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Elder depression among nursing home residents

Alejandro Paul Holguin

ELDER DEPRESSION AMONG NURSING HOME RESIDENTS

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

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ABSTRACT

Elder depression is a huge problem in society, especially as the older population continues to grow at an alarming rate. This study investigated the prevalence of depression among a nursing home sample by using the Geriatric Depression Scale as a measuring instrument. Additionally, this study investigated for correlations between demographic information and item responses. Significant correlations were revealed between the time participants have lived in the facility and life satisfaction, feelings of hopelessness and emptiness. Also, significant relationships were found when participants' age was correlated with life satisfaction and dropping usual activities. After analyzing interview responses, regarding five items on the Geriatric Depression Scale, the responses were analyzed using grounded theory. The responses revealed a theme that medical concerns were related to experiencing depressive symptoms among the sample studied.

Further research can branch off this research by following a purely qualitative format. Depressed nursing home residents can be interviewed in depth, regarding depressive symptoms, in order to gain generalizable

results regarding causes and resiliency factors associated with each symptom on the scale. Future research can also focus on comorbid depression to examine the medical ailments most common in depressed patients.

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DEDICATION

I would like to thank God for the strength, patience, and endurance that was needed to complete this research.

I would like my family for providing me with love, financial support, food, and a roof over my head. Without my family a Masters Degree would not have been possible.

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CHAPTER ONE

INTRODUCTION

The elderly population has grown rapidly within the past 50 years and it is continuing to increase. In 2003, 35.9 million Americans were aged 65 years plus. By 2030, the number is projected to be twice as large, growing to 72 million (Thakur, & Blazer, 2008). The age wave of elder citizens can be contributed to three factors. First, the baby boomers, born between 1946 and 1964 are nearing the age of 65. Secondly, the present birthrate has declined, leading to less youth being represented in the general population. Lastly, life expectancy has risen due to advancements in medicine, improved nutrition, and better health care conduct (Gallagher-Thompson et al., 2001). According to the National Institute of Mental Health Facility Survey and National Nursing Home Survey, nearly 70% of residential care facility residents have psychological health needs, depression included (Gallagher-Thompson et al., 2001).

Problem Statement

Due to the high rate of depression among community dwelling elderly people and those living in residential

care, this study was created to provide further awareness that a serious problem exists, with hope that social services will broaden to include those that live in nursing, convalescent, and retirement homes alike. Regardless of the different policies imbedded in each of the former placements, residents face similar experiences like transitioning from independent living, loss of family with little to no social support, and a host of medical problems (Hendrix, 2001).

The focal point of this thesis project is to examine depression among nursing home residents aged 65 and over. Throughout the general population elderly people are more likely than younger generations to experience depression (Hendrix, 2001). In late life, the prevalence of loss increases, like loss of loved ones, loss of physical abilities, decline of cognitive functions, decline in physical health, loss of social support, etc., and this can overwhelm peoples' aptitude to conduct everyday activities as well as precipitate feelings of frustration (Von Hippel et. al., 2008). An accumulation of such events can become very saddening. Depression is related to a number of harmful outcomes, for example, suicide, suicide ideation, death, pain, and nourishment deficits

(Hendrix, 2001). Outcomes as such should not be taken lightly.

Furthermore, as people age they are more likely to experience medical problems. Medical problems are highly comorbid with depression, and together they can work together to tarnish an individual (Van der Kooy et al., 2007; Hendrix, 2001). The perceptions inviduals have about their outcome after a medical diagnosis can contribute to depressive symptoms, and vise versa. Stress and depression are common contributors to cardiovascular disease, strokes, carotid stenosis, and plenty of other physical ailments (Rao et al., 2001).

When elderly people are admitted to nursing home facilities it is critical to recognize depression as soon as possible to prevent an exacerbation of symptoms (Achterberg et al., 2006). Depression is rarely recognized in nursing homes. Low recognition takes place because nursing facilities operate under the medical model, in which the focus is on medical ailments, not psychological dysfunctions (Cummings & Cockerham, 2004). Strictly following the medical model leaves out other important problems that the elder population faces, making way for an array of problems. False beliefs exist

among nursing home staffs, regarding depression. Ayalon et al. (2008) conducted a study, in which they interviewed staff regarding their beliefs about elder depression, and participants' responses revealed that staff held incorrect beliefs about indicators and symptoms of depression, and were less familiar with the efficiency of particular interventions for depression.

Therefore, research results need to be taken seriously, and action needs to take place to address depression among elderly people in residential care facilities, whether it is prevention, treatment, or maintaining homeostasis. An exploratory study, as this one, allows for a snap shot of the lives of residents, in order for Social Work practitioners to gain a feel for the lives of elders who live in residential care facilities.

Purpose of the Study

The purpose of the study was multifold. The study was designed to confirm the hypothesis that depression is prevalent among nursing home residents. More awareness is needed on depression among elderly nursing home residents (Ayalong et al., 2008), so this research set out to

provide evidence in the locality of San Bernardino County, where very little research exists on geriatric depression among nursing home residents. The participants' responses were examined to explore the dominant symptoms among the sample, in order educate Social Workers on the symptomatic picture of geriatric depression and to open the door for future research. Associations between demographic information and item responses were examined to gain a better understanding on the dynamics of depression, among a sample that is prone to depression.

Thirdly, grounded theory was used to determine any patterns in interview responses given from the participants. By incorporating a interview into the study, it allowed for authentic insight to be gained form the perspective of elder residents in regards to why they believe to be enduring specific symptoms. By asking participants why they may be experiencing no life satisfaction, themes were able to be identified among the sample, indicating that specific factors may have an influence on creating or exacerbating certain symptoms. Incorporating the interview into this study allowed for

data to be created that will lead to future research and broaden the knowledge of the Social Work Profession.

Research Questions

The following questions guided the conduct of this study:

1. Is depression prevalent among the participant group?
2. What are the prevalent symptoms of depression among elderly people living in the residential care facilities being explored?
3. Are there any correlations between the demographics and item responses?
4. Do any patterns/themes emerge from the overall analysis of participant responses to the interview questions?
    a. What are the commonly perceived reasons, among residents, to endure the each of the following: no life satisfaction, boredom, feelings of helplessness and worthlessness, and preferring to stay in their room, rather than going out and doing new things?

Significance of the Project for Social Work

Social Work exists to aid those who are vulnerable, oppressed, and living in poverty. The elder population living in nursing homes is considered a highly vulnerable population. Many elder residents endure depression without receiving any treatment, due to lack of concern by nursing facilities that operate under the medical model, and to lack of awareness throughout society. For macro changes to take place, research needs to be created to push policies into action. This research creates further evidence that depression plagues elder residents. Additionally, this study will be accessible for social workers working in the macro arena who desire evidence that a problem exists, giving force to the changes that need to take place for the elderly population.

In this study, various dynamics of the elder population, pertaining to geriatric depression, were examined. A plethora of depressive symptoms were looked at to bring more insight to the profession of Social Work, benefiting all system levels (micro, mezzo, and macro). Research, like this study, slowly uncovers any ignorance that may exist, regarding senior citizens residing in residential care facilities. As research

continues on this populace, knowledge will be crystallized to allow for an efficacious delivery of services.

As social workers, we are trained to follow the Generalist Intervention Model when engaging clients who need or want services. The steps of the model are, engaging, assessing, planning, implementing, evaluating, terminating, and follow-up. The information drawn from this study will be valuable in all stages, particularly in the assessment stage, where information will be gathered to diagnose and develop treatment plans for clients. This study provides identifiers of geriatric depression among residential care facility residents, providing practitioners with clarification on what depression involves for the elderly population living within residential care facilities.

With adequate knowledge, practitioners, residential care staff, or interns who are working with elder residents, will be better able to spot overt symptoms (isolation, low appetite, fatigue, loss of interest, etc.), and not just assume that such symptoms are associated with old age, which has been a common assumption by those caring for elder residents in

residential care facilities (Ayalon, Arean, & Bornfield, 2008; Gallagher-Thompson, 2001; Bagley et al., 2000). Also, when working with the aged population in residential care facilities, practitioners will be more aware of what type of situations clients are facing (medical, loss, boredom, etc.), emphasizing that a sensitive and empowering approach to practice must be employed.

