A Measurement Model of Depressive Symptoms among Older, African American Women

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Abstract

For more than four decades, researchers have found depression to be a common mental illness among the elderly. Depression is a generalized mood disorder characterized by feelings of sadness and hopelessness, a sense of worthlessness, difficulty concentrating, loss of interest, and decrease in energy level. This definition is reflected in the Geriatric Depression Scale (GDS). The rates of depression among elderly residents of institutions are 67% higher than among elderly adults residing at home. As in the United States, elderly women are twice as likely to be diagnosed with depressive symptoms as elderly men.. Time and again, research has revealed that depression is a significant problem for individuals later in life and may affect their psychological well-being. Using data from the Health and Retirement Study (HRS) 2010 wave, a secondary analysis was conducted to examine depression among community-dwelling, African American women, age 50 and over, as it relates to age, social support, religion, caregiving, and physical health. Intersectionality and social construction were used as theoretical frameworks for the study. Findings indicated significant relationships between depression and age, social support, and physical health. However, depression is treatable with pharmacotherapy, psychotherapy or combination of both.The overall purpose of this study was to explore the factors that may predict depression among older African American females, as well as identify gaps in the literature and add to the knowledge base about depression among this population of color, and develop a framework for future studies investigating mental health issues among diverse populations beyond African Americans.

Keywords: African Americans, women, older adults, depressive symptoms and research

1.0. Introduction

The elderly population has been growing very quickly across the world. According to the Administration on Aging (2016) the number of people in the United States aged 65 and over was 49.2 million, representing about 15.1% of the total population (Department of Health and Human Services, 2012). This figure is likely to increase to 20.3% by 2050 (Winner & Tilly, 2012). For more than four decades, researchers have found depression to be a common mental illness among the elderly (Charatan, 1975; Sreevani & Reddemma, 2012). The rates of depression among elderly residents of institutions are 67% higher than among elderly adults residing at home (Al-Jawad, Rashid, & Narayan, 2007). As in the United States, elderly women are twice as likely to be diagnosed with depressive symptoms as elderly men (Salimah, Rahmah, Rosdinom, & Azhar, 2008).

Depression has been considered variously as both an illness and a syndrome (Salimah et al., 2008). In the early 20th century, depression was known as melancholia (Berrios, 1988). Later in 1980, the term depression was used and incorporated in the Diagnostic Statistical Manual Three (DSM-III) under organic affective syndrome and adjustment disorder (American Psychiatric Association, 1987). Upon revision, most of the depressive symptoms in the DSM III were categorized under mood disorders. As described by the latest Diagnostic of Statistical Manual-Fifth Edition (DSM-5) depression is one of the mood disorders associated with the presence of depressed mood or loss of interest on daily activities that occurs every day for most of the day for at least two weeks (American Psychiatric Association, 2013).

Depression is also considered as a syndrome or a cluster of symptoms, behaviors, and functional disturbance that is characterized by changes in appetite (either increase or decrease), difficulties with sleep pattern, difficulty in concentration, and retarded or increased psychomotor functions (American Psychiatric Association, 2013).

The existence of psychological symptoms such as feeling of worthlessness, hopelessness, 32 indecisiveness, guilt feelings, feeling of anger, and suicidal ideation also reflects the common symptoms of depression (World Health Organization, 2012). Consistent with the definition provided by the DSM-5 the International Classification of Disease-Version Ten (ICD-10) (2010), which is used to define depression as a situation when individuals experience consistent reduction of energy, decreased ability to enjoy interested activities, an increased in social withdrawal, and recurrent deep sadness without valid reasons. These symptoms may cause dysfunction in an individual's physical and mental health and could impair an individual's ability to take care of one's self and fulfill daily responsibilities.

The depressive symptoms are usually much worst in the mornings as compared to other times in the day, which makes it harder for an individual to begin his or her day with a fresh start. The World Health Organization (2013) considers depression as a serious mental disorder that affects 340 million people across the world. As compared to other mental disorders, depression is considered the most prevalent illness in the world, which is estimated to affect 350 million people (WHO, 2013). It is expected to be the second most prevalent worldwide illness after ischemic heart disease by the year 2020 (Abdel-Rahman, 2012). At least 25% of all adults worldwide experience depressive symptoms at least once during their lifetime, and depression does not discriminate. It affects all age groups, from children to the elderly. More seriously, depression has been associated with significant high morbidity and mortality among older adults (WHO, 2013).

The overall purpose of this study was to explore the factors that may predict depression among older African American females, as well as identify gaps in the literature and add to the knowledge base about depression among this population of color, and develop a framework for future studies investigating mental health issues among diverse populations beyond African Americans. Specifically, the research questions addressed in this study probed (a) the relationship between age and depression, (b) the influence of social support on depression, (c) the relationship between religion and depression, (d) the relationship between caregiving and depression, (e) the influence of physical health on depression, and (f) the joint impact of age, social support, religion, caregiving, and physical health on depression.

