SOCIAL IDENTITY RECONSTRUCTION THROUGH EDUCATION:
A PROGRAM FOR OLDER WOMEN

by

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We accept this thesis as conforming
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ABSTRACT

A substantial number of older women are adversely affected by mild to severe levels of depression. In this study the Social Health Outreach Program (SHOP), an educational intervention originally developed for middle-aged women, was modified and implemented with depressed and non-depressed older women. Through an educative process, participants learned ways to strengthen personal social networks as a means of augmenting social identity and overcoming depression. The purposes of the study were:

1) to measure the impact of SHOP on older women's levels of depression and demoralization, and on their social networks; 2) to determine factors either within or outside of SHOP that helped or hindered their progress during the program; and 3) to describe and analyze their experience of depression.

A total of 15 women, aged 58 to 76, participated in a 20 session version of SHOP over a ten week period. Measures of depression and demoralization were obtained before, after and three months following the program; social networks measures were also obtained at three month follow-up. Participants' perceptions about their experience of depression, and about program factors and other concurrent aspects of life that helped or hindered their progress during the program, were obtained in post-program interviews.

Outcomes validated SHOP's approach and demonstrated that with slight modification the program is as effective with older women as it is with mid-life women. Participants who were
depressed at pre-test showed a significant decline in depression scores; on measures of demoralization, changes were in the direction expected, although non-significant. Participants reported significant gains to their social networks in terms of people and groups added. Content analysis of interview data yielded 205 helping incidents and 130 hindering incidents that occurred during the program period; from these, 20 categories of factors that advanced participants' progress during the program, and 19 categories of factors that impeded their progress, were determined.

This study supported the view that for many older women depression originates in their social environment. The findings validated SHOP's educational program as a means of increasing social participation, re-constructing social identity and overcoming depression.
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I. INTRODUCTION

Many older women in Canada suffer from depression, and the number is expected to increase as the population ages (Gee & Kimball, 1987). Older women are a rapidly growing sector of Canada's population (McDaniel, 1986); the majority are reaching retirement age with limited social and economic resources, primarily as a result of occupying traditional female roles. These socio-economic disadvantages place older women at risk for depression (McEwan, Donnelly, Robertson, & Hertman, 1991).

Although older women require resources outside themselves to overcome depression, there is a dearth of knowledge to inform policy or program initiatives; there are few attempts in the literature to understand depression or related interventions from the viewpoint of older women. For many, the accessible treatment option is antidepressant drug therapy, an approach which frequently causes troublesome side effects, and fails to address the range of factors contributing to their depression.

Educational interventions are needed that are aimed at preventing or alleviating depression among older women, particularly depression that is rooted in socio-cultural as well as health phenomena. A preliminary step in such an undertaking involves understanding older women's experience and using their experience as a base for an educational intervention. In addition, it is necessary to discern older women's perceptions about which aspects of intervention are effective.

This study was undertaken to provide further information
about older women's perspectives on the experience of depression and on an educational intervention designed with their needs in mind. The impact of the intervention as a means of alleviating depression was assessed. As background, this chapter provides a profile of older women, pointing out the challenges they face in an aging society. It is argued that traditional medical and psychological therapies fail to address the social roots of older women's depression, and that alternative interventions are needed. Social network augmentation as a focus of educational intervention is discussed as a strategy suited to the needs of many older women. The purpose, scope, limitations and significance of the study are clarified along with operational definitions and hypotheses.

OLDER WOMEN IN AN AGING SOCIETY

Most women manage their aging well; however, a considerable number grapple with rolelessness, social isolation, poverty and health problems. Such circumstances, for many older women, dictate a daily monotony and hardship that engenders depression.

Longevity and Living Arrangements

On average, women outlive men in almost all parts of the world (Mercer & Garner, 1989). Consequently, older women outnumber older men by a sizable margin. In Canada, in 1981 there were 124 females for every 100 males in the age group 65-79, and 184 females for every 100 males in the 80 and over category (Health & Welfare Canada, 1983). Given longevity
patterns, a sizable chunk of the average woman's life will be spent in old age. A related projection is that many women will experience widowhood. Matthews (1987) reported that in Canada widows outnumber widowers by almost five to one. This finding is considered to be a result of three factors: the longer life span of women; their tendency to be two to three years younger than husbands; and their tendency to remain widowed if they become widowed. By 1981 the average age at widowhood had increased so that 69.1% of widows were over 65 (Matthews, 1987). Although the number of older women who are divorced, separated or never-married is small compared to the number of widows, the number is growing (Mercer & Garner, 1989).

Considering the above statistics it is not surprising that in developed countries, where there is a trend toward living alone, most older women live on their own, not with families or in institutions. This tendency to live alone seems to stem from a desire on the part of many older women to maintain privacy and independence and "not be a burden" on others. It does not appear to be due to family unwillingness to assume caregiving roles (Mercer & Garner, 1989).

Income

Economically the picture for older women in Canada is bleak, in fact, income has been cited as their number one problem (Nishio & Lank, 1987). The picture is particularly grim for unattached older women (mostly widows, some divorced and separated), who emerge as financially one of the poorest segments.
of the Canadian population. Gee and Kimball (1987) reported that in 1985 about 60 percent of unattached women aged 65 and over existed at or below the poverty line set at $8,000 for an individual. An additional 18 percent had incomes just above that, between $8,000 and $9,999. In sum, approximately 78 percent of older, unattached, women were poor or close to it.

Nishio and Lank (1987) attributed the poverty of older women to two main sources—pension system inequities and the fact that women work in lower paying jobs. In addition, they stressed that older women are more likely than older men to be poor or dependent on their families for support because of no remuneration for work in the home, and because employment patterns are commonly interrupted in order to nurture children or care for frail family members. Gee and Kimball (1987) argued that women's dependent financial status reflects gender-based divisions of labour. Women's homefront roles are unpaid and their work outside the home is generally considered secondary to primary domestic duties. Thus, as a result of devalued labour roles both inside and outside the home, women tend to be financially dependent on men. Gee and Kimball (1987) pointed out the likelihood of continuing poverty for older women,

...many of the variables that have led to high rates of poverty among the present population of older women continue to operate for younger women. In other words, future cohorts of elderly women are likely to experience high levels of poverty as well, although
perhaps not as high as today's older women (p. 59).

Health Status and Educational Attainment

Mercer and Garner (1989) compare the health status of older women and men as follows, "women report higher morbidity than men and have lower mortality rates; women are, as a group, hospitalized more often than men; they receive the majority of surgical procedures; consume more drugs than do men (especially psychotropics); and are institutionalized more often than men" (p. 37). In addition, these authors maintain that older women experience significantly greater physical mobility problems than older men.

Educationally, although the gap is narrowing, the level of education attained by older people is well below that of younger people. Gender differences are apparent in that older women are less likely than older men to have completed secondary school (Mercer & Garner, 1989).

Thus, a composite picture of older women emerges. Relative to their male counterparts, women are more likely to live longer and live alone in the last quarter of their lives. They will probably have less income and more chronic illness than men, and they will have less education than both older men and younger people. This means that many women face the prospect of aging without adequate finances, and with dismal chances for employment at a time when they may be adjusting to widowhood, living alone and dealing with health problems. This situation, according to Olson (1988), signifies that "Clearly, our society maintains
women's subordinate social, economic, and sexual statuses into old age. Moreover, the issues and problems confronting younger women tend to become exacerbated as they age" (p. 106).

Prevalence of Depression

Given the constraints facing older women, it is reasonable to view them as vulnerable to depression; however, it is difficult to pinpoint a prevalence rate for depression among this group for several reasons:
1. Epidemiological studies differ in how they define and measure depression.
2. Estimates of depression rates based on these methodologically different studies vary widely and are of questionable accuracy.
3. There are no reported comprehensive reviews of depression incidence and prevalence studies from the point of view of older women.

Gurland and Toner (1982) analyzed studies of the general elderly population and found the following:
1. Ten to fifteen percent of older people suffer from clinically significant depression.
2. The rates of demoralization syndrome (less severe symptoms) are thought to be double that of clinical depression.
3. At mid-life rates of depression are much higher in women than men, but after mid-life the rates rise for men and fall for women.
4. After age 75 men have higher rates of depression than
Gurland and Toner distinguish between "clinically significant depression" and "demoralization syndrome", intimating that the latter is a different and milder phenomenon than the former. As will be seen, however, evidence from the Social Health Outreach Program (SHOP) shows that demoralization is a feature of both mild and severe depression in women; this suggests that distinctions in levels of depression on the basis of demoralization may be artificial.

**Consequences of Depression**

At present, a considerable number of older people suffer from depression unaided; less than a quarter receive help for the problem (Klerman, 1983). This is considered to result from several factors: few older people use traditional mental health services (Beck & Pearson, 1989); physicians who are uninformed about late-life depression may dismiss the symptoms as part of the aging process; and, manifestations of depression in older people resemble those of other conditions (e.g. dementia) and are often missed or misdiagnosed. For older people the consequences of undetected, ongoing depression may be severe, including: withdrawal and alienation from family and friends, avoidable suffering, premature retirement, malnutrition, over-medication, addictions, premature aging, unnecessary institutionalization, and suicide (Gurland, Dean & Cross, 1983).

Numerous questions about depression among older women remain unanswered. Nonetheless, the problem is pressing and will
continue unless immediate steps are taken to adequately address the financial, health, educational and social needs of older women.

**INTERVENTIONS FOR DEPRESSION**

The study of depression is plagued by controversy and considerable divergence of opinion regarding its definition, cause and treatment. Coyne (1986) described the study of depression as thoroughly fragmented and polarized. She suggested that enormous differences in terminology, interpretation and emphasis must be confronted before an integration of perspectives on depression is achieved at theoretical and practice levels. While current literature advances multifactorial models of depression, such approaches have yet to be reflected in interventions which tend to centre around the methods of a particular discipline.

When depression among older women is detected it is usually medically treated. A diagnosis is made based on presenting symptoms and most often medical treatment takes the form of psychotropic drug therapy (D'Arcy, 1987). Yet Strauss and Solomon (1983) described the range of studies of drug therapy for the treatment of depression in older people as "severely limited" (p. 16). In another review, Gerson, Plotkin and Jarvik (1988) described the extent of investigation as "appallingly small" (p. 311) and stressed that older people experienced undesirable side effects associated with all of the antidepressant drugs reviewed. Glantz and Backenheimer (1988) contended that older women are a
group at high risk for adverse drug reactions and physician-perpetrated drug abuse involving prescription psychotropic drugs. The evidence suggests that psychotropic drug therapy may cause as many problems for older women as it solves. Of related interest, Lundervold & Lewin (1990) demonstrated that older people have clear preferences with regard to treatment for depression, rating behavior therapy as significantly more acceptable than medication.

Psychological methods such as behavioral, cognitive and analytic therapy have been applied with depressed older people; however, these are used infrequently as compared to drug therapy. Most writers who discuss psychotherapy contend that counsellors have paid limited attention to older people, reflecting a general aversion toward working with them (Sparacino, 1980; Steuer, 1982; Wellman & McCormack, 1984). In addition, Chaisson-Stewart (1985) pointed out the limited amount of outcome research on psychotherapy with depressed older people. Two recent studies offered encouraging results with psychotherapy based on cognitive, behavioral and analytic principles in a group setting (Steuer, Mintz, Hammen, Hill, Jarvik, McCarley, Motoike & Rosen, 1984) and a one-to-one setting (Gallagher-Thompson, Hanley-Peterson & Thompson, 1990). However, there is an absence of studies that have analyzed these therapies from the perspective of older women. Traditional medical and psychological interventions for depression are increasingly viewed as too narrow for older women (Gatz, Pearson & Fuentes, 1984). These
therapies tend to focus on the internal world of the individual older woman (e.g. biochemistry or cognitive processes) placing the onus for change on her. In fact, her depression may be a realistic response to oppressive social realities such as rolelessness and poverty which are external to her and often beyond her sphere of influence.

A clear challenge to practitioners is to design non-traditional interventions which acknowledge the context of older women's lives. Gatz, Pearson and Fuentes (1984) maintained that a whole range of services, including traditional ones, should be available to older women when they are needed and wanted. These authors emphasized that the burden of change in improving the well-being of older women must be socio-cultural.

SOCIAL NETWORKS AS A FOCUS OF EDUCATIONAL INTERVENTION

A large body of research demonstrated that social ties and social support are significantly related to peoples' health status (see for example: Cassel, 1976; Berkman & Syme, 1979; Orth-Gomer & Johnson, 1987). A social network, in structural terms, is a set of ties or linkages among a group of people. In functional terms, it is a set of relationships within which interpersonal feedback and social support are exchanged.

Even though the mechanism of action linking social networks to health is still unknown, there is support for the notion that strengthening of social networks is a desirable goal of intervention, particularly with those older people whose interpersonal contacts have dwindled due to retirement, moving,
or health problems of themselves and others in their networks (Minkler, 1981; Israel, Hogue & Gorton, 1984). One successful educational intervention aimed at augmenting the social network as a means of overcoming depression was conducted by Burnside (1990). She developed and tested the innovative Social Health Outreach Program (SHOP) as a treatment for depression in middle-aged women. Her research, which this study extends, is further discussed in Chapter II.

PURPOSES OF THE STUDY

In this study the Social Health Outreach Program (SHOP) was adapted and conducted with two groups of older women. Since it was expected that the issues affecting older women would be similar to the issues they faced earlier in life, much of the original program content was retained. However, because common stereotypes associate aging with intellectual decline, and because attempts to measure the impact of educational intervention as a means of alleviating older women's depression are absent in the literature, it was important to demonstrate the effectiveness of such an approach with this group.

The purposes of the study were:
1. To determine the impact of participation in SHOP on participants' levels of depression and demoralization and on their social networks.
2. To determine participants' perceptions about which activities and processes helped or hindered their progress during an educational intervention for depression.
3. To describe participants' experience of depression.

**HYPOTHESES**

This study tested the following hypotheses:

1. Participation in SHOP will reduce women's depression and demoralization.

2. Participation in SHOP will increase the size of their social networks.

**OPERATIONAL DEFINITIONS**

**Participation** was defined as attendance at SHOP sessions.

**Social network changes**

were defined as participants' perceptions of changes to their social networks at 3 months following SHOP, as compared to before the program.

**Depression**

For the purpose of consistency with earlier research, the diagnosis of depression was determined using Diagnostic Interview Schedule criteria. Level of depression was defined and measured using the Centre for Epidemiological Studies Depression (CES-D) Scale; a score of 16 or greater defined depression.

**Demoralization**

was defined as a score of 70 or less on the General Well Being Schedule.
ORGANIZATION OF THE STUDY

Chapter II examines the theoretical and research base supporting the intervention applied in the study, and elaborates on socio-environmental issues related to older women's depression. A rationale is provided for small group, educational interventions aimed at augmenting social networks in helping women overcome depression.

Chapter III outlines the design of the study including a detailed description of the research and educational methodologies.

Chapter IV presents the research findings and analyzes them according to the questions addressed by the study, and in relation to findings of other research.

Chapter V provides a summary and discusses recommendations for program planning with older women. Suggestions for future research are included.

SCOPE, LIMITATIONS AND SIGNIFICANCE OF THE STUDY

This study does not provide a comprehensive analysis of depression in older women. Nor does it review in detail the range of treatments for depression. Rather, this investigation describes the application of a small group, educational intervention based on a socio-cultural view of depression among older women.

The findings of the study must be generalized with caution. Subjects were volunteers who possessed sufficient psychological resources to seek out the program and were physically able to get
to the program. Although it is reasonable to assume that many older women are similar to these participants, this group does not represent all older women.

The potentials of the SHOP program as a community-based strategy to help older women avoid or overcome depression and re-integrate in the community are enormous. The significance of the study lies in its potential to inform program planning and service provision for older women—a marginalized and rapidly expanding group.
II. LITERATURE REVIEW

This chapter reviews the theory and research underpinning the program applied in this study. It examines older women's depression as it is understood from a social perspective. Literature related to the following areas was reviewed: depression and intervention from a social perspective; evidence about social identity deficit among older women and factors that place them at risk for depression; older women's experience of depression; and guidelines for social identity reconstruction programs with older women.

First, a brief comment on the current state of research literature pertaining to older women. One of the main criticisms of this literature is that most of it is descriptive and based on no theoretical perspective; an occurrence which can partly be explained by the fact that the study of women and aging is quite new. In a review of literature on older women Robinson (1986), writing from a health field perspective, concluded that much of the research on older women is atheoretical. Furthermore, Robinson noted that evaluative research about the results of intervention projects with older women was generally absent. Gee and Kimball (1987) contended that the failure to incorporate women into mainstream theoretical perspectives on aging reflects the general marginality of women in society. Furthermore, these authors observed that research on aging women tends to focus on their familial and reproductive roles and functions (e.g. widowhood, caregiver, menopause) and only to a limited
extent addresses roles which take place outside of the home (e.g. labour force or volunteer roles).

SOCIAL PERSPECTIVES ON DEPRESSION AND INTERVENTION

One of the pivotal issues in building a theory of depression is the question of cause. Scholars currently describe depression as a multidimensional phenomenon influenced by, and influencing, social, biological and psychological factors. Within these broad parameters the social roots of depression are widely acknowledged as a pragmatic focus of intervention. Models which locate the origin of depression within individuals (e.g. as cognitive or biological disorders), and treatment programs based on these views, are increasingly viewed as inadequate for older women who face glaring social and economic disadvantages. While there is no doubt that biological and cognitive changes are part of the phenomenon of depression, one of the assumptions of this study is that for many older women such changes are not a cause of depression, but rather an effect. Following Burnside (1990), this study presumes that for most older women such problems as depressed mood, low motivation, anxiety, low self-esteem and negative thinking, may be interpreted as symptoms of demoralization in response to a depressing life. According to this view the primary focus of intervention should be the woman's social world, and the central aim should be integration or reintegration in an identity-affirming and supportive community network.

Social cause perspectives on depression rest on studies
which demonstrate that rates are high among those who are in some way socially disadvantaged, for example those who are unemployed, poor, elderly or female. Most older women occupy all of these statuses. Evidence on the relationship of social factors to depression among older women is reviewed later in the chapter.

