present and past, might contribute to dysphoric? How might life’s experiences relate to mental and emotional capture that they could draw on to sustain them in their final years?

The narratives in the study referred to texts at several levels that overlap: stories told by the participants (which were themselves interpretive); and interpretive accounts developed by the researcher based on interview, quantitative indicators data, and fieldwork observation (a story about stories) (Riessman, 2008).

The researcher conceptualised research interviewing as a discursive accomplishment; an interviewer who asked questions and a participant who gave answers was replaced by two active participants who jointly constructed narrative and meaning (Smith & Sparkes, 2005). The goal in narrative interviewing was to generate detailed accounts rather than brief answers or general statements. Narratives therefore came in many forms and sizes, ranging from brief and tightly bounded stories told in answer to a single question, to long narratives that built over the course of several interviews that referred to entire lived experiences. Establishing a climate that allowed for storytelling in all its forms required substantial changes in practice (Riessman, 2008).

Generating narratives required longer turns at talk than were customary in ordinary conversations. One story could lead to another, as narrator and the researcher negotiated openings for extended turns and associative shifts in topic. When shifts occurred, it was useful to explore, with the participant, associations and meanings that might connect several stories. The researcher wanted to learn about an experience in all its complexity and detailed counts that included specific incidents and turning points (Chase, 1995).
Chapter 3 Methodology and Methods

In practice, this meant that the interview guide was just that, a guide, and guidelines followed no set order. Creating possibilities in research interviews for extended narration required the researcher to give up control. Narrative interviewing necessitated following participants down their trails. Giving up the control of a fixed interview format encouraged greater equality in the conversation. The researcher encouraged participants to speak in their own ways. The researcher asked questions that opened up topics to provide narrative opportunities and allowed respondents to construct answers in ways they found meaningful. Narration sometimes depended on expectations. To welcome extended accounts, the researcher and participants collaboratively developed them (Riessman, 2008).

The researcher learned to listen attentively. In the context of the interviews, the researcher opened himself up to the unknown with its ‘new possibilities and frameworks of meaning’ and it was ‘hard work, demanding as it did an abandonment of the self in a quest to enter the world of another; and it took time’ (Andrews, 2007). As demonstrated in the pilot study, a familiar environment ensured the participant was most comfortable and at ease, thus facilitating the quality of data collected. The researcher also had the opportunity to observe the living environment of the participant while visiting his/her own home. The interviews were conducted in a private room at either the participant’s home (17 chose this option) or the day centres/recreational centres for the elderly (14 chose this option), as preferred by the participant. Participants were encouraged to do most of the talking and to tell what the experience was like in their own words. And the researcher would focus on points of clarification and elaboration. Flexibility and open-mindedness were two essential attributes for a qualitative interviewer (Mason, 1996). After the participants had described their experiences, and no further clarification was needed, the interview was considered complete. The time for each interview ranged from 32 minutes in one case (when the participant was less forthcoming) to 108 minutes in another, considered sufficiently long for old, frail and unwell persons, with a mean of 66 minutes (on average, just over an hour each).

**Narrative Data Analysis**

The principles of Van Manen’s (1984) phenomenological method were used for the qualitative data analysis. Phenomenological reflection and writing (Van Manen, 1990) were ongoing from the first interview through all stages of analysis. An iterative process
was used to create an internal dialogue between the researcher and the text from interview with older persons with depression. Through the dialectical process the researcher was able to engage perspectives broader than his own, enrich data analysis (Van Manen, 1997b), and deepen his understanding of the experience of depression. The researcher moved back and forth among the data, literature, and his own experiences. Van Manen (1997a) described five textual features of phenomenological writing and gave suggestions on how to draw them out:

1. Lived through-ness is concrete description placed in the context of the experience;
2. Evocation occurs when an experience is vividly brought to conscious awareness, making it available for reflection;
3. Intensification gives key words their full attention and worth and helps to put the meanings in the text;
4. Tone in certain words, such as those that suggest sound or movement, addresses the reader on a non-cognitive level; and
5. An epiphany occurs when the text stimulates a transformative experience in the reader and an immediate intuitive understanding occurs.

In the present study, “lived throughness” meant that the phenomenon of depression in older persons was placed concretely in the lifeworld so that the reader might experientially recognise it. Concreteness of text placed the reader right in the midst of lived reality where the phenomenon of depression in older persons could be a felt concern. “Evocation” meant that experience was brought vividly into presence so that the reader could phenomenologically reflect on it. What made this story phenomenologically attractive was that it not only provided a concrete description, but the description in turn evoked vivid images and associations that prompted the reader’s thoughtful reflection. “Intensification” meant that the researcher must give key words their full value, so that layers of phenomenological meaning became strongly embedded in the text. The themes in the present study must constantly be “mantly massaged” (Van Manen, 1997a), as it were. “Tone” meant that the researcher must let the text speak to us, address us, so that its deeper meaning had a noncognitive effect on the reader. The researcher did not only explain what something was; it also explored what
the phenomenon of depression in older persons could mean by offering possible interpretations. Every text that was rich could be read interpretively. “Epiphany” meant that the text in the present study must bring about a transformative effect so that its deeper meaning made an edifying appeal to the self to the reader. Epiphany referred to the sudden perception or intuitive grasp of the life meaning of something. The epiphanic sense of the text was directly related to the life meaning that the researcher attempted to evoke.

The interviews were tape-recorded and transcribed verbatim. Transcripts were compared with the tapes for accuracy. Preliminary analysis of the key concepts arising from each interview identified issues that would then be discussed during subsequent interviews with other older persons. The researcher adopted the thematic analysis to uncover and categorise thematically lived experiences of older persons with depression in Macau (Smith & Sparkes, 2005).

This involved reading the transcripts in their entirety. Significant statements about depression were then extracted and the meaning of each statement was formulated. Clusters of themes were organised from aggregated formulated meanings. The original transcripts were examined for each theme cluster. Finally, the results were integrated thematically to yield a description of the depression of older persons. Northcott (1996) introduced a process of conceptual mapping as an effective mechanism for data analysis. The process involved formulating a visual portrayal of the ideas, beliefs, thoughts and experiences of the older persons by accumulating all the ideas on to one sheet of paper and identifying the interconnections. Cognitive mapping therefore became a form of thematic analysis, enabling the creation of a summary picture and consideration of meanings of the key concepts.

To support and strengthen the cognitive mapping, a thematic narrative analysis method was employed. Narrative analysis referred to a family of methods for interpreting texts that had in common a storied form (Riessman, 2008). A narrative approach aimed to ‘open up for analysis the culturally rich methods through which interviewers and interviewees, in concert, generate plausible accounts of the world’ (Silverman, 2003, p. 352). A narrative analysis focused on the ways informants used stories or narratives when talking about their lived experiences. The researcher, using a narrative approach, focused on the ways that participants told stories and that avoided fragmenting their
data through coding (Hansen, 2006). That was, chunks of text that told a story were the unit of analysis, reflected the sociological approach in analysis. Narrative accounts could be analysed linguistically or sociologically. A linguistic focus paid particular attention to the use of language and structures within the narratives. A sociological approach, the approach used in the present study, focused more on what the types of narrative told could tell us about the ways that participants had experienced their lives and the narratives available to them (Richardson, 1990).

Narrative analysis was an exciting way to take advantage of the richness of qualitative data and it allowed the researcher to gain and to convey insight into the beliefs, actions and values of participants, from within their own frame of reference (Grbich, 1999). For the researcher in search of insight into the older persons’ worlds, stories were fundamental to the work. Understanding the data in terms of stories was a recognition that the issues that emerged in the research were embedded in participants’ lives, and that their understandings of their lives were constructed through language and interaction.

Narratives focused on the details of the story and emphasised the context dependant nature of the particular story told. Narratives changed depending on who told them and ambiguity became a central part of the study (Rice & Ezzy, 1999). The world of narration did not drift freely but was anchored and related to the lived world of the participant. It was possible to understand specific situations contextually, which encompassed both the participant’s life and the context of the narrative situation. The narrative contained a direction that made its wholeness into something greater than its parts (Ricoeur, 1981).

By interpreting the narratives, the researcher’s understanding was changed and expanded, which thereby formed a new continued interpretation. Achieving productive interpretations occurred by both suspecting and listening, distancing from and empathising with the narrative, critically analysing and internalising the narrative, and relating the structure of the narrative to its meaning and context (Frid, Ohlen, & Bergbom, 2000).

The narratives focused on the deconstruction, or exploration, of the source of problem in the form of stories that constituted the life of participants and recruited participants
into lives of suffering (Moules & Streitberger, 1997). Naming the theme arising from the data occurred as a co-creation between the researcher and the participants, recognising that it was most useful if the name was in the language of the participant rather than in the languages of the researcher. For example, actual words participants used such as feeling “useless” became the labels of themes. After the theme was named, the plot, which described ways that the theme had taken control over the participant and gained influenced on participant’s life of the story was indentified (J. Freeman & Combs, 1996). These themes and plots were reflected in the following chapters reporting the findings of the study.

**Mixed Methods Analysis**

Of all the procedures, analytic integration might be the trickiest of all. The mixed methods, if truly different methodologically, were likely to come with their own preferred and distinct analytic techniques. Under this circumstance, the goal was not to force the mixed methods into the exact same analytic routines. Rather, the goal was to design and carry out what might be called counterpart analyses (R. K. Yin, 2006). If findings were corroborated across different approaches then greater confidence could be held in the singular conclusion; if the findings conflicted then the researcher had greater knowledge and could modify interpretations and conclusions accordingly (Onwuegbuzie & Leech, 2004).

In this study, the mixed methods analysis followed a dominant to less dominant and sequential mixed designs (Tashakkori & Teddlie, 2003) in which there were two phases that occurred chronologically: quantitative analysis (low priority) → QUALITATIVE analysis (high priority). The conclusions that were made on the basis of the results of the quantitative analysis phase led to formulation of questions, data collection, and data analysis for the next qualitative analysis phase. The final inferences were based on the results of both phases of the study. The qualitative analysis phase of the study was conducted either to confirm/disconfirm the inferences of the quantitative analysis phase or to provide further explanation for findings from the quantitative analysis phase (Tashakkori & Teddlie, 2003). To be considered a mixed-method design, the findings must be mixed or integrated at some point, seeking convergence of results and adding breadth and scope to the study (Tashakkori & Teddlie, 1998). A quantitative phase might be conducted to inform a qualitative phase, sequentially. In the case of this study
the first part of the analysis (based on data from MSQ, GDS-15, BI, Lawton IADL, LSNS, and SF-36QOL) were used to quantify a variety of psychosocial factors that might be associated with the experiences of older persons with depression in Macau, via descriptive statistics and inferential statistics. Based on these quantitative analyses, questions raised by these quantitative results were then reflected on and expanded through the narratives of the participants related to this phenomenon. In this strategy, the objective was first to establish the relationships between dominant categories and themes through inferential statistics of quantitative data and then to collect qualitative data to confirm and expand upon the information that was available regarding these relationships (Tashakkori & Teddlie, 1998). Both quantitative data and qualitative data were combined to create consolidated data sets and integrated into a coherent whole in this study (Onwuegbuzie & Johnson, 2004).

**Validity and Reliability**

A range of standardised and validated measures were used to generate the quantitative data to supplement the qualitative data, and to determine eligibility to participant and included: the Mental Status Questionnaire (MSQ), The Geriatric Depression Scale-15 (GDS-15), the Reduced Item Barthel Index (BI), the Lawton Instrument of Activities of Daily Living Questionnaire (Lawton IADL), the Lubben Social Network Scale (LSNS), and the 36-item Short-Form Health Survey of Quality of Life (SF-36QOL). The validity and reliability of each of these instruments were now reported in detail.

The MSQ had been translated and validated in Chinese older population in Shanghai, China with a satisfied reliability Cronbach $\alpha$ of 0.78 (T. Y. Li et al., 2001). Furthermore, the MSQ had also been translated and validated in Cantonese for Chinese older population in Hong Kong with a reliability Cronbach $\alpha$ of 0.79 (Ngan et al., 1996) and in Macau with a reliability Cronbach $\alpha$ of 0.77 (Macau Social Welfare Bureau, 2006).

The GDS-15 had been translated and validated in Chinese elderly populations (A. C. M. Chan, 1996; H. F. K. Chiu et al., 1994; H. B. Lee et al., 1993) as well as in other cultural groups (Mui et al., 2001). Furthermore, the GDS-15 had also been translated and validated in Cantonese for Chinese older population in Macau with a reliability Cronbach $\alpha$ of 0.83 (Macau Social Welfare Bureau, 2006).
Chapter 3 Methodology and Methods

The BI had been translated and validated in Chinese older population in Shanghai, China with a satisfied reliability Cronbach $\alpha$ of 0.94 (T. Y. Li et al., 2001). Furthermore, the BI had also been translated and validated in Cantonese for Chinese older population in Hong Kong with a reliability Cronbach $\alpha$ of 0.89 (Ngan et al., 1996) and in Macau with a reliability Cronbach $\alpha$ of 0.78 (Macau Social Welfare Bureau, 2006).

The Lawton IADL had been translated and validated in Chinese older population in Shanghai, China (T. Y. Li et al., 2001). Furthermore, the Lawton IADL had also been translated and validated in Cantonese for Chinese older population in Hong Kong (Ngan et al., 1996) and in Macau (Macau Social Welfare Bureau, 2006).

The LSNS had been used in a wide array of studies since it was first reported a decade ago (Ceria et al., 2001; K. L. Chou & Chi, 2001b; Hurwicz & Berkanovic, 1993; Lubben, 1988; Martire et al., 1999; Mor-Barak & Miller, 1991; Okwumabua et al., 1997; Potts, 1997; Rubinstein et al., 1994). It had been used in both research and practice settings and it had been translated into several languages; including Chinese, Korean, Japanese, and Spanish; for use in cross-cultural and cross-national comparative studies. The LSNS had also been translated and validated in Cantonese for Chinese older population in Macau with a reliability Cronbach $\alpha$ of 0.80 (Macau Social Welfare Bureau, 2006).

The SF-36QOL had been translated and tested in more than 40 countries and validated in 12 countries. Ren et al. (1998) developed and tested a Chinese version of the SF-36QOL on Chinese Americans and Lam et al. (2003; 1998; 1999) developed, tested and validated a Chinese (HK) version of SF-36QOL on Chinese living in Hong Kong. The SF-36QOL Chinese version had also been tested and validated in mainland China (J. Li et al., 2001; Liu et al., 2001).

The low numbers of 31 participants in the present study needed to be identified as a factor that might affect the validity of some statistical tests used in the study. No power analysis was undertaken however because the purpose of the present study was exploratory in nature and not confirmatory ie to prove cause and effect. The study aimed to explore the possible differences between perceived ADLs, social network, and quality of life etc and actual as determined by the tests. Furthermore, the study explored
the similarities of differences between the study population and that of the wider community for which data were already available.

In contrast to standardised instruments, the human sciences were deemed by some to be less rational or less rigorous than the behavioural or experimental sciences. The response to this criticism depended on the criteria of rationality that one applied to the human sciences. If the criteria were the same as those that governed the experimental sciences then the human sciences might seem rather undisciplined. But those criteria did not have the same meaning; otherwise there would be no essential difference between the human and the natural sciences. The meaning of human science notions such as “truth, method, understanding, objectivity, subjectivity, valid discourse,” and the meaning of “description, analysis, interpretation, writing, text,” were always to be understood within a certain rational perspective (Van Manen, 1997a). Van Manen (1997a) did not deny the need for a rational foundation, but appeared to work towards a broadened notion of rationality. Human science was rationalistic in that it operated on the assumption that human life might be made intelligible, accessible to human logos or reason, in a broad or full embodied sense. To be a rationalist was to believe in the power of thinking, insight and dialogue. It was to believe in the possibility of understanding the world by maintaining a thoughtful and conversational relation with the world. To believe in the power of thinking was also to acknowledge that it was the complexity and mystery of life that called for thinking in the first place. Human life needed knowledge, reflection, and thought to make itself knowable to itself, including its complex and ultimately mysterious nature. Furthermore, we should acknowledge that human science operates with its own criteria for precision, exactness, and rigor. Human science strived for precision and exactness by aiming at interpretive descriptions that exacted fullness and completeness of detail, and that explored to degree of perfection the fundamental nature of the notion being addressed in the text. The term “rigor” originally meant “stiffness,” “hardness”. Human science research was rigorous when it was “strong” or “hard” in a moral and spirited sense. A strong and rigorous human science text distinguished itself by its courage and resolves to stand up for the uniqueness and significance of the notion to which it had dedicated itself. In the human sciences, as stated as Bollnow (1974), objectivity and subjectivity were not mutually exclusive categories. “Objectivity” meant that the researcher was oriented to the object that stood in front of him or her. Objectivity meant that the researcher remained true to the
object. The researcher became in a sense a guardian and a defender of the true nature of the object. “Subjectivity” meant that one could be in order to show or disclose the object in its full richness and in its greatest depth. Subjectivity meant that we were strong in our orientation to the object of study in a unique and personal way.

Reliability and validity were addressed by procedures suggested by Lincoln and Guba (1985). These authors identified the following criteria to establish trustworthiness of the qualitative data: credibility, transferability, dependability, and confirmability.

Credibility (comparable with internal validity) addressed the issue of ‘fit’ between respondents’ views and the researcher’s representation of them (Schwandt, 2001). It posed the questions of whether the explanation fitted the description (Janesick, 2000) and whether the description was credible. Credibility was demonstrated through the following strategies: each interviewee was invited to talk and discuss the preliminary analysis with the researcher once to check for any misinterpretation. The researcher read it out to the participants in case of illiterate ones. These issues could be corrected at the second interview. Consultations were obtained from supervisors, three experts on qualitative research who reviewed the transcripts and commented on data analysis. A consequence of this procedure was a refinement of themes and coding.

Transferability (comparable with external validity) referred to the generalisability of inquiry. The reader must be provided with sufficient information to facilitate understanding of how the research fitted in with what was already known about the subject area. Donmoyer (1990) argued that naturalistic inquiry had individual subjective meaning as central. In the study, the researcher continued enrolling participants until repetition of the salient points (themes) was reached; this was the point at which saturation had been achieved (J. Green & Thorogood, 2004; Lincoln & Guba, 1985). Totally, data was collected from 31 participants with various conditions and seven caregivers.

Dependability (comparable with reliability) required that the researcher was responsible for ensuring that the process of research is logical, traceable and clearly documented (Schwandt, 2001). Confirmability (comparable with objectivity) was concerned that interpretations of the findings were clearly derived from the data. The researcher, therefore must present the reader with sufficient information to understand the processes...
that had been gone through, and furthermore, carefully logged all sessions dealing with interpretation of data to keep track of how coding strategies evolved during the study. Notes about raw data, fieldnotes, formulated meanings, and memos and notes on analysis, interpretations and insights were carefully documented.

**Summary**

A mixed methods design using both qualitative and quantitative approaches was adopted in this study. The research approach chosen was influenced by the researcher’s prepositions and Van Manen’s approach of phenomenology and the data collection and analysis procedure by narrative methods, as described in detail. Narratives of the participants generated through a qualitative interpretative methodology reflected naturalistic inquiry tradition. These qualitative approaches were supplemented by the collection of a selection of quantitative data using standardised instruments validated to be used in the population, to strengthen the comparison of the study population with the larger population, and to improve the generalisability of the findings to the wider population of older persons with depression. Details appertaining to the analyses were also presented. Having described in detail the mixed methods design of the study, the following five chapters reported and discussed the study findings.
Chapter 4

Introduction to Study Findings

Using the methods outlined in the previous chapter, an introduction to and overview of the findings of the study were outlined in this chapter. Firstly, the demographic profile of the study participants was presented and other descriptive data were summarised. The four dominant categories found in the study and their associated themes were then introduced. Reflecting the mixed methods approach employed, quantitative data collected using standardised instruments were first reported and then mapped against the four dominant categories that emerged using qualitative techniques. When reporting on quantitative results, where possible the results of the 31 participants were compared with the general population of older persons in Macau, based on a large-scale study of 2039 older persons in 2004 (Macau Social Welfare Bureau, 2006), and/or Macau Census 2006 data (Macau Statistics and Census Bureau, 2007a). Where equivalent data had not been collected in Macau, comparisons were made with Hong Kong population, where the environment and population demographics were similar, based on Lam, Lauder, Lam, and Gandek’ study (1999). This brief chapter served as an introduction and provided a context to the following four chapters that reported and discussed in detail the findings of this study, setting out how these chapters interrelated.

Profile of Participants

Thirty-one older persons and seven caregivers who met the inclusion criteria participated in the study. The ages of the 31 older persons with depression ranged from 69 years to 92 years with a mean of 78.7 years. Most of them were female (71.0%, n=22). The profile of the study population was compared to the general population of older persons in Macau, created following the Macau Census 2006, using z-test. Although the percentage of males was less than in the general population of older persons, there was no statistical difference for the gender component between the two populations (z=1.595, p=0.111). The male gender had previously been identified as an influencing factor for depression in Macau (D. D. Li et al., 2003). Within traditional Chinese culture, men were perceived as strong masculine figures. Chinese idioms
abounded, such as ‘a man prefers blood more than tears’ (男子漢流血不流淚) and ‘men have no fear’ (男人大丈夫) that portrayed a strong masculine figure. Chinese men might find it hard to express their emotions and seek help for their depression (S. W. C. Chan, Chiu, Chien, Thompson, & Lam, 2006). Men were socialised to suppress their emotions and they might perceive seeking help for mood problems as a sign of weakness (D. Thompson, 2000). The result indicated that the participants were representative of the general population of older persons in Macau. Details are showed in Table 4.1.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons</th>
<th>Participants age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>29.0</td>
<td>15282</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>71.0</td>
<td>20073</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100.0</td>
<td>35355</td>
</tr>
</tbody>
</table>

Notes: # z=1.595, p=0.111
* Adapted from: Macau Statistics and Census Bureau, 2007a

Many of the 31 participants were widowed (64.5%, n=20), whilst 9.7 percent (n=3) were divorced, and 12.9 percent (n=4) had never married. Most of the participants (71.0%, n=22) were illiterate. Over half of the participants (54.8%, n=17) were living alone, whilst 48.4 percent (n=15) depended on subsidy and 22.6 percent (n=7) of them received no income resource. The findings revealed that the participants suffered from worse living conditions and social support than the general population of older persons in Macau (see Chapter 7 for further details).

A criterion for inclusion in the study was the presence of depression, as measured by GDS-15 with cut-off point of eight, however the mean of 11.5 indicated that all of the 31 older persons were seriously depressed (H. F. K. Chiu et al., 1994; H. B. Lee et al., 1993). In terms of the SF-36QOL psychological aspects, role-emotional had a mean of 7.53, social functioning showed a mean of 22.18, mental health had a mean of 25.16, vitality showed a mean of 25.81 and general health had a mean of 26.97. These findings
were compared with those of the total population and the general population of older persons in Hong Kong and revealed that the 31 older persons suffered from worse mental states (see Chapter 5 for detailed report).

The questionnaire also demonstrated that all participants suffered from physical disorders. Furthermore, almost all the participants (90.3%, n=28) self-reported at least three or more physical disorders. Nearly half of the participants (45.2%, n=14) had BI scores less than 100, which indicated the participants suffered from varying degrees of physical impairment in activities of daily living. There were 6.5 percent (n=2) who had BI scores less than 56, indicating total to severe dependency for activities of daily living (Wang, 2000). There were 61.3 percent (n=19) of the participants who felt unable to undertake activities of daily living or could do so only with difficulty and with help (Lawton & Brody, 1969; Spector, 1990). SF-36QOL physical aspects consisted of physical functioning with a mean of 40.16, role-physical with a mean of 12.10, bodily pain with a mean of 40.58, vitality with a mean of 25.81 and general health with a mean of 26.97. These data were compared with the total population norm and the general population of older persons norm in Hong Kong (Lam et al., 1999). The results showed that the 31 older persons with depression had worse physical conditions than both the total population and the general population of older persons in Hong Kong. Furthermore, the results showed that high GDS-15 scores (indicating depression) were correlated with low BI, IADL, SF-36QOL physical aspects scores (indicating poor physical function) (see Chapter 6 for detailed report).

From what was observed, all except one of the participants (30 of 31 participants) had a LSNS score less than 20. The findings indicated that most participants tended to reach an extreme risk for limited social networks when compared with the general population of older persons in Macau. The SF-36QOL social functioning aspect, with a mean of 22.18, was compared with the total population norm and the general population of older persons norm in Hong Kong (Lam et al., 1999) and the results showed that the 31 older persons with depression had worse social functioning than the total population and the general population of older persons in Hong Kong, comparable populations. Furthermore, the results showed that high GDS-15 scores (indicating depression) were correlated with low LSNS, SF-36QOL social functioning scores (indicating poor social function) (see Chapter 7 for detailed report).
The BI, SF-36QOL, and GDS-15 were utilised to quantitatively measure the effects of the lives they had lived on the physical conditions and mental states of the participants. Two groups were formed from these results: Group A, who focused on their hard life from early in life, ranked a moderate dependency level of BI activities of daily living with a mean of 83.3, while Group B, who were not so focused on a hard life, suffered from a mild dependency level only, with BI with a mean of 97.3. Moreover, Group A reported worse physical health conditions (GH mean score of 21.7) when compared with Group B (GH mean score of 34.3). Regarding psychological scores, Group A presented with worse mental health state (MH mean score of 20.9) than Group B (MH mean score of 31.1). Furthermore, the results implied that Group A was more seriously depressed than Group B (see Chapter 8 for detailed report).

To summarise, while demographically the participants reflected the Macau population of older persons in term of gender and age, the quantitative data consistently showed that the participants had worse scores than comparable populations previously studied in Macau or Hong Kong. These results and the interpretation of the scores are reported in relevant chapters as indicated.

**Introduction to Dominant Categories Found**

Against a background of negative scores for physical and mental health, and for family and social networks, the findings identified some of the factors in the lives of the study population that might explain the scores, and in particular, high depression scores. The lived experiences of older persons with depression in Macau were complex and, in many ways unique; the lives of no two persons were the same. Using the iterative approaches described previously, the data from the study clustered into four broad dominant categories:

- Negative thinking;
- Physical limitations and complaints;
- Present living conditions and social support; and
- The lives they have lived.
The first dominant category, “negative thinking”, was key to the lived experiences of the 31 depressed older persons since all participants had negative views of themselves. This dominant category consisted of the following themes:

- Feeling useless;
- Hopelessness;
- Sadness; and
- Helplessness.

The second dominant category, “physical limitations and complaints”, was strongly linked with the lived experiences of these older persons and the increased dependency that they were confronted with was likely to also strengthen their feelings of uselessness and hopelessness (Copeland et al., 1999; D. D. Li et al., 2003). It covered the following sub-categories:

- Physical limitations, including themes of limited mobility and dependence on others;
- Physical complaints, including themes of chronic joint pain, cannot sleep, poor appetite and poor memory; and
- Impact of medical treatments and access problems, including themes of complex medication regimens and difficulties in getting to hospital.

The third dominant category, “present living conditions and social support”, played an important role in their lived experiences of these older persons and all the participants expressed great concern about this aspect of life. It consisted of the following sub-categories:

- Hardship, including themes of being poor, being illiterate, and injustice;
- Poor family relationships, including themes of being widowed, living alone, conflict with adult children, and being neglected by children; and
- Limited social network, including themes of being looked down upon by others and lack of social contact.
The final dominant category, “the lives they have lived”, was about their poor experiences from early in life and included the following themes:

- Hard labour, low reward;
- Being fatherless;
- Having a bad marriage;
- Trauma from wars and revolutions.

The relationships among the four dominant categories are illustrated in Figure 4.1. This took the form of a symbol of a damaging flame. The older persons with depression appeared to be deeply “burned”, reflecting a Chinese saying that suffering like being “burned by hot flame and sunk by deep sea” (水深火熱). Their narratives revealed that they were burned by negative thinking, physical limitations and complaints, present living conditions and social support and the lives they have lived, and that they could see no way out of their suffering. These four dominant categories were not independent, but interacted with and were compounded by other dominant categories. The relationships among the four dominant categories and sub-categories and themes are summarised in Table 4.2.
Older persons with depression in Macau

Figure 4.1 Lived Experiences of Older Persons with Depression in Macau
Table 4.2 Dominant Categories, Sub-categories and Themes Found in Participants

<table>
<thead>
<tr>
<th>Dominant category</th>
<th>Sub-category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative thinking</td>
<td>----</td>
<td>Feeling useless</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hopelessness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sadness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helplessness</td>
</tr>
<tr>
<td>Physical limitations and complaints</td>
<td>Physical limitations</td>
<td>Limited mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dependence on others</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>Physical complaints</td>
<td>Chronic joint pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cannot sleep</td>
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<tr>
<td></td>
<td></td>
<td>Poor appetite</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor memory</td>
</tr>
<tr>
<td>Impact of medical treatments and access problems</td>
<td>Complex medication regimens</td>
<td>Difficulties in getting to hospital</td>
</tr>
<tr>
<td>Hardship</td>
<td></td>
<td>Being poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being illiterate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injustice</td>
</tr>
<tr>
<td>Poor family relationships</td>
<td></td>
<td>Being widowed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Living alone</td>
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<tr>
<td></td>
<td></td>
<td>Conflict with adult children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being neglected by children</td>
</tr>
<tr>
<td>Limited social network</td>
<td></td>
<td>Being looked down upon by others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of social contact</td>
</tr>
<tr>
<td>The lives they have lived</td>
<td>----</td>
<td>Hard labour, low reward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being fatherless</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having a bad marriage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trauma from wars and revolutions</td>
</tr>
</tbody>
</table>
Mapping Qualitative and Quantitative Data

Both the qualitative data and quantitative data facilitated the interpretation and illumination of the lived experiences of these older persons with depression in Macau. Quantitative data, generated by standardised instruments, were mapped against the four dominant categories that emerged from the narratives.

The first dominant category, “negative thinking”, was mapped against the following:

- GDS-15; this was used in the study to determine the presence of depression;
- SF-36QOL psychological aspects including role-emotional, social functioning, mental health, vitality, and general health subscales were utilised to investigate mental states of older persons in the study.

The second dominant category, “physical limitations and complaints”, was mapped against the following quantitative data:

- BI and IADL, which were used to evaluate older persons’ capability to perform activities of daily living in the study;
- SF-36QOL physiological aspects including physical functioning, role-physical, bodily pain, vitality, and general health subscales were utilised to assess physical conditions of older persons in the study;
- Physical disorders were the self-reported disorders by older persons and were used to assess physical conditions of older persons in the study.

The third dominant category, “present living conditions and social support”, was mapped against the following quantitative data:

- LSNS, which was used to assess social support network of older persons in the study;
- SF-36QOL social functioning aspect, which was utilised to assess social function of older persons in the study;
- Marriage status, highest educational level attained, living circumstance, and income source, collected using a questionnaire developed for this study, which were utilised to assess present living conditions and social support of older
persons in the study.

The final dominant category, “the lives they have lived”, was mapped against the following quantitative data:

- GDS-15; this was used in the study to determine the variances of GDS-15 between Group A who focused on their hard life from early in life and Group B who were not so focused on a hard life;

- BI, which was used to evaluate the differences of capability to perform activities of daily living between Group A and Group B in the study;

- SF-36QOL psychological aspects including mental health and general health subscales were utilised to investigate the differences of mental states between Group A and Group B in the study.

As mentioned previously, the relationships among the four dominant categories and quantitative indicators are illustrated in Table 4.3.
## Table 4.3 Combination of Qualitative and Quantitative Data of the Study

<table>
<thead>
<tr>
<th>Dominant category</th>
<th>Quantitative indicators*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative thinking</td>
<td>GDS-15</td>
</tr>
<tr>
<td></td>
<td>SF-36QOL: RE SF MH VT GH</td>
</tr>
<tr>
<td>Physical limitations and complaints</td>
<td>BI</td>
</tr>
<tr>
<td></td>
<td>IADL</td>
</tr>
<tr>
<td></td>
<td>SF-36QOL: PF RP BP VT GH</td>
</tr>
<tr>
<td></td>
<td>Physical disorders</td>
</tr>
<tr>
<td>Present living conditions and social support</td>
<td>LSNS</td>
</tr>
<tr>
<td></td>
<td>SF-36QOL:SF</td>
</tr>
<tr>
<td></td>
<td>Demographic data: Marriage status, highest educational level attained, living circumstance, income source</td>
</tr>
<tr>
<td>The lives they have lived</td>
<td>GDS-15</td>
</tr>
<tr>
<td></td>
<td>BI</td>
</tr>
<tr>
<td></td>
<td>SF-36QOL: MH GH</td>
</tr>
</tbody>
</table>

*Notes:

BI=Reduced Item Barthel Index  
BP=bodily pain  
GDS-15=Geriatric Depression Scale-15  
GH=general health  
IADL=Lawton Instrument of Activities of Daily Living Questionnaire  
LSNS=Lubben Social Network Scale  
MH=mental health  
PF=physical functioning  
RE=role-emotional  
RP=role-physical  
SF=social functioning  
VT=vitality
Summary

The overview of the results provided in this chapter indicated that although the participants broadly reflected Macau’s over 65 population demographically, this group, selected because they had depression, generated worse scores on all tests and all participants told stories that reflected present and past challenges. Having introduced and summarised the quantitative and qualitative findings related to each of the four dominant categories, the findings would now be reported and discussed in detail in the following four chapters. The following pattern would be followed in each chapter. First, a brief summary of literature related to each dominant category would be provided as a context for the findings. This would be followed by presenting and discussing the quantitative results. Questions raised by those quantitative results would then be considered and reflected on by drawing on findings from the narratives. Each chapter would conclude by considering how the findings related to the dominant category illuminated the phenomenon of depression in Macau’s older persons.
Chapter 5

Negative Thinking

Negative thinking was central to the lived experiences of the older persons with depression in Macau and in this chapter it was elaborated upon and discussed in detail. Negative thoughts were identified as serious negative emotions, which had the following consequences: negative views of himself/herself; the withdrawal of life interest; lack of motivation; loss of vital energy; and feelings of hopelessness. Firstly, a brief summary of the literature related to negative thinking (reviewed in full in Chapter 2) provided a context for the findings of this study. The mental health scores using standardised instruments, GDS-15 and SF-36QOL psychological aspects were then reported and compared with other studies. Questions raised by these quantitative results were then reflected on by drawing on the interview data (attributed to participants by their pseudonym) associated with this dominant category using an interpretive approach. The link between depressed mood and negative thinking patterns was well-documented (see below) and so the principal contribution of this chapter was to better understand the phenomenon of depression specifically among older persons in Macau, through the thick description of the phenomenon as told by depressed persons.

