The Gerontologist
Vol. 37, No. 6, 709–716

The psychosocial model of mental health posits that late-life depression arises from the loss of self-esteem, loss of meaningful roles, loss of significant others, and diminished social contacts. This study examined the unique, combined, and interactive contribution of existential variables (personal meaning, choice/responsibleness, optimism) and traditional measures (social resources, physical health) as predictors of depression in institutionalized and community-residing older adults, average age 77.8 years. Using multiple hierarchical regression, the results showed that choice/responsibleness, social resources, and physical health predicted depression in community elderly; personal meaning, optimism, social resources, and physical health predicted depression in institutionalized elderly. In both samples, the existential variables accounted for unique variance in depression over and above that accounted for by traditional measures. The important role of existential constructs in transcending personal and social losses and feelings of depression are discussed.

Key Words: Choice, Optimism, Personal meaning, Physical health, Predictors of depression, Social resources

Personal Meaning, Optimism, and Choice: Existential Predictors of Depression in Community and Institutional Elderly

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Late-life depression is one of the most common mental health problems in adults aged 60 or older (Blazer, Hughes, & George, 1987). Prevalence estimates of depression range widely. Among community-residing elderly, the prevalence of depressive symptoms has ranged from 11% to 44%, with an average of about 20% (Blazer, 1982). Rates of depression among institutionalized elderly surpass those in the community, reaching close to 43% for major (12.4%) and minor (30.5%) depression combined (Parmalee, Katz, & Lawton, 1989).

In terms of antecedent conditions, late-life depression has been shown to be influenced by genetic, situational, illness-related biological, and psychosocial factors. However, relative to early-onset depression, late-life depression is less influenced by genetics and more influenced by environmental events. Indeed, the psychosocial model of mental health posits that late-life depression arises from the loss of self-esteem (helplessness, powerlessness, alienation), loss of meaningful roles (work productivity), loss of significant others, declining social contacts owing to health limitations and reduced functional status, dwindling financial resources, and a decreasing range of coping options.

In an attempt to understand the factors involved in the development of depression, traditional researchers have adopted a stress/coping paradigm (SCP). In a stress/coping paradigm, focus is on stressors (negative and positive), resource variables, cognitive appraisals, adaptive coping, and potential outcomes as antecedents to depression. Within the SCP paradigm, late-life depression has been consistently linked to major and minor chronic health problems (Murphy, 1983), life changes and stressful life events (Pearlin, Menaghan, Lieberman, & Mullen, 1981), chronic financial strain (Krause, 1987), and a lack of social support relationships, in terms of both quantitative (e.g., size of social network) and qualitative (e.g., availability of a confidant) aspects of social resources (Holahan & Holahan, 1987; Krause, 1987; Landreville & Cappeliez, 1992). Interestingly, studies have also shown that the giving of social support to others is inversely related to late-life depression (Koenig, 1986; Krause, 1987).

Although much has been learned about the determinants and predictors of depression within an SCP paradigm, the uniqueness of the human *experience*, as expressed phenomenologically, has not been given much consideration. Humans are not merely biological, social, or psychological beings, but beings who are able to rise above these dimensions to achieve a higher level of existential awareness. Human experiences touch on existential issues of human suffering, values, moral decisions (taking responsibility), meaning and purpose in life, transcendence, and transformation (see Farran, 1997). Such

[1]This work was supported by a Population Aging Grant from the Social Sciences and Humanities Research Council of Canada. The work was begun by Paul T. P. Wong and Gary T. Reker and continued by Gary T. Reker under grants from the Trent University Research Fund. Address correspondence to Gary T. Reker, PhD, Department of Psychology, Trent University, Peterborough, Ontario K9J 7B8, Canada. E-mail: greker@trentu.ca

This paper is dedicated to the memory of Viktor E. Frankl, 1905–1997.

concerns can be captured within an existential paradigm (EP). The existential paradigm identifies themes that relate to human conflicts or "ultimate concerns" with the givens of existence, such as death, freedom, isolation, and meaninglessness (Yalom, 1980). The emphasis is on the capacity of humans to choose, to be responsible for their choices, to hope, to transcend, and to find meaning in adversity (Frankl, 1963; Yalom, 1980). As applied to mental health, our understanding of late-life depression may be more enriched and enhanced in a context that also takes into account the existential needs or life concerns of the respondents.

