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Can social workers recognize depression in the elderly?

Teresa Ramon

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CAN SOCIAL WORKERS RECOGNIZE DEPRESSION IN 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

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ABSTRACT

As the population of the United States ages, it is expected that there will be an increasing number of individuals 65 years and older, who will continue to age. With the aging process there will be many issues directly related to their mental health. One of the most prevalent issues surrounding this aging population is depression. A problem with late life depression is the fact that often it is missed, misdiagnosed, or underrecognized and results in no treatment. When late-life depression is treated, eighty percent recover. Therefore, the purpose of the study was to determine if social workers could recognize depression in the elderly. A self-administered questionnaire was made available to participants. A random sample of (N = 99) participants were involved in the study. The participants were twenty-four Hispanics, nine African Americans, forty-nine European Americans, six Native Americans, one Filipino, three others, and four Asians. Thirty of the participants were male and sixty-nine were female. Of the ninety-nine social workers, thirteen had Bachelors, fifty-five had Masters, two had Doctorates (PhD) in Social Work and twenty-seven had Bachelors or Masters in other areas.

The findings are consistent with prior research which is, that social workers lack exposure and training in gerontology. It is suggested that schools of social work improve the gerontology curriculum in an effort to improve the detection of late life depression.

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We would like to thank our research advisor, Dr. Rosemary McCaslin, for your expertise, guidance, and patience during the completion of this research project. Your support and assistance were greatly appreciated, and will never be forgotten.

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DEDICATION

This project is dedicated to my mom and dad who have always believed in me and to my spiritual guides Lori, Woody, Lucy, Tillie, Butter, Guera, Little One, Nicki-pooh, and Monica thank you all for trudging this happy road of destiny with me. It has been an awesome journey. Finally to my Creator, my true guide, thank you.

Teresa "Terry" Ramon

I dedicate this research project to the many important people in my life. First, to my inspiration, my hero, my loving DAD. Thank you for teaching me the value of a hard days work. In that, out of work comes appreciation and fulfillment. Mama, thank you for watching me from above and giving the courage to follow my dreams.

Second, to my children and grandchildren, you have been the light at the end of the tunnel. Thank you for supporting me, and know that the path is paved for you.

Third, to my amiga and research partner "Terry" for picking up the ball and carrying it to the goal line.

Fourth, to my graceful God, for the strength to meet everyday, and to always believe in myself.

Und schließlich, meine Sunshine "Jim" danken, dass Sie mir die Gelegenheit, meine Träume zu verwirklichen. Und für Ihre Geduld, Unterstützung und Verständnis. Sie müssen nie zu hören, "Ich kann nicht, ich habe ein Papier wegen" wieder. Ich Liebe Sie alle.

Monica M. Wettengel

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CHAPTER ONE

INTRODUCTION

Chapter One explains the research focus of this study, which is the failure to recognize depression in the elderly. For the purpose of this study, the elderly are defined as 65 years and older. This chapter provides an explanation of the research as well as the specific questions to be investigated. In-depth insight into prior research studies focusing on the problem of late life depression is discussed. The premise is that although depression is treatable, a problem exists in that late life depression is often missed and/or underrecognized.

Problem Statement

In the 2010 Census, people 65 and older increased from 35 million (2000) to 39.4 million (U.S. Census, 2010). The fastest growing group of older people were the 85 years of age and older; this increase went from 4.3 million (2000) to 5.7 million (2010) (U.S. Census, 2010). The Census Bureau predicts that in 2050, people over the age of 85 will be 18.2 million or 2.3 percent of the population. According to Census Bureau projections, the number of persons aged 65 years and older will increase

from 39.4 million to 69.4 million by 2030 and to 78.9 million by 2050, a figure accounting for 20 percent of the entire population (U.S. Census, 2010). Given that the U.S. population will be significantly older and more ethnically diverse, many issues need to be addressed (U.S. Census, 2010).

Currently, the most prevalent mental health issue in the elderly is depression (Bergmann, 1999; Ron, 2002). Depression has the potential to affect any medical condition by interfering in an elderly person's ability to recover, ultimately rendering the elderly more susceptible to illness (Montgomery, 2002). The most staggering statistical information is that late life depression is most often missed or underrecognized, resulting in untreated cases of late life depression. The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM-IV-TR-2000) defines depression as the presence of persistent depressed mood or loss of interest in almost all usual activities, accompanied by at least four associated symptoms.

In 2000, approximately 6.5 million people, 65 years of age and older suffered from serious and persistent

symptoms of depression (U.S. Census 2000; National Alliance on Mental Illness (NAMI), 2009). More importantly, as the population gets older, the incidence of depression is expected to increase, making it a significant concern (Heo, Murphy, Fontaine, Bruce, & Alexopoulos, 2008). More troubling is the undisputed knowledge that depression not only affects the sufferer, but also places a considerable burden on their families, communities, and the healthcare structure (NAMI, 2009). Furthermore, the elderly who experience depression also experience a higher rate of physical illness and require longer recuperation that results in longer hospital stays (Bartels & Smyer, 2002; Katona & Livingston, 2000). Depression is associated with heart disease, thyroid disorders, Parkinson's disease, diabetes, stroke, cancer, dementia, and/or viral infections (Montgomery, 2002; Ai, Rollman, & Berger, 2010), and often goes underrecognized or seen as inconsequential due to the physical illness (Heiser, 2004).

The problem is that depression in the elderly is often looked at as a part of the aging process; however this is not the case. In late life, depression is one of the most commonly seen mood disorders. However,

depression may be easily overlooked and difficult to diagnose especially when comorbidities such as chronic health conditions, medications, and other mental health disorders are present, hindering the outcome of diagnosis. The elderly are frequently misdiagnosed by the health care community, who fail to identify symptoms of depression, and/or lack of appropriate screening methods and equate their assessments to the stereotypic stages of aging (Rupple, Jenkins, Griffin, & Kizer, 2010).

Unfortunately, depression has serious and often fatal consequences for the elderly who pass undetected through the healthcare and mental health systems. Undertreated depression is the most common cause of elderly suicide, which accounts for eighteen percent of all suicides (Heo, Murphy, Fontaine, Bruce, & Alexopoulos, 2008; NAMI, 2009; Montgomery, 2002) and according to Ron (2002), older European American males have the highest rate of suicide. Agencies such as the United States (U.S.) Department of Human Services, National Institute of Aging, NAMI, Anti-Ageism Taskforce at the International Longevity Center, and Geriatric Mental Health Foundation (GMHF), each address social policies related to micro and macro issues, by expanding

and proposing new policies that service the elderly. Moreover, these agencies are accessible via the Internet and provide easy to understand information to anyone seeking assistance to expand their knowledge.

There are many agencies involved as advocates for the elderly, however, late life depression becomes a social problem when it is missed, misdiagnosed, or undertreated by mental health professionals, social workers, and primary care personnel.

Therefore, the problem of depression is not specific to the elderly, but rather encompasses many aspects that affect all ages. The social problem can be defined as the lowering of the quality of life for the elderly, by creating undue risk factors, such as suicide, higher medical costs, and the underutilization of social services. Issues surrounding this population are already drawing attention, making this a hot topic. The issue of late life depression and the overlooked diagnosis by primary care personnel is having a tremendous financial effect on hospitals. According to NAMI, (2009), there is a concern that there are not enough gerontological social workers to service this community. This is evidenced by the fact that the National Association of Social Workers

(NASW) is recruiting social workers to participant in gerontological training.