The qualitative portion of the study gave insight into the thought content of the sample, in regards to their medical and transitional difficulties, as it pertains to their mood. Such information can be valuable to the intervention stage of the generalist intervention model. By gaining knowledge on the thoughts associated with depressive symptoms, practitioners can apply cognitive behavioral techniques to facilitate optimistic thinking, which will in turn lead to positive behavioral changes.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The elder population is continuing to grow at a fast rate, along with the biopsychosocial problems associated with late adulthood. Suicide is a risk among depressed elders and it should not be taken lightly (Steffens, 2007; Pollock & Reynolds, 2000). As people age, the risk for medical problems arise that may run co-morbid with mental problems like depression, possibly exacerbating symptoms, or giving depression life (Mehta et al., 2008; Vonhippel et al., 2008; Van der Kooy, 2007). It is highly common for heart disease to be co-morbid with depression (Vonhippel et al., 2008). Various changes in the external environment take place that may lead to depressive symptoms. For example, more deaths began to occur within and around social networks of elderly individuals, and loneliness may shed over one's life (Von Hippel, et al., 2008; Thakur & Blazer, 2008, Van der Kooy, 2007). As the elasticity of the brain decreases, cognitions that accompany problems that may occur in late life become difficult to redirect, leaving people ruminating in

depressing thoughts (Von Hippel, et al., 2008). Depression poses various problems for elder people, which makes elder depression, especially among residential care facility residents, a concern among the social work profession.

Placement into a nursing facility may contribute to depressive symptoms or aggravate existing symptoms. Residents must confront life's obstacles (pertaining to old age), along with issues that accompany transitioning (Thakur & Blazer, 2008). As folks transition into nursing facilities they become alienated from family and friends, and such disruptions to social support networks may dramatically affect physical, cognitive and mental well-being (Winningham & Pike, 2007). While under the care of nursing home staff, detection of depression may not occur, due to lack of education on mental health among professionals who care for residents (Ayalon & Bornfield, 2008). The following information will elaborate on the facts mentioned above.

Depression among the Elderly Population

Depression is a mood disorder that is characterized by feelings of worthlessness, diminished abilities to

concentrate, low energy levels, fatigue, rumination of losses within ones life, recurrent thoughts of death, decrease in cognitive functioning, etc. (Thakur & Blazer, 2008; Von Hippel, 2008, Hendrix 2001). Such factors can really take its toll on a human being, especially when little to no social support exists, which is common among the elderly population (Winningham & Pike, 2007). As the aging population continues to grow, depression will soon move from the fourth leading contributor to the global burden of illness-related disability to the second factor (Pollock & Reynolds, 2000).

Loss is a huge part of aging, especially loss of loved ones. It has been found that 10-20% of widows develop major depression within the first year of the grieving process (Pollock & Reynolds, 2000), leading to many other dangers. Other negative changes that elders must endure are diminished social support, limited socioeconomic resources, late life disabilities, stressful life transitions, and medical co-morbidities (Mehta et al., 2008).

A study, in 2007, screened participants for depression with the Geriatric Depression Scale, along with apathy, disability level, and resilience (Mehta et

al., 2007). "The directionality of the relationships was as expected: greater apathy, greater disability and lower resilience were all independently associated with an increased Geriatric Depression Scale score" (Metha et al., 2007, p. 3). Among those aged less than 80, the most significant correlation was between depression and medical co-morbidity. If one acquires a medical illness the chances to become depressed rise (Metha et al., 2007). As the aging process occurs, the chances are high to develop a medical problem. Such problems may lead to depression and work together to tarnish an individual. Medical conditions are atypical of those aged 65 and over, creating a higher probability to become depressed.

Von Hippel et al, (2008), conducted a study which conveyed that executive dysfunction had a positive correlation with the occurrence of depressive symptoms. The latter two dysfunctions can create an undesired outcome for those in late adulthood. As people enter later adulthood many positive and negative things occur simultaneously. Positive changes are the birth of grandchildren, the introduction of in-laws, retirement, and more (Von Hippel, et al., 2008). Negatively perceived changes are death of family members, chronic illness,

thoughts and fears of death, and an overall decrease in executive functioning (Von Hippel, et al., 2008). With a decrease in executive functioning, the ability to control ruminating thoughts decreases, opening the door for depression.

> ...Age related declines in inhibitory ability and other executive functions (attentional control, cognitive flexibility, etc.) lead to impaired ability to regulate ruminative responses to negative affect and thereby contribute to the development maintenance and or intensification of depressive symptoms in older adults. (Von Hippel et al., 2008, p. 483)

For example, if one is loosing the skill to redirect their cognitions, during a bereavement process, they may not be able to transcend the process and continuously repeat sad, powerless, and grieving thoughts (Von Hippel et al., 2008).

Depression is the root to many problems for the elderly. Before the root grows into a tree, hypothetically speaking, it should be dealt with to prevent bigger and deadlier problems from manifesting. As social workers, it is an ethical responsibility to aid

those populations that are considered to be vulnerable. Elderly depression among a vulnerable population (institutionalized elderly citizens) is surely an area of concern for social workers. Depression, as displayed in the literature above, may be manifested in peoples' lives along with other debilitating problems, and may be linked with or exacerbated by other factors. It would be unethical and immoral for the social work profession to stand by and allow elder depression to persist with very low recognition and treatment. A voice is needed to the problem. As human helpers it is the responsibility of social work practitioners and students to make the voice louder by generating research to provide evidence.

Suicide and Depression

A very frightening link that exists among people aged 65 and over is between depression and suicide (Steffens, 2007; Pollock & Reynolds, 2000). Depression has been found to be the most important single risk factor for suicide among older adults, and elder adults constitute a fifth of all suicides (Suominen et al., 2003). Early detection and sufficient treatment of depression, along with early identification of suicide

risk, is needed to prevent suicide from occurring in residential care facilities (Suominen et al., 2003). Depression actually raises the threat of death/suicide among those perceived as fairly healthy (Pollock & Reynolds, 2000). Social Work practitioners serving depressed elders need to become aware of the higher risk for suicide among senior citizens, along with factors that may raise that risk (health declines)(Steffens, 2007, p. 748). If symptoms are spotted, then an intervention can be put into play before suicide is carried out or attempted by individuals at risk.

Suominen et al. (2003) performed a study on suicides in nursing homes. The study was small, but the results are extremely informative to the field of gerontology. The researchers used 12 people, who committed suicide while living under residential care. Each resident was learned about via a psychological autopsy which is based on retrospective and indirect information, gathered from family members and caregivers who attended to the deceased individual during the last year before their death. All 12 of the deceased individuals' family members were interviewed. Following interviews and review of health files it was discovered that 75% of the subjects

were experiencing depressive symptoms prior to death. Prior to death 42% had been placed in residential care during the last year of their life. 33% reported pain, 33% had previous suicide attempts (Suominen et al., 2003). Depression had manifested itself in the lives of 9 out of 12 people prior to their death, which is an extremely significant finding, regardless of the small sample size used in the study.

Nursing Home Residents and Depression

"In residential care residents, major depression increases the death rate by over 50%, independent of physical health. Untreated depression raises the risk of dying after a heart attack by a factor of five" (Pollock & Reynolds, 2000, p. 4). Residential care facility residents bear depressive symptoms at echelons 2-3 times higher than elders living independently in the community (Cummings & Cockerham, 2004; Brown et al., 2002). The high levels of depression among residential care facilities are often severe, undiagnosed, and associated with diminished functioning (Cummings & Cockham, 2004). With the above said, it is evident that a problem poses in the realms of residential care facilities and further

research needs to explore the lives of residents within San Bernardino County.

Pot et al. (2005) stated that admission itself may progress the depressive symptoms, whether they are latent or already in play (Achterberg et al., 2006). Residents transitioning from their own homes contain considerably more overt depressive indications than residents who transition from a shelter or hospital (Achterberg et al., 2006). Loneliness may take a stand in one's life, which is a problem residents may face (Thakur & Blazer, 2008). For example, prior to the transition, death of a spouse or other family members could have occurred, leading to institutionalization. Residents may have to face transitioning issues, along with grief, contributing to a higher dose of problems (Achterberg et al., 2006).

Older individuals entering residential care are vulnerable to various mental health troubles (Bagley et al., 2000). Many residents enter residential care at a time of crisis (decline in health, death of spouse, or caregiver) (Bagely et al., 2000). One may be living independently one day, and the next day he/she may be living in residential care within in a whole new environment, surrounded by a whole new set of routines

and policies. Such a dramatic change in a person's life can be chaotic (Bagley et al., 2000).

