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Generational interdependence: living arrangements and housing programmes

M. Powell Lawton*
Philadelphia Geriatric Center

Abstract

The broad social issue of generational competition versus generational interdependence is discussed. The way elders are housed offers an excellent example of how benefits putatively allocated to older people in fact more often than not subsume benefits to family members of all ages. Data on generationally shared households from a number of countries and the results of recent studies from the United States are discussed in this context. Separate housing of generations is often preferred where feasible. Where economic, environmental, health, or social needs of either elder or young generations make autonomous households dysfunctional, members of each generation show in their household-formative behaviour their willingness to assist the other generation.

Despite differences in support provisions for older people and differences in the mix between public and private sources of financial support, caring for elders introduces many problems that are very similar in every industrialized country. Generations and their relationships is a topic that has preoccupied gerontologists from the beginning. The classic conclusion, demonstrated especially well in the cross-national surveys reported by Shanas *et al.* (1968), is that modern society has not seen the dissolution of family solidarity. Although new forms of assistance (for example, caregiving at a geographic distance) may arise, in every country studied by Shanas and her colleagues the overwhelmingly predominant pattern is for the adult children to remain in close touch with aged parents, to offer assistance when needed, and to maintain close affective exchange relationships in the majority of instances.

The conditions under which informal and formal support are delivered to different segments of society may have a major influence on the way generations perceive one another. The state systems of support for elders have, of course, developed in quite different ways in South Africa, and in the United States. The national government has been a much more active participant in pensions, health, institutional and community-based care in America than in South Africa. Inevitably, however, increasing industrialization and resulting social complexity, including increases in costs of social support for disadvantaged groups expected in the future, will raise questions regarding the equitability of public expenditures among segmented social groups. Such an issue has been prominent in policy debates in the United States for several years, best known by the somewhat emotion-laden term "generational equity". Very briefly, a conservative political movement in the United States is mobilizing pressure to reduce programmes for the aged and their tax support, because other age groups have become disadvantaged in paying for programmes serving the aged. Discussion of this issue may be helpful in anticipating how similar questions might arise and be dealt with in South Africa's future.

Recent gerontological research has been particularly informative in speaking to questions regarding the distribution of assistance as it goes between generations. The basic question is one of who supports whom, the data leading to the conclusion that generational interdependence, rather than generational conflict, characterizes American society and, further, that the same mechanisms probably may be found in South African society. The example of multigenerational dynamics chosen for this article is housing and living arrangements, because of the wide variety of intergenerational exchanges that are possible within the housing context.

Intrafamilial interdependence

National pension systems have transformed patterns of support for older people. In the United States in 1937, two-thirds of the older population was dependent on relatives or public welfare and fully 32 % of all 65+ had no income at all (Upp, 1982). This century saw the advent of Social Security and the growth of employer-administered retirement programmes, as well as federally-assisted health care for elders, all of which changed radically that old style of financial dependence for the older person who no longer worked.

Today few older Americans are dependent in this manner. In 1978 97 % were "self-dependent", 1,7 % were dependent on children and 1,3 % on public funds only (Upp, 1982).

In terms of patterns of assistance, people over 65 provide *more* per capita cash assistance to their children than people under 65 provide for their parents (National Council on the Aging, 1975). A similar situation was reflected in Canadian data from 1978, which showed that the national average annual cash transfer from 65+ parents to an adult child was $213, compared to upward generational transfers to the aged averaging $73 per year (Cheal, 1983). Even older Americans below the poverty level in 1974 (under $3 000) exceeded their children in cash giving (32 % of the poor old gave). The same study showed that a whole series of areas of possible help, such as giving assistance when ill, helping with errands or household tasks, and social-emotional support, are characterized by equity and reciprocity of help rather than a unidirectional flow from young toward old (National Council on the Aging, 1975).

* *Address correspondence to*
Prof. M. Powell Lawton, Behavioral Research, Philadelphia Geriatric Center, Old York Road, Philadelphia, PA, United States of America.

The area of social relationships is particularly noteworthy. Contrary to some social stereotypes, the amount of contact between generations is high and continuous: 86 % of older people have living children; 80 % of them live less than an hour's travel distance from a child; and 70 % had seen one or more children within the past week (Crimmins & Ingegneri, 1990).

Do we need to go any further to illustrate the behavioural togetherness shown by families than these compelling data in the financial and social area? The evidence is clearly on the side of the multigenerational vigour and positive quality of family, while just as clearly those without such resources constitute a target group of high potential need.

Housing and multiple generations

One of the most important areas for intergenerational exchange is housing and living arrangements.

On the face of it, population data on living arrangements may appear to reflect a dissolution of family solidarity. For example, 30,5 % of Americans 65+ live alone, a proportion that has steadily increased, especially since the 1930s (Saluter, 1990). The proportion of older people who lived in the same household with their children was much greater at the turn of this century (Smith, 1981). Furthermore, the usual situation was that the house belonged to the older generation member rather than the younger, an arrangement not always to the liking of the young.

Contrast that situation with the one that holds today. Data that compare different countries in the extent to which older people and their children live together in the same household are informative. In the United States only about 18 % of older people with living children are coresident with their children (Crimmins & Ingegneri, 1990). For contrast, let us consider Japan, where about 67 % live so (Martin, 1989). Data pieced together for other countries indicated that many less industrialized countries were similar to Japan in percentage of shared households (China, Korea, Mexico, for example Kinsella, 1990, and Thailand, South Korea and India, for example Hashimoto, 1991). Southern European countries are only slightly less multigeneration (Greece, Spain, Italy, for example Kinsella, 1990).

Industrialized countries were generally closer to the rate seen in the United States, for example multiple-generation household rates (slightly higher rates as compared to child coresidence rates) were 29 % in France, 27 % in the United Kingdom and 22 % in Denmark (Kinsella, 1990).

What do we make of these data? First, they seem to support that cultural traditions are an important factor in increasing coresidence, as in the case of Japan. Even more strong, however, is the influence of economic development in decreasing coresidence. In South Africa a decade ago, the multiple-generation household was as prevalent among blacks as it was anywhere in the world, in contrast to the situation among whites, where the rate was about the same (22 %) as in the United States (Martine, 1979). Today, coresidence is still very prevalent in a rural area of Zimbabwe (76 %) (Hashimoto, 1991). In South Africa however, blacks have become somewhat more involved in the working economy and considerably freer to relocate, the frequency of multigenerational households has markedly decreased. Even in strongly culturally-determined Japan, the coresidence rate has decreased from 80 % only 20 years ago (Palmore, 1975).

The meaning seems clear: When the state of the country's economy allows it, the generations form separate living units. It is easy to conclude that American pension and medical benefits have liberated the generations and allowed them to be able to choose the way they live. As evidenced by their choices, the verdict is clearly toward separateness.

One question worth asking is whether the separateness of the generations is by mutual agreement or by a unilateral decision of the younger family. In general older people are quite happy with their living arrangements. This goes for older people in most circumstances, including, interestingly, those who live alone (Lawton, 1978). Older people, like everyone else, prize their independence, their privacy, and they cling to their own homes. They view their homes as symbols of their lifelong achievement, as objects of attachment with which older residents relate themselves in the present to themselves as they were in an earlier period, or as places that are extensions of the Self (Lawton, 1989). Thus at the turn of this century older people typically shared their homes with their children and their grandchildren because there were no alternatives. Today the generations actively enjoy their autonomy. Although the evidence is thus clear that separation of dwellings is by mutual and positive agreement of the majority, there still are forces that tend to produce coresidence.

Two recent studies of different representative American samples have provided us with much-improved understanding of the dynamics of living arrangements (Aquilino, 1990; Crimmins & Ingegneri, 1990). We have usually assumed that the coresidence of an older parent and adult child represented a situation where the elder was in some way dependent upon the adult child. Surprisingly, Aquilino (1990) appears to have been the first to characterize *whose* home it was in which the generations live together. He found that in three-quarters of the instances, the parent was the householder. Only one-quarter of the shared households were formed by the child having the parent move into the child's home, a proportion representing only 4 % of the total elder population. It was in this 4 % of all households containing older people that indicators of major needs of the older person were measurable, needs that could easily be considered served by the younger generation: Widowhood, poverty, and (from Crimmins & Ingegneri's 1990 data), poor health were very prevalent among these housing-dependent older people.

If parental dependency is not the major determinant of coresidence, what is? Both studies were unanimous in identifying the existence of an unmarried adult child among the living children as the main correlate of there being a shared household. Furthermore, Crimmins and Ingegneri, using data from Shanas' (1982) survey, reported that more than half of these shared households (56 %) had existed all of the adult child's life. Among the 44 % who had re-formed a shared household after living separately, the reasons for moving back together are shown in Table 1.

With these findings in hand, the reasons for coresidence take on a different look from the view that portrayed the normative situation as one where the adult child provided support for a frail or deprived parent. First, the great preponderance of coresidences occur in the parent's home. Second, the majority of shared households represent states of continuous coresidence. Third, the benefits of re-established shared households accrue approximately equally to parent and to child. We lack good information on what caused the continuous shared households to remain that way, but it is clear that some segment of this total consists of parents helping developmentally, mentally, or physically disabled children in their homes and caring for them for a lifetime. Beyond such clear caregiving that flows from the older to the younger generation is a large segment of what we might call coresidence by mutual agreement. The fact that never-married children are strongly overrepresented in this group provides a good

example of interdependence that could have resulted from many different mixes of dependence and independence for different families. Presumably some who never married found it easier, less expensive, more comforting, or whatever, to stay in the parental hearth. In other families, a parent may have created a subtle pressure on the child to remain unmarried and to stay at home, in the service of the parent's dependency needs. Still others may simply have wished to stay together and others may have lived under external circumstances that facilitated the maintenance of the status quo with a minimum of active violation on the part of either of both parent and child. In any case, most of the instances of coresidence have been selected by both generations.

Table 1
Reasons for re-formation of shared households

Needs of child	Adult child's divorce or widowhood	31 %
	Poor health of the child	6 %
	Other benefits to the child, including economic	15 %
		52 %
Needs of parent	Parent's widowhood	17 %
	Parent's poor health	12 %
	Other benefits to the parent, including economic	19 %
		48 %
TOTAL		100 %

Source: Crimmins & Ingegneri, 1990.

In summary, the ways that people make their living arrangements in the United States show the majority exercising their right to form their own households, where the norm is the nuclear family, the husband-wife pair, or the not presently-married person living alone. Where there are reasons for support being extended, it seems to flow in both directions. Contrary to both popular and gerontological thought, however, in housing, as well as in cash transfers, the balance is on the side of the housing assistance moving from the elder to the younger family member.

Planned housing and needs of families

The living arrangements discussed so far occur in mainstream housing, i.e. ordinary housing in ordinary communities. The great majority of older people live in such unplanned housing. Although space will not be taken here to discuss housing planned specifically for elders, this is another important type of housing in the United States. South Africa's planned housing has been developed primarily in the private or private non-profit sector. Nonetheless public support with a form of planning costs, tax loss, and ultimately some use of tax funds, will probably grow in the future. Brief mention of the intergenerational benefits of this type of housing is thus appropriate.

Where public costs are involved, one may legitimately ask whether these planned housing units limited to the aged have been a luxury accorded one generation at the expense of the young. The best answer is provided by the answer to another question, How do younger families wish to live? The answer could not be clearer. "Intimacy at a distance" (Rosenmayr & Kockeis, 1963) is a phrase that aptly describes the ideal sociospatial relationship among generations in industrialized countries.