Purpose of the Study

The purpose of this study is to explore whether social workers can recognize depression in the elderly. Interestingly, the elderly who are experiencing depression usually do not seek treatment from mental health professionals. Instead, they go to primary care personnel in medical settings. Yet, social workers are employed in medical settings and are part of the primary care personnel. But, often the medical and/or mental health communities' lack of recognition of late life depression results from the attitude that old age is innately a downward spiral into limitations, weaknesses, helplessness, and a burdensome existence (International Longevity Center-USA (ILC), 2006).

Sheehan and Banerjee (1999) found that the elderly who experience depression often somatize the symptoms resulting in a "masked depression," that leads to, missed, underdiagnosed, and undertreated depression. Frequently, depression equates with dishonor in the eyes of the elderly, who fail to disclose symptoms of

depression or who fail to recognize their own emotional suffering (Katona & Livingston, 2000; Heo et al., 2008). No doubt, social workers must enhance their skills in identifying depression when working with the elderly, since underrecognized late life depression is a significant problem. A problem may exist in that social workers' preconceived notions of aging may interfere when working with the elderly, resulting in poor assessments and planning phases of the generalist intervention process. Therefore, it is important to examine the role of social workers in assessing late life depression.

A quantitative research approach was used in this study, since it is based on objective measurements and the study is looking at whether social workers can recognize late life depression (Grinnell & Unrau, 2008). The research question is "Can social workers recognize depression in the elderly?" The study used a survey questionnaire design, since it is the best method in sampling over one hundred social workers to determine whether late life depression is recognized (Grinnell & Unrau, 2008). The survey asked questions such as "Are you familiar with the Geriatric Depression Scale (GAD)? When assessing an elderly individual which tool have you used,

the Beck Depression Inventory or Center for Epidemiologic Studies? Is there one assessment tool that is best suited in assessing an elderly individual?"

Research studies show that the problem with late life depression is that it is missed therefore, it goes untreated. If this research can show that there is a disconnect somewhere between social workers and the depressed elderly, then whatever that disconnect is, can be challenged, and changed by the social work community.

Significance of the Project for Social Work

The research focused on the issue of depression in the elderly, specifically why it is missed and/or underrecognized. Interestingly, when diagnosed properly, and when treatment is rendered, the recovery rate for depression in the elderly is eighty percent (NAMI, 2009). Therefore, it is of vital concern that research be conducted in an illness that is so treatable and where recovery is possible. No person regardless of age should have to endure any mental illness, simply because the professionals, who are supposed to help, fail to diagnose a treatable illness. Hence, excellent research has the ability to alter how social work is practiced, since it

examines what interventions are effective or ineffective. Research is needed on the role of social workers with the elderly during late life depression, specifically in recognizing the illness and using effective treatments. For these reasons, it is important that social workers assess any preconceived notions toward individuals who may experience depression. This research project asked if social workers recognize depression in the elderly since, fifty-four percent of social workers are employed in healthcare communities (Bureau of Labor Statistics, 2010-2011), such as hospitals, skilled nursing facilities, board and care facilities, assisted living communities, and locations where an elderly individual may suffer from late life depression. Social workers have access to the elderly.

The potential contributions of this study to micro social work practice by improving the awareness that late-life depression is not a natural part of aging. More importantly, this study will explore attitudes that may contribute to ageism, such as, depression being a natural process of aging. Furthermore, this study will examine the effectiveness of social work interventions with depression in the elderly by looking at two areas of the

generalist intervention process. The two areas that will be affected by this research are the assessing phase, where gathering information is essential to recognizing late life depression and the planning phase, where working together on a plan of action is fundamental to receiving treatment.

Furthermore, at the macro level, social workers together, are an organization, equipped with a Code of Ethics that demands rigorous compliance with a primary mission (National Association of Social Workers, 2008). Therefore, this study has the potential to contribute results, which may show that social workers recognize depression in the elderly or that social workers do not recognize depression in the elderly. The study's premise is that, if social workers recognize late life depression, then more elderly are likely to receive treatment.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents an overview of literature relating to depression in the elderly. The articles reviewed are sub-divided into topics that relate to depression. Areas that are covered are missed, misdiagnosed, and undertreated depression, somatization, and risk factors for depression, ethnicity, gender, treatment, and theories of conceptualization.

Missed, Misdiagnosed, and Undertreated

In an overview of the lack of treatment for late life depression, the problem has been associated with underrecognition. Failure to recognize late life depression has been attributed to the prevalence of comorbidity with several medical illnesses such as cancer, Parkinson's, heart, stroke, and dementia (Ai et al., 2010; GMHF, 2010; Blazer, 2003). When medical illnesses are present, the tendency to concentrate on the physical illness prevails and the depression is usually not treated. Therefore, the depression continues to negatively affect the recovery phase (Heo et al., 2008).

Both the primary care personnel and the elderly patient may conclude that the depressive symptoms are the result of the illness or choose not to acknowledge them (Katona & Livington, 2000). Yet, depression is not a normal part of aging and any disrespect or disregard toward the elderly is nothing short of ageism (ILC, 2006).

Normal stages of aging can be deceptive to physicians who overlook symptoms of depression and diagnose symptoms as medical conditions (frequent pain, headaches, constipation, indigestion and fatigue). Often primary health care professionals believe that depression is part of the aging process. In fact, many primary health care professionals feel that depression is only a natural reaction to the onset of illness or loss of a loved one. This misconception shared by many primary health care professionals perpetuates the lack of screening for the elderly who are depressed, resulting in lack of treatment. Furthermore, primary health care professionals must confront their attitudes about the elderly as their judgments often prevent them from making referrals to mental health providers. Frequently, the primary care professionals believe that the elderly are

unwilling to accept help from a mental health agency (Benek-Higgins, McReynolds, Hogan, & Savicksas, 2008).

Reactive depression may occur as a result of stressful life events such as illness, death of a family member, or relocation. The elderly may have difficulty in dealing with such transitions (Hooyman & Kiyak, 2008, p. 230). Grief on the other hand, can bear a resemblance to depression. However, grieving is a healthy reaction to loss and should be encouraged. Grieving may last as long as one to three years, and becomes an issue when the abilities to accomplish daily functions are lost. For the elderly, losing a spouse easily creates an environment for depression to fester and without a proper diagnosis the elderly become unable to cope with their symptoms and adjust to life, thus perpetuating depression (Corr, Nabe, & Corr, 2006, p. 367).

Somatization

Frequently, the elderly who are experiencing late life depression are unable to discern feelings of sadness. Often the sadness is minimized in order to avoid any stigma attached to mental illness (Heiser, 2004; Katona & Livingston, 2000; Sheehan & Banerjee, 1999).

Koenig and Kuchibhalta (1998) found that the elderly are more apt to seek out medical, rather than mental health solutions (Katona & Livingston, 2000). Consequently, emotional suffering emerges as a physical malady and conceals the depression.

The medical community responds by ruling out physical illness and concluding that the depressive symptoms are masked (Montgomery, 2002; Sheehan & Banerjee, 1999). What is more incredible is that late life depression may not be obvious to recognize since there are late life events such as losses, illness, normal physical decline, and lack of support.