Answering these questions will have a significant influence on the way mental health services are provided to this population and the way in which research is implemented in the field of social work through practice and policy. The manner in which social work researchers are trained and educated must be adjusted to include these factors, based on the findings of this study and other similar studies. Knowledge of these relationships may help researchers create targeted interventions designed to reduce the prevalence of depressive symptoms in older African American women (Centers for Disease Control and Prevention (2018). Although there have been many studies comparing older Black and White populations, this study focused specifically on the factors of older, community-dwelling, African American women.

2.0. Review of Literature

Depression is a generalized mood disorder characterized by feelings of sadness and hopelessness, a sense of worthlessness, difficulty concentrating, loss of interest, and decrease in energy level. This definition is reflected in the Geriatric Depression Scale (GDS) (Bluth, Campo, Futch, & Gaylord, 2016).In the United States, the elderly is categorized as those aged 65 and older. This categorization follows the age classification used by the Administration on Aging (2012). In 2018, life expectancy at birth for males was 73 years and 78 years for females (Centers for Disease Control and Prevention, 2018). The U.S. Department of Health and Human Services (2018)projected that in 2025, the life expectancy will increase to 77.7 years for males and 83.1 years for females. The projected increase in the number of elderly population and their life expectancy shows the possibility of having new age categorization in the future, where the elderly could be define as those who age 70 years and above.

The main developmental task for an elderly person is to reflect upon and integrate one's life in the face of loss and subsequent death (Erikson, 1982). Facing the reality of aging that is impossible to hide is sometimes painful and challenging to some elderly. The elderly adult who is able to own her life experiences including accepting her failures, frustrations, and unsuccessful life stories is found to be happier in life compared to the elderly adult who is afraid and anxious when facing the end of life changes.One study conducted with 151 elderly people in institutions, on their attitude towards aging, found that elderly who had negative attitudes and refused to accept the reality of aging showed more depressive symptoms and reported to have low life satisfaction (Rashid, Ong & Wong, 2012).Depression is a challenging mental health illness. It can cause tremendous and unbearable amount of suffering on the elderly, their families, and friends who must cope with the 19 uncertainties of care and outcomes of depression. This situation is normally the case when depression is not properly addressed. At the same time, society also has to bear heavy social consequences as well as higher economic cost in dealing with the effects of depression on elderly's well-being (Bschor, Bauer, & Adli,2014).

Depression among the elders is one of the most common and significant mental health issues among people around the world (Bluth et al., 2016; CDC, 2018; Davey-Rothwell, Stewart, Vadnais, Braxton, & Latkin, 2017; Rashid, Ong & Wong, 2012; WHO, 2018), yet it is often seen as inevitable specifically among older adults of color (Sriwattanakomen et al., 2010; Zalaquett & Stens, 2006). Although there is an abundance of research on depression, most of the research tends to relate to majority cultures. Subsequently, there is a limited amount of information focusing on older African American women and their experiences with depression.

Several studies have been conducted on the predictors of psychological well-being among the elderly. About 1415 respondents aged 60-100 years consisting of 722 women and 693 men participated in a nationwide survey to determine socio-demographic predictors of psychological well-being among the elderly (Momtaz, Ibrahim, Hamid & Yahaya, 2011). Their findings showed that age, gender, marital status and household income were significant predictors of psychological well-being among the elders. They also found that the lower the age of the respondents the higher the psychological well-being. In addition, the same study also found that the older women reported to have lower levels of psychological well-being as compared to older men and married respondents were reported to have better psychological well-being as compared to the unmarried.

Respondents with higher income reported to have higher psychological well-being. In terms of employment status and educational achievement, the researchers reported some effects on the respondents even though it was not statistically significant. They found that retired and employed respondents or groups tended to have higher psychological well-being than the unemployed group. Also, those who were in the secondary education group scored higher than the primary and the no-formal education groups. This means the higher the education the better the psychological well-being of the elderly (Momtaz, Ibrahim, Hamid & Yahaya, 2011).

Besides the above predictors, individuals' psychological well-being also depends on their interactions with social environment. Study on the association between social relationships and well-being in old age is an important undertaking. Social relationships are believed to affect elderly's psychological well-being and their quality of life (Hsu & Tung, 2010). A study on quality of relationships showed that social affiliation is highly related to psychological wellbeing, whereas loneliness has the opposite sides (Momtaz et al., 2011). The same study also revealed that it is the quality not the quantity of relationships that was related to psychological well-being. In addition to the above findings, social support from friends, spouse and neighbors are reported to have a significant influence on elderly life satisfaction and psychological well-being (Bluth et al. (2016).

