12-1973

Depression in Elderly Men following Transurethral Prostatectom

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DEPRESSION IN ELDERLY MEN FOLLOWING TRANSURETHRAL PROSTATECTOMY

by

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A Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science in the Field of Nursing

December 1973

Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree Master of Science.

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FORMULATION AND DEFINITION OF THE PROBLEM

THE PROBLEM

The incidence of depression in our society has been increasing at a tremendous rate. According to one survey, over 50 percent of Americans reported feeling depressed at one time or another (Knopp, 1970, p. 1). Although depression occurred in people of all ages, it was most frequently found among the elderly (Dominick, 1968, p. 28). In the United States, three out of every ten patients in mental hospitals were 65 years or older; and, the numbers of aged in institutions have been increasing rapidly (Stotsky, 1968, p. 95). Health professionals have become aware of a relationship between depression and illness, with depression emerging both as a result and as a causative factor in physical illness (Enlow, 1970, p. vi). The problem of this study was to find out the frequency and level of depression in a select group of elderly men, and to identify possible factors which may have influenced the amount of depression experienced.

REVIEW OF LITERATURE

A number of investigators concurred that depressive disorders were the most frequent psychiatric illnesses that occurred among the elderly (Davies, 1965, p. 314; Levin, 1963, p. 303; Zung, 1967, p. 287). Busse (1966) showed that normal old people were subject to recurrent

depressive periods (p. 275). These depressive episodes increased in frequency, duration, and intensity in the advanced years of life. In a study of 332 patients over the age of 70 years, Busse (1955) found that they had depressive periods occurring as often as once a month and varying in length from a portion of an hour to a few days (p. 897). He discovered these findings through social and medical histories and a battery of psychological tests. In the United States in 1962, of 2,680 patients hospitalized with the diagnosis of psychotic depressive reaction, almost 30 percent were 65 years or older (Dominick, 1968, p. 28). These findings were not limited by geography but had comparable results in other countries as well. Gabrynowicz (1968) reported that in a survey of elderly people in England by Kay in 1964, the total prevalence of all forms of functional disorders was 31 percent, with a predominance of depressions and anxiety states. He also reported a study by Anderson in 1965 in Scotland, in which depression was found in 15 percent of healthy aged people, and in 35 percent of those with disease (p. 299).

In a large proportion of elderly patients, physical and mental illnesses were interrelated. Physical complaints often masked mental disease, and, mental illness frequently caused physical symptoms to be overlooked or ignored (Stotsky, 1968, p. 98). In a study by Gabrynowicz (1968) of 103 depressed elderly patients, 52 percent were found to have at least one physical disability and 22 percent had more than one organic illness (p. 300). Depression in the elderly population was frequently precipitated by an organic disease; and, the resultant psychic and somatic symptoms of the depression complicated recovery. The

depression caused a delay in convalescence or lack of return to prior level of function in spite of remission of organic symptoms (Rosenthal, 1968, p. 113). In Busse's study (1955), approximately 85 percent of the 332 elderly subjects could trace the onset of their depression to specific precipitating stimuli. The major precipitating events were experiences associated with physical suffering, lowered financial, professional, or social status (p. 896). In a study by Paykel (1969), a sample of 185 depressed patients was matched on sociodemographic variables with an equal number of subjects from an epidemiological community survey. The frequency of occurrence of life events in the six months immediately prior to the onset of depression was compared to a comparable six month period in the control population. Results showed an excess of life events prior to the onset of depression. Analysis of the different categories of events showed that events regarded as undesirable and those involving losses particularly distinguished the depressed patients from the control subjects. The individual events most likely to precede depression were marital difficulties, illnesses, and work changes (p. 753). Similar results were reported by Schwab (1970) and Gabrynowicz (1968).

Studies conducted in general hospitals revealed that many hospitalized patients were depressed. Schwab (1967) studied 153 medical inpatients, ranging in age from 15 to 90. He utilized four indices to rate depression, including medical staff clinical diagnosis, Beck Depression Inventory, Hamilton Rating Scale, and psychiatrists' reviews. Depression was found in 20 percent of the patients and occurred in all age groups and equally between men and women. The depressed patients

had all types of medical illnesses and all degrees of severity. Their depression was most related to object loss (p. 695). In Boston in 1966, depression was encountered in 52 percent of 192 patients in routine psychiatric consults in a general hospital. One hundred of these depressed patients' records were studied in detail. Half were found to be experiencing depression precipitated by recent events or problems of aging, while the other half had histories of life-long depressive tendencies. Almost half the patients with depression had medical or surgical conditions which contributed to their hospitalization, and seventeen of the group studied were suicidal (Poe et al., 1966, p. 101).

Illness has been recognized as a significant factor in precipitating depression, especially in older patients. When illness occurred in the elderly it represented a major crisis to him regardless of the seriousness of the disease. Lippincott (1968) stated that elderly people reacted more strongly to even minor fluctuations in their health than younger people did (p. 151). Failure to recover completely or with residual disability had a pronounced effect on their emotional adjustment (Linden, 1964, p. 49). In a study by Titchener et al. (1957), 200 surgical patients were studied during their hospitalization, convalescence and recovery. Their study included 45 elderly patients with a mean age of 73 years. The patients were interviewed daily by psychiatrists from the time of admission to discharge, and at three and six month intervals following discharge. They found a progression of mental deterioration associated with some form of organic cerebral damage observed during the hospital stay in eleven of

the elderly patients, with a disabling degree in 22 of the 45 patients. In the three and six month follow-up studies, it was found that patients whose surgical condition remained stationary or worse manifested a worse psychiatric adjustment (p. 63). Gilberstadt (1968) studied the effects of gall bladder and stomach surgery on 63 elderly patients. They were examined a few days prior to surgery, immediately after, six months after, and at three six month intervals. In contrast to other studies, the findings in this group of patients indicated that they had an improvement in their personality adjustment following surgery. The authors of this study suggested that the change may have reflected relief from physical suffering, and they emphasized the desirability of elective surgery in older patients. Another research study of elderly people undergoing surgery was performed by Elizabeth Blundell (1967). She studied 86 patients between the ages of 70 to 91. She discovered a transient postoperative mental disturbance mainly affecting memory and intellectual ability which required organization of thought. This disturbance was transient and disappeared by the time most patients were discharged. Three patients, however, were still disturbed six weeks following operation. Her findings suggested that their disturbance was caused by the effect of anaesthesia upon the cerebral cortex (p. 297). Such varied findings indicated that further research was needed in the area of reactions to surgery in the elderly.

PURPOSE AND NEED FOR THE STUDY

Elderly people have been the forgotten generation in our society for many years. Cultural attitudes were oriented toward youthfulness; aging was looked upon with pessimism; and the older patient was viewed by health professionals with a sense of hopelessness (Davis, 1968, p. 802). Recently, however, the attitude toward the older population has undergone tremendous change. This has resulted in part from the tremendous growth of this segment of the population. The proportion of people over 65 has increased more rapidly than any other age group. They now comprise over 10 percent of the total U.S. population. There are approximately 20 million people above the age of 65 and it is predicted that by 1980 there will be over 25 million (Archer, 1968, p. 729; Linden, 1968, p. 47).