While these are realistic explanations for underrecognizing late life depression, those experiencing late life depression merit an opportunity to receive treatment and recover. Lack of treatment for depression in the elderly has a devastating effect on the sufferer, their families, and results in prolonged hospital stays (Heiser, 2004; Katona & Livingston, 2000; Sheehan & Banerjee, 1999). The elderly may in fact not recognize symptoms of depression, thus confusing somatic symptoms with existing chronic conditions and failing to receive mental health screenings or treatment. Family members,

who encounter resistance from their elderly parents or other elderly family members experiencing depression, also tend to view depressive symptoms as medical issues rather than mental health issues. Moreover, these family members do not seek treatment for depression (Benek-Higgins et al., 2008).

Himelhoch, Weller, Wu, Anderson, and Cooper (2004) found that the elderly with Medicare benefits, who had a chronic medical condition, were twice as likely to visit emergency rooms when depressed. Both family members and the elderly identified the symptoms of depression as medical emergencies. When physicians diagnose depressive symptoms, preventive measures limit the need for such medical services; through proper identification and diagnosis, the elderly receive the services needed.

Stigmas

As aging occurs, society begins to take on a new view of the elderly population. For some, aging is viewed with a positive connotation while, for others it holds a negative connotation such as a stigma. Many of the elderly fail to seek mental health care because of the stigma attached to mental illness, for example being

labeled insane. Without proper treatment and support, the elderly are faced with living within the constraints of isolation just to avoid being stigmatized. Societal stigmas and stereotypes must be addressed and removed if the elderly are to be regarded as acceptable members of society that provide guidance to the next generation. It is essential that social workers conducting initial assessments understand that the aging process may be difficult for some elderly and may be devastating when coupled with a mental illness, such as depression. More important, is that the elderly may withdraw from family and friends only to find themselves spiraling further into depression, just to avoid the stigma that surrounds depression.

Interestingly, the International Longevity Center, (ILC USA) Anti-Ageism Taskforce, (2006, p. 35), conducted a survey and found that individuals age 65 and older are content with aging and satisfied with their lives, which challenges the myth that the elderly are generally unsatisfied and depressed. Stereotypic views on mental health and the elderly incorrectly indicated that depressed elderly are unable to make important decisions, such as self-care and maintaining their finances.

Anti-aging beliefs such as these lead to misconceptions that the elderly are unable to continue to care for themselves since they are too old to change.

Risk Factors

Depression is not a consequence of aging but rather a phenomenon of risk factors that have not all been absolutely identified (Blazer, 2004). A common predictor of late life depression rests in the belief that there is no social support (Blazer, 2004; Roberson & Lichtenberg, 2003). Living alone can be a predictor of late life depression, as well as being poor, needing assistance with every day activities, or being cognitively impaired (Roberson & Lichtenberg, 2003). As a whole, elderly residents of nursing homes have an even higher rate of depression, but residents who are cognitively aware and require more care, have an even higher rate of depression, compared to those that are cognitively impaired but without a physical disability (Heiser, 2004; Benazzi, 1998).

Many elders will not volunteer their feelings to physicians when asked during screenings. Circumstances such as these can place the elderly at risk, and lead to

poor outcomes in receiving treatment and even result in death. The elderly, who have worked and provided for their families over the course of their lives, and who find themselves dependent on others, struggle with losing their independence. As a result, the elderly suffer demoralizing effects that eventually perpetuate symptoms of depression. Moreover, many of the elderly who live in their own homes fear losing their independence; consequently, these elderly withhold depressive symptomology from their families and primary health professionals. Rather than risk being removed from their homes and placed into facilities, the elderly fail to disclose their depression (Benek-Higgins et al., 2008; Hooyman & Kiyak, 2008; Himelhoch et al., 2004).

Other risk factors for depression include a history of depression in the family, life events connected to a loss, previous bouts of dysthymia, and/or depression, and of course, medical illness (Alexopoulos, Vrontou, Kakuma, Meyers, Young, Klausner, & Clarkin, 1996). According to the U.S. National Institute on Aging (NIA, 2009), depression in the elderly is a frequent occurrence (Salzmann, Schneider & Alexopoulos, 2000), that is treatable. In addition, the elderly encounter dysthymia,

a milder form of depression, which may increase the likelihood of developing major depression (Salzmann et al., 2000).

Ethnicities and Gender

Over 25 percent of elderly Mexican-Americans experience depression (Gonzalez, Haan, & Hinton, 2001). Immigrants, in general, experience a higher rate of depression and immigrant women have a higher prevalence of depression than their male counter-parts (Gonzalez et al., 2001), which coincides with research studies that show depression occurs more often in women than in men (Blazer, 2004). Nevertheless, the elderly who are bicultural and less acculturated experience a higher rate of depression than U.S. born Mexican-Americans (Gonzalez et al., 2001). Certain elements increase the possibility of depression in the elderly Mexican-American population, such as lower socioeconomic status (SES), and lack of or no health insurance. Blazer (2003) found that elderly Mexican-Americans experienced depression with chronic diseases, compared to elderly European-Americans who became depressed when they were unable to walk.

Elderly African-Americans somatize their depressive symptoms when seeking medical services (Das, Olfson, McCurtis, & Weissman, 2000). Elderly African-Americans describe overt sadness as the result of not having enough faith (Wittink, Joo, Mald, Lewis, & Barg, 2008). Consequently, elderly African-Americans' rate of late-life depression is lower than European-American or Mexican-Americans (Das et al., 2006). Nonetheless, African-Americans encounter the same lack of health benefits, mental health services, and poverty, as do Mexican-Americans.

Gender differences in depressive symptoms for both men and women vary according to age; at 85 and older the rate is estimated at 19 percent. The rates are similar for African-Americans and European-Americans in both genders. Depression in minorities is more likely to go undetected than in European-Americans due in part to misdiagnosis, cultural, and socioeconomic factors, reducing the ability to receive treatment. Underdiagnosis in Asian Americans is due to the heavy stigma attached to mental illness in their culture, as well as in the Mexican-American culture. Mexican-Americans have a higher

rate (25.6 percent) of depression than that of their European-American counterparts (Hooyman & Kiyak, 2008).

Gonzalez, Tarraf, West, Croghan, Bowen, Coa, and Alegria, (2009) stated that Mexican-Americans are the largest and most underserved group of Latinos. Over 40 percent of this group lack access to medical insurance, which prevents them from receiving medical care. Mexican-Americans face challenges such as language barriers, immigrant status, and limited finances that prevent them from seeking assistance. In addition, social service providers may not always have Spanish language personal available to provide assistance, which dissuades individuals from seeking help.

Treatment

Late-life depression is treatable but first, it must be identified. The most effective solutions involve antidepressant treatment (Salzmann et al., 2000; Montgomery, 2002; Bao, Post, Ten Have, Schackman, & Bruce, 2009), psychotherapy (Cummings, 2003; Husaini, Cummings, Kilbourne, Roback, Sherkat, Levine, & Cain, 2004), and electroconvulsive therapy (ECT) (Flint, & Gagnon, 2002; NIA, 2009). Physicians should approach the

elderly with compassion, empathy, active listening, and encouragement when addressing their depressive symptoms (Hooyman & Kiyak, 2008). Primary health care professionals may choose to treat the elderly experiencing late life depression with antidepressants. However, prior to prescribing the antidepressants it is important that any and all medications taken by the elderly be divulged to avoid interference with each other. Antidepressant treatment is widely used, but often takes many weeks before any relief is reported from the depressive symptoms. Therefore, the goal of the antidepressant treatment is long term and requires strict adherence in order to achieve the desired results.

