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## A communal meal program aimed at reducing the feelings of depression in the elderly

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**A COMMUNAL MEAL PROGRAM AIMED AT REDUCING THE  
FEELINGS OF DEPRESSION IN THE ELDERLY**

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**A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino**

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**In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work**

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**by  
Michael Dane Walper**

**June 1997**

A COMMUNAL MEAL PROGRAM AIMED AT REDUCING THE  
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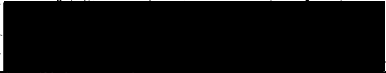
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June 1997

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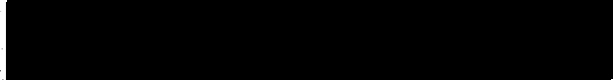
  
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## ABSTRACT

It is important for the direct practice social worker to be aware of the causes and symptoms of depression. Though the elderly population accounts for only 10% of the population, they account for 25% of all suicides. Depression can afflict people at any age. However, due to losses, the elderly are more at risk to develop the symptomology of depression. These losses may involve losing vigor, strength, physical health, cognitive functioning and may include the loss of loved ones. The elderly often find themselves isolated and lonely. This project looked at how we can intervene to break the cycle of depression within the elderly community. The design of this project was a quasi experimental, pretest posttest and introduced an intervention, a communal meal program, to the experimental group. Data was collected using the CES-D, a scale used to measure feelings of depression. The pretest and posttest results of the experimental and comparison groups were compared using the Fisher's exact test for significance. It was anticipated that the communal meal program would assist in lowering the reported feelings of depression as reported by the participants. A communal meal provided a chance for the residents to come together for a meal that they would normally eat alone, they were given the chance to form new relationships and lower their feelings of isolation and loneliness.

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## CHAPTER ONE

### Introduction

Depression can afflict people at any age. This project intends to discuss depression in the context of growing old. Dean et al. (1992) indicate that increasing numbers of elderly persons live alone. They also state that elderly persons who live alone are at a higher risk of depression. This research project intends to introduce an intervention, a communal meal program, that may help reduce some of the symptomology that is experienced by the elderly who suffer from depression. It may even be considered a prevention. There is evidence that indicates that interaction with friends has the strongest effects on well being and morale (Dean et al.,1992).

What causes depression in older adults?

Most older adults experience symptoms of depression at some time during their later years. However, most depressed older people are not treated because no one recognizes their depression as a curable disease. Depression is a normal reaction to any significant loss, and therefore is sometimes considered by many caregivers as a natural consequence of aging. Some people view aging as a continuous chain of losses. It may involve losing vigor, strength, physical health, and cognitive functioning. Schultz & Moore (1984) suggests elderly persons experience loss at greater levels than

younger persons. The elderly experience loss when their friends die and the family moves away; they begin to feel empty and loneliness and boredom begins to become a greater part of their lives.

“I’m old and getting older. There’s nothing I can do about it. I’m lonely, I forget what day it is because each day is just like the next. They’re gray and seem to run together. I’m so disgusted with my life. Some people always did everything exactly right, but I’ve done everything wrong...” these are the laments of far too many older members of our society (Diamond, 1987).

Sadness, discouragement, pessimism, and hopelessness about being able to improve matters are familiar feelings to most people. Most of us are prone to move in and out of these states throughout our lives. Depression is unpleasant, even noxious, when we are in it, but it usually does not last long (Carson & Butcher, 1992).

Normal depressions are almost always the result of recent stress. Carson & Butcher (1992) suggests that depression in its mild form may be actually adaptive. As we come out an episode where we have felt depressed, we often experience it as having been in some sense useful; having experienced the difficulty we find a new perspective on the situation that encompasses many possibilities. We enlist these new perspectives to add to our strategies of coping.



Depression according to Billig(1987) is something which many older adults must contend. However, it is not just sadness. It is a clinical problem, a syndrome, a disorder made up of a set of symptoms which mean that something is not right with the affected person. Billig(1987), Schultz & Moore (1984), Margolis & Rabins (1996) agree that while most of the elderly are not depressed, there is up to 15 to 20 percent of the older people who are. They report the majority of older persons with depression go undiagnosed and suffer in silence. Importantly they go untreated. Older people seldom say they feel depressed and even more rarely seek treatment for depression. They may not recognize that depression is causing their discomfort; instead, they may think it's normal to feel miserable.