**Social Identity Degradation**

Sarbin (1970) provided a conceptualization of depression which accounts for the fact that those who have lower socio-economic status (e.g. finances, housing, education) are more likely to be depressed than those who have adequate resources (Blazer & Williams, 1980; Goldberg, Van Natta & Comstock, 1985). He introduced the notion that the forerunner of mental breakdown or dysfunctional behavior is the "degraded social identity". In this perspective the focus is not on the individual, rather the individual is viewed as a member of a collective, acting and interacting with others. The individual's identity is socially determined through role relationships in social settings. The individual enacts a social role, and relevant others provide feedback which influences the individual's sense of value or self worth.

In describing the process of social identity degradation Sarbin (1970) first explained how an individual's social identity is valued. He proposed that total value can be determined by assessing the following dimensions of the social roles occupied by an individual:

1. **Status** refers to the position of the role in a social
structure. In our society status is granted to those who enact achievement roles (e.g. judge, doctor, professor), not ascribed roles (e.g. retiree, mother).

2. **Value** refers to positive or negative feedback conferred for enacted roles. Performance of achievement or chosen roles may be valued on a scale anywhere from low to high. In contrast, granted or ascribed roles earn no value, but nonperformance of these roles generates negative societal sanction (e.g. neglecting parental duties).

3. **Involvement** is the degree of participation of self in the role enactments (e.g. amount of time, energy) and whether or not there are legitimate opportunities for obtaining role distance or being "out of role". Such opportunities are absent when one occupies only granted roles.

According to Sarbin, an individual's social identity becomes degraded when the individual has few opportunities to engage in role behaviors that have elements of choice and that are valued by self and others.

**The Social Network As Source Of Social Identity**

A social network can be defined as that set of personal contacts through which the individual maintains an identity and receives social support, that is, emotional support, material aid and services, information and new social contacts (Walker, MacBride & Vachon, 1977). From a lifespan perspective, Kahn and Antonucci (1980) conceptualized the personal social network as a convoy, a set of people surrounding an individual who is moving
through life. The social roles that an individual plays at
different points in the life course are the basis for
interpersonal relationships within the convoy. These
relationships are characterized by the giving and receiving of
social support.

Fisher (cited in Minkler, 1981) contended that individuals
create their personal networks from a small set of socially
structured alternatives. In this sense an individual's position
in the social structure determines what opportunities will be
available for forming social relationships and what resources the
individual may possess to pursue those ties. Burnside (1990)
stressed that social identity is what your social network
says you are and that the roles one occupies throughout the life
span construct the shape of the convoy or network. As social
roles and the related personal network undergo change, social
identity changes. Burnside defined social identity as the
aggregate of roles and statuses associated with an individual.

Social Identity Deficit Depression

Burnside (1990) maintained that a satisfactory social
identity is a universal need of all people. She stressed that it
is feedback from others on "how we're doing" which forms the
basis of our self-concept. In Burnside's (1990) view people who
occupy low status or marginal social roles have a hard time
retaining a positive self-concept and sense of self-esteem.
Burnside asserted that a chronic social identity deficit due to
lack of rewarding social roles and status is at the root of most
female depression, low self-esteem and anxiety.

A Psychosocial View of the Depressive Process

Freden (1982) explained how social identity deficit may relate to manifestations such as anxiety, low self-esteem and depression. Like Sarbin (1970) and Burnside (1990), Freden argued that depression is determined primarily by conditions in the social environment. He proposed that there are several interconnected elements in the depressive process. The first is restrictive extrinsic circumstances over which the individual exerts little control, for example social group affiliations based on sex or class; a rigid, isolated family system; and past trauma. Such external circumstances spawn two other elements of the depressive process, namely, rigid action patterns and a limited range of possible actions. These are exemplified by persons who tend to apply the same solution to all problems, depend on a limited number of people for self-esteem, or perceive very few action alternatives as falling within their range of ability.

To illustrate, Freden cited the example of women who are brought up to adopt the traditional female role. Such women often have social restrictions imposed on them in regard to how extensively they can investigate the world and, consequently, they may have a limited repertoire of possible actions to apply when confronted with problems. Furthermore, in keeping with socially structured traditional female role expectations, many of these women live in situations in which their self-esteem is
almost solely contingent on a relationship with a man. If such a relationship is nonexistent or threatened, for whatever reason, the woman's self-esteem is in jeopardy.

In Freden's (1982) explanation having a healthy self-esteem and avoiding depression rest on having access to a range of action opportunities. When one can neither see nor have access to alternative actions as a way to counter threats to self esteem in untenable situations, anxiety and depression are probable. Freden summarized the depressive process as follows:

external circumstances that are inaccessible to influence raise the avoidance of anxiety to the level of a primary goal, and self-esteem is reduced; rigid action patterns are enforced in order to keep anxiety and fear of the uncertain at bay; the limited range of action opportunities reduces self-esteem, which in turn renders the individual more vulnerable in any crisis involving a further threat to his already fragile sense of self-value (p. 172).

Implications for Intervention

A key issue in depression is the question of how to prevent and alleviate it. A common theme in the work of Sarbin (1970), Freden (1982) and Burnside (1990) was that the roots of depression are not within the individual; rather, they are in the wider social context. Accordingly, these authors emphasized that strategies to prevent or alleviate depression must address, at different levels, the social environments of those affected.
On a micro-social level, Sarbin (1970) suggested that case-finding procedures should proceed, not on the basis of psychiatric symptoms, but rather on the basis of identifying individuals with degraded social identities. To adopt this approach practitioners would have to learn to recognize when social identity degradation is occurring and to create situations which give potential sufferers opportunities to be positively valued.

Burnside's (1990) view was that the most appropriate therapy for socially-caused depression should occur at a macro-level, that is, social and economic inequities which create disadvantaged sub-groups should be eliminated. This approach emphasized that depression is a socio-political issue, a viewpoint which Burnside noted is well understood by community seniors' organizations that promote income assistance, better housing and transportation as mental health measures. On the public agenda, however, the social and political roots of mental illness are just beginning to be recognized in Canada. Burnside referred to a report commissioned by the Canadian Mental Health Association which concluded that the mental health of women will improve only when we raise their status in society.

Burnside (1990) argued, however, that depression can be addressed on a micro-social level. Women can learn to promote their own mental health by strengthening their personal social networks and involving themselves in esteem-building community activities. When practitioners are involved in this process
their role is to help women acquire the knowledge, skills and confidence they need to re-integrate in a supportive community.

Freden (1982) proposed that actions to prevent or ameliorate depression must be applied at several interrelated levels: 1) society and its institutions; 2) primary groups such as family, friends, school and work; 3) external life, that is, what people do; and, 4) the inner life which includes peoples' perceptions and experiences. Freden emphasized that an intervention for depression will meet with limited success if the social situation which is undermining the individual's self worth persists. Conversely, to help people overcome depression, Freden argued that it is not enough to recommend changes in society and in the subject's social situation. Depressed people often need help to move beyond crippling negative self-images and beliefs.

**SOCIAL IDENTITY AND DEPRESSION**

A degraded social identity stemming from social disadvantage and marginalization is often at the root of depression in older women. Research findings on the social identity of older women, and the contribution of social factors to their depression, support this view.

**Evidence on the Social Identity Deficit of Older Women**

The literature indicates that older women are at risk of developing a social identity deficit. In our society "older woman" is a low status, undervalued role beset by the ills of ageism and sexism. Breytspraak (1984) pointed out that although
some stereotypes cast older people in a positive light (e.g. they are viewed as friendly, wise, and generous), on balance most are negative (e.g. older people are viewed as frail, forgetful, grouchy, mentally slower, closed-minded and unproductive). This same author described how many older people internalize these stereotypes and come to label themselves as inadequate.

Matthews (1979) contended that, given the current milieu, "oldness" creates a spoiled personal identity. She first described how people use appearance to communicate their identity, values and attitudes; an effective process insofar as appearance can be fairly easily interpreted. In the case of older people, Matthews argued that the behavioral correlates of wrinkles and gray hair are not clear; thus, ambiguity and uncertainty become elements of the identity of older people along with the demeaning experience of being old in a youth-oriented society.

The social identity of older women is further jeopardized by the sexist notion that the worth of a female is defined in terms of her youth and attractiveness. Cohen (1984) underscored how the media and the beauty industry brainwash women, from childhood on, to believe that what counts is a beautiful face and body, and that women are only creditable if they fight the visible signs of their aging.

In interviews with many women Cohen (1984) found that all struggle with myths that depict women's aging as a time of inevitable decline characterized by diminished intelligence,
vigor, sexual attractiveness and usefulness. Furthermore, many women who were successful and powerful admitted to spending large amounts of energy, time and money to appear younger, softer and more feminine. Cohen stated, "The endless harping on the decline of our bodies cannot help but affect our feelings about our value as human beings. Many women I interviewed, especially those older than sixty, claimed that their perceived declining physical appearance made them feel invisible" (p. 14).

The majority of older women manage to retain a positive self esteem while negotiating the insults of old age. In interviews with 142 elderly women MacRae (1990) found that most managed to construct a meaningful role and a sense of personal worth through their interpersonal relationships associated with involvement in voluntary organizations and informal social network ties.

Matthews (1979) found that the older women she interviewed had, through experience, learned strategies which helped them maintain an acceptable sense of self worth. For example, in the interpersonal sphere they sometimes concealed their age or avoided situations in which oldness would be their central identity (e.g. walking through groups of teen-agers on the sidewalk in front of the K-mart). Matthews pointed out that older women have fewer avenues than mainstream "normals" for reducing strain and reclaiming themselves from the social stigma of being old. Moreover, some of the self preservation tactics they use have the effect of separating them still farther from mainstream social life (e.g. avoiding identity-threatening situations).
It is evident in Cohen's (1984) work that although women evolve creative strategies to deal with the multiple insults of aging (e.g. through intergenerational supports and self-help), most struggle to overcome the social realities imposed on them. Cohen reports,

I found that most women over sixty are far from content. I interviewed them about their feelings, perceptions, and personal experiences in a society that is youth-oriented and youth-obsessed. They expressed bewilderment and dismay at the prejudice, indifference, and alienation they suffer. Many are frightened that if they openly state their anger, they will suffer grave consequences. They are repeatedly told by politicians, by the media, by academics, by gerontologists that they are far better off than their foresisters. "Far better off" usually translates into surviving considerably below the poverty line. The quality of their lives is generally abysmal, for they are alienated, and abandoned, cut off from the mainstream of life. As a society, we do not respect or admire our older women. We force them to live financially, emotionally, and intellectually impoverished lives and expect them to be grateful to us (p. 10).

Cohen's concluded that in our society older women must expend superhuman energy to achieve a satisfying life.
Risk Factors For Depression Among Older Women

Few studies have explored risk factors for depression from the point of view of older women. For this review, evidence on the contribution of social factors to their depression was gleaned from four studies of the general elderly population and two studies of older women.

Blazer and Williams (1980) compared 147 depressed subjects (98 women and 49 men, aged 65 and over) with 850 non-depressed subjects (526 women and 324 men, aged 65 and over) to determine the relative frequency of certain demographic, social, economic and health characteristics. They found the following:

1. There was a significantly higher percentage of widowed women and men in the depressed group compared to the non-depressed group.
2. In the depressed group there was a significantly higher percentage of women and men with impaired social and economic resources and impaired activities of daily living.
3. Of those older people who were depressed (14.7%), 6.5% had depressive symptoms associated with impaired physical health.

Blazer and Williams (1980) concluded that "Much of what is called 'depression' in the elderly may actually represent decreased life satisfaction and periodic episodes of grief secondary to the physical, social and economic difficulties encountered by aging individuals in the community" (p. 442).

Murphy (1982) compared 100 depressed subjects (68 women and 32 men, aged 65 to 87 years) with 200 non-depressed subjects in
the general population to investigate the hypothesis that social factors are related to the onset of late life depression. She found the following:

1. Older people who experienced severe life events, major social difficulties or poor physical health were significantly more likely to become depressed.
2. Severe life events and major social difficulties in combination increased the risk of developing depression.
3. Older people with lower socio-economic status had a higher incidence of depression.
4. Those older people without a confiding relationship were at significantly greater risk for developing a depression.

Murphy (1982) concluded,

though some personalities appear to be more vulnerable to developing depression, these people are no more at risk than the 'well adjusted' until faced with a sudden crisis in their lives, a major social problem, or loss of health. We cannot hope to change personality much and we shall not be able to prevent the occurrence of many severe events, but improvements in social conditions and better health care might go some way to improving the mental health of older people (p. 141).

Murrell, Himmelfarb and Wright (1983) investigated the correlates of depression in a community sample of 936 males and 1516 females aged 55 years and over living in the U.S.A. The results reported are consistent with earlier research:
1. Income, education, number of rooms in dwelling and tenure were significantly related (inversely) to depression.
2. There was no difference in depression rates between blacks and whites when adjusted for socioeconomic status.
3. Men and women in disrupted marital statuses had significantly higher rates of depression than the married and never married.
4. The best predictor of depression was overall physical health and this relationship was not a function of older age.

Goldberg, Van Natta and Comstock (1985) investigated whether or not certain demographic and social network characteristics of 1,104 older women were related to their level of depressive symptoms. Analysis of interviews with white, married, women aged 65-75 years living in the U.S.A. revealed the following:

1. Women with low socioeconomic status (i.e. poor housing quality, low educational attainment) were more likely to experience depression than women with high socioeconomic status.
2. The percentage of women with high levels of depressive symptoms was largest among those with poor quality social networks (i.e. small size; no members like self in age, sex and religion; low level of intimacy; no confidant; a husband who was not a confidant).

Holzer, Leaf and Weissman's (1985) study of 1570 women aged 65 and over in the U.S.A. revealed the following relationships to depression:
1. There was a higher prevalence of depression for separated or divorced women than for married, widowed or single never-married women (recently bereaved subjects were excluded from the widowed group).

2. The lowest prevalence of depression was found for women living with a spouse.

3. The highest prevalence of depression was found for those subjects living with a child or parent.

4. There was a slightly lower prevalence of depression in high income category subjects and the highest prevalence of depression was in subjects with the lowest educational attainment.

Finally, Krause (1987) interviewed 351 people (66% female) aged 65 and over to examine the relationship of chronic financial strain and social support to depressive symptoms. He found the following:

1. Older people suffering from chronic financial strain tend to report significantly more symptoms of depression than do those with fewer financial problems.

2. Those older adults who give and receive more social support report fewer symptoms of depression in times of financial strain than those who give and receive less social support.

Findings across these studies clearly demonstrated that socially disadvantaged and marginalized older women (the majority of the subjects were female) were at greater risk for depression than women who have adequate social and economic resources. In
addition, physical health problems contributed significantly to their depression.

OLDER WOMEN'S EXPERIENCE OF DEPRESSION

When designing interventions for older women it is necessary to understand their subjective experience of depression. Aronson (1990) observed that when the real terms of older women's experience are understood, then we will have a more comprehensive basis for developing social policies and programs beneficial to all women. Articles that address older women's experience of depression are few in number. Those that do, focus on symptom patterns or profiles (see for example Holzer, Leaf & Weissman, 1985; Newmann, Engel & Jensen, 1990) rather than older women's perceptions of their experience.

Depression affects people with varying degrees of intensity. The "blues" are considered to fall within the realm of normal reactions to the disappointments and frustrations of life. Within the realm of depressive "disorders" are a range of affective experiences. Blazer (1982) reported that at one end of the spectrum are milder depressed states characterized by the following:

1. feelings such as sadness, despondency, hopelessness, anxiety and irritability.
2. cognitive changes resulting in poor concentration and uncertainty in making decisions.
3. physical symptoms such as fatigue, sleep disturbances, weight loss or gain (more commonly loss), nausea and constipation,
slowed body movements and slowed speech or, in contrast, agitation and pacing.

4. motivational changes such as an inability to take initiative sometimes even on simple tasks.

At the other end of the spectrum are severe depressive states characterized by intense, incapacitating melancholy with psychotic episodes.

A recurring theme in the literature was that the phenomenology of depression is somewhat different among older people relative to other age groups. The gist of this observation is that, although the symptoms of depression in the elderly are similar to those of younger people, there is a tendency for older depressed people to give less emphasis to the mood disturbance and more emphasis to the somatic experience of depression (Gurland & Toner, 1982). Some authors (Blazer, 1982; Gatz, Pearson & Fuentes, 1984) suggested that older people experience fewer guilt feelings, self-critical thoughts and suicidal impulses than younger people. In contrast, these authors maintained that older peoples' depression was manifested more commonly by apathy, low energy, and loss of motivation, sleep disturbances and loss of appetite.

Two recent investigations, however, did not support the contention that depression was manifested differently in older, versus younger, women. Holzer, Leaf and Weissman (1985) analyzed symptom profiles of three groups of women: 1) younger women, 2) older women who experienced depression earlier in life, and
3) older women whose first depressive episode was after age 65. They found a general similarity in the symptom profiles of these three groups, and concluded that there was no evidence that older women experience depression differently than younger women. The authors suggested that "depression for elderly females is much the same process as depression among younger women and ...there is no evidence for a special set of mechanisms being operative among elderly female respondents...depression in elderly females is very much an extension of the depressive process experienced by younger females" (p. 184).

Newmann, Engel and Jensen (1990) attempted to develop a better understanding of the depressive symptoms experienced by older women. They analyzed the symptom profiles of 344 older women and found two main patterns emerging. One symptom pattern suggested the presence of a more severe, clinical depression syndrome and the other suggested a milder form of distress, which the authors believed was reflective of a "depletion syndrome", or a reaction to the stresses and strains of life. The stable features of the "depletion syndrome" were feelings of worthlessness, disinterest, loss of appetite, hopelessness, and thoughts of death, dying and suicide. Women exhibiting the milder form of distress tended not to display a depressed mood or feelings of guilt or self-blame. While this study does not compare symptom patterns across age groups, it does point out that the experience of depression in older women is similar to that of other groups—a complex phenomenon characterized by
varying degrees of severity.

SOCIAL IDENTITY RECONSTRUCTION STRATEGIES

The theoretical perspective framing this study implies that efforts to reduce depression among older women must be directed toward the over-riding goal of achieving a healthy social identity. Participation in rewarding social roles, through an active social network, is essential in creating the amount and kind of feedback needed to build and sustain such an identity. While actions toward this aim can and should occur on macro and micro-social levels, this study concentrates on the latter. Accordingly, this section reviews literature from which guidelines emerge for designing network augmentation interventions for older women. Topics covered include: characteristics of health promoting social networks; types of social network augmentation programs; educational and group interventions as methods of choice; and finally, outcome studies on small group, educational interventions with young and middle-aged depressed women, and group cognitive therapy with depressed older people.