The most prescribed treatment for depression is antidepressants, which increase levels of dopamine, serotonin, and norepinephrine that produce activity in synapses, either blocking or uptaking levels of chemicals. Monoamine oxidase inhibitors (MAOI) suppress enzymes that break down monoamines, Tricyclic antidepressants (TCAs) block or inhibit serotonin and norepinephrine uptake, and Serotonin reuptake inhibitors (SSRIs) increase levels of serotonin (Freberg, 2006). The side effects of these antidepressants may include nausea,

sleep disturbances, headache, and weight gain. The side effects may outweigh the benefits for treating the elderly with depressive symptoms. Antidepressants accompanied with psychotherapy are commonly prescribed and have been known to show positive outcomes in treatment.

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ECT is used with severe late-life depression when antidepressants, SSRIs, and/or psychotherapy yield no results. ECT treatments are dispensed over a period of time. ECT must be carefully used since late-life depression occurs with other illnesses.

Psychotherapy interventions such as Problem-Solving therapy for primary care (PST-PC), Cognitive Behavior Therapy (CBT), and support groups are useful interventions that aid in teaching individuals coping skills to deal with depression. PST-PC can be delivered by primary care physicians in four to eight sessions during office visits and/or can be done in the patient's home. The elderly treated with PST-PC, reported fewer symptoms in a 12-month, follow up (Hooyman & Kiyak, 2008).

Psychotherapy is an effective treatment for the elderly that is used in either individual or group sessions, which last for 10 to 20 weeks (GMHF, 2010). Psychotherapy, however, may or may not include antidepressant treatment. The focus of psychotherapy is to empower the elderly so that they can begin to resume some power over their own lives. Cognitive Behavioral Therapy (CBT), Problem Solving Therapy (PST), and

Reminiscence Therapy (RT) work with the elderly in achieving change (Husaini et al., 2004). Effective treatments often involve a combination of antidepressants, selective serotonin reuptake inhibitors (SSRIs), and psychotherapy (Blazer, 2003; Husaini et al., 2004).

CBT is a short-term approach that changes negative thinking and maladaptive beliefs into positive and adaptive behaviors. In doing so, the elderly who are experiencing depression can be motivated to re-think situations or dilemmas in a positive manner, thus relieving irrational thoughts. CBT has shown to be effective in treatment with and without medications. The elderly benefit from this therapeutic approach by learning new coping skills that alter the way they view themselves, thus minimizing isolation and opening the door to support groups.

Support groups are another facet in effectively treating depression, and may prevent relapse from occurring. In such settings, the elderly can utilize other support group members to help them work through their experiences. A health care provider may refer the

elderly person who is experiencing difficulty in adjusting to the aging process to Reminiscence Therapy.

An RT group allows the elderly the opportunity to discuss painful memories, and process grief and loss (Hooyman & Kiyak, 2008). Furthermore, program developers in senior centers provide classes that integrate groups of elders for social interaction such as card games, low impact exercise, knitting, and arts and crafts, all of which may reduce the effects of depression. Support groups offer socialization and positive reinforcement. This is useful for the elderly who have become withdrawn and/or lack motivation. Support groups can provide incentives in the form of education and camaraderie in the struggle against depression.

Outreach programs focused on improving access to and acceptance of treatment programs for the elderly are on the rise. For instance, Community Based Early Psychiatric Interventional Strategies (CEPIS) enables the elderly to overcome barriers in their communities by becoming aware of social services providers who are receptive to late-life depression (Nyunt, Ko, Kumar, Fones, & Ng, 2009). Training programs for health care providers increase the likelihood of detecting depression. For

example, Improving Mood Promoting Access to Collaborative Training Program (IMPACT) offers elderly care management activities that include exercise programs and problem-solving techniques. The program is tailored to the needs of the elderly in collaboration with physicians and IMPACT trainers (Chapman & Perry, 2008). Programs are useful tools to access the many elderly who are in need of extra support.

Theories Guiding Conceptualization

According to Lesser and Pope (2007), social workers are taught to use the general systems theory as the foundation of the assessment process. Therefore, the general systems theory (GST) will serve as the theoretical orientation in examining whether social workers recognize depression in the elderly (Wakefield, 1996). The GST acknowledges that there are many mechanisms working simultaneously toward a common aim in individuals. Consequently, the biological, psychological, and social mechanisms are explored to determine their specific roles. Additionally, in the field of social work, an environmental component known as the ecosystems approach is considered important in looking at the whole

since one of the suppositions involved is that when one part of the system changes then the whole system is affected. Therefore, the GST involves assessing all aspects of an individual that include the biological, psychological, and social aspects of functioning.

During the GST assessment, social workers are identifying disruptions within the system. Social workers gain valuable insight into various problematic areas. However, literature indicates that the elderly with depression are not being evaluated and treated, leaving the elderly to suffer needlessly. Therefore, research is needed to explore whether social workers can recognize late life depression.

Summary

The chapter presented numerous studies that agreed on the fact that depression in the elderly is a devastating experience for sufferers, families, and the healthcare systems. Research has shown that depression in the elderly exists and is often missed, and/or misdiagnosed. The impact of depression in the elderly clearly affects how healthcare and mental health providers service the elderly. The majority of the

literature focused on medical professionals. Therefore, there is a need for research in the arena of social workers recognizing late life depression.

CHAPTER THREE

METHODS

Introduction

Chapter Three provided an overview of the research study and the methods employed to gather information. The study explored issues surrounding late life depression and failure within the medical and mental health communities to recognize, provide diagnoses, and treat the mental illness. The study's design, sampling, and data collection as well as the instruments utilized and procedures are addressed.

Study Design

The study examined whether social workers recognize late life depression in an effort to explore the phenomenon that late life depression is missed, underrecognized, and underdiagnosed, resulting in undertreatment. The quantitative research approach was chosen to conduct the study, given that it provides an objective perspective. This is important since the study asked whether social workers recognize late life depression via a set of questions on a questionnaire that was self-administered. In the interest of time, a

self-administered questionnaire likely provided enough data from ninety-nine social workers in Southern California.

The limitations of the study are that this research only seeks to explore if social workers recognize or not, late life depression. If the study shows that late life depression is recognized, the study would not seek to explore how late life depression is missed, underrecognized, and underdiagnosed. Conversely, if the results of the study show that social workers do not recognize late life depression, the study would not seek to objectively explore why social workers fail to recognize late life depression. However, the research is looking for a pattern of events in the form of a correlational/descriptive relationship between late life depression, social workers' recognizing late life depression, and treatment rendered. If this research shows that there is a disconnect somewhere between social workers and the elderly who are depressed, then it can be acknowledged, challenged, and changed.

Therefore, the research question is, "Can social workers recognize late life depression?" Consequently, there are other factors involved in the process of

assessment (generalist intervention process) which lead to the missed, underrecognized, and underdiagnosis of late life depression.

