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Cognitive style and depressive symptoms in elderly people – Extending the empirical evidence for the cognitive vulnerability-stress hypothesis

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Abstract

**Introduction:** Depression is common in older people and its identification and treatment has been highlighted as one of the major challenges in an ageing world. Poor physical and cognitive health, bereavement, and prior depression are important risk factors for depression in elderly people. Attributional or cognitive style has been identified as a risk factor for depression in children, adolescents and younger adults but its relevance for depression and mood in elderly people has not been investigated in the context of other risk factors. **Method:** Sixty-four older adults from an ‘extra care’ living scheme (aged 59-97) were recruited for a 6-week prospective study to examine the relationships between cognitive style and depressive symptoms. **Results:** Regression analyses revealed that, when other risk factors were controlled for, cognitive style and its interaction with stress predicted changes in depressive symptoms, therefore partially replicating prior research. **Conclusion:** Cognitive style is also of relevance for depression in elderly people, especially when facing lower levels of stress.

**KEY WORDS:**
Depression, Cognitive Style, Hopelessness theory, old age
Introduction

Depression is the most common mental health problem facing older people. It affects between 20-40% of all older people who live in their own homes or in care settings (e.g. Chen et al., 2007; Geerlings, Beekman, Deeg & Van Tilburg, 2000). In addition to the significant distress it causes for both the sufferers and their carers, depression in later life exacerbates existing physical health problems, accelerates cognitive decline, and is associated with higher mortality (e.g. Mitchell & Subramaniam, 2005; Vinkers, Gusseklo, Stek, Westerndorp & van der Mast, 2004). It also tends to follow a chronic course (e.g. Licht-Strunk et al., 2007). For these reasons, the prevention, identification and treatment of depression in older people is an important topic in an increasingly aged population.

Intrinsic factors including poor physical health, bereavement and prior depression are important risk factors for depression in elderly people (e.g. Blazer & Hybels, 2005; Cole & Dendukuri, 2003; Kazel, 1997; Vink, Aartsen & Schoevers, 2008). With regard to external life events, there is evidence that a) the onset of depression is often associated with stressful life events and b) older people tend to experience more critical life events which are out of their control than do other age groups (e.g. Aldwin, 1992; Karel, 1997).

The Helplessness model (Abramson, Seligman & Teasdale, 1978) postulated that the way that individuals attribute negative experiences is related to the likelihood that they will experience depression – especially if they attribute failure and negative events to internal, stable and global factors such as low intelligence or innate inability. There is a growing body of evidence of the general role of attributions in developing depression (e.g. Abela, 2001; Alloy et al, 1999, 2006; Hankin & Abramson 2002). Conceptually most
studies are linked to the Hopelessness theory of depression and its construct ‘cognitive style’ (Abramson, Metalsky, & Alloy, 1989). Cognitive Style refers to interferences that people make about the cause, consequences, and self-worth implications of stressful life events. According to the Hopelessness theory, individuals who adopt a ‘negative’ cognitive style (i.e. tend to make stable and global attributions for negative life events, and infer negative consequences following the event, and infer negative implications for the self) are at increased risk for depression when confronted with stressful life events (Abramson et al, 1989).

The evidence for a ‘negative’ cognitive style as a risk factor for depression is mainly based on child and working age adult populations. When focusing on an older adult population, the association between cognitive style and depression has not been extensively investigated. There is evidence to suggest that attributional style – referring to the older concept of internal, stable and global attributions - is predictive of depression in older people in the community (Isaacowitz, 2004; Isaacowitz & Seligman, 1999, 2002) and residential care (Bayer & Fleischman, 1987). However, these studies have either not controlled for other risk factors such as age, gender, physical health, cognitive functioning or a history of previous depression, or have not used the more widely used measure of cognitive style developed in accordance to the Hopelessness theory (Haeffel et al, 2008; Isaacowitz, 2004).

