Psychological distress and depression in urbanising elderly black persons

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Summary

The findings of a comparative community survey of the socio-economic, cultural and psychiatric state of elderly black persons in a newly settled township (Khayelitsha — 170 persons) and a long established one (Langa — 195 persons) revealed marked differences. Symptoms of psychological distress, depression and limitation of daily activities were generally more marked in the former and strikingly so among women: 66% had symptoms warranting further investigation and 44% would have been treated for a depressive disorder if seen by a psychiatrist. Extreme poverty existed in both townships but the Khayelitsha subjects were less well educated, their accommodation was poorer, and fewer had old-age pensions. Elderly black women in newly settled townships have therefore been identified as having high priority for psychiatric and social services.

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There has been a large influx of elderly black persons into urban areas in South Africa in recent years as a result of the lifting of political restrictions and a deteriorating social and economic situation in rural districts. This investigation set out to assess the problems and needs of such persons living in the Greater Cape Town area, as well as the possible effects of migration and acculturation. For this purpose a comparison was made between elderly subjects living in Langa, a long established suburban township where 85% of the subjects studied had lived for more than 10 years, and those living in Khayelitsha, a newly settled area established 5 years ago. Both groups had their origins in Ciskei and Transkei and were Xhosa speaking.

Information was gathered covering a broad range of psychosocial factors, psychiatric and cognitive status, socio-economic problems, physical health, activities of daily living, and services used and required. The Comprehensive Assessment and Referral Evaluation questionnaire (Short CARE version) was used, which is a well-validated and reliable semi-structured interview schedule for the assessment of the elderly.[1-3] This is particularly useful in assessing the prevalence and severity of dementia and depression. Several items, which screened specifically for other psychiatric entities, were added, including psychotic manifestations, such as paranoid fears, delusions, depersonalisation and alcoholism. Because educational and cultural factors affect the determination of dementia, the items which concern cognitive fall-off were excluded.

For the purpose of the present study, all questions were translated into Xhosa, and then translated back by a second group of interpreters and finally tried out in a pilot study to ensure that the intent of questions was clear to the subjects.

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Particular attention was given to items that might be influenced by illiteracy or cultural factors. Where necessary certain modifications of items were made in order to meet unique local conditions. Additional questions relevant to cultural factors, demographic details and service facilities were added.

Subjects and methods

A random cluster technique based on detailed ground plans of both areas was used, each cluster consisting of 20 residential plots. Investigating teams visited each house in these clusters and interviewed all persons over 60 years of age. As several families were sometimes living on a single plot the family registered as having occupation was taken as household No. 1, and other families as households 2, 3, and so on. In all, 365 respondents aged 60 years and over were interviewed, consisting of 200 women (101 in Langa and 99 in Khayelitsha) and 165 men (94 in Langa and 71 in Khayelitsha).

Four teams of experienced interviewers were used, each consisting of a psychiatric community nurse and an interpreter who was Xhosa-speaking, and both were trained in the administration of the Short CARE. An acceptable level of inter-rater reliability was achieved ($r = 0,94$).

Khayelitsha was in some respects a disorganised community at the time of the survey (1989 - 1990) with different factions competing for control but satisfactory co-operation was obtained with the assistance of the leaders of the community. In general, the respondents were interested and willing to talk about themselves and their situations.

The interviewers were clearly identified as nurses attached to local hospitals, which are well known and respected by the people in the community, and collateral information was obtained from family members wherever possible. However, when subjective feelings or personal attitudes were being enquired about, only the old person's responses were taken into account. The interviews were usually completed in one session lasting 1 - 3 hours. On occasion it was necessary to return because the respondent was absent or because he or she had become fatigued during the interview.

Certain difficulties with regard to language and understanding had been anticipated, since many of the respondents were illiterate (32%) or had a minimum of schooling (70% had less than 6 years of education). However, the intensive training and extensive experience of the interviewers and indigenous interpreters, all of whom were familiar with the culture and mores of the respondents, assured relevant and accurate responses. Where there was uncertainty about meaning, either on the part of the interviewer or the respondent, difficulties were discussed by the team and resolved.