Comorbidity

Aging is linked with a swift boost of medical ailments, many of which are positively correlated with depression (Taylor et al., 2004; Pollock & Reynolds, 2000). Depression may show itself prior to any medical issues, perhaps leading to health concerns. A common connection is between depression and cardiac dysfunctions. If either of the two manifest first, there is potential for the other to manifest as well (Taylor et al., 2004). The relation does not just exist between heart problems, but with a diversity of health issues (Taylor et al., 2004). As an individual's medical problem leads to low ambulatory functioning, pain, loss of energy, etc., the thought of not being able to do what they use to do can become disheartening, possibly triggering depressive symptoms of hopelessness, helplessness, and worthlessness (Pollock & Reynolds, 2000). Since such important correlations exist between medical and psychological disorders, further scrutiny needs to take place.

Shirley et al. (2000) investigated depression among visually impaired, institutionalized, older adults. The research team recruited 53 participants, all with visual disabilities. Prior to the study, none of the subjects had ever been diagnosed with any depressive syndromes, nor did they receive antidepressants to treat a depressed mood. Visual acuity was tested by physicians, and the Geriatric Depression Scale was administered by the researchers. The percentage of individuals scoring greater than or equal to 6 on the Geriatric Depression Scale (probable depression) was 42.5%, which is significant. After data analysis took place, it was discovered that, as a group, the visually impaired elderly had a higher tendency to develop depressive symptoms, and the intensity of visual disability had a positive impact on the rate of depression (Shirley et al., 2000). Many aspects of life can be affected by loss of sight. For example, activities may no longer be possible (reading, writing, television, etc.), contributing to losses in the area of activities that individuals have been use to for several years; further contributing to losses that commonly occur in late

adulthood (loss of loved ones, decreases in social support, and loss of ambulatory functioning).

Stroke patients are more probable to live in residential care facilities, due to the care required of stroke victims, and to experience depression following the stroke(s) (Rao et al., 2001). Rao et al., 2001 generated a study on depression in older people with mild stroke, carotid stenosis and peripheral vascular disease. The researchers gathered 100 participants, all with one of the heart conditions mentioned above. The researcher administered the Geriatric Depression Scale. Mean scores on the scale were higher in stroke and carotid stenosis groups than the groups that contained people with no heart or stroke related conditions.

Van der Kooy et al., 2007, composed a meta-analysis among 28 studies, in which 11 were considered high quality studies. The mean number of participants was 3,400, and the mean yearly incidence rate per 1,000 people was 11.41. The results conveyed that depressed mood increased the risk for a wide range of cardiovascular diseases, while major depression was recognized as the significant risk factor. Conversely, the results also stated that cardiovascular disease

increased the risk for depressed mood (Van der Kooy et al., 2007, 613). Mood disorders are related to high stress and worry which is linked to a variety of heart problems; on the other hand a person that has been diagnosed with cardiovascular disease may begin to have recurrent thoughts of death and hopelessness, contributing to depression (Van der Kooy et al., 2007).

Taylor et al. (2004), conducted a study of 500 subjects. The researchers divided the participants up into a group of depressed individuals and a control group of non depressed individuals. Each group was examined, by self report, for medical problems such as hypertension, vascular disease, hardening of heart arteries, and ulcers. Upon analysis it was discovered that the depressed group was significantly more likely to report the health difficulties mentioned in the latter sentence, with vascular disease carrying the most significant correlation with late-life depression (Taylor et al., 2004). The results supported previous findings from earlier research conducted by Taylor et al.

Empirical studies support the theory that elder patients who experience pain longer than six months are prone to developing maladaptive coping mechanisms

associated with depression (Campbell, Clauw & Keefe, 2003). Some of the common unhealthy coping mechanisms are high catastrophizing, perceived helplessness, and low-self efficacy. Those who adopt unhealthy coping styles commonly report higher pain levels than those who enforce low levels of catastrophizing and perceived helplessness, and higher levels of self efficacy (Campbell, Clauw & Keefe, 2003). Depressive symptoms can increase pain, and vise versa, pain can induce depressive thoughts. If both are the focus of interventions it is logical that improved life satisfaction will follow.

Throughout the literature it is indicated that comrobid depression is associated with unfavorable consequences ranging from impairments in physical functioning to mortality (Goodwin & Smyer, 1999). Depression is often viewed as a side effect of the physical dysfunctions, and it is often believed that once the physical troubles are solved then the depressive symptoms will diminish, giving little to no precedence to the damage that can come from depression alone (Goodwin & Smyer, 1999). If physical troubles persist, it is highly probable that physicians will continue to focus on other interventions for physical malfunctions, and not shift

the focus to working on both systems, medical and psychological. It is of the utmost importance to intervene at both levels due to the correlations that exist between mental disorders and health problems.

Low Recognition among Staff

Residential care staff needs to be aware of the signs of depression in order to make referrals for treatment to be provided. When depressive symptoms are blatant, nursing staff may not notice the cues. This may be because depression is not the focus of physicians and nursing personnel (Thakur & Blazer, 2008).

Elder inhabitants with depression go untreated for a diversity of reasons. First, caring for depression is usually of low concern. Secondly, residential care facilities view physical health as a priority. Lastly, residential care facilities are not viewed as mental health facilities, therefore they receive little to no training on issues of mental health (Cummings & Cockerham, 2004, p. 28). The facilities mainly operate under the medical model of practice, focusing on physical ailments over psychological dysfunctions (Cummings & Cockerham, 2004).

Depression in long-term care often goes unrecognized, and when it is acknowledged it is usually undertreated, scarcely treated, or treated improperly (Kerber, et al., 2008; Jones et al., 2003; Bagley et al., 2000; Teresi et al., 2001). Cues of depression are not spotted, due to lack of staff training and distribution of research (Ayalon et al., 2008). In a recent study, conducted by Ayalon et al. (2008), paraprofessionals were given a questionnaire to assess their beliefs regarding elderly residents experiencing depression. The results conveyed that 67% believed it was normal to be depressed, 30.8% believed that side effects of antidepressants were so severe that it was better not to take them, 38.7% believed that elder residents should snap out of it and use their will power, 34.5 % said that elderly people were less likely to kill themselves, and 55.6% stated that older adults preferred antidepressants to talk therapy (Ayalon et al., 2008, p. 360).

Teresi et al., 2001, conducted a study in which the researchers interviewed residents and staff. Residents were interviewed by psychiatrists, using the Diagnostic and Statistical Manual of Mental Disorders criteria. The results, when compared to the psychiatrists evaluation,

conveyed that significant depressive symptamology was 44.2%, solely based on measures of symptamology, not actual diagnosis. The estimate for probable and/or definite major depressive disorder was 14.4%. Minor depression was estimated at 16.8%. Staff, who were blind to the psychiatric evaluation results, was then assessed regarding their ability to recognize depression, using Depression Recognition Measures. Pertaining to staff, the corresponding estimates of any depression were 19.7% for social workers, and 29% for nurses (Teresi et al., 2001), which is significantly low when human health, physical or mental, is the concern.

In another study conducted by Bagley et al. (2000), a similar design was followed; further significant confirmations were discovered, in regard to high depression rates and low rates of recognition, on depressive disorders and symptomalogy. Bagely et al.(2000), interviewed 245 residents of residential care facilities. Of the 245 residents, 107 were classified as depressed. For each tenant interview, there was a interview with staff members in charge of the daily care of residents. Of the 107 classified as depressed, staff only recognized 27.1%. The researchers also sent out 332

postal questionnaires to care and nursing staff of the 30 participating facilities, regarding received training in psychological or psychiatric care Of the 332 questionnaire respondents, only 7.8% receive mental health training (Bagley et al., 2000). The significant discoveries of the study were: nursing staff revealed a low level of recognition of mood disorders in admitted residents, there were no major differences in the competence of nursing staff compared to care staff in their aptitude to identify depression, and training offered to staff was absent in the studied facilities (Bagley et al., 2000).

The above studies confirm the hypothesis that the prevalence of mood disorders among residential care facility residents is high, while depression recognition is quite low (Teresi et al., 2001). It is obvious that depression has found itself a home within residential care homes, and among the general aging population. Those who have depressive symptoms while institutionalized may go unrecognized and untreated. Depression may follow people into facilities or it can manifest after admission. The transition phase into a new environment can lead to depression among residents or exacerbate

symptoms that have been dormant for years (Ames, 2008). If depression is unrecognized it is likely that referrals for treatment will not be made and clients will continue to live the remainder of their life depressed.

Prognosis for Treatment

It is not correct to say that depression cannot be treated in the elder population. Along with physical aging there may be decreased brain functioning, memory loss, decreased brain elasticity which makes redirecting negative thoughts more difficult, and medical problems that can exacerbate psychological disorders, however, there is plenty of hope for a bright outcome with effective treatment, at the psychological level, by way of medicine and therapy based treatments (Levkoff et al., 2006; Gallagher-Thompson et al., 2001).