The prevalence of depressive illnesses in late life has compounded both medical and sociological problems in the expanding elderly population. Whenever depression has been suspected in the elderly individual, the possibility of suicide must be carefully considered (Litman, 1970, p. 140). Suicide increased progressively with advancing age. The incidence of suicide was higher in males and reached a peak after the age of 65. Awareness of physical or mental decline was a powerful incentive for suicidal preoccupation among the elderly (Moss, 1966, p. 220; Stotsky, 1969, p. 112).

Depression in the elderly has been precipitated by combination of events particularly characteristic of the aging process, with the theme of loss central to most cases. Regardless of the age of the

individual, the elements of depression were similar. Depression has been defined as a response to a loss--of a loved person, loved object, security, health, or function. It may have represented actual, anticipated, or imagined loss; but was very real to the person (Neylon, 1961, p. 77; Thayler, 1966, p. 11). For the older individual, these losses were compounded and unavoidable. Unsuccessful coping with their loss resulted in depression. Haikaz Grigorian (1970) related this loss to loss of self-esteem as the central element in depression (p. 87). As the older person suffered increasing loss, he had greater difficulty in sustaining his self-esteem. He had both physiologic and psychosocial changes, as a natural result of aging. These changes gradually stripped the elderly individual of his feelings of personal worth and greatly diminished his self-esteem (Warner, 1966, p. 411).

Various researchers have found that the physiologic changes experienced by the aged were all-pervasive and real. There was a loss of visual acuity, loss of hearing, diminished smell and taste, loss of teeth, decline in motor strength and loss of muscle mass. The physical appearance gradually changed. Skin tone was lost and wrinkles appeared. Cellular changes occurred and there was an increase in the percentage of body fat. There were changes in the digestive system, and an increased incidence of stroke and heart disease. Sexual capacity was reduced; however, continued sexual activity was more affected by general health of the individual and the availability of a partner than physiological change (Freeman, 1968, p. 130; Pfeiffer, 1969, p. 151; Stotsky, 1968, p. 3; Warner, 1966, p. 410).

Although psychosocial change and loss were difficult to identify

in the elderly, they had great significance in maintaining self-esteem. Several studies have focused on these changes in the aging population. Linden (1964) reported that because of cultural exclusion of the elderly and an overemphasis on the value of youth, many elderly people experienced a form of self-rejection as they grew older (p. 48). Their values were challenged by younger people and they suddenly became a minority. Even the environment of the elderly gradually disintegrated. Every individual develops life relationships which link him with his environment, which represents his world, and which provide him with a protective shell. Through this web of relationships people were preserved and supported. As the older persons' relatives and friends died and their social roles changed, they lost the security of this framework. There was often loss of social prestige and financial security when mandatory retirement or illness forced them out of their work role. Concurrently, they lost professional responsibilities and contacts. Family relationships and support may have ceased as spouses died, and children moved away. Even the older persons' homes were sometimes taken away when financial or health problems forced them into apartments or nursing homes. Loss of health and physical decline greatly restricted their ability to continue social contacts or activities (Levin, 1963, p. 305; Stotsky, 1968, p. 5).

Depression following surgery in the elderly population has received little attention in the literature. For this study, a group of aged men having transurethral prostatectomy were selected. This group of patients was chosen because they represented the most common surgical patients in the older population. It was reported that

enlargement of the prostate gland occurred in 80 percent of men beyond 80 years of age (Kasselman, 1966, p. 1026). The symptoms of prostatic hypertrophy appeared gradually and treatment was often delayed until the condition was severe. Many patients did not seek medical care because they were fearful that prostatectomy might affect their sexual ability (Weinberg, 1969, p. 160). While several studies have considered the physical and sexual aspects of prostatectomy, none has reported the emotional affects. The threats to the individual undergoing prostatectomy were numerous, and encompassed physical, functional, and psychological determinates. This study was primarily concerned with the relationship between the patient's illness and his emotional response to it, rather than physical sequelae. If certain groups of older patients could be identified as ones in which the possibility of depression was apt to be high, nursing personnel could be more aware and better prepared to recognize the symptoms and plan nursing intervention.

HYPOTHESES

It was hypothesized that:

1. Elderly men following transurethral prostatectomy will have a higher level of depression than normal elderly adults.

2. The level of depression will be directly related to the number of complications. (Patients with a greater number of complications will have a higher level of depression.)

3. The level of depression will be higher in patients with a diagnosis of carcinoma than those with a diagnosis of benign prostatic

hypertrophy.

4. The level of depression will be higher in unmarried patients than married patients.

DEFINITION OF TERMS

The following terms were defined in a special way for this study:

Elderly. A person of 65 years or older. The terms older and aged were used interchangeably with elderly.

Complications. Any problem or factor hindering the return or attainment of optimal functioning or health. Complications are those which the individual himself identifies as hindrances, whether or not they are directly associated with his physical functioning or resultant from his surgery. Problems which existed before his surgery will not be considered as complications, unless they have been increased or intensified, or unless they should have been corrected by the surgery.

Depression. Defined as a feeling of sadness, reaction of grief, and the emotional response to a loss. It is being measured on the basis of symptomatology alone. The specific cause, etiology, duration, onset, or category is not being considered; but only whether it is present as determined by the selected criterion measure.

Environmental support. Term used to indicate emotional support from other people in the patient's home environment.

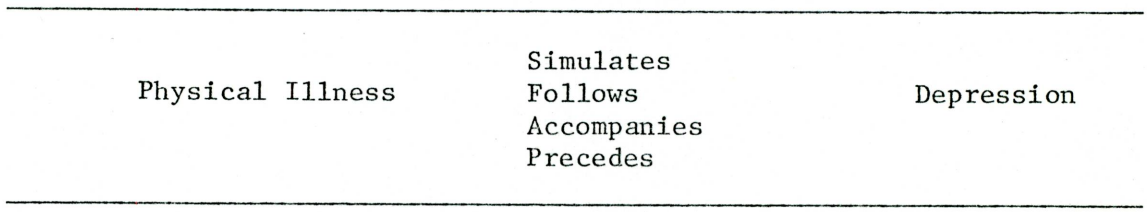
Functional loss. Loss of normal body functioning, such as bladder control.

THEORETICAL FRAMEWORK

When the biologic and psychological stresses heaped on the elderly were examined it suggested that older persons suffered more depression than other age groups partly because they were so plagued with the events that precipitated depression. Birren (1964) stated that the total complex of issues involved a body that was less able to withstand the effects of depression and yet was more frequently exposed to the precipitating influences (p. 259).