“The problem of depression in the elderly is compounded by the fact that it is one of the great masqueraders of medicine (Billig, 1987).”

Depression in the elderly may first manifest itself within the context of a medical complaint, as in headaches, muscle aches, chest symptomology or bowel disorders. Thus, depression among the elderly often is expressed indirectly. Instead of talking about feeling depressed, the elderly person may complain about a physical ailment. Accordingly Margolis & Rabins (1996) state: “What makes depression in the elderly so insidious is that neither the victim nor the health care provider may recognize its symptoms in the context of multiple physical problems of many elderly people.” Factors that

may lead to a misdiagnosis include: the unwillingness of the elderly person to report a low mood, multiple medical conditions and the social and economic problems associated with old age. Diamond & Ross (1987) report that 65 percent of the elderly men and 62 percent of elderly women showed excessive concern with their health. However, research indicates that physical complaints actually contribute less to depression than do loss of help, loneliness and uselessness.

Depression in the older adult is complex and involves the biology of aging, the mixture of losses and successes throughout life, the interplay of medical illnesses and their treatments. Carson & Butcher (1992) indicate that the degree or depth of depression is contingent on the strengths and weaknesses of the individual. Although severe depression is readily recognized, it can be difficult to distinguish the milder forms of depression from the emotional changes that are part of everyday life (Margolis & Rabins, 1996).

So why are the elderly so vulnerable? As time goes on and we age we become less flexible in our schedules, activities, diets and daily living patterns. The elderly lose the ability to adapt coping skills that they had used effectively in the past. Impairment in hearing, vision, taste, and decreases in stamina may add to the generalized feeling that coping ability is

decreasing. Thus, their inflexibility makes them more susceptible to the changes and losses that come about over the years (Billig, 1987).

The specific cause of depression according to Margolis & Rabins (1996) is unknown in most cases. They relate that there may be some combination of genetic, psychological and medical factors. Billig (1987) reports that there are biological changes in the chemical neurotransmitters of the brain. It has been reported that this decrease in these neurotransmitters may have a role in predisposing the elderly to depression.

Erik Erikson views old age as a stage of life that involves a struggle of “ego integrity versus despair”. He describes this stage as one in which as the person reaches old age, they must come to terms with the positive and negative aspects of their life as it has been lived thus far. They must come to terms with the fact that they cannot make up for things in the past. Some, however, are mired in bitterness and blame, fearful of death, unable to accept either the past or the future. They do not reach integrity and despair wins out.

Growing older inherently means coming face to face with losses. the elderly population faces losses in biological functioning, family, status, stamina, and health. Diamond(1987), Billig(1987), Schultz & Moore (1987) and Margolis & Rabins(1996) support the notion that though losses are a part of everyone’s life experience, for the elderly the losses are cumulative

and intense. Depression according to Gallo, Reichel & Anderson (1988) becomes a clinical problem when the person's resources and coping strategies are overwhelmed by the losses they have endured.

Billig (1987) indicates that not only current losses predispose a person to depression but also earlier life experiences that they have not been able to have satisfactorily worked through or "mourned and otherwise dealt with". They may resurface because of some current reminder and then complicate the elder person's mental state, making them more vulnerable to depression in the here and now.

The importance of social aspects of losses suffered by the elderly cannot be over emphasized (Gallo, Reichel & Anderson, 1988). Social disorganization or few social and community ties put the elderly person at a greater risk for depression. The social system in which older adults find themselves is of vital importance in assessing their vulnerability to psychological problems, and to depression in particular. Because of the losses of loved ones and friends, the support system that had become increasingly important over the years may now be considerably diminished. Schultz & Moore (1987) suggest that growing older in Western society represents a time of significant losses in the social network of support. Importantly, loss of a spouse leaves the older person in a state of a widower or widow that may contribute to their social isolation as they retreat into a virtually solitary

existence. Dean et al.,(1992) also support the notion that social support has a direct effect on depression. Their families grow, move out, develop relationships and live their own lives. Though loneliness is not a problem for the majority of older adults, loneliness is a serious problem for 12% of the elderly (Schultz & Moore, 1987). When more isolated elderly people have psychological problems, they may not come to medical attention unless they seek it on their own initiative. The elderly find themselves increasingly isolated as they incur the losses of spouses, family and friends.

