HOPELESSNESS AND HOURS OF SERVICES

RECEIVED BY ELDERLY AND DISABLED CLIENTS

By

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ABSTRACT

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Hopelessness is defined as the degree to which an individual is pessimistic about the future. This paper is set out to address the relationship between disabled individuals, and feelings of hopelessness based on the hours of services they receive. This study could lead to improvements in the well-being of many individuals and treatment received.

A review of the literature shows that disabled individuals receive services based on their perceived needs. Studies have also shown that persons with disabilities are vulnerable to depression and hopelessness. This present study examines the relationship

between hopelessness and hours of services disabled clients receive. The Beck Hopelessness Scale (Beck, 1974) was administered to 27 participants and the scores were correlated to determine whether a relationship exists between the two constructs.

Data analysis using Pearson's r correlation coefficients suggests a positive correlation exists between hopelessness and hours of services received for clients with disabilities.

Table of Contents

Tables

Pages

CHAPTER I

Introduction

The size of the elderly and disabled population is increasing due to progress in Medical Technology. Consequently, nursing homes and home care providers are busier than ever trying to meet the needs of all those who need services. In many counties, home-care funding is being cut, limiting the agencies ability to provide services. In Barron County, home health was recently discontinued. Non-profit organizations are trying to pick up the individuals who are now without care.

This produces many additional stressors for elderly and disabled individuals. Not only do they have to try to find care, but they must also learn a whole new system, with new regulations and different workers. Given a choice, the majority of the elderly and disabled population would prefer to live in their own home, and receive services as long as possible, before going to a nursing home or residents home.

The negative side of this is that many become isolated experiencing social with drawl, as they get older. The home care aid will get their groceries for them so there is no need for them to leave their house. This with draw from the community and social events tends to have other negative impacts on the clients as they show signs of depression and less interest in life.

Worry and nervous tension are common presentations of depression in older people. Studies show that there is a rise in depression and hopelessness among the elderly. Depression is common in chronic debilitating physical conditions (Elliott & Shewchuk, 1995). The cognitive vulnerability theories, specifically hopelessness theory

(Abramson et al., 1989), state that particular cognitive styles bestow vulnerability to depression and hopelessness.

When people are faced with a disabling illness according to (Bruce et al., 1994), their symptoms are strong and significant predictors of negative mood and psychological distress. Research shows that individuals with-out a strong social support system are more likely to show depressed moods and poor physical health.

Social support networks, especially family networks, often help ease adjustment to disabilities and chronic illnesses (Bloom & Spiegel, 1984) Generally, individuals who require the most care are lacking a strong social support group. According to Mor, Allen, Seigel & Houts (1992), The perceived reliability of one's social support network may be critical for people with long-term disabilities and little or no chance of improvement.

More than 75 percent of Americans favor legislation allowing terminally ill patients or their family members to with-drawl life-sustaining treatments, but severe depression may influence patients to reject medical care they might otherwise accept if their depression were treated.

Hopelessness is defined as the degree to which an individual is pessimistic about the future. Among many depressed individuals, hopelessness, pessimism, and excessive emphasis on the burdens of treatment temporarily alter their ability to weigh risks and benefits of treatment.

Sometimes, older adults can feel unworthy of medical attention or may worry about burdening their family. Lack of interest in personal care in an elderly patient, including diminished concern for personal appearance, should prompt an evaluation for

depression. Hopelessness and low mood are two symptoms of depression. These symptoms appear to be present among the majority of the elderly and disabled clients receiving home care services.

Future thinking is derived from hopelessness; this paper set out to address the relationship between disabled individuals feelings of hopelessness, and the number of hours of service they receive. This study could lead to improvements in the well being of many individuals and treatment received if hopelessness is significantly correlated with hours of service received.

A review of the literature shows that disabled individuals receive services based on their needs. Studies have also shown that persons with disabilities are vulnerable to depression and hopelessness. Therefore, the research hypothesis for this study is that there will be a significant positive correlation between the hours of service disabled individuals receive per week and the degree of hopelessness they feel.

Statement of the Problem

The purpose of this study is to determine the degree of correlation between levels of hopelessness as measured by Beck Hopelessness Scale and the amount of service measured in hours that disabled clients require per week.

Null Hypothesis

There is no statistically significant correlation between hours of service, and level of hopelessness for clients with disabilities.

Definition of Terms

Chronic Illness: suffering from a disease for a long time.

Debilitating: to make feeble or weak.

Depressed: feelings of sadness lack of response to stimulation and with drawl.

Disability: the condition or state of being mentally or physically disabled or unable.

Home-Care Provider: individual who assists clients with personal care, and needs in their home.

Hopelessness: negative expectancies toward self, future, and environment.

Psychopathology: a general term used to describe a wide range of psychological disorders.