3.0. Theoretical Framework

Throughout the literature, several theoretical perspectives are used to analyze this social problem, including the life course perspective, psychology of religion, stress and coping model, and social cognitive theory. More than one theory is often used concurrently to examine depression among African Americans (Black, Gitlin, & Burke, 2011). Given their unique history in the United States and their continued plight and circumstances, it is important to look at older African American women from varying perspectives. The major theoretical perspectives used to guide this study were social construction theory and intersectionality. These perspectives do not entirely explain depression among older African American women; however, they do offer an overarching framework for better understanding the factors connected to depression within this group (Black et al., 2011).

The theory of social construction is used primarily in the social sciences and humanities disciplines but also has been adopted by other disciplines such as business studies (Otubanjo, 2012). Berger and Luckmann introduced the term "social construction" in 1966 as a means to describe the way in which individuals and groups construct their own realities given their social, cultural, and historical contexts (Otubanjo, 2012). They observed that all knowledge and understanding of the world comes from social interactions, as opposed to reasoning and experimentation (Otubanjo, 2012; Payne, 2005). The social construction theory seeks to examine how social phenomena and trends develop into customs and beliefs about the changing processes within the society (Otubanjo, 2012). This interpretivist postmodernist theory, along with reflective and intentional theories, is a part of cultural representation theories and is linked to social psychology and social constructivist theory (Otubanjo, 2012; Payne, 2005).

Social workers use the social construction theory as a basis for psychotherapy (Payne, 2005). In practice, social construction models respond specifically to clients' own views of their world and assessment of their problems. In research, human interactions, such as conversations, are systematically analyzed, often using video- and audio-taped recordings of interactions. These analyses help to reveal communication and behavior patterns that may be hidden (Payne, 2005).

Rooted in Black feminist scholarship, intersectionality is similar to the cumulative advantage/disadvantage theory, cumulative inequality theory, and the double/triple jeopardies perspectives (Bowleg, 2012; Crenshaw, 1991; Mair, 2010; Spence et al., 2011), which are also referred to in the literature as multiple-stratification or multiple-hierarchy stratification perspectives (Schieman & Plickert, 2007).

Although some scholars call it a theory or approach (Walby, Armstrong, & Strid, 2012; Warner & Brown, 2011), others refer to intersectionality as a unifying, interpretive, theoretical framework or perspective (Bowleg, 2012). Bowleg (2012) stated that intersectionality is not a traditional theory in that it does not have any basic principles or variables that can be measured operationally or empirically tested. It is more of an analytical framework or paradigm. Although previous studies using intersectionality have been mainly qualitative research, it is also important for quantitative research to take this approach into account as this approach speaks to the importance of gathering information about cultures, communities, and other factors that intersect with people's experiences (Warner & Brown, 2011).

The term "intersectionality" was first coined by feminist legal scholar Kimberle Crenshaw during the 1990s (Bowleg, 2012). However, the idea has been around for more than a century. Abolitionist Sojourner Truth challenged the idea of viewing the social constructs of gender and race separately in her famous "Ain't I a Woman?" speech at the 1851 Women's Convention in Akron, Ohio (Bowleg, 2012). It illustrated how African American women have often had to choose between their rights as African Americans and their rights as women. Not having to choose one identity over another is crucial, as it is impossible for one to just be seen as an African American without the gender aspect and vice versa. Crenshaw also used the term to explain the exclusion of Black women from feminist discourse, which centers around White women, and antiracist discourse, which centers around Black men. Intersectionality is also used to examine the multiple, interlocking influences of various systems of oppression and privilege such as, sexism, racism, and ageism (Bowleg, 2012).

Social construction and intersectionality are complementary frameworks. The social constructionist theory views experiences, such as depression, as culturally and socially constructed (Black et al., 2011). Depression develops in a context, as opposed to developing independent of one's experience (Black et al., 2011; Black & Rubinstein, 2009; Black et al., 2007). Older adults are the active creators of their own unique worlds and as the experts in explaining those worlds to other individuals (Black et al., 2011). Furthermore, the intersectionality perspective in aging research, especially quantitative aging research, is scarce, yet offers the ideal foundation for exploring the effect of various risk and protective factors on depression for African American women (Mair, 2010). As older African American women, the concept of depression varies by not only race/ethnicity, but also by gender and one's experiences of it. Adding age into the component makes for a more in-depth perspective, since older African American women are often society's least privileged group in terms of socioeconomic status and health (Black et al., 2007; Hunn& Craig, 2009).

