Depression among the elderly

Lynda Lee Omagari

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DEPRESSION AMONG THE ELDERLY

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

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

by

Lynda Lee Omagari

June 2008
DEPRESSION AMONG THE ELDERLY

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ABSTRACT

Society now consists of the beginning of a growing population of elderly people. Modern medicine and the eradication of disease have enabled people to live much longer lives. This comes with great responsibility to meet the changing needs of this new cohort, people living to the age of 65 and older. Living longer does not necessarily mean that quality of life is extended into those additional years of living. Depression in the elderly is the most prevalent mental health problem.

According to the National Institute on Aging, over two million of the 35 million elderly are severely depressed, in addition to over five million suffering from lesser forms of depression. This is a serious problem that has increased over the past 15 years. The purpose of this study is to educate people on the prevalence of depression in the elderly population, and the need to alleviate symptoms through proper diagnosis and treatment.

This study will examine depression among the elderly in an assisted living facility. The main problem in depression in the elderly is the lack of diagnosis and treatment. Left untreated it affects the elderly person’s overall well-being and may eventually lead to their mortality.
ACKNOWLEDGMENTS

I would like to thank my research advisor, Dr. Rosemary McCaslin, for all her time, guidance, and patience during completion of this research project.

I would also like to thank Dr. Tom Davis for his guidance and humor during the origination of this project. I also acknowledge the faculty of the social work department, and my social work cohort for their continued support.

Finally, I acknowledge the staff and residents of Mt. San Antonio Gardens for providing research data and the opportunity to work with a wonderful group of people. Everyone has contributed to an experience I will never forget.
DEDICATION

I dedicate this research project to my family. Thank you all for your support, encouragement, and patience during this educational and personal journey.

In particular, I wish to thank my husband, my best friend, and life partner for his endless support throughout this process. Also I dedicate this to both my children Kendall and Chase for their endless adaptations.
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CHAPTER ONE

INTRODUCTION

This chapter will examine depression among the elderly population. Depression is prevalent among the elderly and often is undiagnosed and untreated. This study is relevant to social work practice due to the increasing numbers in the elderly population occurring over the next 30 years. The number of depressed people will significantly increase, leading to serious consequences for the well-being of a significant portion of society.

Problem Statement

According to the National Institute on Aging (2007), over two million of the 35 million elderly are severely depressed, in addition to over five million suffering from lesser forms of depression. During the last 15 years the incidence of depression has risen among the elderly. These statistics are alarming. With proper diagnosis the elderly are very responsive to treatment with antidepressants, similar to the responsiveness of young adults. The problem lies with the lack of recognition
that depression in old age is not a normal part of aging, but a serious illness that must be diagnosed and treated.

Depression is the most common mental health issue for the elderly and yet it is often undiagnosed and untreated (Krohn & Bergman-Evans, 2000). One standardized instrument known as the Geriatric Depression Scale can quickly assess whether an elderly person is depressed. Overt actions that manifest as interference with a person’s daily functioning abilities are signs of depression. This is known as depressive disorder or clinical depression according to the American Psychiatric Association’s Diagnostic and Statistical Manual (A.P.A., 2000). Depression that lasts for more than two weeks is considered a problem for the elderly population. It can fall into three different categories, ranging from mild or moderate, to severe. Without medication and treatment the depression can progress through the three stages, leading to more severe depression.

Untreated depression in later life compounded with other factors of aging increases the symptoms of depression. Factors associated with aging such as chronic medical illnesses and cognitive impairment increase the symptoms and levels of depression. Suffering from
depression combined with medical issues can lead to both physical and cognitive disability (Alexopoulos, 2005).

Among the elderly, depression that is under recognized and under treated leads to serious complications in their lives. The inherent risks associated with depression affect various aspects of their lives, including health, well-being, and ultimately their mortality. These three factors are co-dependent and must be recognized or the ultimate consequence of untreated depression can result in suicide (Holwerda, T, Schoevers, J. Deeg, D. Jonker, C., & Beekman, A. (2007). In 2003, persons 65 and older accounted for 17% of the 30,000 suicides in the United States. According to Alexopoulos, (2005) suicide occurs at twice the rate among the elderly, compared with those less than 65 years of age. Of those 74 years and older who commit suicide, 80% presented with depressive symptoms. The underlying factor for elderly suicide is depression. This depression combined with other contributing factors such as chronic illness, disruption in social structure and forced relocation for housing can ultimately result in suicide.

This social problem of depression among the elderly is relevant to social work practice because through
proper diagnosis and appropriate treatment the elderly person's depression can be treated. The importance of studying depression among the elderly is relative to the elderly population growth America is currently experiencing. This social problem can and will affect everyone as we ultimately grow old, day by day.