Context of Negative Thinking: A Brief Review of Literature

Negative thinking was found to be a symptom of depression (Peden, Rayens, Hall, & Grant, 2004; Tam & Wong, 2007), however, it was also acknowledged as contributing to and reinforcing depression (Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000; Blazer, 2002b; Charoensuk, 2007). Older persons with depression regarded themselves, their future, and their experiences in an idiosyncratic manner (A. T. Beck et al., 1979). Previous researchers had found that older persons with depression suffered from a dysphoric mood that resulted in loss of interest in life and in loss of vital energy and feelings of hopelessness (Anderson, 2001; Ebersole & Hess, 2001; D. D. Li et al., 2003; Lueckenotte, 2000; Ning, 2001). Similar negative thinking patterns were also reflected in 367 Chinese older persons, clients in the day centres/recreational centres for the elderly in Macau (D. D. Li et al., 2003). Having close cultural and population
environments to Macau, a representative community sample of 1903 Chinese elderly people were discovered to suffer from the negative emotions in Hong Kong (K. Chou & I. Chi, 2005a). Similar symptoms were also found in 150 elders randomly selected in Taiwan (Y. Tsai et al., 2005), in 630 community-dwelling older persons in Mainland China (Feng et al., 2004), and even in the immigrant Chinese elderly in the United States of American (Mai-Nakagawa, 2005). Taken together, these studies reviewed had generated similar findings regarding depression among older persons. However, a limitation of most research based on closed response questionnaires was that reasons behind the responses were not known, and results did not tell us what was the focus or substance of negative thinking and what were the effects on the person. It was this gap in understanding and knowledge that this study was seeking to address.

Negative thinking was expected in the participants, all of whom had depression, since negative thinking was a recognised symptom of depression. However, the researcher was interested not only in measuring and establishing the presence of negative thinking; the study was also concerned with the substance (content, themes, focus) of such negative thinking. Negative thinking was elaborated on in this study using both the quantitative and qualitative data, which were now presented beginning with the mental health assessments.

**Mental Health Scores Using Standardised Instruments**

The older persons with depression in the present study described themselves, their future, and their experiences in a consistently and profoundly negative manner. The GDS-15, and the SF-36QOL (psychological aspects) were used to collect quantitative indicators for the mental states of the 31 older persons, firstly for the purposes of establishing eligibility to participate, and secondly to provide a ‘hard’ measure so that this sample could be compared with other older populations, and a measure against which to consider the stories the participants told. Reflecting the inclusion criteria, the researcher first screened the older person referred by managers of day centre/recreational centre for depression. The GDS-15 was used in the study to determine the presence of depression, an instrument that has been translated and validated in Chinese populations of older persons (A. C. M. Chan, 1996; H. F. K. Chiu et al., 1994; H. B. Lee et al., 1993). Twenty-one older persons were excluded from the study because in the case of them the GDS-15 score was less than eight (below eight
indicated not depressed), leaving the 31 eligible persons all of whom agreed to participate. The SF-36QOL psychological aspects, including role-emotional, social functioning, mental health, vitality, and general health subscales, were utilised to investigate the mental states of older persons in the study. SF-36QOL Chinese version had been developed, tested, and validated in America (Ren et al., 1998), Hong Kong (Lam et al., 1999), and mainland China (Lam et al., 1999; J. Li et al., 2001; Liu et al., 2001; Ren et al., 1998).

Table 5.1 summarises the GDS scores of the 31 participants. A criterion for inclusion in the study was presence of depression as measured by GDS-15 with cut-off point of eight, the higher score indicating the more severe the depression (H. B. Lee et al., 1993). Consequently, all the participants had GDS-15 scores of eight or more with a mean of 11.5, indicating that all were seriously depressed (H. F. K. Chiu et al., 1994; H. B. Lee et al., 1993). The profile of the study population was compared to a proportionate stratified sample of 2039 older persons in a large-scale investigation in Macau 2004 (Macau Social Welfare Bureau, 2006) using $t$-tests. The results revealed that all 31 participants were more seriously depressed than both the general population of older persons and also the population of older persons with depression in Macau, and that the differences were significant ($p<0.001$ for both sets of results). The scores of GDS-15 in the present study were expected given the eligibility criteria and sampling method.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
<th>Population of older persons with depression*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>GDS$^1$</td>
<td>11.5</td>
<td>2.1</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Notes: 1 GDS=Geriatric Depression Scale-15

* Adapted from: Macau Social Welfare Bureau, 2006

Table 5.2 presents the scores of SF-36QOL psychological aspects: role-emotional had a mean of 7.53, social functioning had a mean of 22.18, mental health had a mean of 25.16, vitality had a mean of 25.81 and general health had a mean of 26.97. Scores on the SF-36QOL scales were transformed to a 0–100 scale, with higher scores indicating
better health status (Ware et al., 1993). Using these variables, the profile of the study population was compared to the total population norm and the general population of older persons norm in Hong Kong (Lam et al., 1999), which had similar cultural and population environments to Macau, using t-tests. The results showed that the 31 participants suffered worse psychological health status than the total population and the general population of older persons in Hong Kong, and that there were significant differences among the three populations (p<0.001 for both sets of results). For the variable of role-emotional, the 31 older persons had a much lower mean of 7.53 which, when compared with the Hong Kong norm, indicated the participants might have extreme role limitation due to emotional problems.

Table 5.2 t-tests for SF-36QOL Psychological between Participants and HK Norms

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Participants</th>
<th>HK population norm*</th>
<th>HK older persons norm*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>RE¹</td>
<td>7.53</td>
<td>25.40</td>
<td>71.67</td>
</tr>
<tr>
<td>SF²</td>
<td>22.18</td>
<td>16.99</td>
<td>91.19</td>
</tr>
<tr>
<td>MH³</td>
<td>25.16</td>
<td>11.51</td>
<td>72.79</td>
</tr>
<tr>
<td>VT⁴</td>
<td>25.81</td>
<td>19.63</td>
<td>60.27</td>
</tr>
<tr>
<td>GH⁵</td>
<td>26.97</td>
<td>15.98</td>
<td>55.98</td>
</tr>
</tbody>
</table>

Notes: 1 RE=role-emotional  2 SF=social functioning  3 MH=mental health  4 VT=vitality  5 GH=general health  * Adapted from: Lam, Lauder, Lam, & Gandek (1999)

The mental health scores of the participants in the present study, therefore, revealed that the 31 older persons in this sample were significantly more depressed than other comparable populations of Chinese people. These included 367 community-dwelling older persons (D. D. Li et al., 2003) and the general population of older persons (Macau Social Welfare Bureau, 2006) in Macau. A similar conclusion was drawn by comparing the current study data with that from 1903 representative community Chinese older persons (K. Chou & I. Chi, 2005a), 759 community-dwelling older persons (Woo, Ho, & Wong, 2005) in Hong Kong, 150 older Taiwanese (Y. Tsai et al., 2005) and 187
suburban community-dwelling older persons (C. Lu, Liu, & Yu, 1998) in Taiwan. The scores of the participants of the present study were also compared with two study samples in mainland China, 621 community-dwelling older persons (Feng et al., 2004) and a stratified sample of 1263 older persons (Woo et al., 2005), and again the 31 participants in the present sample and also community-dwelling, were more depressed than those study samples. The participants of the present study also had worse mental health scores than 1537 community-dwelling Chinese older persons in Canada (Lai, 2004), and 162 community-dwelling older Chinese migrants in Auckland (Abbott et al., 2003).

The presence of depression, was expected but the consistently poor mean depression scores, when compared with other older Chinese populations in Macau, Hong Kong, Taiwan, mainland China, Canada, and in Auckland, were a concern. The depression rates in Macau’s older persons were high, ranging from 10.4 percent to 53.1 percent in different studies (D. D. Li et al., 2003; Ning, 2001). It must be cautioned that the sample of 31 participants was a small sample and was recruited using a purposive sampling strategy, therefore the study population with its higher level of depression than normal was not statistically representative among the whole population of older persons in Macau (as shown in Table 5.1). However, these results raised the question: why did these older persons score so negatively using these scales? Therefore, in-depth interviews were conducted with the 31 participants; this process generated some insights and yielded sad and moving narratives that shed light on their negative thinking and poor mental states.

All 31 participants held personal negative views and consistently interpreted their ongoing experiences in a negative way. They also had negative views of the future. Consequently, negative thinking was a key factor to emerge from the lived experiences of the older persons with depression in Macau and was the emotion that was most frequently mentioned by the participants throughout those conversations. The dominant category “negative thinking” reflected four themes: feeling useless; hopelessness; sadness; and helplessness.
Chapter 5 Negative Thinking

Feeling Useless

The theme “feeling useless” captured how the participants perceived themselves. Most of the participants (24 of 31 participants) described themselves using words such as “useless”, “defective”, “inadequate”, or “deprived”. They tended to negatively estimate or criticise themselves and maintained a belief that they lacked the attributes necessary to achieve happiness and contentment. The participants consistently evaluated their situation unpleasantly and not in a more positive way.

An example of this was given by Madam Kuang, one old woman who was widowed and had been living alone for 50 years. She recalled her early life when she was living like a “superstar”, singing Cantonese Opera in front of audiences, dressed in beautiful clothes, making money by gambling and popular with the men. Latterly her fortunes turned: she had been confined to lying in bed constantly since she was paralysed by a stroke several years previously. Her family had little contact with her, and she was isolated from society due to her personal circumstances:

It is tragedy. I am like rubbish lying in bed. I am like a stack of rubbish lying in bed… I am a Three-Wait-Citizen (三等公民): Wait for eating, Wait for sleeping and Wait for dying… My mind is willing, but I am incapable to achieve them. I’m failing my wishes because my ability is limited. So am I a stack of rubbish?... I am so old and ugly. Now I am like an old monster… I am ashamed to fulfill any contributions to the society. What have I fulfilled? I dedicate nothing to Caritas. (Madam Kuang)

While in the first example, “Three-Wait-Citizen” (三等公民) sounded as “third class citizen” in Cantonese, her strong negative feeling of uselessness arose from loss of health and functioning, leading to immobility, dependence on others and inability to pay her way, and secondary to this related to a loss of positive familial relationships. Madam Lin, another old woman had been widowed for 18 years since her husband, whom she had taken care for a long time, died from tuberculosis. She lived apart from her daughter, with whom she had a good relationship, because the daughter was living in Hong Kong in poor circumstances. She therefore had to live with her son who, she
said, did not care about her and she was in constant conflict with her daughter-in-law whilst living there:

Alas, I am useless (無用) as I’m 80 years old… I feel useless to forget everything like an idiot... I feel nothing without any property left… I am useless till the day I die. I prefer to die quickly now… It’s no use for me to exist any longer here when my husband died already. (Madam Lin)

For Madam Lin, her sense of purpose had been related to her role in caring for her sick husband and to having property, and when these were lost she felt only uselessness. In the case of Madam Wang, not having had a child was the root of her feelings of uselessness. She had lost her father early in life and was forced to work hard for a living since childhood but still was poor. She felt shame for not having had her own child as to not have a child is the worst example of failure of filial piety in Chinese Confucianism culture (無後為大) (Hwang, 2001). Now, to make matters worse, she had fostered a son from her sister but now he did not care about her:

Alas, (I am) a lonely useless (無人無物) poor widow, I have no possessions… I have no possessions with me. No, a family and no, any possessions… I am really miserable to speak out what I have suffered. It’s miserable too that there is no one I could complain to about all of this… It is a big misery to be like that with no children around me. How good it is to have even half a child around me! I seem to be humble most of the time. (Madam Wang)

Feeling of uselessness (無人無物) was a strong negative feeling for Madam Wang, that resulted directly from her extreme impoverishment and not having had her own child and the associated sense of shame, all of which made her alone and lonely in final stage of her life.

Feelings of uselessness at the present time were a dominant theme in negative thing. For some, present uselessness was relative to former purpose in life: financial independence, having property, caring for loved ones and being important to and loved by significant others (lovers, husband), common themes reflected in these stories. Typical of many participants, evidencing in these texts, was the use of strong, powerful negative
language to express their sense of uselessness, e.g. *rubbish, useless, idiot, miserable,* and *humble.* In addition, being physically and financially burden on others compounded feelings of uselessness. Uselessness was also related to hardship, poverty, having no positive relationships, summed up in Madam Kuang rhetorical question: “What have I fulfilled?”

**Hopelessness**

The theme of hopelessness captured the participants’ negative feelings about their future. All except two participants anticipated that their current difficulties or suffering would continue indefinitely. They foresaw unremitting hardship, frustration, and deprivation. For several, present feelings of uselessness were strongly related to hopelessness about the future:

> How can I be satisfied with my status, just lying in bed? I don’t know when will be the end... Alas, I am quite pessimistic. The sooner I die, the less pain it will be. It makes no difference to me to live one day more or less. The pain would be less if I live one day less, on the contrary, the pain would be more if I live one day more... I am very pessimistic! I have gone through tragic situation already and future means nothing for me. (Madam Kuang)

While hopelessness for Madam Kuang was directly related to her actual physical helplessness, Madam Lin’s hopeless feeling reflected her sense of being trapped in an extremely unhappy living situation:

> I prefer to die quickly now. I would rather have died earlier before my husband than being bullied by my daughter-in-law... I wish I would die fast but I can’t. Would you commit suicide if you couldn’t die fast? ... It would be a relief if I would have died... I don’t want to live any longer... Nothing I can expect and I prefer to die soon... why I couldn’t have died earlier than husband... Alas, I just want to die to suffer less... I don’t want to see doctor as I want to die fast. (Madam Lin)
A further example was taken from Madam Nv, an old lady who had divorced her husband 50 years previously; a husband who had been heavily engaged in gambling meaning she had struggled throughout her life. She had to live separately from her only son because of his poor situation and limited space:

I am too old to expect anything for myself. I only wish to pass away peacefully… Alas, it’d be better for me to die while sleeping. It’d be better I would have heart attack suddenly… It’s best for me to pass away when I faint. I’ve told my son not to rescue me when I would faint… It’s tougher if life is longer. No one says it’s more energetic and easier if you live longer. (Madam Nv)

Hopelessness for these three women, all without a spouse or partner, was expressed as a desire to die soon. Continuing life, moreover, was linked to pain, suffering, and to life being tougher. Suicidal thinking was also suggested, both as an act and passively by not treating a life-threatening event. For those women, death was welcomed as the only relief from present suffering.

Sadness

The theme of sadness predominantly arose from their physical environment. Many participants (17 of 31 participants) viewed their world as presenting insurmountable obstacles to reaching their life goals. They conveyed their interactions as representing a defect or deprivation and construed situations negatively, even when other positive interpretations were available. For example, Madam Kuang had described her life as a popular singer, yet in this excerpt dismissed her entire life as “bitter”:

It’s really painful with everything out of expectation. I am so unhappy… Alas, all in one word: pain. The pain includes all the sufferings. I endure too much pain inside. There is too much depression in my heart. It is such a tragedy… It’s a pain including everything… My whole life is great bitterness. I don’t want to mention it. (Madam Kuang)

Madam Kuang’s sadness arose from her inner pain over failed hopes and expectation, feeling of tragedy and bitterness. For Madam Huang, her sadness arose from severe
trauma decades earlier, memories and experiences of which still haunted her. This old lady experienced a hard life after her husband was shot in the Civil War between the Chinese Communist Party and the Nationalist Party 50 years previously. Her husband had been an official commander of the Nationalist Party military army, and when the initial stage of the Chinese Communist Party first came into power, her husband got caught by the Chinese Communist Party and ten soldiers shot him. Her only son was horrified by the dreadful scenario, became deranged and later died:

I am 90 years old and living alone in a miserable situation… I have been widowed for fifty years. How miserable I am… I’ve been going through all kinds of sufferings during past years but I am still a lonely old person nowadays. I just hope to quickly close eyes… What happiness do I have when I’m 90 years old?… In the past decades of years, most unhappiness is my husband got shot. What happiness I can find? I am never happy. (Madam Huang)

A further perspective on the relationship between early traumatic experiences, the effects on life from then on, and present feeling of sadness about life came from Uncle Liang, a 73-year-old gentleman who felt weak continuously, having suffered serious coronary heart disease for more than 10 years. His father had been killed in the Japanese army attack on Guangdong (a province in mainland China close to Macau) when he was eight years old, and since then, lacking parental support, he had worked so hard as to cause him to vomit blood. As a result of his poor health he could only ever take low-paying jobs. He never married and now lived alone in ill health and poverty:

There are never joyful things happened on me. There is nothing happy ever. Firstly, I am poverty-stricken. Secondly, I have no wife and kids. I have no hope in life when I think about my poor situation. I’ve been living always in dull and trivial details situation… The unhappy experience is my disease I have been suffering. I feel upset with my bad health. (Uncle Liang)

For Uncle Liang the traumatic loss of a father in war when he was a child led on to life-long ill-health and suffering, partly because of his need to labour hard to support himself, while at the same time carrying a heavy burden of grief. In turn, ill health and
poverty led to his not marrying and establishing a family. He described an impoverished, dull lonely life with no joy, only sadness.

As illustrated in these accounts, sadness was described in powerful terms including tragedy, suffering, unhappiness, no joy, dullness and pain of life, illness, poverty, all terms also used by other participants describing themselves as sadness. For some sadness had been a constant companion since a particular traumatic event, for others it arose from a more recent event that robbed them of purpose, role or relationship. Also reflected in these narratives was that the participants had absolutely no control over the event that lay as the root of sadness, nor of the subsequent impacts. They were helpless in the face of events greater than they were — being struck down by disease, ill health, caught up in war, losing a loved one in that war, with some believing their circumstances were their fate.

**Helplessness**

Helplessness referred to the non-material spiritual beliefs of the participants. Macau is a city characterised by a rich traditional Chinese culture, and many residents are followers of Buddhism, Confucianism or Taoism (K. Chou & I. Chi, 2005a). According to these beliefs, one person should have three lives: past life, current life, and future life. A full circle of three lives was reflected in other major religions of Asia (such as Hinduism), and was popularly known in the West as “Karma”. Some of the participants (10 of 31 participants) talked a lot about fate or destiny, by which they believed the sufferings and hard events, which they could not control in the current life, were caused by having done something wrong in a past life.

An example of this was given by Madam He, an 80-year-old woman who became homeless after her husband died. She was neglected by her children, and her daughter and grandchildren never responded when she tried to talk to them. Her grandchildren even hated having her live with them because they said the grandmother occupied their place in the small apartment, where there were only two small rooms for three adults and three children. The space was so narrow that it only allowed for putting a small shabby bed for her in the living room, which was also used as a study table for her grandchildren:
My uncle used to say I was not lucky. I wanted to go to see astrologist (on judgement of destiny). I said I wanted to know why my life was so poor, why I was treated by my children in this way. The astrologist finally said my eyebrow nearly didn’t appear which means I could find very few support from others. I could only help others but I couldn’t seek others’ favours most of the time. (Madam He)

The belief that one could not change, or control, fate was also reflected by Madam Zhou, an old lady who had been widowed for 40 years and had struggled to raise her three young children. She had been living alone for 20 years since she migrated illegally to Macau and became separated from her children in mainland China:

It’s difficult going through all my life. But this is one’s destiny beyond my control… I have a fate of poor life. It is really difficult and all is my fault to implicate my children. My bad life has implicated directly on my children’s bad lives… My fate is poor so that my children suffer from my bad life. (Madam Zhou)

While both these women explained their hardship in terms of fate and destiny, thus absolving themselves of responsibility, Madam Zhou also laid blame on herself for her children’s hardship. This apparent contradiction was also reflected in the narrative of Uncle Cheng, an old gentleman who suffered from emphysema and could not do anything because of shortness of breath. He was fostered by his uncle after his parents died when he was young. His son then suffered from poliomyelitis, bone fracture, and divorce. He was living alone because his wife needed to stay with their daughter to care for a grandson a few months old:

All my past memory is fate of hardship… Life is decided by god. My son wouldn’t have suffered the infantile paralysis if we had certain medical knowledge at that time. He would not have been like that if I had pushed my wife to feed all the necessary pills to my son. I can not blame anyone. This is destiny. (Uncle Cheng)

In these accounts, belief in ‘fate’ or ‘destiny’ was a double-edged sword: feelings that one lacked or had lost of personal control over events and one’s life (evident in previous
themes of uselessness, hopelessness and sadness) were heightened by fate. But at the same time participants blamed themselves for certain actions they did or did not take.

**Discussion of Negative Thinking and Depression**

The use of both quantitative and qualitative approaches to generate data revealed that strong negative thinking was prevalent among the participants in the present study. Negative thinking referred to feeling useless, hopelessness, sadness, and helplessness. All the participants regarded themselves, their future, their physical environment, and their nonmaterial spiritual belief in a negative manner. According to Beck (1979), older persons with depression tended to view themselves negatively as *defective*, or *inadequate*. They also underestimated or were critical of themselves. The older persons in the present study anticipated that their current difficulties or suffering would continue indefinitely, foreseeing unremitting hardship, frustration, and deprivation. The study also found that the older persons tended to interpret their ongoing experiences in a negative way, viewing their world as one that made exorbitant demands on them and this presented insuperable obstacles to reaching their life goals.

It was clear that most participants in the present study held the beliefs that they were useless, inadequate, and incompetent. They attributed their unpleasant experiences to psychological or physical defects in themselves, or to a fate they were powerless to change. When the participants had negative views towards the future, they anticipated that current difficulties would continue indefinitely and expected to fail in their endeavours. Participants expressed pessimism about the future and displayed a sense of hopelessness about themselves.

As several researchers (Chen & Jiang, 2000; Ebersole & Hess, 2001; Lueckennotte, 2000) had pointed out, depression was considered to be the most common of mental health disorder in older persons. But depression was also believed to be grossly underreported in the older persons (Anthony & Aboraya, 1992). Some researchers had concluded that depression was a cultural phenomenon based on an emotional state. The importance of individual schemas about depression played a major role in how depression was assessed by professionals, older persons, or others, and, according to Medeiros (2006), older persons had internalised concepts of depression. According to Lai (2004), having more cultural barriers and a higher level of identification with Chinese cultural values
resulted in a higher probability of being depressive. Examining the nature of depression, Kleinman (1990; 1982; 1986; 1988) also strongly argued that depression was a socio-cultural construct. His research in mainland China also demonstrated that Chinese experienced depression somatically rather than cognitively, for example presenting not with dysphoric mood but with complaints such as chest pain or abdominal pain. Kleinman concluded that both the depressive experiences and the expression or manifestation of depression stemmed from the lived experiences in a socio-cultural environment.

Similar findings related to negative feelings were also found in a number of other studies conducted in Chinese society (Fung, Lui, & Chau, 2006; Tam & Wong, 2007) and in Western society (Fung et al., 2006; Ingram, Slater, Atkinson, & Scott, 1990; Kendall, Howard, & Hays, 1989; Nystrom & Nystrom, 2007; Tam & Wong, 2007). The rates of depression found in this study were supported by the studies of community-dwelling Chinese older persons in Hong Kong (K. L. Chou & Chi, 2001a; K. L. Chou & I. Chi, 2005), institutionalised Chinese elderly in Taiwan (Y. Tsai et al., 2005), Chinese older persons living in the community in mainland China (T. Y. Lu et al., 2001), and immigrant Chinese elderly in United States of American (Mai-Nakagawa, 2005). All the above studies adopted a quantitative approach using the Geriatric Depression Scale (GDS) or the Center of Epidemiological Studies of Depression (CES-D) scales to investigate the phenomenon. The scores of the scales to indicate depression reported in the above studies facilitated comparison and statistical aggregation of the data, but did not capture the depth of understanding of the participants and situations studied (Patton, 2002). By adopting mixed methods in the present study, augmenting quantitative data with qualitative accounts, it had been possible to gain, for the first time, a deeper understanding of the nature and meaning of the negative feelings experiences by older persons with depression in Macau. The present study had thus advanced previous research by illuminating the negative feelings associated with their lives, thereby contributing to our understanding of the phenomenon of depression among Chinese older persons. Also the mixed methods allowed a wider and more complete picture and produced a fully grounded interpretative research approach (Denzin, 1989), and the approach increased the ability to interpret findings (Thrumond, 2001).

Negative thinking, such as feeling uselessness, hopelessness, sadness or helplessness, were symptoms of depression, which resulted in the withdrawal of life interest and loss
of vital energy (Peden et al., 2004; Tam & Wong, 2007). On the contrary, some studies argued that negative thinking caused and predicted depression (Barry et al., 2000; Blazer, 2002b; Charoensuk, 2007; Peden, Hall, Rayens, & Beebe, 2000). In the present study, negative thinking and depression seemed mixed and interacted together to influence how the participants interpreted their lives in relation to their depressed mood.

The older persons expressed helplessness in the context of their reference to nonmaterial spiritual belief. They regarded their difficulties in current life as punishments caused by former evil behaviours or wrong conducts in their past life. They referred to ‘fate’ or ‘destiny’. This finding was consistent with the research of Chinese-Australian patients with mental illness (Hsiao, Klimidis, Minas, & Tan, 2006), and with a study of elderly Chinese immigrants living in the community in Canada (Lai, 2004). Kleinman (1988) illustrated that culture shaped experiences of suffering because ways to think about their stress, how to respond with the appropriate emotions and how to act as expected were all learned in the local cultural and social context. Many Macau residents believed in Buddhism, Confucianism or Taoism (Pina-Cabral, 2004). This study illustrated that cultural rules governed the older persons’ interpretations of why they had been suffering and going through in current life due to fate or destiny.

However, contrary to Kleinman’s findings of somatisation as a preferred way to present their psychological distress by Chinese persons with depression, all the 31 participants in the present study appeared to interpret their ongoing experiences using powerful emotional terms including uselessness, tragedy, misery, pain, suffering, and unhappiness. A possible reason for these differences was that Chinese patients consulted Kleinman, a doctor, with physical symptoms but no physical abnormalities were detected, leading to a somatisation of depression explanation. In the present study, in contrast, participants were recruited because depression was detected using GDS-15. A second possible explanation was that the Chinese older persons in Macau, which had been exchanging between Chinese culture and western culture for more than four hundred years, experienced depression more cognitively. Therefore, the findings of the present study advanced the current understanding and body of knowledge regarding how depression was experienced and expressed among Chinese, especially Chinese older persons.
Chapter 5 Negative Thinking

Summary

Both quantitative and qualitative findings related to negative thinking were elaborated on and discussed in this chapter. Negative thinking was reflected in feelings of uselessness, hopelessness, sadness, and helplessness. However, there was no evidence of participants describing their negative thoughts in isolation; all of them went on to explain why their thoughts were so negative. Indeed, the various situations and life events they themselves related to their negative thinking inferred that depression was an understandable outcome of their lives and circumstances. The findings thus began to provide reasons for these people interpreting their lives in such profoundly negative ways. Further exploration of the lived experiences of these older persons, in particular their physical limitations and complaints, their present living conditions and social support, and the lives they have lived, were discussed in depth in the next several chapters, and illuminated further why such strongly negative thinking patterns were dominating the everyday experiences of these older persons.
Chapter 6

Physical Limitations and Complaints

Older persons suffering from poor physical health might become increasingly dependent on others, and the consequences of increasing dependence were feeling of uselessness and hopelessness, emotions poignantly demonstrated in the previous chapter. Building on the first dominant category “negative thinking”, this chapter added to our understanding of the influences on depression among the older persons in Macau by reporting in detail on the second dominant category “physical limitations and complaints”. Physical limitations and complaints were mentioned frequently by the participants during the interviews. As with the previous chapter, a brief outline of literature related to physical limitations and complaints was provided as a context. Results of quantitative tests utilised were then reported and compared with other studies employing various instruments. These included the BI, Lawton IADL, and SF-36QOL physical aspects involving physical functioning, role-physical, bodily pain, general health, and vitality, as well as self-reported disorders. Various questions emerged from these quantitative data that were addressed through the qualitative phase of the study, giving rise to the themes related to the dominant category of physical limitations and complaints from the narratives. While there was a large literature related to impacts of physical decline associated with ageing, this chapter contributed to and advanced our understanding by showing how physical limitations and complaints contributed to the negative thinking patterns of the 31 participants, and thereby to their depressed mood.

Physical Limitations and Complaints and Depression: A Brief Review of Literature

Previous studies had suggested that the increased physical dependency that older persons suffered might be related to their low self-esteem and hopelessness (Copeland et al., 1999; D. D. Li et al., 2003). These relationships had also been reported in other populations of Chinese older persons. Similar relationships between physical limitations and complaints and negative thoughts were reported in 367 community-dwelling Chinese older persons in Macau (D. D. Li et al., 2003). Functional disability related to
depression was discovered in 1903 community-dwelling Chinese older persons in Hong Kong, similar in cultural and population circumstances to Macau (K. Chou & I. Chi, 2005a). The associations between depression and functional disability were also reported in the Chinese urban and rural older persons in Taiwan (H. Chiu, Chen, Huang, & Mau, 2005), and in Chinese older persons in mainland China (S. W. C. Chan, Jia et al., 2006). Furthermore, the associations of depression and poor perceived health were presented in 407 Chinese immigrant elderly (Mui & Kang, 2006; Wu, Tran, & Amjad, 2004) and the effects of chronic illnesses on depression were found in 177 Chinese immigrant elders in United States of America (Wu et al., 2004). While the relationship between depression and declining physical vitality was widely accepted, in the case of Chinese older persons, the prominence of the themes related to physical complaints might be a reflection of somatisation of depression, the substitution of dysphoric affect with somatic preoccupation in the form of complaints of physical symptoms, in the Chinese culture (Kleinman, 1982).

Taken together, these studies had generated similar findings regarding the relationship between poor physical health and depression among older persons. However, most research was based on closed response questionnaires, not explanatory approaches, and did not elucidate on the focus or substance of physical limitations and complaints, nor the effects on their depression. Furthermore, most studies reported only one or two factors related to depression, e.g. disability or dependency, not on all possible factors.

It was this gap in understanding and knowledge that the present study was seeking to address. The researcher was interested not only in measuring physical limitations and complaints; the study was also concerned with the substance (content, themes, focus) of such physical limitations and complaints. The physical conditions and mental states of the older persons with depression interacted to become intertwined in the lived experiences of the older persons with depression in the present study and were identified by both the quantitative and qualitative data. These data were now reported beginning with the quantitative results.
Quantitative Tests Related to Physical Limitations and Complaints

To quantitatively measure the physical conditions of the 31 participants, a series of validated instruments and self-reported disorders were used. These instruments were also useful to provide an ‘objective’ set of data so as to compare with similar populations. The BI (see Chapter 3 page 66 for detailed description) and Lawton IADL (see Chapter 3 page 67 for detailed description) were utilised in this study to evaluate the capability of activities of daily living of older persons. The SF-36QOL (see Chapter 3 pages 68-69 for detailed description) physical aspects including physical functioning, role-physical, bodily pain, general health, and vitality subscales measured the physical conditions of the older persons.