Illness was the most common of these precipitating influences. It was a frequent occurrence in the elderly population, and had a great affect on their psyche. Comprehensive studies of admissions to general hospitals and of medical in-patient units revealed that many medical and surgical patients of all ages were depressed; however, only a fraction of them were referred for psychiatric consultation (Schwab, 1970, p. 110).

The relationship between illness and depression was expressed by J. J. Schwab (1970) in a model of segmental relationships. He stated that the precipitating factor of illness was followed by depression. Sometimes this pattern occurred in reverse, so that depression sometimes followed, sometimes accompanied, and sometimes even preceded physical illness (p. 110).



Using this model as a theoretical framework, the relationship between illness and depression becomes one in which they compounded and enhanced one another. This relationship presented a framework within which to view the elderly patient. For the purpose of this study it served as the basis for the hypothesis that depression would occur in the elderly male following prostatectomy.

Other losses besides illness, have been precipitating factors in depression. Losses were seen as directly proportionate to age, and the longer a person lived the more losses he experienced. The individual's adaptation to his loss was both unique to his personality and affected by the number and quality of losses, and his previous experience in adapting to loss (Gregorian, 1970, p. 88).

When the elderly patient was viewed with this concept of loss in mind, the importance of his physical-psychological relationship was evident. The older person undergoing surgery needed more than his physical needs assessed. Nursing assessment of his psychological state was needed upon admission and throughout his illness experience. Older patients who were even mild to moderately depressed have rapidly progressed to a suicidal state (Rosenthal, 1968, p. 1). The high incidence of surgery in elderly men, compounded by increased losses occurring at this time in their lives suggested a group of patients in which the probability of depression would be high.

Previous authors have said that hospitals were places where the incidence of depression was high (Neylon, 1961, p. 78). The time of occurrence of psychiatric symptoms during illness is variable, and the

latent interval between surgical treatment and psychological disturbance may be days to weeks (Schwartz, 1969, p. 376). Although many surgical patients were depressed during their hospitalization, it was a transitory episode and improved when the patient was released. No attempt was made to measure depression of the patients in this study preoperatively or immediately after their surgery. The unnatural situation of hospitalization, the forced dependency, and the surgical pain would have influenced their responses. While depression may have occurred in patients at any stage in their illness, return to health was dependent upon working through the depression experience. The level of depression in the patients studied was evaluated at three weeks following surgery because depression still present at this time was apt to be more than just a transitory reaction. Measuring depression at this time was expected to give a more reliable picture of the patient's emotional status. Depression evident at this time was more likely to be a prolonged reaction, either precipitated by the illness or of a long standing nature.

Whether depression in the elderly surgical patient was a result of the surgery, or a temporary reaction in their stage of illness, or an indication of unsuccessful adaptation to previous loss was not important to this study. Identification of a group of older patients who had a high probability of depression even after going home was the objective. Recognition of such a group would substantiate the need for patients of this type to receive the comfort, support, and guidance that nurses could give.

Little and Carnelli (1969) stated that nurses should develop

guidelines in observation and care of particular groups of patients. If it were possible to identify patients in age groups, with particular diagnoses or operations as being at high risk for depression, planning of their nursing care could be facilitated.

Nursing interventions for depressed patients have been discussed by many authors. Gertrude Ujhely (1966) suggested that nursing actions for depressed patients follow Caplan's three modes of prevention--which are primary, secondary, and tertiary prevention. In primary prevention, the nurse attempted to relieve and lessen an impending depression by discussing the loss and what it meant to the patient, allowing them to express feelings and fears. Secondary prevention was directed toward reducing the duration of a depressive episode by early recognition, acceptance and support of the patient. Tertiary prevention was suggested in dealing with patients having a long-standing depression, offering a caring and protecting presence.

The nursing measures suggested were all based upon awareness, and the first step was that of recognition. Care of the elderly must encompass his psychosocial needs as well as his physical infirmities. Awareness of depression and those factors which may have accentuated it, was seen as a first step toward development of preventative or remedial measures.

Chapter 2

METHODOLOGY

DESIGN OF THE STUDY

Depression among elderly patients has become a dangerous and often undetected occurrence, frequently precipitated or intensified by an illness experience (Rosenthal, 1963, p. 114). This study was designed to measure the level of depression in a group of elderly men following transurethral prostatectomy. A descriptive survey was chosen as the mode for this investigation in an attempt to identify depression and the factors related to it.

Population

The patient population consisted of males, 65 years or older, having transurethral prostatectomy. The sample was selected during a four-month period from patients undergoing surgery at Loma Linda University Medical Center. The patients utilizing this hospital came from a wide geographical area and from every socioeconomic level.

Procedure

Patients undergoing prostatectomy were initially identified from the schedule of surgical operations. They were visited during their postoperative period, and if they met the criteria for selection given below, they were asked to participate in the study. An explanation was given to the patients that the researcher was interested in

how patients recovered after prostatectomy. They were asked to allow the researcher to visit them within a period of three weeks to discuss their condition. They were also informed that a questionnaire would be given to them to fill out at the time of the interview.

After approximately three weeks, a visit was made to the patients. The date and location were determined at the convenience of the patients and the researcher. The criterion measure, a self rating depression scale, was given to the patients at the beginning of the visit. They were asked to complete the scale without help from their family or the researcher. It was explained that the questions concerned how they were feeling. Following the scale, a structured interview was conducted. An interview guide was followed and questions directed to the patients. Other family members were not encouraged to participate in the interview. Whenever possible, the interview was conducted without other family members present. Self-pacing of speech was attempted by the researcher during the visit to allow the patients ample time to understand the instructions and questions (Stone, 1969, p. 2124). They were not rushed into conclusive statements, but allowed to express themselves at their own pace.

COLLECTION OF DATA

The Data Sheet

Identifying information about each patient was initially collected from his hospital chart and recorded on a data sheet. This data sheet was formulated to include the essential facts taken from his chart and the observations later collected at the time of interview.

Significant information regarding age, marital status, post-operative diagnosis, complications, and patient responses during the interview were recorded on this sheet. These particular items were selected as factors which may have shown some relationship to his level of depression.

A portion of the data sheet was used for listing the interview questions. This guide was followed closely so that each interview was conducted in a similar fashion. The questions on the interview guide were structured so that the patient could not answer with just a yes or no but was required to elaborate on his condition. The questions were formulated to encompass several aspects of the patient's physical condition and give him latitude in his responses.

The data sheet was also used for recording the patient's depression test score, so that all information about each patient was recorded on the data sheet. (See Appendix A.)

Criterion Measure of Depression

The self-rating depression scale (SDS) by Zung (1965) was utilized for measuring depression in this group. (See Appendix B.) This scale measured the amount of depressive symptomatology present through evaluation with a self-rating scale. Zung described this scale as all inclusive with respect to symptoms of depression. Advantages of this test were numerous. It was short and simple to understand, as well as being easy to administer and score. It indicated the patient's own response at the time the test was given.