Contrast intimacy at a distance with the alternative. Sharing households is willingly done in response to familial, economic, emotional, or health-related need but is not the first choice of the majority of people in either generation. In Russia, China and many other countries with major all-generation housing problems one of the major daily irritants is the necessity for young couples to continue to live in a parent's home, often lasting well into the period when the third generation further crowds the tiny flat. Most people in relatively affluent countries have successfully pursued the ideal of privacy and individual space without ever being aware of what the diversity of housing options in their countries' newer housing programmes that include units earmarked for the aged has minimized: Doubling and tripling of children in a single bedroom; a daybed for grandmother in the living room; the daily kitchen drama of mother and daughter, or, worse yet, daughter-in-law, vying for ascendance; hushed expressions of love, irritation and other emotions between husband and wife. While these are situations with which people cope when they have to, the behaviour of all generations attests that they *choose* not to do so when possible. For better or for worse, mutual choice has led to geographic separation as the preferred solution to territorial sharing and the risk of conflict.

This scenario characterizes housing for the elderly as a luxury of an affluent society, perhaps, but as a luxury bought for all generations. Advocates for the elderly need not ask that housing for the elderly be given greater priority than family housing, but rather that a rational planning process recognize that most often the needs of the generations are served by the same policies.

Conclusion

The answer to possibly different interests of the generations in housing and in other areas lies not in stopping age-specific programmes but in supporting additionally what may have to be quite different initiatives for each segment. Although housing has been used as the example of how preferred mixes of autonomy and support have been achieved by the several generations, similar reasoning could be applied in other sectors of life, such as income and health care. To elevate overall quality of life for the poor or disadvantaged younger family the initiative will have to be the dauntingly expensive one of fortifying the roots of the family through education, rewarding solidarity rather than single parenthood, and putting real money into housing the family, whether by separate generation being a matter of family choice within the bounds of economic reality. Every such successful effort on behalf of the family will have a potential payoff for the *older* members of such families. A together younger family is in a far better condition to respond to the needs of a grandparent in need than is a fractured problem-ridden single-parent or nuclear family. Just as subsidized housing for the elderly has provided special assistance for vulnerable elders, there is a tremendous need to target the most-vulnerable young – the homeless, the mentally ill, the economically and culturally disadvantaged, the isolated individual – for special assistance.

Effective mobilization of public support for major national investment of effort whether in the public or non-profit sector may be accomplished more readily when support is given by a coalition of all ages, rather than one pitting generation-specific interests against one another.

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Successful ageing in South Africa: opportunity structures and subjective wellbeing[1]

Valerie Møller*
University of Natal

Monica Ferreira
HSRC/UCT Centre for Gerontology

Abstract

South Africa's seniors number over 1,5 million and they age in a variety of social circumstances. The 1990-91 multidimensional survey is the first comprehensive socio-economic study of South Africans of all population groups over 60 years of age. The questionnaire survey, which was conducted among a representative sample of 4 400 urban and rural dwellers, covers aspects of financial security, health, living arrangements and lifestyles, social support and perceived quality of life. The article gives an overview of preliminary research findings. Successful ageing is indicated by measures of subjective wellbeing. The paper describes the social circumstances of the different elderly population groups and explores their relationship to perceived wellbeing. It is concluded that lifestyle advantages do not offset socio-economic disadvantages among the less privileged elderly. Redressing social inequalities affecting seniors in a youthful society is a challenge for post-apartheid society.

Introduction

What are the markers of successful ageing in South Africa? The Multidimensional Survey of Elderly South Africans, 1990-91[2] sought to answer this question while taking into account the different opportunity structures and constraints which seniors face in a plural society shaped by apartheid which is currently undergoing rapid social and political change. This article gives an overview of preliminary findings. The full report on the key findings is given in Ferreira, Møller, Prinsloo & Gillis (1992).

The questionnaire survey was a partial replication of cross-cultural inquiries conducted in southeast Asian countries.[3] A multistage stratified cluster sampling method was used to draw a sample of 4 000 equally represented black, coloured, Indian and white persons who were 60 years and older, and who lived in metropolitan areas and were non-institutionalized. In addition an exemplary sample of 400 blacks in deep-rural areas of two homelands[4] was drawn.

Approximately two-thirds of the sample were women. The median age of the respondents in the five subsamples ranged from 67 to 71 years. About two in five black, coloured and Indian seniors, and half the white seniors were married. Slightly more than half of the black, coloured and Indian seniors, and slightly more than two-fifths of the white respondents were widowed.

The Multidimensional Survey report

Conventional social reporting on South Africa breaks down statistics into broad racial categories which are a close approximation of the major socio-economic and sociopolitical divisions. The Multidimensional Survey report indicates the results for five groups of seniors according to the conventional style.

Selected indicators in Table 1 illustrate the wide variety of social constraints and opportunities afforded South African seniors under the headings socio-economic, health, housing and lifestyle, social support and social integration indicators.

Socio-economic conditions reflect the unevenness of development of the different communities. In terms of education, income and health factors the white seniors are the most privileged group (Ferreira, 1986). The mean monthly income of the black, coloured and Indian seniors is equivalent to a social pension which is subject to a means test. The self-reported health status of the sample appears to be broadly consistent with the differential rates of life expectancy at birth. A white woman can expect to live to 75 years and a black woman to 65 years.

The housing and lifestyle indicators suggest that there may be greater opportunities for the socio-economically less privileged groups to remain integrated in the community throughout their lives. A main focus of African gerontology is the social support of the elderly through family networks or kinship ties. The role and position of the black elderly have traditionally been prescribed by seniority principles – the basis of intergenerational mutual support systems which afford economic and social security in old age. Over 80 % of the surveyed black, coloured and Indian seniors live in multigeneration households, while a similar proportion of white seniors live alone or with their spouses only (Table 1). There was no evidence to suggest that seniors living in multigeneration households would prefer a different residential lifestyle.[5]

* *Address correspondence to*
Prof. Valerie Møller, Centre for Social and Development Studies, University of Natal, King George V Avenue, Durban, 4001, Republic of South Africa.

Table 1

Selected social indicators, Multidimensional Survey of Elderly South Africans, 1990-91

	Whites	Coloureds	Indians	Urban blacks	Rural blacks
N	989	978	999	997	400
Socio-economic indicators					
No formal education (%)	0	30	46	50	79
Monthly income > R500 (%)	79	14	15	11	3
Perceived adequacy of income (%)	77	32	35	32	28
Made provision for old age (%)	79	25	23	18	7
Money is not a serious problem (% agreement)[a]	91	58	67	19	9
Modern household items index (mean) (10)[b]	9,7	7,2	9,1	4,8	1,5
Health indicators					
Good health (self-assessment) (%)	66	46	43	29	24
Good health (peer comparison) (%)	87	74	71	64	52
Physical competencies in ADL[c] index (mean) (44)	39,4	35,5	34,9	31,8	32,3
Ailments do not interfere with ADL (%)	78	58	54	41	34
High level of mobility (self-asessment) (%)	82	72	70	54	49
Social support indicators					
Number of living children (median)	3	5	2	4	4
Receives financial support from children (%)	15	59	61	68	66
Gives financial support to children (%)	25	40	41	59	60
Feels respected by family (%)	88	89	92	78	84
Children manage respondent's income (%)	4	9	16	18	12
Housing and lifestyle indicators					
Home ownership (%)	62	48	50	46	91[d]
Lives alone/with spouse (%)	79	10	8	5	6
Multigeneration household (%)	17	87	90	92	93
Respondent/spouse is head of household (%)	91	80	60	82	84
Satisfaction with living arrangements (%)	91	86	87	49	65
Social integration indicators					
Social activities index (mean) (10)	7,5	5,1	4,9	4,0	2,9
Availability of a confidant (%)	78	76	66	43	43
Club membership (%)	51	37	21	45	31
Successful ageing indicators					
Life satisfaction index (LSIA) (mean) (30)	24,5	23,6	22,1	19,4	19,0
• Zest for life subscale (mean) (12)	10,0	9,1	8,5	7,7	7,2
• Congruence subscale (mean) (12)	10,6	10,4	9,7	8,1	8,4
• Positive mood tone subscale (mean) (6)	4,0	4,1	4,0	3,7	3,5
Satisfaction with life-as-a-whole (mean) (5)	4,27	4,18	3,91	3,06	3,14
Global happiness (mean) (5)	4,25	4,13	3,93	3,16	2,99
Freedom from depressive symptoms (CES-D index) (mean) (54)	50,2	47,6	46,1	39,7	41,3
Psychosocial indicators					
Freedom from problems index (mean) (45)	41,9	39,0	37,6	31,2	30,6
Feeling in control of one's life (% agreement)	89	84	78	51	41

Notes to Table 1

a An item in the problem index. See the psychosocial indicators.

b Maximum score values are parenthesized throughout Table 1.

c ADL = activities of daily living.

d Responses indicated that two-thirds of rural structures are traditional huts.

The social support afforded by the extended family in the case of the majority of blacks, coloureds and Indians may partially offset the need for intimate social contacts and extensive activities outside the home (cf. the social integration indicators in Table 1).

The question underlying the argument in this article is whether socio-economic and health conditions, and lifestyle factors impinge on successful ageing. In order to answer this question it is necessary to define successful ageing.

Indicators of successful ageing

Without doubt some senior South Africans might regard as an achievement and a marker of successful ageing the mere fact that they have reached three score years. Certainly, earlier research suggests that attaining a ripe old age is regarded as a blessing and a privilege by some older South Africans (Møller, 1984).

Beyond mere survival to the third age, the Multidimensional Survey turned to the more telling and conventional indicators of what is commonly known as morale, contentment, adjustment or adaptation in later life (Lohman, 1977; Larson, 1978). Assuming that individuals themselves are the best judges of their situation, the Multidimensional Survey applied several measures of subjective wellbeing which have been used in both developed and less developed contexts. The first measure was the suitably rephrased Life Satisfaction Index A (LSIA) (Neugarten, Havighurst & Tobin, 1961; Adams, 1969), shortened by one item. The LSIA, a scale specifically designed to measure senior satisfactions, taps the dimensions of positive mood tone, zest for life and sense of achievement in life, i.e. congruence between expectations and achievement (Liang, 1984). Two further indicators of successful ageing included the widely used one-item measures of global happiness and satisfaction with life-as-a-whole (Andrews & Withey, 1976). A short depression scale based on the Centre for Epidemiological Studies Depression (CES-D) item catalogue (Radloff, 1977) was the fourth measure. Depressive symptoms are considered to be correlates and determinants of subjective wellbeing (Abbey & Andrews, 1986).

All measures of subjective wellbeing shown at the bottom of Table 1 are highly and significantly correlated with each other. LSIA scores are lowest for both groups of blacks, highest by far for whites, with coloured and Indian seniors falling in between. The widest gap is between blacks and all other groups. This gradient also applies to the subscales shown in the table. The three other indicators of successful ageing – satisfaction with life-as-a-whole, global happiness and depressive symptoms – follow the same pattern. Moving up the table we observe that the social profiles on health, physical coping and social integration are a mirror image of perceived quality of life. However the economic gradient transposes the position of Indians and coloureds.

The findings suggest that successful ageing in South Africa may be closely linked to favourable social circumstances and living conditions, and may reflect the accumulated experience

of a lifetime. The subjective wellbeing gradient emerging from the Multidimensional Survey is also observed in trend surveys of younger generations of South Africans (Møller, 1989; Møller & Schlemmer, 1989). Under the apartheid system social rewards have been distributed unequally. The brief review of lifestyles above and the income statistics reproduced in Table 1 confirm this point. Assuming that greater effort is required to overcome social disadvantage, it is small wonder that a larger proportion of the more privileged sector of the South African population has managed to achieve a higher degree of subjective wellbeing in later life.

Congruence between socio-economic conditions and subjective wellbeing is found in other parts of Africa and Asia (Veenhoven, 1984). It would be short-sighted to interpret the survey findings solely in terms of the socio-economic divide between First and Third World development levels. The individual experience of subjective wellbeing and the diversity of lifestyles in plural society call for closer examination.