CHAPTER II

Review of Literature

General Information

This review will focus on hopelessness and the effects of social interaction among elderly and disabled individuals. Hopelessness has been found to be a major component in the severity of various disorders. Therefore, this review of literature focuses on the relationship of hopelessness among elderly and the disabled populations.

Hopelessness

Individuals who are hopeful can be described as optimistic, vigorous, and energetic. On the other hand, individuals who are hopeless are described as pessimistic, apathetic, and dull. This type of individual tends to keep to themselves and not have many friends. People do not like to be around someone who feels hopeless because it also drags them down.

Hopelessness can be expressed as a way of feeling, away of thinking, and a way of acting. As a feeling, hopelessness if expressed as discouragement, and despair. When people feel hopeless it can also impair their thinking. They have difficulty making good decisions and find it hard to rationalize alternative methods of resolving issues. These feelings and ways of thinking also influence the way the persons behave. Hopeless individuals generally experience an inability to act (Farran, Herth, & Popovich, 1995).

When an individual starts to feel hopeless its generally a signal something is wrong. Either their needs and goals have not been met or life has become difficult or unbearable (Farran, et al., 1995). This type of hopelessness might be seen in response to

loss and grief experiences or major life changes such as illness. Generally with activation of internal and external resources this type of hopelessness resolves or recedes over time (Farran, et al., 1995). Hopelessness can also be described as a way of relating and expressing oneself, and as a deep personal orientation that nothing one can do and nothing that happens externally can bring meaning or enthusiasm to life (McKenney, 2000).

The difference between hopelessness associated with "normal" responses to difficult experiences and hopelessness associated with psychiatric disorders is that persons have succumbed to the challenge and have given up. These feelings of hopelessness last longer, are more persistent, have more associated symptoms, and more profoundly interfere with routine activities and tasks (Farran, et al., 1995).

The hopelessness of a severely depressed individual is characterized by the following beliefs and expectations: 1) the individual believes that personal skills and plans of action are no longer effective for reaching goals set: 2) the individual attributes personal failures to own incompetence so that he or she must now rely on others; and 3) the individual deems previous investments in long-range goals to have been met with numerous frustrations and failures (Melges & Bowlby, 1969).

Antecedents and sources of hopelessness can be identified as intrapersonal, interpersonal, or environmental/sociological. Schmale (1964) associates hopelessness with anxiety. He believes that if emotional needs are not gratified. The effects of helplessness, anger, and fear become differentiated from anxiety. If the emotional needs are met, goodness, pride, and hope are differentiated and emerge. If not effects of guilt,

shame, and hopelessness are differentiated. Melges et al., (1969) suggest that the antecedents and sources of hopelessness are associated with feelings of alienation from society.

Hopeless individuals believe their personal future is out of their control and others cannot be counted on. Scotland (1969) suggests that the major cause of hopelessness is the individual's inability or refusal to face actual hopelessness as it occurs in daily lives. He believes that part of the individual's refusal to accept reality comes form within and other aspects comes from external sources.

Social Interaction

The term social interaction generally refers to the extent to which individuals socially engage with others, typically outside of their family networks. The opposite of social interaction is social isolation. This tends to be common among people with disability. Disabling conditions may lead to a reduction in recreational activities, severance in community ties, and reduction in opportunities for socializing with friends and relatives. Hopelessness and negative self-esteem are likely to be associated with social withdrawal, resulting from the perceived futility, helplessness, and lack of confidence of social encounters. Limited social interactions with others are likely to foster diminishing social reinforcement, withdrawal, or lack of approach responses on the part of others and, in a reciprocal fashion, further social withdrawal (Coyne, 1976; Youngren & Lewinsohn, 1980).

Melges and Bowlby (1969) hold a more environmental/sociological perspective concerning the antecedents and sources of hopelessness. They believe it is associated

with feelings of alienation from society. When these individuals feel hopeless they believe their future is out of their control and they cannot count on others to help them. They tend to limit contact with friends and often turn down invitations they would have gladly accepted in their past. After a while the invitations quit coming because it is obvious to others they will not participate. Once they start alienating themselves, some depressed individuals find it hard to even leave their home to attend a funeral or birthday celebration of a close friend.

Research has found community attachment and higher levels of socialization to be inversely associated with negative mood states, including lower levels of depression, among residents of rural communities and lower anxiety scores among spouses of terminally ill individuals (O'Brien, Hassinger, & Dershem, 1994). Similarly, feelings of belonging and social activity mediated depression among people with a variety of chronic illnesses (Bloom et al., 1991).