The SDS contained twenty items, based on the clinical diagnostic

criteria most commonly used to characterize depressive disorders. These items were phrased as sentences based on patient interview material and selected as most representative for the particular symptom. In using the SDS, the subject was asked to note each of the twenty items as to how it applied to him at the time of testing, in four quantitative terms, which had numerical value of 1 to 4. The scale was devised so that of twenty items used, ten were worded symptomatically positive and ten symptomatically negative. An index for the SDS was derived by dividing the sum of the raw scores obtained on the twenty items by the maximum possible score of 80, converted to a decimal and multiplied by one hundred (Zung, 1967, p. 543).

Reliability. Several studies have been carried out to test the reliability of this scale. Results showed that the outcome of the SDS was not affected by the patient's sex, marital status, educational level, financial status, or intelligence level (Zung, 1967, p. 546). A study of 250 normal aged persons indicated that older people score somewhat higher than younger persons on the SDS indicating a greater degree of depression in the normal aged than in the younger population. Therefore, a higher baseline has been used in evaluation of depression among the elderly with this tool (Zung, 1967, p. 291).

Validity. There was a highly significant correlation between the results of groups of patients tested with the SDS and the Minnesota Multiphasic Personality Inventory Depression Scale (MMPD). The correlation coefficient between the SDS indices and the Depression Scale T-scores of the MMPD was 0.65 (Zung, 1967, p. 546).

SELECTION OF SAMPLE

The population of patients from which the study sample was chosen consisted of elderly men of 65 years or older. The age precluded the use of a random sample. It was felt that patients with outstanding difficulty in communication could not participate in this type of study. The distance from which some patients lived from the medical center also prevented their inclusion in the study.

A convenience sample was utilized in selecting patients for the study. It was based on the ability and willingness of the patient to participate and the distance required to travel for the postoperative visit. Patients were chosen according to the following criteria:

A. Ability to read

B. English-speaking

C. Unaffected by severe loss of hearing

D. Reasonably good vision

E. Living within a 60 mile radius of the medical center

PROCESSING OF DATA

The raw scores on the depression scale were calculated for each patient and converted to an index using a conversion scale published by Zung (1965, p. 66). The scoring of the tests was performed initially by the researcher and repeated by an assistant to assure accuracy. This index was then listed on the individual patient's data sheet.

The mean depression score of the sample group was computed. A comparison was made between the mean of the sample group and the normal

mean of aged adults established by Zung for the SDS. A t-test was performed to measure the significance of the difference between the means of the two groups.

The total number of complications reported by each patient was calculated after the visit by the researcher and listed on the data sheet. A comparison was made between the total number of complications and the depression score of each patient. A regression analysis was performed to test this relationship and measure its significance.

Patients were grouped according to marital status, and the mean depression scores of the married and unmarried patients were computed. A comparison of the mean scores for these subgroups was made, utilizing a two-tailed t-test to measure the significance.

The mean depression score of those patients with carcinoma was computed and compared to the mean depression score of those patients with benign prostatic hypertrophy. The significance of the difference between the two means was computed using a two-tailed t-test.

ASSUMPTIONS AND LIMITATIONS OF THE STUDY

The study population was limited in size by the availability of patients that met the criteria of the sample. Influencing factors in the patient's environment at the time of the interview were variables not possible to control. Patients' misunderstanding of questions or incorrect interpretation were variables that may have affected the results.

It was assumed that the SDS scores were as reliable and valid

for this population as for other groups. Results obtained were assumed to be the true feelings of the patients tested. It was also assumed that the third week after surgery gave a relatively accurate picture of the patients' emotional status.

The method of selection of the sample influenced the reliability of the results. A convenience sample is less reliable or representative of the population than a random sample. Nevertheless, it was assumed that this sample would give a picture of a population of patients undergoing prostatectomy which could indicate the need for additional study.

Chapter 3

PRESENTATION AND DISCUSSION OF FINDINGS

CHARACTERISTICS OF THE STUDY SAMPLE

Population

There were thirty men included in the study sample. Two patients originally included in the sample were deleted from the study group. One man expired shortly after his operation, and the other had moved without leaving a forwarding address. The patients in the study group ranged in age from 65 to 91 years, with an average age of 74 years. All patients had undergone transurethral resection of the prostate. Twenty-four of the patients were diagnosed postoperatively as having benign prostatic hypertrophy. Six patients had postoperative diagnosis of carcinoma of the prostate. Twenty-eight of the patients were retired and two were employed. Twenty of these men were married, eight were widowed, one was divorced, and one had never married. The divorced and single man lived alone, while the remaining twenty-eight lived with their spouses or with relatives. (See Tables I and II.)

Complications

All patients in the study sample reported at least one complication. The number reported ranged from 1 to 4. The mean number of complications reported was 2.3. Only complications occurring after the surgery or conditions aggravated by it were listed. Those reported were similar for most patients and included the following:

TABLE I

AGE, MARITAL STATUS, SDS SCORE*, NUMBER OF COMPLICATIONS AND POSTOPERATIVE DIAGNOSIS OF PATIENTS IN THE STUDY GROUP

Patient Number	Age	Marital Status	SDS* Score	Number of Complications	Diagnosis
1	70	M	33	1	BPH**
2	76	M	35	1	BPH
3	72	M	38	2	CA***
4	65	M	39	]	BPH
5	80	M	46	2	BPH
6	91	W	48	1	BPH
7	79	W	49	2	BPH
8	71	M	50	2	BPH
9	69	M	51	3	CA
10	75	M	53	2	BPH
11	67	M	53	2	BPH
12	86	M	54	1	BPH
13	76	S	54	1	BPH
14	81	M	55	2	BPH
15	81	M	55	1	BPH
16	69	M	56	3	BPH
17	65	D	56	2	BPH
18	67	W	59	2	BPH
19	83	W	59	2	BPH
20	67	M	60	3	BPH
21	76	W	61	3	BPH
22	68	M	61	4	CA
23	74	M	64	4	CA
24	72	W	65	4	CA
25	78	W	66	4	BPH
26	74	M	66	4	BPH
27	71	M	66	4	CA
28	68	M	66	3	BPH
29	77	W	68	4	BPH
30	69	M	73	1	BPH

* Self-Rating Depression Scale (Zung, 1967)
** Benign Prostatic Hypertrophy
***Carcinoma of the Prostate

TABLE II

DISTRIBUTION OF PATIENT POPULATION ACCORDING TO AGE

	Years						
	65-70	71-75	76-80	81-85	86-90	91-95	Total
Total number of patients	11	7	7	3	1	1	30
Married	9	6	2	2	1		20
Widowed	1	1	4	1		1	8
Single			1				1
Divorced	1						1
Diagnosis of carcinoma	2	4					6
Diagnosis of benign prostatic hypertrophy	9	3	7	3	1	1	24

Mean age - 73.9

frequency (15), dribbling (9), nocturia (8), fever (6), weakness (4), nervousness (4), neck pains (2), back pain (2), leg pains (2), stomach pain (2), generalized pain (8), joint stiffness (2), impotence (2), inability to start and stop urination (2), bleeding (1), and incontinence (1).