4.0. Method

Drawn from an original sample of 22,034 individuals, the sample for this research consisted of 2,249 respondents. HRS data from the 2010 wave were utilized, due to the data's availability. The National Institute on Aging and the Social Security Administration sponsor the HRS and the study is led by University of Michigan researchers. It is an ongoing, nationally representative, non-experimental, quantitative, longitudinal panel study of individuals, 50 years of age and older. The measures were drawn from the RAND HRS Data file (Version M), which is a cleaned version of the dataset. This dataset was chosen due to the oversampling of African Americans and the different measures of depression, as it relates to social support, religion, caregiving, and physical health, as well as, the demographic measure of age.

 The original sample in 2010 consisted of 22,034 individuals. Of those 22,034 respondents, there were 9,231 (41.9%) men and 12,803 (58.1%) women. Of the 22,034 people in the study, 18,953 (86.0%) did not consider themselves Hispanic or Latino. There were 4,284 (19.4%) individuals who identified as black or African American. Drawn from the original pool, there were 2,249 living individuals who identified as black or African American (non-Hispanic nor non-Latina), female, were at least 50 years old, completed the interview themselves without a proxy, were not nursing home or other health care facility residents, and agreed to the interview in the sample.

4.1 Instrument

The Center for Epidemiologic Studies-Depression Scale (CES-D) instrument was used to evaluate one's depression (Aneshensel, Wight, Miller-Martinez, Botticello, Karlamangla, & Seeman2007). In each of the waves of the study, respondents were asked about eight common symptoms of depression taken from the CES-D instrument (U.S. Department of Health and Human Services, 2007). In validation studies against the full CES-D battery, exhibiting four of eight symptoms is connected to being clinically depressed (U.S. Department of Health and Human Services, 2007). Telephone interviews and mail-in surveys were the methods of data collection. The two categories for this study, ever had depression and felt depressed in the past year, were based on questions from HRS that incorporated the CES-D scale.

Confidentiality and anonymity of participants were strictly upheld. All data accessed were handled with the utmost care. Morgan State University's Institutional Review Board (IRB) approval was obtained prior to the beginning of the analysis, in order to confirm that the benefits of the study outweighed its risks and that it protected human subjects. Approval from the HRS was also obtained in order to use the data. The National Association of Social Workers' Code of Ethics were adhered to. Data were analyzed by the researcher, and all data accessed for this secondary analysis was discarded at the end of the study. The information was discarded by shredding all materials associated with the study

5.0. Data Analysis

SPSS version 20, a comprehensive statistical computer program, was used to analyze the data. Descriptive statistics were run first to tabulate the frequency of the two measures of depression in relation to the independent variables of age, social support, religion, caregiving, and physical health. Multiple logistic regression, which is defined as a statistical procedure for predicting a dichotomous dependent variable based on at least one independent variable, was used for the statistical analyses in order to examine the variables associated with the presence of depression (Levin, Fox, & Forde, 2010; Steffens, Fisher, Langa, Potter, &Plassman2009). The model building approach (i.e., step-wise, forward or backward elimination) was not used in this study, in order to show the relationship between all of the independent variables in this special population.

5.1 Measures

The purpose of this study was to examine risk and protective factors for depression among older African American women in the United States. This study was limited to examining self-identified, African American (non-Hispanic), community-dwelling women, ages 50 and older. The intersectionality model and social construction theory were used to frame this study. Specific factors explored included age, social support, religion, caregiving, and physical health as risk and protective factors for depression among community-dwelling African American women. This chapter outlines the methodology for this study.

As stated previously, the research questions that guided this investigation were driven by an integrative perspective derived from theories and translational/intervention research that may heighten the research and practice relevancy of variables predictive of depression among community-dwelling older African American women. The integration of theories and research may offer the opportunity to develop specific recommendations for future research and practice. Whereas theoretical perspectives provide essential explanatory knowledge about the problem of depression among the elders, translational research attempted to apply such explanatory knowledge to interventions involving depression among older adults, particularly community-dwelling African American women.

Data collection began in 1992, when the Health and Retirement Study was first launched, and biennially thereafter (U.S. Department of Health and Human Services, 2007). Through a multi-stage clustered area probability sampling design, 69,336 households were selected (Mojtabai & Olfson, 2004). Those born between 1931 and 1941, who were between 51 and 61 years old in 1992, were asked to participate in the study, with 78% consenting to participate (Mojtabai & Olfson, 2004). Participants were first interviewed in person in 1992, then re-interviewed biennially (Warner & Brown, 2011). Their spouses or partners, regardless of ages, were also included in the sample (Mojtabai & Olfson, 2004). Following the first wave of in-depth interviews, the majority of interviews thereafter were conducted via phone (Mojtabai & Olfson, 2004). Data for this analysis were extracted from the 2010 wave of the study.