The majority of the elderly do not associate with many individuals and the feelings of hopelessness tend to increase. Emotional support helps to ease the distress associated with alterations in lifestyle and self-image that accompany disability by offering self-validation and reassurance (Morgan, 1989). Having someone to confide in appears to be the most powerful measure of social support. After a spouse dies if the widow does not have good social support she may experience feelings of depression and hopelessness. Not only is the spouse gone, but also her life has changed drastically. If she does not try to fill the void of his absence she will more than likely start neglecting other areas of her life such as, personal cares, diet, and hygiene.

Home Care

Home care tends to be very personal. For the majority of clients all their personal cares and bathing are performed by their aid. All of a sudden, a new agency takes over and starts sending different workers every day. This can be extremely difficult for the elderly to accept. Many of the individuals who receive care have had the same nurse and aid for years. In many cases, the worker has become a close friend to the client. This may be the only interaction the client has received all week. Now that person is no longer coming. They feel a loss in losing their previous worker and feel vulnerable around new help. It is understandable that the anxiety level the individual is experiencing would increase with the new stressors placed on them.

The services are provided based on need and severity. Services received can range from four hours a week (primarily help with house hold chores) to care twenty-four hours a day. Only a few clients receiving home care services qualify for twenty-four hour care. These are extreme cases where the individual is dependent on the caregiver for all their needs. Generally clients who are elderly or disabled and require this degree of services reside in a nursing home or group home where they are given the care they need. It is cheaper for the county to pay a personal care worker than it is to house the clients in a nursing home. If the client is able to reside in their own home, and if they qualify for the services, home care is usually what they prefer.

Most disabled clients have been receiving some type of services on a continuous basis through out their life. They tend to receive more hours of services based on their need. Where as, an elderly or middle aged individual may receive home care while they

are recovering from an injury and need help for a short period of time, or they may have recently experienced a decline in health and can no-longer perform some of the daily tasks they use to. As their health deteriorates their home care services will increase to accommodate for their changing needs.

Many times the clients express feelings of despair and hopelessness. By this time they are in a rut and do not want to or simply can't see the benefits of change. Many of them get to the point where they don't care if they bath or eat. When it reaches this extreme there is a problem and they should get help. Unfortunately, home care cannot take the place of counseling or provide services to address these issues.

In many cases immediate family members have moved away. They may go years with out seeing each other. This tends to be especially true in small towns. The homes many of them are living in are very old and run down. The limited income they are living on is not enough to cover home repairs so many have missing tiles in the floor or leaking ceilings. Not to mention the shape of furniture and appliances. Just to live in that environment would be depressing for me. Now imagine what a widow goes through when her spouse passes away and she now has to adapt alone.

Grief following the death of a loved one is an important risk factor for both major and minor depression. At least 10-20 percent of widows develop clinically significant depression during the first year of bereavement. With out treatment, such depression tends to persist, becoming chronic and leading to further disability and impairments in general health (Zisook & Shuchter, 1993).

McLaughlin and Miller (1996) point out that hopelessness has also been shown to affect motivation and the pursuit of a better life. People often give up in situations that continue to get worst. Studies show that hopelessness scores are correlated with weaker motivation scores (Shiomi, 1995). When negative situations are experienced it tends to send a depressed individual into a down ward cycle. What was bad keeps getting worse and now they cannot see beyond the despair and become victims to feelings of hopelessness.

By the time agencies come into their home to and provide services help assist them, the majority show signs of depression and hopelessness. Clients let the providers help them but lack self motivation. It is a challenge for some to even get out of bed. The whole time they may complain about their aches and pains and want to return to bed after they eat. It is obvious they are depressed and are not enjoying life. It is not good for this type of individual to be alone. They would be much better off in a nursing home or managed care so they can associate with others on a daily basis. Not only does associating with others give them something to do, it encourages positive feelings of self worth. They now have a friend who is counting on them to go for a walk together or play cards before dinner.

The clients who reside in a managed care setting are surrounded by a completely different type of atmosphere than those living alone. Clients there can visit each other but also have their own space. The opportunity is there to socialize and attend weekly events. There are always groups of people sitting in the lounge or outside on the patio visiting. Their attitude and outlook on life is completely different then the majority of

clients living alone. They tend to be more positive and it is easier to motivate them. They enjoy outings and want to get involved in community events because they are use to being active and social. That seems to be the main difference between these individuals. If they live alone they tend to be more passive and to them selves. When too much time has gone by this way they tend to get depressed and the behaviors of hopelessness are noticeable if not verbalized.

Hopelessness and Mental Illness

Research within the adult population has focused on the importance of hopelessness as a key factor in a variety of psychopathological conditions (e.g., depression, suicide). Recent investigations have revealed that adults with high hopelessness scores were found to be at greater risk for depression, suicide, and overall psychopathology. A study by O' Connor, Connery, and Cheyne (2000) revealed there was a correlation between depression and hopelessness, and adults with a negative cognitive style. According to McKennedy (2000), Suicide thoughts and depression may be a precursor or a consequence of hopelessness. This psychopathological type of hopelessness is associated with psychiatric disorders such as depression, suicide ideation or sociopathic disorders (Beck et al., 1985).