Variations in coping styles: recipes for successful ageing

It is proposed that a broad conceptual distinction can be made between a "sharing" ethos and an "independence" ethos. The first ethos is based on co-operation, interdependence and mutual support between the generations, and reflects the more traditional mode of adjustment in later life. The second is rooted in the notion of self-reliance, which is akin to a more western-modern style of adaptation and coping in later life.

The two ethoses are evidenced in the data relating to living arrangements, money management, and the social security provision of seniors which have been described above. Among rural and urban blacks the social solidarity mode prevails with the emphasis on intergenerational financial support, nurture and care. The sharing ethos is perhaps best epitomized by the Indian lifestyle, where the extended family system appears still to remain intact and great respect is shown to seniors.

Survey evidence suggests that white seniors subscribe to the second ethos. Independence appears to be the principle guiding their living arrangements, preparation for retirement, financial security and social integration.

South Africa is a society in transition and the data patterns are not consistently clear-cut. The black response patterns suggest that the ideal of mutual solidarity has been disrupted at both the urban and the rural pole. Alienation and loss of respect is most keenly felt at the urban end. The majority of urban black seniors appear to be permanent urban residents who have cut their rural ties. They stand to forfeit the social security afforded by the traditional family support system. Meanwhile they cannot afford the high cost of urban living.

At the rural end, it appears that seniors feel that they have been left behind in the urbanization process. Their need for conveniences and more accessible health care is critical. A small number wish to be reunited with their families who have migrated to town.

The dilemmas faced by individuals caught between the two ethoses may in itself have a depressing effect on wellbeing.

Signs of a convergence of coping styles can be detected in the survey data. The independence ethos is emergent among urban blacks. For example, an increasing number of urban black seniors are benefiting from private pension schemes. Black rural seniors – women as well as men – are predominantly household heads who manage their own money.

The two contrasting ethoses may affect reporting styles among seniors. Quality of life research has discovered a general tendency for seniors to report relatively higher levels of satisfaction than younger age cohorts. One explanation advanced for this trend is that seniors seek to conceal their disabilities and personal problems while overstating their coping abilities as a means of maintaining morale (Herzog & Rodgers, 1986). Denial is compatible with the independence ethos.

By contrast, a sharing ethos calls for people to confront the issues squarely, to air problems and concerns as a means of raising support and inviting mutual assistance in solving them.[6] It is suggested that where social disadvantage and a sharing ethos coincide, the issues tend to be exaggerated.[7] This may be the case with the data profiles of the black groups.

The ingredients of successful ageing

What are the factors contributing to successful ageing? An answer to this question was sought in the results of regression analyses involving LSIA scores as the criterion of success, and a wide range of social background characteristics and lifestyle factors as predictor variables. The findings suggest that there are common dimensions of successful ageing regardless of differing life conditions and coping styles. The selection of factors figuring in the regression solutions varied according to the opportunity structures and constraints applicable in the case of the different groups of seniors. In all cases five broadly defined common factors made significant and independent contributions to subjective wellbeing: feeling in control of one's life, health, financial security, satisfactory living arrangements, and a measure of social integration. Admitting to fewer problems was a predictor of above-average life satisfaction among white, coloured and Indian seniors.

Conclusions

The social report on South African seniors identifies the constraints which prevent South Africans from realizing their potential to age successfully. It reveals that older South Africans have developed coping styles which enable them to maximize opportunity structures and to enhance their quality of life. It is apparent that social inequalities as they affect the quality of life of seniors need to be redressed. Integrating the needs of the older generation for greater social equality with those of the younger generation in an essentially youthful society poses a real challenge to the social policy makers of the post-apartheid era. Given the disparities between the status and resources of the white seniors and those of the disadvantaged groups, there is a need for monitoring progress in social equity through trend studies.

Notes

1. Revised version of a paper with the same title read at the 25th Annual Conference of the Australian Association of Gerontology with the theme "Successful ageing", held in Canberra, Australia, October 1-4, 1990. In Lefroy, R.B. (Ed.) *Proceedings of the 25th Annual Conference of the Australian Association of Gerontology*. Parkville, Vic: Australian Association of Gerontology.

2. The Multidimensional Survey of Elderly South Africans, 1990-91 was conducted by the former Centre for Research on Ageing at the Human Sciences Research Council (HSRC) in Pretoria, later incorporated in the HSRC/UCT Centre for Gerontology in Cape Town. Monica Ferreira, the project leader and director of the centre, drew upon specialist inputs from L.S. Gillis (aspects of depression), V. Møller (subjective wellbeing) and F.R. Prinsloo (health). Valerie Møller is based at the Centre for Social and Development Studies at the University of Natal. The authors acknowledge the contributions of co-investigators Professor Gillis (Department of Psychiatry, University of Cape Town) and Dr Prinsloo (Department of Community Health, University of Stellenbosch) to the research effort.

3. The research design and measuring instruments of the Multidimensional Survey were adapted from those used in three major comparative surveys conducted in southeast Asian countries over the past 2-3 years, namely the National Survey of Older Adults conducted jointly by the Institute of Gerontology at the University of Michigan and the Tokyo Metropolitan Institute of Gerontology, the Socio-Economic Consequences of the Ageing of the Population project conducted in six countries under the ASEAN Population Programme, and the Comparative Survey of the Elderly in Four Asian Countries conducted jointly by the Population Studies Center at the University of Michigan and co-investigators in the Philippines, Singapore, Taiwan and Thailand.

4. The self-governing states of Lebowa and KaNgwane.

5. Low percentages of black, coloured and Indian seniors expressed a preference to live in a home for the aged. Institutionalization of seniors is in any case rare in these groups: a rate of less than 1 %, compared with a rate of 8-11 % for whites (Ferreira & Lamont, 1990).

6. The authors are indebted to Catherine Cross at the Centre for Social and Development Studies, University of Natal for drawing their attention to this point.

7. Hampson (private communication, 1991) correctly points out that in a society characterized by a group ethos of disadvantage and sharing, members will seek to minimize individual response differences. It is this mechanism which contributes to the negative exaggeration phenomenon observed in the data. The authors thank Joseph Hampson for sharing this insight.

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Social research for empowerment: the case of South African seniors

Valerie Møller*
University of Natal

Abstract

Community organizations and non-governmental bodies in South Africa are concerned about the benefits accruing to their constituencies from social research. The article addresses social research questions from the perspective of the emergent grey-power movement in South Africa. The advantages and disadvantages of isolating the elderly as a separate research category are discussed drawing on comparisons with other marginalized social categories. The paper reviews the role of social research in promoting emancipation of the elderly during the apartheid and transition period. It is argued that during the apartheid era attitude studies provided the few means for the disenfranchised elderly to voice their grievances concerning social inequities. It is recommended that research on ageing during the transition period move beyond problem-oriented studies of the elderly to discover the positive contributions which older South Africans can make to post-apartheid society. Better knowledge of the strengths as well as the weaknesses of the elderly are essential to build a database for grey power.

Research on ageing and the aged in South Africa has a short history. This is to be expected in a society which is youthful in demographic terms. African societies are more concerned with youth issues. "Ordinary Africans still tend to think of old age as a time of rest and honour for *a small number of people*" (Peil, 1987: 459, emphasis added). The bibliography of Southern African publications in the field of gerontology shows that the volume of research on ageing expanded rapidly between 1970 and 1990 (Ferreira, Esterhuysen, Rip & Setiloane, 1991). Fifty publications are listed for 1990, compared with only eight for 1970. It is evident that a greater number of researchers have been attracted to the field and that the range of topics under investigation is widening.

From the viewpoint of the professional researcher the increase in the volume of gerontological research might be construed as a positive sign of the growth of knowledge about the older segment of the South African population and its concerns. For target groups and other parties involved in the research enterprise this interpretation may not be self-evident. Although there is great respect among lay persons for good social research which subscribes to the basic principles of scientific inquiry, there is considerable public debate about the benefits to be derived from basic and applied research. In more recent times public opinion tends to favour applied research which produces emancipatory benefits for target groups. Applied research which addresses social equity and underdevelopment issues is placed high on the social research agenda of community groups and non-governmental organizations. Increasingly, marginal or disadvantaged target groups are commissioning their own policy-relevant research and inquiries which fit the description of what is commonly known as action or advocacy research.

The emergent culture of entitlement to which many disadvantaged groups in South African society subscribe adds a new twist to the contemporary debate about the public benefits of social science research. From the vantage point of disadvantaged groups, many basic research endeavours appear callous in that they do not address social equity issues which require urgent attention. While many socially disadvantaged target groups may have a high regard for scientific integrity, they also acknowledge a partisan interest in the research conducted on their behalf. In their quest for empowerment these target groups are particularly concerned about the selection of foci of research and personnel, and about the manner in which the research is conducted.

South Africa's emergent grey-power movement[1] may share the concerns of other community initiatives. The movement can be expected to have a vested interest in gerontological research to realize its objective of empowering elderly individuals and furthering their collective cause. The empowerment task is made more difficult because the movement caters for a heterogeneous elderly population made up of diverse socio-economic and ethnic groups. To date the movement has attracted its main support from the privileged white sector of the population (Ferreira, 1991). This following includes the more militant activists who advocate collective action to further the cause of the elderly. Among the black urban sector of the population the luncheon club movement (Mzizi, 1987, 1989) fulfills many of the aims typically associated with grey power. It is possible that the more tradition-oriented rural blacks, who are the numerically strongest group of elderly in South Africa, do not support the activist stance. Recent studies suggest that the majority of the black elderly subscribe to the ideals of the veneration society (McCallum, 1991), which regards as self-evident that advanced age is or should be a social advantage. The common concern about quality care for the frail aged, which conforms to the veneration ideal, cuts across the many socio-economic and cultural divides in South Africa's plural society.

A legitimate question posed by the grey-power movement is how its following of both the activist and veneration persuasion can derive maximum benefit from the social research endeavour. It is against the background of the contemporary

* *Address correspondence to*
Prof. Valerie Møller, Centre for Social and Development Studies, University of Natal, King George V Avenue, Durban, 4001, Republic of South Africa.

South African debate on the utility of social research that trends in gerontological research are reviewed.

This article addresses three focal questions:

(1) What are the consequences of singling out a particular social category, such as the elderly, for special consideration in social research?

(2) How should research roles be redefined to empower members of the grey-power target group?

(3) Which research products make the largest contributions to a database for empowerment?

Special studies of the elderly

The first question concerns the need for a special research status for the elderly. Before attempting to provide an answer it is important to consider that the elderly are inadequately represented in regular research efforts. There is a tendency to overlook older cohorts in general population surveys conducted among South Africans. It is noteworthy that exclusion criteria linked to chronological age discriminate against the old and the young in equal measure. Cut-off points for defining the target population for opinion polls and general population surveys are usually fixed somewhere at 16 – 18 years at the lower end and 60 – 65 years at the upper end. The younger and older age cohorts are treated as marginal groups for research purposes. Exclusion is usually justified on technical and convenience grounds. The substantial extra costs of sampling small segments of the population are cited as an excuse for an age cut-off. This can be resisted. In a society that has denied the vote to its numerically stronger minorities, responding to attitude surveys and opinion polls represents one of the few channels for participation in the democratic process. In terms of its mission statement the grey-power movement would be advised to urge seniors to exercise this vote.