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6.0. Results

This article presents the results of the study of 2,249 Black and/or African American, non-Hispanic women, 50 years of age or older, who were not in nursing homes or other health care facilities. Six research questions guided this study. The results are organized as follows. First, a descriptive analysis of the data is presented. Secondly, an inferential analysis including a Chi-Square Analysis and a Logistic Regression of Ever Had Depression by Selected Independent Variablesfor women who ever had depression and women who felt depressed are presented. The independent variables are discussed in order of age, social support, religion, caregiving, and physical health.

6.1. Descriptive Analysis

Table 1 shows the number of women for each of the independent variables in the sample. Over 47% (n=1,066) were in the 50-59 age group. There were 25.4% (n=571) in the 60-69 age category. Among the social support variables, 31.8% (n=715) were currently married, while 25.4% (n=571) were widowed. Additionally, there were 94% (n=2,073) who reported that they did not currently receive help from relatives. The majority of the sample, 72% (n=1,565), had no relatives near. There were 52.5% (n=1,141) participants who reported having good friends near. When asked about how often the women get together with other people, 35% (n=754) reported that they almost never do, while 31.6% (n=680) reported that they get together with people at least on a weekly basis. About 82% (n=1,461) reported that they believe they have relatives and/or friends that would be able to help them with any future needs.

In terms of how often one attends religious services, 28.1% (n=630) of the sample reported attending more than once a week during the past year. Another 27.8% (n=623) stated that they attended religious services once a week during the past year. Furthermore, 92.5% (n=2,077) viewed religion as very important, while less than 2% (n=41) thought that it was not too important. Most women, 59.6% (n=1,058), did not report providing 100 or more hours of care to grand or great grandchildren since the previous wave. On a scale of 1 to 5, 34% of participants gave themselves a rating of 3 (n=765) for good health. About 20% (n=455) had ever experienced depression and conversely almost 80% (n=1,789) had never experienced depression, while 80.5% (n=1,808) reported that they had not felt depressed in the past year and 19.5% (n=437) stated they had felt depressed in the past year.

Table 1. Number and Percent of Women in the Sample by Age Group, Social Support, Religion, Caregiving, Physical Health, and Depression (cont'd.)

Independent Variables	Frequencies	
	N	%
Age Group:		
50-59	1066	47.4
60-69	571	25.4
70-79	464	20.6
80-89	121	5.4
90 and Older	27	1.2
Total	2249	100.0
Social Support: Marital Status		
Never Married or Other	316	14.1
Widowed	571	25.4
Divorced	504	22.4
Separated	143	6.4
Married	715	31.8
Total	2249	100.0
Receive Help from Relatives		
No	2073	94.0
Yes	132	6.0
Total	2205	100.0
Relatives Near		
No	1565	72.0
Yes	608	28.0
Total	2173	100.0
Good Friends Near		
No	1032	47.5
Yes	1141	52.5
Total	2173	100.0

Number of Times Get Together with People

Day		
Week	222	10.3
Every Two Weeks/Bi-Weekly	680	31.6
Month	64	3.0
Year	325	15.1
Almost Never or Other	109	5.1
Total	754	35.0
	2154	100.0

Relatives/Friends Help with Future Needs

No	315	17.7
Yes	1461	82.3
Total	1776	100.0

Religion:How Often Attend Religious Services

Not at All	246	11.0
One or More Times a Year	328	14.6
Two or Three Times a Month	418	18.6
Once a Week	623	27.8
More Than Once a Week	630	28.1
Total	2245	100.0

Importance of Religion

Not Too Important	41	1.8
Somewhat Important	128	5.7
Very Important	2077	92.5
Total	2246	100.0

Caregiving: Care of Grandkids-100 or More Hours

No	1058	59.6
Yes	716	40.4
Total	1774	100.0

Physical Health:

Poor	212	9.4
Fair	649	28.9
Good	765	34.0
Very Good	482	21.5
Excellent	139	6.2
Total	2247	100.0

Dependent Variables	N	%

Ever Had Depression:

No	1789	79.7
Yes	455	20.3
Total	2244	100.0

Felt Depressed in Past Year:

No	1808	80.5
Yes	437	19.5
Total	2245	100.0

Table 2. Chi-Square Analysis for Ever Had Depression by Selected Independent Variables