The Short CARE consists of six indicator scales (homogeneous scales) that assess depression, organic brain syndrome (dementia), subjective memory impairment, sleep disorder, somatic symptoms, and activity limitation. These scales were constructed from items regarded as a priority by clinical judgement to be relevant to the abovementioned manifestations, and which have been shown by statistical analysis to reliably discriminate problematic from non-problematic conditions.[1] Cut-off scores serve as screening devices to identify areas that warrant further investigation. It should be noted, however,

that a score above the cut-off level does not necessarily indicate a problem of clinical severity, i.e. one requiring intervention. In essence, these scales differentiate between a possibility that certain dysfunctional states may exist or that there is no indication of these.[3] The Short CARE also identifies more severe depression by means of 18 items, some of which also form part of the homogenous scale. This has been shown to have validity when compared with clinical judgements.[3]

Results

The mean age of the sample population was 68,7 years, that of women being 68,8 years and men 68,5 years. There was no significant difference between Langa (68,9 years) and Khayelitsha (68,5 years). The sample was largely young-old with 83% of the respondents being < 75 years. Four per cent were over 80 years. A more detailed breakdown is shown in Table I.

There was a marked difference in educational attainments between the two areas, although the general level was low because school opportunities were limited in the respondents' young days. In Khayelitsha 52 women (53%) and 31 men (44%) had no schooling compared with 18 (18%) and 15 (16%) in Langa. Similarly, 14 Khayelitsha respondents (80%) had completed primary school compared with 96 (49%) in Langa, and only 7 (4%) had some secondary school education compared with 50 (26%).

A smaller proportion of respondents in Khayelitsha spoke the dominant languages of the city — only 19% of the women spoke English compared with 42% in Langa — and many were unaccustomed to urban ways, for instance, significantly smaller proportions in Khayelitsha knew where to find medical and welfare assistance or were familiar with the transport system. This is not surprising, since the majority of the Khayelitsha women had come to Cape Town in the last 10 years (59% compared with 8% of those in Langa) and, even more significantly, half had lived there for less than a year. Not all had come directly from rural areas, since a proportion had previously been living in back yards and squatter camps. However, most considered themselves to be sojourners: many had come to be with their husbands for a while before returning to Transkei, and others for medical treatment. It is significant that 47% of those who considered themselves to be in transition were depressed.

Accommodation also differed. Ninety-eight per cent of the Khayelitsha respondents lived in shacks with no electricity or inside taps and the investigators considered 70% of their dwellings to be inadequate. In Langa, on the other hand, 84% lived in substantial if simple council houses, most had electricity and water, and it was felt that 90% were adequately accommodated.

Money was an important factor. The old-age pension was the major (and usually the only) source of income for the majority in both townships, but while 75% received it in Langa only 48% had pensions in Khayelitsha. In addition, many of the latter had to fetch the money in Transkei, which involved a good deal of expense, and it was less in amount. This situation is reflected in the finding that 97% of Khayelitsha residents said that they were struggling financially and 38% of the women who were categorised as depressed could hardly afford the basic necessities compared with 18% of the women in Langa. There were also more elderly people in Khayelitsha who spoke of financial problems of a lesser yet still substantial degree.

Psychological and psychiatric manifestations

The Short CARE assesses depression according to the Depression Homogeneous Scale and the Depression Diagnostic Scale. The former consists of 30 items pertaining to the subject's emotional and motivational state, vegetative symptoms, and functional impairment. The Diagnostic Scale assesses what is termed pervasive depression, to which were added three additional items as shown in Table II.

As regards the Homogeneous Scale, the proportion of respondents rated as positive for most of the items was considerably larger in Khayelitsha than in Langa and, in general, more women than men had such symptoms in both townships. The most common symptoms in all four groups were worry; headaches; slowness in the mornings; and decrease in usual activities and loss of interest.

Note that in Table II subjects were given ranked scores on items 8, 9 and 11, which are mutually exclusive, e.g. on item 8, subjects could be rated on *either* 8(a) *or* 8(b). Scores were allocated as follows: 8(a) = 1 point, 8(b) = 2 points; 9(a) = 1 point, 9(b) = 2 points, 9(c) = 3 points, 9(d) = 4 points; and 11(a) = 1 point, 11(b) = 2 points. These scores, together with the other 22 items which scored as 1 point each if present, gave a maximum of 30 points for the entire scale.