Almost half of the participants (45.2%, n=14) had BI scores less than 100, which indicated that they suffered from certain different degrees of physical impairment in undertaking activities of daily living (see Table 6.1). Only 38.7 percent (n=12) were found to have independent instrumental functioning, based on the Lawton Instrument of Activities of Daily Living. In contrast, 61.3 percent (n=19) of the participants were unable to undertake instrumental activities of daily living with varying degrees of difficulty and also required assistance from others (Lawton & Brody, 1969; Spector, 1990). Of these, a minority (6.5%, n=2) generated BI scores of less than 56, indicating a total to severe dependence for activities of daily living (Wang, 2000). The goodness-of-fit test was utilised to investigate the differences in the results arising from the BI, whilst z-test was used to compare the differences of the IADL between the participants and a proportionate stratified sample of 2039 older persons in a large-scale investigation in Macau 2004 (Macau Social Welfare Bureau, 2006). The results showed that there were significant differences in both scores; the BI ($\chi^2=40.32, p<0.001$) and IADL ($z=12.97, p<0.001$). The findings indicated that the participants of the present study suffered from greater physical impairment than the general population of older persons in Macau. It was noted that although participants were selected based on their depression scores, no such selection criteria were applied to physical health scores.
Table 6.1 Physical Comparisons for BI & IADL between Participants & Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>BI(^1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0~</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>56~</td>
<td>12</td>
<td>38.7</td>
</tr>
<tr>
<td>100</td>
<td>17</td>
<td>54.8</td>
</tr>
<tr>
<td>IADL(^2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>12</td>
<td>38.7</td>
</tr>
</tbody>
</table>

\(x^2 = 40.32\) \(z = 12.97\) \(<0.001\)

Notes:
1 BI=Reduced Item Barthel Index
2 IADL=Lawton Instrument of Activities of Daily Living Questionnaire

The scores generated by the SF-36QOL physical aspects are presented in Table 6.2: physical functioning had a mean of 40.16, role-physical showed a mean of 12.10, bodily pain had a mean of 40.58, vitality showed a mean of 25.81 and general health had a mean of 26.97. Scores on the SF-36QOL scales were transformed to a 0–100 scale, with higher scores indicating better health status (Ware et al., 1993). The profile of the participants was compared with the results from the total population norm and the general population of older persons norm in Hong Kong (Lam et al., 1999) using \(t\)-tests. The results showed that the 31 participants suffered worse physical health status than the total population and the general population of older persons in Hong Kong, and there were significant differences found in all of SF-36QOL physical aspect components when analysed separately as unpaired samples \((p<0.001\) for both sets of results). This was especially so regarding the role-physical measure, where the current sample had only a very low mean of 12.10 when compared with the Hong Kong norm, which indicated they had extreme role limitations due to physical health problems. The results indicated that the 31 participants had worse physical conditions than both the total population and the general population of older persons in Hong Kong (a comparable population to that of Macau).
Table 6.2 t-tests for SF-36QOL Physical between Participants and HK Norms

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Participants</th>
<th>HK population norm*</th>
<th>HK older persons norm*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>PF 1</td>
<td>40.16</td>
<td>25.28</td>
<td>91.83</td>
</tr>
<tr>
<td>RP 2</td>
<td>12.10</td>
<td>30.87</td>
<td>82.43</td>
</tr>
<tr>
<td>BP 3</td>
<td>40.58</td>
<td>29.51</td>
<td>83.98</td>
</tr>
<tr>
<td>VT 4</td>
<td>25.81</td>
<td>19.63</td>
<td>60.27</td>
</tr>
<tr>
<td>GH 5</td>
<td>26.97</td>
<td>15.98</td>
<td>55.98</td>
</tr>
</tbody>
</table>

Notes:
1 PF=physical functioning
2 RP=role-physical
3 BP=bodily pain
4 VT=vitality
5 GH=general health
* Adapted from: Lam, Lauder, Lam, & Gandek (1999)

One of the objectives of the quantitative tests was to identify the strength of the relationships between mental health scores and physical functioning for this population. Table 6.3 summarises the association (using Pearson’s $r$) between GDS-15 scores and BI scores, IADL scores, and SF-36QOL physical aspects scores in the 31 participants compared with a proportionate stratified sample of 2039 older persons in a large-scale investigation in Macau 2004 (Macau Social Welfare Bureau, 2006). The results showed that high GDS-15 scores (indicating depression) were correlated with low BI, IADL, SF-36QOL physical aspects scores (indicating poor physical function) and there were significant negative relationships between GDS-15 and BI in the 31 participants ($r=-0.422$, $p=0.018$) and in the general population of older persons in Macau ($r=-0.134$, $p<0.01$); and IADL ($r=-0.462$, $p=0.009$), physical functioning ($r=-0.365$, $p=0.044$), and vitality ($r=-0.390$, $p=0.030$) in the participants.
Table 6.3 Pearson’s $r$ between GDS and BI, IADL, and SF-36QOL Physical

<table>
<thead>
<tr>
<th>Variable</th>
<th>GDS in participants</th>
<th>GDS in population of older persons*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$r$</td>
<td>$p$</td>
</tr>
<tr>
<td>BI$^1$</td>
<td>-0.422</td>
<td>0.018</td>
</tr>
<tr>
<td>IADL$^2$</td>
<td>-0.462</td>
<td>0.009</td>
</tr>
<tr>
<td>PF$^3$</td>
<td>-0.365</td>
<td>0.044</td>
</tr>
<tr>
<td>VT$^4$</td>
<td>-0.390</td>
<td>0.030</td>
</tr>
</tbody>
</table>

Notes:
1 BI=Reduced Item Barthel Index
2 IADL=Lawton Instrument of Activities of Daily Living Questionnaire
3 PF=physical functioning
4 VT=vitality
* Adapted from: Macau Social Welfare Bureau, 2006

The participants in the study self-reported on a variety of physical disorders (see Table 6.4), with a large proportion of all the participants (90.3%, $n=28$) reporting that they suffered from three or more physical disorders. Goodness-of-fit tests were utilised to investigate the distribution differences of physical disorders between the current sample and a comparable population of 2039 older persons proportionately stratified in Macau 2004 (Macau Social Welfare Bureau, 2006). The results showed that there were significant differences in physical disorders scores between the participants and the general population of older persons in Macau 2004 ($\chi^2=106.35, p<0.001$). The findings indicated that the 31 older persons suffered more serious physical impairments and were worse off than the general population of older persons in Macau. High levels of impairment had been associated with low self-esteem and hopelessness in 367 community-dwelling Chinese older persons in Macau (D. D. Li et al., 2003).
### Table 6.4 Physical Disorders Comparisons between Participants and Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
<th>$x^2$#</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Code</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td>31</td>
<td>100.0</td>
<td>392</td>
<td>19.2</td>
</tr>
<tr>
<td>Sensory</td>
<td>29</td>
<td>93.5</td>
<td>797</td>
<td>39.1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>28</td>
<td>90.3</td>
<td>253</td>
<td>12.4</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>25</td>
<td>80.6</td>
<td>1448</td>
<td>71.0</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>10</td>
<td>32.3</td>
<td>789</td>
<td>38.7</td>
</tr>
<tr>
<td>Respiratory</td>
<td>8</td>
<td>25.8</td>
<td>219</td>
<td>10.7</td>
</tr>
<tr>
<td>Neurologic</td>
<td>7</td>
<td>22.6</td>
<td>103</td>
<td>5.1</td>
</tr>
<tr>
<td>Endocrine</td>
<td>6</td>
<td>19.4</td>
<td>392</td>
<td>19.2</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>6</td>
<td>19.4</td>
<td>155</td>
<td>7.6</td>
</tr>
<tr>
<td>Skin</td>
<td>3</td>
<td>9.7</td>
<td>21</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Co-morbidities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>315</td>
<td>15.5</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>3.2</td>
<td>475</td>
<td>23.3</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>6.5</td>
<td>486</td>
<td>23.8</td>
</tr>
<tr>
<td>3~</td>
<td>28</td>
<td>90.3</td>
<td>763</td>
<td>37.4</td>
</tr>
</tbody>
</table>

Notes: # Goodness-of-fit test

* Adapted from: Macau Social Welfare Bureau, 2006

The participants had poorer scores on all scales/measures than the general population of older persons in Macau. This highlighted that older persons with a high level of physical disorders had good cause to be more depressed. Similar associations had been found in various populations of older persons in Western countries, for example a large, nationally representative, and longitudinal sample of Americans, showing or evidencing a link between disability and depression (Schnittker, 2005). A survey conducted in USA revealed an association between increasing depressive symptoms and lower arm mobility in 187 older women (Caban et al., 2006), while another, also in the USA, found evidence of depression associated with tooth loss and chronic conditions related to pain in 701 community-dwelling older persons (Persson et al., 2003). A longitudinal
data of 723 older persons demonstrated that severity levels of disability were associated with depressive symptoms in Europe (van den Brink et al., 2006).

Similar relationships had been reported for Chinese older persons. The association between poor perceived health and depressive symptoms was found in a probability sample of 407 Chinese immigrant elders in USA (Mui & Kang, 2006). Relationships between depression and chronic illnesses were also indentified in 2611 community-dwelling Chinese older persons in Singapore (Niti, Ng, Kua, Ho, & Tan, 2007). Yet more evidence for this association, specifically between depressive symptoms and chronic medical conditions and functional disability, were presented in 1005 multi-stage sampling community-dwelling Chinese older persons in Taiwan (H. Chiu et al., 2005). Depression was also observed to be associated with under-nutrition in 3999 older persons living in community in Hong Kong (Woo et al., 2006). Furthermore, a higher level of depression was found to related to poorer health in the older persons in Shanghai China (S. W. C. Chan, Jia et al., 2006).

Poor physical health appeared to be a risk factor for depression, possibly due to the outcome of functional incapacitation. Similar findings were revealed among Chinese older persons in Singapore (Niti et al., 2007) and in Taiwan (H. Chiu et al., 2005). Among Japanese older persons who had arthritis, self-reported poor health and greater functional disability were associated with depression (Nakajima, Kamitsuji, & Saito, 2006). Among patients with heart failure, attitude towards functional impairment was found to be a strong contributing factor for depression (Turvey, Klein, & Pies, 2006). Other studies found that functional disability in toileting was embarrassing, deeply personal, and was often considered a shameful condition and consequently, was likely to cause psychological pressure and lead to depression in the long run for older persons (H. Chiu et al., 2005; Prince et al., 1997). Health conditions such as impaired visual acuity and incontinence had also been associated with a decrease in self-care abilities and a commensurate increase in dependence, thus having the potential to impact on a person’s self-esteem (S. W. C. Chan, Chiu et al., 2006). Apart from functional incapacitation, the extent of self-control of the illness was another possible explanatory factor of depression, found in those with similar diseases to those suffered by the present study such as arthritis; this had been associated with limited personal and medical control and a low sense of mastery (B. W. J. Penninx, Beekman, & Ormel, 1996). Moreover, a higher risk for depression was evident with chronic disease due, in
part, to greater barriers to accessing rehabilitation services, unavailability of health professionals or lack of facilities for providing necessary care or health education (H. Chiu et al., 2005). Furthermore, direct biological mechanisms by which chronic illnesses caused or contributed to depression had been suggested as strongly related to certain chronic diseases, such as, stroke, diabetes, heart failure, arthritis (D. L. Evans, Charney, & Lewis, 2005). Direct biological mechanisms associated with some chronic illnesses were also thought to directly cause pathophysiological aberrations in the brain, endocrine, immune function, or vascular aetiopathogenetic mechanism (Koenig, 2006; B. W. J. Penninx et al., 1996).

Using goodness-of-fit tests, z-test, Pearson’s r and independent t-tests, the quantitative indicators revealed the extent of the poor physical health and physical impairment within this study population but revealed little about the participants’ perceptions of their physical conditions, and the impact of their physical health on their lives in Macau. The data from the in-depth interviews addressed some of these issues through three emergent sub-categories; physical limitations, physical complaints and impact of medical conditions and the treatments. Each was made up of a number of themes, as reported next.

**Physical Limitations**

With advancing age, the physical problems of older persons increased unavoidably (L. Yin, 2000). The participants suffered from varying degrees of physical impairment and a range of physical disorders, all of which weakened their capability of being independent and mobile. These factors were closely connected with the lived experiences of the 31 older persons with depression. The influence of “physical limitations” was composed of two themes; limited mobility and dependence on others.

**Limited Mobility**

The theme “limited mobility” reflected the comments related to disabilities that frequently disturbed older persons. Most of the participants (27 of 31) identified their limited mobility as being a dominant problem and a barrier to achieving a better quality of life. They described their mobility as “can’t walk”, “can’t move”, “can’t do anything”,...
“weak”, or “having no strength”. They had difficulties walking or moving smoothly, resulting in restrictions on their daily activities.

This was illustrated in the words of Madam Zhen, a single 79-year-old lady who suffered from many physical disorders, such as stroke, heart problem, stomach cancer, spur, and rheumatism and had undergone operations several times. She complained of low mobility related to having no strength, weak, and “can’t walk”:

I suffered severely rheumatism last year. My swollen fingers were stuck together before once I touched the cold water. Now my ten fingers are still a little paralysed. I don’t know why I lose my strength… It’s unsteadily like my brain loses the balance. Sometime I will be inclined to walk toward one side being like I am going to fall down… I can’t walk one step after another fast due to spur problem. I have to take a rest after one step and then to make another step. (Madam Zhen)

While Madam Zhen, complained of loss of strength and difficulty in walking, for Uncle Liang it was his chronic coronary heart disease that caused his limited mobility, described as “only sitting” and “no strength”:

I just do nothing but sitting there because of my heart problem. My physical health is worse and worse… I can’t move like others to exercise and move around because they need hard strength. I just can’t as my heart will not be well if I do. My heart will be as bad as it is being pinched by the fingers. Recently, since I am set up with pacemaker, my arms are strengthless. (Uncle Liang)

In the case of Uncle Yu, chronic obstructive pulmonary disease (COPD) caused shortness of breath, dizziness and dependence on oxygen all the time, leading to his being confined to bed and “can’t move”:

I suffer pulmonary emphysema. I always feel difficult to breathe… I do nothing but lie on the bed sleeping. I can’t do anything else. I am not able to manage any activities… I must stand still for minutes to ease the breath if I walk about 20 feet … I can’t move with strength or
I would not breathe. (Uncle Yu)

For Uncle Yu, the immediate consequence of his limited mobility was restricted daily activities and limitation in basic self-care:

Sometimes I will hardly breathe when I go to toilet. I will breathe oxygen once I go out of toilet… I am even out of breath when I take bath and clean up body… Sometimes I am out of breath when I am eating so I need to take oxygen at once. I can’t eat well in this way… Eating and excretion are both difficult for me… I will be dizzy if I have not gasped for breath for a while after shit. (Uncle Yu)

Similarly, Uncle Liang and Madam Zhen experienced restricted activities of daily living resulting from his/her limited mobility:

My heart will hurt when I wash clothes. I will stop washing if it’s really uncomfortable and I will continue if it’s better. It takes me over an hour to wash two or three clothes because I can’t be fast to adapt to my body’s slow situation. (Uncle Liang)

I even can’t wash clothes or wash face because my hands are so paralysed. (Madam Zhen)

These accounts reflected the light of biological ageing and disability, and their impacts on the person. While the medical condition(s) varied, the impacts on participants were similar, resulting in loss of strength, independence and mobility. For some, this led on to an unwelcome need to depend on others. Those participants who were living alone with nobody at hand to assist were in even worse circumstances.

**Dependence on Others**

The theme “dependence on others” reflected the finding that the older persons could not perform their activities of daily living independently and needed help from others that at times, for some, was unavailable. Some participants (8 of 31 participants) felt that they could not take care of themselves freely and depended on others for simple activities of daily living, such as “getting dressed”, “taking a bath”, “cleaning the floor”, or “cooking”.

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An extreme example came from Uncle Guan, a single 72-year-old gentleman who had suffered from a stroke, was paralysed and his joints had become fixed, and been bedridden for 40 years. He was filled with “guilt” arising from his total dependence on his two sisters who were also single, having never married due to the heavy burden, involved in taking care of their brother’s daily living requirements:

Every morning I have a sister who helps to take water for me to wash up… I rely on my sister who cooks two meals for me every day… My sister helps me to wash clothes… I rely on people from day centre for bath and wash up… The girls in the day centre help me to dress in clothes sometimes. (Uncle Guan)

His two sisters, the caregivers, did not disagree with their brother, commenting on the hard work and work overload in taking care of their brother during many years. Uncle Guan suffered feelings of guilt arising from his total dependence on his sisters. Similarly, Madam Li found it “demeaning” to have her husband to look after her daily care, whereas in Chinese culture it should be her responsibility to take care of her husband. Her husband, the caregiver, shared this view but said they had no alternative. Madam Li had suffered from a stroke 2 years previously and her vision was poor. Totally dependent on her husband to take care of her, she told of the assistance that her husband provided:

My husband helps me for daily living. He helps me get up and I brush myself but he helps with water. My husband cooks breakfast and washes dishes… He accompanies me to here (the day centre). I sit on wheelchair and my husband run the wheelchair… My husband cooks dinner for me. (Madam Li)

Also reliant upon others was Uncle Cheng, an old gentleman who suffered from emphysema, who could not do anything because of his shortness of breath and his constant dependence on oxygen:

I feel exhausted most of the time so I can’t cook. I will breathe rapidly if I stretch a little… The person in day centre sent meals to me every day (before)... I do not cook breakfast. I ask my daughter to buy for me most of the time… (Now) I rely on my daughter to prepare the
food (lunch) and leave some for dinner. (Uncle Cheng)

Consequent upon being dependent on others to take care of own activities of daily living, these participants expressed their negative feelings in powerful terms including “guilt”, “demeaning”. As a family member, he/she failed to fulfil his/her responsibility to take care of family, failed to maintain familial harmony and, on the contrary, implicated other family members and depended on them to take care of activities of daily living, which sometimes caused conflict among them, as described in Chapter 7. Reflected in their narratives was the lack of control that the participants had over themselves and their circumstances, and that lay at the root of their negative thinking.

**Physical Complaints**

The sub-category “physical complaints” uncovered further concerns and perceptions that the participants had about their physical limitations, all of which were the symptoms and interpretations related to their physical health circumstances. This comprised a range of themes: chronic joint pain, cannot sleep, poor appetite, and poor memory.

**Chronic Joint Pain**

“Chronic joint pain” referred to physical body pain which many participants (13 of 31) complained about, referring to “pain”, or “hurt”. Of the experiences that were spoken about in the interviews, Madam Wu, a 71-year-old lady explained how pain was a dominant factor in her life:

> I feel pain in my waist and leg. I started to feel pain long time back and it becomes more painful now. The bone is in sharp pain and my two knees are hurting so much that they seem hurting by a knife. I feel pain day and night. (Madam Wu)

While in the first example, chronic joint pain was described as being cut by a knife, others perceived it intolerable, affecting their sleep. Two were elderly women, who attributed their difficulties to having worked hard all their lives, causing poor physical health and constant pain:
I can’t sleep well because both my legs will hurt suddenly. The pain hurt from the knees. I have to apply medicine oil to lessen the pain otherwise I can not sleep… It will hurt constantly if I am not sleeping, even my elbows suffer. The most suffering moment is 3am to 4am in early morning… Like a few days earlier when the weather was bad, I was hurting severely into the bone. (Madam Liang)

I have spurs in my two legs for over ten years. I hurt from osteoporosis from time to time… The most suffering are my legs and the spine spur which are the cause of osteoporosis that I feel painful frequently… I suffer really hard by the spur on my legs that I can’t sleep. It is really hurting. (Madam Xie)

For Madam Wu, chronic joint pain adversely reduced her mobility and dominated her life:

I feel more pain when I walked. It’s really hurting me… I’m immobile because of my foot pain. So I walk very little. It’s more painful if I walk more. I give up walking when it hurt more and more after I walk around. (Madam Wu)

Illustrating the relationship between chronic pain and the theme of helplessness related to negative thinking (see Chapter 5), Madam Liang referred to “being unlucky”:

It has been many years, since three and four years back. I really think in a bad way because the pain I’m suffering will never end. I just always talk to myself, why I am so unlucky to be chosen to suffer this pain (Madam Liang)

These three women attributed chronic joint pain to hard labour from early in life; chronic joint pains impacted on their mobility and sleep, seemed unending and unendurable, adversely affecting their body and emotion. Suffering from the chronic and severe joint pain, some believed their circumstances resulted from their fate, and this was a theme to be explored in a subsequent chapter.
Cannot Sleep

Problems with sleeping, commonly referred to as insomnia, might be both a direct result of depression and a contribution to depression. As indicated in the excerpts, poor sleep was a frequent complaint. Most of the participants (21 of 31) complained of their poor sleep, referring to this phenomenon as “can’t sleep”, “tossing or turning to left and right in the bed.” This was captured in the story told by 71-year-old Uncle Yu who suffered from COPD and depended on oxygen:

I can only sleep for an hour, and then I wake up to gasp for breath for a while. Sometimes I wake up to watch TV again for a while and I sleep again. I can just sleep for three hours maximum… I just sleep for an hour and wake up for a while, and then I sleep another hour and wake up again. I can’t sleep long. Sometimes I can’t lie on one side for too long. (Uncle Yu)

In contrast with being prevented from sleeping by physical symptoms, it was mental anguish that kept Madam Xiao, a 74-year-old widowed woman awake. She told of her feelings of regret that she could not accompany her husband when he died alone in hospital because of the “unreasonable” hospital visiting policy. She would prefer to live with her daughter but couldn’t because of her daughter’s poor living environment. She lived with her son and daughter-in-law with whom she was in constant conflict. All of these factors she attributed to her difficulty in sleeping well at night:

I don’t sleep well. I can’t sleep for whole night. I am just turning to left and right repeatedly by lying in the bed. I just can’t sleep. It’s useless to take sleeping pill offered by the doctor. I can’t sleep… I’m stressed and I want to sleep so much but I can’t. I often become sleepless. When it is really bad, really bad time for me to suffer insomnia, I am not able to go out onto the street being afraid of fainting or becoming sleepy. (Madam Xiao)

In the case of Madam Liang, a combination of physical pain, and worry that she was unable to take care of her older son with paralysis in mainland China were the causes of her insomnia:
I can’t sleep well because my leg would hurt sometimes… I can’t sleep. I will wake up once it hurts. I can’t sleep until 5am in the morning… My older son has been sitting in wheelchair after stroke for seven years… He can’t take bath; neither can he get up to eat by himself. It is a difficult job to take care of him… The maid I hire to take care of my son disgusts that he is heavy and smelly so they leave one after another. (Madam Liang)

These participants indicated that they were deprived of even the blessed release of a period of unconsciousness when sleeping. Insomnia might be a key symptom of depression they suffered, meanwhile, it made the persons feel “faint”, ”exhausted”, or “confusing in mind” to cause them more depressed.

**Poor Appetite**

Poor appetite referred to both a loss of interest in food and an unwillingness to eat. Poor appetite had been identified as a somatic symptom of depression or a factor that contributed to depression (G. Parker, Cheah, & Roy, 2001). This phenomenon was identified by some participants (9 of 31) who mentioned it as “poor appetite”, “eat little”, or “reject food”. This was captured in the words of 73-year-old Uncle Wu:

> My appetite is not good especially in recent two months. I only eat that little, half bowl… I don’t know why but I seem reject food now. I had all kinds of food before but now I reject the food if I don’t like it… I just get tired of foods with no reason. No appetite. (Uncle Wu)

Uncle Wu went on to say that having only a few teeth left, and suffering from constant shortness of breath made eating difficult. He felt he was a “burden” to his wife, depending on her to take care of his activities of daily living, and he had no pleasure in his life. His poor physical status, negative thinking, and painful experiences of being adopted by an orphanage as a child when his parents died early and not having had a child of his own, all combined to make him lose his appetite.

While Uncle Wu attributed his loss of appetite to physical symptoms, negative thinking and haunted memories, Madam Wang and Madam Tai attributed their loss of appetite to illness, medications and the poor taste of food:
I have poor appetite because I am ill... The drugs’ side-effects even influence my appetite ... My appetite is not stable, sometimes it’s good so I cook, and sometimes it’s bad that I don’t eat any... The food here (the day centre) has very less salt and oil which make it hard to taste. (Madam Wang)

I suffer from diseases and I even feel worse appetite. Very poor, I can’t finish half a bowl of rice. My poor appetite, I can’t digest, how can I eat more. I give up eating if I lose appetite… I got the big operation so my appetite becomes like that… I eat very little. In a meal, I can’t finish rice and fish most of the time. I always have been eating less than others during years. (Madam Tai)

In Chinese culture, the saying “Eating is the first priority” (民以食為天) reflected that a person needed the food necessary to support his/her lives. Loss of appetite in the case of those three participants, resulted from their physical health, side-effects of treatment, past life experiences and negative thinking. Judging by the minute amounts of food they reported eating, their physical condition was so weak as to be close to death.

**Poor Memory**

“Poor memory” reflected the findings that the participants could not remember something or someone correctly whenever the affair took place, whether recently or long ago. Many participants (17 of 31 participants) complained that they “forget everything”, or that their “memory is worse” or “poor memory”. Madam Lin was an old woman, who had been widowed for 18 years (she could not remember exactly but the year was recalled by her son, the caregiver, with whom she lived) since her husband died of tuberculosis. Her account captured what it meant to lose one’s memory and the frustrations that were associated with it:

I don’t remember the conversation we had last week. My memory is so poor to forget everything… I don’t remember how many years ago my husband died? I really lose the memory on that! I feel useless to forget everything like an idiot! (Madam Lin)
In the case of two elderly ladies, poor memory was related to their physical illnesses, and they complained about the impact of their poor memory on their activities of daily living:

I have such a poor memory… My memory is not as good as before. It fails a little… I forget the telephone numbers… I remember some but forget some also. Things are not coming in my mind right now… Sometimes, I forget what I should do early in the morning. I forget them. That’s like I forget what I planned to cook. (Madam Nv)

My memory is worse much. Sometimes I forget where I put the stuff when I turn around. I can not find it even if I try hard to remember. (Madam Jing)

Madam Yan vividly remembered her younger years but could not remember recent and current events:

I feel my memory is worse now. I will forget what I have talked about a few minutes ago. My memory is poor. I still remember how it is when I was a young girl but I can’t recall what is going on recently. It becomes poor memory now. (Madam Yan)

Poor memory, whether related to recent or past events, might be a somatic symptom of depression or a consequence of declined physical function. These women suffered from serious medical conditions including heart problems and Parkinson’s disease, and these conditions combined with the treatment they took could have contributed to poor memory. Depression had been associated with impairment of memory and seemed to have some effect on memory. The loss of memory, an essential cognitive function, negatively affected activities of daily living of some of the participants, causing them to be even more depressed.

**Impacts of Medical Treatments and Access Problems**

The sub-category “impacts of medical treatments and access problems” referred to the negative consequences and experiences arising from the treatments for their diseases.
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This sub-category included the following themes: complex medication regimens and difficulties in getting to hospital.

**Complex Medication Regimens**

The theme “complex medication regimens” focused on the impact of taking medicines for their physical disorders, including physical side effects and negative perceptions. The participants used such language as: “volume—so many drugs”; “reliance—depend on them”; “side-effects”; “being scared to take so many drugs”; and “perspective as poison”. Most of the participants (21 of 31) commented that they had to take many different kinds of medicines, and had been doing so for long periods of time. They acknowledged the necessity to take these medicines because of their numerous physical problems. One of the major reasons for the provision of large supplies of medicines was the services or practices of medical agencies. The average waiting period for an appointment with a doctor in the Hospital Centre S. Januario was 38 days in Macau (Leong, 2004), and as a result the doctor would prescribe enough medicines for the patient to last them until his/her next visit. The quantity of medicines provided and the effects, including feeling muddleheaded and fearful, were described by Madam Yan, a 78-year-old widowed woman who suffered from many disorders, such as myocardial damage, chronic joint problem, and diabetes:

I am supposed to have many kinds of drugs for these problems and the drugs are such a big bag for me to take that it was like a bag of rice weights 10kgs… They (the doctors) offer so many drugs that I have to finish them within several months… I need to take six times a day. So many capsules I need to take a day, at least six capsules for six times… The big bag of diabetes drugs plus a big bag of spine drugs almost make me muddleheaded… You will be scared to see what a big bag of pills I need to take… Every time they offer me such a big bag of drugs. Every one is scared to see such big bag… My friends used to be scared when they saw so many drugs at my home. (Madam Yan)

While for Madam Yan, the impact of complex medications regimen arose from the huge amount medications prescribed by doctors, Uncle Cheng was concerned about the negative side effects after taking medications, such as “bleeding”, “uncomfortable
throat”. He perceived it as a poison, and was worried about being confused and making an error in taking the drugs. Uncle Cheng, too, suffered from many disorders, such as emphysema, prostate hypertrophy, and cataracts:

I just mean it’s frustrating for me to face so many drugs every day… So many drugs. The drugs are placed everywhere in the house… The drugs are poison. It is poisonous with no doubt. It is described on the drug packaging box… I don’t know if I take too many drugs that make my throat very uncomfortable. I dare not to take too many now. You see here it is bleeding… Sometimes I am confused with so many varieties of drugs. It even happens to me to eat the wrong drugs… It seems I just live for the drugs. (Uncle Cheng)

For Madam Wang, the impacts of the medication regimen arose from the huge quantity of medications and its side effects including weakness, dizziness, diarrhoea, poor appetite and reliance on medications. She even tried to escape cognitively from the impacts by calling the drugs her “long-life fruits” (萬壽果), like those employed by the kings eager to live forever in the world. The effects of the polypharmacy were summed up by Madam Wang:

I’ve been taking those multiple drugs for over 10 years. They’re for hypertension, stomach… There’re many kinds of drugs that I don’t remember clearly… Many kinds, multiple drugs. There are blood pressure and stomach pills. So many drugs in my stomach… I am not aware of effect of the pills for sleeping as they don’t indicate to me in the beginning. So I take the pills early which make me feel like drunk and dizzy… I can’t stop diarrhoea after taking drug for three times. I feel painful and dizzy and shit… The drugs’ side-effects even influence my appetite… I can’t go to sleep without the (sleeping) pills… The sleeping pills will make me obtuse if I get addicted to them… I call the drugs “long-life fruits” because I pretend not to have side effect of drugs. The more you take it, the weaker you are. (Madam Wang)
The side-effects of the medications, including the reduced effectiveness of medications over time, clearly distressed a 71-year-old widowed lady with renal failure who needed medications to minimise the side effects of renal replacement therapy; these included low blood pressure and vomiting. She complained of “not any more space for food” in her stomach after taking the huge amounts of medications:

I still feel painful after pills effect had gone. It doesn’t work much on me. It’s not good for me to take too many anodynes… The prescription is not helping cure the disease but only stop the pain temporarily… I take blood transfusion by 2 bags and I vomit… I take drugs for long term. Wa, as many as over 10 pills make me full every time. I don’t need to eat any food after taking pills. The pharmacists always say how I am going to have all the pills. I have to endure it no matter how hard it is. (Madam Wu)

Impacts of complex medications regimens in the accounts of those participants, were likely a double-edged sword: they did need the huge amounts of medication to treat and relieve their multiple physical problems and limitations, problems which were a root of negative thinking (reported in previous themes). But at the same time the uncomfortable physical side-effects after taking such big amounts of medications certainly contributed to their negative perceptions.

**Difficulties in Getting to Hospital**

Difficulties accessing healthcare services were reflected in the theme “difficulties in getting to hospital”. Difficulties reported included the social regulations associated with the treatments for the participants’ physical disorders, such as “queues/long intervals” or “cost”, and “difficult” physical access. The Macau government policy is that free medical services are offered to Macau’s older persons, and these include services at health centres and at the Hospital Centre S. Januário. However the hospital is located on the top of a hill where few buses pass by. The long waiting times to get an appointment with a doctor (Leong, 2004) meant that the older persons might instead visit Kiang Wu Hospital or private doctors, located in the downtown city and more accessible, but private services incurred high costs. Many participants (17 of 31) commented on the difficulties created by the long waiting times and high treatment costs; these thoughts
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were summarised by the words of Madam Xiao, a widowed woman who had had a stroke:

There are too many people, normally we have to queue up. I hardly received treatment in 2005 when I got stroke in 2004. I need to register at the hospital before queuing when it becomes my turn; I get the notice and go for treatment for a period. It can not sustain treatment which has many intervals… There are too many patients. Over two hundred people go to take blood pressure early in the morning… S. Januario Hospital requires long time to register before treatment while Kiang Wu Hospital provides non-free treatment that I can not afford. (Madam Xiao)

While for Madam Xiao, difficulty in getting to hospital arose from the long delay in accessing treatment for her stroke, leading to a poor quality of treatment, Madam Wu mentioned difficulties related to physical access to the hospital and high cost to buy things needed for treatment. Requiring frequent hospital treatment, Madam Wu spoke of the difficulties experiences when trying to access the services:

I go to S. Januario Hospital every week and it’s quite troublesome for me to walk that precipitous road. It's unlucky for me, and it’s so hot sometimes!... I walk with difficulty one step after another. Very difficult… Health centre is too far for me to walk there as I need to measure blood pressure 3 times a day... For gauzes, tissues, there're many things I need to buy for an operation including disinfectant and blood pressure measurement which cost me $400 every time. What is worse, I have to buy a new one if the old one was broken like the measurement and warm blanket and weighing-scale which cost me hundreds of dollar again. (Madam Wu)

Madam Tan was an 83-year-old widowed woman who was neglected by her children and living alone. Her medical conditions required frequent attention, and her account highlighted difficulties related to inflexibility of government health services:

Their rules (government hospital) are twice a year so you can go there only twice a year for treatments. It’s been a long interval so I prefer
seeing private doctor as I must see doctors more often. Since their
timetables are fixed so I can’t go there whenever I suffer the pain. But
my situation doesn’t allow me to go there according to the schedule…
If I do not feel well, I have to go to see doctor, not to mention to spend
money. The Kiang Wu Hospital cost me a lot to pay for medical
treatments. My money is not enough to support the food and medical
treatments. I go to see private doctors sometimes and I also go to
Gongbei (a place in the mainland close to Macau) to get injection for
$200… When I feel not well, I would take the medicine descriptions
in private doctors. I used to pay $95 including $40 for doctor’s
treatment every time. (Madam Tan)

As illustrated in these account, difficulties in getting to hospital, delays, long queues
and inflexibility, were obvious barriers blocking them in getting timely access to the
free medical services offered by the Macau government, for most the only way for them
to get the medical treatment. A few resorted to using private medical services, but this
came at a high cost, often involving a trade-off with food or other necessity of life. To
make matters worse, many were extremely impoverished and neglected by their
children, forced to face with their difficulties alone, even when accessing services was
beyond their capability. They had to wait and wait again, powerless to control the
situation, summed up in Madam Kuang’s words: “Wait for dying!”

Discussion of Physical Limitations and Complaints and
Depression

Mixed methods using both qualitative and quantitative findings revealed that the
participants suffered a range of physical limitations, impacting adversely on their
abilities to undertake activities of daily living and appearing to contribute to the
depression that all were found to have. They had more and worse physical conditions
compared with the general population of older persons in Macau. Most suffered
multiple chronic illnesses over long periods of time, many spoke of life-long treatment,
and as well as they suffered the side effects of treatments and medicines. The qualitative
findings were consistent with the quantitative indicators, revealing that the 31 older
persons with depression experienced serious physical disorders and adverse impacts of
medical conditions and the treatments, which, in turn, contributed to negative thinking.
Self-perceived poor health had been shown to be associated with depression in previous research, and the data from the current study added further to this body of knowledge. For example, previous studies had reported that poor physical health status was correlated with depression symptoms in urban older persons in mainland China (Sun, 2004), and had a significant impact on depressive experiences of Chinese older persons in Beijing China (Zhang et al., 1997). Perceived health conditions as a variable significantly predicted depressive symptoms in elderly nursing home residents in Taiwan (Y. Tsai et al., 2005), whilst poor self-rated health was significantly related to depression in the community Chinese older persons in Hong Kong (K. Chou & I. Chi, 2005b). Having poorer self-perceived health and more chronic illnesses increased the probability of having depressive symptoms within a community of Chinese immigrants in Canada (Lai, 2004) and among Chinese older persons in USA (Mui & Kang, 2006).

The older persons in the current study indicated an increasing reliance on others and subsequent dependence for support in undertaking activities associated with daily living, leading to their feelings of low self-esteem and hopelessness. What remained unclear was the causal factors for depression in this population, despite the evidence in other research that self-reported physical disability was associated with depressive symptoms (Bruce & Seeman, 1994; Gallo et al., 1997). Studies had found that depression caused neural, hormonal, and immunological alterations, and so might enhance susceptibility to disease and resulted in decreased physical health in general (Miller et al., 1993; Stein, Miller, & Trestman, 1991). Also, persistent somatic symptoms of depression, such as fatigue and sleeplessness, might affect the motivation necessary to maintain functional ability and worsen the health status over time (Femia, Zarit, & Johansson, 2001). Via psychological mechanisms, depression might impede recovery by discouraging persons from engaging in healthy physical exercising (B. W. J. Penninx et al., 1998). All of these studies suggested that depression and poor physical function were mutually reinforcing, causing a progressive downward spiral in the physical and psychological health of the older persons (Callahan, Kroenke, & Counsell, 2005; B. W. J. Penninx et al., 1998). Therefore in this population, the primary causal factor for depression might be the hardships experienced earlier in life, resulting in poor physical health and chronic illnesses.