The aging of America is a reality that is creating new social implications, most rapidly within the next 30 years. Americans are living longer than ever before with an increase in those 65 years of age and older. According to Spitzer, Neuman, and Holden (2004), the population of aged 65 and older has grown from four percent at the turn of the century to 12% in the year 2000. Most startling is the estimation for the year 2030; the older population will reach 20%. The fastest growing cohort is those 80 years and older, referred to as the "oldest old." In 2000, those 80 and older represented three percent of the population and it is projected this will increase to five percent in 2030. This results in the doubling of the older people from 2000 to 2030.

There are several reasons for the influx of the aging population. The baby boom generation is partially responsible for an increase in the number of people who
will begin turning 65 in the year 2011. This is the beginning of the aging of this cohort, born between 1946 and 1964. Another reason for the growth in the aging population is an increase in life expectancy. The combination of disease eradication and improvements in medical care are responsible for multiple societal changes. These improvements bring responsibility that may be both positive and negative. Extending people’s lives does not necessarily mean a greater quality of life. People now will live longer, although much of the time will be extended at 65 years and older (Spitzer et al., 2004).

Depression will increase indirectly due to the number of people aging. Social policies at both the micro and macro level have acknowledged the larger problem of the aging of America exists. This, has clearly been identified within the area of gerontology, referring to the study of aging, which shares concerns regarding implementation and provision of necessary services directly related to the elderly.

There are aging policies at both the macro and micro level of social work. Several organizations and policies at the macro level are: The National Institute on Aging,
The Administration on Aging, The Gerontological Society of America, and the Older American’s Act. There are also multiple micro policies including Adult and Aging Services and Adult Protective Services. Both the macro and micro areas deal specifically with the elderly population.

The issue of depression affects all ages, not just the elderly. The social problem is depression not being recognized and treated. Often it is associated with normal aging, rather than the distinct problem it is within itself. A policy source associated with depression would be the National Alliance on the Mentally Ill (2007), encompassing all ages, not specifically the elderly.

Purpose of the Study

The purpose of the proposed study is to examine depression among the elderly. Depression affects on the average, according to Waugh (2006), one in eight elderly people with this number increasing to nearly 13 percent for those living in transitional housing. The prevalence of depression significantly increases for those living in assisted living facilities. These numbers are significant
and representative of an underlying problem that needs immediate attention. Senior housing must accommodate the vast numbers of the aged requiring this type of care, especially with the increase of the oldest old, requiring more care than the younger old.

One alternative becoming popular in long-term care is assisted living facilities. Aging consists of losses and a monumental loss occurs when a person must transition into a long-term care facility. Equally important is how a person copes with this change. The loss of independence, combined with dependency on others is the first step to an assisted living facility. This transition changes multiple aspects of the person's life. Their psychological well-being changes dramatically, leading to an increase of depression among the elderly (Hooyman & Kiyak, 2005).

Qualitative research would be beneficial for the study of depression among the elderly. According to Grinnell and Unrau (2005), qualitative research is more subjective, based upon the subject's and researcher's perception of their own reality. Data are obtained by interviewing the participants, and then the data are analyzed, following eight phases, according to Grinnell.
and Unrau (2005): problem identification, question formulation, design, collecting data, analyzing, interpreting data, and last the presentation and dissemination of findings. This will give structure to the research, and review of the literature will be utilized during all eight phases.

Qualitative interviews will be conducted among residents in the assisted living facility. They will be asked 15 yes/no questions and one open ended question verbally due to their possible visual impairment. The elderly people studied offer the most reliable data as participants are researched in the natural setting, where they live. The data will be obtained through personal interviews, consisting of 15 people, conducted by the researcher. The quantitative standardized instrument to be used is the Short Form Geriatric Depression Scale. The population of elderly in assisted living facilities needs to be clearly defined to enable data to be generalized to other populations. The sampling criteria will be both males and females from the age of 65 and greater with intact cognition.

The dependent variable in this research study is depression to be measured by the Short Form Geriatric
Depression Scale, consisting of 15 questions. It will be administered verbally to the residents individually during a brief interview. The dependent variable is a measurement of depression among the elderly living in assisted living facilities. The constant of living in transitional housing may be one contributing factor that increases the depression that is not diagnosed or treated.

Significance of the Project for Social Work

The significance of the project for social work practice is its importance for those suffering from depression, which is treatable with proper diagnosis. The findings of this study will increase awareness, educate, and hopefully facilitate change in the diagnosis and treatment of depression in the elderly. Social workers at both micro and macro levels may identify and intervene with depressed elderly more often, reducing the prevalence of depressed elderly.

The National Alliance on the Mentally Ill recognizes depression, and the field of gerontology recognizes the importance of aging issues. These two need to overlap into the area of elderly depression and address this
specific issue that has deadly complications. Social workers at the macro level would benefit from this interdependency with increased research on elderly depression, demonstrating its significance as a severe social problem. Research on depression among the elderly provides a foundation to build on, emphasizing the importance of the identification and treatment of depression. Depression among the elderly will continue to grow at tremendous rates with the influx of the Aging of America. This problem holds extreme significance for an aging society and will soon affect the elderly population during the next 30 years.