Reker, Peacock, and Wong (1987) have proposed that the existential constructs of personal meaning and personal choice/responsibleness have value in understanding adaptation to physical and mental health problems in older adults. Personal meaning is defined as having a purpose in life, having a sense of direction, a sense of order and a reason for existence, a clear sense of personal identity, and a greater social consciousness. Personal choice/responsibleness refers to the degree to which a person perceives having personal agency and takes responsibility in directing his or her life. Personal meaning and personal choice/responsibleness have been shown to be related to a number of measures of psychological, physical, and mental well-being, and are a major source for bolstering self-esteem, life satisfaction, and personal growth in the face of disability and losses that often accompany advancing age (Reker, 1994; Reker & Butler, 1990; Reker et al., 1987; Zika & Chamberlain, 1992).

Optimism reflects the human capacity to transcend temporal boundaries, to anticipate a positive future, to hope. Optimism is defined as looking forward to many desirable events and being very confident that these will take place. A number of studies have examined the relationship between optimism and physical and mental health. Scheier and Carver (1985) found that individuals with high levels of dispositional optimism were less likely to complain of physical symptoms. High levels of optimism were also found to lead to more successful treatment outcome for cancer, heart disease, and general surgery (Scheier & Carver, 1992). With regard to mental health, dispositional optimism was found to contribute to lower levels of postpartum depression in women (Carver & Gaines, 1987). In a series of studies of community and institutionalized older adults, Reker and Wong (1985) found that short-term and self-initiated optimism was positively related to perceived physical and psychological well-being and inversely related to depression. Moreover, optimism predicted well-being and happiness over a two-month period even when initial well-being scores were controlled. Thus optimism, as a positive interpretational construct, appears to be an important variable in understanding mental health, particularly the cognitive facet of depression.

Many of the losses that accompany the aging process are brought on by factors external to the older adult over which he or she has little or no control, resulting in less than optimal adaptation. However, one's sense of meaning, choice/responsibleness, and optimism are personal resources that are not only under individual control but also readily available to the individual, independent of life's circumstances. Indeed, Frankl (1963) has argued that although individuals are not free of external conditions, they remain free to take a stance, to adopt their own attitude toward those conditions, even in the face of horrendous atrocities. Thus, it makes sense that a person who perceives life as meaningful, who has a clear sense of personal choice and responsibility, and who has a positive outlook on life will be less vulnerable to depression.

Institutionalization, as a nonscheduled life transition, is often implicated in the genesis of late-life depression (Pearlin et al., 1981). Depression is augmented by the coexistence of chronic illnesses, which serve to further erode positive concepts of the self. Being institutionalized and having suffered physical, personal, and social losses may leave the institutionalized older adult more vulnerable to depression compared to community-residing counterparts. Remaining intact, however, is the potential to find meaning in suffering, to make responsible choices, and to make the best of the situation. Thus, a sense of meaningfulness, personal choice, and optimism might be expected to play an even greater role in the maintenance of self-esteem and the alleviation of depression in the institutionalized elderly.

The primary purpose of this study is to examine the unique and combined contribution of three existential constructs (personal meaning, choice/responsibleness, and optimism) and two traditional measures (social resources and physical health) in predicting depression in institutionalized and community-residing older adults. In addition, the contribution of demographics and the existential variables × physical health interactions to the prediction of depression will also be examined.

Method

Subjects

Subjects consisted of 99 community-residing and 87 institutionalized adults, aged 65 to 94 years. Participants lived in a mid-sized city in eastern Ontario, population 67,000. The community-residing elderly were recruited through local newspaper advertisements, posters, and by word of mouth. Institutionalized elderly were recruited with the cooperation of the administrators of several institutions, largely through internal poster advertisements and personal contacts. The sociodemographic characteristics of both elderly samples are presented in Table 1.

Measures

Depression. — Depression was measured by the Zung Self-Rating Depression Scale (SDS: Zung, 1965). The ZUNG is a 20-item scale covering somatic, psy-

chological, psychomotor, and mood areas. Ratings are on a 4-point scale (1 = none or little of the time, 4 = most or all of the time). Scores can range from 20 to 80. For the present study, alpha coefficients of .77 and .81 were found for the community and institution elderly, respectively.

Personal Meaning. — Personal meaning was measured by a composite index of the Life Purpose (life goals, mission in life, sense of direction), Will to Meaning (sense of order, reason for existence, clear sense of identity), and Future Meaning (future potentialities, fulfilment, positive expectations concerning one's future life) subscales of the Life Attitude Profile (LAP: Reker & Peacock, 1981). Scores for each subscale (7-point) are expressed as a mean and summed across subscales. Scores can range from 3 to 21. Alpha coefficients for the community and institution elderly were found to be .83 and .81, respectively.