Sampling

The sample studied were social workers who possessed either a Doctorate (PhD) or Masters (MSW) or Bachelors in Social Work (BSW). Ninety-nine social workers were surveyed in an effort to ensure an adequate representative sampling.

This sample was chosen because research in the arena of missed, underrecognized, and underdiagnosed late life depression involves medical health care professionals but does not specifically address social workers. Often other medical personnel request that social workers conduct a biopsychosocial assessment of the elderly, and often it is simply a requirement from a doctor or other medical personnel. Additionally, the United States Bureau of Labor Statistics reported that fifty-four percent of social workers are employed in the arena of medical health. In addition, to ensure that a representative sample was collected, efforts were made to include similar numbers of males and females and comparable

numbers of various ethnicities, as well as similar numbers of doctoral, masters and bachelors of social work.

Access was gained to the ninety-nine social workers by attending National Association of Social Workers (NASW) meetings in San Bernardino and Riverside counties to invite social workers to participate in the study. Currently, there are over 23,000 members, who are either Licensed Clinical Social Workers (LCSW) or Accredited Clinical Social Workers (ACSW) throughout California. Hence, recent graduates from social work schools such as California State University, San Bernardino were invited to participate in the study, as well as social workers at various social service agencies, such as Adult Protective Services (APS). These invitations occurred in person and over the internet. Social workers employed in facilities that treat the elderly, such as hospitals, nursing homes, dialysis centers, mental health treatment centers, and long-term board and cares, were contacted personally or via the internet to reach as many social workers as possible.

Data Collection and Instruments

The independent variable is the social workers' capacity to recognize late life depression. The dependent variable is the likelihood that the elderly with late life depression will be treated for their depression, which was measured by including a question on the questionnaire addressing either providing or referring the elderly for treatment. This was a descriptive design study that did not have strong external validity.

If the outcome of this research shows that social workers recognize late life depression, then more elderly are likely to receive treatment. The relationship will be positive because there are two outcomes: the higher the recognition, the higher the probability of treatment or the lower the recognition, the lower the probability of treatment. Conversely, the relationship may be negative because higher or lower recognition of depression may have no effect on the probability of treatment.

The data was collected via a self-administered questionnaire (Appendix A) that was developed and used to capture data during the winter quarter, 2011, after approval of the questionnaire was granted via the facility advisor. The questionnaire was a collection of

twenty-six questions directed at gathering sociodemographics (3), educational information (2), and tools used to assess depression such as geriatric depression scales (4), and knowledge based questions involving signs and symptoms of depression in the elderly (14), and vignettes requiring a solution (2). For example, "If you were screening an elderly person for depression, how effective do you believe your instrument tool is? 1 always effective, 2 very effective, 3 somewhat effective 4 hardly effective, 5 not at all effective, 6 never used an instrument tool." A Likert scale was used in some of the questions and reverse coding was instituted to counter for any likelihood that participants' would answer all the questions similarly. Another question on the questionnaire was, "Are you comfortable with the level of training you received in detecting depression in the elderly? 1 not at all comfortable, 2 hardly comfortable, 3 somewhat comfortable, 4 moderately comfortable, 5 very comfortable, 6 highly comfortable." Some of the questions were nominal, some were ordinal, and some were scale. The reliability of this instrument was not calculated via a

test-retest format and is addressed in the limitations section.

Procedures

Requests were made to the various NASW chapters to allow the researchers to attend a meeting and invite social workers to partake in the study. Additionally, telephone calls were made to various agencies located in the San Bernardino, Riverside, and Los Angeles Counties to contact any PhD, MSW/LCSW/ACSW, or BSW employees. Questionnaires were constructed and available via the Internet through SurveyMonkey, and hard copies were used at NASW meetings where access had been granted. Researchers traveled to agencies and presented the questionnaire, which was returned to the researchers that same day. When ninety-nine questionnaires were completed, the study was closed, and the questionnaires were analyzed.

Protection of Human Subjects

In the process of collecting data, there was minimal contact with the study participants, other than an invitation to participate in the study, a written informed consent statement (Appendix B) discussing

confidentially issues and a debriefing statement (Appendix C) made available to every participant after the questionnaire was completed. The researchers provided the informed consent statements and requested that each participant sign the consent form with an X. After the completion of the questionnaire, the participants were given a debriefing statement detailing the study, as well as directions on how to receive assistance should any questions or concerns arise and where to access the study's findings.

Data Analysis

The questionnaire consisted of quantitative questions with some questions requiring an explanation to the yes or no response. The sociodemographics variables measured knowledge of late life depression as well as tools used to assess late life depression, and vignettes, which were used to measure treatment provided and/or referrals made. The data collected was quantitatively analyzed through the Statistical Package for the Social Sciences (SPSS), evaluated, and interpreted via descriptive statistics including frequencies distributions, measure of central tendency or measures of

dispersion were used to describe the demographics of the participants, age, gender, and education. Crosstabs and T-tests were run to determine significance between some variables.

Summary

Chapter Three provided the details of what the research study entailed, from detailing the research sites, to how study participants were selected, and how quantitative analysis was achieved. An explanation of how the data was gathered and analyzed was rendered.

CHAPTER FOUR

RESULTS

Introduction

Chapter Four presents an overview of the descriptive data collected in this study. The data were grouped into nine tables for a clearer presentation of the findings. The demographic characteristics of the sample included age, gender, ethnicity, education, and employment these were grouped and presented in Table 1. Then the mean and standard deviations were noted for Table 1 as well. The knowledge based questions were presented in Table 2. The association between questions that identified education level and knowledge were tested and the results are presented in Tables 3 through 7. The means of questions involving education and knowledge were compared and the results are presented in Tables 8 and 9.

Presentation of the Findings

The total participants recruited for the study was 99 (N = 99). The ages of the participants ranged from 23 to 70 years of age. Age groups were created and presented as grouped frequency distributions. The mean age was 44.2 years, although 21.3 percent were between the ages of 53

and 58 years. The majority of the participants were female (69.7) and Caucasian (49.5%), although, when grouped, minorities accounted for a little more than half of the participants (50.4%). The bulk of the participants held Masters in Social Work (55.6%). Slightly more than half of the participants worked with the population sixty-five years and older (55.1%). Table 1 presents the descriptive characteristics of the sample collected.

Table 1. Demographic Characteristics of the Sample

Characteristics	Frequency (N)	Percentage (%)
Age (N=94) Mean=44.2 (SD=13.4)		
23-28	18	19.1
29-34	9	9.4
35-40	13	13.9
41-46	11	11.6
47-52	8	8.6
53-58	20	21.3
59-64	10	10.7
65-70	5	5.4
Gender N = 99		
Female	69	69.7
Male	30	30.3

Characteristics	Frequency (N)	Percentage (%)
Ethnicity N = 99		
Caucasian	49	49.5
African American	9	9.1
Latina/Latino	24	24.2
Asian	4	4.0
Native American	6	6.1
Filipino	1	1.0
Pacific Islander	0	0.0
Other Hispanic	3	3.0
Other	3	3.0
Degree N = 97		
Doctorate in Social Work	2	2.1
Masters in Social Work	55	55.6
Bachelors in Social Work	13	13.4
Other	27	27.8
Work with the Elderly (65+)		
N = 98	54	55.4
Yes	44	44.9
No		

The study explored whether social workers could recognize depression in the elderly. Questions were presented in the survey to examine methods of recognizing late life depression (NIMH, 2011; GMHF, 2010; Benek-Higgins et al., 2008; DSM-IV, 2000). To answer the research question, the participants' responses to questions involving knowledge were summarized through descriptive statistics. Frequency distributions and percentile ranks were computed. The results described

only the numbers and percentages of responses in the sample question. Therefore, no conclusions could be drawn.