RELATIONSHIP OF FINDINGS TO HYPOTHESES

Depression Indices of the Total Sample

In this study, it was hypothesized that elderly men following transurethral resection of the prostate would have a higher level of depression than normal aged adults. The findings of this study supported this hypothesis. The depression level of this group of patients was significantly higher than is usual for normal elderly adults. Their depression (SDS) scores ranged from 33 to 73, with most patients scoring above 48. There were no extremely low or high scores. The mean depression score of the group was 55.3. In comparison, the mean depression score set by Zung (1967) for normal elderly adults on the SDS was 48.3 (p. 291). This difference was found to be significant at the level of .01. A comparison of the mean score of the study sample and the mean score set by Zung for normal aged adults on the SDS is shown by a bar graph in Figure 1.

Effect of Select Factors on Depression Level

Marital status. A small difference was observed between the depression levels of patients married and those who were unmarried. These findings were in agreement with the hypothesis that unmarried

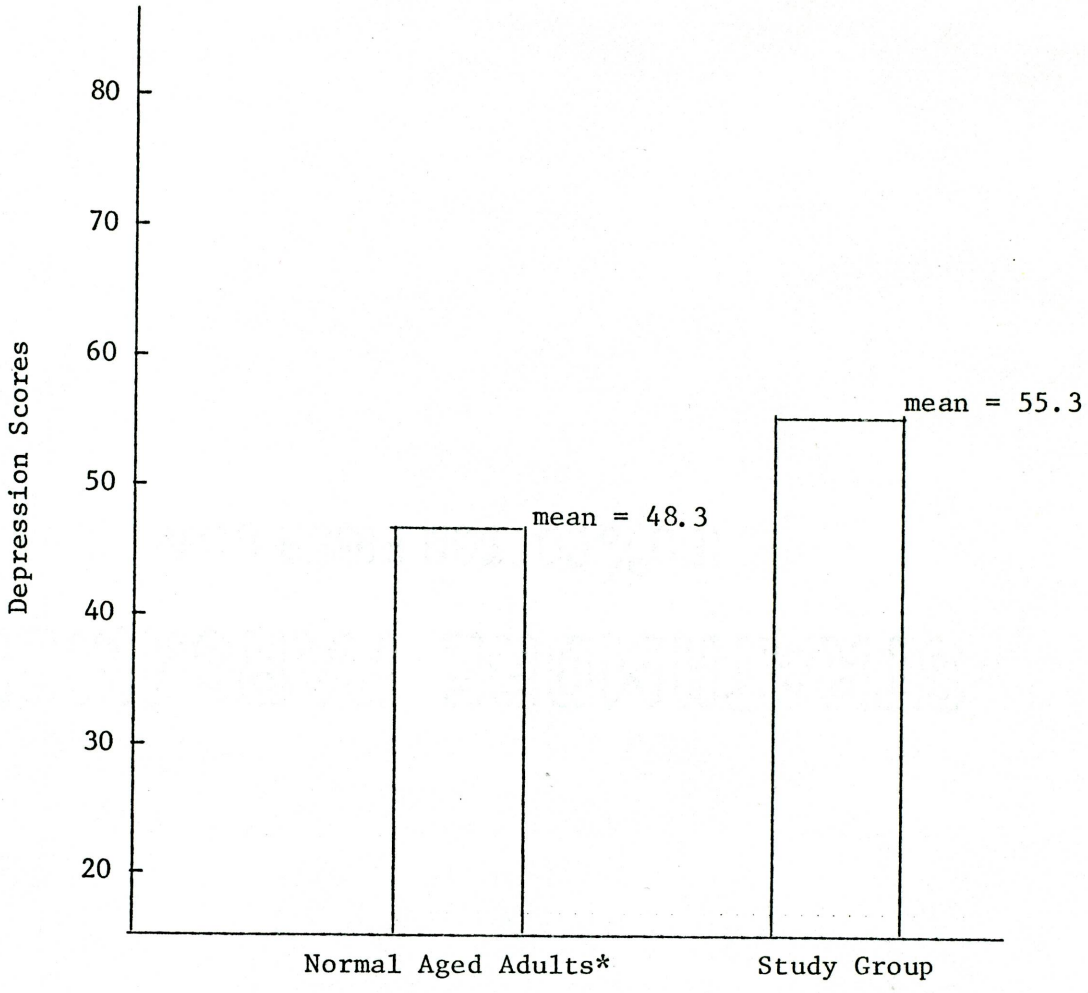


Figure 1. Comparison of the Mean Depression Scores of the Study Group and the Standard Mean Depression Scores for Normal Aged Adults on the Self-Rating Depression Scale (Zung)**

*The difference between the means was significant at the level of .01.

**Zung, 1967, p. 291.

patients would experience more depression than married patients after prostatectomy. The mean depression score of the unmarried patients within the group was 58.7, while the married patients had a mean score of 53.7. (See Figure 2.) This difference was not statistically significant. Although eight of the ten unmarried patients in the study scored above the mean, the wide range in scores affected their group score. Two unmarried patients had relatively low scores of 48 and 49, thereby lowering the group mean.

Postoperative diagnosis. It was hypothesized that patients within the study group who were diagnosed postoperatively as having carcinoma of the prostate would have a higher level of depression than those with a diagnosis of benign prostatic hypertrophy. However, the patients with carcinoma only had slightly higher depression scores than those with benign enlargement. The mean scores of the groups were 57.5 for those with cancer, and 54.7 for those with benign prostatic enlargement. The difference between the means was not statistically significant. These findings did not support the hypothesis; however, the wide range of depression scores of the patients with carcinoma may have lowered the mean of the group significantly. Although four of the six patients with carcinoma had scores of 61 or higher, there was one patient who scored 38.