Health Promoting Social Networks

An adequate personal social network structures an individual's social identity and provides the support needed to master the challenges of daily living and navigate the inevitable crisis of life. A resurgence of interest and research in the area of social support over the 1980's expanded the knowledge

Network dimensions which contribute positively to mental health have been identified. Minkler (1981) referred to studies which point to the following network characteristics as health promoting: adequate network size, presence of a confidant, and interpersonal reciprocity. Studies reviewed earlier in this chapter (see for example Goldberg, Van Natta & Comstock, 1985; Krause, 1987) are consistent with Minkler's finding.

Burnside (1990) maintained that there is no one health-promoting network structure, rather there are variations between individuals, and throughout one individual's life span, regarding what constitutes a healthy network. Like Minkler (1981), Burnside found that large network size and presence of a confidant were health-promoting. In addition, Burnside suggested that the following network characteristics appear to be health-promoting: presence of many friends; links to community organizations; a relatively loose-knit structure (ie. not all network members know each other) with at least one dense cluster; some degree of homogeneity (members like self); and, friends and acquaintances outnumbering relatives (p. 66). In light of the above, network augmentation programs for older women should aim
Types of Network Augmentation Programs

Biegel, Shore and Gordon (1984) conducted a comprehensive overview of network interventions with older people. Their research revealed seven main categories of network interventions: clinical treatment, family caregiver enhancement, case management, neighborhood helping, volunteer linking, mutual aid/self help, and community empowerment. They describe each type of intervention along the following dimensions: the kind of intervention modality, professional roles most central to each modality, who the client is, who the helper is, where the intervention is occurring geographically, and finally, the level of help (prevention, treatment or rehabilitation). Biegel, Shore and Gordon's framework provides a useful tool for understanding the range network interventions; however, as the authors point out, in practice such programs are not in discrete categories. Instead, multiple approaches may be combined in a single intervention. These authors do not discuss specific strategies for older women, rather they target the general elderly population.

Educational and Small Group Strategies

Education is a key means of providing social experience and stimulating learning (Thornton, 1986); as such, education can be considered one approach to helping older women "learn their way
out of a depression". From a life-span perspective, learning is considered an essential developmental process, in which meaning is derived out of experience (Thornton, 1986). The learning process is operational throughout the life of every individual and, in this sense, can be considered an indispensible aspect of the development of older women. Positive behavior changes, which reflect learning outcomes, are essential in overcoming depression. Learning can occur in many settings and can be self- or other-directed; nonetheless, educational and small group learning forums support participants' efforts to strengthen their personal networks and reconstruct their social identities.

Education-oriented interventions have the potential to contribute directly to the goal of helping older women achieve healthier social identities. Participants in educational activities assume the role and identity of "learner" in contrast to the negatively tinged "sick role", which tends to be affixed to depressed people and therapy group participants. The negative perceptions of the "mentally ill" label held by older women (Beck & Pearson, 1989), and the hesitancy of older people to use traditional mental health services are described in the literature (Filinson, 1986).

Well designed educational activities can contribute to older women developing the knowledge, skills, and sense of self worth prerequisite to social participation in the wider community. But to accomplish this aim education must be viewed as more than a transmission of information to enhance coping or adaptation.
Rather, it must be viewed as a means of stimulating learning and experiencing which enables an older woman to transform her view of herself and of women collectively, and to act on her new insights.

Mezirow (1990) defined transformative learning as "the process of making a new or revised interpretation of the meaning of an experience, which guides subsequent understanding, appreciation, and action" (p. 1). He argued that "emancipatory" education to foster such transformative learning involves critical reflection on the validity of the set of beliefs and assumptions that structure the way we interpret our experiences. Furthermore, it involves critical self-reflection of how one has posed problems and of one's own meaning perspective or frame of reference for interpreting experience. Finally, transformative learning includes subsequent action based on new insights.

The critical reflection and perspective-shift processes that Mezirow (1990) described can enable older women to create and value their own knowledge about what it means to be an aging woman in this society. Changed perspectives occur, for example, when a group of older women reflect on, analyze, and discuss their life experiences, and what shaped them. They learn that many experiences were common to all women. In such a milieu an older woman can reframe her perception of herself from "a failure, who should be blamed" to "one of many women who have endured in an often hostile society".

The notion that personal experience can be tapped as a
powerful learning resource is well recognized by adult educators. Personal experience as a source of knowledge is a key guiding principle in feminist education (Hayes, 1989). From the perspective of educational gerontology, Moody (1990) suggested "that the education of older people should be grounded in life experience: in the history and the life cycle of the learner" (p. 23).

The Women's Movement has evolved educational models which address the marginalization of women. Building on this base and a resource development perspective, Harold (1991) described four essential components of education that is aimed at helping older women strengthen their resources, including social identity. These components can be viewed as program development guidelines for practitioners who work with older women. First, education for older women should encourage the kind of participation which helps them develop their "voice" in a way that counteracts their experience of invisibility. Harold's notion of "voice" included expressive capacities ranging from verbal power and fluency to the ability to create meaning and knowledge out of one's own experience. Secondly, such education should teach skills such as communication and assertiveness, problem posing, problem solving and goal setting. These are the kinds of skills which foster social confidence and self-efficacy. Thirdly, Harold proposed that resource development education for older women should foster horizontal networking. She argued that many services for older adults set up a vertical relationship between professional as
"expert" and client as "subject" creating an identity of incompetence for the older person. Harold stated, "The goal of horizontal networking in education is to encourage the development and enlargement of the individual women's peer network to strengthen her social and personal identity as a valuable, competent and 'thinking' person" (p. 115). Finally, resource development education with older women should stimulate an awareness that problems do not occur in isolation; rather, individual lives are moulded by societal as well as individual forces. Such education requires the processes of reflective and experiential learning described above, in which personal perspectives are transformed.

An educational group rather than individual counselling is the method of choice in helping older women strengthen their social networks. Besides the more obvious advantage of economy, such an approach is logical when addressing depression or other problems engendered by social invisibility, or powerlessness. Groups provide a medium in which the support necessary for self-acceptance, social connection and action is available (Cox, 1989). Groups are in keeping with the perspective espoused in this study; that is, helping an older woman develop a collective, not individual, perspective on her experience is the preferred intervention approach to preventing or resolving depression.

The literature points out the benefits of group interaction for older people. Therapy groups are believed to promote the following "healing" functions with older people: 1) provision of
information, an opportunity to develop cohesiveness among members, and acknowledgement of the universality of members' problems (Van Servellen & Dull, 1981); 2) provision of mutual emotional support, an opportunity to "try out" new roles or behaviors, friendship, interpersonal learning, and options for participating in different roles (Edinburg, 1985); 3) provision of a setting for meaningful social interaction, a forum for feedback about individual problems from which alternatives may be obtained, and an opportunity to work through unresolved conflicts (Tross & Blum, 1988); and finally, 4) provision of contacts with therapists who serve as role models, a forum for reality testing, a supplement to other forms of therapy, and an opportunity for members to help each other (Lazarus, 1989).

The paramount value of therapy groups appears to be in the provision of mutual support including information, feedback, advice, camaraderie, a sense that one is not alone with a problem and encouragement. The group provides a supportive arena for participants to observe and experiment with new roles--essential processes in reconstructing social identity. Although these functions are attributed to therapy groups, it is likely that other groups (e.g. educational or self help) impart similar preventive and curative benefits. In fact, most group modalities are characterized by both therapeutic and educative elements.

**Intervention Outcomes**

Although the literature describes models for a variety of health promotion programs, there are few evaluation studies of
educational, or any, interventions designed to reduce depression among older women. In an overview of all types of group work with older women Burnside (1989) located only 13 articles, including anecdotal and descriptive ones, spanning the period 1953 to 1987. Out of these 13 articles, only three targeted reduction or prevention of depression as a goal of intervention, and only two reported depression-related outcomes. One was a reminiscence group with 15 nursing home residents who met for 6 sessions. The only reported outcome was a "downward trend in depression score". The other group was described as a weekly discussion/therapy group which met at a seniors' centre. The outcome was reported as a "fluctuating pattern in participant's depression scores using the Hamilton Depression Inventory over an 18 month period". Burnside described the domain of group work with older women as "unchartered" and stressed the need for an improvement in the amount and quality of work in this area.

For this investigation, three studies of socio-educational interventions with young and middle-aged depressed women were reviewed. In addition, outcomes of cognitive-behavioral and psychodynamic group therapy with older people were reviewed.

Haussmann and Halseth (1983) conducted a 13 week (2 hrs., once a week) group program for 14 rural, depressed women averaging 35 years of age. They described their approach as socio-educational, with participants taking an active role in voicing and working on personal concerns as the program progressed. Educational content centered on the following
topics: socialization messages girls and women receive, depression, assertiveness, anger, sexuality, community resources and women's activities. Instructional techniques included: brief lectures and handouts, short homework assignments, and small group discussions about such topics as personal experiences and rights, career and lifestyle choices, dealing with anger, nurturing oneself and networking. Refreshment breaks which encouraged mutual support and informal network building were included.

Participants' written, subjective evaluations of the program were positive, reflecting an increased sense of personal power and a decrease in depression and helplessness. The investigators attempted to objectively measure depression levels using the Centre For Epidemiological Studies Depression Scale (CES-D); however, results were reported as "inconclusive" due to a low return rate from participants who completed the questionnaire at home. Based on feedback from the written evaluations the authors concluded, "rural women can be assisted in decreasing their depression through a non-traditional, feminist approach. Important in this process is learning to challenge societal role expectations and to develop a healthy definition of one's self" (p. 113).

Gordon and Ledray (1986) reported on a 14 session intervention (2 hrs., once a week) led by two professional nurses who had received training in group intervention. Ten depressed, middle-aged women were assigned to a treatment group and eleven
were assigned to a control group and given the opportunity to participate in future treatment groups. Educational content included the following topics: goal setting, feelings and depression, cognitions and feelings, self-worth, relationships, communication skills, assertiveness, conflict management and decision-making, stress, relaxation, exercise, nutrition, menstruation\menopause and strength building. Instructional techniques included lecture, discussion, other small group activities (not described) and homework assignments.

Outcome data from this study reflect mixed findings. One measure (Beck Depression Inventory - Significant Other Report) demonstrated statistically significant treatment effects in reducing subjects' depression; however, findings from the other measure (Beck Depression Inventory - Self Report) were not consistent with this. The authors speculated that this could be due to subjects' hesitancy to report improvement, or an unreliability in the pre-test sample. In evaluating the program the authors noted that, given the study design, it was not possible to determine which program factors were responsible for the improvement in level of depression experienced by women in the treatment group.

The Social Health Outreach Program (SHOP), applied in this study, was originally developed and tested by Burnside (1990) through an action research process. She initiated SHOP as a social treatment for the depression reported by many women seeking membership to the First Mature Women's Network Society, a
non-profit organization in Vancouver, Canada. The central aim of SHOP is to empower participants through group support to overcome depression and raise their self-esteem by achieving a healthy social identity through social participation. Group participation, education and network building are core elements of this program.

SHOP participants attended sessions for 12 weeks (2 hrs., twice a week). Educational content covered such topics as what constitutes a healthy social network; personal network assessment; theories of depression; the medicalization of life problems; women and alcohol abuse; sleep disorders; eating disorders; and the relationship of gender roles, marriage and social networks to mental health. In the "retooling" component of the program participants learned such skills as cognitive strategies to combat negative thinking, communication and assertiveness. The "recycling" component of the program was designed to support participants in the process of enacting their social goals, which for many related to gaining employment. It included exercises on goal setting and resume preparation. Throughout the sessions the importance of building network ties and community involvement were stressed. Instructional techniques included short lectures by the facilitator or guests, small group discussion, homework assignments and in class activities such as network mapping and completing a personal strengths inventory.

Burnside (personal communication, October, 1990) reported on
a test of SHOP's effectiveness. Fifty-one women, aged 45 to 65, diagnosed 'depressed' (non-psychotic, non-bi-polar) were randomly assigned to either treatment or a wait-control condition. Using CES-D scores as the dependent variable, it was found that post-program scores of the treatment group had decreased significantly (by 45%), while control group scores had declined by only eight percent. After going through the program, the wait-listed group's CES-D scores showed a significant decrease (42%) over pre-start-up scores. Retesting one year later demonstrated SHOP's long term effectiveness, the combined CES-D scores of both treatment and wait-control groups sustained a 35 percent decline over pre-program scores. Burnside concluded that SHOP is an effective treatment for depression in middle-aged women.

Two studies of group cognitive therapy with older people were located. Steuer et. al. (1984) applied cognitive-behavioral group therapy (n=10) and psychodynamic group therapy (n=10) with depressed, elderly, community dwelling volunteers. Subjects attended at least 26 out of 40 therapy sessions (1 1/2 hrs., once or twice a week) over a nine month period. Both groups demonstrated statistically significant reductions in observer and self-reported depression and anxiety. The authors concluded that both approaches were equally effective in relieving depression.

Yost, Beutler, Corbishley and Allender (1986) developed a comprehensive guide to applying group cognitive therapy with depressed older people. Based on their clinical experience, Yost et. al. advocated a flexible, eclectic approach in group therapy
with older people, incorporating a wide range of procedures to help them develop "the skills needed for self-assertion and self-acceptance, which will help them restore interpersonal and social contacts" (p. 13). The view of these authors was that a desirable treatment for older people would resemble an educational approach rather than a dynamic, interactional therapy group.

Beutler et. al. (1987) explored the relative and combined effectiveness of the drug alprazolam (Xanax) and group cognitive therapy among older people experiencing major depressive disorder. A total of 56 depressed subjects (31 women) aged 65 or over were treated over a 20-week period in one of four groups: alprazolam support, placebo support, group cognitive therapy plus placebo support, and group cognitive therapy plus alprazolam support. The cognitive therapy followed the form developed by Yost et. al. (1986). Depressive symptoms were measured by self-reports on the Hamilton Rating Scale for Depression and the Beck Depression Inventory, and by Sleep Efficiency recordings. Although subjects in all groups improved over time, improvement was significantly affected by cognitive group therapy and was non-significantly affected by alprazolam. In addition, subjects in group cognitive therapy sustained their improvement over a 3 month follow-up period in contrast to non-group therapy subjects. The study failed to find specific cognitive changes that might explain the differential improvement in group cognitive versus drug-based therapies, leading the authors to conclude that "the
questions remains, therefore, as to whether cognitive group therapy is more effective than other forms of psychological intervention or, simply, of group support" (p. 555).

Tross and Blum (1988) reviewed studies of group therapy outcomes with older people. They found results that characterize the general psychotherapy outcome literature, that is, similar benefits are achieved even when different therapy approaches are used. These authors suggested that elements present in all the therapies (e.g. therapist attention, interpersonal contact, and empathy) likely explain the uniform benefits.

**SUMMARY**

The concepts of social identity degradation and social identity deficit explain how the disadvantaged status of older women places them at risk for depression, anxiety and low self esteem. Chief among the factors compromising older women's mental health are the stigmas attached to being old and female and the difficulties accompanying socio-economic strain and chronic health problems. The majority of older women manage to negotiate old age and carve out a life for themselves, mainly by involving themselves in volunteer organizations and informal social networks. Nonetheless, too many succumb to the insults of later life because they simply do not have the social and personal resources to do otherwise.

The notion that depression results from a social identity deficit implies that preventive and remedial programs should focus on improving older women's social environment.
Evidence on factors that place older women at risk for depression suggests that macro-level policies and programs must be aimed at ensuring that women of all ages have access to adequate income and housing, appropriate health and support services, and opportunities for education, training and employment. Micro-level initiatives must be aimed to help depressed women create healthy social identities through mutual group support, education, skill development and network augmentation. Health-promoting social networks are particularly crucial during times of diminished health, marital disruption, bereavement and financial strain.

But the degree to which interventions are effective in strengthening older women's identity and reducing depression will depend on how well program designers are informed about older women's experience, and on how well programs fit older women's learning needs. According to the literature, educational and small group approaches are the methods of choice in promoting the kind of learning and experiencing which helps older women achieve healthy social identities.

Results on outcome studies of small group, education-oriented programs applied with young and middle-aged depressed women, and depressed older people, indicate that such strategies are effective in reducing depression. None of the studies demonstrated specific program components (e.g. cognitive therapy, psychoanalysis procedures, or education) as responsible for the beneficial outcomes. The findings suggested that the ingredient
common to all of the interventions was "relational" support, and that this factor may be the one that produced positive change. The main premise of the Social Health Outreach Program is that social involvement and relational support are essential elements in achieving a healthy social identity and overcoming depression.
III. METHODOLOGY

This study incorporated two methodological components: 1) The research methodology section which includes discussion on study design, setting, recruitment, screening, subjects, dropout, instruments, data collection procedures, and data analysis procedures; and 2) The educational methodology section which describes how the original Social Health Outreach Program (SHOP) was adapted for this study in terms of program goals and course outline, facilitator's role, and instructional techniques.

THE RESEARCH METHODOLOGY

Design of the Study

Two groups of women, aged 58 - 76, participated in an adapted version of SHOP. The main aims of the SHOP program were to help older women augment their personal social networks and achieve healthier social identities, thus reducing depression. A quasi-experimental, time series research design was applied as illustrated in Figure 1. Data collected through questionnaire and interview procedures were used to determine the following: 1) the impact of the intervention on participants' levels of depression and demoralization, and on their social networks; 2) their perceptions about which activities and processes helped, and which hindered, their progress during the program; and, 3) their perceptions of the experience of depression.
Figure 1: Design of the Study

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public announcement and recruitment process began</td>
<td>6 weeks before program</td>
</tr>
<tr>
<td>Screening; pre-tests administered (CES-D; GWB)</td>
<td>2 weeks before program</td>
</tr>
<tr>
<td>SHOP commenced</td>
<td>Week 1 of program</td>
</tr>
<tr>
<td></td>
<td>Week 2</td>
</tr>
<tr>
<td></td>
<td>Week 3</td>
</tr>
<tr>
<td>Background Information Interviews conducted</td>
<td>Week 4</td>
</tr>
<tr>
<td></td>
<td>Week 5</td>
</tr>
<tr>
<td></td>
<td>Week 6</td>
</tr>
<tr>
<td></td>
<td>Week 7</td>
</tr>
<tr>
<td></td>
<td>Week 8</td>
</tr>
<tr>
<td></td>
<td>Week 9</td>
</tr>
<tr>
<td>SHOP ended; evaluation questionnaires completed; Post-tests (CES-D, GWB) and Post Program Interview completed</td>
<td>Week 10</td>
</tr>
<tr>
<td></td>
<td>Week 11</td>
</tr>
<tr>
<td>Administration of: Follow-up Interview; CES-D and GWB.</td>
<td>3 months after program ends</td>
</tr>
</tbody>
</table>
The Setting

The SHOP program was conducted at two busy seniors' centres close to downtown Vancouver. These sites were chosen for several reasons: 1) They were readily accessible by public transportation and one was located in an area where women could walk to the centre; 2) They were community based and not associated with traditional mental health services, which older women tend not to use; 3) Research on older peoples' learning activities has demonstrated that seniors' centres were a sponsor of choice (Clough, 1990), and finally, 4) The centres operated on a drop-in basis, offering an array of opportunities to participate in educational and recreational programs, or as a volunteer. Selecting these sites also familiarized participants with a senior centre in the event that some might view it as a place to "get involved" after completing SHOP.