Common medicines given to elderly with depression are, tricyclic antidepressants, selective serotonin reuptake inhibitors, serotonin/nonrepinephrine reuptake inhibitors, monoamine oxidase inhibitors, and antidepressants such as buproprian and trazadone (Levkoff et al., 2006; Gallagher-Thompson et al., 2001). Common therapeutic interventions are Cognitive Behavioral

Therapy, behavior therapy, and interpersonal therapy, which are efficient in treating depression among the elderly population, whether living independently in the community or in residential care facilities.

Blanchard et al. (1995) carried out a study in which various interventions were applied to residential care residents. The interventions consisted of cognitive therapy, behavior therapy, new assessment and medication trials. There was a pre-test, and three months later there was a post-test. There was a significant improvement in the rated depression, in pre and post-test results. Residents were provided with counseling. Following three months, each participant was assessed, by a staff member who was blind to the pre-test of each individual and to the intervention received. The results conveyed that counseling can produce decline in depressive symptoms, of elderly patients, within a three month period, providing further proof that depression can be effectively treated in the elderly population (Gallagaher-Thompson et al., 2001).

Contrast to Existing Studies

Reviewed studies used interviews to learn about the perspective of residential care staff on depression, which is very beneficial to the geriatric population. After an intense review, no interviews were located that asked the opinions, other than what the scales asked for, regarding the day to day lives of residential care facility residents. Therefore, this study does just that, in order to gain an authentic perspective of issues pertaining to geriatric depression among residential care facility residents.

The majority of the reviewed studies solely followed a quantitative format (Thakur & Blazer, 2008; Von Hippel et al., 2008; Ayalon et al., 2008; Mehta et al., 2008; Van der Kooy et al., 2007; Achterberg et al., 2006; Kerber et al., 2008; Hendrix, 2001). There was a trend in the literature to focus on the perspectives of staff and other professionals. When elder people were involved the researcher mainly stuck to a scale or questionnaire, rarely stepping outside of it to gather personal perspectives from those aged 65 and over, who are prone to depression.

To take a different route than the reviewed studies, this study goes a step further to interview participants regarding their psychological health, as it pertains to five items listed on the 15-item Geriatric Depression Scale. The reason that this study interviewed participants on 5 specific items was due to the high response rate to those items, in the past, among individuals who scored a 5 or more on the scale, indicating probable depression. Regarding the 5-items that were followed by a question, participants were asked why they believe to endure each symptom. This type of format allowed for perceived causal factors to be gained from the sample.

Theories Guiding Conceptualization

For the purpose of this study, the following terms will be defined theoretically and operationally:

Depression

Theoretical: Depression is a mood disorder that is characterized by a constellation of cognitive, physiological, behavioral, and affective symptoms. The list of symptoms associated with depression as given by

the Diagnostic and Statistical Manual (IV-TR) exemplifies depression as containing the following symptoms:

- diminished social interaction or being withdrawn
- depressed mood most of the day
- diminished interest/pleasure in most activities
- weight loss or weight gain
- guilty feelings
- fatigue or loss of energy
- feelings of worthlessness
- feelings of helplessness
- inability to concentrate
- recurrent thoughts of death and suicide

Operational: In this study, a total score of 5 and above in the Geriatric Depression Scale was used to identify possibly depressed elder residents (Yesavage et al., 1983).

Nursing

Theoretical: Nursing homes are long-term institutions providing nursing care; assistance with personal care activities; and room and board to people

often afflicted with chronic illnesses and/or mental impairments (Ignatavicius, 1998).

Operational: In this study, one registered nursing home in California was targeted as a study site. Also, throughout the study the term nursing home is used interchangeably with residential care facility.

Summary

The problems that come with depression were examined from various articles and studies. The mentioned studies exemplify that depression can lead to a multitude of problems in the lives of elderly citizens, the worst case scenario being suicide, which is common among depressed individuals (Steffens, 2007). On the other hand, depression has been associated with cardiovascular disease, heart attacks, and strokes, and host of other medical problems. Overall, the literature provides evidence that various studies have been conducted, that follow a quantitative design, which is why this study goes a step further and incorporated an interview into a quantitative study, making way for statistical results to be revealed, along with insight from participants on why they believe to experience specific symptoms.

CHAPTER THREE

METHODS

Introduction

This study was designed to confirm the hypothesis that elder depression plagues elderly people in nursing homes. It was not the intent of this study to say that nursing homes cause or exacerbate depression, but to create awareness in San Bernardino County, where very little research exists on the matter. The sample included 20 participants, who responded to the 15-items on the Geriatric Depression Scale and interview question that followed 5-items on the scale. Each participant was given a informed consent form prior to collecting data, and a debriefing statement following the collection process.

Study Design

The literature suggests that depression is highly prevalent among community dwelling and residential care facility residents. This study set out to answer the question: What is the prevalence of depression among a nursing home sample within a nursing facility in San Bernardino County? There was a diversity of independent variables and dependent variables that were examined in

this study. The primary independent variable of the study was the length of time participants lived in the nursing home, and the dependent variable was the depressive symptoms common among residents who have lived in the nursing home for less than a year (no life satisfaction, empty, helpless). A series of One-Way ANOVA tests were ran between variables to examine for any significant correlations associated with depressive symptoms (dependent variables) and factors associated with living in a nursing home (independent variable).

In order to explore the prevalence of depression, among the recruited sample, the GDS was used. In the GDS, scores of five to ten indicate mild to moderate depression, scores within 11-15 indicate moderate to severe depression (Marquez et al., 2006). Research indicates a high response rates to questions 1, 4, 8, 9, 12, therefore the data was investigated, via the Statistical Package for the Social Sciences, for the response rate of the five items prevalently responded to throughout the literature.

Along with the prevalence of depression and symptoms, correlations were investigated among demographics and item responses by use of the Statistical

Package for the Social Sciences. Furthermore, the responses to the interview questions were analyzed, using grounded theory, in order to bring themes to the forefront. Working from grounded theory the researcher codes the interview transcripts for context, people, meaning, and process, noting themes and patterns (McLachlan & Justice, 2009). Once themes were identified in this study, using grounded theory, the researcher compared and contrasted the data with existing literature. This study is quantitative in nature with a qualitative component.

Sampling

The sample (n = 20) for this study consisted of adults aged 65 and over. All 20 participants resided in a nursing home or a convalescent home. Ten participants were recruited from the nursing home and the other 10 from a convalescent home. A convenience sample was used. The researcher gathered a diverse sample of males, females, and age groups. The researcher recruited the sample within a two month time frame.

The researcher visited a nursing home and a convalescent home and asked for permission to conduct

research at their facility. The researcher well informed the administrators on confidentiality, via an informed consent form, and on the content of the interview. The administrator of each facility approved the research and provided the researcher with letters of approval. The study was approved by the Institutional Review Board at California State University of San Bernardino.

The administrators and activity directors asked various residents, at both participating facilities, if they would like to participate in a study on depression of residential care facility residents, in which incentives would be offered. The researcher felt it would be best if the administrators and activity directors asked participants, due to the established rapport and trust between them, which would in turn would bring more recruitment; instead of the researcher entering into the environment, of a vulnerable cohort, and asking to interview them regarding personal information.

Staff only asked those who were known to be of sound mind. Soundness of mind was evaluated by staff reviewing residents' files, and by referring to interpersonal experiences with clients. Residents diagnosed with any psychotic disorder were excluded from the study, to avoid

delusional responses. Once all residents gave consent, the activity directors at each facility informed the researcher on the number of willing participants. The researcher then scheduled an appointment with participating residents, in order to gather the data.

Prior to any questioning, each participant was given an informed consent form, stating their right to confidentiality and right to terminate participation at any time. The researcher read the consent form aloud to each participant, while participants followed along, if they desired. Each participant was then given an incentive for participating in the study. Participants chose from crossword puzzles, Starbucks cards, calendars, magnifying glasses, music, and miniature reading lamps.

Data Collection and Instruments

The 15-item Geriatric Depression Scale (GDS) was used for this study. The 15-item scale has acceptable psychometric properties and a high sensitivity as a screening measure of depression (Von Hippel, 2008). After strict review, the Geriatric Depression Scale was easily accessible, economical, highly doable for participants,

and had acceptable internal consistency in past studies (Von Hippel, 2008).