Choice/Responsibleness. — Choice/Responsibleness was measured by the Life Control (LC) subscale of the Life Attitude Profile (LAP: Reker & Peacock, 1981). LC is a six-item, 7-point measure of freedom to make all life choices, exercise of personal responsibility, and perception of internal control of life events. Scores are expressed as a mean and can range from 1 to 7. Alpha coefficients for the community and institution samples were found to be .75 and .70, respectively.

Table 1. Sociodemographic Characteristics of the Elderly Samples

	Community (N = 99)		Institution (N = 87)	
Variables	N	%	N	%
Age				
90–94	0	0	13	15
85–89	5	5	16	18
80–84	13	13	23	26
75–79	26	26	22	25
70–74	24	24	10	11
65–69	31	31	3	4
Sex				
Male	34	34	28	32
Female	65	66	59	68
Marital status				
Single	4	4	13	15
Married	41	41	4	5
Widowed	51	52	69	79
Divorced	3	3	1	1
Education				
Grade eight	23	23	45	45
Part high school	27	28	13	15
High school diploma	9	9	9	10
Part university	26	26	16	18
University graduate	11	11	4	5
Post graduate	3	3	0	0
Family income				
$3,000–$7,000	13	13	18	18
$7,001–$11,000	32	32	17	19
$11,001–$15,000	17	17	20	23
$15,001–$19,000	8	8	4	5
$19,001+	29	29	28	32

Optimism. — Optimism was measured by the Future Orientation Survey (FOS: Reker & Wong, 1985). The FOS is an open-ended measure of the number of desirable events looked forward to and the degree of confidence (5-point scale) that these events will take place. Subjects can list up to 12 items. Scores can range from 0 to 60. Twelve-month test-retest reliability among a combined sample of community-residing and institutionalized elderly was reported to be .72 (Reker & Wong, 1985).

Social Resources. — Social resources was measured by a subset of eight questions from the OARS Manual (OARS: Duke University Center, 1978) that asks about the extent of the friendship network, frequency of contact with family and relatives, availability of help when sick or disabled, quality of social relationships, and feelings of loneliness. Scoring varies by item from 2 to 4 scale points. Scores are averaged and can range from 1 to 3.25. A high score reflects high availability of social resources. Coefficient alpha was .56 for the community sample and .65 for the institutionalized elderly.

Physical Health. — Physical health was measured by a 26-item physical health checklist of illnesses (OARS: Duke University Center, 1978) most commonly encountered by the elderly. Subjects respond yes or no to the question: "Do you have any of the following illnesses at the present time?" A high score reflects a large number of physical health problems.

Procedure

In addition to providing demographic information, subjects were asked to complete a large number of psychosocial measures that were part of a larger study on successful aging. Most of the measures were completed by participants at their leisure; some measures required one-on-one administration. For a small number of the institutionalized elderly, a research assistant administered all of the measures in a one-on-one context. This study reports on a subset of six of the psychosocial measures investigated.

Results

Means and standard deviations on the six psychosocial variables for community and institutionalized elderly are presented in Table 2. The institutionalized elderly were found to be significantly more depressed, had a lower sense of personal meaning, perceived less choice/responsibleness, were less optimistic, had fewer meaningful social contacts, and were in poorer physical health.

The bivariate correlations of depression with demographic data and the predictor variables for community and institution elderly are presented in Table 3. For community elderly, none of the demographic variables were significantly related to depression; for institution elderly, females were significantly more depressed compared to males.

Table 2. Means, Standard Deviations, and *t* Values of Depression and the Predictor Variables for Community and Institution Elderly

	Community ($N = 99$)		Institution ($N = 87$)		
Variables	Mean	*SD*	Mean	*SD*	*t* Value
Depression	32.2	8.1	38.3	9.4	–4.72***
Personal meaning	15.1	2.2	14.1	2.4	2.83**
Choice/responsibleness	5.3	1.1	4.7	1.1	3.69***
Optimism	22.6	12.5	13.1	8.8	6.11***
Social resources	2.8	0.3	2.3	0.4	8.72***
Physical health	3.6	2.2	4.6	2.5	–2.79**

*$p < .05$; **$p < .01$; ***$p < .001$.