The stages of the generalist model that are most relevant to this study are assessment and action, or implementing. To assess depression would mean to judge the severity of the problem and examine its components. This would be an initial step towards identification of depression, to recognize its existence within the elderly population, not just as a part of growing old, or a normal variable of their life circumstances. Social workers at the micro level would benefit from this research in working directly with the elderly population.
The second stage would be implementation. Implementation would lead to reflection upon assessment of the social problem of depression in the elderly. Assessment or diagnosis is the first step followed by implementation. This would be a tangible process towards achieving a goal of appropriate treatment of depression, after proper diagnosis.

All this research leads to the question relating to the social problem studied. "Is there depression among the elderly living in assisted living facilities?"
CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents a review of the literature relating to depression among the elderly. The articles reviewed are organized by subsections according to the area of depression that is addressed. The areas of review are: the prevalence of depression among the elderly, the symptoms of depression, the risk factors for depression, and the risk factors for depression in assisted living facilities.

Prevalence of Depression

Depression is the most common mental health condition among the elderly. According to the National Institute on Aging (2007) over five million of the 35 million Americans age 65 and over suffer from depression. Approximately two million suffer from severe depression and left unidentified and untreated, have fatal consequences.

These statistics should be used to increase awareness and educate people on the prevalence of depression in the elderly. The statistics state that in
2003 of the 30,000 suicides in the United States, 17,000 were people aged 65 and above. Research shows that depression is treatable and 80% of people improve with proper medication. Proper identification and treatment of depression then improves co-existing medical conditions (National Institute on Aging, 2007).

The prevalence of depression is increasing as a natural result of the aging of America. Due to life expectancy increasing because of both eradication of many diseases, and improved health care, people are living longer. More people live to the age 65, and longer, to 80 and above. This increase in an aging society over the next 30 years leads to many changes in society (Spitzer et al., 2004).

This information provided is important because it affects not only certain individuals, but society as a whole. The aging of America will definitely affect everyone as they age themselves. There will be a disproportionate number of services to provide care for the elderly. The findings of a study by Spitzer et al., 2004) address the need for societal changes in health care and housing needs. The increase in depression affects the quality of care and life, for the elderly
population that will be heavily dependent on society as a whole. The need for long term housing for the elderly will increase three times.

In comparing and contrasting articles regarding the prevalence of depression the information found was consistent. The main information in this subsection consists of statistics on the aging of America. Limitations may exist with the levels of depression according to various socioeconomic groups of the elderly.

Symptoms of Depression
An examination of the symptoms of anxiety and depression were looked at among different age cohorts, because previous studies had not included older populations. Teachman, Siedlacki, and Magee (2007), measured several variables because they discovered that mood, anxiety, and depression often existed together. It is difficult to distinguish the symptoms of depression and anxiety.

The material confirmed that, in working with the elderly, depression is not a normal part of aging; it crosses all age cohorts. Depression can be measured and identified for appropriate treatment because depression
and anxiety although highly related, can be distinguished.

Teachman et al. (2007) found that the single factor model (depression) was worse than the two factor model (depression and anxiety) although the tripartite (depression, anxiety, and age) fared the best. The single factor lacked a distinction between depression and anxiety while the two factors did distinguish differences. Last the tripartite fared the best because the distinction between depression and anxiety was clarified in addition to being age specific to the elderly. Mood disorders and depression were lower in the elderly although this may be representative of the low rates of diagnosis and treatment. This would be relevant to intervention with certain age cohorts, or groups.

Another comparison study was done to examine the etiological and phenomenological distinction in depressive symptoms of participants. Two different cohorts were studied to look at early-onset and late-onset depression. The two cohorts were under age 60, and over age 60 years of age (Heun, Kockler, & Papassotiropoulos, 2000).
This study demonstrated that depressive symptoms differ in early and late onset cohorts and found that major depression that represents a smaller percentage of depressive symptoms among the elderly. Findings showed that symptoms of early and late onset depression are different throughout the course of the disorder. It suggested there may be etiological differences at late age onset.

In another study, older adults were found to experience more pain than younger age cohorts. Depression and positive and negative social changes occurs but the independent variable correlation was unclear. The sample was fairly representative and comparable to the 2000 United States Census. The participants were aged 65 and older, and their ethnicity was 83% white, 17% minority, the latter consisting of 11% black, five percent hispanic, and the other one percent not stated. The sample was also large, consisting of 916 non-institutionalized individuals. The limitation was that socioeconomics were not addressed (Mavandadi, Sorkin, Rook, & Newsom 2007).