Since the gambling industries were liberalised in 2001, Macau had achieved dramatic economic growth, which had largely improved citizens’ personal income and living
standards. However, ironically, such rapid economic development had weakened, rather than strengthened, the security of public healthcare and such a trend was quite likely to continue. Disparity in income was increasing resulting in excessively long waiting periods for the government hospital, while the increasingly expensive pay-for-service private health system raised barriers to basic healthcare for many older persons. The results in the present study highlighted declining access to universally provided public medical care and the widespread concerns related to this among Chinese older persons, with the older persons’ perceptions of the adequacy of medical care coverage having a substantial impact on their well-being.

Despite all the participants meeting the inclusion criteria of a MSQ score of six or more, which indicated no memory impairment, many participants (17 of 31 participants) still complained about their ‘poor memory’. This might be a somatic symptom of depression since the effects of depression on memory were complex. Depression had been associated with impairment of visuospatial recognition memory (Rabins, 1998), decreased free recall and normal-cued recall and recognition (Fava, 2003), as well as impairment in short term memory (Giblin, Clare, Livingston, & Howard, 2004). Other research, however, found no negative effects of depression on automatic memory performance (MacMahon & Lip, 2002). Differences in findings might be due to differences in research designs, selection of participants, depression measures, and memory tasks. Two meta-analyses had been conducted. Blazer (2002a) combined data from 147 studies published from 1967 to 2001 on adults of all ages. These investigators found that depression was associated in small to moderate degrees with specific aspects of memory. In addition, memory impairment was more likely to occur among inpatients than in outpatients. Kendig, Browning, and Young (2000) conducted a meta-analysis of depression and memory research based on 40 studies published between 1973 and 1997, with samples restricted to participants of age 55 years and older. Most of the studies showed moderate effect size, with larger effect sizes found in older groups. Depression did therefore seem to have some effect on memory but that the effect might vary, based on the participant’s age, the severity of depression, and the specific memory tasks participants were asked to perform.
Chapter 6 Physical Limitations and Complaints

Summary

Mixed methods, using both quantitative and qualitative approaches, identified the physical limitations and complaints that were experienced by this sample of older persons with depression in Macau. The dominant category of physical limitations and complaints was reflected in themes of limited mobility, dependence on others, chronic joint pain, cannot sleep, poor appetite, poor memory, complex medications regimens, and difficulties in getting to hospital. Their physical functioning were worse than that of the general population of older persons in Macau and the findings suggested that the physical limitations and complaints were associated with low self-esteem and hopelessness, and these conditions were compounded in the lives of the participants. Poor physical health appeared to be a risk factor for depression, possibly due to the outcome of functional incapacitation. Also, persistent somatic symptoms of depression, such as fatigue and sleeplessness, might affect the motivation necessary to maintain functional ability and worsen the health status over time. Depression among older persons and their poor physical function were mutually reinforcing, causing a progressive downward spiral in the physical and psychological health of the older persons. The combination of quantitative and qualitative methods allowed for an interpretation of the link between physical limitations and complaints in the lived experiences of older persons with depression more holistically than either approach in isolation could have achieved. However, physical limitations were not the only factors concerning participants; the recollections of the older persons also indicated that social issues had had a huge impact on how they lived their lives today, and these issues would be reported and discussed in the next chapter.
Building on the previous chapter, the third dominant category “present living conditions and social support” was reported and discussed in depth in this chapter. Present living conditions and social support emerged as a significant factor since all of the older persons raised concerns and referred to daily living difficulties during the interviews. Firstly, a concise summary of literature related to older persons’ living conditions and social support was provided as a context. Quantitative measures including the Lubben Social Network Scale (LSNS), the SF-36QOL social functioning aspect, and demographic data, such as marriage status, highest educational level attained, living circumstances, and income source, were then reported and compared with like populations. Questions raised from these quantitative results were then reflected on by drawing on the thick descriptions derived from qualitative data. This chapter contributed to the study by presenting further accounts specifically highlighting the present living conditions and social support of these older persons with a view to further illuminate the issues behind their negative thinking patterns and how these might contribute to depression.

Living Conditions and Social Support and Depression: A Review of Literature

Poor mental wellbeing among Chinese was frequently associated with stress in the family environment or intergenerational relationships (Kleinman, 1980). Social factors were also considered to have an impact on psychological and mental health problems (Bond, 1986; T. Y. Lin, Tseng, & Yeh, 1995). The relationship between depressive symptoms and poor family relationships was identified through a survey of 80 community-dwelling Chinese older persons in Hong Kong (S. W. C. Chan, Chiu et al., 2006). Another study, this time of 367 community-dwelling Chinese older persons in Macau also revealed that the older persons who were living alone and widowed reported more serious depressive states (D. D. Li et al., 2003). The strong association between hardship in social support and depression was demonstrated in a multi-stage sampling
community survey on 1005 community-dwelling Chinese older persons in Taiwan (H. Chiu et al., 2005). A study based on a probability sample of 407 Chinese elderly immigrants in USA showed a similar relationship between stress of hardship from daily life events and depressive symptoms (Mui & Kang, 2006). In summary, these studies generated very similar findings regarding the relationship between present living conditions and social support and depression among older persons. However, most of these research were based on closed response surveys, not explanatory designs, did not expand upon the focus or substance of present living conditions and social support, nor the effects on their depression. Furthermore, most studies reported only one or two relationships, e.g. depression and poverty or living alone, not on all possible factors.

It was this gap in understanding and knowledge that the present study was seeking to address. The researcher was interested not only in measuring present living conditions and social support, but also with the substance (content, themes, focus) of such present living conditions and social support. Again, through a combination of quantitative and qualitative approaches, the older persons with depression were found to be caught up in difficulties of hardship, poor family relations and limited social networks, which made them think and feel negatively. The results relating to this dominant category were now reported, beginning with the quantitative approaches.

**Quantitative Measures Related to Present Living Conditions and Social Support**

A series of validated instruments and demographic data, such as marriage status, highest educational level attained, living circumstances, and income source were utilised to generate information about present living conditions and social support of the participants. The LSNS (see Chapter 3 pages 67-68 for detailed description) was utilised in this study to assess their social network and social support of the participants. The SF-36QOL (see Chapter 3 pages 68-69 for detailed description) social functioning aspects was utilised to investigate social health conditions of the participants in the study. Demographic data of marriage status and living circumstances were used to measure the social support of the participants in the study while income source and highest educational level attained were utilised to assess living conditions of the participants in this study.
Table 7.1 highlights that 20 of the 31 participants were widowed (64.5%), 9.7 percent (n=3) were divorced, and 12.9 percent (n=4) had never married, which meant most of the 31 participants (87.1%, n=27) were living with no companion or partner in the final stage of their life. Most of the participants (71.0%, n=22) were illiterate, which meant they could neither read nor write, thereby limiting their ability to access information, which resulted in lost social opportunities (Hartsell, 2005). Goodness-of-fit tests were utilised to investigate the distribution differences of marriage status and highest educational level attained between the participants and the general population of older persons in Macau, created following the Macau Census 2006. The results reported in Table 7.1 also demonstrates that there were significant differences of marriage status ($\chi^2=32.95, p<0.001$), with 87.1 percent of participants single (never married, widowed or divorced), as well as differences in the highest educational level attained ($\chi^2=16.64, p=0.001$), mainly in the proportions who were illiterate and achieved primary schooling, between the 31 older persons with depression and the general population of older persons in Macau based on the Macau Census 2006.

### Table 7.1 Demographic Data Comparisons between Participants and Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
<th>$\chi^2$#</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Marriage status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>4</td>
<td>12.9</td>
<td>1140</td>
<td>3.2</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>12.9</td>
<td>20432</td>
<td>57.8</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>9.7</td>
<td>877</td>
<td>2.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>20</td>
<td>64.5</td>
<td>12906</td>
<td>36.5</td>
</tr>
<tr>
<td>Highest education level  attained</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>22</td>
<td>71.0</td>
<td>13305</td>
<td>37.6</td>
</tr>
<tr>
<td>Primary school</td>
<td>3</td>
<td>9.7</td>
<td>14109</td>
<td>39.9</td>
</tr>
<tr>
<td>Middle school</td>
<td>5</td>
<td>16.1</td>
<td>5845</td>
<td>16.5</td>
</tr>
<tr>
<td>University</td>
<td>1</td>
<td>3.2</td>
<td>2096</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Notes: # Goodness-of-fit test
* Adapted from: Macau Statistics and Census Bureau, 2007a

The results reported in Table 7.2 reveals that over half of the participants (54.8%, n=17) were living alone, whilst only 2 participants were living with their spouse (6.5%) and
38.7 percent of the participants (n=12) were living with their family members, which included their adult children, grandchildren, siblings, or parents of the participants. Almost half of the participants (48.4%, n=15) depended on the state provided old age subsidy, however nearly a quarter of the participants (22.6%, n=7) reported that they had no income resource at all.

Goodness-of-fit tests were utilised to investigate the distribution differences of living circumstances and income resource between the 31 older persons with depression and a comparable population (a stratified sample of 2039 older persons in a large-scale investigation in Macau 2004; Macau Social Welfare Bureau, 2006). The results (see Table 7.2) showed that there were significant differences of living circumstances ($x^2=46.74$, $p<0.001$) and income resource ($x^2=11.82$, $p=0.001$) between the 31 participants and the general population of older persons in Macau 2004. The findings indicated that the participants suffered from worse living conditions and social support than the general population of older persons in Macau.

Table 7.2 Support Comparisons between Participants and Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
<th>$x^2$#</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Living circumstance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>17</td>
<td>54.8</td>
<td>266</td>
<td>13.4</td>
</tr>
<tr>
<td>With spouse</td>
<td>2</td>
<td>6.5</td>
<td>506</td>
<td>25.5</td>
</tr>
<tr>
<td>With family</td>
<td>12</td>
<td>38.7</td>
<td>1215</td>
<td>61.1</td>
</tr>
<tr>
<td>Income source</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>7</td>
<td>22.6</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Pension</td>
<td>9</td>
<td>29.0</td>
<td>463</td>
<td>77.4</td>
</tr>
<tr>
<td>Subsidy</td>
<td>15</td>
<td>48.4</td>
<td>135</td>
<td>22.6</td>
</tr>
</tbody>
</table>

Notes: # Goodness-of-fit test  
* Adapted from: Macau Social Welfare Bureau, 2006

The old age subsidy of MOP 1650 per month was a direct financial aid offered to a Macau senior resident who was proved to have no means of self support or lacking any means of livelihood. The old age pension of MOP 1150 per month was to provide financial assistance supported the basic life needs of a Macau senior resident after he/she retired, provided he or she had been staying continuously in Macau for at least
seven years and had contributed at least 60 months of instalment into the Macau Social Security Fund. A Macau senior resident had access to only one of these supports, and only if eligible. The findings indicated that most of the participants (71.0%, n=22) in the present study lacked an adequate means of livelihood.

Especially for the seven participants who had no income resource at all, these findings raised the question: why were they unable to get any financial support, either the old age pension or the old age subsidy, even though they were Macau residents over 65 and had no independent means of support? The reason was that all the seven of these participants did not meet the requirements for the old age pension, that was, they had not lived continuously in Macau for at least seven years and had contributed at least 60 months of instalment into the Macau Social Security Fund. All those seven participants were female and they used to spend most of their time at home to take care of their children, grandchildren, husbands, and family. Since they lacked an employment record in the past, this made it impossible for them to contribute instalments into the Macau Social Security Fund. Furthermore, the seven participants could not gain the old age subsidies from Government because they had families in Macau who were supposed to support them (see Chapter 1 page 16 Table 1.1 for detailed description), no matter how poor the family was and how bad the treatment the older person encountered in the family.

Turning now to the Lubben Social Network Scale, an LSNS score less than 20 indicated an extreme risk for limited social networks (Lubben, 1988). The mean score of participants was 6.7. Participants’ scores were compared with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006) using \( t \)-test, and that demonstrated that the 31 participants were significantly at much higher risk for limited social networks than the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006) \( (t=16.39, p<0.001) \) as shown in Table 7.3.

| Table 7.3 \( t \)-test for LSNS between Participants and Population |
|----------------------|-----------------|---------------------|--------|--------|
| Variable             | Participants    | Population of older persons* | \( t \) | \( p \) |
| LSNS\(^1\)          | Mean            | SD                  | Mean   | SD     | 16.39 | <0.001 |

Notes: 1 LSNS=Lubben Social Network Scale
* Adapted from: Macau Social Welfare Bureau, 2006
Table 7.4 demonstrates that all except one participant (30 of 31) had a LSNS score of less than 20. These data were compared with the general population of older persons in Macau 2004 (Macau Social Welfare Bureau, 2006) using z-test to show there was a significant difference between the 31 older persons and the comparable population (Macau Social Welfare Bureau, 2006) ($z=8.85$, $p<0.001$). The findings indicated that most participants were at extreme risk for limited social networks compared with the general population of older persons in Macau where only a quarter were at extreme risk.

Using the SF-36QOL social functioning aspect, a mean of 22.18 was found. Scores on the SF-36QOL scales were transformed to a 0–100 scale, with higher scores indicating better health status (Ware et al., 1993). When compared with both the total population norm and the norm of the general population of older persons in Hong Kong (Lam et al., 1999) using t-tests as shown in Table 7.5, there were significant differences found between the 31 older persons and the total population norm in Hong Kong ($t=22.62$, $p<0.001$), and with the Hong Kong general population of older persons norm ($t=22.91$, $p<0.001$). However, results between the general population of older persons in Macau and Hong Kong were very similar. The results revealed that these 31 older persons with depression had worse social functioning than the total population and the general population of older persons in Hong Kong (a comparable environment).

### Table 7.4 z-test for LSNS\(^1\) between Participants and Population

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participants</th>
<th>Population of older persons*</th>
<th>$z$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt;20(^9)</td>
<td>30</td>
<td>96.8</td>
<td>500</td>
<td>26.6</td>
</tr>
<tr>
<td>&gt;=20</td>
<td>1</td>
<td>3.2</td>
<td>1382</td>
<td>73.4</td>
</tr>
</tbody>
</table>

Notes: 1 LSNS=Lubben Social Network Scale  
9 <20 indicate an extreme risk for limited social networks  
* Adapted from: Macau Social Welfare Bureau, 2006

### Table 7.5 t-tests for SF-36QOL Social between Participants and HK Norms

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Participants Mean (SD)</th>
<th>HK population norm* Mean (SD)</th>
<th>t</th>
<th>$p$</th>
<th>HK older persons norm* Mean (SD)</th>
<th>t</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF(^1)</td>
<td>22.18 (16.99)</td>
<td>91.19 (16.49)</td>
<td>22.62</td>
<td>&lt;0.001</td>
<td>92.07 (17.31)</td>
<td>22.91</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Notes: 1 SF=social functioning  
* Adapted from: Lam, Lauder, Lam, & Gandek (1999)
One of the objectives of the quantitative tests was to identify the strength of the relationships between mental health scores and social functioning. Table 7.6 shows the Pearson’s $r$ between GDS-15 scores and LSNS scores, and SF-36QOL social functioning scores between the participants and a proportionate stratified sample of 2039 older persons in a large-scale investigation in Macau 2004 (Macau Social Welfare Bureau, 2006). The results indicated that high GDS-15 scores (indicating depression) were correlated with low LSNS, SF-36QOL social functioning scores (indicating poor social function), and that there was a significant negative relationship between GDS-15 and LSNS in the general population of older persons in Macau ($r=-0.396$, $p<0.01$), but no significance in the participants ($r=-0.078$, $p=0.677$), a small and purposive sample. However, a significant negative relationship between GDS-15 and SF-36QOL social functioning was still found in the participants ($r=-0.350$, $p=0.027$ one-tailed).

<table>
<thead>
<tr>
<th>Variable</th>
<th>GDS in participants</th>
<th>GDS in population of older persons*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$r$</td>
<td>$p$</td>
</tr>
<tr>
<td>LSNS$^1$</td>
<td>-0.078</td>
<td>0.677</td>
</tr>
<tr>
<td>SF$^2$</td>
<td>-0.350</td>
<td>0.027#</td>
</tr>
</tbody>
</table>

Notes: 1 LSNS=Lubben Social Network Scale  
2 SF=social functioning  
# 1-tailed  
* Adapted from: Macau Social Welfare Bureau, 2006

Using indicators of living circumstance, financial support, highest educational level attained, social networks and social functioning, the quantitative scores of the present study indicated that the 31 older persons with depression suffered from extremely poor living conditions and social support. The findings were consistent with a study involving 407 Chinese elderly immigrants in USA using probability sampling techniques (Mui & Kang, 2006). A study of 1005 multi-stage sampling of community-dwelling Chinese older persons in Taiwan demonstrated the relationship between hardship of being widowed and living alone and depression (H. Chiu et al., 2005). A Hong Kong study of 80 Chinese elderly showed the association between poor parent-children relationship and depression (S. W. C. Chan, Chiu et al., 2006). The association
between hardship of living alone and being widowed was identified in 367 community-dwelling Chinese older persons in Macau (D. D. Li et al., 2003).

While the sample size of the present study was small compared with other studies reviewed, the results were nevertheless consistent in indicating a relationship between depression and present living conditions and social support, however, those other studies did not report in detail on the nature of living conditions. The quantitative findings indicated that the 31 older persons with depression generally suffered from poverty, poor living conditions and seriously weak social support that might influence profoundly on their lived experiences. It must be questioned how the 31 participants could survive in such extremely poor living conditions and weak social support? How did the 31 participants feel about these issues? The in-depth interviews generated rich data from the narratives of their lived experiences explored these issues by three sub-categories. These sub-categories were hardship, poor family relationship, and limited social network, and each sub-category was comprised of a number of themes.

**Hardship**

Social factors were acknowledged to have an impact on psychological and mental health problems (Bond, 1986; T. Y. Lin et al., 1995). The 31 participants had to bear with the poor living conditions under which they struggled to survive, and in all cases influenced their lived experiences negatively. The sub-category “hardship” referred to themes of being poor, being illiterate, as well as injustice experienced.

**Being Poor**

The theme “being poor” reflected the impoverished conditions of the participants and how the older persons with depression fought for day to day living issues and struggled to survive. Most of the participants (25 of 31 participants) described themselves as being poor. They described their present poverty and its impacts in the following ways: as “depending on the old age subsidy/pension”, “cannot earn money”, “high cost” making essentials unaffordable, “not enough money”, “cannot afford”, “penniless”, and “homeless”.

The way in which poverty could dominate one’s thinking and life were captured in the accounts of Uncle Li, an 85-year-old widowed gentleman who was living alone and
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lacked the means to support his day to day life. Now he totally depended on an old age subsidy from the government, a direct financial aid of MOP 1650 (equivalent to USD 200) per month (see above explanation):

My present life is quite difficult. I live on the old age subsidy… Now I spend all the saving and depend on the subsidy only… Now I am concerned about whether I get two meals a day mostly. There’s nothing else I worry about other than the meals. I always rely on the subsidy. (Uncle Li)

Unfortunately, the old age subsidy that Uncle Li counted on was not enough to sustain his basic needs of life, food and place to live, due to increasing high inflation in Macau. Uncle Li stressed the worry he experienced because he felt insecure and vulnerable when his conditions worsened:

I worry that I can not support living in a place which costs over a thousand to rent. If I use the subsidy for renting, there will not be left any extra for two meals… I feel worried about the meals which are not stabilised yet… It will be less difficult if I get more subsidies which I think are not enough at the moment. (Uncle Li)

Another illustration of this came from Madam Zhou, an old lady, who had not been able to work for any income since a bone fracture ten years previously and who, like Uncle Li, depended on the old age subsidy. She also complained the old age subsidy was not enough to live on, because of the high costs of rent, water, and food:

The (house) rent costs me over MOP 600 plus water and electricity fee, there’s very little left… I can’t eat better, it’s out of my expectation. I have no property so I have to rent a place which costs me most of the expenses. I hardly can find extra to spend on better food. Now I almost spend MOP 900 for rent and water and electricity. I only have MOP 800 left every month for meals, so I can’t buy any good food… I don’t have much money to see Chinese medicine which need more cost. (Madam Zhou)
While in the case of Madam Zhou, the old age subsidy was not enough for medical treatment after trading off her basic needs of life, Madam Yan lost eligibility for the old age subsidy from the government, which had supported her food and medical treatment, after moving in to live with her daughter, even though her daughter was also poor:

I used to get the old age subsidy. They (Macau Social Welfare Bureau) stopped offering the subsidy for two years because they said my daughter could support me since she immigrated here... There are three meals a day normally but I dare not to have three meals. I have not enough money so I only take two meals a day... I suffer so many diseases that I have no choices but to go to the government hospital or health centre where provides free medical treatments. I will not go anywhere if it is not free charges as I really can’t afford to. (Madam Yan)

Madam He became homeless after her husband died and she was neglected by her children:

I am homeless and penniless... I tried to rent a place without success because the agent refused to find an apartment for old people and the rent fee was very high so I went to the Macau Social Welfare Bureau for help. They said it was too difficult to find a cheap place for an old woman who was 80 years old... It’s so cold being homeless. Sometimes I am afraid of raining. It’s so cold. I am so miserable... I always say the day centre is my home, hospital is my home and the Worker’ Union is my home... I am poorer than a beggar. (Madam He)

Even those who owned their own homes could be affected by poverty. This was illustrated by Madam Liang, a 77-year-old woman who was living alone in her ruined house, without any means to repair it:

My house is leaking water. Everywhere is broken. The concrete is bad to sustain the house well... There are two walls upstairs which are damaged by extreme humidity with leaking water... In winter it is cold at home and I pray it’d better not to rain or I would be frozen to die in the shabby house. The house is broken. How can I live in such a
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broken house? It’d better not to rain… People ask me to repair the house but it needs four thousand at least. Where can I get MOP 4000? (Madam Liang)

Madam Zhou had spent many years in her impoverished circumstances, which meant that her children also lived their lives in poverty. There was no opportunity of education for her children who were also illiterate and unable to better themselves; hence inter-generational illiteracy and poverty became a source of mental suffering for Madam Zhou:

My two sons and a daughter are in poverty too. They’re illiterate so there’s very little choice of good jobs for them. Not like others who can earn over ten thousands per month being equal to three months salaries that my children earn in one month. It’s not possible to compare with others. What a miserable reality! We can’t compare and expect. (Madam Zhou)

Uncle Wu felt himself a burden on his wife, because since here was relying on his old age pension, he could not afford his living expenses and medical treatment:

We rely on the government for only MOP 1150 of the old age pension. Certainly it’s not enough to support living expenses… My life is very hard. For example, the oxygen machine consumes plenty of electricity so I have to pay four to five hundred every month… The hospital cost is too expensive. We always go there (hospital) to spend so much on both western and Chinese treatments that how can we have enough to support basic life? My wife goes to pick up waste paper card every day for making little money… If you were me, you would feel yourself a big burden. (Uncle Wu)

Uncle Li also made a connection between his extreme poverty and mental anguish, seeing relief only in death:

I mean the old age subsidy which I count on it entirely. I would be dead if I lost it… I worry about both food and place for basic living which make me feel so hard that I wish I could pass away soon to
lessen the pain I am still suffering. I want to be set free from those suffering in life. (Uncle Li)

As reflected in the participants’ stories, the interaction between poverty and depression might be explained as follows. The old age subsidy or pension was inadequate to support the basics of life. Once money for rent, utilities and medical treatment was paid for there was often insufficient left for adequate nutrition. Participants worried constantly about how they would manage if prices got higher or if there were changes to the subsidy. They expressed guilt at burdening their spouse or children, similarly impoverished. It was even worse for those not eligible for government support, resulting in homelessness for one lady and severe deprivation in others. Trade-offs had to be made between whether to spend the tiny amount of money on rent, food or medicine. Depression was likely in circumstances of constant worry, poor and insecure housing, inadequate nutrition and guilt about impacts on children and spouse. And as one man said, in such circumstances death was welcomed as an end to such suffering.

**Being Illiterate**

The theme “being illiterate” captured the finding that for the older persons with depression, who could neither read nor write, they were limited in their ability to access information, resulting in lost social opportunities. Most of the participants (22 of 31) were illiterate, having had no education, and for them this meant “can’t read newspaper”, or “can’t write name”. Furthermore, many connected illiteracy with stupidity and misery. This was illustrated by Madam Zhou, an old lady who had been widowed for 40 years had struggled to raise her three young children. She had had no opportunity to attend school in her youth:

I can’t read newspaper as I am illiterate. I’m illiterate that I even can’t write my own name, am I miserable? (Madam Zhou)

Madam Zhou went on to describe the impacts of her illiteracy on herself and her children, who could not find good jobs because of their inter-generational illiteracy, and then blamed herself:

I have no education diploma to get a good job so that I can’t support my children well. A widow raising three kids is a poor situation. My
sons are illiterate too so they are unable to get good jobs… My sons completely lost the chance to receive education. We were too difficult to send them to school because I was incapable to support them. At that time we even couldn’t find enough foods for two meals so how could we find extra money to support them to school? It is really difficult and all are my fault to implicate my children. (Madam Zhou)

Madam Yan said she couldn’t get access to good jobs as a consequence of being illiterate. She was poor with a low income even if she worked hard:

I am illiterate. You know I do not have any education. I hardly recognise any Chinese letters and I can’t read it… I have been in Macau for many years but I can only find a job as babysitter to raise kids and just accompany the kids watching TV or singing. (Madam Yan)

In the case of Madam Liang, she regarded the consequences of being illiterate as synonym of being incapable and foolish. In addition, time dragged because she couldn’t read and passed the time:

I never get education and I only know how to plough and weave… I am illiterate and foolish. I am both old and incapable… What can I do? I can’t read newspaper. I just spend one day after another. (Madam Liang)

Based on the narratives, being illiterate had wide ranging ramifications. An older person who was illiterate and who had no educational qualifications also had no access to good jobs with higher pay. Unable to participate in the knowledge society, they felt ashamed and foolish. Being unable to access to better paying employment, they and their children were unable to exit from poverty. Finally they were vulnerable to depression.

**Injustice**

Whereas some participants blamed themselves for their hardships related to being poor and illiterate, about half (48.4%, n=15) pointed out that social injustice was partially responsible. Many of the older persons (15 of 31 participants) mentioned the injustice
they had suffered, referring to these as “unfair social system” and “unfair treatment”. One example was Madam Chen, a 92-year-old lady. She became homeless in Macau after her children abandoned her and she had to live with her grandson in mainland China. However she was fighting for the old age subsidy and public house from Macau Government to sustain her basic needs of life, arguing that she should qualify for the old age subsidy under the policy of “stay in Macau continuously”. Therefore, she shuttled between Macau – to maintain her claim to continuous residency - and the mainland – to get the needed support from her grandson – everyday, even she perceived it as unfair:

I have been a Macau resident for twenty years. I have no income, not a cent, but I can’t get the old age subsidy that government provides!… Now they make me come here and go back every day… I come and go back in the same day. I come here and forth just in order to maintain the relationship with Macau by presenting enough visa records. That would help me to possibly access to the public house or the old age subsidy from the government. (Madam Chen)

Her strategy, however, proved unsuccessful, directly impacting on Madam Chen emotionally:

Ms. Chen (day centre staff) told me she wanted to try this (applying for the old age subsidy and public house) to see if it was possible. But they also told me it was difficult to apply this now. My heart was down when I heard of this. (Madam Chen)

While for Madam Chen, injustice arose from what she saw as the unfair application of criteria to apply for the old age subsidy and public house, Madam Yan had her old age subsidy cut off for what she also believed were unfair reasons. Madam Yan lost her old age subsidy from government after living with her daughter, who had emigrated from the mainland, even though her daughter was also too poor to support her mother:

The (officer in) Macau Social Welfare Bureau said I could rely on my daughter but did not allow me to explain my situation (daughter was poor). My daughter applied to immigrate to Macau with the reason that she needed to take care of her mother and everybody immigrated in the same reason… They stopped offering subsidy for 2 years
because they said my daughter could support me since she immigrated here. (Madam Yan)

Madam Yan disagreed that she was not qualified for the old age subsidy, however, she felt powerless in the face of a more powerful bureaucracy in the government, a powerlessness that led to feelings of helplessness:

The (officer in) Macau Social Welfare Bureau just figured out roughly how much I needed. I totally had no idea how much she calculated for the family expense. The young people (in Macau Social Welfare Bureau) were not familiar with the family income balance plan. I was annoyed as all their sayings were not realistic…. If the Government cared a little more about my life by offering me a place and two meals, I would be happy. What else I can expect. I can not find anyone to help me as I am not capable to do anything. (Madam Yan)

In the case of Madam Xie, injustice came from the unfair regulation for the old age pension, when compared with the policy in Hong Kong. She had to stay in Macau alone to get her old age pension from the government even though she needed care from her children living in the mainland:

I am required to go to present in the Macau Social Security Fund every year and the problem is no one would wire transfer the money to me if I were in mainland China. Hong Kong is better because the Hong Kong government allows the old age pension to be transferred to mainland China while Macau doesn’t have such advantage… My children ask me to come back to mainland China for the rest of my life but I can’t leave my pension in Macau. It is not like Hong Kong that people could bring the pension to China. There’s no such rule in Macau… It would be better if I could get the pension in China. Hong Kong has such policy but Macau doesn’t. (Madam Xie)

In addition to being deemed ineligible for an old age subsidy or old age pension, another kind of injustice was described by Uncle Pan, a 72-year-old formerly single gentleman who had just got married to a woman from the mainland. His wife was not
allowed to live with him because he lived in a low-rent public apartment restricted to older persons living alone:

We got married two years ago. My wife doesn’t come home most of the time. It is not approved by the Government yet. She is not allowed to reside here… This is a public house only for old persons living alone. The government will take back the place if I get married. It is not allowed to let my wife move in especially if she has no Macau Identity Card. (Uncle Pan)

For Uncle Pan, the injustice even interfered in the relationship with his wife that could support him, leading to his negative perception of helplessness:

We just get along with each other like friends more than a couple… It’s a problem: firstly, I have no place for her. Secondly, she doesn’t have meals with me. She is like homeless in Macau… I am not capable to support a wife so she tells me she will find another man in Macau since I am helpless… I can’t deal with it if she tries to find other man because it is reality. That was the reason why I refused to marry when I was young. I had to support both the family and work which were too difficult for me to handle. (Uncle Pan)

As illustrated in these accounts, participants perceived social regulations and their application as unfair in relation to the old age subsidy, old age pension and social housing offered by Macau Government to aid the impoverished older persons to get basic needs of their life. The unfair regulations and powerful bureaucracy exacerbated their suffering, made it more difficult to get basic needs of life, even pushed people to extreme decisions and measures. For these participants, injustice made them perceive helpless and powerless which, as shown in Chapter 5, were strongly linked to depression.

**Poor Family Relationships**

According to Kleinman (1980), among Chinese poor mental well-being was frequently associated with stress arising from family environment or intergenerational relationships. Many of the participants referred to poor family relationships, and their narratives
demonstrated how these poor family relationships impacted on their lived experiences in a negative manner; the caregivers’ comments, although limited in nature, served to further support these findings. The sub-category “poor family relationships” referred to themes of being widowed, living alone, conflict with adult children, and being neglected by children.

**Being Widowed**

The theme “being widowed” reflected the complex emotional reactions and impacts on the participants since their spouses died. Many of the 31 participants (20 of 31) were widowed, and of these 18 were female; they felt alone and lonely in their final stage of life and described being widowed negatively using words such as “loss of meaning”, “lonely”, “miserable”, or “suicide”.

For example of Madam Lin, an old woman who had been widowed for 18 years since her husband, whom she had been taking care for long time, died of tuberculosis. Her husband’s death left her feeling her life had no purpose, and was meaningless. For her death would come as a relief:

> My husband died when he was 71 years old… I am 80 years old now. He died at 71 years old… I am useless till the day I die. I prefer to die quickly now. I would rather have died earlier than my husband… Why I couldn’t have died earlier than my husband? Why he passed away before me? It would be a relief if I had died. (Madam Lin)

While Madam Lin was widowed in late life, several participants had been widowed when they were young, with small children to raise. Madam Zhou, who had been widowed for 40 years, not only suffered a life of loneliness; she suffered greatly in the struggle to raise her children unsupported:

> My husband died of hunger when I was 36 years old. A widow bringing three kids was a poor situation… My husband died much earlier and I would have died if I couldn’t have cheered up to raise my three kids. All the pigs died after I tried hard to raise them and I got nobody’s help to support my family. I felt very bitter and astringent… The tragedy was I lost my husband. I had been widowed for decades
of years and had gone through so much hardship during lonely years. I lost my husband when I was 36 years old and now I am in my seventies. What could make me happy? I feel lonely and miserable when I go home where it is empty with no possession. (Madam Zhou)

Madam Huang had been widowed for half a century. She remained extremely sad, and had attempted suicide several times:

It was in the beginning of liberation, the initial stage of the Chinese Communist Party came into power, and my husband was shot by them. He got caught and ten people of a line shot him… I had been widowed for fifty years. How miserable I was… I felt so sad and tragic that I didn’t want to live any more. I tried several times to commit suicide by hanging my neck but I was stopped by the neighbours who said I had to raise my kids. (Madam Huang)

For Madam Xiao, she had been feeling guilty that she could not accompany her husband when he died in hospital alone. It was a worst situation of filial piety in Chinese Confucianism culture that no family member, especially herself as the spouse, was with her husband at the final moment when he died alone:

It was most unhappy moment in the past when my husband passed away alone… He died of lung cancer over 10 years… He passed away in S. Januario Hospital. It was for last moment approaching the death. I should have stayed with him at night, I already thought of such idea that I wanted to stay with my husband day and night. But my husband had gone at 12 o’clock at noon before I proposed the thought to the doctor. I prepared to propose at that night but it was too late because he had gone before I planned to stay with him at night. (Madam Xiao)

In Chinese society, Confucianism had played a very important role in determining rules for the appropriateness of interpersonal relationships between husband and wife (Hwang, 1978). In Chinese hierarchical structure, men were the head of families, holding more power and being expected to take more responsibilities (Hwang, 2000). A ‘relatively powerless’ social status was one of the risk factors that could lead women to suffer from depression (Desjarlais, Eisenberg, Good, & Kleinman, 1995). A Chinese proverb said
“Be a couple when young and then be a partner when old” (年少夫妻老來伴); it was very important in Chinese culture to have an old partner to accompany each other in the final stages of her/his life. Marriage was certainly the priority issue and most critical event for Chinese, especially for a woman. It meant a couple should be bonded together and count on each other with care and love forever until death. Traditionally, a man should take the leading role of a family, especially in the financial aspect (男主外女主內). It would be seen as a terrible disaster if a woman became widowed, especially when she would need to raise small children without any income or inheritance!