The GDS is the most commonly used tool among cognitively intact individuals over the age of 65 (Thakur & Blazer, 2008). The GDS ask various questions pertaining to hopelessness, boredom, isolation, etc., in order to gain a well rounded view of the dynamics of geriatric depression. Plenty of evidence supports the use of the 15-item Geriatric Depression Scale among people who live in residential care facilities (Llewellyn-Jones & Snowdon, 2007; Von Hippel, 2008; Kerber et al., 2008; Mehta et al., 2008; Thakur & Blazer, 2008). Results of 4 or less on the scale indicate no depression, 5-10 indicates mild to moderate depression, and 11-15 indicates moderate to severe depression (Vonhippel et al., 2008; Yesavage et al., 1983).

The GDS has a high response rate among probable depressed individuals on questions 1, 4, 8, 9, and 12 (Marquez et al., 2006; Rinaldi et al., 2003; Hoyl et al., 1999). To explore these five questions further, this researcher will probe further by asking an interview question following these five common responses. Participants will be asked: why they believe the symptom

exists? The interview allowed for the researcher to explore, more in depth, the dynamics of depression among elder individuals living in the studied facility.

Procedures

The researcher read out each question on the 15-item Geriatric Depression Scale, while residents followed along with their own copy. The researcher offered clarification of terms in the survey when participants asked. The researcher asked participants to elaborate on five items in the scale, which was facilitated by an interview question. For example, when a respondent reported having no life satisfaction, feelings of boredom, helplessness and worthlessness, and if they reported that they would rather be in their room than going out and doing new things, the researcher then asked, why do you believe you presently feel bored, etc.? As the interview questions were answered the researcher took notes, verbatim, using short-hand and asking participants to repeat what they said when needed, in order to ensure that all data was written down correctly.

The interview question was asked to gain more insight into five of the 15-items. The reason for asking

an interview question, following questions 1, 4, 8, 9, and 12, was due to the high response rate throughout the literature to the five items, among individuals who score a five or above on the GDS, indicating probable depression.

The questions pertaining to life satisfaction, boredom, helplessness, isolation, and worthlessness were followed by an interview question (Why do you believe you endure the symptom?), due to the high response rate associated with the above symptoms in various studies in the past (Hoyl et al., 1999; Rinaldi et al., 2003; Marquez et al., 2006; Thakur & Blazer, 2008, p. 84). Whenever clarification of terms was needed the researcher provided synonyms.

Following the questionnaire and interview, the researcher handed each participant a debriefing statement. The researcher then read it aloud while each participant either followed along, or listened as the researcher read aloud. Further discussion was carried out with those who had further interests and questions. Those that scored a five or higher on the Geriatric Depression Scale were then informed about Agewise, a program in the Department of Behavioral Health, which links them with

available resources in the community. One participant requested to be referred to Agewise. The researcher contacted Agewise and informed them of the resident's situation. The Agewise agency provided the resident with a list of resources. All others were not interested in receiving mental health services.

Protection of Human Subjects

All information was kept private and confidential. No identifiable information was gathered for this study. The only information that will be reported for each participant is age, gender, ethnicity, length of time they lived in the facility and item responses. Location of residency will not be revealed in this study to protect participants and agencies involved. Informed consents and debriefing statements were issued to all that participated.

Data Analysis

The results were inputted into the Statistical Package for the Social Sciences (SPSS) for analytical examination. Demographic data was inputted, along with the quantitative responses to the Geriatric Depression Scale. Each item was weighted as one point, each response

that indicated a symptom of depression was given a point. At the end of the inputting process, the scores were computed giving each respondents score. One-Way ANNOVA tests were ran between demographic information and item responses to investigate for any associations. The interview responses were analyzed using grounded theory to draw for any themes of significance (Wilson, 2009).

Summary

This chapter covered the overall methodology that was used to collect data and then analyze it. This study followed a qualitative format, with a quantitative component. The design was intended to provide the prevalence of depression among the sample, along with information on the dynamics involved with elder depression by way of statistical analysis and scanning for themes among interview responses.

CHAPTER FOUR

RESULTS

Introduction

The results are presented for the following areas: (a) sample demographics and descriptive data; (b) prevalence of depression among the sample; (c) symptom frequencies of the sample; (d) the impact of demographics on life satisfaction, feelings of happiness and emptiness, and dropping of any activities; (e) and the central themes in the interview response pertaining to question 1, 4, 8, and 9 of the Geriatric Depression Scale.

Presentation of the Findings

The total of participants recruited for the study was 20 (N = 20). The majority of the sample was male (60%) and Caucasian (60%), 4 participants were Hispanic, and 4 were African-American. The mean age was 80.8 years. The bulk of the sample has been living in the facility longer than 2 years (50%). Table 1 presents the demographic characteristics of the respondents.

Table 1. Demographic Characteristics of the Sample

(N = 20) Characteristic and category	n	%
Age (years)		
65-75	6	30
76-85	7	35
86-93	7	35
Gender		
Male	12	60
Female	8	40
Ethnicity		
Caucasian	12	60
Hispanic	4	20
African-American	4	20
Time in Facility		
Less than a year	7	35
1 to 2 years	3	15
More than 2 years	10	50

Prevalence of Depression among the Sample

A score of 5-10 indicates probable depression, and any score over 10 indicates moderate to severe depression. 16 of the 20 participants scored 5 or more on the Geriatric Depression Scale (80%). When broken down into categories of mild to moderate, moderate to severe the breakdown is as follows: 8 participants scored within the range of five to 10 (40%), indicating mild to moderate depression; 6 of the participants scored within 11-15, indicating moderate to severe depression (30%);

and 6 scored a 4 or less, indicating no depression (30%). Among the 12 males in the sample, 9 scored a 5 or above (75% of males). The mean score was 7.7 among the respondents. Table 2 lays out the scoring of the 20 respondents.

Table 2. Scores of Each Participant

(N = 20) Identification #	sex	age	Ethnicity	Score
1	M	93	C	15
2	M	88	C	11
3	M	85	C	0
4	M	65	C	11
5	M	87	H	6
6	F	71	C	4
7	F	83	C	4
8	M	80	AA	9
9	F	90	C	0
10	F	91	C	7
11	M	80	C	10
12	F	67	AA	10
13	M	87	C	4
14	M	67	C	12
15	F	65	B	4
16	F	81	H	7
17	F	90	AA	5
18	M	73	C	15
19	M	73	H	6
20	F	79	H	14

Symptom Frequencies of the Sample

The items that had a response rate above 50% were: drop in activities, boredom, having low spirits most of the time, feeling unhappy, staying in one's room rather than trying new things, having low energy, and believing that others are better off. Table 3 examines respondents' replies to each close ended item on the scale. The bolded numbers, under the yes or no sections, indicate the responses that were weighted (one point each) towards the overall score for each person, depending on the form of the question. For example, a yes to the first question would indicate a symptom of depression, as a response of no on the second question would indicate a depressive symptom, adding to the points of each completed scale.

Table 3. Responses to Questions on Geriatric Depression Scale

(N = 20) Questions	Yes	No	%
Are you satisfied with your life?	12	8	60
Have you dropped any of your activities?	15	5	75
Do you feel that your life is empty?	9	11	45
Do you often get bored?	16	4	80
Are you in good spirits most of the time?	9	11	55
Are you afraid that something bad is going to happen to you?	7	13	35
Do you feel happy most of the time?	7	13	65
Do you often feel helpless?	9	11	45
Do you prefer to stay in your room?	15	5	75
Do you feel that you have more problems with memory than most?	6	14	30
Do you think it is wonderful to be alive?	15	5	25
Do you feel worthless the way you are now?	8	12	40
Do you feel full of energy?	6	14	70
Do you feel that your situation is hopeless?	4	16	20
Do you think most are better off than you?	14	6	70

Impact of Demographic Characteristics upon Life Satisfaction, Feelings of Helplessness and Emptiness, and Involvement in Activities

A series of One-Way ANOVA analyses were conducted to measure the significance of the associations. Significance was revealed between time in facility and no life satisfaction; time in facility and helpless; time in facility and feeling empty; gender and dropping usual activities; and between age and no life satisfaction. A slight significance existed between time in facility and not feeling happy (.058); and between time in facility and happiness (.058).

Tables 4 through 8 provide summaries of the significant outcomes among item responses on the Geriatric Depression Scale. The results outlined show that respondents who have lived in the facility for the least amount of time reported to feel no life satisfaction, as opposed to those who have lived in the facility longer than two years (table 6). Table 7 and 8 designates that the less time an individual has lived within residential care facility the more likely they were to feel helpless and empty. Table 9 presents the fact that, among the sample, as individuals aged they were more satisfied with their life, as opposed to the

younger cohort, who were more likely to state that they were not satisfied with their life. Table 10 reflects that the oldest cohort was more likely to drop their usual activities.