Margolis & Rabins (1996) report the elderly are susceptible to depression due to the prevalence of chronic illness. Medical illness is not pleasant to endure at any age, and for the older adult it is even more difficult. They indicate that depression can also result from the chronic administration of beta blockers, reserpine derivatives, benzodiazines, cimetidine, or anti-cancer drugs. Billig (1987) Margolis & Rabins (1996) both concur that between 25% and 50% of all elderly persons having a Cerebral Vascular Accident (stroke) develop depression, either from the injury itself or from the disabilities suffered after recovery.

Depression is often expressed indirectly. Instead of talking about feeling depressed, the elderly person may complain about some physical complaint. Billig (1987), Diamond & Ross (1987) advise that the signs and symptoms of depression are extensive and cover a wide range of behaviors,

feelings, thought, and physical functions. Depression exhibits within a wide range of conditions, it may be a brief exaggeration of normal sad feelings, may be incapacitating, or even life threatening.

It is important for the direct practice social worker working with the elderly to be aware of the potential consequences of an unnoticed or undiagnosed depression. The prevalence is higher among the elderly than any other group, and so is suicide Harper(1989). Suicide rates for men over the age of 60 rise dramatically. Harper (1989) reports that white males over 65 have a suicide rate four times the national average; white females over 65 have a suicide rate twice the national average. Suicide rates among elderly non whites are much lower than those reported for whites. Diamond & Ross (1987), Billig(1987), Gallo, Reichel & Anderson(1988) all indicate that though the elderly population accounts for only 10% of the population, they account for 25% of all the suicides.

When elderly persons discuss openly their thoughts of suicide, the direct practice social worker must take them seriously. Though older persons make fewer attempts than younger persons, they frequently are successful in carrying out their plans. Interestingly, the risk of suicide is greater when a person begins to come out of a depression. Earlier they felt suicidal, but were unable to act because of the numbing effect of their depression. Now as they

come out of the depression they may still feel suicidal but can plan and take action to complete their attempt.

The purpose of this project was to introduce a communal meal program to a population of independent living elderly persons to test its effectiveness in the reduction of the symptomology of depression. Research indicates that depression is one of the most treatable disorders. However, it often goes unrecognized and untreated. Most older adults are not willing to invest the time to embark on a lengthy regimen of psychotherapy. It is not the purpose of this project to go into a lengthy discussion of the pharmaceutical treatments for depression. It attempted to offer a social intervention to assist in the treatment and prevention of depression in the elderly. Elderly persons through their losses tend to be isolated and lonely. The communal meal program is designed to bring them together with other adults in a friendly environment. It was anticipated that by dealing with their issues of loneliness and isolation that they will feel less depressed.

This project adopted a positivist perspective. Guba (1990) describes the appropriate methodology within the positivist paradigm as empirical experimentalism. The positivist belief system includes a realist ontology, which supports that there is a reality based on natural laws. The positivist approach aims to discover this reality by using scientific methodology.

Rubin & Babbie (1992) indicate that as social work practitioners we have a responsibility to discriminate between social work research that has credible findings, from social work research that has used methodologies that are weak. Being a professional social work practitioner involves providing the best possible support networks and services to assist our clients. Research from a positivist perspective methodology uses known scientific methods to insure that the services we provide are effective and produce the results we intended. Research from a positivist perspective can also assist in weeding out those services that are ineffective or even harmful to our clients (Rubbing & Babbie, 1992).

Epistemology is the science of knowledge. Research from a positivist perspective is interested in the scientific gathering of knowledge. The researchers remain distant from the subjects that are being studied in order to avoid contamination of the subjected knowledge they are gathering (Guba, 1990).

Rubin & Babbie (1992) relate that social science theory is based on fact or “truth”, what is and not what should be. Social science theory from the positivist paradigm does not attempt to address what should be. It does not attempt to address values.

This research project discusses depression in the elderly from a scientific theory approach and asks the questions: What is the cause(s) of



depression in the elderly? Will an intervention be effective in decreasing the reported symptoms of depression in the population being studied? This approach to research, the positivist perspective, will emphasize the production of quantitative data that is measurable and generalizable. The use of scientific social theory formatting will enable this research to verify whether or not the intervention causes a decrease in the reported symptomology or feelings of depression in the subjects.