Living alone

Living with family members and taking care of each other were wishes for the Chinese old generation (Tam & Wong, 2007). However, many participants in this present study (17 of 31 participants) were living alone and described their life as “bitterness”, “isolated”, or “no support”. An example of this was given by Madam Kuang who had been widowed and had been living alone for 50 years. She had been lying in bed all the time since she had a stroke and was paralysed years previously. Her family had little contact with her even though she desired contact. She was isolated from society due to her personal circumstances, leaving her feeling cold and bitter:

I am living alone! I have been living alone since 1953… My children are cold! They don’t come… I am not able to contact with others. I want to contact with family to express my wills but no one comes. They are not sure to be available to come… I don’t expect them to come. I don’t want to bother them. They will be annoyed to see me lying here all the time… They never come. I just want to see the family. I have wills to express but all of them are too busy to come. I have no one to talk to… Anyhow my whole life is a big bitterness. I don’t want to mention it. (Madam Kuang)

For Madam Jing, living alone also came from broken relationships with her family. She was neglected by her only son who was a refugee from Cambodia years previously, and they were not close anymore after their long term separation:

I stay separately from my son… My son seems not close to me after
we have left each other eight to ten years ago… Now I have no idea where he is. I lose contact with him over ten years. He has gone with other woman leaving behind his wife, his children and his mother… I live alone now with no children around. I have to rely on my own. (Madam Jing)

While in the examples above, living alone resulted from their broken family, Madam Hao related it to her poverty. Under impoverished circumstances, most of her children went to work in the mainland for making money. Even though one son was in Macau, their relationships had broken down and they were in conflict with each other due to small space in the apartment where they had both lived. Madam Hao was forced to move out and was living alone, making her unhappy:

I am living alone. I have one child stay in Macau and 5 others in mainland China. Some live in Zhongshan city, some live in Xinhui city (places in the mainland), far from here. It has been long when they only come to visit me by chance… There is not enough space to live with my son in Macau. No space for me. There’re six people in two-bedroom apartment… The young generation don’t respect older person and don’t want to stay with me… I am forced to apply for social housing from the government, so I move out. (Madam Hao)

Consequently, living alone might engender social isolation and be associated with depression for Chinese older persons (Mui, 1996). As illustrated in these accounts, living alone resulted from broken family relationships compounded by impoverished circumstances. Also reflected in their narratives was that the participants had absolutely no control over the situation that lay as a root of their negative thinking.

**Conflict with Adult Children**

The theme “conflict with adult children” captured the poor relationships between the two generations, especially an older woman and her daughter-in-law (婆媳關係). Some participants (10 of 31 participants) in this present study talked about the conflict with their adult children as “fighting”, “quarrelling”, or “pushing out”. A comment came from Madam Lin who had been widowed for 18 years. She had to live with her son who,
she said, did not care about her. She was in constant conflict, quarrelling, fighting and being bullied and neglected, with her daughter-in-law. The conflicts she described made her unhappy, unsupported and like to die:

My daughter-in-law is a trouble; certainly it’s not happy to get along with her. She will argue with me if she doesn’t like what I did. I will quarrel and fight back even if she doesn’t agree with it. She asks me to go away… She doesn’t like me. There’s nothing she take care of me… I don’t like to stay with my daughter-in-law who is a stubborn person. I just like to stay with my son, not my daughter-in-law… I would rather have died earlier before my husband than being bullied by my daughter-in-law… In a word, it’s harder to live together than to meet together occasionally and it’s more difficult to have meals together (相見容易相處難). (Madam Lin)

Unfortunately, the constant conflict between Madam Lin and her daughter-in-law is regarded as a common situation in Chinese culture and clearly not to be taken seriously by Madam Lin’s son, the caregiver, who during the interview with him was dismissive of her complaint. In the case of Madam Tan, an 83-year-old widowed woman, the conflict arose from fighting over the property left by her husband with her children including her daughter and daughter-in-law, even though she should have the priority to reside in the house under the Macau law. She described ongoing conflict with her children, who were both verbally and physically abusive, making her emotionally cold, insulted and hurt:

My daughter-in-law wants to force me out of the house as she says the house don’t belong to me. The younger generation is cold to old people. My daughter-in-law says why I don’t die right away. She fights with me… My daughter-in-law pushes me out of the house even if I tolerate so much of her bad deeds and I say I will go away if she really dares to challenge the traditional moral relationship. I say I am not as strong as they are but I am an old grandma who works hard to buy the house. She has no right to kick me out. If she dares to completely break up the relationship, I will go away leaving her as the evil daughter-in-law who pushes her mother-in-law out to die… My
daughter is very bad to me after her father died. She is very fierce to me so I don’t want to live with her… My daughter yells in front of the gate for hours. Do you think I am happy? She just comes home and keeps yelling on me for not opening the gate so long. My head is hurting and my heart is hurting too. (Madam Tan)

A further example came from Madam Xiao, a 74-year-old widowed woman who had suffered a stroke six years previously. She had constant conflict with her son and daughter-in-law while living together, just because they regarded her as a burden to affect their life:

It’s between my son and me, we often quarrel. He always complains I occupy the bathroom for a long time… My daughter-in-law is not quiet most of the time. My son will be annoyed by my trouble such as I am wordy sometimes and I occupy the bathroom too long… He blames me affecting his normal life. (Madam Xiao)

In Chinese culture family harmony was admired and a strong emphasis was placed on family togetherness and the interdependence of family members. As illustrated in these accounts, in reality children might fail to behave in the expected ways, older persons might not get the respect that they regarded as deserved from the younger generations, and families appeared to find it difficult to adapt to these changes. Intergenerational conflicts lessened family support and caused depression consequently (Blonder, Langer, Pettigrew, & Garrity, 2007). For some of them, death was seen as a way out.

**Being Neglected by Children**

Most Chinese older persons regarded their children as their main source of support both emotionally and economically, and this value was reflected in Macau government policy that endorsed the responsibilities of children to care for their aged parents. Traditionally, the Chinese placed great values on filial responsibility and children were expected to look after their old parents (S. W. C. Chan, Chiu et al., 2006). However, many participants (14 of 31) in this present study suffered from being neglected by their children, referring to “no care”, “no support”, “ignoring”, or “silent treatment”. An example was given by Madam He, one 80-year-old woman who became homeless after her husband died. She was neglected by her daughter and sons because of their own
extremely poor living circumstances as confirmed in an interview with her son-in-law, the caregiver, during a visit to their home. Experiences of being ignored, “silent treatment” and material neglect made her feel bad and cry:

I stay with my daughter who doesn’t care about me. My grandsons don’t care about me either… My daughter is like that attitude all the time, ignoring me. I just fell bad to see her face but I have no place to go. I cook and take bath and eat and go to bed alone. She never intends to talk to me. She only goes to her room after work and never brings food for me. It is the same as my grandsons who ignore me too. They never respond when I try to talk. They never speak to me and treat me like a stranger… My children never give me any money to support my life. They never come to see me. One son is afraid of his wife and the other is only with debts because of gambling. They only come to see me when I have money to give. My elder son even refuses to see me when I am penniless… I feel badly once I go home. I can not help crying every time when I talk about this. (Madam He)

While Madam He’s neglect by her children came from their poverty, Madam Tai related this phenomenon to the intergeneration gap as well as the poverty of her children. Madam Tai seldom communicated with her 43-year-old single daughter with whom she was living, because they had different interests and her daughter was extremely busy making money. The daughter, the caregiver, admitted ignoring caring for her mother because of intergeneration gap and poverty of children during a home visit:

I have six kids. They’re busy and they have no money so they dare not to come. I have not seen some of them over two years… My children never call nor visit. I never hear from them… Even in the hospital, I have to count on my own. Those children need to work, who else will take care of you? I also go by myself to have the subsequent body check… My daughter goes to work early so she doesn’t make breakfast. I normally cook for my own since daughter eats outside… I have to take care of my own. (Madam Tai)
Further comments were drawn from Uncle Wang, an 86-year-old gentleman who had divorced his wife who betrayed him during the Cultural Revolution 40 years previously. He had nothing left when he migrated to Macau alone after the Cultural Revolution. He remained neglected by his ex-wife and his children, who did not contact him at all:

My son and his wife and my former wife who is divorced from me have already gone to Taiwan. It’s been twenty years. There have been never any calls and letters, not even a call… My family has never been nice to me as they have always listened to what my former wife comments. (Uncle Wang)

As illustrated in these accounts, the participants were unable to get tangible or emotional support from their family members. In spite of being neglected by their children, care and support from their children were still indispensable to the participants, not only in a financial sense but also psychologically. Lacking contact with their children caused them to feel sad, and was linked to negative thoughts and depression.

Limited Social Network

Social network and social support could mediate the impact of stress among older persons and were associated with depression (Hwang, 2006; Mui, 1996). The poor social network of these older persons, who lacked any support from friends, relatives, and community, might deepen their difficulties. Moreover, isolation from social contacts also meant they had no way to escape from the depression they suffered. The sub-category “limited social network” consisted of themes of being looked down upon by others, and lack of social contact.

Being Looked down upon by Others

The theme “being looked down upon by others” revealed the participants’ perceptions of being discriminated against by other people surrounding them because of their impoverished circumstances. Some participants (5 of 31) felt they were looked down upon by others as “discrimination”, “being bullied”, “being blamed”, or “being humiliated”. This was illustrated by Madam Wang, a widowed old woman who had suffered from extremely impoverished circumstances since her early childhood. She had lost her father early in life, which, as Hwang (2000) observed, might lead to the lower
social status of her family in society. She had to work hard for a living since childhood but still was impoverished. She felt guilty for not having had her own child, because childlessness was the worst failure of filial piety in Chinese Confucianism culture (無後為大) (Hwang, 2001). Now her foster son from her sister (Madam Wang’s caregiver) did not care about her and during the interview with the caregiver they ridiculed each other. All of these factors appeared to be contributing to her feeling of discrimination:

I have seen too many discriminated eyes… People look down upon me all the time because I am in an impoverished situation… I’ve told you I’ve never been happy since childhood because we are bullied. No one ever respects our family with a widow and 3 children without a stable income. Our neighbours bully us and even those governors who are Portuguese also humiliate us… I don’t dare to speak out the unfair treatments we have experienced till now after those have died… Relatives to me (smile bitterly), I dare not to say. They are not nice to me; they look down on me too… Now my nephew (fostered son) listens to his family’s gossip to look down on me too. (Madam Wang)

While in the first example, discrimination arose from Madam Wang’s extreme poverty and having been fatherless in childhood and not having had her own child, Madam Zheng confirmed her poverty led to the discrimination that she felt. Madam Zheng, a 75-year-old widowed woman who had no income, had to stay with different children in turn from place to place. She had no friends and relatives to visit and limited social activities because of her poverty. A Chinese proverb summed up the social attitudes and customs that Madam Zheng experienced: “Be close to the rich and be far from the poor” (喜富厭貧):

Friends are coming to you if you are rich. How can I have friends when I am so poor? They will look down upon you… I mean I am not willing to involve into any social contacts since I am penniless. How can I get along with others if I have no money? The social relationship is based on certain spending such as parties and banquets that you are supposed to spend money.… I’m poor so I can’t accept any invitation more than once to embarrass myself because I have to invite others by courtesy demands reciprocity next time. If I order any cheap foods in
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the restaurant, they will stay away from me for sure. I dare not to compare with others... I have relatives but I never go up to them. The reality is, the kinship is cold. I am poor, this is the reason. They’re afraid I go to borrow money from them. (Madam Zheng)

For Madam Zhou, discrimination arose from being controlled and blamed by the house owner. She had been widowed since her youth, and there was a belief in Chinese traditional culture that it was her fault to bring bad fate to her husband, causing him to die young (

Sometimes the house owner comes to say this is not allowed and that is not allowed. All these make me feel upset. He is so picky and troublesome. It is bad to get blamed by others while I already pay the rent to him. I don’t like to get blamed like that any more. I already pay the rent to him and get blamed too… I feel being discriminated. Some people look down upon me. They say I am miserable and poor to be a widow so why I don’t marry another guy. (Madam Zhou)

As illustrated in those accounts, discrimination was described in powerful terms including “bully”, “blame”, and “humiliation”. Also reflected in these narratives was that the participants suffered from extreme impoverishment, and personal experiences of being fatherless and widowed were extremely negative, placing them in a position of discrimination, and contributed to their negative thinking.

Lack of Social Contact

The theme “lack of social contact” referred to the social isolation of the 31 participants in the present study, which might closely link with depression of older persons (Mui & Kang, 2006). All the 31 older participants in the present study felt they lacked social contact, both with extended family and friends. Moreover, they attributed their lack of social contact to both ill health and poverty. This was illustrated in comments from two men. Uncle Yu, a 71-year-old gentleman, was unable to go out because he suffered from symptoms related to COPD. His friends did not contact with him because of his poverty:

It’s useless to have friends who will get away from you since you’re penniless. Those friends will not even look at you if you’re a poor guy.
They will stay away when they think you will borrow money from them… Nobody sympathises with you and cares about you. They are afraid that you will borrow money from them because they’re also poor. I have no chance to meet rich people so all people around me are afraid to be close to me… Poor people can’t help each other. (Uncle Yu)

Uncle Liang reinforced the relationship between lack of social contact and extreme impoverishment, poverty that arose from his low-pay job because of poor health:

I have no friends. I seldom have social contact with others. There is little chance for me to know any friends. There’s no friend to talk with… It will be good that you share happiness with others but if it is negative issues, they will feel sympathy but that is all. What is the use for you to share unhappiness with others? You will get nothing except sympathy. They will not agree with you when you talk too much. Some people are like that even if they’re your friends. There’s a saying in Chinese: there’s no real friends but only friends who will accompany for drinking and eating (酒肉朋友). There are no friends if there are no drinks and banquets. This is true. (Uncle Liang)

Uncle Lu related his lack of social contact to his being very old and to changes in transitional culture and values. He expected to have contact with his relatives, but all of them tended to be busy working. Uncle Lu, a 91-year-old widowed gentleman, had no children because his wife had several miscarriages:

All the friends whom I am so familiar with and talk closely with are dead… Some of the relatives can not help you. All of them need to work hard so how they have extra efforts to help? (Uncle Lu)

For Uncle Wu, he and his wife agreed that a lack of social contact was an outcome of his limited mobility, poverty resulting from the cost of treatment and the scattering of his family. Uncle Wu, a 73-year-old gentleman who had COPD and stayed at home all the time because of shortness of breath and dependence on oxygen for 10 years. He had no property and depended on his wife for daily living needs. His family, who might otherwise have supported him, were living far away in different places where they, too,
struggled for a living, due to the extreme poor living condition in the mainland at that time:

I have many friends but we don’t get in touch often. They seldom contact me and I never contact them… Now as I suffer this disease so who will come to visit? Even they come for once or twice, they will not come again. I will be also embarrassed to welcome my friends under this situation. It will be more embarrassed to let them see my wife doing this (picking waste paper card for living)... How much they can help me, I don’t expect that... I have relatives, but they’re all in mainland China. (Uncle Wu)

Lack of social contact, for these gentlemen, resulting from limited mobility and extreme impoverishment, created social distance. To deepen their difficulties, they lacked any support from friends, relatives and community. Furthermore, within traditional Chinese culture, men were perceived as strong masculine figures. Chinese idioms like ‘a man prefers blood more than tears’ (男人濘流血不濘淚) and ‘men have no fear’ (男人大丈夫) portrayed a strong masculine figure. Having to rely on a wife or child for support threatened the ideal image of masculinity. Further, Chinese men might find it hard to express their emotions and seek help for their difficulties (S. W. C. Chan, Chiu et al., 2006). For these gentlemen, lacking contact with the society and isolation might be their ways to escape.

**Discussion of Present Living Conditions and Social Support and Depression**

Previous research had highlighted the importance of families as the backbone of the support of older persons in Macau and of Chinese people elsewhere. The accounts of the participants in the present study illustrated the profound consequences when family support broke down or was unavailable, and the serious impacts on older persons’ health.

Liang and Gu (1989) reported that of the Chinese older persons who were physically dependent, the overwhelming majority were cared for by their families and that less than 0.5 percent were institutionalised. A more recent survey indicated that among those Chinese older persons who were totally depended on others, 48 percent relied on their
spouses and 40 percent relied on their children (Hong & Tracy, 1999). Chinese people
paid great attention to relationships with family members (Hwang, 2000). In Chinese
culture, an individual was embedded in the family and a failure to fulfil one’s duty and
obligations often led to feelings of guilt (Bedford & Hwang, 2003). The significant role
of the family could be attributed to at least the following reasons. Firstly, taking care of
the older persons was strongly advocated by Confucian philosophy and traditional
culture. Children were expected to place the interests of the whole family, their parents’
welfare in particular, ahead of their own (Whyte, 2003). It was a shared consensus that
children should provide a wide range of support to their parents, including financial
assistance, personal care, and emotional support, as reflected in the following Chinese
saying, “to store up food in anticipation of famine, to bring up children against ageing”
(積穀防饑, 養兒防老). Secondly, due to the lack of financial independence of many older
persons and the limited social welfare programs, families inevitably took on the
responsibility of providing a safety net for older persons. Finally, the value and practice
of family support were reinforced by local laws. In light of rapid population ageing, on
one hand, and their comparatively low economic level, on the other, social policies
regarding old-age security in Macau continued to place an emphasis on family support
(Zhang et al., 1997). In 1994, Macau Government had approved the Basic Political Law
of Family, which explicitly required families to take responsibility for old-age support.
The law stipulated that children had the obligation to support their parents and
prohibited abuse or abandonment (Macau Government, 1994). Therefore, due to
cultural, historical, and social policy reasons, the family was intended to play a critical
role in supporting the older persons in Macau. However, in reality, as illustrated in the
accounts of participants, the family support rooted in culture and valued by society, an
assumed support implicit in policy, was shown in this study to falter, with dire
consequences. Some possible reasons for this were explained.

Due to recent rapid social economic developments in Macau, Chinese family support
systems might have changed: nuclear families, in which family members were more
independent and maintained less contact, had become much more widespread (S. W. C.
Chan, Chiu et al., 2006; D. D. Li et al., 2003; Ning, 2001). The younger generations had
tended to develop an outlook that was more self-centred. As a consequence, older
persons might not be able to get the respect that they regarded as deserved from the
younger generations and might find it difficult to adapt to these changes (Yip, Chi, & Chiu, 2002).

Mixed methods using both qualitative and quantitative findings in the present study revealed that the older persons with depression in Macau suffered from poor living conditions and social support, such as, hardship, poor family relationship, and limited social network, which might contribute to the development of their depression. Several researchers had found a beneficial effect of being married on depressive symptomatology (D. R. Brown, Milburn, & Gary, 1992; Dean, Kolody, Wood, & Matt, 1992; Williams, Takeuchi, & Adair, 1992). Death of a significant person in an older person's life might be more difficult for the Asian older persons because they lost not only the loved one, but also a significant source of support and hope (Mui, 1996). It had also been found that the greater the frequency with which old people interacted with others in their social networks, the fewer depressive symptoms they had (Dean, Kolody, & Wood, 1990; Dean et al., 1992).

In studies of the relationship between depression and instrumental support, i.e., tangible assistance with tasks ranging from feeding to doing household chores or shopping, results had been contradictory. Reviski and Mitchell (1990) reported that higher levels of instrumental help were associated with lower psychological stress, whereas Mitchell, Matthews, and Yesavage (1993) found a negative effect of instrumental support on depressive symptoms. Emotional support was the presence of a close relationship with someone who could always be counted upon to share feelings (Murphy, 1982); this entailed the subjective perception of emotional intimacy in the relationship (Oxam, Berkman, Kasl, Freeman, & Barrett, 1992). Most studies found emotional support contributing to a lower level of depressive symptoms among older persons (Antonucci, Fuhrer, & Dartigues, 1997; Oxam et al., 1992). The perceived adequacy of social support or satisfaction with the amount or quality of social support was an important component of social support. Perceived high-quality support appeared to have a salubrious effect on depressive symptoms (Dean et al., 1990; Holahan & Holahan, 1987; Krause, 1987; Turner & Noh, 1988).

Studies had shown that cultural factors might affect the nature and amount of social support provided to older persons (Krause & Liang, 1993; Palmore & Maeda, 1985). Some Western studies had shown that the effect of support from their friends on
psychological distress among the older persons was stronger than the effect of support from their adult children and other relatives (Dean et al., 1990; G. R. Lee & Ishii-Kuntz, 1987). In contrast, family support played the more important role in social support among Chinese older persons. Filial piety, the traditional Chinese attitude of respect and concern for old persons, required young family members to maintain the material and mental well-being of elderly family members (Bond & Hwang, 1986; Chang, Chang, & Shen, 1984; D. Y. F. Ho, 1996; Sher, 1984). Furthermore, it was reported that 69 percent of the older persons in Hong Kong lived with their unmarried children or in extended-family households (Hong Kong Central Committee on Services for the Elderly, 1988). This particular type of living arrangement facilitated support from family members. Family support was still indispensable to older adults, not only in a financial sense but also the psychological aspect (Chow, 2000). The reason was that the older persons were likely to receive tangible or emotional support from their family members.

Another stressful life event of great emotional impact for the older persons was the splitting up of household between the older persons and their adult children. This was especially so for those older persons who might still have high expectations of family solidarity and co-residence (Mui, 1996). Culturally, the splitting up of family household might be another indication of intergenerational conflicts (J. J. Lee, 2005). The older persons might be confronted with the loss of power and respect because his or her role as cultural conservator and family decision maker might be undermined. The association between fewer children living in proximity and depression was consistent with research in the United States and Asia (Chi & Chou, 2001; J. J. Lee, 2005). Culturally, Chinese older persons might still expect their adult children to live with them or to live in proximity so that they would be available to provide support to him/her. Fewer accessible children might lead to the older person's sense of social isolation and insecurity. Moreover, living alone was often an extremely stressful event for an ageing Chinese because it engendered great disappointment, shame, and feelings of failure (Mui, 1996).

Chinese older persons tended to describe themselves in terms of family roles. They had the propensity to use roles, and their performance within them, to evaluate themselves. This involved maintaining ‘familial harmony’ (Tam & Wong, 2007). The obligation of respect and obedience to senior members of the family remained a traditional value.
Chapter 7 Present Living Conditions and Social Support

(Bedford & Hwang, 2003), was adhered to in Macau. Maintenance of a harmonious relationship in family was shown to be of great concern (P. S. Ho, 2001). The participants in the present study had expectations that their family members would behave in certain specific ways, so as to maintain harmony. If family members failed to behave in these expected ways, such as, conflict or being neglected, unmet expectations were likely to be related to depression.

The participants with depression in the present study suffered from hardship, such as being poor and illiterate. They even struggled to get three meals a day, to live for a bed only. Older persons with poverty were exposed to several risk factors for depression, such as living in deteriorated neighbourhoods and having unstable housing (Arean et al., 2007), increased exposure to crime and victimisation (Ostir, Eschbach, Markides, & Goodwin, 2003), and poor nutrition and poor physical health (Angel, Frisco, & Angel, 2003). Their negative thinking could be related to the increased rate of stressful life events (Ross, 2000) and exposure to trauma in the poor (P. Roy-Byrne et al., 2006), along with a relative lack of adequate resources to cope with these stressors (Taylor & Seeman, 1999; Wilkinson, 1999). Moreover, it appeared that the participants living in poverty had fewer material and social resources in a variety of domains, which might also make it difficult for the participants to sustain supportive social relationships with others (Kubzansky et al., 2005). Older persons with poverty were found to have more depressive symptoms than older persons who were not poor (Pinquart & Sorensen, 2000). Most of the participants in the present study were illiterate. It had been theorised that a consequence of illiteracy was that people were less well prepared to problem solving and handle stress better, resulting in more distress and less ability to benefit from support. Furthermore, illiteracy might be a proxy for other important variables, such as chronic poverty (Gum, Arean, & Bostrom, 2007). That as seen in the accounts of these participants, might also be intergenerational.

**Summary**

Through the use of both qualitative and quantitative approaches, the impact of extremely poor living conditions and lack of social support, described as hardship, poor family relationship, and limited social networks, was clearly seen. The mixed methods in the present study made the interpretation of the lived experiences of the participants
more comprehensive and gave an understanding of how such circumstances affect Macau’s older persons than either approach alone.

The poor living conditions and social support might cause physical limitations and complaints and negative thinking or vice versa. Which came first? They interacted and were intertwined in the lived experiences of the older persons with depression in Macau. The dominant categories of negative thinking, physical limitations and complaints, and present living conditions and social support were explored in previous three chapters. Finally, how the lives they have lived link to present lives and experiences were reported and discussed in the next chapter.
Chapter 8

The Lives They Have Lived

Three dominant categories of “negative thinking”, “physical limitations and complaints”, and “present living conditions and social support” had been explored and elaborated on, in the previous three chapters. In this chapter, the final dominant category, “the lives they have lived” was described and discussed in depth. The past lives of the participants, in terms of engaging in hard labour with low reward, being fatherless, having a bad marriage, experiencing trauma from wars and revolutions, all contributed to mental trauma reflected on their negative thinking. As in previous chapters, a brief outline of literature linking to the lives they have lived presented a context to this chapter. Results of quantitative tests (employing various instruments including the GDS-15, BI, and SF-36QOL) were then reported, with results compared between two groups: Group A included those who in the interviews were very focused on their really difficult lives, whereas Group B were those who did not volunteer stories about really difficult lives even when prompted. Questions emerged from these quantitative data, and were addressed through the qualitative phase of the study. This chapter contributed to the thesis with exploration in-depth of the link between the past lives they have lived with negative thinking patterns in the present.

The Lives They Have Lived and Depression: A Review of Literature

Previous studies had demonstrated a significant relationship between stressful past life events and depression among Chinese older persons (K. L. Chou & Chi, 2001b). A longitudinal study in the USA, involving a national sample of 1842, showed that those with a higher level of marital disagreement experienced a greater increase in depressive symptoms (Choi & Marks, 2006). A further study in the USA demonstrated that past life events perceived negatively played a role in development of depressive symptoms (Esbensen & Benson, 2006). A longitudinal study involving 8865 older persons, also in the USA, revealed that a father’s death in childhood led to depression for the children (Marks, Jun, & Song, 2007). Together, these studies reviewed generated similar
findings regarding the relationship between negative past life events and depression among older persons. However, most research had been based on closed response questionnaires, not explanatory approaches, and did not tell us what was the focus or substance of these past events for older persons. Furthermore, most studies reported only one or two factors related to depression, e.g. having a bad marriage or being fatherless, not on all possible factors and their interaction.

It was this gap in understanding and knowledge that this study was seeking to address. The researcher was interested not only in measuring the lives they have lived; the study was concerned with the substance (content, themes, focus) of such past events in their lives. The lives they have lived and mental states of the older persons interacted and compounded to be embedded in the lived experiences of the older persons with depression in the present study and were identified by both the quantitative and qualitative data, which were now reported beginning with the quantitative results.

**Quantitative Tests Related to the Lives They Have Lived**

All the participants were invited to reflect on and talk about their past lives; some had a great deal to say, while others said little. For the purposes of analysis, the 31 participants were assigned to one of the two groups: Group A included those who in the interviews were very focused on their really difficult lives, and Group B were those who did not volunteer stories about really difficult lives even when prompted. This was not to infer that Group B did not have hardships in their lives, simply that when prompted they had little to say about their previous lives. Group A (n=18) had experienced hardship from early in life, while the early lives of those in Group B (n=13) were not so hard or were not as intrusive. The BI (see Chapter 3 page 66 for detailed description), SF-36QOL (see Chapter 3 pages 68-69 for detailed report), and GDS-15 (see Chapter 3 page 66 for the detailed) were utilised to quantitatively measure the effects of the lives they had lived on the physical conditions and mental states of the participants.

Based on the BI, analysis of means revealed that there were differences between the two groups. Group A ranked a moderate dependency level of BI activities of daily living with a mean of 83.3, while Group B suffered from a mild dependency level only, with BI with a mean of 97.3. Moreover, Group A reported worse physical health conditions (GH mean score of 21.7) when compared with Group B (GH mean score of 34.3).
Regarding psychological scores, Group A presented with worse mental health state (MH mean score of 20.9) than Group B (MH mean score of 31.1). Mann-Whitney U tests, nonparametric tests for non-normal distribution of critical variables (Polit & Beck, 2004), were utilised to test the differences of the BI and SF-36QOL between the two groups. The results suggested that there were significant differences of the BI (Z=2.13, \(p=0.034\)), mental health (Z=2.04, \(p=0.041\)), and general health (Z=2.05, \(p=0.040\)) between the two groups (see Table 8.1). The findings illustrated that Group A suffered from more severe physical impairment and worse mental states than Group B.

### Table 8.1 Mann-Whitney U tests for BI and SF-36QOL between the Two Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A</th>
<th>Group B</th>
<th>Z</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Median</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>BI¹</td>
<td>18</td>
<td>95.0</td>
<td>83.3</td>
<td>29.0</td>
</tr>
<tr>
<td>MH²</td>
<td>18</td>
<td>22.0</td>
<td>20.9</td>
<td>7.8</td>
</tr>
<tr>
<td>GH³</td>
<td>18</td>
<td>20.0</td>
<td>21.7</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Notes:
1 BI=Reduced Item Barthel Index
0~ total dependency 35~ severe dependency 56~ moderate dependency
85~ mild dependency 100~ independent

2 MH=mental health
3 GH=general health

The variances of GDS-15 between the two groups were investigated by \(t\)-test. The findings presented in Table 8.2 find that there was a significant difference of GDS-15 between the two groups (\(t=3.42, p=0.002\)). The results implied that Group A was more seriously depressed than Group B.

### Table 8.2 \(t\)-test for GDS between the Two Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A</th>
<th>Group B</th>
<th>(t)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>GDS¹</td>
<td>18</td>
<td>12.4</td>
<td>2.0</td>
<td>13</td>
</tr>
</tbody>
</table>

Note: 1 GDS=Geriatric Depression Scale-15
Group A participants tended to focus on hardships from early in their lives, suffered from more severe physical health conditions and worse mental health states than Group B. The findings implied that their hard lives from early in life, such as hard labour with low reward, loss of their father, having a bad marriage, experiencing trauma from wars and revolutions, had had sustained negative effects on their health and wellbeing, physical impairment, and depression. While the differences between Group A and Group B were statistically significant, the sample sizes were too small to generalise beyond these participants. However, the relationship was supported in other research involving larger samples, reviewed below.

Similar findings emerged among Chinese older persons in Hong Kong (K. L. Chou & Chi, 2001b). This study concluded that the exposure to stressful past life events had such a strong detrimental effect on sense of control that no one could conserve their sense of control under these circumstances and it in return increased depressive symptoms. American older persons were also found to be sensitive to depression with the depressogenic effects of stressful past life events (Kendler, Kuhn, & Prescott, 2004). Negative past life events, such as higher ratings of marital disagreement, were found to lead to a greater decrease in global happiness and a larger increase in depressive symptoms over the period (Choi & Marks, 2006). This suggested a possible negative relationship between depression and marital satisfaction, and one possible explanation was that decreased marital satisfaction might indicate a lack of support, thereby contributing to depression (Blonder et al., 2007). Another study describing past life events reported by the depressed, found that loss featured strongly, especially, losses in a family context, such as, loss of close family members. This might be a reflection of socio-economic stressors that were common in low-income classes with difficulty in managing expenditure (Muhwezi, Agren, Neema, Maganda, & Musisi, 2008). Further research found that loss of a father led to less personal mastery, decreased self-esteem and an increase in depressive symptoms for their children (Marks et al., 2007). The need for control was associated with depression in another study, suggesting that perceived lack of control over past life circumstances was a critical component in the etiology of depression, and that the belief that one could not control the effects of untoward past life events induced hopelessness, which was likely to be a proximal cause of depressive onset (Mazure, Bruce, Maciejewski, & Jacobs, 2000).
The quantitative results strongly pointed to the impacts that an early hard life had on the physical and mental health of the participants and contributed to their negative thinking. What, then, was the nature of these early hard lives? How did these early hardships impact on their physical health and thinking? The data from the in-depth interviews addressed these issues through four themes: hard labour with low reward, being fatherless, having a bad marriage, and trauma from wars and revolutions.

**Hard Labour, Low Reward**

In the early 20th century, China, including Macau, was a poor and struggling country where many people were illiterate with no opportunity for education. They had no access to good jobs with higher pay because of the lack of educational qualifications and had to work very hard as a labourer for a living, such as a farmer tilling land or a porter coolie. Most of the participants (24 of 31) were involved in doing hard labour but for low reward when they were young. One example was Uncle Liang, a 73-year-old single gentleman who said he had worked so hard in his youth in the mainland and this had caused damage to his internal organs:

I watched over cows from age 5 to 8… I needed to plough the land as I was only about ten. I would catch fish when I was a little bit older. We went out fishing when it was good day and we ploughed when it was not good day… I began to vomit blood when I was in the village. I vomited blood since I worked hard in the hometown when I was twenty two. I used to go fishing at 4am in the early morning. That day when I had lunch, I began to vomit all I had and I saw blood coming out. Because I worked too hard to cause my internal organs damage and it hurted my heart as well. (Uncle Liang)

Uncle Guan had similar experiences, hard labour related to his non-stop physical work:

It was such a hardship to make a living when I was young in Zhongshan China. I stepped the pedal of the machine to make the rope. It was like I controlled the machine by stepping the pedal non-stop so the rope would keep twisting. I used to fight hard to make living by making ropes. It was so hard that I kept stepping for over ten hours a
day. It lasted for half a day without a break… It was very hard. My feet started to hurt at that time. (Uncle Guan)

Not only was the physical labouring work hard, the reward was low. Even though he worked hard, Uncle Liang still had not enough food:

Life was tough. It was a hard time. It was very hard because there were not enough lands to plough so there was not enough food. (Uncle Liang)

Uncle Li also had not enough food even though he worked hard, struggling for a living in Macau:

I just followed my friends to do whatever jobs were available. In the beginning we did all kinds of hard work such as bricklayers. It was hard works all the time. I did it for two meals only. I also tried to sell cosmetics for wholesale business once upon a time but I lost all the investments. Of course it was hard by doing sundry duties. But I had no choice to make a living for two meals. (Uncle Li)

While Uncle Liang and Uncle Li complained that in spite of hard work they could not earn enough to eat properly, Uncle Guan added that there was on enjoyment of life either:

There was no any fun and happiness under that circumstance. I hardly found any happiness in life. I couldn’t recall any happiness. I even couldn’t go to watch movies. I never had a chance to theatre… There was not enough food by doing a hard job. I worked so much and so hard that I wanted to eat more. The food supply at that time was limited to let me absorb enough energy. All the fish and meat needed coupon to attain. They requested coupon for everything, such as cloth, fish and oil. It was a difficult time. It was very hard. (Uncle Guan)

As illustrated by these gentlemen, they attributed the hard labour they endured to destroying their bodily health, and the life-long poor nourishment caused later physical pain and health problems, such as limited mobility and chronic joint pain, as reported in previous themes in Chapter 6. In turn, these past events and their consequences led to
their negative thinking. For these gentlemen, hard labour with low reward placed them in a state of poverty. Poverty gave them no opportunity and allowed them no time to cultivate friendships and invest in social networks. It also contributed to the poor relationships with their family, reported in previous themes in Chapter 7, contributing to their negative thinking patterns.