The high incidence of the complaint of worry in Khayelitsha subjects was also a feature of a community study[5] of elderly coloured persons, 100% of those who were categorised as depressed on the Present State Examination (PSE) complained of worry.

Overall, taking a cut-off score of 7, 21% of respondents in Langa (15% of men and 27% of women) and a remarkable 66% of those in Khayelitsha (53% of men and 76% of women) had symptoms warranting further investigation. Of note was that while women in Khayelitsha complained more frequently of depressive symptoms, men appeared to experience these more severely. This gender difference did not appear in Langa.

More definitive forms of depression were assessed on the Depression Diagnostic Scale at a cut-off level of 6, as recommended.[2] Relevant findings of the Gospel Oak study[4] are mentioned to give perspective, where appropriate, since this study also dealt with a deprived community using the same instrument. Taken together, 92 respondents (25%) in both townships were regarded as clinically depressed. This figure is higher than the 17% reported by Livingston *et al.*,[4] but the

TABLE I. AGE v. AREA/SEX

	Langa				Khayelitsha			
	Men (*N* 94)		Women (*N* 101)		Men (*N* 71)		Women (*N* 99)	
Age (yrs)	No.	%	No.	%	No.	%	No.	%
60 - 64	**27**	**29**	**27**	**27**	**23**	**32**	**33**	**33**
65 - 69	**26**	**28**	**33**	**33**	**24**	**34**	**19**	**19**
70 - 74	**24**	**25**	**24**	**24**	**15**	**21**	**25**	**25**
75+	**17**	**18**	**17**	**17**	**9**	**13**	**21**	**21**

TABLE II. FREQUENCIES OF SUBJECTS RATING POSITIVE FOR ITEMS ON THE DEPRESSION HOMOGENEOUS SCALE

	Langa				Khayelitsha			
	Men (*N* 94)		Women (*N* 101)		Men (*N* 71)		Women (*N* 99)	
Age (yrs)	No.	%	No.	%	No.	%	No.	%
1. Admits to worrying*	38	40	44	44	60	85	84	85
2. Worries about everything*	14(3)	15	21(3)	21	24	34(1)	25	25(2)
3. Sad/depressed in past month	8	9	14	14	8	11	12	12
4. Depression of lasting duration*	7	7	11	11	5	7	9	9
5. Depression worst in morning*	2	2	4	4	3	4	5	5
6. Feeling that life not worth living*	7	7	8	8	23	32	45	46
7. Cried in past month or felt like it	9	9	26	26	18	26	47	47
8(a) Pessimistic about future*†	11	12	13	13	17	24	16	16
8(b) Future seems unbearable*†	4	4	4	4	1	1	3	3
9(a) Wish to be dead*†	5	5	3	3	4	6	14	14
9(b) Fleeting suicidal thoughts*†	2	2	2	2	—	—	—	—
9(c) Suicidal intent*†	—	—	—	—	—	—	—	—
9(d) Suicidal attempt*†	—	—	—	—	—	—	—	—
10. Unhappiness in past month	11	12	10	10	21	30	42	42
11(a) Regrets about life†	—	—	1	1	1	1	4	4
11(b) Unrealistic self-blame†	—	—	—	—	—	—	—	—
12. Sleep disorder due to mood	2	2	4	4	13	18	41	41
13. Listlessness	19	20	27	27	27	38	51	51
14. Movement slowed	24	26	31	31	33	47	57	58
15. Decrease in activity	47	50(2)	57	56(2)	57	80(2)	89	90(1)
16. Slowness worst in mornings	12	13	23	23	48(4)	68	74	75
17. Headaches*	47(1)	50	63(1)	62	38	54	78(3)	79
18. Almost nothing enjoyed*	9	10	19	19	37	52	65	66
19. Decreased interest in activities	32(4)	34	37(4)	37	49(3)	69	77(4)	78
20. Too depressed to enjoy activities	4	4	7	7	8	11	18	18
21. Unhappiness/ dissatisfaction*	18	19	19	19	20	28	29	29
22. Distressed — social isolation	5	5	3	3	3	4	10	10
23. Often feels lonely*	9	10	11	11	10	14	19	19
24. Increased irritability	2	2	2	2	10	14	27	27
25. Loss of appetite due to mood	2	2	1	1	3	4	3	3
Has cried	6	6	21	21	12	17	36	36
Awakes early or tired*	16	17	19	19	20	28	48	48
Restlessness*	4	4	3	3	3	4	5	5

* These items form part of the Depression Diagnostic Scale (see text). Figures in parenthesis indicate rank order.
† Items from the Depression Diagnostic Scale, plus 3 additional items.