Recruitment

The recruiting process targeted older women, living independently in the Vancouver area, who were able to get to a senior centre on their own. Recruiting was a challenging task which began about seven weeks prior to the first session of the program. The following strategies were used:
1. Three seniors' groups were addressed directly in order to provide verbal and written information about the program and to invite them to call for further information, or to suggest the program to their friends.
2. The program was listed in a parks and recreation brochure
which outlined local programs for seniors.
3. A feature article was printed in two community newspapers.
4. A paid advertisement was run in the Province newspaper.
5. Women on the Mature Women's Network waiting list for SHOP were contacted. This wait list was established when earlier SHOP programs were unable to accommodate all applicants.
6. Local agencies that provide services to seniors were informed about the program and invited to make referrals.
Information sheets about the program were delivered to the following agencies: seniors' centres, health department seniors' wellness programs, a community mental health centre, a seniors' outreach program neighborhood houses, geriatric short stay assessment and treatment centres and community libraries.
Although each strategy produced at least one phone call, number three was the most successful.

The need to adjust the language of mental health to terminology that is meaningful to older women is discussed in the literature (Beck & Pearson, 1989). The initial recruitment poster used in this study (see Appendix A-1) was viewed somewhat dimly by senior centre personnel. Two of them suggested that the language was too "heavy". One volunteer commented, "This comes across as a bit negative. Who wants to talk about depression, it's too depressing". As a result of this feedback, promotional material was revised and prospective participants were invited as follows: "Learn ways to restore your social confidence, build support in your life and overcome depression in an atmosphere of
friendship and support" (see Appendix A-2).

Screening

All prospective volunteer participants were first informed about the program and the research. They were made aware that the aim of the research was to improve the quality and delivery of programs and services for women. They were assured that their responses would be kept confidential, and that a numbering system had been devised to assure the anonymity of the data. They were asked to sign a consent form (see Appendix A-3). In addition participants were invited to inform their physicians about their participation if they so desired, although it was not mandatory. The screening interviews started two weeks prior to and continued into the first week of the program mainly because some women arrived at session one without having called ahead of time. The purposes of these interviews were to meet the women, inform them about the program, answer any questions, and administer three instruments: the National Institute for Mental Health Diagnostic Interview Schedule (DIS) (Helzer & Robbins, 1988), the Centre for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977), and the General Well Being Schedule (GWB) (Fazio, 1977).

The DIS has been established as a reliable and valid tool that can be used to detect a broad variety of psychiatric conditions and can be applied by trained lay or clinician interviewers for screening as well as diagnosis. The DIS was originally developed for use in a large U.S. survey commissioned by the National Institute of Mental Health (Helzer & Robins,
1988). Since the CES-D scale measures level of depressive symptoms only, the DIS was administered by a trained lay interviewer in this study to establish a diagnosis of depression, and to screen out women with any of the following disorders: bipolar disorder, phobias, panic disorder or untreated alcoholism. The decision was made to exclude women with these conditions from the study since it was felt that they likely required treatment specific to their problems first, in order to benefit from SHOP. The diagnosis of depression was established so that data on participants who met the DIS depression criteria could be added to an already established data base on SHOP outcomes. However, the change in emphasis for this version of SHOP meant that it was no longer being promoted exclusively as a treatment for depression and, thus, a diagnosis for depression was not a requisite for inclusion. As a result participants had levels of depression ranging from "severe" to "non depressed".

Although the initial intent in this study was to include only women 65 and over, 3 depressed women aged 58, 59 and 63 expressed interest in participating. A decision was made by the researcher to accept women 55 and over, in keeping with the wishes and admission policy of the seniors' centres hosting the program.

Subjects

A total of 15 women from Vancouver and New Westminster, British Columbia completed the program. The first group session ran from November, 1989 through January, 1990 and the second ran from end January to mid April, 1990. A profile of participants
is provided in Table 1.

Most of the participants lived alone (73%), and most were not employed (93%). In addition, over half of the subjects reported limiting physical disabilities (53%), and one third reported using psychotropic drugs regularly (33%). The subject group was dissimilar to the general population of older women in Canada as follows: most of the subjects were unattached due to divorce, separation or single status (73%), rather than widowhood; the average educational attainment was grade 12, which is slightly higher than that for women of this age group; and finally, they had slightly higher incomes—while almost half of the unattached subjects (47%) had annual incomes of $10,000 or less, for the general population of unattached older women, 78% live on $10,000 or less annually, (Gee & Kimball, 1987).

Dropouts

Since severely depressed and non-depressed women were mixed in the groups there was some concern that this might have a detrimental effect on group cohesion and on depressed participants' sense of belonging. In the November to January group this was not a problem. One of the non-depressed participants initiated lunch outings and activities outside the group which many of the depressed women joined and enjoyed. There were no dropouts from this group and attendance was excellent. In the January to April group one depressed woman withdrew stating she "could not keep up with the discussion". She may have been more willing to continue had she perceived
TABLE 1
PARTICIPANT SOCIODEMOGRAPHIC AND HEALTH-RELATED CHARACTERISTICS

<table>
<thead>
<tr>
<th>Variable</th>
<th>(n=15)</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>58-76 years</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>65.6 years</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>11</td>
<td>(73%)</td>
</tr>
<tr>
<td>With spouse or adult child</td>
<td>4</td>
<td>(27%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never-married</td>
<td>3</td>
<td>(20%)</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>(13%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>(13%)</td>
</tr>
<tr>
<td>Divorced or Separated</td>
<td>8</td>
<td>(53%)</td>
</tr>
<tr>
<td>Reported Annual Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ 0 - 2,000</td>
<td>1</td>
<td>(7%)</td>
</tr>
<tr>
<td>5,000 - 9,999</td>
<td>6</td>
<td>(40%)</td>
</tr>
<tr>
<td>10,000 - 14,999</td>
<td>4</td>
<td>(27%)</td>
</tr>
<tr>
<td>15,000 - 19,999</td>
<td>2</td>
<td>(13%)</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$40,000 and over</td>
<td>2</td>
<td>(13%)</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not employed</td>
<td>14</td>
<td>(93%)</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial high school</td>
<td>4</td>
<td>(27%)</td>
</tr>
<tr>
<td>Completed high school</td>
<td>7</td>
<td>(47%)</td>
</tr>
<tr>
<td>Partial or complete university degree</td>
<td>4</td>
<td>(27%)</td>
</tr>
<tr>
<td>Limiting Physical Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>(47%)</td>
</tr>
<tr>
<td>One or Two</td>
<td>8</td>
<td>(53%)</td>
</tr>
<tr>
<td>Level of Depression at Pre-test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;16 on CES-D</td>
<td>5</td>
<td>(33%)</td>
</tr>
<tr>
<td>16 or greater on CES-D</td>
<td>10</td>
<td>(67%)</td>
</tr>
<tr>
<td>Previous Depression Episodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>(27%)</td>
</tr>
<tr>
<td>One</td>
<td>3</td>
<td>(20%)</td>
</tr>
<tr>
<td>Two or more</td>
<td>8</td>
<td>(53%)</td>
</tr>
<tr>
<td>Psychotropic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>(73%)</td>
</tr>
<tr>
<td>One or Two</td>
<td>4</td>
<td>(27%)</td>
</tr>
</tbody>
</table>
others in the group to be like herself. Thus, the "mixed" nature of the group may have been problematic in this case.

Many of the women in both groups were coping with physical health problems, most often arthritis or back problems. Although this did not affect attendance in the first group, it did result in absenteeism for some members of the second group. In addition, four women dropped out of the second group--three due to fear of falling in poor weather conditions (snow, ice) and a fourth when she got a job.

**Instruments and Data Collection Procedures**

*The Centre For Epidemiological Studies Depression Scale (CES-D)* (see Appendix B-1) is a 20 item self-report scale designed to determine level of depressive symptoms in the general population. Its original development was based on clinical findings, frequency of item use in other depression questionnaires and factor analytic studies (Radloff, 1977). The reliability and validity of the CES-D has been established over a wide variety of sub-groups including the elderly (Radloff & Teri, 1986). Test items relate to depressed mood, feelings of guilt and worthlessness, fearfulness, helplessness and hopelessness, physical and cognitive slowing, loss of appetite and insomnia. The scale measures current level of depressive symptoms and does not measure duration or prevalence over a lifetime. The potential range of scores is 0 to 60; in this study, following previous research (Radloff & Teri, 1986), depression was operationally defined as a score of 16 or greater. Scoring for
each item is on a four point scale and the sum of the numbers for each item represents the total. Scoring for positively worded items (4,8,12,16) is reversed. In this study the CES-D was administered at screening, post-test and 3 month follow-up. Some participants asked to do the questionnaire orally at the screening session and the researcher accommodated this request.

The General Well Being Schedule (GWB) (see Appendix B-2) is a self-report instrument which, in validation tests, has been found to constitute a unidimensional scale measuring what has been labelled as distress/depression by Fazio (1977), and demoralization by Link and Dohrenwend (1980). Murrell and Himmelfarb (1983) found a statistically significant correlation between the GWB and the CES-D as measures of mental health in an elderly population. The 18 item GWB sub-scale asks participants to report on mental status symptoms "during the past month"; so does not indicate duration or prevalence throughout a lifetime. The potential range of scores on the GWB subscale is 0 to 110; scores of 70 or less indicate distress/demoralization. In this study the GWB was administered concurrently with the CES-D at screening, post-test and 3 month follow-up. The main purpose, as with the DIS, was to replicate procedures used in previous SHOP research and contribute to the data base. Previous SHOP research used the GWB as a measure of demoralization with a view toward exploring the assumption that female depression is a manifestation of low morale.

Background Information Interviews (see Appendix B-3) were
conducted in order to outline sociodemographic and health-related characteristics of the study sample. Interviews were conducted during the first few weeks of the program.

Post Program Interviews (see Appendix B-4) were the main source of data in regard to participants' experiences of depression before the program and their perceptions about what factors helped or hindered their progress during the program. The interviews were conducted in the week immediately following SHOP. The procedure followed an in-depth interviewing approach developed by Amundson and Borgen (1987, 1988) to study the experience of unemployment. This approach combines phenomenological and critical incident procedures to arrive at subjects' perceptions about their experience. In this study each interview lasted from 30 to 45 minutes and was audiotaped. Interviews began with open-ended questions designed to encourage participants to describe, with a minimum of imposed direction, their experience of depression and their experience during the SHOP program. Later the interview questions addressed specifically the high points and low points for participants' during the program, either in SHOP or outside the program, and their expectations for the future. Appointments for interviews were scheduled in the last program session and were conducted in the week following the program.

Follow-Up Interviews (see Appendix B-5). At the end of the program participants were informed that they would be contacted in approximately three months for a follow-up interview. They
were contacted by telephone to arrange a time to meet. Appointments were half an hour in duration and were designed to solicit information about the following: quantitative changes that occurred in participants' social networks following SHOP; and, any comments they wanted to make about SHOP after a period of reflection.

Data Analysis Procedures

The quantitative data was analyzed using the Statistical Package for the Social Sciences (SPSS). Each participant was assigned a code letter for recording sociodemographic information and test scores. Network changes and test score changes were calculated from the raw data.

The main statistical measures used in this study included: the Pearson product-moment correlation coefficient to show the degree of relationship between means, and t-tests of paired means to determine whether or not pre-, post- and follow-up changes were due to chance. Significance level was set at $p \leq .05$.

The qualitative data was analyzed using content analysis of interview data based on a method originally developed by Flanagan (1954) and extended by Amundson and Borgen (1987; 1988); and on a method used by Keller, Leventhal and Larson (1989). The content analysis process consisted of the following steps:
1. Transcribing of taped interviews.
2. Summarizing of interviews (see Appendix C) to provide an overview of participants' experience of depression and their experience during the program.
3. Conducting a validity check of these summaries. Eight out of 15 participants (53%) were contacted by telephone. The decision on who to contact was made on the basis of the ease with which they could be reached by telephone. Respondents were informed that a summary of their experience before and during the program would be read to them, and after, they would be asked to verify the accuracy of this summary. All of the respondents felt the summary accurately reflected their experience. One requested a small change of wording in regard to a medical problem to protect her anonymity, and a second requested addition of the sentence, "what I learned in SHOP was how to beat the blues".

4. Writing "meaning units" on cards, as derived from analysis of transcriptions.

5. Grouping responses to the first question into broad categories which reflect the main themes in participants' experience of depression before the program. A card sort procedure was used.

6. Next, establishing categories of helpful, and hindering, activities and processes during the program by sorting meaning units via themes, as derived from responses to the remaining interview questions.

7. Reliability check of the category system. A student who had completed an M.A. in education was asked to assign meaning units for each subject to the established categories. The 86% agreement rate exceeded the 80% rate criterion established as an acceptable standard.
Based on the effectiveness of this methodology established in earlier studies, and on the validity and reliability checks in this study, it is reasonable to conclude the following: the summaries accurately represent participants perceptions of their experience of depression; and, the category system is a reliable representation of which activities and processes participants perceived as helpful, and which they perceived as hindering, to their progress during the program.

THE EDUCATIONAL METHODOLOGY

Modifications to the SHOP Program

SHOP has evolved over time based on feedback from participants and evaluation by the program designers. Although SHOP's original purpose was "sociotherapy" for depression in middle-aged women, the program can be modified and applied in a variety of ways. Besides extending SHOP to an older group of women, for this study several adaptations were made:

1. The program length was reduced to 20 sessions (2 hrs., twice a week). This decision was made when initial publicizing of a 36 session (18 week) program yielded a limited response. Senior centre programmers suggested that many older people would hesitate to commit to an 18 week program.

2. In view of reduced program time, some content was deleted. Since most of the women were not seeking a paying job, some sessions devoted to resume preparation and job
finding were omitted. Material relating to depression was substantially condensed as well.

3. For this version of SHOP the author conducted all of the sessions with resource "experts" featured in some (a pharmacist, a sleep disorders specialist, a seniors' network coordinator, a senior centre board member). Earlier SHOP programs used different facilitators, with appropriate expertise, for each of three components--"education", "retooling" and "recycling"--with resource experts brought in for some of the sessions.

The program goals and a course outline for the 20 session version of SHOP are described in Appendix D-1.

Facilitator's Role and Instructional Techniques

Since SHOP aims to empower participants, and following SHOP's established policy, the facilitator did not adopt an "expert" stance. "Being facilitative essentially means that the worker is helping others, including other persons and their support systems, to do the doing by increasing their capacities for problem-solving" (p. 142, Biegel, Shore & Gordon, 1984). Other roles the facilitator assumed are: program coordinator, instructor, resource provider, counsellor, supporter and linker (stimulating network development). The facilitator for this group was the researcher, a 35 year old graduate student. At the first session she discussed with participants the difference between herself and them in terms of age and life experience. Participants were invited to comment if they considered this a
problem at the outset or during the program. The age difference was not perceived as a problem then or later.

The following instructional techniques created an interactive learning experience: "mini" lectures followed by discussion, small group in-class activities and discussion, reflection on life experience, case studies and homework assignments. In addition, the facilitator informally encouraged humour and some light-heartedness in the sessions.

Program Evaluation

During the final program session participants completed a written SHOP evaluation questionnaire (see Appendix D-2) which was designed to solicit feedback about SHOP activities. Questionnaire items focused on specific knowledge and skill development sessions. Results are discussed in Chapter IV.
IV. FINDINGS AND DISCUSSION

The findings of the study are presented and discussed in five sections: 1) outcome measures; 2) activities and processes that helped, or hindered, participants' progress during the Social Health Outreach Program (SHOP); 3) evaluation of SHOP program content; 4) participants' experience of depression; and 5) summary of field notes.

OUTCOME MEASURES

Levels of Depression and Demoralization

Table 2 summarizes Centre for Epidemiological Studies Depression Scale (CES-D) and General Well Being Schedule (GWB) scores at pre-, post- and three month follow-up intervals, for the whole group (n=15), and for two subgroups that evolved from the data analysis--those who were depressed at pre-test (n=10) and those who were non-depressed at pre-test (n=5). As will be seen, depressed participants test scores on CES-D and GWB measures differed in comparison to non-depressed participants. Participants' CES-D and GWB scores were expected to improve from pre-test to 3 month follow-up; however, it was anticipated that a temporary heightening of depressive symptoms may occur at post-test related to sadness or concern over the group ending.