**Being Fatherless**

The theme “being fatherless” captured the consequences of both the emotional impacts of their father’s death and the economic consequences in the participants. A third of participants (10 of 31), all in Group A, mentioned that he/she had lost their father early in childhood. With the consequences of this loss being extreme poverty, a weak social foundation, and a low social position occupied by their family, the participants described their lives in these terms: “life-long hard working”, “difficult life”, “fragmented family”, “being tragic”, “life-long unhappy” and “humiliation”.

This was illustrated in the recollections of Madam Wang, an old woman who had lost her father early in life and had to work hard for a living since her early childhood. In the telling of her story she identified numerous consequences of her father’s death, including lack of education, hard labour but low income, and poor access to jobs, which resulted in her life-long unhappiness:

> I lost my father as a child as well as losing the opportunity of education. I never went to school… My mother sold fishes and my older brother helped her to deliver fishes from place to place after school. That was how we survived, by selling fishes for poor income. It was such a misery. What we earned was hardly enough for two meals… The situation at that time was bad for people like me who had a poor family background. I couldn't find a job. It was very hard for me to find a job… I had never been happy since childhood. (Madam Wang)

While Madam Wang’s account highlighted the trilogy of no education, poverty and hunger, Uncle Wang (no relation to Madam Wang) described similar experiences, because being fatherless also resulted in lifelong hard labour marked by hunger:
I lost my father when I was seven years old. He died of hunger. Life was tough at that time... I started to work when I was 13 years old. I did washing dishes and housekeeping to earn a living. I had been through really difficult years... We couldn’t have enough food even porridge. I had only one sister who was sold to other family. She was sold in exchange of 13 barrels of rice. (Uncle Wang)

Poverty in Uncle Wang’s case was so severe that his sister was sold to make ends meet; his small family was fragmented. Uncle Wu also talked about a broken-up family after his father died:

I had nine sisters. It was useless for me. They were all useless. Those sisters never took care of me. I was only five years old at that time. So what was the use to have so many sisters? My sisters ignored me at that time. They ignored me and cared nothing about me. I went to my own ways. Some of them were busy with marriage so how could they care about me? I was not welcome when I visited them. I just didn’t know where I had offended them ever. (Uncle Wu)

In the case of Uncle Wu, in Chinese culture a boy child was preferred to a girl, and it might seem surprising why a sister did not care for him. Because after marriage girls went to live in the husband’s household, it was not usual for them to bring with them a sibling not of the husband’s family, and moreover, to care for the brother could jeopardise their chances of a good marriage. His sisters’ unwelcoming response to his visits reflected that nobody wanted to take the responsibility if too many persons were involved into one task (三個和尚沒水喝).

In addition to the consequences of hard living captured above, Madam Wang complained about a lack of respect, discrimination and bullying from others, after her father’s death:

We were looked down upon all the time because of our poor situation. I had been going through discrimination for so many years because I was not a rich person with better social class... Can you imagine the environment for us to grow up, my mother raised us up by her own and other people humiliated us from time to time... No one ever
respected our family, a widow and 3 children without a stable income.

(Madam Wang)

Such was the pain associated with their lives following the loss of a father, it was clear that the entire lives of affected participants were blighted to the extent that both Madam Wang and Uncle Wang found it difficult to speak of these events:

I had been in tragic for years. I was so miserable… It was painful to speak out what I had been suffering. (Madam Wang)

It was so miserable to think about that. I did not want to talk of these… That was poor people’s reality. (Uncle Wang)

In the presence of such pain, a strategy was to avoid speaking of one’s past. Suffering thus became private, but constantly present. One reason for such suffering after losing a father was related to the social and economic consequences. In Chinese hierarchical family structure the father was the head of the family, held the power and was expected to take responsibility for the care of the whole family (家長制). As illustrated in these accounts, the consequences of being fatherless were poverty, a reliance on hard labour to survive which was attributed to causing their later physical health problems, no opportunities of education leading to illiteracy, no time to cultivate friendships and invest in social activities, and a fragmented family with poor relationships, and discrimination by others. In the case of participants, the effects were lifelong and went on to affect the next generation. Reported in previous themes in Chapter 6 and Chapter 7, all of these factors appeared to be contributing to their negative thinking.

**Having a Bad Marriage**

The theme “having a bad marriage” reflected poor marriage experiences and the impacts on the participants. Some participants (9 of 31), all old women, suffered from a bad marriage, which was a “stigma” or “shame” in itself and for the spouse and her family. They felt unloved and, with no support from a spouse, they needed to support themselves and their families through hard labour.

An example was Madam Tan, an 83-year-old widowed woman who twice experienced unhappy marriages. Her first husband died after just two years’ marriage:
My whole life was a tragedy. I got married at 16 and my husband died when I was 18. He was suffering a mysterious disease that was about superstitious affairs. They said he was not supported by the God because he lacked of energetic strength. He died once he got up that day. He died while he said hurting. He just died without a word left… You could see, how miserable. I became a widow after being married for two years. (Madam Tan)

Madam Tan was not only bereaved; she was also stigmatised because in Chinese traditional culture it was believed she was responsible for bringing bad fate to her husband, causing him die early (剋夫). Madam Jing, an 84-year-old divorced woman, also suffered from being stigmatised, in this case because she was divorced from her husband:

My husband had gone long time ago. We left each other for long time. We divorced when I gave birth to my son because my husband got married again. My husband stayed with me while he had a wife already in Cambodia. So he came back to his wife when my son was only one year old. I had no choice at that time. He married the wife earlier than me so I couldn’t change this fact. (Madam Jing)

For Madam Jing, the stigma had a life-long impact on her and her son. Even after he grew up, he was ashamed to live with his mother and neglected her, as was mentioned in the previous chapter. In the case of Madam Tan, she married again but it was a bad marriage and loveless; her second husband, was a drug addict and was cold to her:

I just spent some tough years until I was twenty two when I married again. My husband was not good. He was having heroin. He used to be cold to me. He was indifferent to whatever I did. He didn’t care whether I ate well or not. He never cared much about me what I served him well or not. (Madam Tan)

While Madam Tan experienced unhappy marriages twice, in the case of Madam Xie, an 81-year-old widowed woman, her bad marriage arose from being sold as a “pig” to be a wife in the mainland because there was no food and no social support, when the Japanese army attacked Hong Kong six decades previously:
I was sold to Zhanjiang (a mainland city hundreds of kilometres distance from Macau) as a pig for $30. I was sold there as a young wife. I didn’t know him… I married him just tried to survive because I was penniless and hungry. I had no choice but marrying a stranger because I didn’t have any relatives or friends who could help me out of poor situation. I couldn’t find a job in Macau to survive even if Macau didn’t get attack by the Japanese. (Madam Xie)

For Madam Xie, the marriage entailed moving from the town to the country, to a place with a different dialect. Her bad marriage experiences resulted also from difficulty in communicating and from doing heavy manual labour:

I was crying all the time from morning when I woke up till the sun set because I was in the poor situation. I couldn’t understand what they were speaking in local language and neither could I get used to the village life which were far from Macau… I was fighting hard to survive so I worked as a porter to carry cargos. (Madam Xie)

The appropriateness of interpersonal relationships between a wife and her husband was largely determined by the Confucianism in Chinese society (Hwang, 1978). Marriage was certainly the priority and most critical issue for a Chinese, especially for a woman. She should follow her husband all the life after her marriage, whether or not her husband was good to her (嫁雞隨雞, 嫁狗隨狗). As illustrated in those accounts, a bad marriage described by those women as tragedy, stigma, loveless and the associated consequences of poverty and hard labour, placed the participants in a position lacking emotional and financial support from their spouse and poor relationships with their family.

**Trauma from Wars and Revolutions**

China suffered badly from extreme social and political upheavals in the mid 20th century, including the Japanese army invasion from 1937 to 1945, and the Chinese Civil War between the Chinese Communist Party and the Nationalist Party from 1945 to 1949. Chinese people couldn’t live in peace. China then experienced a politically turbulent period from 1950s to 1970s, including the Great Leap Forward from 1958 to 1960 that
caused millions of people to die of hunger, and the Cultural Revolution from 1966 to 1976 that was a political and economical disaster affecting the entire Chinese population in the mainland. Many participants (13 of 31), all in Group A, told of their terrible experiences related to the wars and revolutions. The historical disasters that they suffered had ongoing impacts on their lives, causing trauma both physically and psychologically.

Several participants talked about the horror of witnessing widespread death from starvation and war. One example was Uncle Guan, a single gentleman in his 70s, who was constantly haunted by the terrifying and shocking images that took place when the Japanese army attacked the place in the mainland where he lived:

Many people died of hunger because of the war. There were dead bodies all over the street. There were thousands of kids lying in the street whose belly exposed outside with nobody’s attention. I didn’t know if they lacked nutrition or it was a certain disease. Anus was similar to large intestine which were exposed to outside. There were hundreds of children died in the street. They all died of hunger. (Uncle Guan)

Madam Xie recounted similar images that took place in Macau when the Japanese army attacked Hong Kong six decades previously:

The rubbish truck went around the streets to pick up corpses lying everywhere. They carried the bodies to Coloane Island’s (one island of Macau) big pit to bury. We didn’t find rice to eat so we ate the beans and other vegetables which couldn’t support our basic nutrition needs so everyone was swollen. So many people fainted on the street for extremely hunger. It was such a sad image. (Madam Xie)

Likewise, Uncle Pan who witnessed many bodies of people who died of hunger during the Great Leap Forward, and Madam Huang who was shocked to witness numerous bleeding bodies in the Civil War between the Chinese Communist Party and the Nationalist Party 50 years previously:

Life during the Great Leap Forward was tragic. There were many
people died of hunger in 1960s during the period China return the debt to the Soviet Union. Moreover, there was three years’ climate disaster causing poor harvest to worsen the situation. (Uncle Pan)

The Communist Party killed many compatriots of the Nationalist Party at that time. There were numerous bleeding bodies lying on the ground. (Madam Huang)

In the case of two participants, atrocities directly affected them or their loved ones. Then a communist, Uncle Wang was punished physically and emotionally, almost to the point of death, with unwarranted accusations during the Cultural Revolution:

The Red Militia charged me with whatever criminal name they liked and sentenced to death without any evidences in the Cultural Revolution. The Red Militia sued me for unwarranted charges as bribery and capitalised tendency which were serious crimes in the Cultural Revolution. There were many faithful communists died by involving into the unwarranted injustice cases... I was punished to semi-death almost at that time. The situation was a mess and everyone was trying to hurt each other. They just wanted you to lie down on ground. (Uncle Wang)

To make matters worse, Uncle Wang was so sad that his suffering in the Cultural Revolution was caused by his wife, who betrayed him and was divorced from him during the Cultural Revolution:

My wife revealed to others to let me involve into endless punishment. I was divorced during the Cultural Revolution… It was a serious situation that everyone fought against each other. I was so sad that I wished to die. (Uncle Wang)

Madam Huang told of her suffering after she lost her husband, her only son and one daughter in the Civil War 50 years previously:

My husband was shot by the Communist Party. My son saw his father got killed so he was so scared of the scene when the Communist Party soldiers shot my husband. We tried to have my son treated without
success so he died… I used to have another daughter when my husband got killed. But I gave her to other family at that time as it was too cruel reality for me to face at that time so I would rather send her out. (Madam Huang)

Uncle Wang suffered psychologically and physically through the experience of being accused in the Cultural Revolution and betrayed by his wife and family. In the case of Uncle Pan, a 72-year-old gentleman, it was severe hunger during the Great Leap Forward that affected him traumatically:

I worked very hard to support life. I had to carry big and heavy trees. After that, I still needed to feed the pigs by picking vegetables and boiled it. The vegetables I boiled for pigs were also my dish. I was not able to continue the heavy work like that. (Uncle Pan)

Madam Xie, an 81-year-old widowed woman, gave this account of her family being broken up and scattered when the Japanese army attacked Hong Kong:

I was about 16 or 17 years old when the Japanese bombed Hong Kong. Macau was not bombed at that time. We had five sisters and we were sold to other families. I was sold to China alone. I had a younger brother who was adopted in Hong Kong and an elder brother who had joined the army in China. (Madam Xie)

Having suffered severely as a result of political events, both Uncle Wang and Madam Huang saw death as the way out of their present suffering. And as Madam Huang indicated, suffering had been unrelenting since those traumatic events half a century before:

It was miserable. I had been going through all kinds of sufferings during past years but I was still a lonely old person nowadays. I just hope to quickly close eyes. (Madam Huang)

Participants suffered from witnessing and experiencing horrific events. For some the horrors were compounded by guilt. For example, Madam Xie was sad that she could not stay with her parents when they died, which was a worst example of failing in filial
piety in Chinese Confucianism culture that no child was with their parents at the final moment when they died:

My parents died of hunger. I didn’t see them when they died. I did not want to talk about it. (Madam Xie)

A number of participants’ stories indicated that the trauma and pain were branded deeply into their mind. A number said they did not want to talk about those events. They spoke of their tragedy, their misery, and of seeing death as the way to end their suffering.

As illustrated in these accounts, wars and revolutions resulted in the scattering of families, loss of loved ones, continued poor family relationships, being widowed or living alone, all issues reported in the previous chapter, and acknowledged by participants as contributing to their negative thinking. Furthermore, the poor living circumstances resulted from wars and revolutions led them to be impoverished and although they worked hard and struggled for living, they never had enough. The humiliation of being invaded and witnessing bodies shocked these participants causing lasting psychological damage and making participants vulnerable to depression. Finally, as illustrated in these accounts, injustice, and being treated by inhuman way, impacted strongly and lastingy on their soul and psyche, as well as their physical health, causing their negative thinking.

**Discussion of the Lives They Have Lived and Depression**

The qualitative and quantitative findings had revealed that the participants with the poorest mental and physical health and highest depression scores suffered very hard lives from early in their lives, impacting adversely on their thinking and appearing to contribute to their depression they were found to suffer.

These traumatic experiences from wars and revolutions were extremely bitter and brutal for these participants, and not surprisingly were related to depression. One possible explanation could lie in the evidence showing that early life stress led to persistent neurobiologic adaptations, many of which intriguingly resembled neurobiologic findings in depression (Heim, Plotsky, & Nemeroff, 2004). Indeed, it had been suggested that the influence of early stress and emotional trauma on later well-being
might be mediated by the substantial plasticity of the child’s central nervous system, in particular in regions that regulated stress and emotional processing. Most empirical evidence concentrated on the altered activity of the hypothalamic-pituitary-adrenal axis that was associated with early adversities (Bremner & Vermetten, 2001; Carpenter, Tyrka, & McDougle, 2004; Heim & Nemeroff, 2001; Rinne, Kloet, & Wouters, 2002). A further possible explanation stressed the cognitive perspective on attachment. A lack of control had the potential to distort the child’s relational schemas and to lead to generalised vulnerability when confronting subsequent life adversities (Van & Riksen, 2004). One study found that the loss of a father resulted in a higher risk of developing depression, implying that the loss of father might in and of itself create increased vulnerability for depression (Blair, 2000). In the case of these participants of the present study who had lost a father, cognitive impacts were compounded by the impoverished and inferior position in society they subsequently occupied.

The participants in the present study lived through great upheavals during China’s transition into the 20th century, including: the Chinese bourgeois democratic revolution of 1911 led by Dr. Sun Yat-sen which overthrew the Qing imperial dynasty; the Japanese army invasion from 1937 to 1945; the Chinese Civil War between the Chinese Communist Party and the Nationalist Party from 1945 to 1949; the Great Leaps Forward movement causing millions of people to die of hunger from 1958 to 1960; and the Cultural Revolution that was a political and economical disaster affecting all the Chinese in the mainland from 1966 to 1976. Moreover, the participants in the present study suffered from negative personal life events, such as hard labour with low reward, the loss of the father, and having a bad marriage. All the poor personal experiences that the participants suffered had persisted, were painful to talk about, and likely to have led to their negative mental state as depression. A similar study showed that people's early negative life experiences affected their worldviews and development of adaptive resources (Sutker, Allain, & Winstead, 1993). Exploring the diversity in the social and historical contexts that today's cohort of Asian American and Asian immigrant older persons experienced, these authors suggested that an understanding of significant life course events were essential in understanding their social reality and personal struggles with ageing. Each group of Asian immigrant older persons might have been through war-related trauma or political turmoil in their early lives. These negative life experiences might become painful memories, especially if they had hardship, regrets,
accumulated stresses, unresolved family conflicts or even loss of loved ones (Mui, 1996; Mui et al., 2001). History of exposure to traumatic past life events, such as wars, disasters, loss of a loved one, intimidation, abuse and starvation, was reported to play an important and consistent role in predicting depression (Kuwert, Spitzer, Trader, Freyberger, & Ermann, 2007). The findings suggested that continued or repeated exposure to stressful past life events might deplete an individual’s general capacity to cope successfully or to recover from an earlier stressor. Past trauma might result in persistent feelings of vulnerability. Cumulative exposure to serious past life stressors and trauma was associated with increasing rates of depression (B. L. Green et al., 2000).

Summary

This mixed method study generated the final dominant category, the lives they have lived. This referred to the themes of hard labour with low reward, being fatherless, having a bad marriage, trauma from wars and revolutions. Experiencing hardship from their early in life, the participants lost opportunity to invest socially, psychologically, emotionally, economically, and in health. Stresses of old age that commonly emerged were thus more severe, with participants lacking the capacity to cushion such stresses. The analysis reported in this chapter, with its focus on very negative early life events, found a statistically significant relationship with poor mental and physical health and with depression; suggesting these phenomena were linked.

The lived experiences of older persons with depression in Macau, which were clustered into the four dominant categories: negative thinking, physical limitations and complaints, present living conditions and social support, and the lives they have lived, had been elaborated upon and discussed in detail in the previous chapters. In addition, these four dominant categories that dominated the everyday experiences of these older persons interacted and were compounded with consequences for the health and well-being of these older persons. The following chapter proposed an explanatory framework, based on the findings of four dominant categories to understand depression among Chinese older persons in Macau, which postulated the relationships between depressed mood and older person’s present and past lives.
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

The previous four chapters reported and discussed in detail the four dominant categories: negative thinking; physical limitations and complaints; present living conditions and social support; and the lives they have lived. This chapter drew from these dominant categories and the themes making up each category, to propose three meta-categories: physical/material meta-category; social/family meta-category; and mental suffering meta-category. As in previous chapters, firstly, a brief summary of literature related to older persons with depression was provided as a context to aid understanding of the phenomenon of depression in older persons. The key findings of the study, the four dominant categories and the themes comprising each of those dominant categories, were then summarised. Building on the dominant categories reported in previous chapters, an explanatory framework was then constructed, based on the medical and socioeconomic factors related to depression, as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression in older persons in Macau.

Older Persons with Depression

Biological changes associated with ageing and genetic predisposition (C. Walker, 2008), health problems and physical disabilities (Rovner & Casten, 2002), cognitive and behavioural perspectives and losses (A. T. Beck, 1976; Whybrow, 1997), and socioeconomic status (Payne, 2006; Wilton, 2003) were all factors that had been found to contribute significantly to the development of depression in older persons. Depressive symptoms in older persons were complex and might arise from several intersecting situations and conditions including: biologic changes of age, sleep cycle changes, neurotransmitter reduction, and alteration in neuroendocrine substances. Older persons were thought to be more vulnerable to depression because of the reduced production of mood-controlling neurotransmitters (Carpenter et al., 2004). The
helplessness of observing one’s slowly deteriorating physical capacities was also depressing.

Depression had been described as the commonest psychological problem among older persons affecting 10 percent to 15 percent of the population over 65 in the UK (Chen & Jiang, 2000; Ebersole & Hess, 2001; Lueckenotte, 2000). Similar rates of depression had been found in community-dwelling older persons in Macau (Macau Social Welfare Bureau, 2006; Ning, 2001), however, rates as high as 53.1 percent had been reported in those older persons attending day centres (D. D. Li et al., 2003). Improving mental health was a target of the health policy initiatives, ‘Healthy City’ (Macau Health Bureau, 2004) and more recently the ‘Quality of Life of Resident’ (Macau Government, 2005). Nurses had responsibility for taking care of older persons with depression in various settings including hospitals, day centres for the elderly, and residents in community. For nurses, identifying and managing the depression of older persons might help to accelerate recovery and improve quality of life.

Numerous initiatives had been developed to promote preventive and protective measures for depression in older persons (Alexopoulos et al., 2003; Arean & Cook, 2002; Laidlaw, 2001; Lynch et al., 2003; Mather et al., 2002; Reynolds et al., 1999; Serrano et al., 2004). Although the conclusions drawn from such work were invaluable, minimal data had been obtained about the effectiveness of depression-associated interventions in Chinese populations, and this included older persons with depression in Macau. In order to develop appropriate preventative and protective interventions for Macau’s older persons, and to inform future therapeutic interventions, it was necessary to better understand Macau’s older persons’ lives and the factors that contributed to sustaining dysphoria.

**Lived Experiences of Older Persons with Depression in Macau**

Chapter 5 to Chapter 8 reported the four dominant categories of negative thinking, physical limitations and complaints, present living conditions and social support, and the lives they have lived. The relationships among the four dominant categories and themes are illustrated in Figure 9.1, presented as a symbol of a damaging flame. The older persons with depression appeared to be deeply “burned”, reflecting a Chinese saying that suffering was like being “burned by hot flame and sunk by deep sea” (水深火
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

They were burned by negative thinking, physical limitations and complaints, present living conditions and social support, and the lives they have lived. The inner layer of the lived experiences was their negative thinking. The outer layers were the lives they have lived, reflecting the impact from their past lives and personal histories, and impacts from the present including present living conditions and social support, and physical limitations and complaints. These four dominant categories and themes interacted with, and were compounded by, other categories and themes, with the result that the older persons were stuck in a negative cycle with no way out.

Negative thinking was central to the lived experiences of the older persons with depression in Macau. They held negative views of themselves and were more likely to interpret their ongoing experiences in a negative way. They also had negative views of the future. One participant captured this by describing herself as a “Three-Wait-Citizen” (三等公民). “Three-Wait-Citizen” sounded like “third class citizen” in Cantonese, capturing vividly the strong negative feeling, arising from loss of health, poor living conditions and social support, as well as the hard lives they have lived. The dominant category “negative thinking” reflected four themes: feeling useless, hopelessness, sadness, and helplessness. These themes resulted from both the past (the lives they have lived), and the present (present living conditions and social support, and physical limitations and complaints). For some, the present feelings of uselessness were related to former values and aims in life: desires of achieving financial independence, being important to and loved by significant others (lovers, husband). In addition, being physically and financially a burden on others strengthened the feeling of uselessness. Uselessness was also related to hardship, poverty, lack of positive relationships.

Sadness was, for some, a constant companion following a particular traumatic event that occurred in the past; for others, it arose from a more recent event which robbed them of purpose, role or relationship. Hopelessness was expressed as a desire to die soon. Continuing to live was linked to ongoing pain and suffering. Furthermore, they were helpless in the face of events affecting them — being struck down by diseases, suffering ill health, being caught up in war, losing a loved one in that war. Some believed their present circumstances were their fate. Thus helplessness also captured the non-material spiritual beliefs many held, referred to as ‘fate’, or ‘destiny’.
Figure 9.1 Relationships among Four Dominant Categories and Themes
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

Physical limitations and complaints contributed to their negative thinking patterns of the participants. The theme “limited mobility” reflected the comments related to disabilities that frequently disturbed older persons. The theme “dependence on others” reflected the finding that the older persons could not perform their activities of daily living independently and had to seek help from others, some of which were unavailable when needed. The theme “chronic joint pain” referred to physical body pain, which many attributed to life-long hard labour. Chronic joint pain seemed endless and unrelenting, damaged their mobility and sleep, and affected their body and emotion adversely.

Participants described a range of wider impacts of physical complaints that further eroded enjoyment of life. Their suffering was aggravated by insomnia, and they could not regain a moment of blessed release. Loss of appetite, resulting from poor physical health, side-effects of treatment, poor experiences and negative thinking, was associated with a serious condition close to death. Loss of memory, an essential cognitive function, affected the participants in the carrying out of the daily tasks of living, deepening their feelings of depression. The theme “complex medication regimens” focused on the influences of taking drugs for their physical disorders, which produced unpleasant physical side effects or negative perceptions. Difficulties in getting to hospital were obvious barriers that blocking the participants in accessing the free medical service offered by the Macau Government.

Present living conditions and social support emerged as a significant factor to the lived experiences of the older persons with depression in Macau. The theme “being poor” reflected how the participants fought for day to day living and struggled to survive. An older person could not access to employment with better pay when he/she was illiterate, feeling ashamed and foolish. Moreover, these older persons had to bear the injustice coming from the unfair social regulations and policies in terms of the old age subsidy, old age pension and social housing offered by the Macau Government.

The next set of themes in this dominant category reflected family relationships. The theme “being widowed” reflected the complex emotional reactions and impacts of the participants since their spouses died earlier. In Chinese traditional concept, becoming widowed was considered as one of the most disadvantageous situations for a woman, which meant she immediately lost the financial support without any income or inheritance, especially when she still needed to raise children alone. Living alone was
the result, contrary to their desires, because of their broken family or impoverished circumstances. The theme “conflict with adult children” captured the poor relationships between the two generations. Intergenerational conflicts would lessen family support and contribute to the depression. Being neglected by their children, the participants were not able to get tangible or emotional support from their family members. The extreme impoverishment and poor personal experiences of being fatherless and widowed had placed the participants in a position of discrimination, compounding their negative thinking. The intense words such as bully, blame, and humiliation were adopted to express their hatred against discrimination. Lack of social contact resulting from limited mobility and extreme impoverishment, and without support from friends, relatives and community, created a social distance to deepen difficulties of the affected participants.

Participants also attributed their negative thinking to mental trauma experienced during their lives, in terms of engaging in hard labour with low reward, being fatherless, having a bad marriage, experiencing trauma from wars and revolutions. The hard labour that they suffered had harmed their health. Low reward in spite of constant hard labour placed them in a situation of constant poverty, allowing them no opportunity to cultivate friendships and invest in social networks, hence contributing to the poor relationships with their family. Eventually all of these factors compounded to make them habitually think negatively. The consequences of being fatherless were multiple: becoming impoverished, relying on hard labour to survive (attributed as a cause of later physical health problems), no opportunities of education leading to their illiteracy, no time to cultivate friendships and invest in social activities, a fragmented family with poor relationships, and discrimination by others. Meanwhile, a bad marriage consequently, placed the participants in positions of little emotional and financial support from their spouse and poor relationships with their family, all of which contributed to their negative thinking.

Furthermore, poor living circumstances resulted from historical wars, leading them to be so impoverished that they had to work hard and struggled for a living, causing them to be depressed. Moreover, the traumatic experience of being invaded in war to witness horrible scenes of corpses shocked them lastingly and created permanent mental scar, rendering them vulnerable to depression. Finally, injustice and being treated in an inhuman way affected the participants heavily and lastingly, both on their soul and physical health, to cause their negative thinking. The real tragedy for these participants
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

was that, in their old age, they could not rely on the mental and physical “reserves”, which they should have accumulated in their earlier life. Furthermore, struggling to get basic needs of life and fighting for basic rights had intensified their stress.

In summary, the participants’ suffering from their present poor living conditions and social support, physical limitations and complaints, and the hard lives they have lived, had all contributed to habitual negative thinking patterns, making them vulnerable to depression. At the same time, depression and negative thinking led to them interpreting their present living conditions and social support, physical limitations and complaints, and the lives they have lived rather negatively. Consequences of the hard lives they have lived were that hardships had continued to the present, evident in their present poor living conditions, weak social support, physical limitations and complaints. Their present poor living conditions and social support also contributed to their physical limitations and complaints. In addition, their physical limitations and complaints worsened their living conditions and social support. These four dominant categories and themes interacted with and were compounded by other categories and themes, leading to their depression, giving the older persons no way out.

Table 9.1 summarises the presence of each theme for each of the participants. It showed that each participant suffered from the impacts of not just one or two themes, but numerous issues affected the lives of each participant. Only one was exempt from the effect of themes making up the category “present living conditions and social support”, only two did not complain of physical limitations and complaints, and only six did not raise themes related to hardship of past lives. Table 9.1 also suggests that the total number of factors identified by participants was not related to the severity of depression as indicated by the GDS-15 score, reflecting that apparently similar circumstances and experiences (physical illness, poverty, homeless, limited mobility, and past trauma etc.) did not necessarily affect participants equally and in the same way. Thus by unpacking holistically the lived experiences of the older persons with depression in Macau, it was clear that most participants demonstrated the compound and cumulative effects of multiple factors. The most frequently occurring factors the participants spoke of were being poor, being neglected by children, lack of social contact, limited mobility, cannot sleep, poor memory, complex medication regimens, difficulties in getting to hospital, hard labour and low reward, and trauma from wars and revolution. However these factors did not occur in isolation and an important finding to emerge from this
## Table 9.1 Compound & Cumulative Themes of Lived Experiences of Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>GDS²</th>
<th>Present living conditions and social support</th>
<th>Physical limitations and complaints</th>
<th>The lives they have lived</th>
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Notes: * = Selected  1 U.=Uncle  M.=Madam  2 GDS=Geriatric Depression Scale-15
3 a=Being poor  b=Being illiterate  c=Injustice  d=Being widowed  e=Living alone
f=Conflict with adult children  g=Being neglected by children
h=Being looked down upon by others  i=Lack of social contact
j=Limited mobility  k=Dependence on others  l=Chronic joint pain  m=Cannot sleep
n=Poor appetite  o=Poor memory  p=Complex medication regimens
q=Difficulties in getting to hospital  r=Hard labour, low reward
s=Being fatherless  t=Having a bad marriage  u=Trauma from wars and revolutions
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

study was that the cumulative effect and compounding impacts helped us understand more fully the plight of these older persons.

An Understanding of Depression in Older Persons in Macau

By documenting, describing, and interpreting the lived experiences of older persons with depression in Macau, the phenomenon of depression in older persons in Macau can be better understood. Based on the findings, it becomes apparent that the root of this depression lies in social, family, and day-to-day living issues. Three meta-categories emerge, and are now elaborated on. These are drawn from the dominant categories and themes reflected across the findings in Chapters 5 to Chapter 8 and illuminate the complex phenomenon of depression among older persons in Macau:

- Physical/material meta-category: this meta-category is mapped against the dominant category of physical limitations and complaints (see Chapter 6), the dominant category of present living conditions and social support (see Chapter 7), and the dominant category of the lives they have lived (see Chapter 8);

- Social/family meta-category: the second meta-category is mapped against the dominant category of present living conditions and social support (see Chapter 7) and the dominant category of the lives they have lived (see Chapter 8);

- Mental suffering meta-category: the final meta-category is mapped against the dominant category of negative thinking (see Chapter 5) and the dominant category of the lives they have lived (see Chapter 8).

Physical/material meta-category refers to the sufferings of being poor, hard labour, being illiterate, limited mobility, dependence on others, chronic joint pain, cannot sleep, poor appetite, poor memory, complex medication regimens, and difficulties in getting to hospital. Being poor reflects how the older persons with depression fight for day to day living and struggle to survive. The interaction between poverty and depression may be explained as follows: The situation of poverty in the first instance leads to a higher likelihood of having to rely on hard labour to survive. The hard labour that they suffered has destroyed their body. Secondly, life-long poor nourishment is attributed to directly causing later physical pain and health problems, such as limited mobility, chronic joint pain and subsequently, impacts of the treatment. Hard labour and privation allow them
no time or energy to cultivate friendships and invest in social networks, and also contribute to poor relationship with their children and siblings. Under impoverished circumstances, there is no opportunity of an education for themselves or their children, leading to personal illiteracy and inter-generational illiteracy which further limit their intellectual capability. All the issues comprise a cycle leading to worsening social conditions and severely reduced opportunities to rise out of poverty. Being illiterate has a wide range of ramifications. An older person who is illiterate with no educational qualifications has few chances of accessing good jobs with higher pay. They are unable to participate in the knowledge society and feel ashamed and foolish. Being unable to access better paid employment, they and their children are unable to escape from the cycle of poverty. Participants feel guilty at having contributed to the plight of their children. Finally they are vulnerable to depression.

Limited mobility reflects the disabilities that frequently disturb the older persons. Consequently, this leads to an unwelcome need to depend on others. Dependence on others reflects that the older persons can not perform their activities of daily living independently and have to seek help from others, some of whom are unavailable when needed. Consequent to being dependent on others for activities of daily living, these older persons express their negative feelings in powerful terms such as guilt, demeaning. Chronic joint pain refers to physical body pain, which many attribute to life-long hard labour. Chronic joint pain seems endless and unrelenting, damages their mobility and sleep, and affects their body and emotion adversely. The issue with insomnia is that suffering is aggravated, and they are deprived even of the blessed release that a period of unconsciousness can provide. While insomnia may be a symptom of the depression they suffered, its impact is that it makes the persons feel “faint”, ”exhausted”, or “confusing in mind” and deepens the feeling of depression. Loss of appetite, resulting from their poor physical health, side-effects of treatment, poor experiences and negative thinking, is associated, by these older persons with a serious condition close to death. Loss of memory, an essential cognitive function, affects the older persons in the carrying out of the daily tasks of living, deepening their feelings of depression. Complex medication regimens focus on the influences of taking drugs for their physical disorders, which produce unpleasant physical side effects or negative perceptions. Difficulties in getting to hospital are obvious barriers to the older persons in accessing the free medical service offered by the Macau Government, which for most is the only
way for them to attain needed medical treatment. In addition, being extremely impoverished and neglected by their children, they are forced to deal with the difficulties related to physical access alone, even when they are severely compromised in their ability to travel there. They have to wait and wait again, powerless to change the situation. Taken together, the physical/material meta-category captures the relationship between life-long hardship and bio-psycho-social-cultural disability, which in turn lay as the root of their negative thinking.