Table 2. Response to Questions

Question 8
How were you taught to identify late life depression?

			Percentage
Symptoms	Yes	66	67.3
	No	32	32.7
Type of Medications	Yes	28	28.6
	No	70	71.4
Self-Report	Yes	50	51.0
	No	48	49.0
Do Not Recall	Yes	7	7.1
	No	91	92.9
Not Taught	Yes	11	11.2
	No	87	88.8

Question 9
On a scale of 1 to 10 how comfortable are you with the level of training you received in detecting depression in the elderly? Least comfortable 1-Most comfortable 10

Mean	Std. Deviation
5.8	2.5

Question 10
How would you rate your level of concern over late life depression? High 1-Low 10

Mean	Std. Deviation
4.7	2.8

Question 11 On a scale of 1 to 10 how would you rate your level of knowledge of late life depression? Low 1-High 10	Mean	Std. Deviation
	6.5	2.3

Question 13 Which situations place an elderly person at risk for depression?			Percentage
Lives alone	Yes	91	92.9
	No	7	7.1
Has support system	Yes	11	11.2
	No	87	88.8
Loss of spouse	Yes	96	98.0
	No	2	2.0
No support system	Yes	92	93.9
	No	6	6.1
Is elderly	Yes	58	59.2
	No	40	40.8
Has pre-existing medical condition	Yes	90	91.8
	No	8	8.2
Isolated	Yes	95	96.9
	No	3	3.1

Question 19 Do you believe depression in the elderly is a common occurrence due to the normal aging process?			Percentage
	Yes	38	39.6
	No	58	60.4

To further explore the premise and determine whether social workers could recognize late life depression,

several questions were cross-tabulated and presented in tables 3 through 7 (Katona & Livington, 2000). Question 6 "What degree do you hold?" was grouped into graduate (1) and undergraduate (2) degrees. To determine if a relationship existed between the type of degree a participant held and whether the participant thought depression was curable (Rupple et al., 2010; McCrae, Murray Banerjee, Huxley, Bhugra, Tylee, & MacDonald, 2005), degree and opinion on depression as curable, were cross-tabulated. The results are presented in Table 3.

Table 3. Crosstabulation Type of Degree * Curable

Count

	Curable		Total
	Yes	No	
Graduate	48	8	56
Undergraduate	27	12	39

These results indicate that there is statistically significant relationship between the type of degree and thinking that depression is curable (chi-square with one degree of freedom = 3.758, p = .053).

To determine if a relationship existed between the type of degree a participant held, and whether the

participant thought most elderly people in the United States suffer from late life depression just because they are old (Rupple et al., 2010; McCrae et al., 2005),those questions were cross-tabulated. The results are presented in Table 4.

Table 4. Crosstabulation Type of Degree * "They Are Old"

Count

Suffer from late life just because they are old			
	True	False	Total
Graduate	4	53	57
Undergraduate	0	39	39

These results indicate that there is no statistically significant relationship between the type of degree and belief the elderly suffer from late life depression just because they are old (chi-square with one degree of freedom = 2.856, p = .091).

To determine if a relationship existed between the type of degree a participant held, and whether the participant believed that depression is a common occurrence due to the normal aging process (Rupple et al., 2010; McCrae et al., 2005), those questions were cross-tabulated. The results are presented in Table 5.

Table 5. Crosstabulation Type of Degree* Part of Aging

Count

Do you believe that depression is a normal process of aging?			
	Yes	No	Total
Graduate	19	38	57
Undergraduate	19	20	39

These results indicate that there is no statistically significant relationship between the type of degree and the belief that depression in the elderly is a common occurrence due to the normal aging process (chi-square with one degree of freedom = 2.292, p = .130).

To determine if a relationship existed between the type of degree a participant held and whether the participant, after reading a Vignette would refer the Consumer for Mental Health Services (MHS) (Nyunt et al., 2009; Heiser, 2004; Katona & Livingston, 2000), those questions were cross-tabulated. The results are presented in Table 6.

Table 6. Crosstabulation Type of Degree * Refer for Mental Health Services

Count

Vignette 1A Would you refer for MHS?			
	Yes	No	Total
Graduate	53	2	55
Undergraduate	33	3	36

These results indicate that there is no statistically significant relationship between the type of degree and whether the participant, after reading a Vignette would refer the Consumer for Mental Health Services (MHS), (chi-square with one degree of freedom = .924, p = .336).

Table 7. Crosstabulation Type of Degree * Refer to Physician

Count

Vignette 1B Would you refer to Physician?			
	Yes	No	Total
Graduate	49	1	50
Undergraduate	31	3	34

These results indicate that there is no statistically significant relationship between the type of degree and whether the participant, after reading a Vignette would

refer the Consumer to a physician (chi-square with one degree of freedom = 2.078, p = .149).

To further discover and define if social workers recognize late life depression, questions were based on information used to recognize late life depression (NIMH, 2011; Mellor & Lindeman, 1998; Ronen & Dowd, 1998) were grouped and compared to see if the means of the variables differ from one another (Gutheil & Heyman, 2010; Cummings & Galambos, 2002; Rosen & Zlotnik, 2001). The results are presented in Tables 8 through 9.

Table 8. Independent-Samples *t* Test Questions 7 and 12

Group Statistics

Do you think late life depression is curable?				
		N	Mean	SD
Hours of education	Yes	60	14.76	25.76
	No	13	9.00	13.81

An independent-samples *t* Test was calculated comparing the mean number of hours of education received, and whether participants believed that late life depression was curable. No significant difference was found ($t(2) = .780$, $.438 > .05$. The mean of the participants who would refer the Consumer for MHS ($m = 14.76$,

sd = 25.76) was not significantly different from the mean of the numbers of hours of education.

Table 9. Independent-Samples *t* Test Questions 7 and 25

Group Statistics

Vignette 1A Would you refer for MHS?				
		N	Mean	SD
Hours of education	Yes	65	12.4	22.01
	No	4	4.00	4.54

An independent-samples *t* Test was calculated comparing the mean number of hours of education received and participants who would or would not refer the Consumer for MHS. No significant difference was found ($t(2) = .759$, $.451 > .05$.

Summary

This chapter covered the results of the data collection process. Demographic information was presented to illustrate the characteristics of the participants in the study. Various analyses conducted were presented to demonstrate any significant relationships or associations between the variables. The data were presented in Tables

1 through 9, along with brief explanations that addressed the findings.

CHAPTER FIVE

DISCUSSION

Introduction

This Chapter discusses the research findings in more depth and addresses the implications of the analysis in relationship to prior research. The limitations, recommendations for social work practice, policy and research are also discussed in context with this study.

Discussion

The purpose of the study was to examine whether social workers could recognize late life depression. The premise was that if social worker could recognize late life depression then the elderly experiencing depression would be referred for mental health services. Although the findings were not significant, they were consistent with the literature review on social workers' knowledge, training, education, and beliefs.