The whole group, on average, showed an improvement of 2.3 units in CES-D scores from pre- to post-test (9%; p = .4); the improvement continued through to follow-up for a total pre- to follow-up difference of 5.6 units (22%; p = .06).
### TABLE 2

MEANS & STANDARD DEVIATIONS FOR CES-D & GWB MEASURES (*)
AT PRE-, POST, & FOLLOW-UP EVALUATIONS FOR WHOLE GROUP, DEPRESSED, & NON-DEPRESSED PARTICIPANT GROUPINGS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Measure</th>
<th>Pre-Test</th>
<th>Post-Test</th>
<th>3 Month Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES-D n=</td>
<td>15</td>
<td>14</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>25.06</td>
<td>22.78</td>
<td>19.40</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>15.31</td>
<td>12.05</td>
<td>12.94</td>
<td></td>
</tr>
<tr>
<td>Depressed Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES-D n=</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>33.50</td>
<td>25.20</td>
<td>23.40*</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>11.01</td>
<td>11.87</td>
<td>12.73</td>
<td></td>
</tr>
<tr>
<td>Non-depressed Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES-D n=</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>8.20</td>
<td>16.75</td>
<td>11.40</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>3.76</td>
<td>11.75</td>
<td>10.06</td>
<td></td>
</tr>
<tr>
<td>Whole Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GWB n=</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>57.77</td>
<td>61.23</td>
<td>60.23</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>24.98</td>
<td>22.70</td>
<td>20.24</td>
<td></td>
</tr>
<tr>
<td>Depressed Group</td>
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<td></td>
</tr>
<tr>
<td>GWB n=</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>48.88</td>
<td>56.55</td>
<td>54.55</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>24.65</td>
<td>24.26</td>
<td>21.65</td>
<td></td>
</tr>
<tr>
<td>Non-depressed Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GWB n=</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>M=</td>
<td>77.75</td>
<td>71.75</td>
<td>73.00</td>
<td></td>
</tr>
<tr>
<td>SD=</td>
<td>10.34</td>
<td>16.68</td>
<td>8.67</td>
<td></td>
</tr>
</tbody>
</table>

(*) CES-D - Centre for Epidemiological Studies Depression Scale
GWB - General Well Being Schedule

- Pre- to follow-up difference significant at p = .004
In regard to GWB, the mean difference in scores from pre-test to post-test (3.5 units; 6%; p = .4), and from pre-test to follow-up (2.5 units; 4%; p = .5) revealed slight but non-significant improvement.

For the whole group, scores on the CES-D scale were significantly correlated to scores on the GWB schedule which measures demoralization. The correlation between mean change in GWB and mean change in CES-D from pre-test to follow-up was -.58 (p = .01). In other words, on average, as CES-D scores decreased, GWB scores increased; thus supporting previous analyses which pointed out that the GWB measures some of the same constructs as the CES-D (Murrell and Himmelfarb, 1983).

Depressed participants' CES-D scores, on average, dropped by 8.3 units from pre- to post-test (25%; p = .058) and an additional 1.8 to follow-up, for a total pre- to follow-up improvement of 10.10 units (30%; p = .004). Three of the 10 subjects who were depressed at pre-test were non-depressed at 3 month follow-up.

Non-depressed participants' CES-D scores, in contrast, increased by 8.5 points from pre- to post-test, and dropped back by 5.3 points at 3 month follow-up for a net pre- to follow-up increase of 3.2 units—still within the non-depressed score range. Thus, non-depressed participants' scores showed the anticipated end-of-program heightening of symptoms and a return toward 'normal' scores at 3 month follow-up.

A comparison between depressed versus non-depressed
participants on mean change in CES-D scores from pre-test to follow-up showed that the two groups differed significantly at p = .05 on a t-test of paired means. This suggests a treatment effect for the depressed subjects.

GWB scores followed a pattern similar to CES-D scores for the depressed and non-depressed groups. On the GWB the depressed group showed an average pre- to post- improvement of 7.7 units (16%; p = .2) and a dropping back at follow-up for a net pre- to follow-up improvement of 5.7 units (11.6%; p = .30). The non-depressed group showed an average GWB decrease of 6.0 units (7%) from pre-test to follow-up, and a 2 unit improvement at follow-up (non-significant).

CES-D and GWB outcomes demonstrate that SHOP had a positive impact in reducing participants' levels of depression and demoralization, particularly for those women who were depressed at pre-test. The depressed women showed a sharp decline in CES-D scores from pre- to post-test with no heightening of symptoms when the program ended. The declining trend, although not as pronounced, continued to 3 month follow-up.

Impact on Social Networks

Obtaining a measure of social networks required a sensitive approach from the researcher in view of participants' feelings of vulnerability about revealing this type of information. During the fourth program session participants created personal network maps based on written logs kept over a two week period. Some of the depressed participants who had very small networks
disliked the mapping exercise and hesitated to participate. Their feelings were exemplified in the comments of two women:

"I found the exercise depressing. I've never had a social network except for one period in my life when I was single with no kids, and was doing a lot of swimming".

"This exercise is depressing. It shows what a shambles my life is".

To illustrate, the network maps of a depressed woman and a non-depressed woman are replicated on a smaller scale in Figures 2 and 3. On the maps each segment of the "pie" represents a role sector in the woman's life; the tiny squares represent people known by her in each role sector. People seen or contacted by telephone at least every two weeks are closer to the centre of the map (self); people seen less often are further from the centre. As is evident, the depressed participant indicated that she had very few network members (6), and 'role sectors' (4 or 5). In contrast, the non-depressed woman's network map had many members (100+), and revealed a greater variety of 'role sectors' (8).

Although it was possible to build a learning situation around the exercise (e.g. discussion of factors that influence social networks at different points in life), the researcher decided that it was not appropriate to pursue detailed before and after network data from participants when they were obviously feeling so vulnerable about it.
Figure 2: Network Map of a Depressed Participant

- Friends
- Neighborhood
- Browse-mall
- (doctor)
- Seniors' Centre
- Professionals
- Family

SELF
Figure 3: Network Map of a Non-depressed Participant
Thus, to obtain a measure of changes in social networks, at a three month follow-up interview participants were asked to report on network changes in terms of people and groups. They reported retrospectively on how many friends, acquaintances, professionals and groups (including courses taken and new volunteer roles) were added to, or lost from, their networks.

Table 3 reports the number of people and groups added to, or lost from, each participant's social network; it also reports the mean additions and losses of people and groups for depressed participants, non-depressed participants and the whole group. Participants' networks changed, on average, as follows: 1) depressed participants had a net gain of 4.2 people and 1.7 groups, and non-depressed participants had a net gain of 5.0 people and 1.2 groups--there was no significant difference between these two groups; 2) when the whole group was considered, participants had a net gain of 4.5 people ($z = .347; p = .000$) and 1.5 groups ($z = 3.61; p = .000$). Thus, on average, participants reported significantly more additions of people and groups to their networks than losses in the three month period following SHOP. In comparison, depressed participants added fewer people and more groups to their networks relative to non-depressed participants; however, no significant differences emerged between these two participant groupings.

The findings support the hypothesis that women who participate in SHOP will increase the size of their social networks. Moreover, the findings indicate that SHOP mobilized
# TABLE 3
SOzial Network Changes Reported by Participants
at 3 Month Follow-Up

<table>
<thead>
<tr>
<th>Participant</th>
<th># of People added</th>
<th># Groups added</th>
<th># of People lost</th>
<th># Groups lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>E</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>J</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>K</td>
<td>17</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>L</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>O</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant</th>
<th># of People added</th>
<th># Groups added</th>
<th># of People lost</th>
<th># Groups lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>M</td>
<td>1</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>N</td>
<td>1</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

Mean

<table>
<thead>
<tr>
<th></th>
<th>Whole Grp</th>
<th>Depressed</th>
<th>Non-Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td># of People added</td>
<td>5.2</td>
<td>4.9</td>
<td>5.8</td>
</tr>
<tr>
<td># Groups added</td>
<td>.7 (+4.5)</td>
<td>.7 (+4.2)</td>
<td>.8 (+5.0)</td>
</tr>
<tr>
<td># of People lost</td>
<td>1.8</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td># Groups lost</td>
<td>.3 (+1.5)</td>
<td>.3 (+1.7)</td>
<td>.2 (+1.2)</td>
</tr>
</tbody>
</table>

People - includes friends, acquaintances or professionals.
Groups - includes organizations participants joined as a member, volunteer, or employee and leisure interest (e.g. educational and recreational) groups.
the depressed participants to take action on increasing their involvement in community groups.

**ACTIVITIES AND PROCESSES THAT HELPED, OR HINDERED, PARTICIPANTS’ PROGRESS IN SHOP**

While CES-D and social network measures established the beneficial outcomes of SHOP, they did not clarify what produced these positive changes. The Post Program Interview (see Appendix B-4) was undertaken to determine participants' perceptions about change factors; that is, which factors advanced, and which impeded, their progress during the program. With a minimum of imposed structure, participants were encouraged to talk about their experience during the SHOP program, and high points or low points they experienced during that time. The intent was to illuminate activities and processes, either in SHOP or outside of SHOP, that had moved them forward or set them back, during the program.

Based on the theoretical assumptions of this study, one would expect that helping factors would relate to participants' increasing their social involvement, augmenting their social identity and experiencing a greater sense of self worth. Conversely, hindering factors would deter them from social participation and undermine their self worth.

Specific factors reported by participants as helpful or hindering during SHOP were determined by analyzing responses to Post Program Interview items. The 15 women in this study reported 205 helping and 130 hindering incidents which occurred.
either in or outside of SHOP during the program period. An analysis of incidents led to the development of 20 categories of helping, and 19 categories of hindering, activities and processes which are described in the following sections.

Categories and Descriptions of Helping Factors

Table 4 shows how often and how many participants mentioned each helping category. Those mentioned by 25% or more participants are then described, including direct quotations.

Positive Future Plans. A sense of positive planning, goals or intentions for the future.

"I'm going to be more intelligent about how I handle my health....I'm gonna monitor things and I'm going back in two weeks and I'm gonna be asking alot of questions (of her doctor). I bought myself a big fat notebook and I went to the doctor and told her that from now on I'm going to write down during our talk".

"My goal is to get back on my feet and find a place to live".

SHOP Routine and Process. Experiencing SHOP as something to look forward to; that having the structure of the regularly scheduled sessions provided a focus; a sense that coming to SHOP was enjoyable\pleasurable, worthwhile, interesting or stimulating.

"The structure does give relief. I would like to structure my life a lot more".

"These sessions have been a great joy to me and I really have looked forward to them".

"I enjoyed coming to the group because it was interesting".

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### Table 4

**Helping Factors Reported by Participants**

<table>
<thead>
<tr>
<th>Categories</th>
<th>No. of times mentioned</th>
<th>No. of S mentioning factor</th>
<th>% of S mentioning factor</th>
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</thead>
<tbody>
<tr>
<td>Positive future plans</td>
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<td>14</td>
<td>93</td>
</tr>
<tr>
<td>SHOP Routine\Process</td>
<td>25</td>
<td>11</td>
<td>73</td>
</tr>
<tr>
<td>Positive image\outlook</td>
<td>23</td>
<td>10</td>
<td>66</td>
</tr>
<tr>
<td>Family\friend support</td>
<td>12</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Recognizing improvement in self or situation</td>
<td>29</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Mutual support\aid</td>
<td>23</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Reassessment of self</td>
<td>23</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Keeping active</td>
<td>7</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Relief in feeling better</td>
<td>6</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Learning from experience</td>
<td>4</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Pursuing interests</td>
<td>4</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Positive thinking</td>
<td>3</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Sense of contribution</td>
<td>3</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Life skills</td>
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<td>13</td>
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<tr>
<td>Leadership</td>
<td>4</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Relaxed atmosphere</td>
<td>4</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Homework\handouts</td>
<td>3</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Absorbing others success</td>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Information</td>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

78
Positive Image\Outlook. A positive acknowledgement about self or one's accomplishments; a positive attitude toward one's situation and other people; a sense of possibility or optimism, that problems can be solved; that a difficulty is not insurmountable.

"I thought I'd make an appointment to have lunch with M. She lives near my doctor...if she says no I won't feel rejected...I'll try again".

"I realized I've been a good listener...I guess I appear very open about myself".

Family\Friend Support. Feeling encouraged or recognized or experiencing companionship with family or friends outside of SHOP.

"I sent a card to a male friend who I hadn't seen in awhile. We ended up having coffee. We had a great time".

"I've seen and talked to people that were kind to me. It really boosts your self-esteem".

Recognizing Improvement in Self or Situation. An acknowledgement that one has enacted positive behavior change; feeling uplifted as a result of recognizing an improvement in oneself, one's actions, one's situation or relationships with others.

"I actually did a little bit of cooking. That's the first time I've been able to get close to preparing anything".

"I surprised myself with being able to socialize with the women in the group".

"I was really bogged down until halfway through SHOP and then I began to think its not the end of the world".

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Mutual Support/Aid. An experience of belonging, companionship, comaraderie or friendship in SHOP. An exchange of support, assistance, solace, encouragement and recognition among SHOP group members; helping each other.

"I had soulmates in the group. I really felt kinship and less isolated".

"It was nice, the fact that we went to lunch and the company those days".

"The others gave me their phone numbers and I can phone any of them".

Reassessment of Self. Experiencing an increased understanding or insight about oneself or one's situation.

"I can't stand just melding in with the woodwork...A few times I was shocked at what I was saying and I was almost sick when I went home. But then I thought, well it feels good and I want people to accept the person I really am, not what they initially thought I was".

"What works is I understand myself so much better. You know I've lived to this age without knowing a few things about myself".

Keeping Active. A sense that it helps to keep busy by engaging in physical activities, getting out of the house or apartment, or joining a community activity.

"I feel as long as I'm able to keep moving its best not to sit down...try and keep active while I can".

"It is helpful to make myself go out everyday".

Relief in Feeling Better. A feeling of being in better spirits or feeling good; a sense of relief.

"I really am surprised at how much better I feel. In fact, I feel completely normal".

"I am trying to be really truthful..I think I have been feeling better since SHOP".
Learning from Experience. Appreciating learning from reflection on the experience of self and others in group discussion or one-to-one encounters; getting ideas from others; seeing how others live.

"I always like to learn from people...that's how I learn, better than from books".

"The others gave me ideas about things you could do and activities".

Discussion of Helping Factors

When the helping factors were analyzed the prominent ones involved self worth, social identity or social participation. Several helping factors reflected that many participants were developing a healthier view of themselves: positive future plans; positive self image and outlook; recognizing improvement in self or situation; reassessment of self; and relief in feeling better. Other helping factors reflected an increase in social involvement: SHOP routine/process; family/friend support; mutual support or aid from SHOP members; and learning from life experience.

Since participants were specifically asked about their expectations for the future, it is not surprising that such a high percentage of them (93%) mentioned positive intentions or goals for the future. It was clear that participants found it beneficial to have a meaningful focus and involvement in their lives. This was evident in their comments about looking forward to coming to SHOP, enjoying SHOP because it was interesting, and planning for the future. In light of participants' experiences
of boredom and aimlessness prior to SHOP it is not surprising that they found the structure, process and goal orientation of the sessions to be helpful (see section on The Experience of Depression, p. 94). They experienced relief through focusing their attention and energy on SHOP, instead of on negative emotions and thoughts. Throughout the program, several participants continued to assuage feelings of depression through physical activity and "keeping busy" as they had done before the program. SHOP's format as a group educational program, rather than a dynamic therapy group, encouraged participants to concentrate on issues and circumstances external to themselves and, thus, helped them to begin moving beyond the devastating self-criticism which was part of their depression experience. Several participants mentioned that it was helpful to learn from reflection on their own, and others, life experience--a factor which also emerged as helpful on written program evaluations.

There is an interesting parallel between the findings of this study and those of Amundson and Borgen (1988), who determined helping factors for unemployed people (average age 34.6 years) enrolled in group employment counselling. They found that helping factors were those which met participants' basic needs for community, meaning and structure. Similar to younger unemployed people, the older women in this present study reported helping factors that met their needs for meaningful and regular social involvement. Both older women and the unemployed occupy undervalued roles according to our society's standards,
and consequently, it is difficult for them to maintain a healthy social identity.

**Categories and Descriptions of Hindering Factors**

Hindering factors, those that impeded participants' progress, as reported by participants are presented in Table 5. Those categories mentioned by 25% of the participants are described and illustrated.

**Negative Thinking.** Having self-critical thoughts—seeing oneself as useless, as a failure, or as not trying hard enough; having thoughts that focus on problems and negative attributes of others, death or suicide.

"I've made so damn many mistakes that you can't get over them all...I really loused it up".

"I feel so frumpy, you know, my hair and wrinkles".

"I wake up at six o'clock...the first thing on my mind is problems".

**Lack of Sense of Belonging in SHOP.** Experiencing feelings of "not fitting in" to the SHOP group, a sense of being different than the others in the group.

"Nobody's phoned me, and I know they phone one another".

"At first I thought these others don't know what I'm going through, they don't look depressed".

**Feelings of Loneliness, Isolation.** The experience of missing people who had died or moved away; feeling a lack of closeness to friends or family; expressing a sense of having no friends; feeling isolated and alone during periods of unstructured time.
<table>
<thead>
<tr>
<th>Categories</th>
<th>No. of times mentioned</th>
<th>No. of S mentioning factor</th>
<th>% of S mentioning factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative thinking</td>
<td>17</td>
<td>8</td>
<td>53</td>
</tr>
<tr>
<td>Lack of sense of belonging in SHOP group</td>
<td>14</td>
<td>7</td>
<td>46</td>
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<tr>
<td>Feelings of loneliness</td>
<td>11</td>
<td>7</td>
<td>46</td>
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<tr>
<td>Physical health problems</td>
<td>17</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Pessimistic about future</td>
<td>10</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Sleep\energy problems</td>
<td>9</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Family\spouse problems</td>
<td>9</td>
<td>5</td>
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</tr>
<tr>
<td>Boredom</td>
<td>8</td>
<td>5</td>
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<tr>
<td>Christmas\birthday</td>
<td>7</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Money\transportation\housing problems</td>
<td>9</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Diminishing mental faculties</td>
<td>3</td>
<td>2</td>
<td>13</td>
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<tr>
<td>SHOP exercises too personal</td>
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<td>13</td>
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<tr>
<td>Indecision</td>
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<td>2</td>
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<tr>
<td>Lack of motivation</td>
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<td>2</td>
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<tr>
<td>SHOP program ending</td>
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<td>1</td>
<td>6</td>
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<tr>
<td>Negative contacts outside of SHOP</td>
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<td>Negative memories</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>SHOP journal keeping</td>
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<td>6</td>
</tr>
<tr>
<td>Watching TV news</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
"I feel far away where I live. I miss the West End because it was so easy to get around there".

"I've had a lot of depression. I'm fine when I'm here but then I go home and find myself alone".

"I think the pain of losing B. will always be there. B. and I saw each other every day".

Physical Health Problems. Feeling frustrated, discouraged, resentful or worried about health problems, pain and loss of mobility or expressing concern over same.

"I've been worrying about breast cancer and my health".

"I'm still in pain and it makes me mad... I haven't been getting out because it's too hard walking around. I'm tired of it".

"I have too many health problems all at the same time... I feel exhausted with it. My life seems like nothing but aches, pains and physio".

Pessimistic About Future. A pessimistic, uncertain or hopeless sense about the future.

"My future expectations are lousy... There's only one way to go when you're old--downhill".

"My view of the future is not very good. Dark and dim. I think my days are numbered".

Sleep\Energy Problems. Experiencing feelings of insomnia, fatigue or listlessness.