Comparative studies of different age groups and special case studies of the elderly are alternative research options to general population studies. In the case of studies which deal exclusively with the advanced age group, caution is advised concerning the choice of topic for study. Special studies could have serious negative implications for the empowerment of seniors. Literature reviews of studies dealing with specific groups in society suggest that special case studies have tended to focus exclusively on problem issues. In the South African case, numerous problem accounts concern the plight of the white elderly, the inadequacy of their nursing homes, and service centres. Highlighting the problems of a particular group creates social awareness but also tends to stigmatize and marginalize the broader social category to which the problem group belongs. This is the case when negative stereotypes pertaining to problem groups "rub off" on the category as a whole. Once branded as a problem category, it may be difficult for members of the senior lobby to regain their position in mainstream society.

In modern-industrial society there is a danger that problem-focussed research may reinforce the negative image of ageing. Widely publicized results of problem-oriented research may reinforce the "poor dear" or sympathetic endearment approach to issues concerning the elderly, rather than the image of the competent elderly which is conducive to senior empowerment (Giesen & Datan, 1980).

Comparisons with other peripheral age and occupational groups, such as the youth and the unemployed, provide useful insights. Unlike the youth, seniors may experience greater difficulties in undoing negative publicity fostered by problem accounts or using it to their collective advantage. There may be fewer chances to repulse negative images. Seniors, unlike the youth, cannot "outgrow" negative stereotypes. Media coverage of the "lost generation" of South African youth has inspired strong policy reactions which may increase the younger generation's chances for rehabilitation and reintegration into the mainstream of society. It is questionable whether the elderly can evoke such strong sentiments, which would target them for affirmative action measures to redress past disadvantage.

The comparison between the situation of the elderly, who are retirees and pensioners, and the unemployed is also pertinent. The unemployed (under the high rates of unemployment which South Africa is currently experiencing) are not a homogeneous group. The category includes both men and women and vast age differences. Problem accounts tend to overlook these finer distinctions.

Research has revealed that the unemployed cannot identify with what amounts to a negative reference group (Møller, 1990a). In the absence of an alternative positive reference group, they reject the negative stereotypes attached to their social category by making subtle distinctions between good and bad elements among the unemployed. Unemployed individuals sustain morale by aspiring to move out of the category and distancing themselves from negative elements. Older South Africans who cannot come to terms with the negative image associated with the social category of the "aged" in a youthful society may have similar aspirations. Unsympathetic problem accounts which publicize only the negative aspects of growing older heighten society's negative anticipation of ageing and shape distorted intergenerational attitudes. An antidote of positive social reports may be needed to strengthen the self esteem and morale of the elderly. Unlike the unemployed, the elderly cannot and do not need to move outside of their social category to gain self esteem. Here the elderly have a distinct advantage over the unemployed in that they have access to a positive reference group in the local grey-power movement, which embodies a strong and healthy image of ageing.

The grey-power following of the activist and the veneration variety have in common the need for social recognition if their demands are to be met. Their personal images of strength may be undermined by research efforts which concentrate on the negative aspects of ageing. If the route of special studies of the elderly is taken, foci of study which give older people the opportunity to be seen in a positive light would be a recommendation. For example, case studies of the older adults who participate actively in service groups and community life would fit into this category.

To return to the question posed at the outset, whether it is in the interests of elderly South Africans to encourage separate studies of their situation, the compromise solution would be to judge the merit of specific research projects bearing in mind the need to sustain positive images of ageing. Members of the grey-power lobby may deem it in their interests to appoint a research ombudsman to assist with this task. Alternatively, the consumer forums advocated by Ferreira (1991) could fulfil the watchdog role.

Another means of overcoming the senior research dilemma may be to seek a better balance between case studies of problem groups and inquiries into the circumstances of the rank and file elderly. Social reports on the rank and file elderly may go a long way toward dispelling some of the myths surrounding ageing in South Africa.

In South Africa, research among the "normal" elderly has already begun. The first baseline study of the social circumstances of persons 60 years and older was conducted in 1990-91 by the Centre for Research on Ageing at the Human

Sciences Research Council (Ferreira, Møller, Prinsloo & Gillis, 1992).

Trends in South African gerontology suggest that the sheer volume of research activity in the field should in time produce a more balanced picture of ageing with its positive and negative facets, thus promoting a healthier image of seniors in our society. The Co-operative Research Programme on Ageing has a mission to promote such a balance.

The research process

The second question addressed in this article concerns the benefits to be derived from specific research roles. Which research roles empower the elderly and which roles deepen their marginal position vis-à-vis mainstream society? Empowerment suggests the notion of seniors playing active roles in the research process as equal-status subjects and research partners.

Marginal groups in society tend to be treated as objects of research which play passive roles. Therefore a starting point for empowering the elderly through research is to encourage seniors to become actively involved in the study of the issues which concern them most. There are several local and international examples which demonstrate different models of senior-driven research.

In Germany special adult education courses have been developed to train volunteer elderly researchers (Garms-Homolova, 1988). A Durban inquiry into the housing situation of older residents conducted in the 1980s confirmed that local seniors can fulfill useful roles as field workers (City Engineer's Department, 1986). Lay persons were trained in the techniques of data collection and were remunerated for their field work in the Durban study. In Lenasia, Johannesburg, over 30 volunteers resident in the area, most of them elderly persons, underwent training as interviewers and applied their skills in a community study of the elderly (Padayachee, 1989).

The community self-survey (Lund, 1982), pioneered with great success among South African youth, may represent an equally challenging research task for seniors living in retirement communities. The self-survey method involves residents as investigators who pose the research questions, and then design and carry out their own investigation. The Lenasia study referred to earlier was initiated in this manner. The consumer forums, adapted by Ferreira (1991) from the Australian model for local conditions, apply the same self-determination principles underlying the local community self-survey at the regional and national levels of community.

Community participation, in this case the involvement of older persons, can be built into most research designs. This can be done by enlisting the assistance of individuals or groups in the formulation of research questions and the development of appropriate instruments, and the interpretation of results. The extensive life experience of the elderly can be put to good use in these research roles.

With regard to reporting on research results pertaining to senior issues, members of the grey-power lobby, for example through the proposed consumer forums, might volunteer their services to advise authors on the use of non-offensive language. Many academic journals prescribe the use of non-sexist language. Grey power might present a similar case for banning ageism from scientific journals.

Research outcomes

It is chiefly with the research product which one associates empowerment. Products which contain knowledge about the ageing process, the social circumstances of the elderly, the demographic composition of the older cohorts, the diversity of lifestyles and needs, and the economic and health challenges which the elderly face are powerful tools for policy intervention. Pro-active strategies aimed at improving the quality of later life can result from this knowledge. The question is which direction should research for policy formation take if it is to achieve maximum impact?

Bekker (1991) defines development as the process of improving the life chances and living conditions of all members of society, particularly the poor. In his review of development research undertaken over the past two decades he identifies distinctive phases which may also apply to research on ageing, with particular reference to studies of the disadvantaged elderly. Development research undertaken in the late 1970s to mid-1980s, during what Bekker calls the "apartheid continuity phase", concentrated on the failure of the homelands and urbanization policies to provide for decent living circumstances for the poorer section of South African society. Judging from a cursory review of the Southern African bibliography, referred to earlier, the same trend may be observed concerning limited research output on black ageing.

During the apartheid continuity phase, research was mainly descriptive in nature and focussed on the iniquities of the apartheid system as they affected the everyday lives of the black elderly. Social research was one of the few channels of reaching out to the suppressed black minority and amplifying their needs and aspirations (Lawton, 1981, 1989). The researcher created a legitimate forum for voicing complaints for the voiceless minority. This may have afforded an increment of empowerment to the disadvantaged minority subjects. However this author is of the opinion that inadvertently apartheid continuity research may have entrenched the status quo and retarded black advancement by creating a reliance on research. Given the situational constraints of the period there was little scope for the emancipation of the black subjects resulting from this research.

Social transformation is a major focus of development studies in the "post-apartheid" era. New roles are defined for the research participants. There is a shift in the dominant research paradigm with a greater emphasis on the partnership relationship between target groups and social researchers. The researcher may be called upon to act as a technical consultant, rather than the initiator and director of social inquiry (Zulu, 1991). In order to enhance the emancipatory benefits of research to the target group, subjects participate actively in all stages of research, including the definition of research goals and the tools of inquiry. In some cases the ownership of the research product is negotiable. The principles of good research are not in question. Where a conflict of interests arises between the various participants in the research enterprise, the researcher is entrusted with upholding the values of the professional research community to ensure the legitimacy of the research product and its value for all parties involved.[2]

The most prominent examples of apartheid continuity research among the aged are inquiries into social pensions issues (Human Awareness Programme, 1983). The state old-age pension is one of the most researched and debated topics in South African social gerontology in the past 20 years. However it is doubtful whether this genre of research contributed to the emancipation of social pensioners (Møller, 1986).[3] Research conducted at pension pay points involved a captive audience, a situation which did not lend itself to engaging pensioners as active and equal participants in the research process.

During the "transition" period it is foreseeable that empirical research and academic debate will continue to focus on how best to redress past inequities and apply affirmative

action measures where appropriate (Le Roux, 1990). In order to increase pensioner participation a new approach to the dominant research topic of the apartheid continuity era may be apposite. There are two facets to pensioner benefits: they can be considered a right or a privilege (Møller, 1986). The ageism related to preferential treatment for the elderly can be as harmful to self esteem as affirmative action is beneficial to redressing past damages. The manner in which affirmative action measures are implemented often results in patronage which undermines personal power. Results from the Centre for Research on Ageing's multidimensional survey referred to earlier clearly demonstrate the need for personal power among all groups of South African seniors. It was found that feeling in control of one's life, possibly mediated by self esteem, made a significant positive contribution to life satisfaction.

Evaluation research to ensure that measures taken to redress past inequities do not retard the emancipation of pensioners, may represent a new angle on a familiar theme which is a particularly pertinent one for the transition and post-apartheid period. In addition, the post-apartheid research phase may call for topics of inquiry which go *beyond* redressing the inequalities of the past. Research on intergenerational conflict resolution, confidence building, and social identities are but a few examples of new age topics.

In the transition period it is foreseeable that the competition between generations will intensify. Studies which identify divisive tensions and common interests may supply useful tools for conflict resolution between the generations. In order to bring pensioners back into the mainstream of society there is a need to select research topics which cut across the age divide to address multigenerational interests.

One example is the research commissioned by the KwaMashu Christian Care Society into community reactions to training for senior women in educare. Findings (Møller, 1990b) suggest that training enhances the social status of older women, while equipping them to participate in education, a central value for the younger generations. The KwaMashu Christian Care Society has acted upon these results: educare training is now available to KwaMashu women of all ages (Personal communication; letter to the editor of *Thambodala*, 2(2), September 1991).

Another example is the development of a practical manual for lay caregivers (Lund & Madlala, 1991), the result of two years of participative community research. The manual addresses simultaneously the needs of the middle generation of caregivers and the older generation of care recipients.

It is proposed that in the transition era there will be a need to shift away from purely problem-oriented research to topics which better lend themselves to empowerment. Examples are studies which show that seniors are capable of adapting to change in society and even taking on leading roles. In a positive research vein, one might make a case for promoting the study of factors which enhance wellbeing rather than concentrating on the depressive symptoms which affect the elderly.

This is not to deny that positive gains for empowerment can be made from carefully designed problem studies and their implementations. The aged are easy targets of the crime and violence which have increased during the transition period. Data emergent from victimization studies may assist the elderly to better protect themselves and their life-styles (Glanz, 1991). Action research on the ways and means of empowering the elderly might usefully include an evaluation of practical crime prevention programmes for the elderly based on crime studies.

Research on personal competence may assist grey power to gain the self confidence and drive to make real contributions to building a better society. Many of the interventions which are currently being applied to empower marginalized youth may have useful applications among the elderly, particularly the "young old" (persons aged 60 – 74 years). Skills training workshops and leadership training courses to build self confidence may be as useful to seniors as incontinence (Vilakazi, 1990) workshops. Information collected for a project on senior luncheon clubs suggests that seniors respond positively to such training. Further research is required to test this supposition.