The importance of these data is the correlation of acute or chronic pain and depression. Pain is clearly
identifiable and provides a starting point to then examine the individual further for symptoms of depression, and need for treatment. This includes the psychological and social intervention, not just biological. The article also addresses the individual’s pain in relation to social exchanges, or groups of people with whom they interact.

Findings indicated that negative exchanges predicted symptoms of depression over time, although positive exchanges were not limited by depression or pain. These may be correlated with the severity of pain and length of time pain existed.

To compare and contrast these articles shows congruency or incongruence in the subject area of the symptoms of depression. It is verified that depression is not a normal part of aging, although depressive symptoms do vary across age cohorts. The factors of chronic pain and illness may be a contributing factor in depressive symptoms, occurring more in the elderly population. The levels of depression are relatively low in those studied in the elderly, although this may be due to the social problem of lack of proper diagnosis among this cohort, age 65 and older.
Risk Factors for Depression

Three factors increase depression in the elderly population: chronic medical illness, disability, and cognitive impairment. These factors contribute to and increase the chances of depression, in the vulnerable elderly. Although treatment of depression using antidepressants works equally well in the elderly and a younger population, untreated depression causes serious effects on one's health (Alexopoulos, 2005).

Alexopoulos (2005) argues that it is important to have an awareness of the multiple variables affecting depression, including diagnostic, heredity, socioeconomic, epidemiology, prevention, psychopathology, and outlook. It is important to have an awareness of intervention techniques available to identify depression and provide appropriate treatment (Alexopoulos, 2005).

Alexopoulos (2005) covered in depth information and presented broad coverage of variables associated with depression, variables being cognitive impairment and chronic medical illnesses. The emphasis is on prevention, detection of depression, and appropriate intervention applied.
Another study looked at the prevalence of depression and treatment with medication among the elderly population. They did find that depression occurred in women at twice the rate of men. Findings reported that only one in three elderly that presented with major depression were taking medication. Of the 33%, 27% were taking a sedative/hypnotic drug. Concerns arose with findings that four percent of men, and 10% of women that were not depressed were taking antidepressants (Movandadi, S., Ten Have, T., Katz, I., Durai, U., Krahn, D., Llorente, M. Kirchner, J. Olsen, E., Van Stone, W., Cooley, S., & Oslin, D., 2007).

Movandadi et al., 2007 also reported a lack of diagnosis, and new to this study, misdiagnosis of depression in the elderly. The findings confirm that elderly people are depressed and treatable with appropriate medication. There are reasons they are depressed and these should be addressed appropriately. In sum, findings conclude that antidepressants are under-prescribed in the elderly.

In comparing and contrasting the risk factors of depression there were several similarities. The primary risk factors are consistent with aging in general:
chronic illness, disability, and cognitive impairment. In spite of these known factors, few were receiving appropriate medical treatment and taking antidepressants to alleviate symptoms, due to misdiagnosis. Misdiagnosis and under treatment of depression was recurrent. This increased the risks factors for depression.

Risk Factors for Depression in Assisted Living

One out of three older people in acute hospital care experience depression, with that rate increasing for placement in long term care. Waugh’s (2006) intention was to raise awareness of nurses providing care to properly identify depression. Depression undiagnosed and untreated can greatly increase the elder person’s mortality rate (Waugh, 2006).

The complexity of depression detection is related to the way it manifests in the elderly. Anxiety, memory loss, insomnia, and agitation may be presenting symptoms and are often confused with dementia. Proper detection can improve and or increase the elderly person’s life expectancy (Waugh, 2006).

Cummings (2002) studied the factors associated with the well-being of elderly residents in assisted living
facilities. The study was done in an assisted living facility designed to accommodate residents that are predominately widowed and functionally impaired (Cummings, 2002).

The study addressed the macro level in the development of assisted living facilities to meet resident’s needs. Its finds are also applicable to micro practice to educate staff and families about the psychosocial needs of residents through early identification of depressive symptoms. Depression can be identified through assessments among individuals leading to early intervention and treatment. The findings were similar to previous studies of the relationship between social support and functional impairment and their effect on the resident’s well-being.

An examination of appropriate interventions in long-term care found the two most common psychopathologies, depression and dementia. In studying the interventions the modification of the environment was found to maximize functioning of residents. Factors affecting diagnosis are a combination of dementia, behavioral problems, prevalence of pain, and lack of autonomy (Williams, 1999).
Jang, Gergman, Schonfeld, and Molinari 2006 addressed mental health among residents in assisted living facilities. Psychosocial issues and physical limitations were looked at in residents with depressive symptoms. This study sought to identify positive factors that reduce negative factors to promote well-being (Jang et al., 2006).

One cultural diversity issue Jang et al. (2006) addressed was with the Short Form Geriatric Depression Scale, stating it had been reliable and valid in diverse older populations for measuring depression. The residents were 77% female and 91% white. The ages varied with 17% being young old, 35% old-old, and 47% the oldest old. Private pay accounted for 64% of residents and their age, gender, race & marital status of participants similar to those reported by the American Association of Retired Persons (AARP, 2001).