"At night time I lie there awake in the dark. Can't sleep".

"I still feel a little tired. I wish that weren't there".

Family\Spouse Problems. Experiencing worry or concern over family or marital problems.

"I never told anyone how bad my marriage was... I had a bad marriage. My husband treated me as a child".
"Visiting my daughter I came home feeling depressed about what I saw. We're all very different, poles apart. It turns my stomach to see what those kids are doing. Nothing in the house works. I can't stand it...My one grandson is withdrawing. I came home thinking "Oh God, if only I could do something for these kids. But I don't think it is my place. It's just very hard and my heart is really heavy with that middle child".

Boredom. Experiencing a sense of being "fed up" with usual activities, of feeling "cooped up" or stifled from spending too much time in the house or apartment; feeling bored.

"I sort of lost track of being close to people in that sense of talking about interesting things. I'm interested in ideas and world events and politics, and most people don't want to talk about things like that. They just want to talk about things like what they cooked for dinner and, they went out with their cousin, I mean, it was not that exciting".

"I'm doing the same volunteer work. It's very boring".

Christmas or Birthday. Anticipating or experiencing Christmas\birthday, or the period after, as a negative time of the year, due to being alone, worrying about family problems or being affected by the dull weather.

"I always feel sorta down after Christmas with the dull weather".

"I don't like Christmas. I anticipate it more than I should and don't look forward to it".

Money\Transportation\Housing Concerns. Experiencing stress or concern over lack of money, fear of losing an income, or safety concerns.

"There's unbelievable turnover where I live. So many I knew and liked have moved away...There are things that make me nervous about the place. A man with a gun and a boy that was threatening people. There's been a rash of robberies...I haven't done school board classes in the past 2 years on account of not wanting to go out at night. That has put me back alot".
"So much of my activity depends on the weather. I don't have a car. When you have to slosh through muck and mire for three blocks, you think twice about going out".

Discussion of Hindering Factors

Participants reported far fewer hindering factors (130), as compared to helping factors (205), during the program period. Involvement in SHOP brought a positive dimension to participants' lives, relieving some of their boredom, and counteracting the negative overlay in their thoughts and emotions.

Some of the factors which exerted a negative effect on participants prior to SHOP continued to influence them during the program--an expected finding since most participants' circumstances were of long duration (e.g. chronic depression and health problems, isolating living conditions, family problems). All of the predominant categories of hindering factors could have the effect of undermining participants' social participation and social identity.

It is important to observe that while negative, self-critical thinking was mentioned most often as the factor hindering participants' progress, the reverse, positive thinking was far down on the list of factors perceived to help progress. But positive thinking would be necessary for participants to develop a healthy self-image and positive plans for the future. It appears that participants applied positive thinking as a "tool" to help them take positive action in their lives (e.g. getting involved in meaningful social activities; setting goals and making plans; and constructing a kinder self-image).
While most participants thoroughly enjoyed SHOP and looked forward to attending, some continued to experience depression during the program, particularly when alone on weekends or when health problems kept them housebound. Some participants reported feeling a lack of belonging in the SHOP group. This may have resulted from several factors: combining depressed and non-depressed participants in the groups, and thus, causing the depressed ones to feel "different"; some participants joining the group in the third session, after an initial cohesiveness had already formed; and finally, negative thinking tendencies, which are typical in depression (i.e. "I don't fit here, nobody calls me and I know they call each other").

Evaluation of SHOP Program Content

Considerable variation emerged regarding which specific course components were rated by participants as most or least helpful (see SHOP Evaluation form, Appendix D-2). Those placed in the "most helpful" category, by at least 25 percent of participants, are presented in Table 6. None of the components were rated "least helpful" by 25% or more of participants. In terms of what should be added to or deleted from the program most participants felt it was appropriate "as is". However, the following additions to the program were suggested: a list of supplemental reading obtainable at the library; increased time on problem solving and goal setting; a source of further advice on one's capabilities for employment or volunteering; increased group size to compensate for absences due to illness; a
<table>
<thead>
<tr>
<th>Component of SHOP Content</th>
<th>Percentage of Subjects Rating Component as &quot;Most Helpful&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning through reflection on your own experience</td>
<td>46%</td>
</tr>
<tr>
<td>Assessing the adequacy your personal network</td>
<td>40%</td>
</tr>
<tr>
<td>Changing self-talk from negative to positive</td>
<td>40%</td>
</tr>
<tr>
<td>Communicating in difficult situations</td>
<td>40%</td>
</tr>
<tr>
<td>Problem solving</td>
<td>40%</td>
</tr>
<tr>
<td>Goal setting</td>
<td>40%</td>
</tr>
<tr>
<td>Social health, social roles, social participation</td>
<td>33%</td>
</tr>
<tr>
<td>Different views on the cause of depression</td>
<td>33%</td>
</tr>
<tr>
<td>Thought-stopping and creative worrying</td>
<td>33%</td>
</tr>
<tr>
<td>Personal social networks</td>
<td>26%</td>
</tr>
<tr>
<td>Opportunities to participate/volunteer</td>
<td>26%</td>
</tr>
</tbody>
</table>

TABLE 6
PARTICIPANT RATING OF SHOP CONTENT
(n=13)
discussion on facing death; and, an extended program--one participant commented "I feel like we're just getting started and now we're finishing".

The evaluation item, "Since attending SHOP I feel", was responded to by the following numbers of participants: a lot better (5), moderately better (2), a little better (6), about the same (0), worse (0). While all participants judged the course to be helpful, some commented on their ongoing struggles with health problems or depressive emotions.

Examples of participants' comments about the program follow:

"What I have learned coming to SHOP is that I can think".

"Very helpful program for anyone working their way back from depression, anxiety or other social problems into a satisfying, meaningful, enjoyable life style".

"...I've been given so much information that I did not know about prior. The two main goals for me were to find ways to increase my personal network and to investigate more worthwhile activities. From the class I have the possibility of three new friends. It's up to me to act on what has been presented to us".

"Unfortunately missed several sessions because of health reasons, but found the ones I attended interesting, educational and very worthwhile. I also appreciated the opportunity of meeting other people in the group..."

"Very well structured course...good leadership...most everyone had time to speak...would be better to have everyone start from the beginning of the course".

"A course like this should be readily available to everybody who feels the need..."

"I feel that all the social education is of little value to me when my physical health is so poor".

"My only question is, is SHOP really geared to the needs of depressed people? It seems to me the course presupposes the will, energy and initiative of a reasonable healthy
mentally, emotionally) participant. When one is depressed it really isn't possible to tackle all those self-improvements no matter how much one would wish to do this. I'm VERY glad I came, though, and am sad it is ended”.

The last comment raises the issue of SHOP's appropriateness for severely depressed women. In the controlled trial of SHOP with women aged 45-65 (discussed in Chapter II), the mean CES-D score (34) was in the 'severe' range. There were only 3 dropouts out of 36 participants in this trial, and results demonstrated that severely depressed women did take action on expanding their social networks. Thus, previous applications of SHOP suggest that it is appropriate and beneficial with severely depressed women.

THE EXPERIENCE OF DEPRESSION

The main themes describing participants' depression experience were derived by summarizing and analyzing their responses to questions on the Post Program Interview (see Appendix B-4). The open-ended interview format imposed a minimum of structure, for example:

The purpose of this interview is to reflect upon and capture some of your experience over the past two to three months... Think back to just before you started SHOP...How were you feeling then? What were your thoughts like? And what was your daily activity like?

The analysis included responses from 10 depressed participants, plus one non-depressed woman who described herself as "just coming out of a bad depression". Responses were transcribed on to cards, sorted, and grouped into broad themes. Each theme is recorded in Table 7, along with the number of participants
mentioning it, the number of times it was mentioned, and verbatim illustrations.

The themes mentioned most often and by the most participants included: feeling bored or looking for activity; thinking negatively; feeling sad\despondent; feeling desperate\a sense of urgency; experiencing low energy; trying to keep active; feeling lonely\a lack of companionship; and feeling frustrated due to health difficulties and concerns.

The most prominent aspect of participants' experience was boredom or lack of meaningful activity. Burnside (1990) argued that boredom may be a key contributing factor in depression. She proposed that inadequate stimulation at social, physiological and psychological levels may cause symptoms of distress such as depression. Seven of the depressed women in this study spoke of being "fed up" and "needing something to do" when describing their experience before the program. Because older women are not part of mainstream productive society, they are vulnerable to boredom unless they are able to actively seek stimulating involvement. For women who are constrained by limited finances, geographic isolation or disabilities, maintaining involvement is challenging.

A second aspect of participants' depression was self-critical thinking which reflects social identity deficit. Yost et. al. (1986) argued that western society's negative attitude about advancing age is conveyed to older citizens, and can lead to self-devaluative thinking and depression among them.
TABLE 7

FREQUENCY OF RESPONSES ON THE EXPERIENCE OF DEPRESSION

<table>
<thead>
<tr>
<th>Major Categories of Responses with Examples</th>
<th>N. of Participants</th>
<th>N. of Times Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling Bored, Looking for Activity</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>1. I was fed up with my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I really needed something to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I was &quot;cooped up&quot;.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I didn't have too much to do and was looking for an activity that makes you think a little.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I needed something to fill my time because I had just moved here.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking Negatively</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>1. I couldn't think of one useful thing I'd done.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I felt my whole life had been a shambles, a failure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. My mind was racing too much.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was criticizing myself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I was worrying about what is my future going to be.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I was wondering what is it all for and how long will it last.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling Sad/Despondent</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>1. I was feeling very low..very depressed..close to psychotic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was really in a deep pit. I remember once crying for 3 hours in bed. I couldn't stop.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I was pretty depressed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I felt sadness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I was depressed or something. I didn't feel good..in turmoil.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7 (continued)

<table>
<thead>
<tr>
<th>Feeling Desperate/A Sense of Urgency</th>
<th>4</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was feeling desperate. I had nowhere to live. Things were grim.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was desperately anxious to see someone.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I was feeling desperate to find a way to decide what I'm going to do with the rest of my life.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Energy/Low Motivation</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was vegetating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was staying in bed as long as I could, even if not asleep.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I was a bit tired.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Trying to Keep Active</th>
<th>3</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I had to walk every day, that made me feel better, but it didn't last.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I would get dressed everyday and go out.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. It helped to go for lots of walks... to get out of the apartment.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Loneliness/Lack of Companionship</th>
<th>3</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I missed my friends who died. I spent so much time with them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was missing my friends and my son.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I had this friend who died two years ago. Because my friend isn't here, I don't have enough to fill my time.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Difficulties/Concerns</th>
<th>2</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was fed up because of two fractures and not getting any help.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I wanted information about if I had enough mental faculties left so I could find a way to provide for myself.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participants' responses did not support the contention found in the literature that, compared to younger people, older peoples' depression is more often characterized by somatic complaints, listlessness and apathy, rather than mood-related depressive feelings. Participants reported experiencing a host of emotions indicative of depressed mood. While some felt low energy and tended to stay in bed, this was expressed less frequently than feelings like sadness, despondency and desperation. It is possible that older people do not declare their "negative" feelings as readily as younger people, and therefore appear to place more emphasis on somatic symptoms. Because participants became acquainted with this researcher over time, and a trust developed, they may have felt comfortable expressing "negative" emotions.

One potential consequence of assuming that older peoples' depression is manifested physically is reflected in Dobson's (1989) article on cognitive therapy outcomes. In discussing examples of clients who may not be suitable candidates for cognitive therapy he comments, "...it has been argued that depressed geriatric patients are better candidates for pharmacotherapy, because the nature of their symptomatology is often characterized by the so-called vegetative, or physical signs..." (p. 418). While Dobson does state that the utility of cognitive therapy for older people requires further investigation, such a comment implies a bias toward using drug therapy, and away from using cognitive therapy, with older people...
based on the possibly erroneous generalization that older people experience depression physically more so than emotionally.

Losses, particularly bereavement and illness, contribute to loneliness and depression among older people (Yost et. al., 1986). In this present study, participants spoke of their difficulties replacing a companion and "filling" time after friends died. In addition, chronic health problems and frustration with physician contacts emerged as a component of their experience.

The one positive experience mentioned by depressed participants was physical activity. Several found relief through walking and "getting out of the apartment". This supports O'Brien and Vertinsky's (1990) assertion that physical exercise can elevate mood state and relieve tension in older women, in short, it can act as an anti-depressant.

For comparison purposes, the statements of four participants, who were non-depressed prior to SHOP, were reviewed. Examples of non-depressed participants' responses to the question about their experience before the SHOP program are as follows:

Participant H
I was finding it difficult because my mother died in July. I was missing my mother and at the same time I was thinking freedom and a new start. I was trying to keep involved.

Participant M
I had gotten into a volunteer situation and it wasn't working out so I quit. I miss the people. I had nothing lined up to do...I was casting about...looking for something meaningful.
Participant C
Up to now retirement has been dealing with health problems. I decided I have to do something different.

Participant N
I keep looking for things I can get involved in. I'm always looking for friends, real friends.

The experience of "looking for something to do" or looking for friends was common to both depressed and non-depressed participants indicating their intuitive understanding that involvement is beneficial. Non-depressed participants were clearly seeking meaningful activity in SHOP. In contrast, depressed participants disclosed much more about experiencing distressing thoughts and emotions, and seeking relief from these. Thus, participants in both groups were pursuing involvement and friendship, but depressed participants were struggling to move beyond overwhelming thoughts and emotions.

SUMMARY OF FIELD NOTES

Throughout both SHOP programs written observations and informal discussion notes were collected. This information yielded insights about older women's views and about what affects their experience. Themes which emerged, and which were not addressed through earlier data analysis, are summarized in the following sections.

Impact of Low Income on Social Participation

Although seven out of fifteen participants managed their living on incomes of $10,000 a year or less, surprisingly few complained about lack of money. However, two participants whose
marriages had ended were terrified about not having enough income to sustain them through old age since they had no work pension. Low income affected one woman's confidence to participate socially, although coming to SHOP appeared to boost her confidence:

"A nice thing happened to me this week and I wondered if it related to coming here (SHOP). A woman from church, who I've been wanting to get to know, invited me to her house. I've been turning her down, feeling I can't (afford to) reciprocate, but this time I went. And I stayed all afternoon and when I made overtures to go she asked me to stay".

Another woman hesitated to volunteer, because buying presentable clothing and bus tickets put too great a strain on her budget.

**Communication with Physicians**

Most participants had some type of chronic illness (e.g. arthritis, back problems, ulcers) and physician-patient interactions emerged as an issue. Many participants were afraid to pose questions to a doctor. Part of this hesitancy appeared to be related to earlier learning about authority figures. Two women's comments illustrate this,

"We were raised to respect anyone in authority and you certainly didn't question them...you do what your doctor says and don't ask questions".

"When I was younger you never questioned your doctor. They had studied and they knew a lot about it, so you didn't question it".

But part of their hesitancy appeared to stem from a fear of conflict or rejection by the doctor based on earlier negative outcomes after asking questions. A woman commented,

"One doctor kicked me out of the office for asking a
Another woman reported feeling badly after asking her doctor about stopping a medication. She described the doctor's comment as follows,

"Well, that's fine, I guess you won't be needing to see me anymore".

The woman's interpretation of that incident was that her doctor was angry about the question and would no longer accept her as a patient.

The group agreed that it is now more acceptable to ask for information. One woman commented,

"People read more now, and they know more...you can get a lot more information" (ie. about health, illness and treatments).

Another woman shared her method of monitoring her drug therapy,

"I keep a little book with a record of how I react to different drugs my doctor prescribes for me and whether they work or not. At first, she (doctor) looked at me kind of funny, but now she's used to it and thinks it's a good idea".

The Need for Alternatives to Medications

A majority of the participants expressed the view that they did not want to take medications of any kind unless there was no alternative. This belief appeared to stem from earlier experiences with mood-altering medications and fears that medications would cloud their thinking capacity. Several women commented as follows about their experiences with mood-altering medications,

"I took sleeping pills. It was pretty rough getting off. I did it myself, cold turkey".
"I took tranquilizers when my kids were small. When I had a car accident I realized they were affecting me".

"I took an antidepressant for a few months about a year ago, but I quit. It made me sleepy. I was yawning and in a daze".

One woman's comment illustrates her fears about not being able to think clearly if on antidepressant drugs,

"I refused depression tablets when my doctor offered them to me. I guess you could call me a non-compliant patient, but wouldn't it be awful to be old, alone and drugged?"

**Development of 'Voice'**

The notion of 'voice' implies power, but it also encompasses the ability to communicate effectively--verbally, non verbally and in writing (Harold, 1991). At the beginning of SHOP several participants' speaking patterns lacked confidence (e.g. shaky, soft, hesitant). In addition, one woman reported that she could not concentrate enough to read or write. As the program progressed several women projected themselves in a more confident manner--the voices of three women become stronger and their speech more fluent; four took noticeably better care of their appearance; one, who said she couldn't write before the program, sent handwritten Christmas cards to the other group members'; and finally, another reported that the communication sessions encouraged her to go up and talk to someone at a social event.

**Setting Personal Goals: A New Experience**

Only one participant reported having ever engaged in a goal setting exercise. Almost all of the participants found it difficult to set goals for themselves--they described feeling
"stuck". Discussion about this experience revealed that for some women their hesitancy was related to the term "goal", or to the expectations implied by a goal. Their comments follow,

"I don't set goals. I hate that word. But I have lists".

"What if I set a goal and then fail? It seems as if you're driven when you set goals".

Another woman's comment echoes the consensus of the group that they had often made decisions in their lives based on survival, or on others needs, and not their own aspirations,

"I've never had any goals. Before it was set out for me. Go to work, look after my house and raise my son. That's all I could handle".

The one woman who had set goals reported a sense of accomplishment,

"I set goals for the day and goals for the year. It helps me see that I've accomplished something. If you're a perfectionist like me you need that".

**Individual Support of Participants**

Throughout the program, individuals telephoned or approached the facilitator to discuss problems which they did not want to raise in the group (e.g. marital/family issues, job-related problems, concerns about interpersonal relationships with group members or people outside the group, worries about their health). Several women remarked that this periodic support was useful.

One woman wrote,

"I think the most helpful were the conversations I had with (the facilitator) afterward because (a) my point of view was respected, which is rare among professionals, and (b) often a practical, sensible approach would come out of the discussions".