Table 4. Impact of Years in Facility on Life Satisfaction

One-Way ANOVA for comparing means (N = 20)		
Years in facility	Non-Satisfaction	Sig.
Less than 1 year	5 of 7	
1 year to 2 years	2 of 3	.018
More than 2 years	1 of 10	

Table 5. Impact of Years in Facility on Feeling Helpless

One-Way ANOVA for comparing means (N = 20)		
Years in facility	Feeling helpless	Sig.
Less than 1 year	6 of 7	
1 year to 2 years	0 of 3	.013
More than 2 years	3 of 10	

Table 6. Impact of Years in Facility and Feeling Empty

One-Way ANOVA for comparing means (N = 20)		
Years in facility	Feeling empty	Sig.
Less than 1 year	6 of 7	
1 year to 2 years	1 of 3	.020
More than 2 years	2 of 10	

Table 7. Impact of Age on Life Satisfaction

One-Way ANOVA for comparing means (N = 20)		
Age	Non-satisfaction	Sig.
65-75	5 of 6	
76-85	1 of 7	.026
86-93	2 of 7	

Table 8. Impact of Age on Dropping Activities

One-Way ANOVA for comparing means (N = 20)		
Age	Dropped activities	Sig.
65-75	4 of 6	
76-85	4 of 7	.036
86-83	6 of 7	

Themes among Interview Responses

Interview questions followed items 1, 4, 8, 9, and 12 on the Geriatric Depression Scale. The closed-ended questions pertained to life satisfaction, boredom, helplessness, preferring to stay in room, rather than going out and doing new things, and worthlessness. The above questions solicit more points based on studies throughout the literature, among samples exhibiting high rates of depression. Therefore, they were elaborated on by further questioning in this study. The researcher asked each participant why they believe to endure the symptoms, if they stated to experience each symptom. All participants provided feedback to the best of their ability.

Life Satisfaction

The majority of the people, who stated that they were not satisfied with their life, gave medical reasons for not being satisfied. Eight people answered no when asked if they were satisfied with their life. Six respondents gave medical reasons for not being satisfied, which is 75% of the 8 that responded with a no. On the other hand, those that were satisfied stated to be either because their faith in God, their career accomplishments, and/or knowing that their family is secure. One respondent stated:

> My independence ended too early. Suddenly my diabetes lead to blindness and extreme foot pain, which will soon be amputated. I am having tremendous difficulty adjusting to my disabilities.

Another respondent stated:

> No, I use to be. How can I be satisfied now? I can no longer walk.

An additional responded said:

> Arthritis has taken a lot out of my life. I am in pain nearly all day and all night. Medications don't help a bit.

Boredom

Sixteen participants affirmed that they were bored. Of the 16, 11 gave medical reasons for being bored, which is 69% of the 16 that were bored often. The four people that were not bored had a common theme of participating in activities. Three of the non-bored people stated that they read the bible, and the other said he read books on inventions, played solitaire, and had a pen pal. Below are responses from two people who claimed to be bored, due to medical reasons:

> Reading use to be my favorite pass time. Now that my vision is near gone, I really don't know what to do.

None of the activities here bring pleasure to me. Another participant stated:

> Yes, I am bored a lot. I don't have many things to do anymore. I have Parkinsons Disease, you see. First it attacked my upper body, and now my legs. I can't take long walks like I use to.

Helpless

Once again, medical reasons played a role in why many of the people believed to feel helpless. Nine respondents claimed to feel helpless. Six people declared medical reasons for their feelings of helplessness (67%

of those who feel helpless). Among those who did not feel helpless, the content of their responses was that they still had their health and/or they were able to walk (5 of the 11 who did not feel helpless). A respondent stated:

> Sometimes I feel like an infant. I have to be assisted out of bed in the morning and the nurses have to take me a shower everyday.

A respondent who did not feel helpless stated:

> When I can no longer feed myself, walk, or bathe myself, then I might feel helpless. As of right now I am a lucky man.

Prefer to Stay in Room

Amid the responses to question nine on the scale (Do you prefer to stay in your room, rather than going out and doing new things?), the prevalent theme was among those who have lived in the facility less than a year. In the content of the responses, given by five of the seven people who preferred to stay in their room, and who were fairly new to the facility (71% of fairly new residents), difficulties adjusting to their new environment were apparent. Once participant stated:

> I really don't know anyone here. I would rather stay in my room. If people come and talk to me then I will talk to them, but that rarely happens.

Another respondent stated:

> I am new to life behind bars. Plus, I don't want to get use to it here.

Worthless

The dominant theme, among the responses to feeling worthless, was once again, medical reasons. Eight participants responded to feeling worthless. Loss of vision and loss of ambulatory functioning were the medical concerns involved of five participants who felt worthless (63% of those who felt worthless). Out of the 12 people who did not feel worthless, six believed to not feel worthless for reasons of having faith in God (50% of the participants who did not feel worthless). One respondent stated:

> What is the worth of a nearly blind man who cannot walk? I cannot direct anyone, including myself. As I continue to age, and deteriorate, my net worth declines as well.

Another respondent stated:

I can't do anything but lay in bed. I watch everyone else stroll by my room. I wish I could get up and garden like I use to and make myself useful. I cannot do what I use to do.

Summary

This chapter covered the results of the data collection process. Demographic information was laid out to demonstrate the characteristics of the sample studied. Next, the prevalence of depression was explored, along with the dominant symptoms among the sample. The impact of demographic variables on various items on the Geriatric Depression Scale was presented. Lastly, the themes amid the interview responses were laid out.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter presents a discussion of our findings, limitations, recommendations for social work practice, policy and research.

Discussion

The purpose of this study was to identify the prevalence of elderly depression among a sample of nursing home residents within San Bernardino County, in order to confirm the hypothesis that depression plagues nursing home residents over the age of 65. The study explored the dominant symptoms among the sample, in relation to depression. The study examined impact that the number of years one lived in the facility had on life satisfaction, feeling helpless, and feeling empty, along with the impact of age on life satisfaction and dropping old activities. Furthermore, the study investigated the perceptions of participants on why they may be enduring depressive symptoms, with the intent to gain further insight into the causality of various symptoms involved with elder depression. The intended aftermath of this

study was to educate Social Workers, Geriatricians, and nursing home staff on the dynamics of elder depression by creating awareness through research.

Overall, the prevalence of depression, among the sample studied, was significantly high (80%). The literature confirms that there is a high rate of depression among nursing home residents. A meta-analysis on the diagnosis of depression in long-term care, conducted by Thakur and Blazer (2008), revealed that up to 35% of residents, over the age of 65, may be experiencing either major depression or clinically significant depressive symptoms. In a study, included in the meta-analysis, the Minimum Data Set instrument was used to measure depression, and revealed that 20.3% of nursing home residents were depressed, and the researchers stated that the rate revealed underrates depression that would be exposed using structured clinical interviews (Thakur & Blazer, 2008). This study made it known publicly, within a sample (N = 20) in San Bernardino County, that 80% of the participants, according to the Geriatric Depression Scale, indicated probable depression. However, the literature states that there is plenty of unrecognized depression throughout the

elder population in nursing homes, due to low recognition and training on the behalf of staff providing care for residents (Ayalon et al., 2008; Jones et al., 2003; Teresi et al, 2001; Bagley et al., 2000). With further awareness on the problem, by way of research and political advocacy, changes will ensue

The symptoms that had a response rate above 50%, were items 1, 2, 4, 5, 7, 8, 13, and 15 (53% of the 15-items). Each of the items are indicators of depression according to literature on the Geriatric Depression Scale, which was based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (Marques et al., 2006; Yesavage et al., 1983). Items that have been highly responded to, among elder people who are depressed, are items 1, 4, 8, 9, and 12 (Marquez et al., 2006). In this study participants responded, at a rate above 50%, to items 1, 4, and 8. Throughout the literature a plethora of depressive symptoms exist among the symptoms associated with depression. The symptoms expressed in this study will allow Social Workers, Geriatrician, and nursing home staffs gain an understanding on what depression looks like among elder nursing home residents. Further investigations in regards

to each of the dominant symptoms of this sample, will bring more light to the dynamics involved with each symptoms, leading to more effective services for the elderly cohort residing in nursing homes.