Treatment of depression was addressed in a meta-analysis of individual studies, meaning the results were looked at statistically. This leads to a better estimate of the types of intervention used to identify depression. Over 2,300 articles were studied, and then a comparison was made with control group studies. The study
examined earlier studies, to determine which interventions were effective. Psychological treatments were effective and comparable to pharmacological treatments. The benefits of specific psychological treatments were not proven more beneficial than others. (Cuijpers, Van Straten, & Smit, 2006).

Theories Guiding Conceptualization

Psychosocial theories of aging used to determine the criteria for the assessing the overall satisfaction of the elderly were reviewed by Hooyman and Kiyak (2005), and Zastrow and Kirst-Ashman (2007). Many theories individually do not capture completely the elderly population, but a combination of several theories identified an analysis of the problem. Theories of role, activity, disengagement, labeling, and social exchange are relevant to this study.

Role theory describes the elderly person's role connected to their self-concept. Once retired, what role do they now fulfill? This also is related to disengagement theory which state that as people withdraw from society, it withdraws from them in return. Living alone, or in a long-term facility isolates the elderly
person from mainstream society. The activity theory equates life satisfaction with the level of activity a person maintains and that diminishes with age, due to biological and societal living arrangements. Labeling theory is related to all the previous, with the assumption that if society labels the elderly as non-productive and incapable of contributing to society, the elderly people view themselves this way also. Last social exchange theory focuses on the concept of mutual reciprocation between the elderly person and their community. A combination or even one of these lifestyle changes can drastically change a person's view of their life, leading to depression (Hooyman & Kiyak, 2005).

The elderly person may view themselves now as society has labeled them. Their role in life, is now undefined, their activity levels decrease; they feel they have nothing to offer society, and therefore they withdraw into an isolated, negative experience, they now view as their life. Various aspects of their lives are forever changed such as, their community, housing, friendships, independence, social activities, and dignity. All these variables would be representative of the person in environment theory and the previous
theories as being interdependent and leading to depression (Zastro & Kirst-Ashman, 2007).

An underlying problem that may be unaddressed, is whether the elderly are maintaining life satisfaction in his or her new environment? Problems may exist in their new homes because of an unsuccessful transition from their prior home where they maintained more independence. There are varied housing options to choose, and the individual’s needs are the greatest determinant of the housing option chosen. This may be reflective solely of their needs and not necessarily their desires.

Analysis of this problem is an issue for social work, with the interdependency of both micro and macro levels. We must look at the individual and their relation to the community in which they live. This refers to the person in environment theory, with the elderly adapting to life’s changes, often with lessening of control over themselves and their environment. This perspective has been studied by Kondrat (2002), looking at the macro-micro divide and joining them to look at the whole picture.

Analysis of the micro component studies the individual, in this case the elderly. As we age we
experience many changes and the adaptability and
dependency that exists is a challenging aspect for the
elderly. The elderly person's gradual loss of
independence affects them psychologically in various
ways, leading to depression. These issues and the
depression that accompanies them need acknowledgement,
appropriate diagnosis, and intervention.

Summary

In conclusion, this literature review found was
reoccurring themes related to depression in the elderly.
The main areas of concern are the lack of diagnosis, and
the under treatment of depression in the elderly. The
prevalence of depression in those 65 and older is evident
and the consequences when left untreated can be fatal.
Both treatment and medications can help alleviate
symptoms, and in return, provide the elderly population
with a better quality of health, happiness, and life.
CHAPTER THREE

METHODS

Introduction

This chapter covers the methods utilized in gathering research data. It includes study design and the strategy used for sampling. Procedures cover the collection and analysis of data and the instrument used. Last the protection of the human subjects involved in this study is covered.

Study Design

The purpose of this study was to explore the prevalence of depression among the elderly in an assisted living facility. Both qualitative and quantitative methods were utilized to obtain answers for the research questions. The Short Form Geriatric Depression Scale was orally administered, followed by one open-ended question. The latter is intended to expand or clarify thoughts that incurred, while answering the closed-ended questions, on the Geriatric Depression Scale.

The limitations of this study have several components. The sample was obtained through volunteers that participated in the study. Those elderly may have
not been depressed if they were willing to interact with the researcher, and answer questions related to their current mood. Also, among those that did participate there may have been a reluctance to divulge true emotional responses. This may be due to the limited time for engagement of the persons, or fear of revealing feelings.

Research question: Is there depression among the elderly living in assisted living facilities?