Table 3. Bivariate Correlations of Depression with Demographics and Predictor Variables

	Depression	
Measures	Community ($N = 99$)	Institution ($N = 87$)
Demographics		
Age	–.04	.06
Gender (F = 1, M = 2)	–.05	–.23*
Marital status (S = 1, M = 2)	–.10	–.15
Education	.06	.12
Income	–.01	.10
Predictors		
Personal meaning	–.37***	–.52***
Choice/responsibleness	–.22*	–.35***
Optimism	–.14	–.26**
Social resources	–.40***	–.44***
Physical health	.29**	.40***

*$p < .05$; **$p < .01$; ***$p < .001$.

With the exception of optimism in the community elderly, all of the psychosocial variables were significantly related to depression. The overall pattern of associations, however, was noticeably stronger for the institutionalized older adults.

As a test for possible multicollinearity, the intercorrelations among the predictor variables were calculated. For community elderly, the intercorrelations ranged from –.18 to .37, median = .09; for institution elderly, the correlations ranged from –.17 to .53, median = .12. Thus, multicollinearity does not appear to be a concern in this study.

In order to test for the unique, combined, and interactive contribution of the existential variables, a four-step multiple hierarchical regression analysis was performed on the data for the community, institution, and the combined samples. In step 1, the demographic variables were entered as a block, followed by the two traditional measures in step 2. The three existential variables were entered in step 3, followed by their respective interactions with physical health in step 4. The order of entry of the blocks was based on methodological, historical, and theoretical considerations. The demographics were entered first as a control for those variables, followed by the two traditional measures investigated in prior studies. The entry of the existential variables in third place should provide a more stringent test of their unique contribution to depression over and above that of the demographics and traditional measures. Finally, on the premise that the existential variables might be most important when the elderly are faced with poor health, the existential variables × physical health interactions were entered in step 4. In this regression model, the R^2 change reveals information on the variance in depression explained by each block. Within each block, the standardized regression weights provide information on the relative contribution of individual variables. Results are presented in Table 4.

For community elderly, the demographics failed to account for significant variance in depression, and none of the individual variables made a unique contribution. The traditional measures, when entered together, accounted for a sizeable, significant increase in explained variance (24%). Both social resources (beta = –.40, $p < .001$) and physical health (beta = .28, $p < .01$) made significant and unique contributions to the prediction of depression. With demographic and traditional variables controlled, the existential variables made a significant and unique contribution (9%) to the explained variance in depression. Choice/responsibleness emerged as the most salient predictor (beta = –.21, $p < .05$). The existential variables by health interactions failed to account for additional significant variance in depression.

For the institution elderly, the demographic variables accounted for only 9% of the variance in depression, a nonsignificant contribution. Gender, however, contributed significantly to the prediction of depression (beta = –.21, $p < .05$). Being an institutionalized female predicted greater depression. The addition of the traditional measures in step 2 resulted in a large, significant increase in the variance explained (28%). Social resources (beta = –.43, $p < .001$) contributed most to the prediction of depression, while physical health (beta = .29, $p < .01$) made a smaller yet significant contribution. After controlling for demographics and the traditional measures, the existential variables made a sizable, significant contribution, accounting for 15% of the variance in depression. Personal meaning emerged as the most potent predictor (beta = –.41, $p < .001$), but optimism also made a significant contribution (beta = –.16, $p < .05$). Choice/responsibleness, however, did not account for additional variance once personal meaning and optimism had been taken into account. The existential variables by health interactions failed to account for additional significant variance.

For the combined samples, the demographics, the traditional measures, and the existential variables all contributed significantly to the prediction of depression; the existential variables by health interactions did not. With all other demographic variables controlled, only marital status made a unique contribution (beta = –.19, $p < .05$). Being single predicted greater depression. Among the traditional measures, both social resources (beta = –.49, $p < .001$) and physical health (beta = .28, $p < .001$) made significant and

Table 4. Hierarchical Regression Analysis of Depression, Entering Demographics, Traditional Measures, Existential Variables, and Existential by Health Interactions