We mirror ourselves in society. It is not enough for the elderly to overcome their social handicaps and make the most of their life chances. Sustained self confidence requires social recognition. By definition grey power seeks to overturn age discrimination and prejudice. Social intolerance is characteristic of the transition period. We can therefore expect social prejudices, including ageism, to increase in the near future.

Seniors require better knowledge of the image they project to society if they are to fight the prejudices directed toward them. Research on the age stereotypes which exist in South African society can contribute to combating ageism. An attitude survey undertaken by Nair (1990) in the Durban area reveals that the elderly are generally viewed in a positive light. The insights gained from Nair's research may assist the middle and older generation to accommodate each other's needs and fears.

Comparison of Nair's findings with those of the Centre for Research on Ageing's multidimensional study (Møller & Ferreira, 1990) referred to earlier suggests that the middle and older generation share many common values, at least within specific population groups. White seniors seem to take immense pride in their physical and social independence which matches the expectations of the middle generation. Similarly, the younger and the older generation in the black community appear to agree on lifestyles. Results from the multidimensional survey intimate that black seniors are adept at using research for making known their grievances as originally intended by the social indicators research movement. Another interpretation is that the overemphasis of the negative aspects in their lives in response to the inquiry is a leftover from the apartheid continuity era. Nair's research suggests that the middle generation of blacks may resent the "complaining ethic" of the older generation (67% of Nair's (1990: 29) respondents agree with the statement "Old people are often too demanding". Making too many demands on the younger generation is the most negative quality of older people identified in Nair's research).

Nair's attitude study is but one example of basic research into age stereotypes with applications in promoting better intergenerational understanding and communication. Research into the grey-power identity – auto stereotypes – may be one of the most challenging research topics for social gerontology in South Africa in the new era. Further media and attitude research is needed to discover positive identities for seniors which cut across the gender and racial divides in South African society.

To conclude the discussion on the need for research into grey power, it is apparent that the research agenda is wide open. In the transition period there will be a need for good research which fits into the various moulds of basic research, which stands up to scrutiny from the scientific community; policy-relevant research which aids decision makers, and research which produces results which are of direct emancipatory benefit to target groups. Aspects of particpation which enhance empowerment can be built into most kinds of re-

search. There is plenty of scope for social research which will equip South African seniors with the special insights and wisdom that they require to face their future with confidence. New policy research trends outlined in this article should ensure that seniors can anticipate that ageism will not feature in the "new" South Africa and that the elderly will achieve the social recognition which is their due.

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Notes

1. The grey-power movement in South Africa is a non-political interest group. Eckley (1991) gives a working definition for the South African movement which reads as follows: "Grey power refers to the potentially strong collective identity of older persons who are sensitive to issues which affect them as a group; it enables the group to shape its political, social and economic choices."
2. The stakeholders in community projects in Third World countries typically include funding and development agents, local authorities and policy makers, as well as the target group and researchers. The discussion in this article focuses only on the participants in the research process: the professional researcher and the target group/subjects.
3. A time lag may be involved here. Descriptive studies of pension issues conducted for the second Carnegie Inquiry into Poverty and Development in the early 1980s (Wilson & Ramphele, 1989) may have paved the way for the compilation of practical guidebooks for prospective pensioners (see Association for Rural Advancement (1990) among others).

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The epidemiology and presentation of depression in the elderly

F.C.V. Potocnik*
University of Cape Town

Abstract

The epidemiology of depression in late life encompasses the distribution of the illness among the elderly and the factors influencing that distribution. This holistic approach has as its main task that of distinguishing the worried well from the serious psychiatric disorder. The assessment of the epidemiology of depression is fraught with problems and covers the aspects of case identification, their distribution, historical and aetiological studies, as well as the utilization of health services. To date, some key diagnostic categories have been identified, as well as some that still need to find a niche in the psychiatric nomenclature. In many elderly persons the presentation of depression varies considerably, covering a broad spectrum between a state of apparent wellbeing to that of marked psychological and/or physical symptoms. Researchers have thus put forward different diagnostic groupings and prevalence rates, based on their assessment of mood states, functional disability, course of illness and prognosis. Discrepancies in the results of these studies among similar communities have further been compounded by the use of different instruments and approaches to depression. There is a strong need for consensus among researchers in this field.

The epidemiology of depression in late life is the study of the distribution of the illness among the elderly and those factors that influence this distribution. It is primarily a way of thinking about health and disease beyond the traditional clinical approach, and is faced with the task of distinguishing the worried well from the serious psychiatric disorder (Hamilton, 1990; Morris, 1975; Blazer, 1989a).

Using the model described by Morris (1975) (cf. Blazer, 1989a), the epidemiology and its uses pertaining to a given disorder will be described under the following categories:

(1) The identification of cases (e.g. Can the symptoms of depression in the elderly readily be identified in the community as well as in the clinical population?)

(2) The distribution of depression in the population (e.g. What is the prevalence and/or incidence of depression in the elderly?)

(3) The historical trend of the illness among the elderly (e.g. Has the incidence of suicide increased, decreased, or remained the same among the elderly over the past 50 years?)

(4) The aetiology of depression in late life (e.g. Are social factors more prevalent in late life, given less potential for genetic influence?)

(5) The use of psychiatric and other mental health services by the elderly (e.g. Do psychiatrically impaired elderly in the community use psychiatric services?)

Case identification

The methodological problems inherent in the assessment of depression in epidemiological studies of the elderly have been summarized as follows (cf. Katona & Bell, 1990):

(1) *The selection of subjects to be studied.* Hospital-based samples are particularly highly selective and unrepresentative, while community samples may not always be practicable. If the proportion of subjects refusing to participate in a study is high, bias will result in the sample actually examined.

(2) *The definition and detection of depression within the population being studied.* This calls *inter alia* for the operationalization of the criteria of individual symptoms and the standardization of the interviewing techniques.

(3) *The problem of selection of instruments for detecting cases.* The most widely used techniques are questionnaires, semistructured interviews and unstructured psychiatric interviews. It is clearly necessary that measures used in the study of depression in the elderly are both valid and reliable in the specific population being examined.

(4) *The clinical presentation of depression in old age.* This will be discussed below.

Though most epidemiologists and clinicians agree on the core symptoms of psychiatric disorders throughout the life cycle, the absolute distinction between a case and a non-case is not easily established. Furthermore, many of the symptoms and signs of late-life depression may be ubiquitous with the ageing process, thus blurring the distinction between cases (where medical attention is required) and non-cases (Blazer, 1991). Most clinicians would see the process of diagnosis as a reflection of underlying reality or simply as "diagnosis is prognosis"; others again, would prefer the emphasis to be on function (Blazer, 1989a). Improved function should result from remission of the disease, but this is not necessarily so in that social or interpersonal impairment may persist. Thus, while the categorical approach to a diagnosis consisting of a standard clinical measure such as Axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987) is favoured, the family may perceive function as the critical element. This is because they do not view symptom remission alone, but rather a return

* *Address correspondence to*
Dr F.C.V. Potocnik, Psychogeriatric Unit, Valkenberg Hospital, Private Bag X1, Observatory, 7925, Republic of South Africa.

to social involvement and improved life satisfaction as an essential marker of improvement (Blazer, 1989b).

Further, many of the standardized interviews or questionnaires were not designed specifically for use among the elderly. The above-mentioned methodological problems have only recently been addressed and hence results of different studies in the past vary widely (Katona, 1990).

The more reliable methods indicate the prevalence of depression in the elderly at about 18 % in women and 12 % in men, while other studies will vary with an overall prevalence rate of 34,5 % on the one hand, and as low as 2,7 % on the other hand, in similar populations (Katona, 1990). A South African study of 139 non-institutionalized coloured persons, aged 65 years and over, using the Present State Examination (CATEGO) programme, found the prevalence of depression to be 16,5 % (Ben-Arie, Swartz, Teggin & Elk, 1983).

The distribution of depression

This category encompasses characteristics such as age, sex, race, occupation and social class. Depression has been shown to be as prevalent among the elderly as the middle-aged (Katona, 1990). A large study in New Zealand showed a prevalence of depression in elderly women of 14,2 %, against 7,7 % over the whole population (Walton, Romans-Clarkson, Mullen *et al.*, 1990). The sex difference in prevalence between men and women is maintained throughout life, women having rates approximately 50 % above those for men. However the peak prevalence for women falls in the middle years, whereas studies suggest that rates for men rise throughout the life span (Murphy, 1989). When considering major depression across the life span, the ratio of 2:1 for females to males persists into late life. However there is no evidence for a genetic predisposition, i.e. a sex-linked mode of inheritance, that would favour females in the onset of major depression (Blazer, 1989b).

Depression is associated with bereavement, being widowed and single, or isolated (Katona, 1990; Wilson, 1991). In most studies depressed mood is more common in Alzheimer's disease subjects than in healthy elderly controls (Katona, 1990). Regarding institutions, it is increasingly recognized that mentally alert residents and those with mild dementias have a markedly higher rate of depression than those living at home in the community. While it is possible that the drab quality of life provided in some residential homes is one reason for the high prevalence, it is also possible that chronically depressed elderly people are preferentially selected into residential care as a result of their dependence on others and inability to cope on their own (Murphy, 1989). This is borne out in a South African study that analysed the psychiatric reasons for admission of elderly persons to places of care. Compared with psychiatric hospital admissions, people admitted to homes for the aged were significantly older and had more physical illness and socio-economic problems than old persons living in the community (Gillis, Elk, Trichard *et al.*, 1982).

Both health and social support play an additive and an interactive role in the onset of depressive symptoms. In one study, 39 % of the depressed subjects but only 26 % of the control subjects had significant physical health problems (Murphy, 1982). A weak support network in the presence of poor physical health placed older persons at a particular risk for the onset of depressive symptoms. However it must be recognized that depressive symptoms do not necessarily indicate the onset of a major depressive episode (Pfifer & Murrell, 1986; Wiison & Copeland, 1990). Specific physical problems associated with depression have been described as breathlessness, arthritis, visual impairment and limb paralysis (Lindesay, 1990). While the relationship between stressful life events and the onset of major depression across the life cycle has been established in a number of cross-sectional studies (Lloyd, 1980), the relationship weakens when persons are studied longitudinally (Pfifer & Murrell, 1986). In a recent South African survey of health aspects of 365 black elderly persons, using the Depression Homogenous Scale of the Short CARE questionnaire, it was found that 21 % of the respondents in Langa (an established township) and 66 % of the respondents in Khayelitsha (a newly-settled township) had depressive symptoms severe enough to warrant further investigation (Barnes & Yach, 1991; Gillis, Welman, Koch & Joyi, 1991). (Although the depressive symptoms in 66 % of this sample were not necessarily severe enough to be classified as frank disorder, 44 % of the sample would have been treated if they had been seen by a psychiatrist.) Reasons for this discrepancy given by the authors included the effects of urbanization on the squatting community of Khayelitsha, which was more recently established. The effects were compounded by poor quality housing, overcrowding, a high degree of poverty, greater civil unrest and fewer environmental and welfare services, such as water, electricity and sanitation.

Historical studies

It is important to consider the longitudinal history of disorders. Some disorders, such as tuberculosis, are known to wax and wane in incidence over a period of time. New disorders may emerge in a population, such as acquired immune deficiency syndrome (AIDS). Old ones, such as smallpox, are eradicated or disappear naturally (Morris, 1975). Studies of changes in the rates of suicide among older adults during the 20th century illustrate the value of longitudinal studies, despite the methodological problems associated with such studies (Blazer, 1989a).