A significant relationship existed between the time participants lived in the facility, no life satisfaction, and feelings of helplessness and emptiness. The majority of those who lived in the facility less than two years exhibited the three symptoms mentioned above, as opposed to those who have lived their longer than two years, which is consistent with literature pertaining to newly admitted nursing home residents. Literature confirms that admission itself may induce the growth of depressive symptoms, and that newly admitted residents are highly susceptible to depression, due to the transition phase, loss of independence, rapid deterioration of health that may have lead to the need of residential care, and being uneasy about their new environment (Achterberg et al. 2006; Bagley et al., 2000).It has been hypothesized that if depression is recognized upon admission and treated thereafter that it will ease the transitioning phase of elder adults, contributing to a more satisfied life (Bagely et al., 2000). This study provides practitioners

with depressive indicators that may allow those with depression to be recognized by staff and treated by practitioners with evidence-based mental health interventions.

Further findings indicated that there was a correlation between age, life satisfaction, and dropping one's usual activities. Four of the six participants who were within the youngest age category (65-75), and who were not satisfied with life, had been living within the facility for less than a year, indicating that they may still be in the transition phase, and possibly contributing to no life satisfaction, as indicated in the above paragraph. Medical problems, associated with pain, have commonly been linked with age and low life satisfaction in past studies (Campbell, Clauw, & Keefe, 2003). The interviews conducted in this study also confirmed that pain and various medical problems are linked with no life satisfaction. Relevant to the item on dropping usual activities (item 2), research shows that disability and illnesses, which are most common among older cohorts, may prevent elder nursing home residents from participating in their usual activities that kept them satisfied prior to the onset of medical problems

(Aldass & Neville, 2003). Via interview responses, 6 of the 8 participants who said to not be satisfied with life (75%), gave medical reasons. Medical problems and depressive symptoms have been proven, through past research and this study, to work together and tarnish nursing home residents when no treatment is provided (Kerber et al., 2008; Thakur & Blazer, 2008; Hendrix, 2001).

The interview responses indicated that medical issues were highly associated with 4 of the 5 items that were followed by an interview question. As stated above, medical problems and depressive symptoms often exist together among the elder population, whether they reside in long-term care or not (Van der Kooy et al., 2007). Loss of vision in old age is highly associated with depression in institutionalized older people, especially where the environment is not suited to meet the needs of the visually impaired (Shirley et al., 2000), as in the facility where the research was conducted. Five participants stated to have vision problems that were related to them enduring specific depressive symptoms. Respondents believed to feel worthless due to vision problems or other physical ailments that prevented them

from doing what they use to do. An abundance of research hypothesizes that depression and medical ailments are comoribid, and the interview responses give further weight to that hypothesis. A cognitive intervention approach, along with antidepressant medications, would be useful with people in such circumstances, due to the relation with their perspective on their medical problems and their outlook on life (Kerber et al., 2008).

The interview responses to item nine on the scale, asks if you prefer to stay in your room. The theme amid responses was that residents who have lived in the facility less than one year were more likely to stay in their room (5 of 7). The common response was that they were new to the facility, even among those who had lived their longer than a year. Research on newly admitted residents states that new residents are more likely to participate in isolative behaviors (Achterberg, 2006).

Limitations

Not including the mental health exam is a strength of the study's design. A mental health status exam was not included due to the amount of questions and intensity involved with the GDS and the interview questions alone,

along with time needed to gather data. The exclusion of the mental status exam allowed participants to expend their energy on answering the scaling and interview questions. If too much questioning was involved, there would have been a higher probability for participants to lose focus, interest, or become tired.

The presence of an interviewer carries the chance to infuse discomfort when certain questions are asked. In order to prevent uncomfortable feelings among participants, body language and verbal language was carefully used to convey empathy and attentive listening to all participants. A therapeutic alliance was created from the point of initial engagement.

Due to language differences and educational differences among participants, there were times when participants were unsure of the meanings of certain words. To ensure that all participants fully understood the line of questioning the researcher gave clarifications whenever they were needed. If a word was misunderstood it was then simplified with synonyms in order to receive accurate responses.

The small sample size placed further limits on the study, in regards to generalizability. The small sample

size was chosen due to the qualitative aspect that was added to the study, requiring more time with each participant. Therefore, the results of this study will most likely not be generalizable to all elderly people living in nursing homes. However, the gathered data is valuable to Social Work, due to the fact that depression was prevalent among the sample, according to the responses to the Geriatric Depression Scale; along with the fact that residents' perspectives were given in regards to their experiences with specific symptoms of depression.

Recommendations for Social Work Practice, Policy and Research

As Social Workers it is our responsibility to advocate for those who are vulnerable, oppressed, and living in poverty. In order to empower depressed, elder people, living in residential care, Social Workers need to have a grasp on the dynamics involved. This study provides further evidence that depression plagues elder nursing home residents. Additionally, this study gives further details on the residents' perspectives on why they may be enduring depressive symptoms, which is very rare throughout the literature. This research will be

accessible to Social Work students so they can further their education on the elderly population, leading to recognition of depression among nursing home residents, and opening the door for further research to take place.

This study sought to investigate the prevalence of depression and depressive symptoms within a sample of nursing home residents in San Bernardino County using the 15-item Geriatric Depression Scale as a measuring instrument. 5-items on the scale followed an interview question to gain insight into the dynamics involved with specific symptoms of depression, according to the perspectives of nursing home residents. Further research can take this study a step further by exploring boredom, which 80% of the participants claimed to experience most of time, or any other of the dominant symptoms among the sample. A needs assessment can be conducted, pertaining to boredom, among nursing home residents, to discover common themes, in order to provide activities that fit the needs of all residents.

Furthermore, future research can follow an exploratory design to investigate which specific medical problems are highly common among depressed individuals in nursing homes. This can take place by interviewing

nursing home residents already diagnosed with depression. Significant results can lead to further identifiers in the realm of depression, benefiting the assessment phase of the Generalist Intervention Model of Social Work Practice.

Many routes can be taken for further research on this topic. The fact is that not much attention is given to the mental health needs of the elderly population. Therefore, all research on the topic will benefit clients, the Social Work Profession, and care providers to the elderly population.

Conclusions

This research expands upon the fact that depression is prevalent among elderly nursing home residents. Very little research exists on the topic within San Bernardino County, which is where this study took place. The findings support the hypothesis that depression is prevalent among nursing home residents. The other questions of the study were explored by statistical analysis and an interview design, in order to reveal valuable data for Social Work Practice and future research. The results are not generalizable due to the

small sample size recruited for this study. The results will be beneficial to the facility by educating the administration on the mental health concerns of their residents, and to Social Work students interested in the field of Gerontology.

This research also explored the prevalence of dominant symptoms among the sample. The majority of the participants claimed: to have low life satisfaction; to have dropped their usual activities; to be bored often; to not be in good spirits most of the time; to feel unhappy and worthless; and to have low energy. This study intended to explore the dominant symptoms experienced by the studies sample, to gain insight on the dynamics involved with elder depression. This study painted the picture of what depression looks like among a small sample within San Bernardino, giving a feel for what depression might look like in other facilities.

The research examined for correlations between demographics and items responses. Time participants lived in the facility had a significant impact on life satisfaction, feeling helpless, and feeling empty. The majority of those living in the facility less than a year felt, no life satisfaction, helpless, and empty. Age also

had an impact on life satisfaction. Those who were younger and recently admitted stated to not be satisfied with life.

Additional explorations were conducted by way of an interview. The prevalent theme recognized within the interview responses was that the medical reasons were contributing to low life satisfaction, boredom, feelings of helplessness and worthlessness. Recently admitted residents were more likely to stay in their room than go out and do new things.

APPENDIX A

QUESTIONNAIRE

Geriatric Depression Scale (GDS) Scoring Instructions

Instructions: Score 1 point for each bolded answer. A score of 5 or more suggests depression.

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 things?	yes	no
10.	Do you feel that 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 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

A score of ≥ 5 suggests depression Total Score_____

APPENDIX B

INFORMED CONSENT

Informed Consent

The study in which you are being asked to participate is designed to explore elderly depression among nursing home residents. This study is being conducted by Alejandro Holguin under the supervision of Dr. Pa Der Vang, Assistant Professor of Social Work, California State University, San Bernardino. This study has been approved by the Institutional Review Board of California State University of San Bernardino.

In this study you will be asked to respond to 15 questions from the Geriatric Depression Scale, along with one interview question following five items on the scale. The interview should take about 15 to 20 minutes to complete. There will be no audio or video taping of the interview. All of your responses will be held in the strictest of privacy by the researcher. No names will be needed or reported for this study. You may receive the group results of this study upon completion after September, 2009 at the Pfau Library within California State University of San Bernardino, 5500 University Parkway, San Bernardino, CA 92407.

Your participation in this study is totally voluntary. You have all right to withdraw from the study at any time. Each participant has a right to confidentiality. Names of participants and location of facility will not be asked for during the interview. Therefore, names and locations will not be presented in this study to protect the privacy of each participant.