Variables Entered	Beta	F	Multiple R	R^2	R^2 Change	F Change
		Community (N = 99)				
Step 1. Demographics			.14	.02	.02	<1.00
Age	–.07	<1.00				
Gender	.01	<1.00				
Education	.05	<1.00				
Marital status	–.14	<1.00				
Income	.01	<1.00				
Step 2. Traditional			.50	.25	.24	14.43***
Social resources	–.40	17.58***				
Physical health	.28	8.70**				
Step 3. Existential			.59	.34	.09	3.96**
Meaning	–.17	2.68				
Choice	–.21	4.44*				
Optimism	–.07	<1.00				
Step 4. Interactions			.60	.36	.01	<1.00
Meaning × Health	.59	<1.00				
Choice × Health	–.39	<1.00				
Optimism × Health	–.30	<1.00				
		Institution (N = 87)				
Step 1. Demographics			.31	.09	.09	1.67
Age	.00	<1.00				
Gender	–.21	3.71*				
Education	.09	<1.00				
Marital status	–.15	2.00				
Income	.10	<1.00				
Step 2. Traditional			.61	.37	.28	18.00***
Social resources	–.43	21.35***				
Physical health	.29	8.94**				
Step 3. Existential			.72	.53	.15	7.85***
Meaning	–.41	15.38***				
Choice	.01	<1.00				
Optimism	–.16	3.70*				
Step 4. Interactions			.74	.55	.02	<1.00
Meaning × Health	–1.23	2.34				
Choice × Health	1.03	2.60				
Optimism × Health	.28	1.39				
		Community and Institution (N = 186)				
Step 1. Demographics			.28	.08	.08	3.09**
Age	.11	1.80				
Gender	–.08	<1.00				
Education	.03	<1.00				
Marital status	–.19	4.72*				
Income	.11	2.02				
Step 2. Traditional			.61	.38	.30	42.70***
Social resources	–.49	52.82***				
Physical health	.28	21.23***				
Step 3. Existential			.68	.46	.08	8.96***
Meaning	–.24	11.63***				
Choice	–.11	3.05				
Optimism	–.09	1.93				
Step 4. Interactions			.68	.46	.00	<1.00
Meaning × Health	–.04	<1.00				
Choice × Health	.12	<1.00				
Optimism × Health	–.10	<1.00				

*p < .05; **p < .01; ***p < .001.

Table 5. Factor Loadings and Structure of Psychosocial Variables

Psychosocial Variables	Factors I	II	III	IV
Happiness (Munsh)	.81			
General Severity Index (BSI)	–.76			
Psychological Well-Being	.76			
Depression (Zung SDS)	–.72			
Commitment		.82		
Optimism (FOS)		.79		
Activity: work and recreation		.69		
Social resources	.45	.59		
Religious practice		.48		
Physical health			.85	
Physical well-being	.44		–.74	
Choice/responsibleness				.85
Personal meaning				.79
Percent variance	37.8	13.6	9.1	8.2

Note: Only factor loadings equal to or exceeding .40 are cited.

unique contributions to the prediction of depression. Among the existential variables, personal meaning (beta = –.24, $p < .001$) was the most potent predictor, but choice/responsibleness also contributed (beta = –.11, $p < .08$).

It is possible that personal meaning and depression occupy opposite poles of the same unidimensional construct and that the potency with which personal meaning predicts depression may be largely due to construct overlap. As a test of this possibility, a secondary analysis was conducted to differentiate the construct of depression from personal meaning and the remaining existential variables. The data available for the combined sample on 13 psychosocial variables were subjected to a principal components analysis with varimax rotation to simple structure. If depression, personal meaning, choice/responsibleness, and optimism are overlapping constructs, then all should load on the same factor. The results are presented in Table 5. Four interpretable factors emerged. It is clear that depression loads on an "affect" factor, optimism and social resources load on an "active involvement" factor, physical health loads on a "health" factor, and personal meaning and choice/responsibleness load on a separate "existential meaning" factor.

Discussion

The results of this study demonstrate the importance of personal meaning, choice, and optimism in the prediction of depression in community and institutional older adults. Of note is the fact that personal meaning, choice/responsibleness, and optimism account for additional reliable and unique variance in depression once the demographic and traditional measures are taken into account. While studies have consistently identified lack of social support and poor physical health as predictors of depression, the present results, with measures tapping existential constructs, have replicated and extended previous studies demonstrating a strong link between having a sense of meaning and purpose in life and positive mental functioning in the elderly (Reker, 1994; Reker & Butler, 1990; Reker et al., 1987; Zika & Chamberlain, 1987, 1992).

Of particular interest is the way in which the existential variables make differential predictions for community and institutional elderly. For community elderly, the freedom to choose and being responsible for those choices is the most salient existential predictor of the absence of depression; for institutional elderly, having a purpose, a sense of order, a reason for existence, and an optimistic outlook predict the absence of depression. The freedom to choose does not appear to play a major role in the alleviation of depression among the institutionalized elderly, most probably because, in an institutional environment, the opportunity to make choices may be very limited.