Life time mental disorders are often detected in association with somatic illness (Reynolds & Kupfer, 1999). The prevalence of clinically significant depression in later life is estimated to be highest among those with chronic illness (approximately 25 percent). About 5% of individuals initially diagnosed as having Major Depressive Disorder subsequently are found to have another medical illness, which was the cause of

their depression. The relationship between somatic illness and mental disorders is likely to be reciprocal with biological and psychological factors contributing to the role.

Hopelessness is at the core of depression according to Beck's (1967) cognitive theory. The role of negative self-perceptions is emphasized in the development and maintenance of depressive symptoms. This distorted thinking holds an unrealistic, negative, and systematically biased view of self, experiences, and the future.

First of all, when an individual views themselves in a negative way they may feel inadequate, or unworthy and tends to attribute unpleasant experiences to a personal, physical, mental, or moral defect. According to Beck (1967) the individual regards him or herself as undesirable and worthless because of the presumed defect, and tends to reject oneself because of it.

Secondly, when the individual constructs experiences in a negative way, they tend to view personal interactions with the environment as representing defeat, deprivation, or disparagement. They view life as a succession of burdens, obstacles, or traumatic situations.

Finally, when the individual views the future in a negative way they anticipate that difficulties or suffering will continue indefinitely. Life appears to be full of hardship, frustration, and deprivation (Beck, 1967).

These cognitive distortions can lead to the symptoms that are characteristics of depression. For example, the individual interprets an experience as representing a personal defeat. They attribute this defeat to some personal defect, and regards oneself as worthless for having this trait. The individual blames him or herself for having acquired

the trait and dislikes him or herself for it. The individual regards the trait as an intrinsic part of oneself, and sees no hope of changing, and views the future as devoid of any satisfaction or filled with pain (Beck, 1967).

Depression in Older Adults

Depression in late life is a common but treatable illness. Less than 3% of people 65 years and older who live in the community have major depression. Up to 15% report clinically significant depressive symptoms. Prevalence rates of depression are higher in institutional settings: 10%-15% of elderly people in nursing homes or hospitals have major depression and another 20%-30% have significant depressed symptoms.

In elderly people, the consequences of untreated depression include suffering and despair, increased rates of death from medical illness and suicide, medical morbidity and utilization of medical services, exaggerated cognitive impairment, inappropriate institutionalization and care giver burden. The rate of suicide in the elderly population is higher than in the general population, and elderly men are at higher risk. Approximately 75% of elderly people visited a physician in the month before they committed suicide.

Depression causes distress and suffering in older adults and also leads to impairments in physical, mental, and social functioning. Depression often goes undiagnosed and untreated despite being associated with access morbidity and morality. The startling reality is that a substantial proportion of older patients receive no treatment or inadequate treatment for their depression in primary care settings, according to expert consensus (NIH Consensus Development Panel on Depression in Late Life, 1992). Many times it is hard to distinguish depression from other disorders that tend to affect older

people. Evidence that older people are less likely to report feelings of dysphoria (i.e., sadness, unhappiness, or irritability) than younger people suggests that the standard criteria from depression may be more difficult to apply to older adults (Williams, 1996).

Depression as a whole for all age groups is one of the most costly disorders in the United States. The direct and indirect costs of depression have been established at $43 billion each year, not including pain and suffering and diminished quality of life (Finkelstein et al., 1996). Late-life depression is particularly costly because of the excess disability it causes. Older primary care patients with depression visit the doctor and emergency room more often, use more medication, and incur higher outpatient charges.

There are two types of depression, full-fledged major depression, or depressive symptoms that represent "minor depression". Both major and minor depression is associated with significant disability in physical, social, and role functioning. Minor depression is associated with 51 percent more days lost from work than major depression due to its higher prevalence. Both are associated with high health care utilization and poor quality of life.

Minor Depression

Minor depression can be as disabling as major depression and is quite prevalent among older adults. Eight to twenty percent of older adults in the community and up to 37 percent in primary care settings suffer from depressive symptoms. Treatment is successful but it generally takes longer for older adults. The response rates are between 60-80 percent. The diagnosis of minor depression is not yet standardized; the research

criteria proposed in DSM-IV are the same, as those for major depression, but a diagnosis would require fewer symptoms and less impairment.

Major Depression

The term "major depression" refers to conditions with a major depressive episode, such as major depressive disorder, bipolar disorder, and other related conditions. The most common type of major depression in adults is major depressive disorder. It is characterized by one or more episodes that include the following symptoms: depressed mood, loss of interest or pleasure in activities, significant weight loss or gain, sleep disturbance, psychomotor agitation or retardation, fatigue, feelings of worthlessness, loss of concentration, and recurrent thoughts of death or suicide (DSM-IV). The nature and course of late-life depression can be largely affected by the coexistence of one or more other medical conditions.