Langa figures approximate — men 12 (13%) and women 17 (17%). The difference is due to the significantly higher percentage in Khayelitsha — men 19 (27%) and women 44 (44%). The figure for depression in women is considerably higher than any found in a search of published reports. The items that contributed most to the differences between Langa and Khayelitsha residents were worry, a feeling that life is not worth living, sleep disturbance, early morning waking, headaches, crying, and anhedonia. In spite of this high prevalence, it was surprising to find that very few respondents had been treated for a psychiatric disorder — only 5 individuals in Langa and 1 in Khayelitsha.

The Sleep Disorder Scale provides for a maximum score of 8 with a cut-off point of 2. Once again the scores in Khayelitsha were much higher — men 19 (27%) and women 57 (57%) — than in Langa — men 16 (27%) and women 24 (24%). Here, too, the Langa figures and those of the men in Khayelitsha correspond with those of the Gospel Oak study (24%).[4]

The Somatic Symptoms scale consists of 20 items with a cut-off point of 7. The pattern was the same in that Khayelitsha scores were higher — men 15 (21%) and women 39 (39%) — than in Langa — men 4 (4%) and women 12 (12%). The Gospel Oak Study reported a figure of 24%.[4] The most common complaints were of palpitations (47% in Khayelitsha compared with 27% in Langa) and shortness of breath (80% compared with 47%). Dizziness, loss of weight, faintness, loss of appetite, and weakness were also complained of more often in Khayelitsha (approximately 50% for women and 30% for

men) than in Langa (approximately 20% for women and 10% for men). Sixty-four per cent of the women surveyed in Khayelitsha and 27% of men described their physical health as poor compared with 6% and 2%, respectively, in Langa.

The Activity Limitation Scale consists of 26 items which assess various aspects of daily living. Sixty-one respondents scored above the cut-off point of 9 (12 men and 24 women in Khayelitsha and 15 men and 10 women in Langa). Overall a markedly larger proportion of respondents in Khayelitsha indicated that they were not coping in just about every aspect of their lives (58% compared with 11% in Langa). Table III indicates the proportions of respondents rating positive for the constituent items. Once again, item scores were generally higher in Khayelitsha and more so in women indicating a considerable degree of impairment of function. The women in Khayelitsha complained more than the Langa elderly about being unable to perform daily household functions but there was no marked difference in managing personal care, for example, washing, dressing, and grooming.

The prevalence of other psychiatric symptoms was determined by supplementary items taken from the PSE, which covered thought disorder, inappropriate affect, delusions, hallucinations and paranoid fears, as well as severe generalised anxiety syndromes. With the exception of slowing of thoughts, which was complained of by 30 - 40% of all subjects in both townships, the prevalence of these manifestations was minimal. There were, for instance, only 7 individuals in the whole sample with thought disorder and 1 with paranoid delusions. An attempt was made to diagnose dementia and organic brain symptoms using the Short CARE and the Minimental State Examination. Great difficulties were encountered, since a considerable proportion of the subjects were illiterate and there were cultural and language problems. The results were therefore regarded as unreliable and are not reported.

Information about the type, amount and pattern of substance abuse among the elderly was also gathered. There was no instance of the use of habit-forming drugs but 62% of men and 32% of women in Khayelitsha used alcohol regularly, compared with 32% and 12%, respectively, in Langa. More of the latter group, however, abused or were dependent on alcohol (27 of the 30 Langa men drinkers and 11 of the 12 women compared with 6 men and 4 women in Khayelitsha). Eighteen per cent of Khayelitsha men and 28% of women used prescription drugs, compared with only 10% of each in Langa.