There are no foreseeable risks to research participants. This research will benefit Social Work. Social Work practitioners will become informed on the dynamics of depression among nursing home residents. The needs of participants will also be brought to the forefront, possibly leading to future interventions where needs are present.

If you have any questions or concerns about this study, please feel free to contact Dr. Pa Der Vang at (909) 537-3775, or pvang@csusb.edu.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand the nature and purpose of this study, and I freely consent to participate. If you have further questions after I have left please feel free to contact my advisor Prof. Pa Der Vang at (909) 537-3775, or pvang@csusb.edu. Do you have any questions before I begin the survey? Yes_____ or No_____.

___ I have read, understood, and agreed to participate in this study.

___ I have not read, nor do I understand the informed consent.

Today's Date_____

APPENDIX C

DEBRIEFING STATEMENT

Debriefing Statement

The study you have just completed was designed to investigate the prevalence of elderly depression among a sample of nursing home residents. The scaling questions capture valuable information that can be used in working with clients and for future research on the topic, benefiting Social Work and clients. If you have any questions about the study, please feel free to contact Dr. Per Da Vang of the Social Work Department at (909) 537-3775. If you would like to obtain a copy of the group results of this study, please contact the advisor listed above at the end of the spring quarter of 2009.

Again, thank you for your participation.

REFERENCES

Achterberg, W., Pot, A., Kerkstra, A., & Ribbe, M. (2006). Depressive symptoms in newly admitted nursing home residents. *International Journal of Geriatric Psychiatry,* 23, 356-363.

Alpass, F., & Neville, S. (2003). Loneliness, health and depression in older males. *Aging & Mental Health,* 7(3), 212-216.

American Psychiatric Association. (2000). *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders. 4TH ed, Text Revision ed.* Washington, DC: American Psychiatric Association

Ames, D. (2008). Nursing homes. *Psychiatry.* (7)2, 58-60.

Ayalon, Arean, & Bornfield. (2008). Correlates of knowledge and beliefs about depression among long-term care staff. *International Journal of Geriatric Psychiatry,* 21, 1156-1162.

Bagely, H., Cordingley, L., Alistair, B., Mozley, C., Sutcliffe, C., Challis, D., & Huxley, P. (2000). Recognition of depression by staff in nursing and residential homes. *Journal of Clinical Nursing,* 9, 445-450.

Blanchard, M., Watterreus, A., & Mann, A. (1995). The effect of primary care nurse intervention upon older people screened as depressed. *International Journal of Geriatric Psychiatry,* 10, 289-298.

Brown, M., Lapane, K., & Luisi, A. (2002). The Management of depression in older nursing home residents. *American Geriatric Society,* 50, 69-72.

Campbell, L., Clauw D., & Keefe, F. (2003). Persistent pain and depression: a biopsychosocial perspective. *Biological Psychiatry* 54: 399-409.

Carnahan, R., & Perry, P. (2004). Depression in aging men. *Drugs Aging,* 21(6), 361-376.

Cummings, S., & Cockerham, C. (2004). Depression and life satisfaction in assisted living residents: impact of health and social support. *Clinical Gerontologist,* 27(1/2).

Gallagher, D., Mckibbin, C., Koonce-Volwiler, D., Mendez, A., Stewart, D., & Thompson, L. (2001). Psychotherapy with older adults. *Handbook of Psychological Change*. New York: John Wiley & Sons.

Goodwin, P., & Smyer, M. (1999). Accuracy of recognition and diagnosis of comorbid depression in the nursing home. *Aging & Mental Health,* 3(4), 340-350.

Hendrix, C. (2001). Detecting patterns of depression using items in the indicators of depression, anxiety, and sad mood in the minimum data set 2.0 among elderly residents in selected nursing home settings. *D.N.S.* dissertation, Louisiana State University Health Sciences.

Hoyl, M., Alessi, C., Harker, J., Josephson, K., Pietruszka, F., & Koelfgen, M. (1999). A short test gets shorter: the GDS. *Journal of American Geriatrics Society,* 47, 873-878.

Ignatavicius, D. (1998). *Introduction to Long-Term Care Nursing and Practice.* Philidelphia, PA: F.A.Davis.

Jones, R., Marcantonio, E., & Rabinowitz, T. (2003). Prevalence and correlates of recognized depression in U.S. nursing homes. *American Geriatric Society,* 51, 1404-1409.

Kerber, C., Dyck, M., Culp, K., Buckwalter, K.,& Sullivan, C. (2008). Antidepressant treatment of depression in rural nursing home residents. *Issues in Mental Health Nursing,* 29(9), 959-973.

Levkoff, S., Hongtu, C., Fisher, J., & McIntyre, J. (2006). *Evidence-Based Behavioral Health Practices for Older Adults: A Guide to Implementation.* New York: Springer Publishing Company.

Llewellyn-Jones, R., & Snowdon J. (2007). CNS Drugs. 21(8), 627.

Marquez, D., McAuley, E., Motl, R., Elavsky, S., Konopack, G., Jerome, G., & Kramer, A. (2006). Validation of geriatric depression scale: 5 scores among sedentary older adults. *Educational and Psychological Measurement,* 66, 667.

McLachlan, D., & Justice, J. (2009). A grounded theory of International Student well-being. *Journal of Theory Construction & Testing,* 13(1), 27-32.

Mehta, M., Whyte, E., Lenze, E., Hardy, S., Roumani, Y., Subashan, W., & Studenski, S. (2008). Depressive symptoms in late life: associations with apathy, resilience and disability vary between young-old and old-old. *International Journal of Geriatric Psychiatry,* 23, 238-243.

Pollock, & Reynolds. (2000). Depression in late life. *The Harvard Mental Health Letter,* 3-6.

Pot, A., Deeg, D., and Twisk, J. (2005). The longitudinal relationship between the use of long-term care and depressive symptoms in older adults. *Gerontologist,* 45, 359-369.

Rao, R., Jackson, S., & Howard, R. (2001). Depression in older people with mild stroke, carotid stenosis and peripheral vascular disease: a comparison with healthy controls. *International Journal of Geriatric Psychiatry,* 16, 175-183.

Rinaldi, P., Meccocci, P., Benedetti, C., Ercolani, S., Bregnocchi, M., Menculini, G., Catani, M., Senin, U., & Cherubini, A. (2003). Validation of the five-item geriatric depression scale in elderly subjects in three different settings. *American Geriatrics Society,* 51, 694-698.

Shirley, P., Leung, Y., & Mak, W. (2000). Depression in institutionalized older people with impaired vision. *International Journal of Geriatric Psychiatry,* 15, 1120-1124.

Steffens, D. (2007). Spiritual considerations in suicide and depression among the elderly. *Southern Medical Association,* 100(7), 748-749.

Suominen, K., Henriksson, M., Isometsa, E., Conwell, Y., Heila, L., & Lonnqvist. (2003). Nursing home suicides: a psychological autopsy study. *International Journal of Geriatric Psychiatry,* 18, 1095-1101.

Taylor, W., McQuoid, D., & Krishan, R. (2004). Medical comorbidity in late-life depression. *International Journal of Geriatric Psychiatry,* 19, 935-943.

Teresi, J., Abrams, R., Holmes, D., Ramirez, D., & Eimicke, J. (2001). Prevalence of depression and depression recognition in nursing homes. *Social Psychiatry and Psychiatric Epidemiology,* 36, 613-620.

Thakur, M., & Blazer. (2008). Depression in long term care. *Journal of The American Medical Directors Association,* 9(2), 82-87.

Van der Kooy, K., Van Hout, Marwijk, Marten, Stehouwer, & Beekman. (2007). Depression and the risk for cardiovascular disease: systematic review and meta analysis. *International Journal of Geriatric Psychiatry,* 22, 613-626.

Vonhippel, W., Vasey, M., Gonda, T., & Stern, T. (2008). Executive functioning deficits, rumination and late-onset depressive symptoms in older adults. *Cognitive Therapy & Research,* 32(4), 474-487.

Wilson, M. (2009). Dance pedagogy case studies: a grounded theory approach to analyzing qualitative data. *Research in Dance Education,* 10(1), 3-16.

Winningham, R., & Pike, N. (2007). A cognitive intervention to enhance institutionalized older adults' social support networks and decrease loneliness. *Aging & Mental Health,* 11(6), 716-721.

Yesavage, J., Brink, T., Rose, L., Huang, Adey, & Leirer. (1983). Development and validation of a geriatric depression screening scale: a preliminary report. *Journal of Psychiatric Research,* 17, 37-49.