Most older patients with symptoms of depression do not meet the full criteria for major depression. Both prevalence and incidence studies that rely on DSM-based diagnosis of major depression suggest a decline with age (Eaton et al., 1997), whereas symptom-based assessment studies show increased rates of depression among older adults, especially women (Hagnell et al., 1982)

Mood Symptoms

Major Depressive Disorder causes several different mood symptoms:

- Abnormal depressive mood: Sadness is a normal reaction to loss but among people with major Depressive Disorder sadness is abnormal because it causes functional impairment, persists continuously for at least 2 weeks, causes

disturbance in sleep, appetite, weight, energy, and psychomotor activity. It also causes disabling psychological symptoms (e.g., apathy, morbid preoccupation with worthlessness, suicide ideation, or psychotic symptoms). Many who are feeling this way complain of body aches and pains rather than admitting to their true feelings of sadness.

- Abnormal loss of interest and pleasure mood: The loss of interest and pleasure in this disorder is a reduced ability to experience pleasure. Their lack of motivation only encourages and adds to the displeasure.
- Abnormal irritable mood: Irritable depressed individuals often alienate their loved ones with their cranky mood and constant criticisms.

Physical Symptoms

Major Depressive Disorder causes the following physical symptoms:

- Abnormal appetite: Most depressed patients experience loss of appetite and weight loss. The opposite can also occur in a minority of depressed patients. They may turn to food as an escape and eat in excessiveness causing weight gain.
- Abnormal sleep: Most depressed individuals experience difficulty falling asleep, awake often during the night, or wake up very early in the morning. Again, the opposite can occur in the minority of depressed patients.
- Fatigue or loss of energy: Profound fatigue and lack of energy usually is very prominent and disabling.

- Agitation or slowing: Psychomotor retardation (an actual physical slowing of speech, movement and thinking) or psychomotor agitation (observable pacing and physical restlessness often are present in severe Major Depressive Disorder.

Cognitive Symptoms

Major Depressive Disorder causes the following cognitive symptoms:

- Abnormal self-reproach or inappropriate guilt: This disorder usually causes a marked lowering of self-esteem and self-confidence with increased thoughts of pessimism, hopelessness, and helplessness. In extreme, the person may feel excessively and unreasonably guilty.
- Abnormal poor concentration or indecisiveness: Poor concentration is an early sign of this disorder. A depressed person quickly becomes mentally fatigued when asked to read, study, or solve complicated problems. Many times individuals with this disorder become very forgetful, as it gets worse this can be mistaken for dementia.
- Abnormal morbid thoughts of death or suicide: The symptom most highly correlated with suicide behavior in depression is hopelessness.

The National Institute of Mental Health estimates that 75 percent of older Americans with depression are not receiving the proper treatment. As mentioned earlier, the elderly have the highest rate of suicides than any other age group. Elderly people who are lonely and isolated are at risk, particularly elderly white men who have the highest rate of suicide of any group. According to Dan Blazer (1989), men typically lack the support network most women have. Common triggers of late-life depression include losing the

ability to drive, moving, facing changing health, and coping with the unexpected deaths of children and grandchildren.

George Grossberg,M.D. chairman of the psychiatry department at Saint Louis University School of Medicine, says that individuals over the age of 75 are more likely to experience depression, particularly if they have recently lost a spouse or if they use alcohol. Depression can be successfully treated with antidepressants, psychotherapy and, in severe cases shock treatment. The most common prescribed drugs are Prozac and other selective serotonin reuptake inhibitors, which can be given in low doses and have fewer side effects for the elderly than other classes of drugs.

CHAPTER III

Methodology

Participants

This study was conducted January-March 2001 using participants receiving home care in the Western region of Wisconsin. Some of the participants live alone in their own home and others live in apartments or residential settings. Forty elderly or disabled individuals were asked to participate. After reviewing the questionnaire, 27 individuals successfully completed the self-report inventory. Ages of participants range from 40-80.

The participants living alone in their own homes appeared very hopeless about the future. I would recommend focusing on individuals with daily hours of services who live alone. I did not know ahead of time how many hours of services the individuals received because the agencies would not give me any information. It was a challenge to find participants on my own.