Suicide rates at any point in time are determined by at least three factors: (i) Age; (ii) generational or cohort effects, and (iii) unique stressors for a particular age group at a particular point in time (i.e. period effects) (Blazer, 1989a). It is well known that suicide rates increase with advancing years, especially in males. Thus, in the early 1980s the elderly accounted for a third of all suicides in the United Kingdom, even though they constituted only 12 % of the total population (Pitt, 1982).

By studying an age group or cohort at set intervals from young adult life to old age, suicide rates and patterns can be mapped on a longitudinal basis for that group. These figures can then be compared with the next age group. Thus an American group of 15 to 24-year-olds in 1908 had a suicide rate of 13,5 per 100 000, in contrast to the 6,3 per 100 000 rate of the next group of the same age in 1923. The 1908 cohort has continued to have relatively higher rates of suicide at every age through life, though both cohorts showed increases in suicide with age. In other words, the 1923 cohort passing through the 80 to 95 years of age window at this time has always had a lower rate of suicide than the preceding 1908 cohort when it passed through the same window. The 1923 cohort when examined cross-sectionally would have a flattened suicide rate. Current cohorts of elderly people appear remarkably protected against severe or clinically diagnosed depressive disorders. This cohort effect may well explain the current relatively low prevalence of depression in late life, as compared with the now much older age group 20 years ago. A much younger cohort, the 1946 or baby-boom cohort, has exhibited higher rates of major depression throughout the life cycle and increased rates of suicide, which has implications for future studies of this nature (Blazer, 1989a,b).

Period effects have been shown to play a role, as postulated by Murphy (1986) citing the occurrence of World War II and

the detoxification of domestic gas in England, for a fall in a cohort analysis of recorded suicides from 1921 to 1980. Placing one's head in a gas oven containing large amounts of carbon monoxide was a common method of suicide, particularly among the middle-aged and the elderly. As domestic gas was converted to a methane-based product in the 1960s, the rate of gas poisoning decreased dramatically in the older age groups. There was a net saving of life, notwithstanding an increase in suicides by other means.

Aetiological studies

Both environmental and genetic causative agents can be identified in population studies; the aetiology of late life depression is undoubtedly multifactorial (Blazer, 1989a,b). The changing roles and circumstances of older adults are considered by many investigators to stress the elderly and, therefore, contribute to the onset of psychiatric disorders and cognitive difficulties. Thus, as discussed above, social factors including widowhood, divorce, separation and poverty were related to depressive symptomatology in the community (Blazer, 1989a; Katona, 1990; Kennedy, Kelman & Thomas *et al.*, 1989).

Nevertheless, the mitigating effect of social support, the expectancy of the event, the occurrence and perception of the event, and the perceived importance of the event may all contribute to the impact of the environmental stress upon the older adult (Murphy, 1989).

Twin and family studies, along with recent studies of molecular genetics, provide strong evidence for a heritable contribution to the aetiology of major depression and bipolar disorder. However the evidence suggests that the genetic contribution to unipolar depression in late life is weaker than at earlier stages of the life cycle. Thus the risk for immediate relatives of patients with onset of depression that occurred later than age 50 is 8,3 %, compared with 20,1 % for relatives of patients where the onset was before the age of 50 (Blazer, 1989b).

Other contributing factors to late life depression may be selective changes in the activity and metabolism of neurotransmitters. Dysregulation of the hypothalamic-pituitary-adrenal axis is also thought to contribute to a predisposition for depression, as is dysregulation of the thyroid axis and the release of growth hormone. A relatively new putative contributor to the aetiology of depressive disorder is desynchronisation of circadian rhythms (Blazer, 1989b).

Health service utilization

Though the elderly are less likely to use community-based psychiatric services than any other age group, they are more likely to use psychotropic medication. Most investigators conclude that the likeliest source of care for older individuals suffering from emotional problems is their primary care giver within the context of a visit made for physical medical problems (Blazer, 1989a).

Of value are community surveys that collect data on rates of impairment, need for services, perceived needs or demands for services, and the current use of services. This allows authorities to evaluate effective treatment and preventative programmes. This is especially relevant to the care of the elderly, who tend to be isolated, with masked psychiatric impairment and diminished abilities at voicing their mental health needs (Blazer, 1989a; Ben-Arie, Swartz, Teggin & Elk, 1983; Gillis, Elk, Trichard *et al.*, 1982).

The presentation of depression in the elderly

Criteria

Depressed mood as presenting symptom has been rated as low as 5 % in some studies (Katona, 1990), as it is often overshadowed by somatic complaints, delusional beliefs, odd behavioural disturbances or a picture resembling dementia. Frequently the picture will be that of excess worry or disease (Gillis & Zabow, 1982).

Four clinical syndromes are listed under the affective disorders in DSM-III-R, which are relevant to the clinical manifestations of depression in the elderly. They are (i) bipolar disorder (manic, depressed and mixed); (ii) major depression (single episode, recurrent, with or without melancholia, with or without psychotic features); (iii) dysthymia (depressive neurosis), and (iv) atypical depression (American Psychiatric Association, 1987; Blazer, 1989b). The syndromes are shown graphically in Table 12 in the DSM-III Training Guide (Webb, DiClemente, Johnstone *et al.*, 1981: 87).

The criteria for a major depressive episode in the DSM-III-R are essentially the following (American Psychiatric Association, 1987): At least four of the following symptoms, including either depressed mood, or loss of interest or pleasure, have been present over a two-week period, denoting a change from previous functioning: depressed mood; loss of interest or pleasure in usual activities; poor appetite with significant weight loss or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; inappropriate feelings of guilt or worthlessness; difficulties with thinking or concentration and indecisiveness; and ideas of suicide.

Other DSM-III-R disorders manifesting depression include bereavement, adjustment disorder with depressed mood, and the organic mood syndrome. In the latter a specific organic factor, such as a substance (methyldopa), endocrine disease (hypothyroidism), cancer (head of pancreas), viral illness (hepatitis), or structural brain disease (stroke), is considered to be the aetiological agent resulting in depression. Still further psychiatric disorders containing depressive symptomatology as a central component on occasions, are the paranoid disorders, sleep disorders and hypochondriasis (American Psychiatric Association, 1987; Blazer, 1989b).

While community surveys confirm that DSM-III-R major depression is identified among the elderly, when usual case-finding methods are applied across the life cycle (Blazer, 1989), it is the variants of classical major depression among the elderly that cause a problem.

Hence we find community surveys among the elderly reporting a prevalence of only 4,3 % for severe depression and 13,5 % for mild or moderate depression (Katona, 1990; Copeland, Gurland & Dewey, 1987).

Variants of major depressive illness

Two variants of classical major depression that occur among the elderly need to be mentioned. One is seasonal affective disorder, (i) in which the history of depression fulfills the DSM-III-R criteria for major depression; (ii) where there is a history of at least two consecutive years of autumn/winter depressive episodes which remit in spring/summer; and (iii) where either a major psychiatric disorder or a psychosocial explanation to explain the seasonal mood changes is absent (American Psychiatric Association, 1987; Blazer, 1989b). The importance of the disorder lies in that it does not respond to the usual therapy and that the use of tricyclic antidepressants may perpetuate the disorder, or possibly increase the likelihood of rapid cycling. In contrast, lithium carbonate or carbamazepine may be of some benefit in preventing the

cyclic episodes and light therapy may be of value (Blazer, 1989b).

The other disorder is brief recurrent depression, in which the individual suffers full-blown episodes of major depression, but lasting shorter than the stipulated two-week period required by the DSM-III-R, and with cycles occurring on a monthly basis over a period of one year while not coinciding with the onset of menstruation in women (Angst, Merikangas, Scheidegger & Wicki, 1990; Blazer, 1989a).

The significance of this work is that some depressive syndromes which do not meet the criteria for classical major depression may be just as disabling over time as the level of impairment with major depression.

Dysthymia

Dysthymia, literally "ill-humoured", refers to individuals with the disposition to dysphoria (Akiskal, 1990). Dysphoria is defined by the Concise Oxford Dictionary as "a state of unease or discomfort". The classical picture is that of an individual who is habitually gloomy, brooding, overconscientious, incapable of fun and pre-occupied with personal inadequacy (Gillis & Zabow, 1982; Akiskal, 1990).

The recognition of dysthymic disorder as a significant health problem is relatively new to psychiatry. The lifetime prevalence for dysthymia appears to be in the order of 3,1 %; it co-exists with other psychiatric (and often physical) disorders in 70 – 75 % of cases (Keller & Sessa, 1990).

The key characteristics of dysthymia (neurotic depression) as defined by the DSM-III-R (American Psychiatric Association, 1987; Akiskal, 1990) are:

- Depressed mood for at least two years, which is not residual of a major depression.
- Presence, while depressed, of at least two of the following: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self esteem; poor concentration or indecisiveness; and feelings of hopelessness.
- Persistent or intermittent course with symptom-free periods not exceeding two months.

Further, it is necessary to specify whether the symptoms of dysthymia are *primary* or *secondary* to another mood or physical disorder, and whether these symptoms are of an *early onset* with origins in childhood or adolescence (depressive personality or characterological depression) or of a *late onset* at age 21 or later.

Dysthymia is frequently complicated by major depression in 70 – 90 % of cases (Keller & Sessa, 1990), when it is referred to as double depression. Following the major depressive episode these dysthymics will usually revert to their premorbid status.

Dysthymia may thus both precede and follow a major depressive episode. However DSM-III-R, because of the absence of a six-month symptom-free period following the major depressive episode, would refer to the latter situation as "major depression in partial remission" (American Psychiatric Association, 1987). Notwithstanding, the course of primary depressive illness with late onset (after 40 years of age) can be quite protracted, despite a premorbid history free of depressive manifestations (Akiskal, 1990). (In fact, a first-time major depression in old age is often followed by a dementing illness (Katona, 1990).) During this residual phase, which may linger for months if not years, "characterological" manifestations (a sense of resignation, inhibited communication, rigidity, irritability, or emotional lability) may dominate the clinical picture. The lives of these people are marred by overdedication to work and an inability to enjoy leisure activities; marital conflict may ensue and vegetative somatic manifestations may occur. There may be concurrent disabling medical illness and a history of excessive alcohol and sedative abuse (Akiskal, 1990).

Good reasons have been put forward for subtyping patients suffering from dysthymia into two groups (Akiskal, 1990; Rihmer, 1990):

- Predominantly affective (subaffective dysthymic)
- Character pathology (character spectrum disorder)

The subaffective dysthymia group accounts for some 10 – 15 % of the "chronic depressive" population and carries a two-third's share between the two subgroups. Essentially this group has a loaded pedigree with a family history of affective illness, with normal childhood but a predominantly depressed personality (introverted, gloomy, pessimistic, self-critical, sceptical, etc.). There may be brief "well" or "active" periods. There is shortened rapid eye movement latency. And there is a favourable response to tricyclic antidepressants, lithium or both (Akiskal, 1990; Rihmer, 1990).

In contrast, the character spectrum disorder group is the equivalent of a personality disorder with a family history of alcohol and drug abuse, or suicide not related to primary affective illness, sociopathy, broken home, onset in early adolescence, intermittent course (with rarely superimposed major depressive episodes), and a poor response to the above treatment modalities (Akiskal, 1990; Rihmer, 1990).

Masked depression

A common cause for diagnostic confusion in the elderly is masked depression. Here physical or emotional (other than depression) symptoms, be they primary or secondary (due to drugs), mask the underlying depression. The broad concept of masked depression is best expressed in tabulated form (Rihmer, 1990). See Table 1.