Independent Variables	Ever Had Depression			Pearson Chi-Square	DF	P-Value
	No N (%)	Yes N (%)	Total N (%)			
Age Group				35.254	4	*.0001
90 and Over	25 (92.6%)	2 (7.4%)	27 (100.0%)			
80-89	98 (81.0%)	3(19.0%)	121 (100.0%)			
70-79	402 (87.0%)	60(13.0%)	462 (100.0%)			
60-69	468 (82.0%)	103 (18.0%)	571 (100.0%)			
50-59	796 (74.9%)	267 (25.1%)	1063 (100.0%)			
Total	1789(79.7%)	455 (20.3%	2244 (100%)			
Social Support:Marital Status				25.265	4	*.0001
Married	607 (85.0%)	107 (15.0%)	714 (100.0%)			
Separated	109 (76.2%)	34 (23.8%)	143 (100.0%)			
Divorced	383 (76.0%)	121 (24.0%)	504 (100.0%)			
Widowed	458 (80.6%)	110 (19.4%)	568 (100.0%)			
Never Married or Other	232 (73.7%)	83 (26.3%)	315 (100.0%)			
Total	1789 (79.7%)	455 (20.3%)	2244 (100%)			
Social Support: Receive Help from Relatives				9.908	1	*.002
No	1661 (80.3%)	407 (19.7%)	2068 (100.0%)			
Yes	91 (68.9%)	41 (31.1%)	132 (100.0%)			
Total	1752 (79.6%)	448 (20.4%)	2200 (100.0%)			
Social Support:Relatives Near				.120	1	.729
No	1242 (79.6%)	319 (20.4%)	1561 (100.0%)			
Yes	487 (80.2%)	120 (19.8%)	607 (100.0%)			
Total	1729 (79.8%)	439 (20.2%)	2168 (100.0%)			
Social Support:Good FriendsNear				3.602	1	.058
No	803 (78.0%)	226 (22.0%)	1029 (100.0%)			
Yes	927 (81.3%)	213 (18.7%)	1140 (100.0%)			
Total	1730 (79.8%)	439 (20.2%)	2169 (100.0%)			
Social Support: Number of Times Get Together with People				13.201	5	*.022
Day						
Week	177 (80.1%)	44 (19.9%)	221 (100.0%)			
Every Two Weeks/Bi-Weekly	545 (80.3%)	134 (19.7%)	679 (100.0%)			
	56 (87.5%)	8 (12.5%)	64 (100.0%)			
Month						
Year	275 (84.6%)	50 (15.4%)	325 (100.0%)			
Almost Never or Other	88 (80.7%)	21 (19.3%)	109 (100.0%)			
Total	573 (76.2%)	179 (23.8%)	752 (100.0%)			
	1714 (79.7%)	436 (20.3%)	2150 (100.0%)			
Social Support: Relatives/Friends Help with Future Needs				3.474	1	.062
No	256 (81.3%)	59 (18.7%)	315 (100.0%)			
Yes	1244 (85.4%)	212 (14.6%)	1456 (100.0%)			
Total	1500 (84.7%)	271 (15.3%)	1771 (100.0%)			
Religion: How Often Attend Religious Services				17.463	4	*.002
Not at All	185 (75.5%)	60 (24.5%)	245 (100.0%)			
One or More Times a Year	240 (73.2%)	88 (26.8%)	328 (100.0%)			
Two or Three Times a	338 (81.2%)	78 (18.8%)	416 (100.0%)			

Month Once a Week More Than Once a Week Total	520 (83.5%) 503 (80.1%) 1786 (79.7%)	103 (16.5%) 125 (19.9%) 454 (20.3%)	623 (100.0%) 628 (100.0%) 2240 (100.0%)			
Religion: Importance of Religion Not Too Important Somewhat Important Very Important Total	 33 (80.5%) 98 (76.6%) 1657 (79.9%) 1788 (79.8%)	 8 (19.5%) 30 (23.4%) 416 (20.1%) 454 (20.2%)	 41 (100.0%) 128 (100.0%) 2073 (100.0%) 2242 (100.0%)	.862	2	.650
Caregiving: Care of Grandkids-100 or More Hours No Yes Total	 853 (80.8%) 550 (76.8%) 1403 (79.2%)	 203 (19.2%) 166 (23.2%) 369 (20.8%)	 1056 (100.0%) 716 (100.0%) 1772 (100.0%)	4.060	1	.044

6.2. Association between Ever Had Depression and Independent Variables

Table 2 presents the association between ever had depression and each independent variable. A Pearson Chi-squaretest shows that age was associated with ever having depression (p-value .0001). For social support, marital status (p-value .0001), receiving help from relatives (p-value .002), and the number of times women get together with other people (p-value .022) were associated with ever having depression. However, there was no association between ever having depression and having relatives or good friends near (p-values .729, .058), nor for having relatives and/or friends that would help with future needs (p-value .062). While the frequency of attending religious services was associated with ever having depression (p-value .002), the importance of religion was not (p-value .650). Additionally, caregiving and physical health were both associated with ever having depression (p-values .044, .0001).