The primary aim of this study is to investigate whether the same links between cognitive style and depression found in other populations can be found in a sample of older people who do not live in their own homes, and if this association is still evident once other known risk factors are controlled for. This would allow the relationship found
in children (e.g. Abela, 2001), adolescents (e.g. Hankin and Abramson, 2002) and young adults (e.g. Alloy et al., 1999, 2006) to be tested in an older adult population. If the same model holds true for this age group, this would provide a novel area to inform interventions aimed at preventing or treating the high levels of depression in elderly people. In line with the Hopelessness Theory (Abramson et al., 1989) we predict that a ‘negative’ cognitive style will be associated with increased levels of depression over time when elderly people face critical life events and stress.

**Methods**

**Participants**

For the short-term prospective study, 64 participants (n = 49 women, 76.6 %) were recruited who lived in one of five ‘extra care’ living facilities, i.e. individuals had access to 24 hour on site care but lived in their own self contained apartments. The mean age of the participants was 79.5 years (SD = 8.5 years, range 50-97). The mean Mini Mental State Examination (MMSE) score was 26.67 (SD=2.77, range 20-30). The mean score for the number of physical health problem areas (see below) was 1.88 (SD=1.22, range 0-4). Eight participants (12.5%) were identified as having a lifetime history of depression as measured by the Depression Screening Questionnaire (see below).

Potential participants were initially identified by the care managers of the facilities and had to fulfil the following inclusion criteria: a) living in one of the five “extra care” living schemes, b) willing to participate in the study and c) being able to give full informed consent. In order to live in the ‘extra care’ living scheme participants had to be aged over 50 years. Exclusion criteria were: a) recently started or changed anti-depressant
medication to avoid the potential confounding effects of anti-depressant medication, b) a MMSE score < 20, because this would indicate a cognitive impairment serious enough to prevent the person from giving full informed consent to participate (Kurlowicz and Wallace, 1999).

At Time 2 (i.e. six weeks later), 58 out of the 64 participants (90.4%) from Time 1 continued with the study. Participants did not differ from non-participants with respect to level of current depressive symptoms or composite scores in the Cognitive Style Questionnaire. There was, however, a trend for the people who further participated with the study to be slightly older (M = 80.12 [SD = 8.17] vs M = 73.5 [SD = 10.05], t(62) =1.85, p<.07, d=.78). Using Fisher’s exact test, there were no significant differences with regard to gender, cognitive impairment or a previous history of depression

Measures

Cognitive Style Questionnaire for older people (CSQ-OP) No pre-existing measures specifically assess cognitive style as defined in the Hopelessness model (Abramson et al., 1989) in elderly people. We therefore modified the existing ‘Older Adult Attributional Style Questionnaire’ (OAASQ, Isaacowitz and Seligman 1999) which is based upon the original ‘Attributional Style Questionnaire’ (ASQ; Peterson, Semmel, Baeyer, Abramson, Metalsky and Seligman, 1982). The OOASQ consists of twelve hypothetical situations (six positive and six negative situations). Participants are required to read each situation and identify a reason why the situation may have occurred. They are then asked to rate the reason in terms of internality, stability and globality, e.g “Is this totally due to you?” (internality), “Will it always be present?” (stable) and “Does it
affect all areas of your life?" (globality). With approval of the authors (Isaacowitz, personal communication, April 15, 2007) we slightly reworded three items in order to to ensure their relevance to the people living in care homes in contrast to individual living in the community (details available on request). Because the OAASQ does not tap on all factors that are seen relevant for the Hopelessness model of depression (Abramson et al., 1989), the additional items from the Cognitive Style Questionnaire (CSQ, Haeffel et al, 2008) were used to assess those (e.g. the subjective likelihood that further negative consequences will result from the event).

Each item on the CSQ-OP has a maximum score of seven and a minimum score of one. In order to calculate the total composite score for negative items, the participant’s average score on the stability, globality, consequences and self worth dimensions for negative situations are added together and then divided by the number of items answered. This total score can range from one to seven, with higher scores reflecting a hypothesised greater cognitive vulnerability to depression (e.g. Haeffel et al., 2008). Internal consistency for the CSQ-OP for both positive and negative CSQ items in the present sample was sufficient (see Table 1).