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V. SUMMARY AND RECOMMENDATIONS

SUMMARY

A large number of older women in Canada are depressed; estimates indicate that 10 to 15 percent of people over 65 experience clinically significant depression, and double that suffer from less severe, but nonetheless distressing, symptoms. The problem is expected to increase in magnitude; women aged 65 and over are the fastest growing sector of the population, and having occupied traditional female roles, the majority reach retirement age with limited social and economic resources—known risk factors for depression.

The consequences of depression can be devastating, yet few older people receive treatment for this problem. That this occurs is probably due to the following: 1) older people are low utilizers of traditional mental health services, 2) physicians may dismiss depression as part of the aging process and, 3) depression is often "masked" by medical conditions and may be missed or misdiagnosed.

There have been few investigations as to what type of intervention best suits the needs of depressed older women. Alternatives to psychotropic drug therapy are essential; evidence indicates that many older people are prone to particularly severe side effects, and that older women are a group at high risk for inappropriate and over-prescription of these drugs. Psychotherapy is one alternative, but the one-to-one version is costly and inaccessible to many older women, they
are low utilizers of such therapy, and it has not been evaluated from their point of view.

Social phenomena are considered to be at the root of much of the depression experienced by older women. It follows that interventions to prevent or relieve such depression should centre on improving the social context of sufferers' lives and on minimizing the potentially demoralizing impact of circumstances like unemployment, poverty, negative societal stereotyping, bereavement and chronic illness.

This study approached depression among older women from a social perspective. Following Burnside's (1990) research, the personal social network was viewed as the source of social identity; and thus, the locus of intervention. An educational intervention, the Social Health Outreach Program (SHOP) was applied. SHOP is designed to augment women's social networks, expand the number of roles they occupy, strengthen their self-esteem, and, thus, alleviate depression. Previous research demonstrated SHOP's effectiveness in reducing depression among women aged 45 – 65 (Burnside, 1990).

SHOP was modified in order to adapt it to the needs of women aged 65 and over. The purposes of the study were:
1) to measure the impact of SHOP on participants' levels of depression and demoralization, and on their social networks;
2) to determine their perceptions about which activities and processes helped, and which hindered, their progress during the program; and
3) to describe and analyze their experience of
A total of 15 women, aged 58 - 76, in two separate groups completed a 10 week (2 hrs., 2 times a week) version of SHOP at two senior's centres. Centre for Epidemiological Studies Depression Scale (CES-D) and General Well Being Schedule (GWB) measures were obtained at pre-test, post-test and 3 months following SHOP. Gains and losses in participants' social networks were determined at a 3 month follow-up interview. Data pertaining to participants' experiences of depression and their perceptions about which activities and processes helped, and which hindered, their progress were collected at a post-program interview.

Participants average age was 65.6 years. The majority were depressed at pre-test (n=10) and several were non-depressed (n=5). Most lived alone, and about half lived on incomes of less than $10,000 annually. Most were not employed; however, three "retired" participants expressed interest in part time employment either as an income supplement or as a form of regular activity. On average, participants had slightly higher levels of education than the general population of older women. Fifty three percent described themselves as having one or more limiting physical disabilities, and a similar percentage reported two or more previous episodes of depression. The majority were not taking psychotropic drugs, and chose to avoid this type of therapy.

Outcome measures supported the effectiveness of SHOP as an intervention to reduce depression and augment older women's
social networks. Participants' scores on the CES-D, on average, were reduced from pre- to post-program (9%); improvement continued through follow-up for a total reduction of 22% (p = .06). Participants' scores on the GWB were improved by an average of 6% pre- to post-program; scores dropped back slightly through follow-up for a total gain of 4% (p = .5).

Participants who were depressed at pre-test had different outcomes on depression measures than participants who were non-depressed at pre-test. Depressed participants CES-D scores were improved at post-test (25%) and significantly improved at 3 month follow-up (30%, p = .004). Their GWB scores were improved at post-test (16%) and dropped back slightly through to follow-up for a total gain of 11% (p = .3). Three of the participants who were depressed at pre-test reached the level of non-depressed at 3 month follow-up. Thus, for depressed women, outcomes supported the hypothesis that participation in SHOP reduced levels of depression. In contrast, non-depressed participants' CES-D scores showed a temporary increase in depressive symptoms at post-test with a return to normal levels at 3 month follow-up. Their GWB scores were slightly lower at post test and 3 month follow-up than at pre-test.

The impact of SHOP on participants' social networks was measured at a 3 month follow-up interview. Participants reported, on average, significant net gains of 4.5 people and 1.5 groups to their networks in the three month period following SHOP. The majority of depressed and non-depressed participants
expanded their social networks. The findings supported the hypothesis that participation in SHOP increases the size of women's social networks.

Activities and processes that helped, and those that hindered, participants' progress during SHOP were determined in order to clarify which factors generated positive outcomes for participants. In 45 minute post-program interviews, participants reported 205 helping and 130 hindering incidents. From these, 20 categories of helping factors and 19 categories of hindering factors were developed.

Helping categories mentioned by at least 25% of participants in decreasing order of frequency were: positive future plans (93%); the routine and process of coming to SHOP (73%); positive self-image and outlook (66%); friend and family support (53%); recognition of improvement in self or situation (46%); mutual support/aid from SHOP group members (46%); reassessment of self (46%); keeping active (33%); a sense of relief about feeling better (33%); and, learning through reflection on experience (26%).

Hindering categories mentioned by at least 25% of participants in decreasing order of frequency were: negative self-critical thinking (53%); lack of sense of belonging in SHOP (46%); loneliness (46%); physical health problems (33%); pessimism about the future (33%); sleep/energy problems (33%); family/spouse problems (33%); boredom (33%); Christmas/birthdays (33%); and, money/transportation/housing problems (26%).
For most participants the activities and processes that helped them during SHOP can be described as follows: coming to a regularly structured activity that stimulated their interest and got them out, thus, relieving boredom; focusing on positive events and plans, rather than on negative thoughts and emotions; experiencing support, companionship and comaraderie within the group and from family or friends outside the group; reflecting on their own and others' life experiences and as a result viewing themselves in a more positive light; and, finally, sensing some relief from the overwhelmingly negative emotional and thought overlay of depression. These findings support the main premise of SHOP--that regular involvement in rewarding social roles is an essential source of stimulation, and it generates the kind of person-to-person interaction and feedback that helps people build and sustain a positive self-esteem.

Participants' overall experience was more positive during SHOP as compared to before the program; however, as expected, several factors continued to influence them negatively: self-critical thinking, loneliness and boredom particularly when alone on weekends; worries about "not fitting in" to the SHOP group; and, being housebound due to health problems. While negative self-critical thinking topped the list of hindering factors mentioned by participants, the opposite, positive thinking, was far down on the list of helping factors. This finding implies that depression interventions must go beyond cognitive strategies to counteract negative thinking. Rather, techniques to stop
negative thinking and promote positive thinking should be viewed as only one of several strategies to promote social reintegration, positive planning for the future, and reframing of one's view of self—processes which in turn generate positive thoughts. Negative thinking habits should be addressed because of their undermining impact on a woman's efforts to participate socially, not because they are the source of her depression.

Depressed participants' comments revealed that their depression stemmed from social isolation, social identity deficit and physical health problems. The aspects of their experience mentioned most often in decreasing order of frequency are as follows: boredom or lack of stimulating activities; negative, self-critical thinking; sadness/despondency; urgency/desperation; low energy/low motivation; trying to keep active; loneliness/lack of companionship; and, health problems. All aspects of depressed participants' lives that were mentioned, except getting out of the apartment and walking, were negative.

Depressed and non-depressed participants commented that they were looking for "friends" or "something to do" before coming to SHOP. This reflected their peripheral status in society and indicates their intuitive understanding that meaningful social involvement is crucial to well-being.

Several additional issues relating to participants' experiences emerged in field notes:

1. Low income curtailed the efforts of some to get involved socially. Buying adequate clothing and bus tickets for
volunteering, and reciprocating socially, were perceived to strain their limited finances. Fears about being destitute in old age were expressed.

2. Most participants felt frustrated about their interactions with physicians. This stemmed from a hesitancy to ask an "authority figure" questions, and from previous rejection by physicians after having asked a question. One participant reported starting a personal health record and receiving a positive response from her physician.

3. Most participants wanted alternatives besides medication to fight depression. Several had experienced negative side effects from psychotropic drugs and some feared that such drugs would impair their thinking.

4. Participation in SHOP helped some of the women strengthen their 'voices' via increased morale and energy. Observable changes in behavior included: increased speaking fluency and power; neater, more attractive dressing and grooming; increased efforts to read and write; and, greater social confidence.

5. For all but one participant, setting personal goals was a new and difficult experience. Some disliked the term "goal" and others felt pressured by the expectations implied in a goal. But for most, they had never set goals because their lives were contingent on others' needs, not their own.

6. Two helpful aspects of the program were: informal instructor support of individuals outside of class; and taking a one or two week break half way through the program. The instructor
observed that on returning after the break participants were pleased to see each other; members of both groups seemed more relaxed and open with each other.

RECOMMENDATIONS

This study supports the view that for many older women depression originates in their social environment. Moreover, it points out the value of educational intervention as a means of helping older women to reconstruct social identity, increase social participation and, thereby, alleviate depression. The following recommendations for practice and research are drawn from the findings.

Adapting SHOP for Women in Later Life

The outcomes of this study show, as expected, that with slight modification SHOP is as effective with older women as it is with mid-life women. Furthermore, participants' perspectives on which activities and processes advanced, and which impeded, their progress during SHOP support and reinforce its approach.

The revisions required to extend SHOP to older women were minimal. The program was shortened to 10 weeks when initial advertising of a 19 week program yielded one response (see Chapter III for details). Although response to the shorter version was stronger in the recruitment phase, when the program ended several participants expressed the view that it was "not long enough". It is recommended that longer versions, or second phases of SHOP, should be available for women who need more time.
than 10 weeks in a supportive group atmosphere to initiate life changes.

Beyond program length, additional modifications to SHOP involved shifts in emphasis as opposed to structural program changes. When promotion of SHOP as a "treatment for depression" met with limited success, it was decided to publicize it as an educational program in which women could learn ways to "restore social confidence, build support in their lives and overcome depression". The latter approach was more successful.

It is recommended that practitioners use positive language in outreach and recruiting efforts; however, on a cautionary note, changing the language of recruitment influences who comes to the group, and facilitators must then be prepared to work with mixed groups (e.g. depressed and non-depressed participants).

Because the majority of women in this study were retired and planned to remain so (only one was employed), program content on social participation emphasized volunteer roles rather than employment roles. However, three of the non-employed women in the study expressed some interest in part-time work; two were considering it as an income supplement, and a third was seeking a structured activity. It is recommended that employment-related content be made available to those 'retired' women in SHOP programs who want it; for example, referrals to an employment counselling agency that specializes in re-entry with older workers could be arranged.

A shift in emphasis evolved, as it would in any group, from
the experiences that participants raised in discussions. The women in this study, especially those in their late 60's and early 70's, spoke of issues unique to their cohort (e.g. raising children as a single parent in the 1940's). As is essential in any educational activity, facilitators should be prepared to build discussions around experiences that are relevant to groups with particular life histories.

**Extension Of The Social Health Outreach Program**

Older women are a heterogeneous group in terms of interests, experiences and problems. No one intervention approach will address all of their needs. SHOP provides an adaptable model for preventive or restorative educational intervention. SHOP should be modified according to the experiences and interests of specific groups of older women vulnerable to social identity deficit (e.g. those in isolated rural areas, caregivers, ethnic minorities, chronically ill, those recovering from alcohol or drug dependence, widows, and women leaving marriages). Alternate versions of SHOP should be extended to such groups and the impact studied from practitioners' and older women's perspectives. It is recommended that SHOP should be incorporated and researched as part of health promotion activities.

**Guidelines for Facilitators**

The findings suggest that SHOP's effectiveness is increased when the facilitator takes the following actions:

1) adopting a collaborative stance, not an "expert" stance.
2) challenging participants' negative views of themselves and suggesting other possible self-images as appropriate.

3) promoting network-building between participants and the host organization.

4) promoting network-building among group members by circulating lists for those who wish to participate in a telephone number exchange, using name tags until participants know each others' names, setting up coffee breaks, and supporting lunch or out-of-class outings.

5) reinforcing participants' progress by noting and commenting on any observable changes.

6) encouraging regular physical activity.

7) promoting belonging in the group by diffusing participants' sense of feeling "different" than the others.

8) providing informal individual support to participants outside of group time as requested.

It is recommended that the facilitator set in motion a follow-up process prior to the program ending. This is particularly important in shorter version programs. The facilitator can collaborate with participants on what form the follow-up should take (e.g. group meetings over increasing time intervals, individual telephone contacts or interviews, or informal get-togethers). In addition, the facilitator should alert participants to alternative social supports when the program ends (e.g. senior peer counsellors, senior centre personnel).
Experience As A Base For Planning Interventions

The women in this study experienced depression characterized by factors amenable to intervention--boredom, sadness, loneliness, and self-critical thinking--clear evidence that SHOP's central focus on social network augmentation via education and group support was on track. Research needs to further explore the phenomenon of depression among the diverse population of older women; research should attempt to understand the phenomenon from their perspective and from the perspective of others close to them. Practitioners should be aware of how older women experience depression and use the information as a basis for planning interventions. Programs which fail to take older women's perspectives into account may be a waste of time. At best, positive outcomes may be short-lived, especially if women remain in circumstances that generate depression.

Education of Professional and Lay Leaders

Opportunities should be made available for practitioners to become informed about issues and problems affecting older women, and to upgrade their knowledge and skills enabling them to implement effective educational interventions with small groups of older women. A proposal has been initiated through the Mature Women's Network Society (Vancouver, Canada) to conduct SHOP leadership training programs for professional and lay facilitators--as a method of extending SHOP to a broader audience of women.
CONCLUSION

Canadian society is just beginning to come to terms with population aging. While a commitment to "quality of life" for all older people has been voiced at the institutional level, social change toward this end has been slow to evolve. In the current societal context, too many older women find themselves at the sidelines of social life and are there rendered invisible. Under these circumstances it is a daunting challenge, especially with limited resources, to sustain a daily life that generates focus, meaning and self worth, as opposed to stagnation, boredom and demoralization.

Thoughtfully crafted educational programs can serve to equip older women, individually and collectively, with the self-awareness, knowledge and skills needed to alter their experience. Findings of this study and previous research demonstrated that the Social Health Outreach Program is an education-oriented intervention that effectively helps middle-aged and older women establish or sustain health-promoting social networks, rebuild their social identity and reduce depression.

At present, however, older women receive minimal attention as a potential clientele for educational programs, counselling or other human services. Consequently, there are few existing programs that have been designed according to the needs of, and in collaboration with, older women.

A current and timely challenge for human service researchers and practitioners is to join and support the efforts of seniors'
and women's organizations to bring older women's issues to light in public and political domains. If "quality of life" is to mean more than empty rhetoric for vast numbers of older women, then steps must be taken to work with them to put into operation policies, programs and services that enable them to change their daily reality.
REFERENCES


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Appendix B-1

The Centre for Epidemiological Studies Depression Scale

INSTRUCTIONS FOR QUESTIONS. Below is a list of the ways you might have felt of behaved. Please tell me how often you have felt this way during the past week.

0 - Rarely or None of the Time (Less than 1 Day)
1 - Some or a Little of the Time (1-2 Days)
2 - Occasionally or a Moderate Amount of Time (3-4 Days)
3 - Most of All of the Time (5-7 Days)

During the past week:

1. I was bothered by things that usually don't bother me.
2. I did not feel like eating; my appetite was poor.
3. I felt that I could not shake off the blues even with help from my family or friends.
4. I felt that I was just as good as other people.
5. I had trouble keeping my mind on what I was doing.
6. I felt depressed.
7. I felt that everything I did was an effort.
8. I felt hopeful about the future.
9. I thought my life had been a failure.
10. I felt fearful.
11. My sleep was restless.
12. I was happy.
13. I talked less than usual.
15. People were unfriendly.
16. I enjoyed life.
17. I had crying spells.
18. I felt sad.
19. I felt that people disliked me.
20. I could not get "going".

## GENERAL WELL-BEING SCHEDULE (GWB)

**READ** — This section of the examination contains questions about how you feel and how things have been going with you. For each question, mark (X) the answer which best applies to you.

### 1. How have you been feeling in general? (DURING THE PAST MONTH)

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- In excellent spirits
- In very good spirits
- In good spirits mostly
- I have been up and down in spirits a lot
- In low spirits mostly
- In very low spirits

### 2. Have you been bothered by nervousness or your "nerves"? (DURING THE PAST MONTH)

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- Extremely so -- to the point where I could not work or take care of things
- Very much so
- Quite a bit
- Some -- enough to bother me
- A little
- Not at all

### 3. Have you been in firm control of your behavior, thoughts, emotions OR feelings? (DURING THE PAST MONTH)

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- Yes -- definitely so
- Yes, for the most part
- Generally so
- Not too well
- No, and I am somewhat disturbed
- No, and I am very disturbed

### 4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (DURING THE PAST MONTH)

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- Extremely so -- to the point that I have just about given up
- Very much so
- Quite a bit
- Some -- enough to bother me
- A little bit
- Not at all

### 5. Have you been under or felt you were under any strain, stress, or pressure? (DURING THE PAST MONTH)

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- Yes -- almost more than I could bear or stand
- Yes -- quite a bit of pressure
- Yes -- some -- more than usual
- Yes -- some -- but about usual
- Yes -- a little
- Not at all

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<th>Question</th>
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| 6. How happy, satisfied, or pleased have you been with your personal life? (DURING THE PAST MONTH) | 1. Extremely happy - could not have been more satisfied or pleased  
2. Very happy  
3. Fairly happy  
4. Satisfied - pleased  
5. Somewhat dissatisfied  
6. Very dissatisfied |
| 7. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (DURING THE PAST MONTH) | 1. Not at all  
2. Only a little  
3. Some -- but not enough to be concerned or worried about  
4. Some and I have been a little concerned  
5. Some and I am quite concerned  
6. Yes, very much so and I am very concerned |
| 8. Have you been anxious, worried, or upset? (DURING THE PAST MONTH)   | 1. Extremely so -- to the point of being sick or almost sick  
2. Very much so  
3. Quite a bit  
4. Some -- enough to bother me  
5. A little bit  
6. Not at all |
| 9. Have you been waking up fresh and rested? (DURING THE PAST MONTH)   | 1. Every day  
2. Most every day  
3. Fairly often  
4. Less than half the time  
5. Rarely  
6. None of the time |
| 10. Have you been bothered by any illness, bodily disorder, pains, or fears about your health? (DURING THE PAST MONTH) | 1. All the time  
2. Most of the time  
3. A good bit of the time  
4. Some of the time  
5. A little of the time  
6. None of the time |
| 11. Has your daily life been full of things that were interesting to you? (DURING THE PAST MONTH) | 1. All the time  
2. Most of the time  
3. A good bit of the time  
4. Some of the time  
5. A little of the time  
6. None of the time |
| 12. Have you felt down-hearted and blue? (DURING THE PAST MONTH)        | 1. All of the time  
2. Most of the time  
3. A good bit of the time  
4. Some of the time  
5. A little of the time  
6. None of the time |
13. Have you been feeling emotionally stable and sure of yourself? *(DURING THE PAST MONTH)*

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<td>Most of the time</td>
<td>A good bit of the time</td>
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14. Have you felt tired, worn out, used-up, or exhausted? *(DURING THE PAST MONTH)*

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15. How concerned or worried about your HEALTH have you been? *(DURING THE PAST MONTH)*

For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Circle any number along the bar which seems closest to how you have generally felt DURING THE PAST MONTH.