The prevalence of depression among the respondents of both townships was related to a number of concomitant variables using multivariate contingency table analysis with a χ^2 statistic indicating significance. Owing to the relatively

TABLE III. PROPORTIONS OF RESPONDENTS SHOWING ACTIVITY LIMITATION

	Langa				Khayelitsha			
	Men (*N* 94)		Women (*N* 101)		Men (*N* 71)		Women (*N* 99)	
	No.	%	No.	%	No.	%	No.	%
1. Does not go out as often as needs	8	9	13	13	6	9	18	18
2. Someone else prepares meals	56	59	20	20	56	79	52	53
3. Unable to prepare own meals	12	13	13	13	9	13	19	19
4. Cannot reach toes with both hands	5	5	5	5	5	7	12	12
5. Cannot lift both hands over head	2	2	2	2	4	6	6	6
6. Has difficulty cutting toenails	13	14	18	18	16	23	37	37
7. Health interferes with activities	27	29	37	37	30	42	59	59
8. Health limits leisure activities	22	23	27	27	11	16	30	30
9. Health limits light chores	14	15	15	15	10	14	25	25
10. Health limits heavy chores	25	27	31	31	13	18	39	39
11. Health limits employment	26	28	36	36	29	41	62	63
12. Health limits mobility	13	14	19	19	13	18	24	24
13. Cannot carry heavy packages	28	30	41	41	28	39	67	68
14. Cannot travel long distances	14	15	23	23	11	16	24	24
15. Health limits sociability	11	12	16	16	10	14	20	20
16. Health limits other activities	11	12	16	16	11	16	25	25
17. Health limitation getting worse	18	19	20	20	26	37	55	56
18. Problems handling personal affairs	17	18	12	12	20	28	43	43
19. Has difficulty with shopping	14	15	21	21	20	28	35	35
20. Someone else does shopping	25	27	24	24	26	37	32	32
21. Difficulty using bath or shower	5	5	6	6	5	7	6	6
22. Cannot do chores	26	28	31	31	13	18	39	39
23. Someone else does chores	39	41	26	26	10	14	28	28
24. Undone chores problematic	—	—	—	—	3	4	10	10
25. Difficulties with dressing	3	3	5	5	2	3	4	4
26. Difficulties with grooming	3	3	3	3	4	6	2	2

small sample size ($N = 365$) only the four variables that appeared to be most relevant were further analysed by logistic regression (adequacy of housing, length of stay in Cape Town, perceived state of physical health, and gender). This resulted in the derivation of a log-linear model of first- and second-order effects. The inferences drawn from this model, which is the simplest showing an adequate fit to the data (goodness of fit test: likelihood ratio $\chi^2 = 25,7$; df = 23; $P = 0,316$) are as follows:

1. There is a clear association between depression and female gender and an inverse relationship between depression and the number of years spent in Cape Town.

2. In addition, the period of urban living is significantly associated with perceived health status (the longer settled the better respondents perceived their health to be), and adequacy of housing (those who have been settled for longer tend to have better living conditions).

3. There is a dependency between *depression* and *perceived health*, i.e. depression is closely related to how respondents see their health. However, when the level of perceived health is controlled for, there is no significant association between depression and gender, the number of years spent in Cape Town, and adequacy of living conditions. In other words, perceived health appears to be the critical factor.

4. Once the number of years spent in Cape Town and perceived state of physical health are controlled for, however, there is a significant association among women between adequacy of housing and depression (women in inadequate housing are 19 times more likely to develop clinically significant depression). Among men, however, there is no such relationship once perceived health and length of time settled in Cape Town have been controlled for.

To summarise, the period spent in an urban setting and perceived health would appear to be the important factors in depression, irrespective of gender. Among women, adequacy of housing may be added as an important variable.