Geriatric Depression Scale (GDS, Sheikh & Yesavage, 1986). The GDS was used to assess depressive symptoms. The GDS is a 15-item self-report assessment tool designed specifically to be used with an elderly population to assess for depression. Responses to each item are either ‘Yes’ or ‘No’ in reference to how the respondent has felt in the last week. Scores of 9-15 indicate moderate to severe depression, 5-8 indicate mild depression and scores of 0-4 are considered to be normal. Internal consistency in the
present study (Table 1) was lower than reported in previous research (e.g. \( \square = .75 \), Friedman, Heisel & Delavan, 2005).

Elders Life Stress Inventory - Modified (ELSI-M, Aldwin, 1990). The ELSI is a checklist of 30 stressful events that older adults could experience. The participant is required to state if they experienced the item within the last four weeks and also rate how stressful it was (0=did not occur, 5=extremely stressful). Thirty items from the Daily Stress Inventory (DSI, Brantley et al, 1985) were also added to the ELSI. The reason underpinning the inclusion of these extra items was to have a scale that assessed both major life stressors (e.g. illness, death of a friend) and also stressors that may occur on a daily basis (misplaced something) because of the low likelihood of a significant number of major life events within the time frame of the study. The items were selected from the DSI if judged independently by two of the authors (DC, TDM; both experienced Clinical Psychologists) of this paper as relevant for the age group. Any discrepancies in their responses were resolved by the judgement of a third person (EG). The final scale included all 30 items from the ELSI and 30 items from the DSI. Although the amount of distress caused by the events is rated as well, only the number of events was used as a variable in this study to avoid contamination by perceived stress (e.g. Issacowitz & Seligman, 1999).

Physical Health Interview (Kriegsman, Penninx, Van Eijk, Boeke, and Deeg, 1996). Physical health was assessed by a short structured interview. The measure was designed to be used with older adults and was reported to be an adequate measure of physical health in this population. For each problem, the participant is asked whether they are currently seeing a doctor or taking medication for six health areas (lung problems,
heart problems, stroke, cancer, diabetes and arthritis) and a total score out of six is obtained.

**Mini Mental State Examination (MMSE)** (Folstein, Folstein and McHugh, 1975). The MMSE assesses five areas of cognition; orientation, retention, attention, recall and language. Each item is scored and added together to give a total score from 30. One of the exclusion criteria for this study was an MMSE score < 20. Scores below 20 indicate at least a moderate level of cognitive impairment sufficient to make responses to other measures unreliable. Furthermore to control for any potential impact of low cognitive impairment in the analysis, participants were divided into two groups based on their scores. Using a cutoff of 28 in the present sample led to two groups of almost equal size, i.e. one group included all those participants who scored 29-30 (‘cognitively healthy’) and the other included all participants who scored 28-20 (suggesting ‘mild cognitive impairment’) (Kurlowicz, & Wallace, 1999).

**Depression Screening Questionnaire (DSQ, Wittchen and Pfister, 1997).** The DSQ asks for specific symptoms of an episode of major depression as classified by the DSM-IV (APA, 1994). The DSQ was adapted by Baezner, Broemer, Hammelstein, and Meyer (2006) to test for former depression. In the present study Cronbach’s $\alpha = 0.87$. To determine whether participants had a history of depression, all the ‘yes’ responses were added up to provide a total score. A DSM-IV algorithm (APA, 1994) was applied, i.e. a total score of 5 or above, and having responded “yes” on either the criterion ‘depressed mood’ or ‘loss of interest/anhedonia’ classified a participant as having a previous history of depression.
Procedure

Each participant was provided with written and verbal information about the research project, and written informed consent was obtained. The project was independently peer-reviewed at Newcastle University and had ethical approval from an NHS Ethical Committee. At Time 1, each participant completed a MMSE, and was asked about current physical health and previous episodes of depression using the DSQ. They then completed the measure of Cognitive Style (CSQ-OP), and the GDS. A follow up appointment (Time 2) was then made four to six weeks later. At Time 2, the CSQ-OP, the GDS, and the ELSI were completed. The mean length of the follow-up interval was 52.41 days (SD = 32.56, range 28-160 days).

