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Scenario: Emotional Functioning

AARTJAN T.F. BEEKMAN, ARJAN W. BRAAM,
WILLEM VAN TILBURG

Introduction

In the LASA design, emotional functioning was distinguished from cognitive, social and physical functioning. Projected as one of the four key areas of functioning under study in LASA, it was defined in broad terms. Defined in such a way, almost any human experience can be considered under the heading of 'emotional functioning'. Moreover, direct measurement of affect or emotion is impossible: it is always dependent on indirect measurements of the cognitive or physical representation of the construct 'emotion'.

As in the other three areas of functioning, the objective was to measure changes within both the normal and the pathological range of emotional functioning. As most measurements of emotional functioning rely on self-reports, it was not possible to include both subjective (self-evaluations) and objective (performance, or test-based) measurements. Included as dependent variables within the domain of emotional functioning, were (1) measurements of negative emotional experiences, such as anxiety and depression and (2) evaluative measurements concerning well-being and global satisfaction. A series of independent variables were distinguished (Deeg et al. 1993: 60-65). These include a number of supposedly stable, trait-like dimensions of personality (sense of mastery/locus of control, neuroticism, self-efficacy, self-esteem), substance use/abuse, life-events, and a number of elements described in the other domains of functioning. These aspects of emotional functioning were chosen because, at the time that LASA was designed, they were thought to be the most relevant indicators for well-being and autonomy in later life. As religiousness was judged to be important for the well-being and autonomy of older people, it has received much interest within LASA. Although religiousness may be thought of in terms of cognitive, emotional and social functioning, it has been included in the emotional domain in LASA.

Dependent variables

Well-being

Well-being and global satisfaction can be operationalized in many ways. In LASA, simple self-report measurements are included, which are used as outcomes within the emotional domain, and also in many of the other domains of functioning. However, in some studies depressive symptoms are treated as an inverse measurement of well-being.

Depression and anxiety in later life

From the start, an ancillary study regarding depression and anxiety in later life was planned within LASA. Depression has received the most attention so far, because at the time that LASA was designed it was clear from previous research that depression is (1) a common experience in later life, which may (2) disrupt all other domains of functioning, and which (3) is potentially amenable. These are the three ingredients which make depression a very relevant issue for public health and health care policy. Anxiety was included because it was suspected that all three of the above arguments could similarly be applied to anxiety disorders in later life.

Both anxiety and depression may occur on a continuum of severity and both are very basic human experiences, expressing emotional reaction to loss and/or threat. They are, within limits, adaptive responses, which might act as signals for both the individual and the environment, providing an incentive to initiate adaptive behaviour. At the extreme end of the continuum, however, both anxiety and depression take on the characteristics of a disorder, which is maladaptive and might even be potentially dangerous.

In psychiatry there is ongoing discussion on whether or not to conceptualize psychopathological abnormalities as extreme variants of the continuous characteristics of people (dimensional view), or as distinct entities which are qualitatively independent of normality (categorical view). In our opinion, the only effective way to solve this ongoing debate is to apply both the dimensional and the categorical viewpoint to epidemiological data and to systematically assess the merits of each viewpoint.

Independent variables

Personality

Very little is known about the way temperamental and other aspects of personality develop in the later stages of life. This is surprising, as it is generally accepted that personality-related factors are of crucial influence on the way people perceive their circumstances, the way they adapt to changes, and the resulting change in circumstances. Many of the circumstances which are important for older people can be viewed as the end-point of developmental lines of adaptation, which are strongly influenced by personality characteristics. This line of reasoning assumes that personality is a stable aggregation of traits, with a pervasive underlying influence on most activities. However, whether or not these assumptions are valid has not been fully investigated, especially with regard to old age. Therefore, the development of personality traits in later life, is an important research topic within the emotional domain in LASA. Moreover, the impact of personality traits on other developments, which take place in all four domains of functioning, is a second research objective.

Substance use/abuse

Although it is recognized that the use and abuse of substances such as alcohol and drugs is important, this subject has received little priority so far.

Religiousness

Empirical studies concerning religiousness and depression, especially those carried out in North America, strongly suggest that religiousness protects against depression (Kennedy et al. 1996, Koenig et al. 1998). Would this also pertain to Western Europe? As many elderly people have progressed through all the important phases of development within the context of a particular religious tradition, this tradition might have contributed to various social and personal resources (Ellison 1994). In turn, through these resources, religion could either protect against depression, or enhance it. Studies of religiousness and depression are generally based on a multidimensional concept of religiousness, including the religious tradition, religious behaviours, and subjective religiousness.

LASA offers an excellent opportunity to study religiousness, because the study sample was drawn from three regions in the Netherlands, each with different religious traditions. The religious tradition in the west is mainly secularized, in the north-east it is predominantly Protestant, and in the south predominantly Roman Catholic. Mainline religious traditions, whether Calvinist or Roman Catholic, were found to provide a protective background against depression in later life. A hyper-

conservative Calvinist climate, however, was found to enhance depression. Similar results emerged from the study of a different dimension of religiousness, concerning religious practice. Public religious behaviour, such as church-attendance, has received the most attention so far in LASA. Private religious behaviour, such as prayer and meditation, will be evaluated as a source of religious coping.