Instrumentation

To measure the level of hopelessness of the participants, the Beck Hopelessness Scale (BHS) was utilized (See Appendix A). This scale is a self-report instrument used to measure an individual's negative expectations regarding the future. It was developed in 1974 and revised and published during the years of 1978-1988 (Beck & Steer, 1993). This scale consists of 20 true-false items, and the total BHS score can range from 0-20. Nine of the items are keyed false, and eleven are keyed true with ones being assigned to negative expectations and zeros being assigned to positive expectations. The higher the

score, the more hopeless the respondent is thought to be; for example, 'My future seems dark to me' or 'Things just don't work out the way I want them to'. Despite it's clinical importance, for many years this measure remained virtually unchallenged (MacLeod et al., 1993). Researchers at the Center for Cognitive Therapy suggest the following guidelines for interpretation of the BHS scores: 0-3 as with in the normal range, 4-8 as mild hopelessness, 9-14 as moderate hopelessness, and greater than 14 as severe hopelessness (Beck & Steer, 1988). This scale is frequently used and its validity has been confirmed for elderly outpatients.

Studies of the factor structure of the BHS have identified 3 factors: (a) Feelings About the Future, (b) Loss of Motivation, (c) Future Expectations. A principal component analysis was also conducted with 120 depressed elderly outpatients (Hill et al., 1988). The three factors their study yielded were:

(a) Hopefulness About the Future,

(b) Giving Up,

(c) Future Anticipation.

The internal consistency reliability for the BHS is represented by Kuder-Richardson (KR-20) coefficients between .82 and .93 for seven different norm groups. The Pearson Product-moment correlation between the test-retest scores was reported at .69 ($p<.001$) after one week and .66 ($p<.001$) after six weeks (Beck & Steer, 1993).

Procedures

The individuals asked to participate were given an overview of the questionnaire and were informed that participation was strictly voluntary and their responses will be

confidential. The Beck Hopelessness Scale was administered to each individual by this author on a one to one basis, and the hours of services they received each week was documented.

Data Analysis

The data for this study was analyzed using Pearson's r correlation coefficient. Hopelessness scores were correlated against hours of services received to determine if any statistically significant relationship exists.

Limitations

Methodological limitations of this study are as follows:

1. The use of volunteers may not accurately represent all disabled and elderly individuals receiving home care.
2. The reading level of the instruments may have been difficult and not all questions may have been understood.
3. This author read the questionnaire to two of the individuals who were blind. This may have caused a difference in their responses and assessment procedures.
4. Because of the relatively small sample size the results of this study may be viewed as tentative.
5. The age difference between participants may affect their responses.

CHAPTER IV

Results, Discussion, and Recommendations

This chapter will present the results of this study, which investigated the correlation between hopelessness and hours of service received for each participant.

Results

The Null Hypothesis for this study was that there is no statistically significant correlation between hours of home-care services received, and level of hopelessness for clients with disabilities.

Data analysis rejects this null hypothesis. There is a positive correlation between hopelessness and hours of services received for clients with disabilities. The correlation coefficient was found to be .328, the statistical likelihood of this occurring by chance is .05 or less as seen in table 1.

Table I

Pearson's r Correlation Coefficient

		Home Care Services: Every 2 weeks	Total Score Beck Hopelessness Scale
Total Score Home-Care Services: Every two weeks	Pearson Correlation	1.000	.328
	Significant.	.095*	
	N	27	27
Total Score: Beck Hopelessness Scale	Pearson Correlation	.328	1.000
	Significant	.095*	.
	N	27	27

* Statistical Likelihood of occurring by chance is .05 or less

The research hypothesis for this study was that there would be a significant positive correlation between the hours of services disabled individuals receive per week and the degree of hopelessness they feel. Table 2 shows the frequency counts and percentages in items 1-20 from the Beck Hopelessness Scale for the total group of respondents. It breaks down the participants into four categories; minimal, mild, moderate, and severe ranging from high to low levels of hopelessness.

Seven participants scores were with-in the minimal range, nine of the participants scored in the mild range, seven scored in the moderate range, and four participants scores were in the severe range. This data is consistent with the research hypothesis of the study. There is a significant relationship between hopelessness scores and hours of services received.

Table II

Total Score: Beck Hopelessness Scale

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00 minimal range	1	3.7	3.7	3.7
2.00 minimal range	1	3.7	3.7	7.4
3.00 minimal range	5	18.5	18.5	25.9
4.00 mild range	2	7.4	7.4	33.3
5.00 mild range	3	11.1	11.1	44.4
8.00 mild range	4	14.8	14.8	59.3
9.00 mild range	1	3.7	3.7	63.0
10.00 moderate range	1	3.7	3.7	66.7
13.00 moderate range	2	7.4	7.4	74.1
14.00 moderate range	3	11.1	11.1	85.2
15.00 severe range	2	7.4	7.4	92.6
17.00 severe range	1	3.7	3.7	96.3
19.00 severe range	1	3.7	3.7	100.0
Total	27	100.0	100.0	

Table III

Beck Hopelessness Scale Total

This scale shows the total scoring for all 27 respondents and how many hours of care they receive in two weeks. The BHS scores are translated as: 0-3 as with in the normal range, 4-8 as mild hopelessness, 9-14 as moderate hopelessness, and greater than 14 as severe hopelessness.