Social/family meta-category consists of being looked down on, lack of social contact, injustice, conflict with adult children, being neglected by children, being widowed, living alone, being fatherless, and having a bad marriage. Being looked down on is described in powerful terms including bully, blame, and humiliation. Also reflected in this is that the older persons suffer from extreme impoverishment and poor personal experiences of being fatherless and widowed have placed them in a position of discrimination, compounding their negative thinking. Lack of social contact resulting from limited mobility and extreme impoverishment, and without support from friends, relatives and community, create a social distance to deepen difficulties of the affected older persons. Injustice arises from unfair social regulations or unfair application of policy and social support in terms of the old age subsidy, old age pension and social housing offered by the Macau Government to aid the impoverished older persons for their basic life needs. The unfair regulations and powerful bureaucracy exacerbate their suffering, making it more difficult to get basic needs of life, pushing some individuals to extreme levels of despair. For these older persons, injustice exacerbates their perceptions of helplessness and powerlessness, which are strongly linked to their depression.

Being widowed reflects the complex emotional reactions and impacts of the participants since their spouses died earlier. It is regarded as a terrible disaster if a woman becomes widowed, especially when she will need to raise children without any income or inheritance. Living alone is the result, contrary to their desires, because of their broken family or impoverished circumstances. Reflected in this is that the older persons feel they have absolutely no control over the situation that lay at the root of negative thinking. Conflict with adult children captures the poor relationships between the two generations, especially that of an older woman and her daughter-in-law (婆媳關係).
Intergenerational conflicts will lessen the family support and contribute to depression. Being neglected by their children, the older persons are not able to get tangible or emotional support from their family members. For the older persons, care and support from their children are still indispensable to them, not only in a financial sense but also in the psychological aspect. Without support, they unavoidably suffer from sadness and depression.

The consequences of being fatherless are multiple: becoming impoverished, relying on hard labour to survive (attributes as a cause of later physical health problems), no opportunities of education leading to their illiteracy, no time to cultivate friendships and invest in social activities, a fragmented family with poor relationships, and discrimination by others. All of these factors appear to be contributing to their negative thinking. Meanwhile, a bad marriage described as tragedy, stigma and loveless, and the consequences of resulting poverty and hard labour, places the older persons in a position of little emotional and financial support from their spouse and poor relationships with their family, to contribute to their negative thinking. All the above conditions compound severely, causing life-long hardship and bio-psycho-social-cultural disability, which in turn exacerbate their negative thinking.

Mental suffering meta-category consists of being despised, trauma from wars and revolutions, terror/fear, powerlessness, and no dignity. Wars result in the scattering of family, the loss of loved ones, and place them in a position of poor family relationships, being widowed or living alone, and these experiences combine to contribute to their negative thinking. Poor living circumstances result from historical wars, leading them to be so impoverished that they have to work hard and struggle for living, causing them to be depressed. Furthermore, the humiliation of being invaded in war to witness terrifying scenes of bodies shocks these older persons lastingly and creates permanent psychological damage, rendering older persons vulnerable to depression. Finally, as illustrated in these accounts, injustice, and being treated in an inhuman way, impact strongly and lastingly on their soul and psyche, as well as on their physical health, to cause their negative thinking. For these old persons, their entire lives have been marked by stress; now, in their old age, they don’t have the mental and physical “reserves” built up to draw from. Furthermore, stress is exacerbated by struggling to get the basic needs of life, fighting for basic rights, experiencing neglect. The powerlessness resulting from having absolutely no control over their poor physical/material conditions and limited
social/family relationships have resulted in their negative feelings of being despised and no dignity. In summary, the mental suffering meta-category causes their bio-psycho-social-cultural disability and life-long hardship, which in turn influences their negative thinking.

The explanatory framework to understand depression in older persons in Macau is outlined in Figure 9.2, which models the relationships among these three meta-categories, and describes several pathways through which the three meta-categories can contribute to depression in older persons in Macau. At the base of the model, each of the three meta-categories interacts with the others, in such a way that one meta-category both causes and also results from the other meta-categories. Physical/material meta-category of an older person, e.g. being poor and limited mobility, may directly produce the mental suffering meta-category, e.g. being despised and powerlessness, and also directly affect the social/family meta-category, e.g. lack of social contact and conflict with his/her adult children. At the same time, mental suffering meta-category, e.g. being despised and trauma from wars and revolutions, and social/family meta-category, e.g. being fatherless and being neglected by his/her children of an older person, in turn, may worsen the physical/material meta-category, e.g. hard labour and poor appetite. Furthermore, social/family meta-category of an older person, e.g. having a bad marriage and injustice, may influence the mental suffering meta-category, e.g. no dignity and powerlessness. On the other hand, mental suffering meta-category of an older person, e.g. trauma from wars and revolutions, in turn, may limit the social/family meta-category, e.g. being widowed and being fatherless.

The second level of the model demonstrates how the experiences arising from the three meta-categories adversely affect the older persons’ internal and external environments. Life-long hardship refers to their negative external environment from the past right through to the future, and bio-psycho-social-cultural disability sums up their negative internal environment. Life-long hardship and bio-psycho-social-cultural disability lay as the root of the negative thinking patterns of participants.

The third level of the model depicts how negative thinking mediates between the negative external and internal environments and depression in the older persons. Negative thinking is described by the older persons as uselessness; hopelessness; sadness; and helplessness (see Chapter 5). Finally, the consequences and impacts of
their negative thinking appear to feed and sustain depression among the older persons in Macau constantly.

Figure 9.2 Explanatory Framework to Understanding of Depression in Older Persons
Discussion of the Explanatory Framework to Understanding of Depression in Older Persons in Macau

The explanatory framework, which emerged from the findings of the present study to help and understand depression in older persons in Macau, models the relationships among the three meta-categories, physical/material meta-category, social/family meta-category, mental suffering meta-category, and describes several pathways through which the three meta-categories can affect depression in older persons in Macau.

Physical/material Meta-category and Depression

Physical/material meta-category refers to the sufferings of being poor, hard labour, being illiterate, limited mobility, dependence on others, chronic joint pain, cannot sleep, poor appetite, poor memory, complex medication regimens, and difficulties in getting to hospital. Low socio-economic status, e.g. poverty, was found to be associated with depression in older persons (Giblin et al., 2004). Education level and social class, in a random sample of 2032 in Brazil, a country that had also been colonised by Portuguese, were found to have negative correlations with depression; lower education level and poverty were associated with a higher depression level (Almeida-Filho et al., 2004). Disability and financial hardship were also found to predict depression among 235 older persons in the USA (P. F. Tsai, 2005).

Chou (2007) found that an older person who felt pain might subsequently become depressed, and that depressed older persons were more likely to develop pain symptoms. Depression had been demonstrated as an immediate consequence of pain in studies that had been examined prospectively (K. Chou & I. Chi, 2005b; Geerlings, Twisk, Beekman, Deeg, & Vantilburg, 2002). Some investigators had proposed a diathesis stress for understanding the development of depression among older persons with chronic pain (Dersh, Polatin, & Gatechel, 2002; Dworkin, Hetzel, & Banks, 1999). Furthermore, Tsai (2005) found that chronic joint pain had a direct impact on depression. In other words, these psychological characteristics might be activated because of the stress due to chronic pain, which might consequently lead to depression. Conversely, depression might in turn cause pain. This could potentially be mediated through the neurochemical imbalance of neurotransmitters (Bair, Robinson, & Katon, 2003; Fava, 2003) including serotonin, norepinephrine, and dopamine (Blackburn-
Chapter 9 Towards an Understanding of Depression in Older Persons in Macau

Munro & Blackburn-Munro, 2001). The chemical changes in serotonergic or noradrenergic function that occurred as a consequence of depression were believed to increase sensitivity to painful stimuli and thus render older persons more vulnerable to pain (Delgado, 2004). Depression might also reduce tolerance to aversive stimuli that cause pain (Meagher, Arnau, & Rhudy, 2001). The data supporting this direction of association were mixed (K. Chou & I. Chi, 2005b; Geerlings et al., 2002).

Social/family Meta-category and Depression

Social/family meta-category consists of being looked down on, lack of social contact, injustice, conflict with adult children, being neglected by children, being widowed, living alone, being fatherless, and having a bad marriage. The link between social isolation and reduced psychological well-being including depression was well established in sociology (Ostir et al., 2003). The structural aspects of social relationships, e.g. limited social networks, might operate via functional aspects of social relationships, e.g. perceived lack of support (Kawachi & Berkman, 2001). Social isolation was hypothesised to exacerbate responses to stressful events that were damaging to mental health. Isolation might thus act on several different points in the pathway between stressful events and eventual depression. First, the perceived unavailability of social contact or support and sense of isolation that might surface after a stressful event might lead to a worse appraisal of the situation, thereby exacerbating a cascade of ensuring negative emotional and behavioural responses (Kawachi & Berkman, 2001). Furthermore, perceived or received removal of support might either accelerate the negative emotional reaction to a stressful event or deepen the physiologic/behavioural responses to stress (Kamarck et al., 1990). Many life events traditionally conceptualised were actual breaks in social relationship, e.g. divorce or deaths of loved ones. On the other hand, social networks might influence the odds of experiencing a life event, e.g. loss of education. Certain stages of the life course were clearly critical in terms of social relationships. Thus, emotional support during childhood from parents had been shown to influence the risk of subsequent depression (Kaslow, Deering, & Racusin, 1994). At the opposite end of the life course, social isolation and loss of social relationships were among the most potent predictors of depressive symptoms among older persons (Oxman, Berkman, Kasl, Freeman, & Barrett, 1992). On the other hand, no social support received from children could
undermine self-esteem and lead to feelings of helplessness (Kawachi & Berkman, 2001). Impaired social support could contribute to a high level of disability or, conversely, could significantly reduce the level of disability secondary to late life depressions (Blazer, 1993).

Depression overall in older persons could be associated with the cumulative effects of life events, particularly those related to the death of persons close to them, e.g. being widowed or living alone (Kraaij & de Wilde, 2001). Depression was also associated with loss of a parent, marital difficulties, and being neglected by someone close (Brilman & Ormel, 2001). A bad marriage, e.g. divorced or widowed, was a very significant determinant of depression among 1983 Greek older persons (Verropoulou & Tsimbos, 2007).

**Mental Suffering Meta-category and Depression**

Mental suffering meta-category consists of being despised, trauma from wars and revolutions, terror/fear, powerlessness, and no dignity. Depression in old persons was found to be associated with feeling despised in a longitudinal study (Kivela, Kongs-Saviaro, & Laippala, 1996), and powerlessness (Licht-Strunk, van der Windt, van Marwijk, de Haan, & Beekman, 2007). Trauma from early life had consistently been associated with depression (Fuchs, 1999a). Fuchs (1994) hypothesised that the trauma of forced flight might have resulted in feelings of distrust, resentment and injustice, and similarly that stigmatising-discriminating conditions might have fostered a reserved and suspicious attitude towards the environment, leading to a lifetime of feeling like an outsider (Fuchs, 1999a). It was possible that these experiences might set the scene for the development of particular patterns of behaviour and interaction (Fuchs, 1999b).

Furthermore, a study supported the hypothesis that the Holocaust affected the lives of child survivors, even after more than 50 years, who displayed more depression than the carefully matched comparison subjects (Sagi-Schwartz et al., 2003). A research also demonstrated a dose-response relationship between trauma exposure two decades previously and the likelihood of a current depression (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Ageing World War II victims were at risk for long-term after-effects. The more war events that were reported, the higher was the risk for depression. This dose-response relationship was present even 50 years later (Bramsen & van der Ploeg, 1999). This was probably due to the fact that these people experienced years of
continuous and immense threat during which they lost many relatives and friends (Bramsen & van der Ploeg, 1999). Feeling of depression might be regarded as a response to the powerlessness experienced during the war (Carrol, Foy, Brook, & Zwier, 1991). A sense of depression might also be prevalent because the assumption that the world was benevolent, safe and meaningful (Janoff-Bulman, 1992) had been undermined, making it more difficult for the individual to trust other people and authorities. These survivors were now ageing, their social network would become smaller, resulting in a decreasing level of social resources and perhaps an increasing burden of care for those remaining in the social network (Port, Engdahl, & Frazier, 2001).

**Summary**

The chapter presented an explanatory framework based on the medical and socioeconomic factors related to depression as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression among Chinese older persons and examined the three meta-categories, physical/material meta-category, social/family meta-category, and mental suffering meta-category. These meta-categories reflected findings across Chapter 5 to Chapter 8, which referred to the four dominant categories and associated themes: negative thinking, physical limitations and complaints, present living conditions and social support, and the lives they have lived. The findings provided in this chapter indicate that the root of depression in older persons lies in the social, family, and day to day living issues. The explanatory framework, which emerged from the findings of this study, models the relationships among the three meta-categories and describes several pathways through which the three meta-categories can contribute to the development and maintenance of depression among Chinese older persons in Macau. Based on the explanatory framework, the phenomenon of depression among Chinese older persons in Macau can be better and comprehensively understood using a holistic approach. Arising from the findings of the present study, recommendations for health services for older persons in Macau, nursing education and practice, and a future research agenda would be discussed in the next and final chapter.


Chapter 10 Conclusions and Recommendations

Conclusions and Recommendations

Conclusions of the Study

In view of high depression rates among older persons in Macau, the study set out to answer the questions:

- What were the lived experiences of older persons with depression in Macau?
- What were the principal influences on depression among older persons in Macau?
- How could this information be used to inform health care, and nursing services in particular, to help prevent, detect and protect older persons from depression in Macau?

This study documented and interpreted the lived experiences of 31 older persons with depression in Macau. It has indentified the principal influences on depression among a sample of this population and constructed an explanatory framework based on the medical and socioeconomic factors related to depression as a basis to indicate possible risk factors for depression and inform the future development of interventions for depression among older persons in Macau.

By adopting mixed methods, using both qualitative and quantitative approaches, it has been possible to gain, for the first time, a deeper understanding of the nature and meaning of the negative feelings experienced by older persons with depression in Macau. The present study has advanced previous research describing depression among Chinese older persons. Furthermore, the mixed methods approach that has been utilised in the study allowed a wider and more complete picture to be captured and has produced a fully grounded interpretative research approach (Denzin, 1989). The approach increased the ability to interpret findings (Thrumond, 2001), and by adding to the body of knowledge on rates of depression, provided an improved understanding of the lived experiences of older persons with depression in Macau. The present study clustered the lived experiences of older persons with depression in Macau into four broad dominant categories:
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- Negative thinking;
- Physical limitations and complaints;
- Present living conditions and social support; and
- The lives they have lived.

The first dominant category, “negative thinking”, consisted of the following themes: feeling useless, hopelessness, sadness, and helplessness. The second dominant category, “physical limitations and complaints”, covered the following sub-categories: physical limitations including themes of limited mobility and dependence on others; physical complaints including themes of chronic joint pain, cannot sleep, poor appetite and poor memory; and impacts of medical treatments and access problems including themes of complex medication regimens and difficulties in getting to hospital. The third dominant category, “present living conditions and social support”, consisted of the following sub-categories: hardship including themes of being poor, being illiterate, and injustice; poor family relationships including themes of being widowed, living alone, conflict with adult children, and being neglected by children; and limited social network including themes of being looked down upon by others and lack of social contacts. The final dominant category, “the lives they have lived”, included the following themes: hard labour with low reward, being fatherless, having a bad marriage, and trauma from wars and revolutions.

The relationships among the four dominant categories were illustrated as a symbol of a damaging flame. The older persons with depression appeared to be deeply “burned”, reflecting a Chinese saying that suffering was like being “burned by hot flame and sunk by deep sea” (水深火熱). The older persons with depression were stuck in a negative cycle of negative thinking, physical limitations and complaints, poor present living conditions and weak social support, and painful past lives, with no way out. These four dominant categories were not independent, but interacted with and were compounded by other dominant categories. This was summed up by one participant as “Three-Wait-Citizen” (三等公民), a term that sounded similar to “third class citizen” in Cantonese, representing vividly the strong negative feeling of the older persons with depression in Macau, arising from their loss of health, poor living conditions and social support, and the hard lives they have lived.
Chapter 10 Conclusions and Recommendations

By documenting, describing, and interpreting the lived experiences of older persons with depression in Macau, the phenomenon can be better understood. The root of depression in older persons lies in their social, family, and day to day living issues. Three meta-categories, physical/material meta-category, social/family meta-category, and mental suffering meta-category, emerge from the findings of the present study. The explanatory framework to understand depression among these people models the relationships among the three meta-categories, and depression; each one interacts with the others, and thus one meta-category both causes and also results from others. The three meta-categories reveal that the experiences of the older persons lead to their life-long hardship and bio-psycho-social-cultural disability, which form the roots of their negative thinking. Negative thinking is described in powerful, negative terms by the older persons as feelings of uselessness, hopelessness, sadness, and helplessness. The consequences and impacts of their negative thinking appear to feed and sustain depression among the older persons in Macau.

**Recommendations for Health Services**

The findings of the study revealed the lived experiences of older persons with depression in Macau, the principal influences on depression, and these led to the development of an explanatory framework to understand depression among this population, each of which were summarised in Chapter 9. The findings have implications for health service as follows:

**To enhance and expand caregiver roles:** For older persons with depression in Macau, social connection is an important aspect to maintain their emotional and physical well-being. The more integrated into the community they are, the less likely are older persons to suffer emotional stress or physical illness. An important component of befriending services is to decrease social isolation and thereby minimise the incidence of loneliness, providing a preventative effort for potential depression. Befriending services are in a position to perform this as they provide an older person with a friend and confidante, which encourages a meaningful relationship. Befriending services aim to enhance, not replace, an older person’s network, warding off loneliness and enriching an older person’s life by becoming a friend or confidante and assisting them in daily life. Friendships which are reciprocal and intimate can become positive sources of emotional support and can help to buffer the effects of stress.
There are two types of befriending services currently available in Macau, day centres attendance and visiting by volunteer and these can be a basis for strengthening social support. Day centres offer an appropriate level of companionship at a group level and the benefits appear to be based more on the intellectual stimulation the centre provides to improve the development of communication skills with others, rather than emotional support (see Chapter 1 pages 17-18 for detailed description). However, for those older people who are housebound, either due to illness or disability, day centres are generally not a suitable option.

Service providers initiate the first enhancement of social support by appropriately matching older persons and befrienders. For improving the effectiveness of a befriending service, it is necessary to improve the match and support the relationship between volunteers and older persons. The relationship is encouraged to develop into a friendship through the amount and frequency of time spending in each other’s companionship. Service providers are integral in this process and initiate the friendship by thoughtful matching of volunteers and older persons. Appropriate matching allows users to form a friendship with their befriender and thereby attain the social support benefits of a friend, including the opportunity to share and discuss ideas to establish an emotional bond which may help overcome the stresses of life in older age. Knowing that someone will be around at a regular time, or available if they need assistance, can provide support for both older persons and their families. A greater sense of security can also develop if a befriender assists their client with activities or travel. Undertaking shopping or participating in walks can also encourage a positive attitude about the community and the knowledge of independence. Assistance with social activities can help older persons overcome the psychological impact of joining community based services when venturing out of home could be intimidating.

**Talk/cathartic therapy:** Noting the number of participants who said they had no one to talk to, there are two approaches available to ease the social isolation older persons find themselves in, and to give them the opportunity to talk. Conversation with others is an important part of social connectedness and socialising in older persons, which increases the chance to build up their interpersonal skills and self confidence. Close friendships, like those formed through one-on-one befriending, can encourage mental nourishment, due to increased stimulating conversation. The everyday chit-chat is important for an older person with depression. An older person will like caregivers to listen to his/her
Chapter 10 Conclusions and Recommendations

stories about their families and about managing life in the present, to identify where care and support can possibly be enhanced. This may also give older persons an opportunity to recall his/her past experiences, although for some this may be a painful activity. To pass on to a sympathetic and interested listener their intense past experiences may help them gain a perspective on their past lives, and also give meaning to their suffering.

Access to health care: Older persons do have the opportunity to choose the required health service according to their own situation. All the older persons in Macau are entitled to free medical service offered by Hospital Centre S. Januario. However, the hospital is located on the top of a hill where few buses pass by. The long waiting times (38 days) to get an appointment with a doctor, means that the older person with more urgent needs has to visit Kiang Wu Hospital or private doctors, located in the downtown city and thus more accessible and convenient, but also incurring high costs for services. Shortening the waiting time will make the access to health care easier for the older persons. Furthermore, more bus stops along the route of Hospital Centre S. Januario, or more public transport vehicles available in day centres will enable the older persons to get physical access to free medical service more conveniently. In addition consideration can be given to delivering ambulatory services in more conveniently located clinics. In the meantime, it will be helpful to provide specific subsidies for the medical treatment of medical conditions for the older persons in poverty, so that the older persons are truly able to choose the medical service they prefer.

Greater government generosity: The gambling and tourism sector in Macau continues to prosper amid a favourable external environment. The gambling and tourism sector have propelled Macau's GDP to reach MOP (Macau Pataca, Macau’s official currency) 44.17 billion (USD 5.52 billion) in the first quarter of 2008, with a real growth of 31.6 percent over the same period of last year. In 2007, the per-capita GDP of Macau hit MOP 292,200, which is equivalent to USD 36,357. The median monthly employment earning of residents amounted to MOP 10,000 (USD 1250). Therefore, Macau Government has the capability to improve the social welfare system to be more generous in supporting impoverished older persons by: increasing the amount of old age subsidy and old age pension to meet the basic living needs under the inflation; providing more social housing to families having eligible elderly member(s) and more public housing for older persons; by introducing a more flexible policy that will allow
him/her to stay continuously even if he/she gets married in later life. In this way, it will benefit the older person both psychologically and physiologically. The Government can also consider making exceptions to current policy regarding children supporting their parents when the children do not have the means to do so. Furthermore, to offer more subsidised education chances free of charge for older persons will help improve literacy levels. In particular, the day to day struggle of the older persons to make ends meet and simply survive will be eased, and may flow on to improved physical and mental health.

Decade of the older persons: To respect older persons (尊老) is a traditional moral value in Chinese culture. However, in recent years of rapid economic growth and social transition, traditional values in Macau, and Chinese society more generally, have been changing. For instance, nuclear families, in which family members are more independent have become much more widespread; and adult children may have less opportunity and be less well equipped to care for aged parents than in previous generations. The younger generations have tended to develop an outlook that is more self-centred. As a consequence, older persons may not be able to get the respect and support that they expected and are regarded as deserving from the younger generations. Therefore, with society undergoing such rapid social change, the recognition of older persons and its importance to maintaining their dignity becomes the responsibility of Macau society in general. The government, organisations, schools, media (including TV, radio, newspaper, and poster) all have a role in acknowledging older persons and their contribution to society. Meanwhile, positive relationships with family members, e.g. living together, should be better supported by not adding to familial stress through various policies, such as a more flexible social housing policy.

Advocacy services: The findings of this study, which indicated most of the older persons with depression in Macau suffered from limited mobility, chronic joint pain, poor memory, being poor, being illiterate, living alone, being neglected by their children, and lack of social contact, advocates a “one stop service”. Such a service will provide support and assistance at every level to older persons in Macau, from responding to a simple inquiry, assisting older persons in getting the support they need according to relevant services and policies, ensuring procedures are correctly and consistently followed to actually advocating for older persons. The “one stop service” should function closely with Macau Social Welfare Bureau and other organisations.
involved in the services for older persons in Macau, in order to assist in co-ordination, with reliable, sympathetic and consistent support for the older persons.

The intentions of the above recommendations are to reduce older persons’ present stress from mental suffering, physical problem, living conditions and social support. Furthermore, aiming to build dignity and give respect to older persons, across the whole of society will not only foster a harmonious society, but also meet the policy of improving ‘Quality of Life of Macau Resident’ addressed by the government (Macau Government, 2005). As noted Macau has the economic capacity to do more for its elder citizens, and can become a model for other Chinese societies in addressing emerging phenomena affecting older persons related to both past lives and the present rapid social change impacting on families’ capacity to support parents in their latter years.

**Recommendations for Nursing**

The findings of this study have several theoretical implications for nursing. Firstly, the findings make an important contribution to the body of nursing knowledge in relation to mental health of older persons, by providing detailed accounts of the lived experiences of older persons with depression and indentifying the principal influences on depression among old persons in Macau. The four dominant categories that emerged from the qualitative approach, “negative thinking”, “physical limitations and complaints”, “present living conditions and social support”, and “the lives they have lived”, enrich nursing knowledge of depression among Chinese older persons. Furthermore, this study constructs an explanatory framework through the three meta-categories, physical/material meta-category, social/family meta-category, mental suffering meta-category, which offers a more comprehensive understanding of depression among Chinese older persons in Macau, reflecting a holistic approach.

Secondly, the findings of the present study illuminate the conditions of these older persons with depression, in a way that other literature reviewed did not. These provide strong data indicating that depression in older persons has largely been medicalised, including in psychology, whereas the root of depression is seen to lie in their social, family, cultural and day to day living issues. A comprehensive view on depression among Chinese older persons should not remain at a conceptual level, but should apply to nursing practice. Therefore, in addition to addressing the negative thinking of
Chapter 10 Conclusions and Recommendations

Chinese older persons with depression, nursing should consider the broader social issues that affect older person’s health such as increasing their financial and social support, and reducing their loneliness and isolation. Thus interventions that may ease the suffering of older persons, not just focusing on interventions directed at negative thinking and depression, become the proper domain of holistic nursing practice.

Thirdly, the findings of the present study advance the current understanding and knowledge of depression among Chinese, especially Chinese older persons. In contrast to Kleinman’s findings that Chinese persons with depression tended to report distress in terms of somatisation, not mental distress, all the participants in the present study expressed their ongoing experiences in powerful terms of affect, including uselessness, tragedy, misery, pain, suffering, and unhappiness. This may be because the Chinese older persons in Macau represent a particular society, where there has been exchange between Chinese culture and western culture more than four hundred years, leading to them experiencing depression more cognitively. If this conclusion is correct, then the findings of this study have particular implications for the large Chinese populations in western countries. Therefore, in nursing teaching and practice, the cultural context of Chinese older persons should be considered and emphasised, especially during periods of rapid social and economic transition that may impacts strongly on older persons.

Finally, this study illustrates the strengths of mixed research methods for use in a practice discipline such as nursing. The quantitative approach yielded objective data, allowing measurement and description but not explanation; the scope of these quantitative findings was quite narrow in terms of interpreting the lived experiences of older persons with depression in Macau. On the other hand, the qualitative approach yielded subjective data that was limited in its generalisability. By using both qualitative and quantitative approaches, it has been possible to attain, for the first time, a deeper understanding of the nature and meaning of the negative feelings experienced by older persons with depression in Macau. The mixed methods therefore allow a wider and more complete picture to emerge, and produce a fully grounded interpretative research approach that increased the ability to interpret findings.
Chapter 10 Conclusions and Recommendations

**Future Research Agenda**

The present study provides a basis for further research into mental health of Chinese older persons. Firstly, the findings from this study can be used to inform the future development of an interventional programme for older persons with depression in Macau, and more generally, for Chinese older persons in different societies. This programme should address all three meta-categories (physical/material meta-category, social/family meta-category, mental suffering meta-category) that emerged from this study, and the resulting intervention should then be trialled in a subsequent study.

Secondly, the findings of the present study confirm that there is cultural context to the experiences of Chinese older persons. Such information may provide a basis for development of culturally specific depression outcome instruments, to be tested by further evaluative studies.

**Conclusion**

Surveys conducted in recent years in Macau have indicated high rates of depression among older persons. The mixed method approach employed in the present study has highlighted that, far from being a medical complaint treatable by medical therapeutic approaches, depression must be seen in a holistic context. The factors to emerge strongly in the accounts of the 31 participants are prominently in relation to physical/material, social/family, mental suffering aspects of life. The findings of the study have provided a platform for augmenting pharmacological and non-pharmacological medical treatment by holistically addressing depression among older persons, through easing the suffering of these impoverished, lonely and disabled older persons. It has also highlighted a direction for future research to develop instruments and therapies specific to Chinese older persons with depression, based on the meta-categories that emerged from the rich descriptions and stories provided by these troubled and traumatised citizens of Macau.
The Interview Guide for Older Persons with Depression

1. How do you feel about your life at present?
2. Can you tell me your health, the past and the present? How do you feel? E.g.
   2.1 Eating
   2.2 Sleeping
   2.3 Memory
   2.4 Physical activities
3. How do you look after your health? E.g.
   3.1 Consulting a doctor? Traditional Chinese Medicine? Others?
   3.2 Frequency
   3.3 Any medication
4. How do you feel about your friends/family/relatives?
5. Do you have any plans for the coming year?
6. What single thing would you most like to change about your life?
7. Do you have anything you feel satisfied about in the past?
8. Do you have anything you feel dissatisfied with in your past?
9. Do you think of any ways that help improve your situation?
10. Do you have anything more to share with others about your situation?
抑鬱老人心路歷程訪談指引

1. 你覺得而家嘅生活點呀？

2. 你覺得而家嘅身體點呀？同以前比身體有無乜嘢改變呀？你嘅感受點呀？
   2.1 飲食
   2.2 睡眠
   2.3 記憶力
   2.4 身體活動能力

3. 你係點樣照顧健康架？
   3.1 看西醫？中醫？其他？
   3.2 幾耐看一次呀？
   3.3 食緊乜嘢藥呀？

4. 你覺得朋友/家人/親戚對你點呀？

5. 你出年有乜嘢計劃呀？

6. 生活中你最想改變嘅個樣係乜呀？

7. 在過去的日子中你覺得最開心嘅係乜呀？

8. 在過去的日子中你覺得不開心嘅係乜呀？

9. 你覺得點先可以幫到你好 D 呢？

10. 你仲有無其他野想要講呀？
The Interview Guide for Care Giver

1. How do you feel about the present life of the older person you are caring?

2. Can you tell me the past and the present health of the older person you are caring? How does the older person you are caring feel? E.g.