Sampling

The sample consisted of residents of an assisted living facility in Los Angeles County. Residents were obtained based upon a volunteer basis. There are three criteria that the participants had to meet prior to participate in the research project. These criteria consist of the subjects’ being 65 years or older, cognitively intact, and English speaking. The sample obtained consisted of 15 elderly residents. Residents were asked to voluntarily participate in a brief research study to help a graduate student. Participation was requested following their morning exercise program each time the researcher arrived.
Data Collection and Instruments

Data collected were: age, duration in assisted living facility, frequency of contact with family, and activities of daily living. Data included measuring depression, demographic variables, and a qualitative question about participants' current mood. The dependent variable of depression was measured by the Short Form Geriatric Depression Scale. This measurement consisted of a questionnaire of 15 closed ended questions, requiring a yes/no response added to create an interval score varying from zero to fifteen. A score of five or greater suggests probable depression.

There were several independent variables, the first being one qualitative question and the others demographic information. The demographic variables for activities of daily living (ADL) impairment. These variables were interval and were measured by certain criteria. The first was age, measured in years, next duration, measured in months, contact with family, and frequency of visits. Last, ADL impairment relating to three ordinal items including the ability to bathe, ambulate, and dress, were measured by the response to yes/no questions, scoring one through three. The other independent variable was ordinal.
in determining the level of education. The measurement was done to create an interval score ranging from one to four. The following levels being: high school graduate, some college, college graduate, and graduate school.

The instrument used was the Short Form Geriatric Depression Scale (See Appendix). This short form is a form derived from the original GDS. The long form was originally created by (Yesavage, et al., 1983). It has been used extensively and tested with the geriatric population. The short form was created in 1986 based upon questions from the long form. These questions had the highest correlation of depressive symptoms in numerous validation studies (Holwerda, T, Schoevers, J. Deeg, D. Jonker, C., & Beekman, A. (2007).

Clinical practice and other research support the reliability and validity of this instrument. Its cultural sensitivity may be more relevant to American culture. In other countries they may have different cultural standards that would deviate from the questions on the GDS. There also are different concepts of depression in different cultures (Holwerda, et al., 2007).

The strengths and limitations of the GDS are several. A strength is that it a useful tool to screen
for depression in the elderly. Another is that the GDS questions are related to an elderly person's mood, not their physical symptoms, that they generally more readily identify with. Last the test is easy to administer, with little training required.

Another limitation may be it's the cultural relevance to American culture. Additionally it does not assess for suicidal ideation. The qualitative question will consist of one open ended question, "What can be done to improve your current mood?"

Procedures

The data gathered occurred at an assisted living facility. Residents were given the Short Form Geriatric Depression Scale. In addition the participants were asked one open ended question. Data for this one question was obtained and recorded through dictation for later reliable review. Participation was obtained by requesting volunteers by the assistant director of the facility following an exercise class. The data collection took place in a private area for neutrality of environment. The data was collected by the researcher. Data was
obtained over a time period of five weeks, starting January 22, 2008 to February 26, 2008.

Protection of Human Subjects

The elderly that participated in the study by direct questioning were protected. This includes anonymity and approval by the Institutional Review Board. The participants signed an informed consent prior to information obtained, and upon completion were given a debriefing statement.

Data Analysis

The sample was described by univariate statistics. Then the dependent and independent variables were analyzed by correlational bivariate statistics. The question "What can be done to improve your current mood?" was analyzed qualitatively. The qualitative analysis procedure examined the data themes among residents about how their mood could be improved. As themes in their statements emerge, they were categorized.

Summary

In conclusion, this chapter summarizes the components necessary to implement the research study. It
included the study design, sampling, and the procedures utilized. The protection of human subjects was clarified. The results were compiled through data and analysis.
CHAPTER FOUR
RESULTS

Introduction

This chapter summarizes results utilizing a research design that was both quantitative and qualitative. Data analysis consisted of both inferential and descriptive statistics. Demographic variables obtained were age, gender, education, self-reported health, frequency of family contact, and duration of placement. Depressive symptomology was measured by from the Geriatric Depression Scale. Finally, dictation results were analyzed for a common theme in response to one qualitative question.

Presentation of the Findings

The sample consisted of 15 residents in an assisted living facility. They were all volunteers and participated in the study based on meeting two criteria: being at least 65 years old, and being cognitively intact. Age ranged from 85 to 98 years with a mean of 92.1 years. Residents completed the Geriatric Depression Scale Short Form in response to the interviewer asking 15
yes/no questions, and demographic information was completed in the same manner.

The sample consisted of 12 females (80%), and three males (20%).

Table 1. Gender

<table>
<thead>
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<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>female</td>
<td>12</td>
<td>80.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The following four variables were measured ordinally: education level, duration of placement, frequency of contact, and self perceived health.

The education level of the sample was fairly high; 6.7% completed high school, 20% have some college, 53.3% were college graduates, and 20% completed graduate school.
Table 2. Education

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Some College</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>College Graduate</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>Graduate School</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Duration of placement in the assisted living showed 26.7% had lived there less than one year, and 73.3% had resided there more than one year.