A source of coping which has already been studied concerns the salience of religion. This dimension has been used more frequently in epidemiological research (Hoge & De Zulueta 1985, Koenig et al. 1998) and reflects the subjective dimension of religiousness. Religious salience appeared to be relevant in the process of coping with physical deterioration. Furthermore, religious salience was found to predict a more favourable course of depression.

Religiousness will also be approached from a developmental perspective. For this purpose, the development towards gerotranscendence is assessed, based on the construct described by Tornstam (1994), which is very similar to the concept of wisdom and ego-integrity (Erikson, 1950). Gerotranscendence can be considered as a non-religious construct, which can include religious facets, but also mirrors a sense of spirituality in non-religious subjects. Therefore, knowledge of gerotranscendence could be relevant for future generations of elderly people who do not adhere to any religious tradition.

Policy relevance

Depression and anxiety

An ancillary study concentrating on depression was included in LASA, because it was thought that this would yield data which are not only scientifically relevant, but also relevant for public health and health care policy. With regard to primary prevention, knowledge about age-related changes in the prevalence and the impact of risk-factors for late-life depression is very important. An example of the potential impact of the findings is that the cross-sectional analyses suggest that major depression, which is relatively rare in later life (prevalence $\pm 2\%$), is strongly associated with long-standing personal vulnerability factors. Minor depression, which is much more common (prevalence 12.9%), is more often associated with stressful personal and health-related events, which are common in later life. If corroborated in longitudinal studies, these findings could be used to define high-risk groups. These groups can then be targeted for special preventative interventions.

With regard to secondary prevention, the lack of treatment of late-life depression in primary care has already been described. In order to be able to convince GPs that detection and treatment of depression in later life is possible, and also worthwhile,

data are needed with regard to (1) the etiology, course and consequences of depression, (2) the association between physical health and depression, and (3) the symptom profile and the structure of depression in later life. These data could be used to design simple, but effective methods to recognize and treat depression in primary care.

Finally, the course and consequences of late-life depression have obvious relevance for public health. Preventing chronicity and mitigation of the consequences (tertiary prevention) of depression are extremely important public health issues.

All the above arguments may also be applied in a similar way to anxiety disorders. A study of anxiety and anxiety disorders has recently been initiated in LASA, and is already resulting in a growing number of publications.

Personality

The direct policy relevance of studies on (changes in) personality may not seem obvious. However, in many instances the LASA data demonstrate that there are considerable differences between the objective circumstances of older people and their appraisal of these circumstances. For instance, although the majority of participants in LASA have one or more chronic physical illnesses, the vast majority consider their health to be good or very good. This phenomenon is more pronounced in the older cohorts, in which chronic illnesses are more prevalent. There are many reasons why so many older people remain reasonably content about their health status, even though they are facing increasing health problems. Three of the most obvious reasons for this have been described by Idler (1993). Firstly, there may be cohort effects in the perception of health or the expression of discontent. Secondly, as people become older, they increasingly become the survivors of their own generation, which may be reflected in more positive health perceptions. Thirdly, older people may change their standards and expectations to accommodate the demands made by reality, or the changing perspective of many older people could be seen as an attempt to ward off the negative emotions associated with a deterioration in physical health. Whatever the explanation, it is clear that personality factors, such as sense of mastery, self-efficacy, neuroticism and self-esteem, influence the perception of changing demands and opportunities which accompany the aging process. From a practical viewpoint, personality may affect the pathway from illness to the need for care, which also makes it highly relevant for health care policy. Therefore, stability or change in personality, the impact of personality on behaviour and the perception of ongoing changes associated with aging are highly relevant for health care policy.

Religiousness

The study on religion and depression is not intended to over-emphasize the role of religiousness for health care policy with respect to religion and depression. The results, however, warrant some suggestions about the clinical approach to the subject of religion in older adults. Religion represents a generally neglected and sometimes mistrusted aspect in the context of psychiatric or therapeutic contacts. It has been presumed that discussing religion causes even more feelings of mutual discomfort than discussing finances, power, or sexuality. This discomfort may have various causes, one of them concerning the immense heterogeneity of religious beliefs and feelings, and especially the intimate character of religion. Both the patient and the clinician, or therapist, are likely to feel reluctant to discuss the subject, and consequently avoid it. This might be a safe solution in many contacts, but it might also result in therapeutical disadvantages. Openness and respect, or at least awareness of the subject of religion should be considered as the desired approach in contacts with patients for whom religion is important, regardless of whether their religiousness represents a maladaptive or an adaptive characteristic. Inevitable differences between the religious convictions and feelings of the therapist and those of the patient should be anticipated, in extremely devout patients as well as zealous non-believers. Education programmes for health care workers might be adapted to this. These should include issues about the management of normal, traditional (protective) religiousness, such as facilitating religious practices in an intramural setting. A second issue concerns the therapeutic management of problematic religiousness, as may present itself as a symptom of severe psychiatric disorder.

Future plans, ongoing projects

Depression

The longitudinal study of the incidence, course and consequences of late-life depression will be a central field of research on depression for the coming years. The existing data suggest that much may be gained if recognition, diagnosis and treatment of depression outside the domain of psychiatry (in primary care, and in residential and nursing homes) can be improved. The hypothesis regarding improved outcomes generated by the LASA study will be tested in epidemiological/intervention studies which are being designed and implemented. Furthermore, the association between physical illness and depression will be studied more closely in several future sub-studies. Finally, LASA is participating in a European collaboration programme on depression in later life (EURODEP; Copeland et al. 1998), in which the prevalence of