Table 1
The broad concept of masked depression

Subtype	Level of masking	Source of masking	Clinical consequences
Masked I	Biological	Underlying illness, or interaction of personality	Somatic masking: masked depression Psychogenic pain syndrome Atypical depression Psychic masking: atypical depression A-type personality disorder
Masked II	Social	Patient (self-medication)	Substance abuse
Masked III	Educational	Doctor (misdiagnosis)	Inadequate treatment: anxiolytics, sedatives, etc.

Source: Rihmer, 1990.

Minor depression

Definitions of disorders fitting into the category of minor depression vary. For some the category is loosely defined as those cases not suffering from major depression. Others see the category as analogous to the DSM-III-R category of depressive disorder not otherwise specified: in other words, disorders that do not meet the criteria for major depressive disorder, dysthymia or any other DSM-III-R disorders with

depressed mood. The following studies demonstrate the various forms of minor depression:

- Studies using symptom clusters and grade-of-membership analysis have been conducted on individuals to determine which meet the criteria for a statistically defined "pure type" of depressive syndrome (Blazer, 1991).
- The clinical entity of "minor depression" as defined by Research Diagnostic Criteria was found to be frequent within a primary care setting among both older persons and young adults. The association with physical illness was emphasized. The most common symptoms of minor depression were found to be worry (84 %), blaming oneself (79 %), decreased energy (79 %), everything an effort (68 %), irritability (63 %), disturbed sleep (53 %), crying (53 %), and feelings of hopelessness (53 %) (Oxman, Barrett & Barrett, 1990).
- Another study identified a symptom cluster that emerged almost exclusively in the 60+ age group. The syndrome was associated with physical illness and cognitive difficulties. Although this syndrome was characterized by many depressive symptoms, such as depressed mood for two or more weeks, psychomotor retardation, difficulty concentrating, constipation, and poor perceived health, none of the classic diagnoses of depression were associated with this symptom cluster. Specifically this syndrome did not meet the DSM-III-R criteria for adjustment disorder with depressed mood, namely that the symptoms are clearly associated with a stressful event in one's life and subside within six months. It also did not apply to most persons suffering from less severe symptoms, in that the symptoms were more chronic and did not fit the picture of dysthymia. At present the syndrome would have been classified under the DSM-III-R diagnosis of depressive disorder not otherwise specified, or atypical depression. However the authors felt that "minor depression" would be one way of classifying such subjects (Blazer, 1990; Blazer, Woodbury & Hughes *et al.*, 1989).
- In South Africa, Gillis has presented evidence for distinguishing a clinical entity characterized by dysphoria associated with physical impairment, isolation and socio-economic handicap. Personality factors are believed to play a considerable part in the aetiology of the condition which tends to be refractory to treatment (Gillis & Zabow, 1982).

In an attempt to distinguish between the characteristics of dysphoric individuals, those suffering from depression and normal subjects living in the same circumstances, the following criteria (Gillis & Zabow, 1982) using the scoring systems of the Hamilton Depression Rating Scale and the Life Satisfaction Scale (Neugarten, Havighurst & Tobin, 1961) as reference points were proposed:

- **Dysphoria** – a score of less than 15 points on both the Life Satisfaction Scale and the Hamilton Depression Rating Scale.
- **Depression** – a score of less than 15 points on the Life Satisfaction Scale and a score of more than 15 points on the Hamilton Depression Rating Scale.
- **Control** – a score of more than 15 points on the Life Satisfaction Scale and score of less than 15 points on the Hamilton Depression Rating Scale.

In simplified terms, the dysphoric is unhappy with life but not to the extent where clinical depression is evident. The syndrome of dysphoria as described by Gillis above shares features in common with both dysthymia and minor depression.

Notwithstanding the fact that depression in the elderly adopts numerous guises and requires further understanding, researchers with different instruments and differing views on depression have perpetuated an element of confusion regarding the nomenclature and criteria for the various types of depression. To clarify the situation, within the restrictions of current knowledge, researchers should reach greater consensus in this regard.

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Depression in newly-urbanized elderly Africans

L.S. Gillis*
University of Cape Town

Abstract

Two recent South African prevalence studies of depressive symptoms have revealed a high occurence of such symptoms among the black elderly population, particularly in the case of women. In a study of depression conducted in the Cape Peninsula townships of Langa and Khayelitsha (N = 195 and 170, respectively), an alarming vulnerability to depressive symptoms was found among black elderly women, with 27 % of the women sampled in Langa and 44 % of those in Khayelitsha identifying with these symptoms. The Multidimensional Survey (N = 4 400) demonstrated a greater prevalence of depression among elderly blacks than among other elderly population groups. Possible reasons for these findings are discussed.

Depression is the most common psychiatric disorder among elderly people. However not all depression amounts to serious mental illness. Nevertheless because depression affects the outlook and activities of afflicted persons, it causes them much suffering and can be most incapacitating. Reliable community surveys in the United Kingdom and the USA reveal a prevalence of depression in the elderly of between 12 and 18 % (Livingston, Hawkins, Graham *et al.*, 1990; Copeland, Dewey, Wood *et al.*, 1987; Roberts & Vernon, 1983; Weissman & Locke, 1975). Accurate estimates of depression among elderly black South Africans have not been available up to now.

The first large-scale epidemiological surveys of black elderly persons in South Africa have recently been completed. The prevalence of depression among two survey samples is reported in this article. Some effects of the stresses relating to urbanization on the prevalence rate of depression among these populations are also examined.

The first investigation was conducted in the black townships of Langa and Khayelitsha in the Western Cape in 1989 by the Medical Research Council's (MRC) Clinical Psychiatry Research Unit. The Multidimensional Survey (Ferreira, Møller, Prinsloo & Gillis, 1992) was conducted in 1990-91 by the Centre for Research on Ageing of the Human Sciences Research Council (HSRC).

The former study was specifically mounted to explore the differential effects of urbanization in a largely settled and relatively stable community (Langa), and in one to which the majority of the residents had migrated from the country or elsewhere within the last five years (Khayelitsha). The countrywide study included all population groups (N = 4 400). However only the findings pertaining to the urban black subsample (N = 1 000) are reported here.

Methods

Both surveys sampled persons who were 60 years and older. Different instruments were used for the two surveys: The Short CARE scale (Gurland & Wilder, 1984), which elicits defined psychiatric symptoms, was used for the Langa/Khayelitsha study. The CES-D scale (Radloff, 1991) was used for the countrywide survey. The latter scale is mainly concerned with subjective responses. Both instruments are well validated and widely used.

In the Multidimensional Survey the CES-D scale was administered by interviewers from the regular HSRC MarkData panel who were all experienced in this type of investigation. Psychiatric nurses administered the questionnaire in the Langa/Khayelitsha survey. In both surveys the interviewers were rigorously trained and supervised. A great deal of care was taken with the translation of the items in the instruments and the interpretation of the responses.

The Short CARE instrument is concerned with symptoms occurring during the previous month, whereas the CES-D scale is concerned with symptoms occurring in the week prior to the interview. The latter scale consists of 20 items, with 16 negative responses recommended as a cut-off point for probable pathology. Two items were regarded as unsuitable for the South African population because of cultural differences (items 4 and 7); accordingly a threshold of 14 was used. Although the scale grades responses in degrees of severity, only "all" or "most of the time" answers were used in the analysis (Radloff, 1991).

The sampling procedure for the Langa/Khayelitsha study was devised by the MRC's Institute for Biostatistics. Samples of 195 and 170 respondents in the two townships, respectively, were decided upon as adequate to show up differences in the areas under investigation. Clusters of plots were demarcated on town plans and a simple random sample was drawn without replacement. All elderly persons in each selected cluster area were interviewed. Details of the sampling are given in the MRC Urbanisation and Health National Programme Technical Report (Barnes & Yach, 1991).

The sampling strategy for the Multidimensional Survey was designed and carried out by the Centre for Statistical Research of the HSRC, using the adjusted 1985 census figures. A multistage stratified cluster sampling method was used to draw a sample of 4 000 equally represented black, coloured, Indian and white persons who lived in urban areas countrywide. In addition an exemplary sample of 400 blacks who lived in deep-rural areas of two homelands (Kangwane and Lebowa) was drawn. The findings pertaining to the urban black subsample (N = 1 000) are focused on in this article.

* *Address correspondence to*
Prof. L.S. Gillis, Department of Psychiatry, University of Cape Town, Medical School, Observatory, 7925, Republic of South Africa.

Findings

The Short CARE assesses depression on two scales. The first scale pertains to the subjects' emotional and motivational states, vegetative symptoms and functional impairment. However it does not give a certain diagnosis of depression as some of the items are also found in other psychiatric disorders. What it does indicate is whether the person is significantly distressed and dysphoric, and therefore warrants further psychiatric investigation. On this scale a large difference was found between the Langa respondents, 21 % of whom showed depressive symptoms, and the Khayelitsha subjects, where 66 % had such symptoms. The other Short CARE scale gives a more precise indication of depression; because it has a high correlation with similar survey instruments (Weissman & Locke, 1975), it can be regarded as giving reliable results. The use of this scale confirmed that the prevalence of depression among elderly persons living in the community during the previous month was particularly high in Khayelitsha. The results are shown in Table 1.

Table 1

Prevalence of depression in elderly persons in two townships (Langa, Khayelitsha): percentages of the sampled populations

	Langa %	Khayelitsha %
Men	13	27
Women	17	44
N	195	170

The results of the Langa study are similar to those of other surveys which have used the Short CARE scale (Livingston, Hawkins, Graham *et al.*, 1990; Copeland, Dewey, Wood *et al.*, 1987; Gurland & Wilder, 1984). Prevalence rates for other elderly populations obtained by the use of other ascertainment instruments, both in South Africa and abroad, are similar (Elk, Swartz & Gillis, 1983; Blazer & Williams, 1980). However the findings of the Khayelitsha sample reveal a far higher prevalence of depression, particularly among females, than all the other studies. See Table 2.

Table 2

Comparison of prevalence of depression in five study samples: percentages

	Langa %	Khayelitsha %	Liverpool[a] %	London[b] %	New York[c] %
	14,9	36,9	11,3	17,4	12,9
N	195	170	1 070	813	283

a Copeland *et al.* (1987)
b Livingston *et al.* (1990)
c Gurland & Wilder (1984)

In spite of the high prevalence of depressive symptoms in this investigation, only two women in Khayelitsha and one woman in Langa reported that they had received psychiatric treatment. The rest suffered, if not in silence, at least without succour.

The countrywide survey using the CES-D scale provided an opportunity for valuable comparisons as it was also administered to other elderly South African population groups. The important finding here was that there is a markedly higher prevalence of *severe* depression among both urban and rural blacks, than among so-called coloureds, Indians and whites (compare the percentages below). A cut-off point of 14 was used to illustrate this difference. The same trend emerged for all degrees of dysphoria and depression.

Urban blacks	5,5 %
Rural blacks	4,9 %
Coloureds	1,9 %
Indians	2,6 %
Whites	0,2 %

These differences are supported by the findings on the average number of strongly negative responses to items on the scale, expressed as percentages of possible total responses and are shown below:

Urban blacks	22,0 %
Rural blacks	18,9 %
Coloureds	9,6 %
Indians	8,2 %
Whites	5,2 %

A noteworthy finding was the greater prevalence of subjective symptomatology in elderly women of all population groups, which accords with worldwide experience (Krause, 1986; Murrell, Himmelfarb & Wright, 1983). The difference in the proportion of such responses between men and women in the two black subsamples (urban and rural) in the countrywide survey was however exceptional. A method of highlighting these differences was devised by allocating one point to "rarely" or "hardly ever" responses and three points to "all" or "most of the time" responses. Since the CES-D consists of 18 items the minimum score for each population group is 18 points and the maximum score 54 points. See Figure 1.