The expectation that the existential variables would play an even greater role when the elderly are faced with difficult life conditions, such as poor health, was not supported in this study. Previous studies of the elderly have shown that personal meaning moderates or buffers the impact of stressful life events and everyday hassles on their physical health and psychological well-being (Reker, 1994; Reker & Butler, 1990). It may be that physical health was not stressful enough to have an effect, given that only four or five physical symptoms on average (out of a possible 26) were endorsed. Future studies should examine the interactive effects of more traumatic life stressors and existential variables on depressive symptomatology.

The findings pertaining to the existential constructs of personal meaning, choice, and optimism are important for at least two reasons. First, they highlight the need to pay greater attention to the existential concerns of older adults. The present study clearly shows that existential variables account for significant variance in the prediction and alleviation of late-life depression over and above that accounted for by traditional measures. The results of studies investigating related constructs support this position. For example, Koenig (1988) found religious beliefs and attitudes to play a major role in coping with depression among physically disabled and relatively healthy older veterans. Cataldo (1994) noted the importance of healthy attitudes toward death in the alleviation of depression in institutionalized older adults. Second, the findings clearly support the position that the stress/coping and existential paradigms can broaden our understanding and appreciation of the experience of feelings of depression in older adults (Farran, 1997; Reker & Wong, 1988). When both paradigms are considered jointly and in complementary fashion, externally imposed negative and internally generated positive aspects of the human condition can be examined in a much broader and more inclusive context.

The findings of poorer adjustment of the institutional elderly on all psychosocial variables investi-

gated in this study are consistent with the literature. However, the question of whether these findings reflect the effects of an institutional environment or are a consequence of self-selection due to physical decline and multiple losses cannot be answered here. In either case, it is apparent that whereas institutionalized elderly suffer from greater depressive affect, the constructs of personal meaning and optimism can be seen for them to be an even stronger predictor of depression compared to their community-residing counterparts.

The demographic variables investigated in this study accounted for very little variance in depression (only 2% to 9% of the variance). These findings are consistent with the literature reporting on samples of community-residing older adults (Krause, 1987), bereaved and nonbereaved older adults (Feinson, 1987), and community-residing African Americans (Brown, Milburn, & Gary, 1992).

One strength of study is the demonstration that the variables identified as predictors of depression are not simply alternate measures of depressive symptomatology. Construct overlap is a serious methodological problem that, unfortunately, is not always explicitly addressed. It is particularly problematic when the construct under investigation is multifaceted, as is the case with late-life depression. It is clear from the factor analytic results that construct overlap did not pose a threat to the validity of the present study.

This study has added to our understanding of late-life depression by incorporating variables that also address the existential concerns of the elderly, particularly those elderly living in institutions, who are more likely to suffer from severe physical declines and multiple losses. The focus on existential constructs provides an explanation as to why many older adults resist depression in the face of difficult life circumstances. In her work with institutionalized elderly in a long-term care facility, Cataldo (1994) found that a healthy attitude toward death, in which death is perceived as a challenge and not as a threat, led to decreased vulnerability to depression. In her work with the chronically ill, Lukas (1992) has found that meaning in life can give rise to inner calm and composure and to the perception that life is unconditionally worth living.

The results of this study have implications for the treatment of depression, especially for the elderly residing in long-term care facilities. Given the importance of personal meaning as an existential predictor, the methods and techniques of logotherapy seem particularly relevant. The goal of logotherapy is to stimulate the will to meaning utilizing the techniques of dereflection, paradoxical intention, and attitude modification (see Lukas, 1984). According to Eisenberg (1982), logotherapy "restores health and hope by making people aware of the formidable power inherent in them, to stop feeling victimized, and take control of their lives." Although these techniques appear promising, more studies are needed to support their effectiveness in the treatment of depression (see Guttmann, 1996).

In conclusion, the findings of the present study suggest that a sense of personal meaning, choice, and optimism, coupled with meaningful social contacts, and adequate physical health offer promising ways of transcending personal and social losses, and feelings of depression in old age. It is hoped that the present results will encourage further research with greater emphasis on the positive human experiences, as assessed phenomenologically, and their impact on the mental well-being of older adults.

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Received July 17, 1996
Accepted June 26, 1997