Total number of complications. It was hypothesized that patients with a greater number of complications following surgery would experience more depression than those with fewer complications. The findings of the study supported this hypothesis. The patients in the

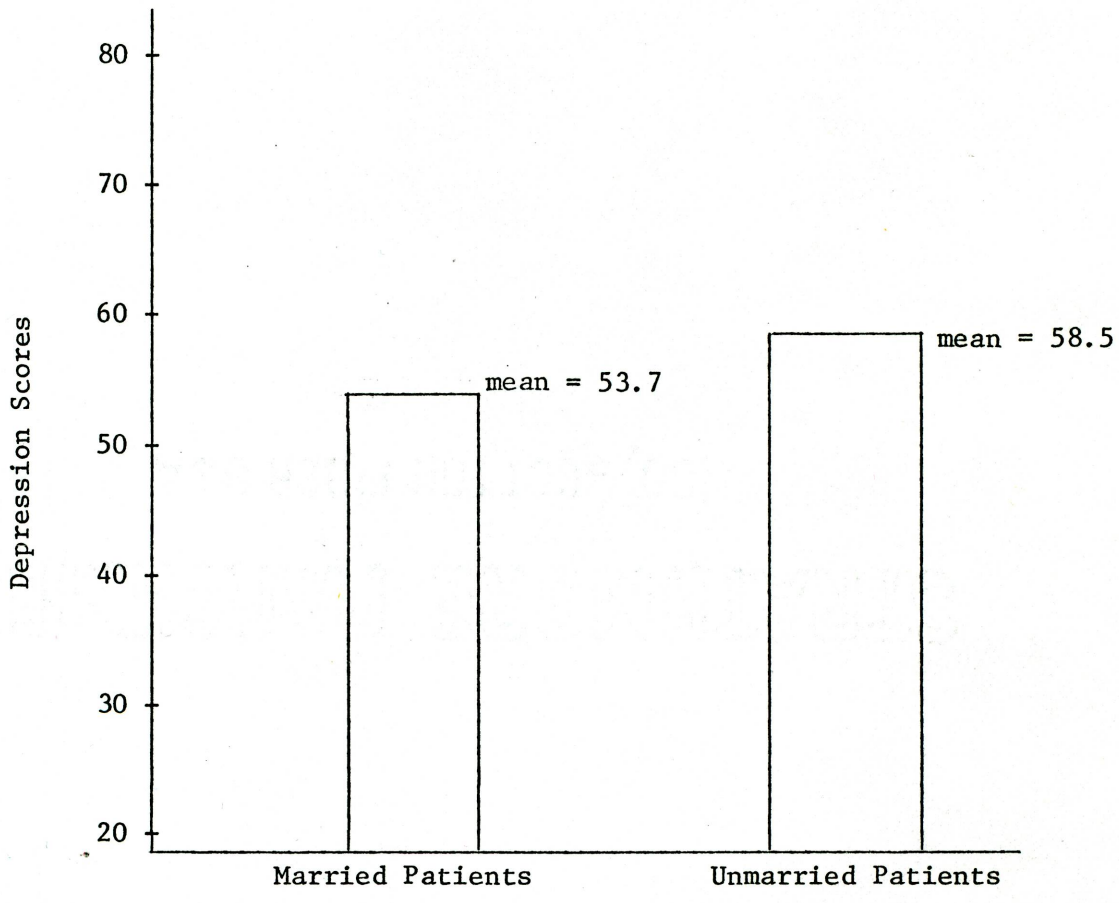


Figure 2. Comparison of the Mean Depression Scores of Married and Unmarried Patients Within the Study Group

study group showed a high correlation between the amount of depression experienced and the number of complications they reported. A regression analysis of these factors indicated a positive correlation between increased depression and greater number of complications. The correlation coefficient was 0.53. (See Figure 3.) The number of complications reported ranged from 1 to 4, and as seen in Table I the number consistently increased with an increase in depression. Nevertheless, the patient with the highest depression score reported only one complication. It was of interest that this patient was married and had a diagnosis of benign prostatic hypertrophy, so none of the factors considered in this study could be identified as influential in his depression.

DISCUSSION AND INTERPRETATION OF FINDINGS

In the past, emotional disturbances or depressive reactions in the elderly were accepted as a natural sequence in the process of aging, and any older person whose behavior suggested abnormality was simply dismissed as senile. However, recent studies have shown that psychological illnesses in the older person can be effectively treated if the disorders are recognized (Gabrynowicz, 1968, p. 303). In this study, an attempt was made to find out the incidence of depression in a specific group of elderly patients and suggest possible factors contributing to their depression.

Relationship of Illness and Depression

Of the thirty elderly men included in this study, twenty had

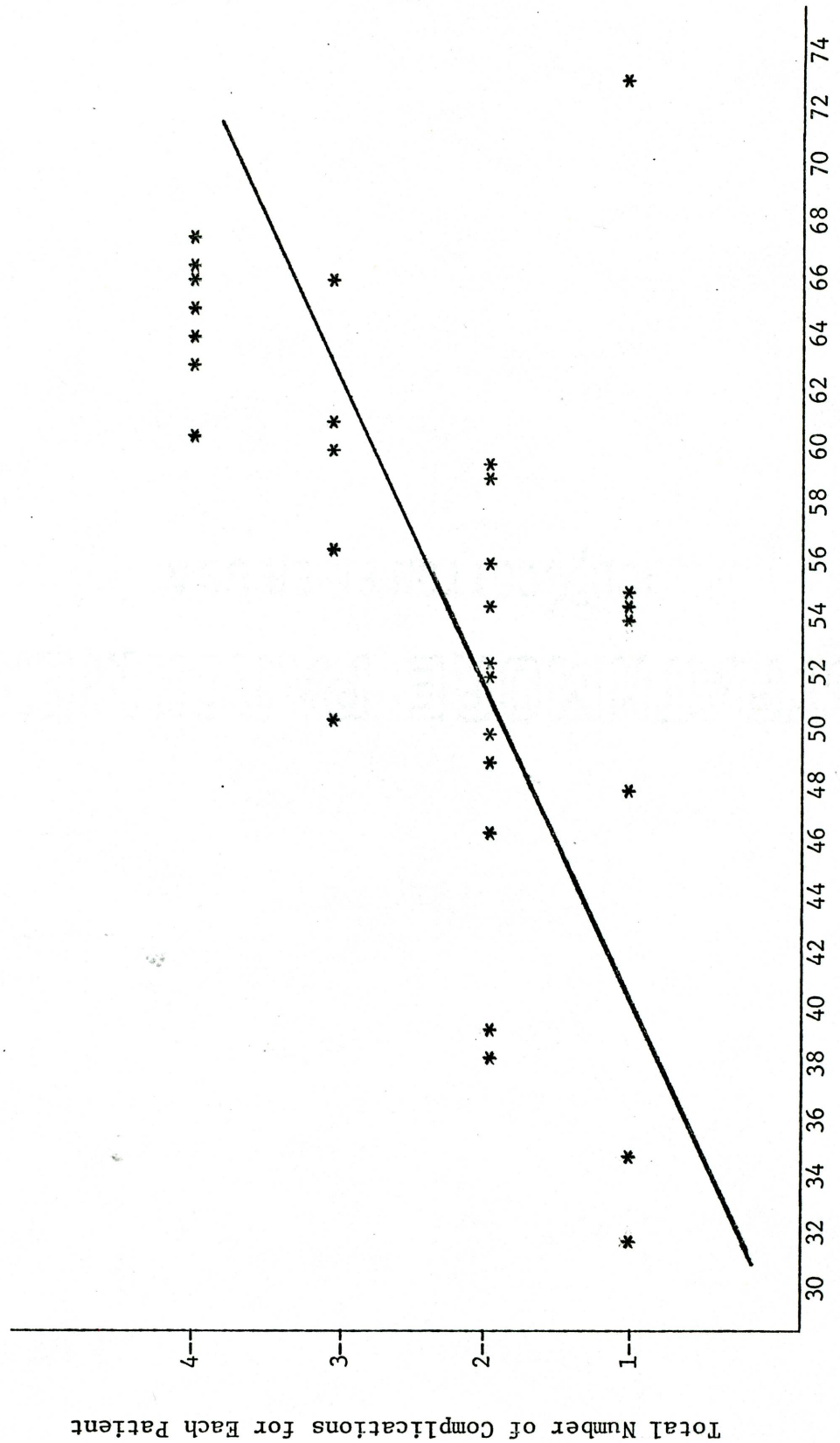


Figure 3. Depression Indices and Total Number of Complications Reported for Each Patient