In order to be an effective social worker, education, knowledge, and training is required (Peach, Koob, & Kraus, 2001; Rosen & Zlotnik, 2001). According to Berman, Silverstone, Simmons, Volland, and Howe (2000), there is a problem with the number of social workers who

are skilled enough to work with the elderly. Over ten percent of NASW members, reported employment with older adults and over sixty-one percent of those reported that understanding the aging process and all its ramifications was vital to being effective (Peterson & Wendt, 1990). In addition to possessing knowledge on aging, social workers need positive experiences (McCaslin, 2004), as well as regular contact, and a desire to work with the elderly (Cummings & Galambos, 2002).

One question on the self-administrated survey attempted to gage how social workers were taught to identify late life depression. The results indicated that 92.9% of the participants did not recall how they were taught to identify late life depression and 88.8% indicated that they were not taught how to identify late life depression. This seems to be consistent with prior research, that the social worker had little or no training in the field of gerontology. Moreover, classes in geriatrics and gerontology are not offered often enough at most schools of social work (Berkman, Silverstone, Simmons, Volland, & Howe, 2000). When classes are offered, the classes are electives, which means that the student must purposely select gerontology

as a field of interest. Interest in employment with the elderly is low (Cummings & Galambos, 2002).

Another question was designed to determine if the participants were able to choose situations that placed an elderly person at risk for depression. Again this question was based on knowledge and/or training. The results show that the participants chose most of the correct responses; however, 59.2% chose "is elderly," as a risk factor for late life depression. When participants were asked if late life depression was a common occurrence due to the aging process, remarkably, 39.6% believed that was this was true.

Although the findings seem shocking, prior research shows that 54% of social workers are employed in the healthcare community where the elderly seek services (Bureau of Labor Statistics, 2010-2011). Nevertheless, the fact that a person is elderly is not a precursor to depression and points to the bigger culprit, ageism (Benek-Higgins, et al., 2008; ILC, Anti-Ageism Task Force, 2006; McCrae et al., 2004; Mellor & Lindeman, 1998; Ronen & Dowd, 1998).

In 2002, Cummings and Galambos found that social work students who had taken courses in gerontology rated

the training and knowledge slightly over average. Interestingly, questions that attempted to capture the participant's self-appraisal of their training, concern, and knowledge on a Likert Scale, suggest that the participants were slightly better than average in their comfort with the training they received, their level of concern over late life depression, and their level of knowledge of late life depression.

In an effort to explore whether the participant's degree, graduate or undergraduate, influenced their beliefs regarding late life depression, two questions were grouped for analysis. The results showed that there was significant relationship between the level of education and believing that late life depression was curable. Although, this finding is significant there is no current literature that supports the results that more social workers with graduate degrees think late life depression is curable. Rosen and Zlotnik (2001) found that gerontology education is not readily available in either the Bachelor or Master level programs at most schools of social work and if offered, a very small percentage of social work students are interested (Cummings & Galambos, 2002). This study did not determine

if the graduate level social worker participants received gerontology education.

The results of the analysis from grouping questions about degree type and belief that most elderly persons suffer from depression "just because they are old," produced no significant relationship. Yet another grouping of questions concerned with the social worker's belief system involved questions, on type of degree and whether depression is part of aging. Again no significant relationship was revealed. Both questions looked at education as a variable that could affect the social workers' thinking process. However, education had no effect on transcending the ideology that late life depression is a normal result of aging that cannot be escaped (GMHF, 2010; NAMI, 2009; ILC-Anti-Ageism Task Force, 2006; Rosen & Zlotnik, 2001). In fact, prior studies have found that myths regarding the aging process are a form of ageism (GMHF, 2010; NAMI, 2009; ILC-Anti-Ageism Task Force, 2006; Rosen & Zlotnik, 2001). Unfortunately, ageism does influence social workers' level of interest in specializing in employment with the elderly (GMHF, 2010; NAMI, 2009; ILC-Anti-Ageism Task Force, 2006; Rosen & Zlotnik, 2001)

Limitations

The primary limitation of this study is that the reliability of the self-administrated questionnaire was not calculated in a test-retest format. As a result several of the questions were incorrectly worded, but were not discovered until the data collection began. For example, "Do you believe that late life depression is curable? "should have asked, "Do you believe that late life depression is treatable?" Vignette 2 involved Frank a "56," year old, who was supposed to be 65 years old or older. In addition, two questions did not measure whether a social worker could recognize late life depression.

The questionnaire was replicated on SurveyMonkey within their guidelines. Consequently, the questionnaire appeared slightly different from the hardcopy. For example, three questions involved Likert Scales, which SurveyMonkey was not capable of creating. Nevertheless, adjustments were made and twenty-five questionnaires were collected from SurveyMonkey.

Recommendations for Social Work Practice, Policy and Research

This study confirms that there is and continues to be a disconnect between social workers recognizing late

life depression and the elderly experiencing depression since the findings are consistent with past and current research. Research points to the same findings in various studies. For instance, gerontology requires specialized training similar to the training that produces competent child welfare social workers, however, that is not occurring.

Ageism has a role in excusing late life depression symptomology as a normal process of aging, hence continuing to cripple the elderly experiencing depression by not providing treatment. Somehow the idea that getting old equates to a miserable life is utterly unsupported by the numerous research studies. The fact is this; eighty percent of the elderly experiencing late life depression recover when treated.

The NASW Code of Ethics addresses the fact that the social work profession has a duty and a responsibility to advocate for those who are "vulnerable and oppressed." The elderly who experience depression and fail to receive treatment become the vulnerable and oppressed. It is important that as a profession, social workers begin to acknowledge that ageism is alive and well in the ranks of our profession.

Future research must focus on methods to recruit social work students into the field of gerontology. Research into how schools of social work could engage in joint MSW programs with other universities who provide gerontological studies programs, such as the University of Southern California Los Angeles (UCLA) is worth exploring.

Conclusions

Although the findings of this study were not significant, they do have strong implications for the profession of social work. The findings are consistent with research that implicates social workers for failing to recognize late life depression. Therefore, this study added information to the pool of findings, in that social workers are in need of additional training in the area of gerontology.

According to the U.S Census (2010) there will be an increase of elderly individuals who will be in need of services, many of which will require detection, assessment, and treatment of depression. It is imperative that social workers be knowledgeable in this area of gerontology. The significance of obtaining and furthering

knowledge in the area of late-life depression lies heavily on the education provided to the social work student. In doing so, schools of social work must re-define and improve curriculum to include gerontology as a core requirement, thus, providing students with exposure in identifying depressive disorders, use of assessment instruments, and referral and/or treatment planning of older adults.

APPENDIX A

DEPRESSION QUESTIONNAIRE

Depression Questionnaire

1. What is your gender?
   A. Male.
   B. Female.

2. What year were you born? _____

3. What ethnic group do you consider yourself to belong to?
   A. Caucasian, Non-Hispanic.
   B. African American.
   C. Latino/Latina.
   D. Asian.
   E. Native American.
   F. Filipino.
   G. Pacific Islander.
   H. Other Hispanic.
   I. Other.