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<td>Not concerned</td>
<td>Very concerned at all</td>
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16. How RELAXED or TENSE have you been? *(DURING THE PAST MONTH)*

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<td>Very relaxed</td>
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17. How much ENERGY, PEP, VITALITY have you felt? *(DURING THE PAST MONTH)*

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<tr>
<td>No energy AT ALL, listless</td>
<td>Very ENERGETIC, dynamic</td>
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18. How DEPRESSED or CHEERFUL have you been? *(DURING THE PAST MONTH)*

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<td>Very depressed</td>
<td>Very cheerful</td>
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Appendix B-3
Background Information Interview

The purpose of this interview is for me to ask you some questions about your background, for example, where you live, what grade you completed in school, etc. As you know, you are under no obligation to participate, so if you would prefer to omit any questions, please let me know.

1. Age:

2. Marital status:

3. Parental status:

4. How many years of schooling did you complete?
   - less than seven years
   - junior high school
   - partial high school
   - high school diploma (or trade school equivalent)
   - partial university
   - professional degree

5. Current employment status:

6. Within which of the following categories does your current annual income fall?
   1) unmarried
      - under $2,000
      - 2,000 - 4,999
      - 5,000 - 9,999
      - 10,000 - 14,999
      - 15,000 - 19,999
      - 20,000 - 24,999
      - 25,000 and over
   2) married
      - under $5,000
      - 5,000 - 9,999
      - 10,000 - 14,999
      - 15,000 - 19,999
      - 20,000 - 24,999
      - 25,000 - 29,999
      - 30,000 - 39,999
      - 40,000 and over

7. Living Arrangements:

8. History of depression (including first onset, chronicity):

9. Do you have any physical handicaps or disabling diseases?

10. Prescription drugs:
Appendix B-4

Post Program Interview

The purpose of this interview is to reflect upon and capture some of your experience over the past two to three months.

1. Think back to just before you started SHOP... How were you feeling then? What were your thoughts like? And what was your daily activity like?

2. Now, please reflect on the time since SHOP started.... How have you been feeling? And what have your thoughts and daily activities been like?

3. Thinking back to just when the program started... Describe what you consider to be your lowest points since that time. For example, starting with the first low point you can remember, what happened exactly and why was it difficult for you?

Any others?

4. Now the high points. Starting with the first high point, what happened exactly and why was it a high point for you?

Any others?

5. What are your expectations about the future right now?
Appendix B-5

Follow-Up Interview

The purpose of this interview is to follow-up on your experience in the 3 months since SHOP ended, and to get an update on your social network. The questions will seem familiar since we have discussed the material before.

1. Think back to when SHOP ended and reflect on your experience since then...How have you been feeling? What has your thinking been like? What has your daily activity been like?

2. Now I'd like to discuss what changes have occurred in your social network, in terms of people or groups added to your network, or lost from your network...

   I have added ____ "new people". Please categorize new people in terms of acquaintance/friend/confidant/professional.

   ____ individuals have "left" my network (categorize as above.

   I have added ____ new "groups" to my network (other than one time events). Please specify nature of group and frequency of attendance.

   I have stopped attending ____ groups/organizations (please specify).

   I have ____ have not ____ taken part in a course/program since SHOP (please describe nature and purpose).

   I have ____ have not ____ done volunteer work since SHOP (please describe).

What else would you like to tell me about your plans or activities?

Now that you've had 3 months to reflect, what comments would you make about your experience in SHOP?
Appendix C

Post Program Interview Summaries

The following summaries provide anonymous "snapshots" of participants, creating a more holistic and contextual representation of their experience. The letter assigned to each participant is not her initial.

Participant A:

A. reported that before she joined SHOP she was looking to belong to a different group that was interesting, that made her think, and that was easy to get to. She didn't want to repeat some activities that she had already tried, and was interested in meeting some new people. She was feeling a bit annoyed with herself because she thinks of things to do but has trouble getting around to doing them.

A. enjoyed coming to the group because the material was interesting and she enjoyed meeting people. She felt it was encouraging to hear about the successes of other people--it gave her ideas about things she could do. Although coming to the group stirred up her thoughts a bit, she found it helpful because it encouraged her to think about how to improve her situation.

The program ended not long after Christmas, a time when A. feels "sorta down" and "bored", partly due to the dull weather which keeps her in the house more than she would like. Over Christmas, A. visited a relative who encouraged her to move to eastern Canada. While it was good to visit this relative, A. did not think she wanted to move east; however, she was mulling this over in her mind. A. is thinking about what specific activities she can pursue in the future.

Participant B:

B. came to SHOP because she really needed something to do and was looking for a structured activity. Also, her doctor suggested the program and she wanted to follow this advice. In the time before SHOP, B. was feeling very depressed, staying in bed as long as she could wondering "what is life for anyway" and "how long is it going to last". She got dressed and went out every day for meals in spite of how she was feeling.

B. really enjoyed coming to the group. She didn't feel obligated to make it and appreciated the group's free atmosphere. She found that the people in the group were very
interesting, and she enjoyed their company for lunch. She surprised herself with being able to socialize with the women in the group. During SHOP B. noticed that she did more walking and she completed the homework assignments. She recognized that she is a good listener and that she had come to a point where she was better able to accept things she can't change. B. experienced feelings of relief when at SHOP; however, her feelings of depression continued at home, especially over the weekends when she was alone. Although B. felt aware of a lack of knowledge through not being a reader, she realized that she has a fair intelligence to have worked her way up to a position of office manager before she retired. She amazed herself because she picked up a newspaper one day--before she couldn't keep her mind on anything like that. Christmas occurred about mid way through the program. B. spent it alone and was pleased to have managed "alright". B. stated that her expectations of the future are "not great but its up to me". She noted that she is a person who seems to be "searching all the time".

Participant C:

Before the program C. spent most of her retirement (2 yrs.) dealing with health problems. She decided that she needed a change. While keeping busy had helped her to feel "not too bad", she described an underneath feeling of boredom, uselessness, hopelessness and a sense that there was too little time left in her life to get over earlier mistakes.

C. looked forward to SHOP and was glad she was attending. She particularly enjoyed being with people and talking about the kinds of things she wanted to talk about. Although C. looked forward to the "doing" aspect of coming to SHOP, she sometimes felt incompatible with the other women, as though what she talked about "put them off". She found some of the one-to-one work too personal. During the program C. realized that she experienced low self-esteem and that she had a tendency to put negative thoughts in the way of doing things.

C. felt a "real let down" when the program ended. She described the last day as "the lowest day I've had this winter". She would like to see some structure added to the program re: what people are going to do afterward. C. stated that she expects declining energy in the future, and her plan is to get through each day aiming to maintain her present capacities.

Participant D:

In the time before attending SHOP, D. was experiencing
mixed emotions. While she had started to resolve some problems, in general she was fed up with her life, and was not looking forward to Christmas and her birthday. D.'s activity was limited because of health problems and she was feeling frustrated about ongoing pain, and angry about receiving limited help and support. Her thoughts tended to be self critical and she reported noticing that angry feelings were surfacing more often.

During SHOP D. at times felt like quitting. It irritated her when new members joined late, as it changed the "tenor" of the group. While she felt like confronting some of the members who seemed "high pressure", she did not want to be in conflict. She decided to resolve these feelings of irritation by listening. She would have preferred if the sessions hadn't reached such a personal level. D. reported that she had more positive feelings about her own life after the group started. She noticed that she didn't put herself down as much as before. She felt less isolated and experienced a sense of kinship in the group. While at times she shocked herself by speaking out on certain issues, she felt good about expressing herself and not being a "phoney". She's hoping in the future to feel happier and to find a nice companion.

Participant E:

E. reported that before the program she was feeling very low, very depressed and at times close to psychotic. She had left an abusive marriage and had no place to call home. She felt desperate and worried about what her future was going to be.

E. looked forward to SHOP and described it as her "oasis". She liked the warm, easy, no-pressure atmosphere and the relaxed style of the instructor. E. noticed that half-way through the program she began to feel less "bogged down". She started to realize that it would have been stupid to stay in such a destructive marriage. She felt that the "how-to" approach in SHOP was helpful and opened up some avenues for her. She enjoyed the other women and looked forward to going for lunch with them. E. expressed the desire to have the group continue to meet in some format for discussions. Her future goal was to find a place to live and "get back on my feet".

Participant F:

F. was just coming out of a bad depression at the time SHOP started and she was feeling desperately anxious to see someone. Her thoughts were quite negative and self-critical.

She was just getting back into daily activities and was looking for something to occupy her time.
F. felt unhappy about starting the program late and having to miss the lunch outings. However, she did feel more encouraged and hopeful as a result of things that came out in the meetings. In particular she found it useful to consider some of her successes in life. She found that each group meeting brought things to mind, often positive.

F. often felt frustrated about medical problems that limited her ability to get around and necessitate her having to lie down during the day to manage her energy needs. Sometimes she felt discouraged about family problems. F. has thought about doing some writing in the future and she hoped to make a friend out of the group.

Participant G:

G. reported that before attending SHOP she was quite depressed. There were days when it was "just awful", when she was "down so low that it was too hard to look on the bright side of things". Her thinking at the time was very negative and self-critical. She described the feeling as being "really in a deep pit". She wasn't able to figure out why she was depressed. She was walking everyday due to a problem with her leg and that would help for awhile, but it didn't last.

G. described herself as always willing to try something new. When she heard about SHOP, she went ahead and made an appointment. She felt hopeful thinking, "this will be of some use". During the program the high point for G. was being in the group and realizing that if you look for friends they're out there. She also had a more positive experience at Christmas time.

G. was surprised at how much better she did feel after the program and described herself as feeling "completely normal". After the program she felt she understood herself better, and she was thinking more positively. She expects in the future to be better able to handle anything negative that comes up and she thinks she'll take more chances. She feels she now knows how to "beat the blues".

Participant H:

H. was experiencing mixed feelings before the program started. She missed her mother who had died several months before (H. was the caregiver for her mother). At the same time she was thinking "freedom and a new start". She was trying to keep involved in the community.
H. appreciated that being part of the program allowed her to be honest with her feelings of sadness after her mother and best friend died. She believed that the social parts of the program (e.g. lunch outings) were really important to build a sense of trust in the group, and also to give the participants a chance to feel "grounded" after all the insightful thinking during sessions. She appreciated that the leader took a facilitator role instead of lecturer. In that way, group members were able to find out for themselves. H. felt a great thing about the program was thinking about times when she's been successful in her life. She really appreciated the chance to find out about some of her strengths. She felt happy to see that SHOP had changed the other women too. H. found the thought stopping and goal setting sessions helpful, particularly she found herself being more realistic about goals. She appreciated the one-to-one interactions in the sessions because she felt participants risked more. She did not like journal keeping--it was "tedious". She suggested a follow-up component be built into the program.

Participant I:

I. has had troublesome health problems for a number of years. Prior to SHOP she was able to walk around; however, she experienced pain from her buttocks to her legs and received a lot of physiotherapy. At the time SHOP started, I. was feeling "cooped up" in her apartment and was thinking it would be good for her to get out and see other people.

Attending SHOP was a positive experience in that she found it interesting to hear about other people's experience--it helped her to feel more connected with the world. I.'s health problems intensified during the course and she had to miss several sessions. She felt discouraged and reported that her life seemed filled with illness. She reported a very scary happening, of falling in the crosswalk on a very busy street. At the program end, I. was feeling exhausted with too many health problems at the same time.

Participant J:

On interview J. reported that she has experienced feelings of uselessness for many years. Although the SHOP program did not alleviate those feelings, J. really enjoyed coming to SHOP and stated that she has "VERY positive feelings about it". She looked forward to coming to the sessions. At times in the sessions J. felt that she was more depressed than other people. At these times she held back from saying things thinking that others "wouldn't want to hear it".

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J. felt the program was more for depressed people who just needed some direction, rather than for people who think "I just can't".

J. reported that a source of great support and encouragement in her life is her church and her faith. J. is looking forward to taking some educational courses in the future.

Participant K:

K. stated that before the program started she was feeling very sad. She felt desperate to find a way to make decisions about how to provide for herself. She was worried because she felt that her memory had diminished compared to five years ago. She wanted to find sources of information about her capacities so she could make decisions about her life. When K. was not at work, she was spending most of her time in bed. At work, she was asked to perform duties which aggravated a medical condition. This created an uncertainty about a future income. K.'s anxiety about being able to keep the job interfered with her ability to remember things. At the time K. was frustrated because she was not getting satisfactory medical help. She felt "patronized" by her doctor.

During the program K. felt as though she was channeling her energy into a direction. She found relief in having a structured activity. She thought she was feeling better during the program and reported feeling calmer in certain situations than she would have earlier. She found it helped to know she had a place to discuss things. K. stated that she hoped in the future to get the information she needs to make decisions and to have a schedule that includes time to pursue creative interests.

Participant L:

Before the program started L. was feeling "cooped up", "tired" and "in turmoil". She was missing friends who had died and with whom she had spent a great deal of time. She had been home a lot for two months due to illness. She was beginning to look for something to fill her time.

L. reported a feeling of relief in coming to SHOP. She developed new interests and started to go out more. She particularly enjoyed attending a community centre and getting involved with friends. L. reported that her financial future is secure and that she is making plans to travel while she still can.
Participant M:

M. was feeling "at loose ends" before SHOP started. She was "casting about" for some meaningful program or activity to pursue. She had stopped a previous volunteer activity which was not satisfactory and she missed some of the people associated with that.

What M. liked most about SHOP was the exposure to possible activities and volunteer opportunities. She felt she "knew more when she finished the program than when she started", and appreciated the emphasis on learning from other people rather than from books. She started making efforts to cultivate the acquaintance part of her network.

M. felt "quite good" at the end of the program with a sense of "anticipation". She thought she would possibly pursue developing friendships with a couple of group members.

Participant N:

Prior to SHOP, N. was looking for things to get involved in. She was missing a long time friend who have died. She expressed the desire to find a "real" friend and noted that she was working on trying to be less judgemental and fault-finding when she met people. Although N. was trying to keep active and enjoyed the SHOP group, she felt badly when health problems left her "crippled up" and unable to get out for several sessions. This health problem contributed to her feeling worried, frustrated and resentful.

N. reported that during the time of being shut in she thought about facing the fact of death and wondered about the afterlife. She was particularly troubled with feelings of incompetence due to her lack of mobility. One thing that really "boosted her self-esteem" was talking to people who were kind to her. N.'s main wish for the future was to regain her health and mobility and to be able to do something worthwhile.

Participant O:

Just before SHOP started O. was thinking she should start doing something to fill her time. Because she had experienced a recent move following the death of her husband, she was "missing little everyday things" that she was used to in her other location. She felt that she had to do something pretty quickly because her "mind was racing" and she wasn't able to sleep. At times O. felt stifled in her apartment and found it helpful to get out and go for walks or do some shopping. It was comforting
to see other people who were doing the same thing.

O. enjoyed coming to the SHOP sessions and her view was that the group was good. She found that having something to look forward to relieved boredom, and the structured activity was helpful. O. felt encouraged by talking to people at the volunteer centre and plans to look into volunteer work after moving to her new apartment.
Appendix D-1

Goals of SHOP

To help participants:

1. Define social health and understand what contributes to it.
2. Gain knowledge about issues related to demoralization and depression.
3. Evaluate the health of their social networks using a mapping technique.
4. Establish goals for augmenting their social networks.
5. Develop or refurbish the skills needed to reach their social goals.
6. Identify a community role that is of interest to them.

Course Outline

1. Introduction to SHOP (overview)
2. Social Health, Social Roles, Social Participation
3. Introduction to the Personal Network
4. Introduction to "Self Talk"
5. Differing Views on the Cause of Demoralization and Depression
6. Enhancing "Self Talk"
7. Drugs, and Behavioral Treatment of Insomnia
8. Introduction to Communication
9. Increasing Your Success in Communication
10. Communicating in Difficult Situations
11. Personal Social Networks
12. Social Networks and Health
13. Problem Solving
14. Setting Social Goals
15. "Taking Stock" - the Strengths Inventory
16. Rediscovering Interests and Abilities
17. Volunteering and Other Community Roles
18. The Resume
19. Summary and Evaluation
20. Wrap-Up Celebration
Appendix D-2

SHOP Evaluation

Since attending SHOP I feel: about the same as before____, a little better____, moderately better____, a lot better____, worse____.

SHOP's main components will now be outlined. Please read this over to refresh your memory. Then, under the headings listed below, please comment.

EDUCATION: 1. Social Health, Social Roles, Social Participation
2. Learning Through Reflection On Your Experience
3. Different Views on the Cause of Depression
4. Personal Social Networks
5. Assessing the Health of Your Personal Network
6. Medication Safety
7. Managing Sleep Problems

SKILLS: 8. Changing Self Talk from Negative to Positive
9. Thought Stopping and "Creative Worrying" Techniques
10. Increasing Your Success in Communication
11. Communicating in Difficult Situations
12. Problem Solving
13. Goal Setting
14. Inventory of Interests and Abilities
15. Opportunities to Participate or Volunteer

Which components were most helpful for you, personally? Why?

Which were least helpful? Why?

What would you add to SHOP? Why?

What would you delete? Why?

General Comments: (Please use reverse side if necessary)