ID	Hours of Care	Hopelessness Score
1	6.00	3.00
2	42.00	8.00
3	56.00 *	14.00 *
4	8.00	5.00
5	336.00	5.00
6	42.00	2.00
7	168.00 *	17.00 *
8	224.00 *	9.00 *
9	42.00 *	10.00 *
10	6.00	4.00
11	8.00	14.00
12	10.00	8.00
13	28.00 *	15.00 *
14	14.00	.00
15	42.00	8.00
16	336.00 *	19.00 *
17	10.00	3.00
18	8.00	3.00
19	16.00 *	13.00 *
20	24.00 *	15.00 *
21	8.00	4.00
22	6.00	5.00
23	6.00	3.00
24	28.00 *	14.00 *
25	4.00	8.00
26	12.00	3.00
27	1.5	13.00

* The majority of the clients receiving high levels of service also have high hopelessness scores.

Tables IV and V show the mean, median, and standard deviation of the hopelessness scores, and of hours of services every two weeks. The average score of 8 falls high in the mildly hopeless category. A score of 9 would be moderately hopeless just one category away from the severe range of hopelessness.

Twenty of the twenty-seven clients receiving hours of services scored higher than the normal range of hopelessness. Out of the seven clients who fell in the normal range of hopelessness five of them averaged only four hours of services each week. This clearly shows us that the individuals who are less hopeless require less service.

Table IV

Total Score: Beck Hopelessness Scale

N	Valid	27
	Missing	0
Mean		8.3333
Median		8.0000
Standard Deviation		5.3493

Table V

Total Home Care hours every 2 weeks

N	Valid	27
	Missing	0
Mean		55.2407
Median		14.0000
Standard Deviation		95.1417

Discussion

Hopelessness, defined as negative expectancies toward oneself and toward the future, may cause the elderly and disabled populations to become more depressed and socially withdrawn. The results of the data analysis indicate there is a statistically significant positive correlation between hopelessness and hours of services received. This is consistent with both the literature and the research hypothesis proposed earlier.

We do not know the chronological sequence of these two variables. Are the hours of care received driving hopelessness, or is the level of hopelessness driving the need for services? Alternatively, both situations may be caused by a third unknown factor. However, in recent studies depression was associated with increased health service utilization, independent of the severity of the medical illness.

According to recent studies, elderly men are at the greatest risk for suicide than any other age group. This fact alone should encourage family members and physicians to be more cautious and attentive when treating them. The literature stated that physicians are not being educated on the warning signs to look for when treating the elderly. As mentioned in the literature review, identifying elderly depressed patients who require anti-depressive treatment may be difficult because many of the symptoms of depression are symptoms of physical illness.

Recent investigations have revealed that adults with high hopelessness scores were found to be at greater risk for depression, suicide, and overall psychopathology. Despite the significant rates of morbidity and morality associated with depression, most

depressive illnesses go undetected, and therefore, untreated. We need to focus on the detection and treatment of hopelessness and depression in the elderly.

Now that we have rejected the null hypothesis and know there is a link between hours of services and hopelessness scores we need to develop beneficial program plans that will build hope in each client. Program directors could invest their time more productively by looking at hopelessness levels in their clients and spend more time developing a positive self-gratification plan for clients who feel so dependent on the system and hopeless. By focusing on hopeful things the client will become more future oriented and will gradually become less depressed. The workers themselves would need to follow the plan and not spend so much time playing games or in other social activities that are not encouraging the client to become more independent.

This would also reduce the number of home care hours needed to provide services for these clients. There will always be some clients who need more care than others but if we monitor the hours spent more effectively we can reduce home care cost by teaching the clients how to be more self reliant and instill in them hope for their future.

Recommendations

This study provides some useful data concerning the relationship between hopelessness and hours of services disabled and elderly individuals receive. There have not been many studies that combine the two and I suggest a need for further research in these areas. Additional knowledge could be found in a larger study with sample participants that receive similar hours each week. I would also suggest a closer age group. Older participants are going to answer these questions differently than a

participant 30 years younger. It was quite obvious to me that many of these individuals are extremely depressed.

I would also suggest finding an agency that would be willing to share some of this information. It would be very helpful to see ages of individuals and hours of services received to help you decide what areas you want to concentrate your study on. I tried to get some information from the non-profit agency in my area and was told that they could not give any private information out. I didn't have time to try to get permission from another source and wasn't told whom I could even contact. Luckily, I knew individuals receiving home care and went on my own searching for voluntary participants.