4. Do you work with the elderly (age 65 and older)?
   A. Yes
   B. No

5. Are you employed? If so, where? _____

6. What degree do you hold?
   A. Doctoral in Social Work
   B. Master in Social Work
   C. Bachelors in Social Work
   D. Other _____

7. About how many hours of depression education did you receive in your degree program? _____

8. How were you taught to identify depression?
   Circle all that apply.
   A. Symptoms
   B. Type of Medication
   C. Self-Report
   D. Do not recall
   E. Not taught

9. On a scale of 1 t 10 how comfortable are you with the level of training you received in detecting depression in the elderly?

Least Comfortable									Most Comfortable
1	2	3	4	5	6	7	8	9	10

10. How would you rate your level of concern over depression?

High				Moderate					Low
1	2	3	4	5	6	7	8	9	10

11. On a scale of 1 to 10 how would you rate your level of knowledge of depression?

High				Moderate					Low
1.	2	3	4	5	6	7	8	9	10

12. Do you think depression is curable?
    A. Yes.
    B. No.

13. Which situation places an elderly (65 years and older) person at risk for depression. Circle all that apply.
    A. Lives alone.
    B. Has support system.
    C. Loss of spouse.
    D. No support system.
    E. Is elderly (65 years and older)
    F. Has a pre-existing medical condition.
    G. Isolated.

14. If you were screening an elderly person for depression, how effective do you believe your instrument tool is?

    A. Geriatric Depression Scale (GDS).
        1. Always effective.
        2. Very effective.
        3. Somewhat effective.
        4. Hardly effective.
        5. Not at all effective.
        6. Never used an instrument tool.

B. Zung Self-Rating Depression Scale (ZSRDS).
   1. Always effective.
   2. Very effective.
   3. Somewhat effective.
   4. Hardly effective.
   5. Not at all effective.
   6. Never used an instrument tool.

C. Center for Epidemiologic Studies Depression Scale (CES-D).
   1. Always effective.
   2. Very effective.
   3. Somewhat effective.
   4. Hardly effective.
   5. Not at all effective.
   6. Never used an instrument tool.

D. Beck Depression Inventory (BDI).
   1.Always effective.
   2. Very effective.
   3. Somewhat effective.
   4. Hardly effective.
   5. Not at all effective.
   6. Never used an instrument tool.

15. Most elderly people in the United States suffer from depression just because they're old.
    A. True.
    B. False.

16. Has depression affected you or someone in your extended family?
    A. Yes
    B. No

17. If you answered yes to question # 16, who was the person afflicted in relation to you? Circle all that apply
    A. Parent
    B. Guardian
    C. Grandparent
    D. Aunt/Uncle
    E. Sister/Brother
    F. Child
    G. In-laws
    H. Spouse/Significant Other
    I. Other
    J. You

18. The last time you assessed a person with depression, what method of assessment did you use?
    A. Instrument scale.
    B. Observation.
    C. Client history.
    D. All of the above.
    E. None of the above.

19. Do you believe depression in the elderly is a common occurrence due to the normal aging process?
    A. Yes.
    B. No.

20. If you answered yes to question #19, what is your rationale for choosing yes?
    _____

21. If you answered no to question #19, what is your rationale for choosing no?
    _____

22. In the past have you successfully assessed depression in an elderly client?
    A. Yes.
    B. No.

23. If you answered Yes, to question #22, why do you think you were successful?
    _____

24. If you answered No, to question #22, why do you think you were unsuccessful? _____

25. VIGNETTE 1

You receive a request from a medical doctor, to do a bio-psychosocial evaluation on an 83-year-old, European-American, married female, who is "delusional." She (consumer) reports that whenever she is out in public people talk about her, so she avoids going out in public. After interviewing the consumer you learn, she no longer attends church, visits her children, cooks, cleans, spends time with her husband, reads, and has stopped bathing. She tells you all she can do is cry and sleep. She reports feeling this way for over three months and has lost weight. You learn that she has Parkinson's and that she is uncomfortable about her hands shaking. The consumer tells you she knows people are talking about how bad her hands shake. She sees them whispering to one another and laughing at her. Is the person depressed?

A. Would you refer Consumer for mental health services?

Yes or No Why? _____

B. Would you refer Consumer for a follow up visit to his physician?

Yes or No Why? _____

26. VIGNETTE 2

Frank a 56-year-old male European-American is facing an early retirement due to his ongoing physical disability from a back injury sustained at work. Frank is not prepared financially to retire for at least another six years. Frank has also had a heart attack two years ago following the death of his wife of 25 years. Frank's physician has prescribed medication for his heart condition and emphysema. Frank has three children (two daughters and one son), who live in neighboring cities. Frank's children have grown concerned about the well-being of their father. Frank's children have noticed that Frank is no longer attending family functions. Frank states that he is too tired to make it to family gatherings and would rather stay home and watch his favorite T.V. show. Frank's son has noticed that Frank has not tended to his garden, one of his favorite activities. Frank's son questions his father as to why he has not done any gardening lately, Frank states that his back is acting up and he is having some pain in his shoulder region, and would rather not be bothered by anyone and would appreciate if he were just left alone. Is this person depressed?

A. Would you refer Frank for mental health services?

   Yes or No Why? _____

B. Would you refer Frank for a follow up visit to his physician?

   Yes or No Why? _____

Developed by Teresa Ramon and Monica Wettengel

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

You are invited to participant in a study conducted by Teresa Ramon and Monica Maria Wettengel, MSW students at California State University, San Bernardino. This study investigates depression. As a participant in this study, you will be asked to complete a series of questions in a questionnaire, followed by two vignettes. Completing this study should take about 15-20 minutes. Any information that you provide will be anonymous. At no time will your name be reported along with your responses, you may decide not to respond to the questions asked. Your participation in this study may aid in our understanding of depression. Your participation in this study is voluntary and you are free to withdraw at any time, or to not answer any questions that make your feel uncomfortable. This study has been approved by School of Social Work Sub-committee, California State University, San Bernardino. If you have any questions regarding this study please contact Professor Rosemary McCaslin (909) 537-5507.

By placing an X in the space 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. I also acknowledge that I am at least 18 years of age.

_____

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING FORM

Thank you for your participation today! The purpose of this study was to examine whether social workers recognize late life depression in an effort to explore the phenomenon that late life depression is often missed, underrecognized, and underdiagnosed, resulting in undertreatment. If this research can show that there is a miss-connection somewhere between social workers and the elderly who are depressed, then whatever that miss-connection is, it can be acknowledged, challenged, and changed. If you have experienced some distress and would like to discuss your responses, please contact California State University, San Bernardino Counseling Center at (909) 537-5040 or the Community Counseling Center at (909) 537-5569. It is very important that other participants in this study come in without knowing what we are studying so that their answers are completely honest; therefore, we ask that you not discuss questions asked in the study to potential participants. If you have any further questions or are interested in learning more about the results of this study, please direct your inquires to Professor Rosemary McCaslin at (909) 537-5507 or email at rmccasli@csusb.edu. Again, thank you for your participation.

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection: Combined Effort

   Team Effort: Teresa Ramon & Monica Wettengel

2. Data Entry and Analysis:

   Team Effort: Teresa Ramon & Monica Wettengel

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Teresa Ramon & Monica Wettengel

   b. Methods

      Team Effort: Teresa Ramon & Monica Wettengel

   c. Results

      Team Effort: Teresa Ramon & Monica Wettengel

   d. Discussion

      Team Effort: Teresa Ramon & Monica Wettengel