In summation, living alone has been shown in several studies to be a contributor to the development of depression in the elderly. The elderly are constantly reminded how susceptible they are to losses. Self esteem may suffer as older adults come to see themselves in a negative light. Schultz & Moore, (1984) indicate they discovered through their research that the more lonely individual was more likely to be anxious, depressed, possess low self-esteem, and exhibit low levels of happiness and life satisfaction. In their study forty-four of the subjects attributed loneliness to "being without others". Schultz & Moore (1984), Weiner (1992), Dean et al. (1992), Gallo, Reichel & Anderson (1988) all indicate that loneliness as it contributed to depression was closely linked to lack of contact with friends.

### Hypothesis

The introduction of a communal meal program will decrease the amount of reported depression among the elderly participants.

## CHAPTER TWO

### Methods

#### Design:

The design for this project was a quasi-experimental design as explained in Rubin & Babbie(1992). It is also called the non-equivalent control groups design. Rubin & Babbie (1992) explain that the most frequent use of experimental designs is to see if the interventions we are using are effective. The use of this type of design is indicated when the assignment of subjects to experimental and control groups cannot be randomized. The components of the design are to pretest the experimental group and comparison group, introduce the independent variable (communal meals), to the experimental group and then to posttest the experimental and comparison groups.

The strength of this design is that it controls for threats to internal validity. There would be no reason for the experimental group to improve other than the introduction of the independent variable. The weakness, on the other hand, in this approach is that it does not address the possible effects of how the pretest will change the results of the posttest. When the subjects have prior knowledge from taking the pretest it may bias their posttest responses. There is also very little that can be done completely to

avoid experimental mortality. There may be individuals who decide to drop out of the communal meal program, move, or become ill and can no longer participate in the program.

This project utilized as the unit of analysis the elderly population of two HUD, Section 8, Section 202 housing buildings. The two HUD buildings are located in Southern California. The criterion for living within each of these communities is governed by the Housing and Urban Development Agency of the Federal Government. The basis for being considered for either housing complex is means tested. Since the criteria for each complex is the same, the population in each complex is similar in its makeup. There are approximately 100 elderly persons living in each of these settings. The elderly adults are living in an independent apartment community. They are low income and they are generally living alone. There is no communal meal program available at either site.

This project design is limited in the generalizations that can be made to only the population being studied. Rubin & Babbie (1992) report when our studies include only certain kinds of people we must only generalize our findings to that particular population. Thus the findings of this research project can only be generalized to low income elderly adults who are living alone and within the community of these two, and similar HUD housing complexes. Another concern is that the subjects will not be randomized

which will raise the possibility that the experimental group is not representative of the comparison group. However, it should be kept in mind that each group must meet certain criteria to reside in these housing units. They are alike in that they all are means tested, lower socioeconomic groups, elderly, generally living alone, isolated, and have suffered losses.

The experimental group came from a San Bernardino County HUD complex. The individuals living at this complex will be given the opportunity to participate in a communal meal program. The meal program will be operationalized as: either the noon or evening meal. The meal program will be offered three times a week. There currently is not onsite meal preparation. Participants will be requested to, but not required to, remain in the dinning room during the meal. This group will receive a pre test, the meal program, and then a post test to measure any changes in their reported depression. There were approximately 23 participants in this program.

The comparison group came from a Los Angeles County HUD facility. There is not currently a meal program instituted in this facility. This group will receive a pretest and after approximately 30 days a post test to measure any changes. There were approximately 30-40 participants in the comparison group.

### Sampling:

The sample for this experiment is representative of the population of this type of HUD facility. The sample population for the experimental group and comparison group will come from a convenience sample of the population. The current agency administrators request that whomever requests participation in the meal program being offered be allowed to participate. Thus, randomization of the experimental group was not possible.

### Data Collection and Instruments:

Data was gathered using a survey design, a questionnaire was used as the instrument to compile the data from the pretest and posttest. The instrument used was the CES-D scale for the measurement of depression (Appendix A). The Center for Epidemiologic Studies Depression Scale (CES-D) "has been widely used and reflects acceptable validity and reliability" (Margolis & Rabins, 1996, Radloff, 1977 as cited in Dean et al. 1992).

The questionnaire was one page and easily readable for the population to be studied. The CES-D is a matrix formatted, Likert-like scale measuring symptoms of depression as described by the subject in the range; rarely or none to most or all of the time. According to Rubin & Babbie (1992) "This format may increase the comparability of responses given to different questions for the respondent as well as for the researcher."