Discussion

The most significant finding of the present study was the extent of psychological distress and depression in Khayelitsha where three-quarters of the women and just over half the men studied had symptoms severe enough to warrant investigation. Scores indicated that 25% of men and 44% of women would certainly have been treated for depression if brought to the attention of a psychiatrist. In Langa the figures were: men 13% and women 17%, which correspond approximately with those of other investigations using symptom scales — the Gospel Oak Study (17,4%),[4] the coloured elderly in South Africa (16,5%),[5] Gurland *et al.*'s[6] 12,9% in New York, and Copeland *et al.*'s[7] 11,3% in Liverpool, both the latter using the Short CARE. Blazer and Williams[8] obtained a figure of 14,7% in North Carolina.[8] More serious forms of psychiatric disorder were uncommon, in keeping with the findings of other investigators.[9,10]

Mild psychiatric and depressive symptoms are generally recognised to be an expression of suffering as a result of adversity and situational stress,[9] particularly poverty,[7,11–14] and there was an excess of these in Khayelitsha. Depression is known to have a close association with poor health[9] and in the present study depressed persons certainly complained more about their health, but since physical examinations were not performed it is not clear whether this actually represented physical illness or was a manifestation of low morale or discontent. Certainly, most responses to those questionnaire items that involved a subjective assessment of daily activities and health circumstances were answered in a negative way by women in Khayelitsha. Somatisation of affect was particularly common, as were reports of limitation of activities due to symptoms.

The higher prevalence of subjective symptoms and mild depressive disorders among women has been shown in many community surveys.[9,12] Several explanations have been put forward, among them that women are more likely to admit to symptoms and there is more help-seeking behaviour; also that they manifest higher levels of dependence and passivity because of their status and social role in society.[9] While these were not studied in detail, the investigators were impressed by the low levels of self-esteem among the women in Khayelitsha, which was also manifest in lower standards of self-care and personal regard.

The question arises to what extent dysphoric and depressive symptoms are simply manifestations of psychological distress. This matter has been much argued, but Brown *et al.*[15] concluded that depression, as identified in community surveys, is not simply distress. However, they demand a recognisable threshold of severity. The criteria of the Short CARE, which define the more severe forms of depression, have been strictly set and validated against concurrent clinical assessment.[1,3] There were, however, cases at the less severe end of the spectrum, as determined by the homogeneous scale, where it could be argued that the term 'distress' would be more appropriate.

Several circumstances would appear to bear on the differences between Khayelitsha and Langa. The number of years spent in an urban environment emerges as a very salient factor.

Adversity is also important. By all the usual standards the Khayelitsha women were in a less advantageous situation: money, living conditions, and lack of familiarity with services all emerged as factors, and in addition, many of these elderly women were subject to extra stress in relation to their social role. They take a more instrumental role in their communities, the pattern being that women are responsible for the daily management of the household, they do the shopping and preparation of meals and, where money is limited, this is an enormous worry. They are frequently also responsible for the daily care of the children and grandchildren while the rest of the family is at work, and many of them complained of this burden. The men, although not free of the strain of providing, are more likely to be served or freed of daily detail.

Social support is generally acknowledged to buffer the effects of adversity, but the relationship to depression is complicated and largely dependent on the quality of support and its perceived adequacy.[16–19] This was difficult to judge but the Khayelitsha women had somewhat less contact with relatives and children, as determined by the number of visits and letters over a 3-month period (135 compared with 186 in Langa). A larger proportion of Khayelitsha women were married (62% compared with 23% in Langa) and this may have added to their burden as household managers. There was no significant relationship of depression to living alone in either township. Traditional values and practices may be expected to have a supportive effect but do not appear to play a major role in the differences between the two townships because the majority of residents in both believed in the customs and traditions of their forefathers. The women in Khayelitsha, however, did practise traditional rituals more frequently than those in Langa (85% compared with 68%), and a similar proportion knew where to find a traditional healer (compared with 21% in Langa) and many more used such 'services'.

Conclusions

The main finding of this investigation was the strikingly high prevalence of psychological distress, depression and limitation

of activity among newly settled elderly residents in a black township, particularly the women. The figures exceed those of similar surveys elsewhere but circumstances differ in that there is an exceptionally disadvantaged social situation and much recent movement into the area. It is important to note that the more settled Langa community did not show symptoms and disability to the same degree, but it was not possible to define precisely which of the differing social circumstances were critically relevant. Poverty as a general factor is in itself probably not instrumental because most of the women in Khayelitsha had been living in similar conditions in their places of origin and, in any case, the Langa residents, although better off in some respects, were also living in very straitened circumstances. Translocation and acculturation appear to be particularly important, not least because they do not apply to anything like the same extent in Langa, and because they are known to have particularly damaging effects.[20] Possibly, on the basis of an already high level of stress, this additional straw breaks the already overloaded camel's back. Further research is needed.