Table 3. Duration of Placement

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Greater than one year</td>
<td>11</td>
<td>73.3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Frequency of contact with family was assessed as daily, weekly, or monthly. Findings show that the majority of residents had weekly contact with family (53.3%): daily contact was 26.7%, and contact monthly was 20%. 

36
Table 4. Contact with Family

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>4</td>
</tr>
<tr>
<td>Weekly</td>
<td>8</td>
</tr>
<tr>
<td>Monthly</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Residents reported their self perceived health as good, fair, or poor. The majority rated their health good (46.7%): 33.3% rated it fair, 20% poor.

Table 5. Self Perceived Health

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>7</td>
</tr>
<tr>
<td>Fair</td>
<td>5</td>
</tr>
<tr>
<td>Poor</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
</tr>
</tbody>
</table>

Residents needed assistance with three ADLS: walking (93%), dressing (13.3%), and bathing (13.3%).

The Geriatric Depression Scale was administered to all the residents orally. Depression at the mild level was found in 13.4%, moderate levels in 6.7%, and 80% showing no depressive symptoms.
Pearson’s correlation coefficients were assessed among two ordinal and interval variables. These bivariate findings showed that of the nine demographic variables examined, only two had a significant association with the geriatric depression scale.

Findings show a moderate positive correlation \( r = .570, \ p = .027 \) between ADL impairment and GDS scores for depressive symptomology. Self-perceived health scores also showed a significant positive correlation \( r = .793, \ p = .000 \) with GDS scores.

An independent sample test was run with two categorical variables gender, and length of time lived in the assisted living facility. No significant differences were found.

Qualitative Data

Qualitative data were obtained in addition to the Geriatric Depression Scale by the researcher asking one additional open ended question: “What can be done to improve your current mood?” Several themes emerged from this question.

Residents’ dissatisfaction was related to three items: transportation, declining health, and vision.
Transportation was a problem for all residents because they lost independence, and the ability to pursue leisure activities. They felt limited and reliant on other people to provide transportation. Transportation was provided at the facility, but only for physician visits and necessary appointments, not for leisure activities. Declining health contributed to the inability to sustain prior activities they enjoyed. Vision limited their ability to both read and drive. There was a good library with large print books available that many residents stated was an asset. The majority of the residents stated they were receiving good care at this facility and were thankful. One resident stated nobody lives here because they want to, but if you have to be here, and then this is a great facility. Another resident stated she enjoys her independence living alone at the facility, giving her family independence also. They were satisfied with the staff, activities, and food at the facility.

Summary

Chapter Four reported analysis of quantitative and qualitative data. Nominal, ordinal, and interval variables were examined for their relationship to the
scores calculated on the Geriatric Depression Scale. Pearson correlations and test were used to determine relationships of independent variables with depression scores and several significant associations were found. Last, the qualitative data obtained directly from the residents were analyzed for common themes.
CHAPTER FIVE

DISCUSSION

Introduction

Chapter Five is a discussion of findings of the study to explore depression among the elderly, in an assisted living facility. Limitations of the study are discussed, and the implications for social work practice, policy, and research are summarized.

Discussion

This study examined depression among the elderly in an assisted living facility. Both quantitative and qualitative methodologies were used to give the researcher a thorough representation of the issues.

There were 15 residents that participated in the study, 12 women, and three men. The average age of the residents was 92.1 years old, and the majority has lived in this facility for more than one year. The education level of residents was high with 53.3% being college graduates, and 20% attending graduate school. The majority 53.3% had weekly contact with family members. Also self perceived health was reported as good by 46.7% of the residents.
Statistically significant positive correlations were found for two variables and the Geriatric Depression score symptomology. The two variables related to depressive symptomology were: ADL impairment, and self perceived health.

Limitations

Several limitations of this study were recognized during the research process, and during data analysis. The study was voluntary and the sample was not random. Residents were selectively chosen by the director, based upon availability when the researcher was present at the facility. This may have excluded depressed individuals who were not asked to participate in the study.

Research was conducted at only one assisted living facility with one sample of 15 residents. The facility director was open to allowing the researcher to conduct research in the facility. This may indicate that levels of depression were thought to be low prior to beginning research. She stated that this facility welcomed researchers often and the residents enjoyed participating in research studies.
Finally, the residents themselves may have responded more cognitively than emotionally. The residents often had difficulty responding to the Geriatric Depression Scale, based upon the strictly yes/no questions. They expressed difficulty responding without explanation of their answers. The residents’ high level of education may have influenced their responses.

Recommendations for Social Work Practice, Policy and Research

Research results from this study showed mild levels of depression among the elderly living in this assisted living facility. Recommendations for future social work practice include education of staff and residents, program and policy changes to identify and treat depression, and continued research. This study raises societies’ awareness of the presence of depression among the elderly. Residents were educated that depression is identifiable and treatable, and to seek treatment to alleviate depressive symptoms.