#### Procedure:

There are twenty questions and each answer was given a value. The values of each question were then added together and a total score was given to the subject. A score of 22 or higher on the CES-D indicates the possibility of depression. The CES-D was given to the experimental and comparison groups prior to the implementation of the intervention. The intervention was allowed to run for a period of thirty days. The experimental and comparison group were then given the CES-D again.

The Resident Services Coordinator at the HUD in Long Beach was responsible, under my direction, to administer and pick up the CES-D and separate consent forms. The Resident Services Coordinator at Long Beach was advised of the confidentiality of the responses to the CES-D. I was responsible for administering the CES-D at the Upland HUD and provided protection from injury to those participants.

#### Protection of Human Subjects:

In order to prevent harm to any of the participants they remained anonymous. They were requested to sign a consent form that was attached to the CES-D. After signing the consent form they were advised to remove it from the questionnaire and place it in an envelope, separate from the questionnaire. This ensured that they would remain anonymous and prevent them from suffering any injury or embarrassment. They were also

advised not to answer any question that would make them uncomfortable. If during their participation of the survey there were issues that became apparent to them and made them uncomfortable they were advised to contact the appropriate agency for their geographic location. This information was provided on the consent form and was available from the Resident Services Coordinators at each HUD complex.

Each individual was given a score. Using a test for statistical significance the experimental and comparison groups were evaluated to see if the intervention had any effect on the level of depression reported by the experimental group. There are two broad categories of significance tests; parametric and non parametric. The test used is determined by the level of measurement of the variables, sampling, the number of variables, and the way in which the variables are distributed in the population studied (Rubin & Babbie, 1992). Parametric tests are used when there is an interval or ratio relationship between the variables being studied. The t-test is the most commonly used parametric test. When comparing multiple ratio variables, as in the outcomes of the experimental and comparison groups the ANOVA statistical test for the analysis of variance is used. It produces a statistic called an F value, the probability that the differences between the groups are due to chance.

The concept of this project was: "How do we intervene with depression in the elderly"? The construct was: "Would a communal meal program lower the feelings of depression in the elderly. The independent variable in this project was the communal meal program. The dependent variable was the feelings of depression expressed by the elderly subjects. I anticipated that the communal meal program would have a positive effect on the feelings of depression. By providing a chance for the residents to come together for a meal that they would normally eat alone, I believed they would form new relationships, lower their feelings of isolation and loneliness and thus lower their feelings of depression.

The results of this project's analysis were causal. The independent variable caused the lowering of the measured dependent variable's feelings of depression.



## CHAPTER THREE

### Results

**Table 1**  
**Mean Scores for the Pretest and Posttest of the Experimental and Control Group.**

Group	Pretest	Posttest
Experimental	14.67	10.93
Control	9.4	11.00
	n=30	n=30

Table 1 shows the mean scores for the pretest and posttest of the experimental and control groups. The range of scores for the pretest for the experimental group was: 0-31, mean score: 14.67. The range of scores for the pretest for the control group was: 0-48, mean score: 9.4. The range of scores for the posttest for the experimental group was: 0-30, mean score: 10.93. The range of scores for the posttest for the control group was: 0-42, mean score: 11.00. There were 23 questionnaires distributed to the experimental group for the pretest and 15 returned for a 65% return rate. There were 15 questionnaires returned for the posttest for a 100% return rate. There were 35 questionnaires distributed to the control group for the pretest and 15

returned for a 42% return rate. There were 15 questionnaires returned for the posttest for a 100% return rate.

Table 1 indicates that there was improvement within the experimental group and that the control group deteriorated. A test of significance, chi square was performed on the data but due to the small number of participants the results did not meet the assumptions of chi square.

### Discussion

The results of the experiment support the hypothesis that a communal meal can decrease feelings of depression among the elderly. A closer look at the means evaluation indicates there is a trend within the two groups. The experimental group began to decrease its measured feelings of depression, pretest mean: 14.67, posttest mean: 10.93. While the control group's feelings of depression increased, pretest mean: 9.4, posttest mean: 11.00.

One would expect in this population a continued deterioration of the feelings of depression. However, this research project clearly shows that a communal meal not only slows this deterioration but in effect reverses its course. The members of the intervention group continued to lower their reported feelings of depression, while the control group member's reported feelings of depression increased.