6.3. Predictors of Ever Had Depression

Table 3 presents the predictors of ever had depression by selected independent variables. Age was a significant predictor of ever having depression. Furthermore, there was a significant difference within the age categories. Women who were in the 70 to 79 age group had a p-value of .003. These individuals were 53.2% {(100)(1 – .468)} less likely to have ever had depression than people in the 50-59 age group. Some aspects of social support were significant predictors of ever having depression. When compared to people who had never been married, married respondents were 50% times (odds ratio .500) less likely to have ever had depression (p-value .007). None of the other social support measures were predictors of ever having depression (p-values >.08). The two religious measures and caregiving were not significant predictors of ever having depression (p-values >.2).

When compared to women who had rated themselves as having poor health, people who rated themselves as having excellent health were 86.5% (odds ratio .135) less likely to have ever had depression (p-value .0001) and people who rated their health as very good were 85.5% (odds ratio .145) less likely to have ever had depression (p-value .0001). Those who rated their health as good or fair were 74.1% (odds ratio .259) and 50.2% (odds ratio .498) less likely, respectively (p-values .0001, .023).

*Table 3.*Logistic Regression of Ever Had Depression by Selected Independent Variables

Independent Variables	Ever Had Depression			
	P Value	(Exp)B	Lower 95% CI	Upper 95% CI
Age Group				
90 and Older	.899	.869	.099	7.612
80-89	.222	.564	.224	1.415
70-79	*.003	.468	.284	.770
60-69	.438	.862	.591	1.256

Social Support: Marital Status				
Married				
Separated	*.007	.500	.301	.830
Divorced	.059	.480	.224	1.029
Widowed	.416	.813	.493	1.339
	.127	.660	.387	1.126
Social Support: Relatives Near	.774	.987	.904	1.078
Social Support: Good Friends Near	.545	.972	.887	1.065
Social Support: Number of Times Get Together with People				
Day	.242	.703	.390	1.268
Week	.556	.883	.583	1.337
Every Two Weeks/Bi-Weekly	.088	.331	.093	1.178
Month	.211	.719	.429	1.205
Year	.946	.971	22	2.239
Social Support: Relatives/Friends Help with Future Needs	.176	1.073	.969	1.188
Social Support: Receive Help from Relatives	.093	.874	.747	1.023
Religion: How OftenAttend Religious Services				
More Than Once a Week	.418	1.299	.689	2.449
Once a Week	.982	1.007	.535	1.895
Two or Three Times a Month	.839	.932	.474	1.834
One or More Times a Year	.335	1.371	.722	2.606
Religion: Importance of Religion				
Very Important	.727	.817	.263	2.540
Somewhat Important	.997	.998	.291	3.416
Caregiving: Care of Grandkids-100 or More Hours	.289	.957	.882	1.038
Physical Health				
Excellent	*.0001	.135	.054	.341
Very Good	*.0001	.145	.073	.289
Good	*.0001	.259	.142	.472
Fair	*.023	.498	.273	.907

6.4. Summary of Associations and Predictors of Depression and Selected Independent Variables

There were many similarities in the bivariate analyses, as illustrated in Table 4. For both measures of depression, age, marital status, receiving help from relatives, the number of times one gets together with other people, how often a woman attends religious services, and physical health all had significant associations. Caregiving, which had a significant association with ever having depression, did not have a significant association with feeling depressed in the past year. Having relatives near, good friends near, having relatives and/or friends who would help with future needs, and the importance of religion did not have significant associations with ever having depression or feeling depressed in the past year. Table 4 shows the similarities between the multiple logistic regression analyses. Age, marital status, and physical health were the only three significant predictors of ever having depression and feeling depressed in the past year. No other variable measures were significant predictors of depression, when controlling for all the variables.

Table 4: Summary of Multiple Logistic Regression Results for Women in the Sample

Independent Variable	Depression Ever Had Depression	Felt Depressed in Past Year
Age	X	X
Social Support		
Marital Status	X	X
Receive Help from Relatives		X
Relatives Near		
Good Friends Near		
Number of Times Get Together with Other People		
Relatives/Friends Help with Future Needs		
Religion		
How Often Attend Religious Services		
Importance of Religion		
Caregiving		
Physical Health	X	X

Note: X, variable was significant for (p≤.05) the respective depression categories.Results indicated that in the general population age, social support, and physical health can inform the likelihood of depression.

7.0. Discussion

This study sought to determine the risk and protective factors associated with depression among a sample of older, African American women in the United States. The study had the following research questions: (1) what is the relationship between age and depression, (2)what is the influence of social support on depression, (3) what is the relationship between religion and depression, (4) what is the relationship between caregiving and depression, (5) what is the influence of physical health on depression, and (6) what is the joint impact of age, social support, religion, caregiving, and physical health on depression. Ultimately, this research explored the association and/or predictors of the independent selected variables with ever having depression and feeling depressed in the past year. Guided by intersectionality and social construction theories, several factors that may have had an impact on depression were studied.