Statistical analyses

An apriori power analysis assuming a medium effect size revealed that a minimum sample size of n = 58 participants will be needed to test the hypothesis in a hierarchical regression analysis at p <.05 and power of 80%. A hierarchical regression model was used with the first block including the covariates (i.e. age, cognitive impairment, health, previous depression). The second block included the number of life events/hassles encountered in the follow-up. The third block included cognitive style (Time 1), and the final one the interaction of stress and cognitive style (Time 1).

All data was visually screened for missing or abnormal values. If single items of a questionnaire were missing and this did not exceed 10%, then the missing values were replaced with the individual’s mean score for the other items in that scale (e.g. GDS). For ELSI a more conservative approach was used by replacing missing values by the value
‘0’ indicating the event did not occur. The assumption of normal distributions was tested for each variable and data transformed if appropriate.

. Results

Time effects and correlations between measures

Table 1 shows the means, standard deviations, range of the variables at Time 1 and Time 2 and the corresponding correlations. A paired-sample t-test was carried out to check for any systematic group trends in change of depressive symptoms over time in the sample but there was no significant effect of time, GDS: t(57) =1.70, p=.10. Overall, low to modest stability was found GDS and CSQ (Table 1).

Prediction of change in depressive symptoms

Table 2 shows the percentage of the overall variance explained by the model as a whole (R²) and the independent variables (ΔR²), the standardised (beta) and unstandardised (B) coefficients and the part correlations in the final model. The overall model including all predictor variables proved to be significant, F(8, 57) = 2.19, p = .04, therefore explaining a significant proportion (R²=0.26) in the change of depressive symptoms during follow-up. Including the potential confounding effects of age, gender, physical health, cognitive functioning and previous history of depression (Block 1) did result in a non-significant trend explaining changes in depressive scores (ΔR²: F(5, 52) = 2.16, p = .07). Adding the number of stressful life events or cognitive style did not significantly increase ΔR². As hypothesized, the interaction term of cognitive style and negative life events led to a significant increase in ΔR² implying that it significantly
contributes to the explanation why changes in depressive symptoms occurred over time, \( F(1, 49) = 4.60, p = .03 \). Table 2 reveals that cognitive style and the interaction of cognitive style and stress were significant predictors, while stress on its own showed a trend. Figure 1 illustrates the interaction: After taking into account the main effects of CSQ and stress with both independently increasing depressive symptoms, their interaction reveals in addition that a high cognitive vulnerability is especially related to an increase in depressive symptoms when elderly people face lower level of stress.

Because of the low internal consistency of the GDS we repeated the analyses with an abbreviated version of the GDS which omitted three items with low or even negative corrected item-total correlations. This increased reliability, \( t_1 \alpha = .59 \) and \( t_2 \alpha = .49 \). The results of the hierarchical regression were almost unchanged.

**Discussion**

Prior research shows a clear link between cognitive style, as a specific way of making interferences about negative life events, and depression in adolescent and young adult samples (e.g. Alloy et al, 1999, 2006; Hankin & Abramson 2002), but its relevance to age groups beyond age of 60 and higher is less established (Isaccowitz & Seligman, 2002). To our knowledge this is the first study looking at cognitive style – as conceptualized in the Hopelessness Theory (Abramson et al., 1989) - in elderly people and its associations to depression. The final model including all variables revealed that as hypothesized, a ‘negative’ cognitive style significantly predicted changes in depressive symptoms over time and there was a trend for stressful life events as well. In addition cognitive style also interacted with stress, but contrary to one might expect: when elderly
people reported a high cognitive vulnerability, a low level of stress was associated with an increase in symptoms. This suggests that cognitive vulnerability for depression does not matter so much when stress level is high, but when stress level is lower.