Large scale movements of rural people to the cities are characteristic of our times, and the consequences in terms of social dislocation and disorganisation, poverty, and suffering are well known. The most important finding of this survey has been the identification of recently arrived elderly women, and to a lesser extent, elderly men, as having strikingly high levels of depressive and psychological distress symptoms. It is clear that they constitute a priority for social, psychiatric and other helpful interventions.

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REFERENCES

1. Gurland B, Wilder DE. The Short CARE: an efficient instrument for the assessment of depression, dementia and disability. *J Gerontol* 1984; **39:** 166-169.
2. Gurland B, Kuriansky J, Sharpe L, Simon R, Stiller P, Birkett P. The Comprehensive Assessment and Referral Evaluation (CARE) — rationale, development and reliability. *Int J Aging Hum Dev* 1977-1978; **8:** 9-42.
3. Teresi JA, Golden RR, Gurland BJ, Wilder DE, Bennett RC. Construct and validity of indicator scales developed for the CARE Interview Schedule. *J Gerontol* 1984; **392:** 147-157.
4. Livingston G, Hawkins A, Graham N, Blizard B, Mann A. The Gospel Oak study: prevalence notes of dementia, depression and activity limitation among elderly residents in Inner London. *Psychol Med* 1990; **20:** 137-146.
5. Ben Arie O, Swartz L, Dickman BJ. Depression of the elderly living in the community. *Br J Psychiatry* 1987; **150:** 169-174.
6. Gurland B, Copeland RM, Kelleher MJ, Kuriansky J, Sharp L, Dean L. *The Mind and Mood of Ageing: The Mental Health Problems of the Community Elderly in New York and London.* New York: Haworth Press, 1983.
7. Copeland JRM, Dewey MR, Wood N, Searle R, Davidson IA, MacWilliam C. Range of mental illness amongst the elderly in the community. *Br J Psychiatry* 1987; **150:** 815-823.
8. Blazer DS, Williams CD. Epidemiology of dysphoria and depression in an elderly population. *Am J Psychiatry* 1980; **136:** 439-444.
9. Hirschfeld RMA, Cross CK. Epidemiology of affective disorders: psychosocial risk factors. *Arch Gen Psychiatry* 1982; **39:** 35-46.
10. Weiss MM, Myers JV. Affective disorders in a US urban community. *Arch Gen Psychiatry* 1978; **35:** 1304-1311.
11. Murphy E. Social origins of depression in old age. *Br J Psychiatry* 1982; **141:** 135-142.
12. Warheit GJ, Holzer CE, Schwab JJ. An analysis of social class and racial differences in depressive symptomatology. *J Health Soc Behav* 1973; **14:** 291-299.
13. Morgan K, Dalloso HM, Arie T, Byrne EJ, Jones R, Waite J. Mental health and psychological well-being among the old and very old living at home. *Br J Psychiatry* 1987; **150:** 801-807.
14. Ilfield FW. Current social stressors and symptoms and depression. *Am J Psychiatry* 1977; **134:** 161-166.
15. Brown GW, Craig YKJ, Harris TD. Depression: distress or disease. *Br J Psychiatry* 1985; **147:** 612-622.
16. Elk R. The relationship between life events, social support and depression: a community study of a coloured elderly population. Ph.D. thesis, University of Cape Town, 1989.
17. Anashensel CS, Stone JD. Stress and depression: a test of the buffering model of social support. *Arch Gen Psychiatry* 1982; **39:** 1392-1396.
18. Henderson S. Social relationship, adversity and neurosis. *Br J Psychiatry* 1981; **138:** 391-398.
19. Wetherington E, Kessler RC. Perceived support, received support and adjustment to stressful life events. *J Health Soc Behav* 1986; **27:** 78-89.
20. Arling J. Strain, social support and distress in old age. *J Gerontol* 1987; **42:** 107-113.