The first research hypothesis, which was the prevalence rate of depression will differ by age, was supported. These data suggest that there is variation in age groups with respect to depression. In other words, depending on the age group of an individual, age can be a source of risk or protection for depression.

The second research hypothesis was that the six types of social support, individually, will be associated with depression. Under the categories of social support, marital status, receiving help from relatives, and the number of times a woman gets together with other people were associated with depression. However, relatives near, good friends near, and having relatives/friends help with future needs were not associated with depression. That is, social support can be a source of risk or protection for depression.

The third research hypothesis, which stated that religion will be associated with depression, was supported for how often one attends religious services, but rejected for the importance of religion. In other words, how often one attends religious services may serve as a risk or protective factor for depression. The fourth research hypothesis stated that caregiving will be associated with depression. This research hypothesis was supported for ever had depression but rejected for felt depressed in the past year. Caregiving may or may not be a source of risk or protection for depression. The fifth research hypothesis, which was physical health will be associated with depression, was supported. This suggests that physical health can be a source of risk or protection for depression.

With regard to the sixth and final research hypothesis regarding age, social support, religion, caregiving, and physical health independently and/or jointly predicting depression, only age, marital status, and physical health jointly remained significant predictors of depression, after controlling for all the other variables in the model. In other words, age, marital status, and physical health were possible sources of risk or protection for depression. Receiving help from relatives remained significant for feeling depressed in the past year. However, receiving help from relatives was attenuated for ever having depression, after controlling for all the other variables in the model.

In summary, age, physical health, and marital status, were all predictors of whether or not a woman had ever had depression and whether or not a woman felt depressed in the past year. That is, these factors are possible sources of risk or protection for ever having depression or feeling depressed in the past year. Basically, it is possible that age, health and illness, and marital status can contribute to depression. These findings were consistent with research that states that age, social support, and physical health can inform the likelihood of depression (Kelley-Moore & Ferrara, 2005; Lo et al., 2010; Mair, 2010).

8.0. Implication for Practice

This study has implications at the micro, meso, and macro levels in relation to social work research and theory, policy, and practice. First, additional areas for research and theories are discussed. Next, specific policy implications are suggested, relative to the Affordable Care Act. Lastly, suggestions for social work practice and education are provided. Several areas of research should be expanded upon. Future research should focus on how being in multiple roles (e.g., caregiver, employee, volunteer, student, community leader) (Baker & Silverstein, 2008b) may influence women's mental health status, particularly among African American women. Studies could include a cross-cultural comparison between older African American women in urban environments and other women of color. Though support group was not a factor examined in this study, it has been found to reduce stress and ease isolation (Blustein, Chan, & Guanais, 2004), thus further research including aspects of support groups may be necessary, specifically as it relates to helping to treat depression among African American women and other people of color. Furthermore, in order to compare individuals in different situations in a systematic way, more cross-cultural nationally representative data, like the Health and Retirement Study is needed. Although this study uses a cross-sectional analysis, using a longitudinal analysis (Mair, 2010) for the data could be beneficial to suggest causal pathways and to illustrate changes over different periods in time. Studying the social variation within groups (Warner & Brown, 2011) would also help to better understand the process leading to health differences with age.

More studies need to focus on the connection between age and depression, marital status and depression, and physical health and depression, linking each individually and jointly. While focusing on these connections, the next steps would include targeting specific treatment options for ethnic and minority populations, particularly women of color. While treatment is available for these groups, they are often underutilized or not utilized at all for many different reasons including lack of cultural awareness and sensitivity (Min, 2005). Mixed methods approaches are recommended in order to investigate the complete account of barriers to treatment.

Mental health is a broad topic that needs much more research, especially among older generations of color. Because there are so many different types of mental health issues, future studies could benefit from not only researching those issues, but also factors that may intersect with mental health challenges including substance abuse and chronic diseases among the aged. Prevention may or may not be possible, but studying mental health issues such as depression more in-depth will at least allow researchers to see if there is a pattern of how and when it develops and what can alleviate the issue and help maintain better health.

While most of the major theoretical perspectives have been applied to White European males in the United States, they can gain value from the inclusion of older, African American, community-dwelling women. For instance, the contextual perspective of intersectionality and social construction theory takes into account the physical, cognitive, personality, and social worlds of individuals which were core components in this study in relation to depression among African American women (Bowleg, 2012; Otubanjo, 2012). In alignment with these theories, factors such as age, social support, and physical health can be used as buffers or protective factors for depression in older, African American women. Findings from this study can inform not only perspectives from intersectionality and social construction but also existing theories such as the sociocultural theory by Lev Semenovich Vygotsky and the bioecological approach by Urie Bronfenbrenner (Feldman, 2003).

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