As one might expect, depressive symptoms only showed a moderate stability, implying that some change occurred even over that short period of time of 4-6 weeks. The same was, however, true for cognitive style which is usually considered a trait-like characteristic.

The primary hypothesis that the interaction between cognitive style for negative events and life stressors will account for additional variance over and above the influence of gender, age, cognitive functioning, health, and previous episodes of depression in the change in depression scores during the follow-up period in older adults was partially supported and explained an additional 7% of the variance. As the Hopelessness Theory (Abramson et al., 1989) would suggest cognitive style and its interaction with stress accounted for significant changes in depression. Based upon our results there is evidence that cognitive style constitutes a psychological vulnerability across all age groups from children to elderly people (e.g. Abela, 2001; Alloy et al., 2006; Hankin & Abramson, 2002; Hankin, Abramson, Miller & Haefel, 2004). However, it seems that the nature of the interaction between cognitive style and stress might change at a much higher age. Abramson, Alloy and Hogan (1997) provide some explanations why such a seemingly counterintuitive interaction of stress and cognitive style can occur.

Before drawing final conclusions, it seems important to keep in mind the main limitations of the present study. First, looking at a sample of elderly people in a specific care setting limits the generalizability of our results because the sample is not
representative for the elderly population in general. However, though we might have recruited a homogeneous sample of elderly individuals, we were still able to find evidence for the relevance of cognitive style as a predictor of depressive symptoms. Second, reliability of the GDS was low in the present sample which might have been related to the specific setting we chose (e.g. the item ‘Do you prefer to stay at home, rather than going out and doing new things?’ had zero variance). Although this may have compromised the results, a reanalysis relying on a shorter and more reliable scale essentially left the results unchanged. Nevertheless, measures adapted and validated for specific samples might be needed (for example: Hammer, Häcker, Hautzinger, Meyer, & Kübler, 2008). Third, we used the CSQ-OP, a combination of the OAASQ (Isaacowitz & Seligman 1999) and the CSQ (Haefel et al., 2008), to assess the facets of the Hopelessness Model (Abramson et al., 1989). While internal consistency was sufficient despite the low number of items, the low retest-reliability of the CSQ-OP over 4-6 weeks raises the question whether the tool should be further revised to capture the more-trait like cognitive vulnerability outlined in the theory, or alternately whether cognitive style is less stable in older people. We hypothesize that older people may adopt a more here-and-now stance when answering questions and not - as originally intended - disclose a trait-like way of attributing events. This would explain why Isaacowitz reported a similarly low test-retest reliabilities in a sample of community dwelling older people of $r = .44$ and $.50$ for a two month-period (Isaacowitz & Seligman 1999). Last but not least, although we also included daily hassles, choosing a short follow-up period may have not been sufficient for critical life events to happen. This may explain why we did not find any
main effects of stress in contrast to Hankin et al (2004) who reported a significant main
effect of stress over eight week and a two year time frames.

Despite the limitations our results support that psychological vulnerabilities such as
cognitive style are of relevance in predicting depressive symptoms in elderly. This is in
line with the conclusions of a recent review about the role of dysfunctional coping and
negative self-concept for depression in older age (Vink et al., 2008). Future research
should extend the time frame and also look prospectively at clinical episodes of
depression in different groups of elderly individuals with greater variation in their
degrees of physical impairment and living conditions.
References


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Footnotes

2 Using the reduced GDS Block 1 including the potential confounding variables led to a significant $R^2$, $R^2 = 0.195$, $F(5, 52) = 2.52$, $p = .04$, with age and a lifetime history of depression turning out to be significant predictors. As before including only the interaction of stress and cognitive style increased prediction, $\Delta R^2 = 0.069$, $F(1, 49) = 4.48$, $p = .04$. The overall model for $R^2 = .28$ was significant as well, $F(8, 57) = 2.39$, $p = .03$ (Details available on request)
### Table 1