2.1 Eating

2.2 Sleeping

2.3 Memory

2.4 Physical activities

3. How does the older person you are caring look after his/her health? E.g.

3.1 Consulting a doctor? Traditional Chinese Medicine? Others?

3.2 Frequency

3.3 Any medication

4. How does the older person you are caring feel about his/her friends/family/relatives?

5. Does the older person you are caring have any plans for the coming year?

6. What single thing would the older person you are caring most like to change about his/her life?

7. Does the older person you are caring have anything he/she feels satisfied about in the past?

8. Does the older person you are caring have anything he/she feels dissatisfied with in his/her past?

9. Does the older person you are caring think of any ways that help improve the situation?

10. Do you have anything more to share with others about the situation of the older person you are caring?
主要照顧者訪談指引

1. 你覺得老人家而家嘅生活點呀？

2. 你覺得老人家而家嘅身體點呀？同以前比身體有無乜嘢改變呀？老人家嘅感受點呀？
   2.1 飲食
   2.2 睡眠
   2.3 記憶力
   2.4 身體活動能力

3. 老人家係點樣照顧健康架？
   3.1 看西醫？中醫？其他？
   3.2 幾耐看一次呀？
   3.3 食緊乜藥呀？

4. 你覺得朋友/家人/親戚對老人家點呀？

5. 老人家出年有乜嘢計劃呀？

6. 生活中老人家最想改變嘅個樣喺乜呀？

7. 在過去的日子中老人家覺得最開心喺乜事也呀？

8. 在過去的日子中老人家覺得不開心喺乜事也呀？

9. 你覺得點先可以幫到老人家好 D 呢？

10. 你仲有無其他嘢想要講呀？
Towards the Development of Mind Over Old-age Depression (MOOD) Programme for Older Persons with Depression in Macau

Address: __________ Street (Road)  __________ Number __________ Building (Garden)
                          __________ Block __________ Floor __________ Room __________

Telephone:
Mobile:
Contact time:

**X. Record of the Interview**

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Time (24-Hour System)</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 First Interview</td>
<td>month day</td>
<td>hour minute</td>
<td>minutes</td>
</tr>
<tr>
<td>1.2 Second Interview</td>
<td>month day</td>
<td>hour minute</td>
<td>minutes</td>
</tr>
<tr>
<td>1.3 Third Interview</td>
<td>month day</td>
<td>hour minute</td>
<td>minutes</td>
</tr>
<tr>
<td>1.4 Fourth Interview</td>
<td>month day</td>
<td>hour minute</td>
<td>minutes</td>
</tr>
<tr>
<td>1.5 Fifth Interview</td>
<td>month day</td>
<td>hour minute</td>
<td>minutes</td>
</tr>
</tbody>
</table>
## A. Mental Status Questionnaire

<table>
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<td>1</td>
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<td>Address</td>
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<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Today’s date</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4</td>
<td>Month</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Year</td>
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<td>☐</td>
</tr>
<tr>
<td>6</td>
<td>Days in a year</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>Date of Macau return to China</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>20 minus 3 (then minus 3 again)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9</td>
<td>Name of current Chief Executive of Macau</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10</td>
<td>Name of previous Chinese President</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

## B. Geriatric Depression Scale

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>No 0</th>
<th>Yes 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Are you basically satisfied with your life</td>
<td>☐</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>Have you dropped many of your activities and interests</td>
<td>☐</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Do you feel that your life is empty</td>
<td>☐</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Do you often get bored</td>
<td>☐</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>Are you in good spirits most of the time</td>
<td>☐</td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>Are you afraid that something bad is going to happen to you</td>
<td>☐</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>Do you feel happy most of the time</td>
<td>☐</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td>Do you often feel helpless</td>
<td>☐</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>Do you prefer to stay at home, rather than going out and doing new things</td>
<td>☐</td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td>Do you feel you have more problems with memory than most</td>
<td>☐</td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>Do you think it is wonderful to be alive now</td>
<td>☐</td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td>Do you feel pretty worthless the way you are now</td>
<td>☐</td>
<td>22</td>
</tr>
</tbody>
</table>
23. Do you feel full of energy
  ☐  ☐

24. Do you feel that your situation is hopeless
   ☐  ☐

25. Do you think that most people are better off than you are
   ☐  ☐

C. Reduced Item Barthel Index

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Need some help</th>
<th>Need a lot of help</th>
<th>Totally dependent</th>
<th>Helpers *</th>
<th>Living with Help</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
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<td>26 Feeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>27 Bathing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>28 Grooming</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>29 Dressing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>30 Bowel</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>31 Bladder</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>32 Toilet use</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>33 Transfer</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
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<tr>
<td>34 Mobility</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
<tr>
<td>35 Stairs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>a_____</td>
<td>☐</td>
</tr>
</tbody>
</table>

* ☐ : represents items not available as a choice

36. In your daily living, who is your main caregiver?

   ☐  ☐

* Code of relationship with the interviewee:

### D. Lawton Instrument of Activities of Daily Living Questionnaire

<table>
<thead>
<tr>
<th>(☐) Whoever chooses 0 or 1 or 2, please fill in the name of the helper</th>
<th>Independent</th>
<th>Need some help</th>
<th>Need a lot of help</th>
<th>Totally dependent</th>
<th>Helpers *</th>
<th>Living with Helper b</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 0</td>
<td>Yes 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 Do you make phone call to others?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Do you do your own shopping?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 Do you cook?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Do you do light house work?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41 Do you do heavy housework?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 Do you take bus/taxi?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43 Do you manage your medications prescribed by doctors?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44 Do you manage your own money when you are out?</td>
<td>☐ ☐ ☐ ☐</td>
<td>a _____</td>
<td>☐ ☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Code of relationship with the interviewee:
- 0. No
- 1. Spouse
- 2. Son
- 3. Daughter
- 4. Daughter-in-law
- 5. Son-in-law
- 6. Brother
- 7. Sister
- 8. Grandson
- 9. Granddaughter
- 10. Other relatives
- 11. Friend
- 12. Helper
- 13. Neighbor
- 14. Organisation
- 15. Volunteer
- 16. Others
## E. Lubben Social Network Scale

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
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<td>45</td>
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<tr>
<td>46</td>
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<tr>
<td>47</td>
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<td>54</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

"☐" : represents items not available as a choice

- **45** How many relatives do you see or hear from at least once a month?
  - 0 = zero  1 = one  2 = two  3 = three or four  4 = five to eight  5 = nine or more

- **46** Tell me about the relative with whom you have the most contact. How often do you see or hear from that person?
  - 0 = < monthly  1 = monthly  2 = a few times a month  3 = weekly
  - 4 = a few times a week  5 = daily

- **47** How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help?
  - 0 = zero  1 = one  2 = two  3 = three or four  4 = five to eight  5 = nine or more

- **48** Do you have any close friends? That is, do you have any friends with whom you feel at ease, can talk to about private matters, or can call on for help? If so, how many?
  - 0 = zero  1 = one  2 = two  3 = three or four  4 = five to eight  5 = nine or more

- **49** How many of these friends do you see or hear from at least once a month?
  - 0 = zero  1 = one  2 = two  3 = three or four  4 = five to eight  5 = nine or more

- **50** Tell me about the friend with whom you have the most contact. How often do you see or hear from that person?
  - 0 = < monthly  1 = monthly  2 = a few times a month  3 = weekly
  - 4 = a few times a week  5 = daily

- **51** When you have an important decision to make, do you have someone you can talk to about it?
  - 0 = never  1 = seldom  2 = sometimes  3 = often  4 = very often  5 = always

- **52** When other people you know have an important decision to make, do they talk to you about it?
  - 0 = never  1 = seldom  2 = sometimes  3 = often  4 = very often  5 = always

- **53** Does anybody rely on you to do something for them each day? For example: shopping, cooking dinner, doing repairs, cleaning house, providing child care, etc.
  - 0 = never  1 = seldom  2 = sometimes  3 = often  4 = very often  5 = always

- **54** Do you live alone or with other people?
  - 0 = live alone  1 = live with other unrelated individuals (e.g., paid help)
  - 4 = live with other relatives or friends  5 = live with spouse
F. 36-item Short-Form Health Survey of Quality of Life

55. In general, would you say your health is? (Circle one number)

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>1</td>
</tr>
<tr>
<td>Very good</td>
<td>2</td>
</tr>
<tr>
<td>Good</td>
<td>3</td>
</tr>
<tr>
<td>Fair</td>
<td>4</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
</tr>
</tbody>
</table>

56. Compared to one year ago, how would you rate your health in general now? (Circle one number)

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much better now than one year ago</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat better now than one year ago</td>
<td>2</td>
</tr>
<tr>
<td>About the same</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat worse now than one year ago</td>
<td>4</td>
</tr>
<tr>
<td>Much worse now than one year ago</td>
<td>5</td>
</tr>
</tbody>
</table>

57. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Circle one number on each line)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes, limited a lot</th>
<th>Yes, limited a little</th>
<th>No, not limited at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vigorous activities such as running, lifting heavy objects, participating in strenuous sports</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Lifting or carrying groceries</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Climbing several flights of stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Climbing one flight of stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Bending, kneeling, or stopping</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Walking more than a mile</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Walking several blocks</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Walking one block</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Bathing or dressing yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

58. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of physical health? (Circle one number on each line)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cut down the amount of time you spent on work or other activities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Accomplished less than you would like</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Were limited in the kind of work or other activities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Had difficulty in performing the work or other activities (for example, it took extra effort)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

59. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Circle one number on each line)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cut down the amount of time you spent on work or other activities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Accomplished less than you would like</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Didn’t do work or other activities as carefully as usual</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

60. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Circle one number)

<table>
<thead>
<tr>
<th>Extent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td>Slightly</td>
<td>2</td>
</tr>
<tr>
<td>Moderately</td>
<td>3</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>4</td>
</tr>
<tr>
<td>Extremely</td>
<td>5</td>
</tr>
</tbody>
</table>
61. How much bodily pain have you had during the past 4 weeks? (Circle one number)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Very mild</td>
<td>2</td>
</tr>
<tr>
<td>Mild</td>
<td>3</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
</tr>
<tr>
<td>Severe</td>
<td>5</td>
</tr>
<tr>
<td>Very Severe</td>
<td>6</td>
</tr>
</tbody>
</table>

62. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one number)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>A little bit</td>
<td>2</td>
</tr>
<tr>
<td>Moderately</td>
<td>3</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>4</td>
</tr>
<tr>
<td>Extremely</td>
<td>5</td>
</tr>
</tbody>
</table>

63. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks... (Circle one number on each line)

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you feel full of pep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2. Have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3. Have you felt so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4. Have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5. Did you have a lot of energy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6. Have you felt downhearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7. Did you feel worn out?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8. Have you been a happy person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9. Did you feel tired?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10. how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

64. How TRUE or FALSE is each of the following statements for you. (Circle one number on each line)

<table>
<thead>
<tr>
<th></th>
<th>Definitely true</th>
<th>Mostly true</th>
<th>Don’t know</th>
<th>Mostly false</th>
<th>Definitely false</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I seem to get sick a little easier than other people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am as healthy as anybody I know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I expect my health to get worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My health is excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## G. Demographic Data

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 How old are you?</td>
<td>______ years old</td>
</tr>
<tr>
<td>66 Gender:</td>
<td>1 Male 2 Female</td>
</tr>
<tr>
<td>67 What is your marital status?</td>
<td>1 Single 2 Married 3 Separated 4 Divorced 5 Widowed 6 Others</td>
</tr>
<tr>
<td>68 Could you please tell me your education level?</td>
<td>1 Have never received formal education 2 Primary 3 Junior secondary 4 Senior secondary 5 Tertiary education 6 Others</td>
</tr>
<tr>
<td>69 Are you retired?</td>
<td>0 No 1 Have never worked 2 Unemployed 3 Yes</td>
</tr>
<tr>
<td>69.1 At what age did you retire?</td>
<td>______ years old</td>
</tr>
<tr>
<td>69.2 What was your job before you retired?</td>
<td>1 Stay at home and do nothing 2 Housekeeping 3 Do voluntary work 4 Study 5 Others</td>
</tr>
<tr>
<td>69.3 What do you usually do after retirement?</td>
<td>(Choose 3 items the maximum)</td>
</tr>
<tr>
<td>70 Your daily living expenses mainly depend on: (can choose maximum 3 items)</td>
<td>1 Personal savings/Investment 2 Income of spouse 3 Children 4 Relatives 5 Old age subsidies 6 Old age pension 7 Others</td>
</tr>
<tr>
<td>71 Your income (MOP/month):</td>
<td>0 None 1 500 2 501-1000 3 1001-1500 4 1501-2000 5 2001-2500 6 2501-3000 7 3001-3500 8 3501-4000 9 4001-4500 10 4501-5000 11 5001-5500 12 Refuse to answer</td>
</tr>
<tr>
<td>72 Do you think your living expenses are sufficient?</td>
<td>1 Very insufficient 2 Insufficient 3 Reasonable 4 Enough 5 Sufficient</td>
</tr>
<tr>
<td>72.1 How much do you regard your living expense as sufficient?</td>
<td>1 500 2 501-1000 3 1001-1500 4 1501-2000 5 2001-2500 6 2501-3000 7 3001-3500 8 3501-4000 9 4001-4500 10 4501-5000 11 5001-5500 12 Refuse to answer</td>
</tr>
<tr>
<td>73 Your living expenditure chiefly goes to: : (can choose 3 items the maximum)</td>
<td>1 Medical consultation/Health care 2 Transportation 3 Clothing and food 4 Social activities 5 Rent/Mortgage 6 Others</td>
</tr>
</tbody>
</table>

233
創建澳門老人抑鬱情緒管理模式研究

住址: 街(路) 號 大廈(花園) 座(期) 樓 座(室)

電話:
手機:
聯繫時間:

X. 訪談情況記錄

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 第一次訪問</td>
<td>月 日</td>
<td>時 分</td>
<td>分</td>
</tr>
<tr>
<td>1.2 第二次訪問</td>
<td>月 日</td>
<td>時 分</td>
<td>分</td>
</tr>
<tr>
<td>1.3 第三次訪問</td>
<td>月 日</td>
<td>時 分</td>
<td>分</td>
</tr>
<tr>
<td>1.4 第四次訪問</td>
<td>月 日</td>
<td>時 分</td>
<td>分</td>
</tr>
<tr>
<td>1.5 第五次訪問</td>
<td>月 日</td>
<td>時 分</td>
<td>分</td>
</tr>
</tbody>
</table>
### A. 精神認知狀態 (MSQ)

我而家問你一 D 問題，想知道你嘅記性點樣，你盡量回答就得喇，唔記得都唔緊要。

<table>
<thead>
<tr>
<th>問題</th>
<th>畫 0</th>
<th>畫 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 你住緊嘅地方係屬於澳門邊一區？</td>
<td>[ ] 填入區</td>
<td>1</td>
</tr>
<tr>
<td>2 你喺住址係邊度？</td>
<td>[ ]</td>
<td>2</td>
</tr>
<tr>
<td>3 今日係幾號？</td>
<td>[ ]</td>
<td>3</td>
</tr>
<tr>
<td>4 係幾月份？</td>
<td>[ ]</td>
<td>4</td>
</tr>
<tr>
<td>5 係乜野年份？</td>
<td>[ ]</td>
<td>5</td>
</tr>
<tr>
<td>6 一年有幾多日？</td>
<td>[ ]</td>
<td>6</td>
</tr>
<tr>
<td>7 澳門係邊一年回歸中國？</td>
<td>[ ]</td>
<td>7</td>
</tr>
<tr>
<td>8 20減去3等於幾多?(再減去3等於幾多?)</td>
<td>[ ]</td>
<td>8</td>
</tr>
<tr>
<td>9 現任澳門行政長官，係邊個？</td>
<td>[ ]</td>
<td>9</td>
</tr>
<tr>
<td>10 前任中國國家主席叫乜嘢名？</td>
<td>[ ]</td>
<td>10</td>
</tr>
</tbody>
</table>

### B. 老人抑鬱狀態 (GDS-15)

以下嘅問題係想瞭解你呢個星期嘅 D 感受。如果有，就請答“係”，如果沒有，就請答“唔係”。

<table>
<thead>
<tr>
<th>問題</th>
<th>畫 0</th>
<th>畫 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 一般來講，你係唔係對而家嘅生活基本上都滿意呀？</td>
<td>[ ]</td>
<td>11</td>
</tr>
<tr>
<td>12 而家係唔係已經無做一 D 你以前鍾意做嘅嘢了？</td>
<td>[ ]</td>
<td>12</td>
</tr>
<tr>
<td>13 唔係唔係觉得生活無所事事呀？</td>
<td>[ ]</td>
<td>13</td>
</tr>
<tr>
<td>14 係唔係成日都覺得好悶呀？</td>
<td>[ ]</td>
<td>14</td>
</tr>
<tr>
<td>15 係唔係時時都觉得幸福呀？</td>
<td>[ ]</td>
<td>15</td>
</tr>
<tr>
<td>16 唔係唔係擔心有 D 唔係幾好嘅事情會發生呀？</td>
<td>[ ]</td>
<td>16</td>
</tr>
<tr>
<td>17 係唔係大部分時間都覺得幾開心呀？</td>
<td>[ ]</td>
<td>17</td>
</tr>
<tr>
<td>18 係唔係覺得可能無乜人可以幫到你呀？</td>
<td>[ ]</td>
<td>18</td>
</tr>
<tr>
<td>19 唔係唔係寧願留喺屋企，都唔想落街行街呀？</td>
<td>[ ]</td>
<td>19</td>
</tr>
<tr>
<td>20 係唔係覺得自己記性比幾個星期前差咗呀？</td>
<td>[ ]</td>
<td>20</td>
</tr>
<tr>
<td>21 係唔係覺得長壽係唔係一件好事呀？</td>
<td>[ ]</td>
<td>21</td>
</tr>
<tr>
<td>22 係唔係覺得自己無乜嘢用呀？</td>
<td>[ ]</td>
<td>22</td>
</tr>
<tr>
<td>23 唔係唔係覺得自己精神都幾個好呀？</td>
<td>[ ]</td>
<td>23</td>
</tr>
<tr>
<td>24 唔係唔係覺得好似無乜希望呀？</td>
<td>[ ]</td>
<td>24</td>
</tr>
<tr>
<td>25 係唔係覺得大部分人都好過你呀？</td>
<td>[ ]</td>
<td>25</td>
</tr>
</tbody>
</table>
### C. 日常活動能力 (BI)

<table>
<thead>
<tr>
<th>(凡選擇0或1或2者, 請在a處填寫協助者)</th>
<th>獨立</th>
<th>需要部分</th>
<th>需要大</th>
<th>完全</th>
<th>協助者*</th>
<th>協助者同住</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>助協者同住 b</td>
<td>番</td>
<td>番</td>
<td>番</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>26 你食野要唔要人餵呀?</th>
<th>□</th>
<th>□</th>
<th>□</th>
<th>□</th>
<th>a _____</th>
<th>□</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 你沖涼要唔要人幫手?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>28 你洗面、刷牙、剃鬚或梳頭要唔要人幫手?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>29 你著衫要唔要人幫手呢?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>30 你忍唔忍到大便呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>31 你忍唔忍到小便呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>32 你去廁所和去完之後要唔要人幫手整埋D衫裤</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>33 你自己落床去到椅子並返回有冇困難呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>(包括鎖輪椅、移腳踏)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>34 你能唔能夠自己行路?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>35 你自己上落樓梯要唔要人幫手呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><em>(用手杖也算獨立)</em></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

*“* 為不可選項

36 在生活上，邊個係你最主要的照顧者? (填關係代碼)*

* 協助者代碼: 0 沒有、1 配偶、2 兒子、3 女兒、4 媳婦、5 女婿、6 兄弟、7 姊妹、8 孫仔、9 孫女、10 其他親戚、11 朋友、12 傭人、13 嚴居、14 機構、15 義工、16 其他

* 原因: 17 沒條件、18 其他

### D. 居家與社交活動能力 (Lawton-IADL)

<table>
<thead>
<tr>
<th>(凡選擇1或2者, 請在a處填寫協助者, 凡選擇0者, 請在a處填寫其原因)</th>
<th>獨立</th>
<th>需要部份</th>
<th>需要大</th>
<th>完全</th>
<th>協助者/原因*</th>
<th>協助者同住 b</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 你能唔能夠自己打電話俾人呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>38 你能唔能夠自己去買嘢呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>39 你能唔能夠自己煮飯呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>40 你能唔能夠自己做好似沖茶、洗碗或鋪床 D 嘢呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>41 你能唔能夠自己洗衫呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>42 你能唔能夠自己撿拾士的手呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>43 你能唔能夠自己按醫生嘅指示食藥呀?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
<tr>
<td>44 你能唔能夠自己找錢 D 錢呀？</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>a _____</td>
<td>□</td>
</tr>
</tbody>
</table>
### E. 社會網絡 (LSNS)

<table>
<thead>
<tr>
<th>Q</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 你有幾個不同住，但至少一個月見面或傾偈一次嘅家人/親戚呢？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>46 你同佢地中最常接觸嘅一個，每個月見面或傾偈有幾多次呢？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>47 你有幾個可以相處、傾心事、幫忙嘅家人/親戚？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>48 你有幾個可以相處、傾心事、幫忙嘅朋友？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>49 你有幾個可以相處、傾心事、幫忙嘅朋友？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>50 你有無幫人買餸煮飯、清潔、或湊BB等？</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

"□" 為不可選項
### F. 生活質量狀況 (SF-36QOL)

#### 健康狀況調查問卷SF-36 (中文版)

下面的問題是詢問您對自己健康狀況的看法。您的感覺如何以及您進行日常活動的能力如何。如果您沒有把握如何回答問題，盡量作一個最好的答覆。再在第10個問題之後的空白處寫上您的答覆。

#### 請打一個勾

1. 总体来讲，您的健康状况是：
   - 非常好
   - 好
   - 一般
   - 差

#### 以下方框內

由審核員填

2. 跟一年前相比，您覺得您現在的健康狀況是：
   - 比一年前好多了
   - 比一年前好一些
   - 和一年前差不多
   - 比一年前差一些
   - 比一年前差多了

#### 健康和日常活動

3. 以下这些问题都与日常活动有关。您的健康状况是否限制了这些活动？如果有限制，程度如何？

<table>
<thead>
<tr>
<th></th>
<th>很多限制</th>
<th>有点限制</th>
<th>根本没限制</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 重体力活动（如跑步、举重物、激烈运动等）</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>(2) 轻度活动（如移桌子、扫地、做操等）</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>(3) 手提日杂用品（如买菜、购物等）</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>(4) 上几层楼梯</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>50米上一层楼梯</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Appendices

SF-36 (97中文版)

<table>
<thead>
<tr>
<th>(6) 弯腰、屈膝、下蹲</th>
<th>有很多限制</th>
<th>有一点限制</th>
<th>根本没限制</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7) 步行1500米左右的路程</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(8) 步行800米左右的路程</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(9) 步行约100米的路程</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(10) 自己洗澡、穿衣</td>
<td>〇</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

4. 在过去四个星期里，您的工作和日常活动有没有因为身体健康的原因而出现以下这些问题？

每个问题都回答有或没有

<table>
<thead>
<tr>
<th>(1) 减少了工作或其他活动的时间</th>
<th>有</th>
<th>没有</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) 本来想要做的事情只能完成一部分</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(3) 想要做的事情或活动的性质受到限制</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(4) 完成工作或其他活动有困难（比如，需要额外的努力）</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

5. 在过去四个星期里，您的工作和日常活动有没有因为情绪（如感到消沉或者忧虑）而出现以下问题？

每个问题都回答有或没有

<table>
<thead>
<tr>
<th>(1) 减少了工作或其他活动的时间</th>
<th>有</th>
<th>没有</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) 本来想要做的事情只能完成一部分</td>
<td>〇</td>
<td>〇</td>
</tr>
<tr>
<td>(3) 做工作或其他活动不如平时仔细</td>
<td>〇</td>
<td>〇</td>
</tr>
</tbody>
</table>

6. 在过去的四个星期里，您的身体健康或情绪不好在多大程度上影响了您与家人、朋友、邻居或团队的正常社交活动？

请打一个勾

- 根本没有影响 〇
- 很少有影响 〇
- 有中度影响 〇
- 有较大影响 〇
- 有很大影响 〇
7. 在过去四个星期里，您有身体上的疼痛吗？

<table>
<thead>
<tr>
<th>选项</th>
<th>是/否</th>
</tr>
</thead>
<tbody>
<tr>
<td>根本没有疼痛</td>
<td></td>
</tr>
<tr>
<td>有轻微疼痛</td>
<td></td>
</tr>
<tr>
<td>有中度疼痛</td>
<td></td>
</tr>
<tr>
<td>有重度疼痛</td>
<td>□</td>
</tr>
<tr>
<td>有非常严重疼痛</td>
<td></td>
</tr>
</tbody>
</table>

8. 在过去四个星期里，身体上的疼痛影响您的正常工作吗（包括上班工作和家务活动）？

<table>
<thead>
<tr>
<th>选项</th>
<th>是/否</th>
</tr>
</thead>
<tbody>
<tr>
<td>根本没有影响</td>
<td></td>
</tr>
<tr>
<td>有一点影响</td>
<td></td>
</tr>
<tr>
<td>有中度影响</td>
<td></td>
</tr>
<tr>
<td>有较大影响</td>
<td></td>
</tr>
<tr>
<td>有极大影响</td>
<td>□</td>
</tr>
</tbody>
</table>

您的感觉

9. 以下这些问题有关过去一个月里您的感觉如何以及您的情况如何。
（对每一条问题，请标出最接近您感觉的那个答案）

请在每一行打一个勾

<table>
<thead>
<tr>
<th>在过去一个月里持续的时间</th>
<th>所有的时间</th>
<th>大部分时间</th>
<th>比较多时间</th>
<th>一部分时间</th>
<th>小部分时间</th>
<th>没有此感觉</th>
</tr>
</thead>
</table>

(1) 您感觉生活充实吗？  □
(2) 您是一个精神紧张的人吗？ □
(3) 您感到喜气洋洋，什么事都不能使您振作起来吗？ □
(4) 您觉得平静吗？ □
(5) 您感觉精力充沛吗？ □
(6) 您的情绪低落吗？ □
### SF-36 (97中文版)

<table>
<thead>
<tr>
<th>在过去一个月里持续的时间</th>
<th>所有的时间</th>
<th>大部分时间</th>
<th>比较多时间</th>
<th>一部分时间</th>
<th>小部分时间</th>
<th>没有此感觉</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7) 您觉得疲倦吗？</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(8) 您是个快乐的人吗？</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(9) 您感觉疲劳吗？</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(10) 您的健康限制了您的</td>
<td><img src="image" alt="社交活动(如走亲访友)吗？" /></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
</tbody>
</table>

### 总的健康情况

10. 请对下面的每一句话，选出最符合您情况的答案

<table>
<thead>
<tr>
<th></th>
<th>绝对正确</th>
<th>大部分正确</th>
<th>不能肯定</th>
<th>大部分错误</th>
<th>绝对错误</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 我好像比别人容易生病</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(2) 我跟我认识的人一样健康</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(3) 我认为我的健康状况在变坏</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
<tr>
<td>(4) 我的健康状况非常好</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>□</td>
</tr>
</tbody>
</table>

### 您的批评或建议：

8
### G. 基本資料

<table>
<thead>
<tr>
<th>項目</th>
<th>答案</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 你而家幾多歲？</td>
<td>_____________ 周歲</td>
</tr>
<tr>
<td>66 性別</td>
<td>1 男 2 女</td>
</tr>
<tr>
<td>67 請問你嘅婚姻狀況係？</td>
<td>1 未婚 2 已婚 3 分居 4 離婚 5 鰥寡 6 其他 _______</td>
</tr>
<tr>
<td>68 請問你嘅教育程度係？</td>
<td>1 未參加正規教育 2 小學 3 初中 4 高中 5 專上教育 6 其他</td>
</tr>
<tr>
<td>69 你而家退休未呀？</td>
<td>0 否 _______ 81.0 是而家做乜佢工？ _______________</td>
</tr>
<tr>
<td>69.1 你幾歲退休？</td>
<td>_____________ 岁</td>
</tr>
<tr>
<td>69.2 你退休前做乜佢工？</td>
<td></td>
</tr>
<tr>
<td>69.3 你退休後點安排你嘅生活呀？ (最多可選 3 項)</td>
<td>1 閒居 2 家務 3 參加義工 4 讀書 5 其他</td>
</tr>
<tr>
<td>70 你嘅日常生活費主要依靠： (最多可選 3 項)</td>
<td>1 個人儲蓄/投資 2 配偶收入 3 子女傳錢 4 親友傳錢 5 政府救濟金 6 社會保障基金的養老金 7 其他</td>
</tr>
<tr>
<td>71 你嘅日常生活收入金額 (澳門幣/每月)：</td>
<td>0 沒有 1 &lt; 500 2 501<del>1000 3 1001</del>1500 4 1501<del>2000 5 2001</del>2500 6 2501<del>3000 7 3001</del>3500 8 3501<del>4000 9 4001</del>4500 10 4501~5000 11 &gt; 5000 12 拒答</td>
</tr>
<tr>
<td>72 你覺得生活費夠唔夠用呀？</td>
<td>1 非常不足夠 2 不足夠 3 一般 4 足夠 5 充裕</td>
</tr>
<tr>
<td>72.1 你覺得生活費要幾多錢先至夠用呢 (澳門幣/每月)？</td>
<td>1 &lt; 500 2 501<del>1000 3 1001</del>1500 4 1501<del>2000 5 2001</del>2500 6 2501<del>3000 7 3001</del>3500 8 3501<del>4000 9 4001</del>4500 10 4501~5000 11 &gt; 5000 12 拒答</td>
</tr>
<tr>
<td>73 你嘅日常生活開支主要用係 (最多可選 3 項)</td>
<td>1 聽醫生/保健 2 交通 3 衣食 4 社交活動 5 房租/供擔 6 其他</td>
</tr>
</tbody>
</table>
Appendices

Towards the Development of Mind Over Old-age Depression

(MOOD) Programme for Older People with Depression in Macau

The Research Committee has received your ethical application of the research proposal for the above doctoral study. It is a project worth to be conducted for developing a program to help the depressed old age in Macau. No ethical implication if informed consent obtained from participants and proper referral from day care centers or participants themselves. Your application is approved.

Yours sincerely,

Luk Lueng

Chairman of Research Committee

Kiang Wu Nursing College of Macau
18 December, 2006
MEMORANDUM TO:
Wen Zeng
School of Nursing

Re: Change to application

I wish to advise you that the Committee met on 13 December, 2006 and reviewed the request for change to your application titled "Towards the Development of Mind Over Old-age Depression (MOOD) Programme for Older people with Depression in Macau" (Our Ref. 2006/433).

The Committee approved the change.

If the project changes significantly you are required to resubmit your application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

Please contact the Chairperson if you have any specific queries relating to your application. He and the members of the Committee would be most happy to discuss general matters relating to ethics provisions if you wish to do so.

Margaret Rotondo
Executive Secretary
University of Auckland Human Participants Ethics Committee
c.c. Head of Department, School of Nursing
Wen Zeng
Kiang Wu Nursing College
Est. Repouso No 35
Macau
Dear Mr. Zeng Wen,

Towards the Development of Mind Over Old-age Depression (MOOD) Programme for Older People with Depression in Macau

The Centro De Cuidados Especiais Rejuveneser Da U.G.A.M. has received your application for the above doctoral study. It is a research to develop a programme to support the older people with depression and will benefit the elderly service in Macau. The study plans to get the participants from The Centro De Cuidados Especiais Rejuveneser Da U.G.A.M.. You can get the permission to access to the older people if you can get the signed consent form from the participants. The Centre will support you while you conduct the study in The Centro De Cuidados Especiais Rejuveneser Da U.G.A.M..

Yours truly,

Ms. Ma Pui Wan
Director
The Centro De Cuidados Especiais Rejuveneser Da U.G.A.M.
Consent Form

I, ____________________, agree to participate in the research study titled “Towards the Development of Mind Over Old-age Depression (MOOD) Programme for Older persons with Depression in Macau”. I have been given an explanation of the study by Mr. Zeng Wen and fully understand the purpose and process of the study.

I understand the interview will be audio taped. However, all information and data will be kept confidential and will only be used in this research study. The consent form will be held for six years. Data will be destroyed by Mr. Zeng Wen 6 years later.

I understand I am free to withdraw at any time and can withdraw the information provided up to one month after the interview has been completed, and this action will not affect my present or future services in the day centre.

I understand a little gift (a towel) will be offered to me after the interview to show gratitude for my participation. I understand that I am free to withdraw from the research at anytime without giving a reason, irrespective of whether or not a little gift is involved.

If there are any questions about the research study, I can contact Mr. Zeng Wen directly (Office Tel: 2956236; Mobile: 66136787; E-mail: zengwen@kwnc.edu.mo).

Participant’s signature: ____________________ Date: _______________

Researcher’s signature: ____________________ Date: _______________

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 13 December 2006 for 3 years from 1 January 2007 to 31 December 2009 Reference Number 2006/435
知情同意書

本人同意參加「創建澳門老人抑鬱情緒管理模式的研究」。本人完全明白曾文助理教授解釋的研究目的。

本人知道屆時訪談會錄音記錄，所有的資料會絕對保密，只作為研究用途，6 年後資料將會由研究者予以銷毀。

本人有權隨時退出研究而不會受到任何不公平的待遇；同時本人提供的資料會立即作廢。

本人知道訪談之後會有一份表示謝意的小禮物。

如果有任何問題，本人知道可以直接聯繫曾文助理教授（電話 2956236，手機 66136787，電郵 zengwen@kwnc.edu.mo）。

參與者簽署: _______________ 日期: 

研究者簽署: _______________ 日期: 

紐西蘭奧克蘭大學人類研究倫理委員會於 2006 年 12 月 13 日批准，為期三年，2007 年 1 月 1 日至 2009 年 12 月 31 日生效，批文號 2006/435
You are cordially invited to participate in a doctoral study, entitled “Towards the Development of Mind Over Old-age Depression (MOOD) Programme for Older persons with Depression in Macau”, conducted by Mr. Zeng Wen, a research student of the School of Nursing at The University of Auckland. You have been referred by the day centre workers for participation in this study.

This study aims to interpret the lived experiences of older persons with depression and then identify the principal influences on depression among older persons in Macau. It is anticipated that the findings from the study will subsequently be used to inform the development of a Mind Over Old-age Depression (MOOD) programme for older persons with depression in Macau in a subsequent study.

The study involves a 2-hour face-to-face individual interview. The interview will be tape-recorded and then transcribed in full by the researcher. You will have the opportunity to review the transcript for accuracy and make any changes. You will not experience any physical harm from your involvement in this study but talking about your experiences might be a little distressing for you; if this occurs, we will have a break to allow you to take some rest or assistance if this is needed (The support worker is Dr. Luk Leung, an experienced psychiatric nurse. Tel: 2956223; E-mail: luk@kwnc.edu.mo).

The data can only be used by the researcher for this study. The information you provide will be reported or published but this will be done in a way that does not identify you as
its source. The data will be destroyed by the researcher 6 years after completion of the study.

A little gift (towel) will be offered to you after the interview to show gratitude to your participation.

You are not obligated to participate in this study and you can refuse to answer any question. If you choose not to participate or do not want to continue your involvement, you can withdraw from the study at any time and can withdraw the information provided up to one month after the interview has been completed, and this action will not affect your present or future services in the day centre.

If you agree to participate in this research study, please sign and date the attached consent form. Thank you very much for your participation.

At any time you want to know the progress of the study or have any question, please feel free to contact Mr. Zeng Wen (Office Tel: 2956236; Mobile: 66136787; E-mail: zengwen@kwnc.edu.mo) or supervisor Dr. Bridie Kent (Office Tel: 0064 9 373 7599 ext 86460; Mobile: 0064 21 726 392; E-mail: b.kent@auckland.ac.nz) or Head of School of Nursing Associate Professor Judy Kilpatrick (Office Tel: 0064 9 3737599 ext 82897; E-mail: j.kilpatrick@auckland.ac.nz)

If you have any ethical concerns, you can contact the Chair of the University of Auckland Human Participants Ethics Committee, Room 005 Alfred Nathan House, 24 Princes Street, Auckland, New Zealand, Tel: 0064 9 3737599 ext 87830.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 13 December 2006 for 3 years from 1 January 2007 to 31 December 2009 Reference Number 2006/435
研究資料單張

誠邀閣下參與曾文助理教授主持的一項紐西蘭奧克蘭大學的博士研究項目「創建澳門老人抑鬱情緒管理模式的研究」。您是通過老人中心介紹過來的。

本研究的目的在於探索澳門抑鬱長者的生活體驗，並進一步確定影響老人抑鬱的主要原因。本研究的結果可以幫助後續的創建澳門老人抑鬱情緒管理模式研究項目。

研究過程為約2小時的個人面談。面談將會錄音記錄，之後再由研究者逐字轉譯。您可以有機會核對轉譯文本的準確程度。所有資料只作研究用途，保證您的名字絕對不會出現在相關的任何文章或報告中，6年後資料將會由研究者予以銷毀。研究以訪談的形式進行，絕不會造成任何身體上的傷害。極少數人可能會感覺不好，情緒波動，屆時研究者會暫停訪談，並在有需要時協助您尋找相關的幫助（轉介资深心理學專家陸亮博士，電話2956223，電郵luk@kwnc.edu.mo）。

訪談之後會有一份小禮物，以表謝意。

本研究為自願參加。您有權拒絕回答任何問題、拒絕參與或隨時退出研究而不會受到任何不公平的待遇或影響您現有的各種服務；同時您所提供的資料會立即作廢。

如果您同意參加本研究，煩請您在知情同意書上簽名。多謝您的支持！

如有垂詢與賜教，請隨時聯絡研究者曾文助理教授（電話2956236，手機66136787，電郵zengwen@kwnc.edu.mo）、導師Bridie Kent博士（電話0064 9 3737599轉86460，手機0064 21 726392，電郵b.kent@auckland.ac.nz）、校長Judy Kilpatrick教授（電話0064 9 3737599轉82897，電郵j.kilpatrick@auckland.ac.nz）。

有關本研究的任何倫理事宜，敬請聯絡紐西蘭奧克蘭大學人類研究倫理委員會主席，地址：Room 005 Alfred Nathan House, 24 Princes Street, Auckland, New Zealand，電話0064 9 3737599轉87830。

紐西蘭奧克蘭大學人類研究倫理委員會於2006年12月13日批准，為期三年，2007年1月1日至2009年12月31日生效，批文號2006/435。


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