Policy makers regulating aging issues must be educated regarding depression in the elderly that is under recognized and under treated, and the fatal consequences it can produce. Guidelines must be initiated
and enforced to identify and treat depression in the elderly. Depression can be identified through assessment of the Geriatric Depression Scale, or other assessment measurements upon entering assisted living, or other long term care facilities. A complete psychosocial assessment should include history of depression and medications taken. Repeated assessments bi-monthly or quarterly would be beneficial to assess variances in scores and determination of contributing factors. Residents the researcher studied were unaware that there was a social worker on staff to assist them with resources.

Research is necessary in numerous other facilities, with larger random sample sizes, and different socio-demographic variables. Additional research may indicate other positive correlations with similar or different variables. Significant correlations identify variables relating to depression, leading to identification and treatment.

Conclusions

The researcher attempted to assess depression among the elderly in assisted living facilities. Fortunately high levels of depression were not found at this facility
with the research methods utilized, and the selected sample chosen for the researcher. Depression may exist although hidden from this researcher on random days, and among selected residents participating in data collection. Further research is needed at various facilities for identification and treatment of depression among the elderly.
APPENDIX A

INFORMED CONSENT
Informed Consent

The study in which you are being asked to participate is a research project designed to explore depression among the elderly. Lynda Omagari is conducting this study under the supervision of Dr. McCaslin, Professor of Social Work at California State University, San Bernardino. The Department of Social Work Sub-Committee of the California State University San Bernardino, Institutional Review Board has approved this study.

In this study, you will be asked to answer a confidential questionnaire on your current mood. Following this questionnaire you will be asked one additional question, “What can be done to improve your current mood?” This question will be recorded using a dictation device for the sole purpose of assisting Lynda Omagari to remember your comments. The entire process should take about 20 minutes. Only the researcher and project advisor will have access to the completed forms and questionnaires. Finally, the information you provide on the questionnaire will be held in the highest form of confidentiality.

Your decision to participate in this study is entirely voluntary. If you do not feel comfortable with any part of this study you are encouraged and free to stop and withdraw at any time. This study has no foreseen risks. Completing this study you will be given a statement describing the study in more detail. Your Participation in this study will help the researcher understand the relationship between your mood and being age 65 and older.

If you have any questions or concerns about this study, please feel free to contact my faculty advisor, Dr. McCaslin at (909) 537-5507, or email rmccasli@csusb.edu

_____ Place a check mark here if you agree to be in this study

_____ Place a check mark here if you agree to be recorded
APPENDIX B

DEMOGRAPHIC DATA SHEET
Demographic Data Sheet

1. How old are you?

2. Gender?

3. How long have you lived in an assisted living facility?
   Less than 1 year ______
   Greater than 1 year ______

4. How often would you say you get visits or telephone calls from your family?
   Daily _____  Weekly _____  Monthly _____

5. What is your highest level of education?

6. How would you rate your health?
   Good _____  Fair _____  Poor ______

7. Number of Activities of Daily Living (ADL’s) you need assistance with?
   Bathing _____  Dressing _____  Walking ______


APPENDIX C

GERIATRIC DEPRESSION SCALE
Geriatric Depression Scale – Short Form

Choose the answer that best describes how you have felt over the past week, responding with either yes or no.

1. Are you basically satisfied with your life? Yes / No
2. Have you dropped many of your activities and interests? Yes / No
3. Do you feel that your life is empty? Yes / No
4. Do you often get bored? Yes / No
5. Are you in good spirits most of the time? Yes / No
6. Are you afraid that something bad is going to happen to you? Yes / No
7. Do you feel happy most of the time? Yes / No
8. Do you often feel helpless? Yes / No
9. Do you prefer to stay at home, rather than going out and doing new things? Yes / No
10. Do you feel you have more problems with memory than most? Yes / No
11. Do you think it is wonderful to be alive now? Yes / No
12. Do you feel pretty worthless the way you are now? Yes / No
13. Do you feel full of energy? Yes / No
14. Do you feel that your situation is hopeless? Yes / No
15. Do you think that most people are better off than you are? Yes / No

Additional question

1. What can be done to improve your current mood?

________________________________________________________________________
APPENDIX D

DEBRIEFING STATEMENT
Debriefing Statement

I, Lynda Omagari would like to say thank you, and that your participation in this study was greatly appreciated. The researcher wanted to explore how common depression is in the elderly. This study will benefit other elders by increasing knowledge regarding the identification, and subsequent treatment of depression among the elderly.

Once again thank you for your participation and for not discussing the contents of this research with other residents until this study is completed. If you have any questions about this study, please feel free to contact my faculty advisor Dr. McCaslin at 5500 University Parkway, San Bernardino, CA, 92407 or at (909) 537-5507.

If this study has raised any personal issues that you feel need further discussion please consult with your Department of Social Services staff.
REFERENCES