Appendix A

Beck's Hopelessness Scale

Please answer the following questions by placing a check in either the true or false column.

	True	False
1. I look forward to the future with hope and enthusiasm.		
2. I might as well give up because I can't make things better for myself.		
3. When things are going badly, I am helped by knowing they can't stay that way forever.		
4. I can't imagine what my life would be like in 10 years.		
5. I have enough time to accomplish the things I most want to do.		
6. In the future, I expect to succeed in what concerns me most.		
7. My future seems dark to me.		
8. I expect to get more of the good things in life than the average person.		
9. I just don't get the breaks and there's no reason to believe I will in the future.		
10. My past experiences have prepared me well for my future.		
11. All I can see ahead of me is unpleasantness rather than pleasantness.		
12. I don't expect to get what I really want.		
13. When I look ahead to the future, I expect I will be happier than I am now.		
14. Things just won't work out the way I want them to.		
15. I have great faith in the future.		
16. I never get what I want so it's foolish to want anything.		
17. It is very unlikely that I will get any real satisfaction in the future.		

18. The future seems vague and uncertain to me.		
19. I can look forward to more good times than bad times.		
20. There's no use in really trying to get something I want because I probably won't get it.		

(Source: Beck, Weissman, Lester, Trexler 1974)

I receive _____ hours of home care services every two weeks.

-or-

If you receive daily services how many hours each day? _____

Bibliography

Abramson, L.Y., Metalsky, G. I. & Alloy, L.B. (1989). Hopelessness depression: a theory-based subtype of depression. Psychological Review, 96, 358-372.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. 4th ed. Washington: The Association.

Beck, A.T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Harper and Row.

Beck, A.T. & Steer, R.A. (1993). Beck hopelessness manual. San Antonio: The Psychological Corporation.

Beck, A.T., Weissman, A., Lester, D., & Trexler,L. (1974). The measurement of pessimism: The hopelessness scale. Journal of Consulting and Clinical Psychology, 42, 861-865

Blazer, D. (1989). Depression in the elderly. New England Journal of Medicine, 320,164-170.

Bloom, J., & Spiegel, D. (1984). The relationship of two dimensions of social support to the psychological well being and social functioning of women with advanced breast cancer. Social Science and Medicine, 19, 381-387.

Bruce, M.L., Seeman, T.E., Merrill, S.S., & Blazer D.G. (1994). The impact of depressive symptomatology on physical disability: Mac Arthur studies on successful aging. American Journal of Public Health, 84, 1796-1799.

Coyne, J.C. (1976). Toward an interactional description of depression. Psychiatry, 39, 28-40.

Elliott, T.R. & Shewchuk, R.M. (1995). Social support and leisure activities following severe physical disability: Testing the mediating effects of depression. Basic and Applied Social Psychology, 16, 471-487

Farran, C.J., Herth, K.A.,& Popovich, J.M. (1995). Hope and hopelessness: Critical clinical constructs. Thousand Oaks, CA: Sage Publications, Inc.

Macleod, A.K., Pankhania, B., Lee, M. & Mitchell, D. (1997) Paracicide, depression, and the anticipation of positive and negative future experiences. Psychological Medicine, 27, 973-977

Macleod, A.K., Rose, G.S. & Williams, J.M.G. (1993). Components of hopelessness about the future in parasuicide. Cognitive Therapy and Research, 17, 441-455.

Mclaughlin, Jo-Ann, Miller, Peter, & Warwick, Hilary. (1996). Deliberate self harm in adolescents: hopelessness, depression, problems and problem solving. Journal of Adolescents, 19, 523-532.

Melges, F.T., Bowlby, J. (1969). Types of hopelessness in psychopathological process. Archives of General Psychiatry, 20, 690-699.

Mor, V., Allen, S., Siegel, K.,& Houts, P. (1992). Determinants of need and unmet need among cancer patients residing at home. Health Services Research, 27,337-360.

O'Brien, D. J. Hassinger, E.W. & Dershem, L. (1994). Community attachment and depression among residents in two rural Miswestern communities. Rural Sociology, 59, 255-265

O'Connor, R.C., Connery, H., Cheyne, W.M. (2000). Hopelessness: the role of depression, future directed thinking and cognitive vulnerability. Psychology, Health & Medicine, 5, 155-162.

Shiomi, Kunio. (1995).Correlations of hopelessness with motivation and personality traits among Japanese school children. Perceptional and Motor Skills, 717-718.

Stotland, E. (1969). The psychology of hope. San Francisco, CA: Jossey-Bass, Inc.

Williams, J.M.G. (1996) The psychological treatment of depression. London: Routledge.

Youngren, M.A., & Lewinsohn, P.M. (1980). The functional relationship between depression and problematic interpersonal behavior. Journal of Abnormal Psychology, 89, 333-341.