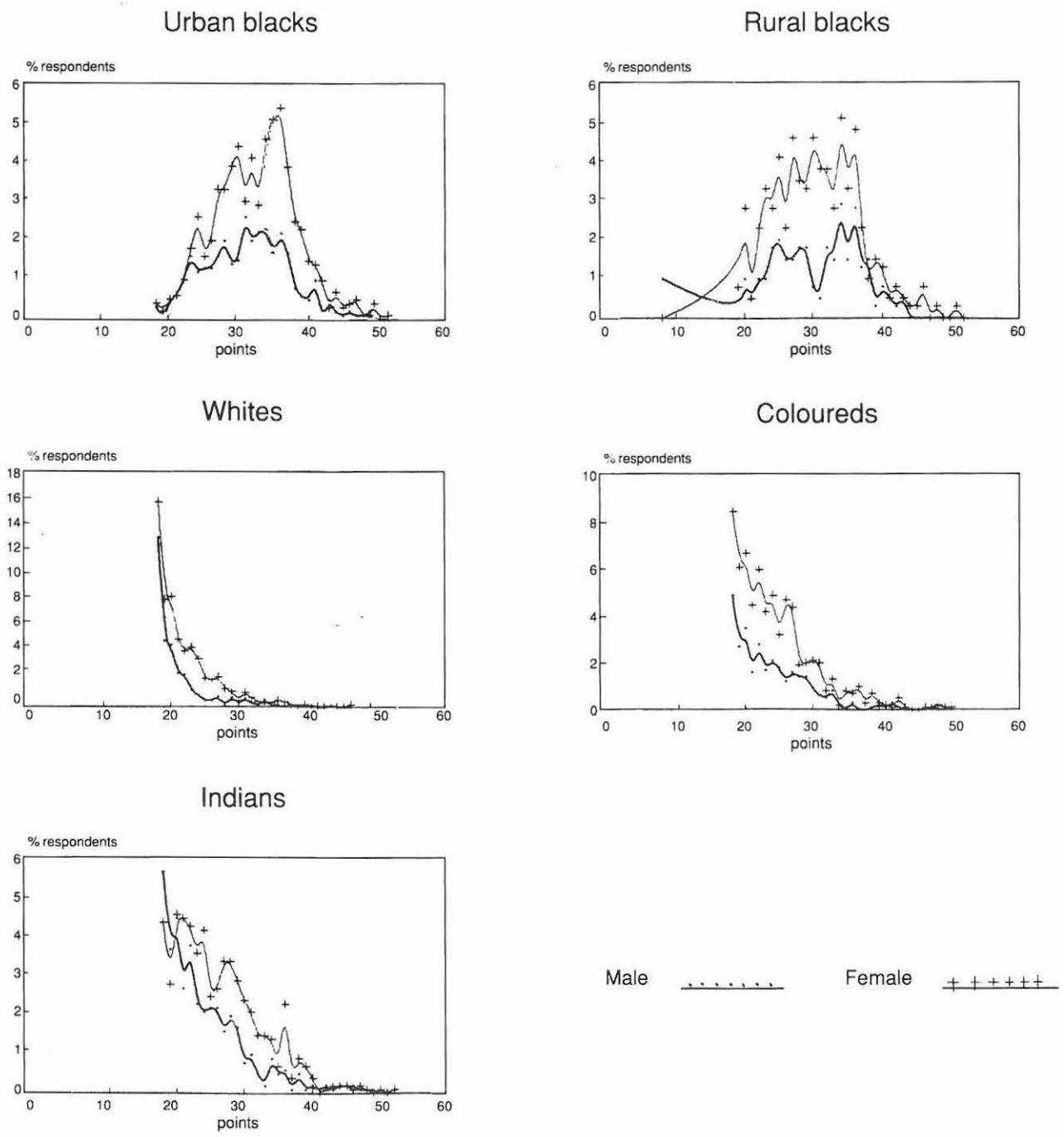
An analysis was also made of a number of social and other factors in the Langa/Khayelitsha study relating to daily life in the townships and the results are reported elsewhere (Barnes & Yach, 1991). To determine the influence of these variables on the rates of depression, the variables that showed a significant relationship to symptomatology were further analysed by multivariate contingency tables analysis. The results confirmed that length of stay in Cape Town, gender, adequacy of housing and perceived state of health were significantly related to depressive symptoms. Further analysis by logistic regression resulted in a log-linear model of first and second order effects which supported these findings.

No physical examinations of the respondents nor medical investigations were made. An accurate estimate of physical ill-health, or the health status of the respondents, could not therefore be determined. However the dependency between psychological distress, particularly anxiety and depression, and complaints of subjective bodily dysfunction is well known. It can be inferred that at least some of the complaints of ill-health were due to this association.

Discussion

It is not possible to compare the findings of the Langa/Khayelitsha survey with those of the countrywide investigation as different scales were used in the two surveys to measure depressive symptomatology. The corresponding value on the Short CARE scale, which would indicate a comparable degree of depression as measured by the cut-off

Figure 1
Gender differences in the rate of depressive symptomatology in the five subsamples of the countrywide survey



point of 14 on the CES-D scale, is not known. In addition, the duration of the ascertainment time periods differed, with the CES-D scale referring to the previous week and the Short CARE scale measuring symptoms over the previous month. However the CES-D scale has been satisfactorily tested against other measures (Weissman & Locke, 1975) and has been shown to identify 71 % of subjects with major depression (Roberts & Vernon, 1983). The Short CARE instrument also correlates highly with other reliable measures (Livingston, Hawkins, Graham *et al.*, 1990).

Taken together, both instruments make it clear that mild psychiatric and depressive symptoms are very common in black elderly persons in South Africa, particularly women. The question arises as to what extent such symptoms are simply manifestations of psychological distress and do not indicate frank disorder. According to DSM-III-R (American Psychiatric Association, 1987) dysphoria in itself is not diagnostic of a depressive disorder, although it is mandatory for such diagnoses in association with other well defined symptoms. The matter has been argued in the literature (Bebbington, Tennant & Hurry, 1991; Brown, Craig & Harris, 1985). The general feeling is that, given a sufficiently stringent threshold of severity, depression as identified in community surveys can be regarded as a distinct clinical entity.

In the investigations there were many cases at the lower end of the spectrum where the term distress would be more appropriate; but there was also a hard core of really depressed people in both surveys. The proportion of those depressed people in the Langa investigation (14,9 %) is of the same magnitude as that found in overseas studies, for example

Murrell, Himmelfarb and Wright (1983) (13,7 % for males and 18,2 % for females), Blazer and Williams (1980) (14,7 %) and Frerich, Anesheusel and Clark (1983) (16,7 %). The figure for Khayelitsha, as shown in Table 2, is much higher (36,9 %) than that found in other studies. In respect of the countrywide survey no meaningful comparisons can be made with CES-D investigations elsewhere because of the different cut-off points and the sampling variabilities. It is clear however that the prevalence of depressive symptomatology among elderly black persons is considerably greater than that of the elderly of other South African population groups using the same ascertainment instrument and cut-off point. Possible reasons for such differences should be sought through an investigation of varying sociocultural factors.

Several explanations have been put forward for the higher prevalence of subjective symptoms and mild depressive disorders among women. It is generally accepted that psychosocial rather than psychobiological factors account for most of the difference between the sexes (Bebbington, Tennant & Hurry, 1991), but the exact causal circumstances are not clear. Brown and Harris (1978) consider that women experience more stressful life events than men; Pearlin and Johnson (1977) feel that women are exposed to more long-term stresses. Others feel that women are more willing to admit to symptoms, or that they report a significantly greater intensity of symptoms (Weissman & Klerman, 1977). This contention receives support from the finding that more serious forms of bipolar depressive illness which have a genetic rather than a stress basis have a more or less equal incidence in men and women. Krause (1986, 1988) found that mean differences in depressive symptoms between the sexes could largely be explained by the fact that, given equal exposure to stress, life events exert a more negative effect on elderly females, particularly the stress of ongoing financial difficulties. Men are certainly not exempt though, for it is a general finding that alcoholism and suicidal rates are much higher among older men than older women (Krause, 1988).

In the Langa/Khayelitsha investigation situational stress was undoubtedly a factor in the prevalence of depression, since the majority of the respondents lived in impoverished conditions and, often, with disorganized families. In Khayelitsha 98 % of the subjects lived in shacks, while the same proportion in Langa were living in substantial permanent dwellings. Housing was rated as barely liveable or completely inadequate in the case of 65 % of the former subjects but only in the case of 11,9 % of the latter subjects (Barnes & Yach, 1991). Financial stress was generally a problem as there is a high rate of unemployment among the township residents. A social old-age pension was the major resource of many families but while over 74 % of the elderly in Langa received a social pension, only 45 % of the elderly residents sampled in Khayelitsha did (Prinsloo, 1991).

Cultural factors certainly played a part. In the traditional South African context there is an ideology of male dominance and control (Ramphele & Boonzaier, 1988); although men are not free of the burden of providing, and those of pensionable age do receive a pension, they are not traditionally encumbered by the daily detail of household management. The domestic role of females continues among the elderly; where money and resources are limited, these scarcities are a constant worry for women.

Another stress affecting elderly women which was often mentioned by female respondents in the Langa/Khayelitsha study was that they were expected to look after grandchildren while the mother was at work; many found this to be a burden. In addition, in the transitional community of Khayelitsha older women have the added strain of acculturation, as most have come from a rural village background and have little formal education. Only 5 % of the female respondents in Khayelitsha had completed primary school, compared with 27 % of the women in Langa. Fewer elderly women in Khayelitsha than in Langa spoke English or Afrikaans, the main languages in Cape Town. Nearly half did not know where to find a doctor, a clinic, a social worker or a traditional healer, compared with 13 % of the elderly women in Langa (Prinsloo, 1991). There did not appear to be any diminution of the respect that normally goes with being old in a traditional society.

Social support as a mitigating factor in respect of depressive symptomatology was not investigated in the present studies. However in a review of the literature, Krause (1988) states that research indicates that elderly women generally appear to receive more social support than elderly men. Despite this greater support, women appear to be more vulnerable to depressive symptoms than men. Krause (1988) suggests that this vulnerability may be because external support tends to erode feelings of personal control.

It was not possible to define precisely which of the many social circumstances that were present were critically relevant in respect of the marked differences in depressive symptomatology between Khayelitsha and Langa women, since most of the latter, although somewhat better off materially than those living in Khayelitsha, also lived in severely straitened circumstances. Overall however, the women in Langa were more settled and familiar with community resources and services than their counterparts in Khayelitsha. The main difference between the two samples lay in respect of the recent translocation and the stresses of urbanization. This is supported by the finding of the countrywide survey that there was a significantly higher prevalence of depressive symptoms among urban elderly black persons than those living in rural areas ($p < 0,01$).

Conclusions

The impartial findings emerging from these surveys show that depressive symptomatology is more frequent in elderly black South Africans than in the other elderly population groups; the prevalence is greatest in elderly black women; and that there is a high prevalence among people living in the newly-settled community of Khayelitsha. The latter finding is significant: at the time of the investigation, Khayelitsha was a typical squatter settlement; the number of these settlements in South Africa is growing rapidly. The indications are that the stresses of urbanization are at least a contributory factor to the prevalence of depressive symptomatology among the elderly in these settlements. Further research is proceeding to determine the valency of specific life stresses and to identify appropriate intervention strategies that could be instituted to diminish the effects of the stressors.

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Contents

Generational interdependence: living arrangements and housing programmes
M.P. Lawton 1

Successful ageing in South Africa: opportunity structures and subjective wellbeing
Valerie Møller & Monica Ferreira 5

Social research for empowerment: the case of South African seniors
Valerie Møller 9

The epidemiology and presentation of depression in the elderly
F.V.C. Potocnik 14

Depression in newly-urbanized elderly South Africans
L.S. Gillis 20

Inhoud