**Correlation, retest-reliability, internal consistency and descriptives for the Geriatric Depression Scale (GDS), Cognitive Style Questionnaire – Older People (CSQ-OP) and Elders Stress Inventory – Modified (ELSI-M).**

<table>
<thead>
<tr>
<th>Measure</th>
<th>GDS (t1)</th>
<th>GDS (t2)</th>
<th>CSQ-OP (t1)</th>
<th>CSQ-OP (t2)</th>
<th>ELSI-M (t2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>t1</td>
<td>t2</td>
<td>t1</td>
<td>t2</td>
</tr>
<tr>
<td>GDS (t1)</td>
<td>.54 a</td>
<td>.47** b</td>
<td>-.01</td>
<td>.17</td>
<td>.28*</td>
</tr>
<tr>
<td>GDS (t2)</td>
<td>.36 a</td>
<td>.19</td>
<td>.23*</td>
<td>.28*</td>
<td></td>
</tr>
<tr>
<td>CSQ-OP (t1)</td>
<td>.70</td>
<td>.39**</td>
<td>-.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSQ-OP (t2)</td>
<td>.73</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ELSI-M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.77</td>
</tr>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Range</td>
<td>2.71 (1.79)</td>
<td>2.33 (1.54)</td>
<td>3.42 (0.83)</td>
<td>3.44 (0.72)</td>
<td>6.17 (3.56)</td>
</tr>
<tr>
<td>0 - 9</td>
<td>0 – 6</td>
<td>1.84 – 6.30</td>
<td>1.10 – 5.35</td>
<td>0 – 17</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** Raw scores were reported so that direct comparisons could be made with other research. In the diagonal Cronbach’s α is reported for each scale and each time. CSQ-OP - Negative-Composite score for Negative situations on the Cognitive Style Questionnaire

* p < .05
** p < .01

a When eliminating three items with low item-total correlation, α increased to .59 at t1 and to .49 at t2. The items were ‘9. Do you prefer to stay at home, rather than going out and doing new things?’, ‘12. Do you feel pretty worthless the way you are now?’ and ‘13. Do you feel full of energy?’;

b When eliminating three items with low item-total correlation, retest reliability remained unchanged with r_{tt} = .51
Table 2

Regression model predicting changes in depressive symptoms

<table>
<thead>
<tr>
<th>Regression Model</th>
<th>r²</th>
<th>Δ r²</th>
<th>B (Std. Error)</th>
<th>Beta</th>
<th>Part Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Block 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.17 (*)</td>
<td>0.17(*)</td>
<td>-0.05 (0.31)</td>
<td>-0.21</td>
<td>-0.18</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>-0.56 (0.52)</td>
<td>-0.14</td>
<td>-0.13</td>
</tr>
<tr>
<td>Physical Health</td>
<td></td>
<td></td>
<td>0.30 (0.18)</td>
<td>0.21</td>
<td>0.20</td>
</tr>
<tr>
<td>Cognitive Functioning</td>
<td></td>
<td></td>
<td>0.23 (0.49)</td>
<td>0.07</td>
<td>0.06</td>
</tr>
<tr>
<td>Previous Depression</td>
<td></td>
<td></td>
<td>-0.95 (0.66)</td>
<td>-0.18</td>
<td>-0.17</td>
</tr>
<tr>
<td><strong>Block 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Events</td>
<td>0.18 (*)</td>
<td>0.01</td>
<td>0.72 (0.37)</td>
<td>1.49 *</td>
<td>0.24</td>
</tr>
<tr>
<td><strong>Block 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Style (t1)</td>
<td>0.20</td>
<td>0.01</td>
<td>11.81 (5.11)</td>
<td>0.69 *</td>
<td>0.28</td>
</tr>
<tr>
<td><strong>Block 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Style (t1)</td>
<td>0.26 *</td>
<td>0.07*</td>
<td>-1.47 (0.69)</td>
<td>-1.67 *</td>
<td>0.26</td>
</tr>
</tbody>
</table>

* p < .05
(*) p < .10
Notes: GDS – Geriatric Depression Scale