depression scores on the SDS that were above the mean for normal aged adults. These findings seemed to indicate a relationship between illness and depression, and suggested that illness should be considered as a precipitating factor in the depression of this group.

Previous studies have found a high positive correlation between physical illness and mental illness in the aged (Stotsky, 1968, p. 57), and, other authors have stated that physical factors were increasingly recognized as having functional consequences in older persons, not only in causing depression, but also in precipitating other mental disorders (Birren, 1964, p. 271). Birren (1964) stated that older men in particular had difficulty in accepting illness; and that physical disability, chronic illness, or the diagnosis of an incurable disease have led to depression (p. 258). Busse (1955) found illness to be a precipitating stimuli in many of the 332 elderly depressed patients he studied (p. 896). The impact of illness on the elderly person has been intensified not only by the fear of incapacitation and loss of independence, but by accentuated fear of death (Stotsky, 1968, p. 113).

Possible Determinates of Depression in Study Group

Although identification of depression in the study group was easily accomplished, recognition of variables contributing to their depression was difficult. Two distinct factors emerged which seemed to have significant influence on the patients in this study. Other factors, although documented in the literature as influential, were not shown to be important in the experience of these elderly men.

Type of surgery. The high incidence of depression in the sample group may have been associated with the particular surgical procedure. The patients had surgery performed on their reproductive organs. Wu (1973) stated that illnesses associated with the reproductive organs threatened patients' sexuality and the operation may have threatened masculinity as well (p. 37). On the other hand, Gilberstadt's findings (1968) suggested an improved personality adjustment following surgery on the stomach and gall bladder. This may have indicated that the site of operation and the meaning to the patient influenced the patients' emotional response.

Weinberg (1969) found that although prostatectomy did not directly affect potency and a high proportion of men remained sexually active after prostatectomy, this was less likely in men over the age of 65. Studies of elderly persons revealed that aging men were usually able to continue active sexual expression into the 70 and 80 year age groups (Newman, 1960, p. 33). Threatened or actual loss of this ability may have a profound effect on the older male. Depressive illnesses in late life have been associated with cessation of sexual activity following a serious illness, and operations on the urogenital system were examples of these phenomena.

Only two patients in the study sample reported loss of sexual activity as a complication of their surgery; however, this number was not considered representative of the total sample. The majority of the patients were reticent to discuss this activity with the researcher and would not comment about their past or present sexual capabilities. The short time span of three weeks since operation may have affected

their sexual pattern; and, they may not have yet been physically well enough to even attempt intercourse. Previous studies have indicated that there is a general assumption in society that the role of sex greatly loses in importance as people grow older. Elderly people have sometimes even shared this feeling and felt that at their age sexual activity ought to have ceased, or if continued, should have been hidden (Levin, 1963, p. 305).

Functional loss. Although several aspects of the patients' internal and external environment were examined to suggest relationship to depression, only one seemed consistent. Functional loss appeared to be a central element in the development of depression in these patients. Those with increased number of complications following surgery experienced the greatest amount of depression, and, the majority of these complications concerned problems related to body function. Loss of control of their body functioning, inability to void at will, dribbling, and continued incontinence frustrated the patients. Even though these problems may have been only temporary in nature, they had a profound impact on the patients. Depressive reactions have been cited as frequent occurrences in any type of physical disability, especially in the acute stage. Loss of body function, whether real or imagined, directly contributed to loss of self-esteem and thereby led to depression (Gabrynowicz, 1968, p. 302). Lane stated that loss of functional ability to do those things for themselves from which they gain self-satisfaction was perhaps the greatest stress experienced by the older population (1972, p. 266).

Diagnosis of cancer. Surprisingly, the diagnosis of cancer did not appear to influence the level of depression in the study group. Other authors have shown that the diagnosis of cancer, with its inherent threat of death, strongly affected the psychological state of individuals (Birren, 1964, p. 258). Ujhely (1966) stated that each emotional experience a person has resounds in the recesses of past similar experiences; therefore, any impending loss whether it be loss of life or loss of function revived all unfinished business concerning previous losses (p. 27). Anxiety has been reported as a frequent concomitant of the diagnosis of cancer even though it may have had no relation to the facts of the individual case (Day, 1968, p. 204). Although the patients with cancer experienced slightly more depression than the others in this study, this difference was insignificant and much smaller than anticipated. Perhaps their reaction was lessened because of the location of their disease. Prostatic cancer has been controlled successfully with medication and radiation, and the surgeon usually assured the patients of a good prognosis.

Environmental support. It has become accepted that external circumstances and environment influence the general health of individuals. Likewise, it was expected that environmental support, indicated by marital status, would affect the depression levels within the study group. However, there was not a significant difference between the depression levels of patients married and those unmarried. Upon further examination, it was noted that all patients except two lived with family members even if they were widowed. This fact

suggested that this particular group of elderly men still maintained close environmental supports and relationships, and their marital status alone could not be used as an indicator of environmental support. The two patients that did live alone had scores very close to the mean; nevertheless, their scores could not be compared to the rest of the group because there were not enough patients living alone to make a statistically significant comparison.

IMPLICATIONS FOR NURSING

While conducting this study, certain facts seemed to emerge that could be useful in dealing with elderly patients. Older men in particular have been known to have difficulty in accepting and experiencing illness, and the patients in this study seemed to indicate this phenomena. There appeared to be a relationship between illness and depression. Awareness of this possible relationship, and early detection of the symptoms of depression could enhance the nursing care of elderly men undergoing prostatectomy.

For the particular patients in this study sample, undergoing urogenital surgery, with the threat to body image and loss of bodily function, seemed particularly stressful. Nursing care of patients undergoing this type of surgery should be especially supportive and reassuring.

Chapter 4

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

This study was done to find out the frequency and degree of depression in elderly men following transurethral prostatectomy. An attempt was made to suggest factors in their illness or environment which may have influenced the amount of depression they experienced. Thirty patients were included in the study group. They were given a self-rating depression scale three weeks after their operation to measure their level of depression. They were also interviewed at this time to assess their complications after surgery and to collect data regarding their environment.