Depression among the elderly is an important issue. The prevalence of depression is higher among the elderly than any other group. This project

attempts to evaluate an intervention that may assist in the prevention and treatment of depression. Many elderly persons are alone due to losses. In most family's meal time is a time for interaction, conversation, and support. Loneliness is also a contributor to depression (Schultz & Moore, 1984). In independent living situations without meal programs meal time is a very lonely experience for the elderly living alone. The communal meal program started with the experimental group continues. Therefore the experience of sharing with others and being part of a community provide those persons with gratification, improved self esteem and lower stress. Thus, it will assist in preventing and may be seen as an intervention in the treatment of depression in the elderly population.

While this study illustrates that a communal meal program can effect the feelings of depression in the elderly, many questions remained unanswered. For example, the participants of the experimental group were not chosen randomly and thus may have been less likely to report feelings of depression. Further, this study does not touch on what other influences may lead to feelings of depression in the elderly; data were not collected on other contributing factors, such as: chronic medical conditions or family support.

In many ways more questions were raised than answered. This research project demands that future studies should look at measuring a larger group. A larger sample population is indicated to provide statistically

measurable data. Perhaps looking at communal meal programs in situations where they are provided as part of the community care program.

## Appendix A Questionnaire

**Do not place your name on this form.** Please answer the following questions:

Age: \_\_\_\_\_. Living alone: (YES) (NO) Location: (Long Beach) (Upland)

Do you have any major medical problems? (YES) (NO). Family? (YES) (NO)

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the Past Week:	Rarely (less than 1 day)	(1-2 days)	Some (3-4 days)	Occasionally (5-7 days)	Most/All
1. I was bothered by things that don't usually bother me.	( )	( )	( )	( )	( )
2. I did not feel like eating; My appetite was poor.	( )	( )	( )	( )	( )
3. I felt that I could not shake off the blues, even with the help of my family or friends	( )	( )	( )	( )	( )
4. I felt that I was just as good as other people.	( )	( )	( )	( )	( )
5. I had trouble keeping my mind on what I was doing.	( )	( )	( )	( )	( )
6. I felt depressed.	( )	( )	( )	( )	( )
7. I felt everything I did was an effort.	( )	( )	( )	( )	( )
8. I felt hopeful about the future.	( )	( )	( )	( )	( )
9. I thought my life had been a failure.	( )	( )	( )	( )	( )
10. I felt fearful.	( )	( )	( )	( )	( )
11. My sleep was restless.	( )	( )	( )	( )	( )
12. I was happy.	( )	( )	( )	( )	( )
13. I talked less than usual.	( )	( )	( )	( )	( )
14. I felt lonely.	( )	( )	( )	( )	( )
15. People were unfriendly.	( )	( )	( )	( )	( )
16. I enjoyed life.	( )	( )	( )	( )	( )
17. I had crying spells.	( )	( )	( )	( )	( )
18. I felt sad.	( )	( )	( )	( )	( )
19. I felt that people disliked me.	( )	( )	( )	( )	( )
20. I could not get "going"	( )	( )	( )	( )	( )

## Appendix B

### Protection of Human Subjects

The study in which you are about to participate is designed to investigate the relationship between communal meals and depression. This study is being conducted by Michael D. Walper under the supervision of Dr. Lucy Cordona, professor of Social Work. This study has been approved by the Institutional Review Board of California State University San Bernardino.

In this study you will be asked to fill out a questionnaire regarding your feelings during the day. If you should become uncomfortable while answering any of these questions, feel free to skip that question or to discontinue filling out the survey.

Please be assured that any information you provide will be held in strict confidence by the researcher. At no time will your name be reported along with your responses. All data will be reported in group form only. At the conclusion of this study, you may receive a report of the results.

Please understand that your participation in this research is totally voluntary and you are free to withdraw at any time during this study without penalty, and to remove any data at any time during this study.

I acknowledge that I have been informed of, and understand, the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

---

Participant's Signature

---

Date

---

Researcher's Signature

---

Date

## Appendix C

### Debriefing Statement

Please detach this paper from the rest of the forms. The study that you are participating in is confidential. Your name will not appear on any of the studies documents or charts. Only your response, its numerical value, is used in this research project.

If at any time during this survey you become uncomfortable answering any of the questions feel free to skip the question or to discontinue filling out the survey. If you would like to explore further any issues that arise for you personally from this survey, please contact your Resident Services Coordinator for a referral to the appropriate agency in you area.

You may also contact Dr. Lucy Cordona, faculty advisor to this project, at California State University San Bernardino, Department of Social Work, 909-880-5501.

Thank you for your participation in this study.

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