Results of the study firmly supported the primary hypothesis that elderly men following transurethral prostatectomy would have a higher level of depression than normal aged men. The mean depression level of the study group was 55.3, in comparison to the standard mean for normal aged adults of 48. This difference was found to be significant at the level of 0.01. These findings could not be conclusive for the entire population, but represented a small segment of thirty patients.

Complications after surgery appeared to have a significant effect on the depression levels of the patient sample. It was hypothesized that patients with a greater number of complications following

surgery would experience more depression than those with fewer complications. A regression analysis of these factors showed a positive correlation and gave some support to this hypothesis, with a correlation coefficient of 0.53.

Another hypothesis stated that patients with a postoperative diagnosis of carcinoma would experience more depression than those with a diagnosis of benign prostatic hypertrophy. The findings of the study did not support this hypothesis. Although the mean depression score of patients with carcinoma was higher than the mean of those with benign hypertrophy, this difference was not statistically significant.

Depression among unmarried patients was slightly higher than that among married patients. The mean depression scores were 58.7 for unmarried patients and 53.7 for married patients. These findings gave support to the hypothesis that unmarried patients would experience more depression than married patients.

The most important elements influencing depression in this group appeared to be factors related to the type of surgical procedure and the amount of functional loss experienced.

CONCLUSIONS

The results of this study gave conclusive information that applied to the select group of patients only. Generalization to the entire population of prostatectomy patients could not be done with a sample of this size.

As a result of this study, it was concluded that depression

was more frequent among the selected groups of elderly men following transurethral prostatectomy than among normal aged men.

It was concluded that patients in the study group with a greater number of complications following surgery experienced more depression than those with fewer complications.

No clear cut relationship between postoperative diagnosis or marital status and depression level was shown from this study.

RECOMMENDATIONS

Successful care and treatment of elderly patients depends on the knowledge and insight of the health professionals involved in their care. The problem of depression among elderly people following surgery needs broad investigation. In particular, the problem of depression after prostatectomy should be more deeply researched.

The following suggestions might be considered by others interested in pursuing this problem further.

1. Measurement of depression before prostatectomy, immediately postoperatively, one month following prostatectomy, and six months following prostatectomy.

2. Comparison of depression among prostatectomy patients receiving active nursing intervention and those without such intervention.

3. Comparison of depression in other types of surgical patients to depression in prostatectomy patients.

4. In depth study of depression among elderly men in the general population.

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APPENDIX A

DATA SHEET

DATA SHEET

Patient Profile:

name _____ age _____

hospital # _____ D. score _____

date of surgery _____ marital status _____

date interviewed _____ diagnosis _____

address _____ number of complications ___

Interview Guide:

1. In what way has your condition changed since you were in the hospital? Better, worse, or the same?
2. Do you have difficulty starting or stopping urination? Nocturia, burning, or frequency?
3. Have you noticed any fever?
4. What kinds of changes have there been in your sexual activities?
5. Do you have problems now bothering you that you didn't have before surgery?

Complications:

Pertinent observations:

nocturia _____

fever _____

dribbling _____

frequency _____

other _____

APPENDIX B

SELF-RATING DEPRESSION SCALE (ZUNG)

Name _____

QUESTIONNAIRE

1. I feel down-hearted and blue----------

a little of the time	some of the time	good part of the time	most of the time

2. Morning is when I feel the best----------

a little of the time	some of the time	good part of the time	most of the time

3. I have crying spells or feel like it----------

a little of the time	some of the time	good part of the time	most of the time

4. I have trouble sleeping at night----------

a little of the time	some of the time	good part of the time	most of the time

5. I eat as much as I used to----------

a little of the time	some of the time	good part of the time	most of the time

6. I still enjoy sex----------

a little of the time	some of the time	good part of the time	most of the time

7. I notice that I am losing weight----------

a little of the time	some of the time	good part of the time	most of the time

8. I have trouble with constipation----------

a little of the time	some of the time	good part of the time	most of the time

9. My heart beats faster than usual----------

a little of the time	some of the time	good part of the time	most of the time

10. I get tired for no reason----------

a little of the time	some of the time	good part of the time	most of the time

11. My mind is as clear as it used to be----------

a little of the time	some of the time	good part of the time	most of the time

12. I find it easy to do the things I used to----------

a little of the time	some of the time	good part of the time	most of the time

13. I am restless and can't keep still----------

a little of the time	some of the time	good part of the time	most of the time

14. I feel hopeful about the future----------

a little of the time	some of the time	good part of the time	most of the time

15. I am more irritable than usual----------

a little of the time	some of the time	good part of the time	most of the time

16. I find it easy to make decisions----------

a little of the time	some of the time	good part of the time	most of the time

17. I feel that I am useful and needed----------

a little of the time	some of the time	good part of the time	most of the time

18. My life is pretty full----------

a little of the time	some of the time	good part of the time	most of the time

19. I feel that others would be better off if I were dead----------

a little of the time	some of the time	good part of the time	most of the time

20. I still enjoy the things I used to do----------

a little of the time	some of the time	good part of the time	most of the time

LOMA LINDA UNIVERSITY

Graduate School

DEPRESSION IN ELDERLY MEN FOLLOWING TRANSURETHRAL PROSTATECTOMY

by

Brenda Leach Allocco

An Abstract of a Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science

in the Field of Nursing

December 1973

ABSTRACT

This study was concerned with the problem of depression among elderly patients following surgery. The purpose of the study was to find out if older men following transurethral prostatectomy experienced a higher level of depression than normal elderly people in the general population. An attempt was made in the study to suggest factors in the patients' illness or environment which may have influenced the amount of depression they experienced.

Thirty patients, sixty-five years or older, were included in the study sample. Depression was measured by a self-rating depression scale (Zung) three weeks following their operations. Other facts about the patients were gathered by an interview at the time the test was given.

The central hypothesis of the study was that elderly men after transurethral prostatectomy would have a higher level of depression than normal older adults. The data supported this hypothesis in that 80 percent of the study sample had scores that were above the standard mean for normal aged adults.

Another hypothesis, relating to the effect of complications on the level of depression, was supported by the study findings. It was shown that an increase in total number of complications was accompanied by an increase in the level of depression. A regression analysis of these factors indicated a positive correlation. The correlation coefficient was .53.

Other factors in the environment of the study sample could not

be related to the level of depression experienced by the group. Hypotheses suggesting a relationship between marital status or post-operative diagnosis and level of depression were not supported by statistically significant data.

It was concluded from this study that depression in older males following surgery upon the genitourinary system as represented by this select sample, was a significantly frequent occurrence. Although evidence was lacking to suggest that surgery was the primary cause of their depression, the high percentage of patients who experienced depression after their operation was significant.