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Perceptions of Depression in Older Adults

Kasey D. Weber
St. Catherine University

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Perceptions of Depression in Older Adults

By

Kasey D Weber, CSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
Andrea Nesmith, Ph. D., LISW, (Chair)
Lisa Kielty, LICSW
Amanda Thooft, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation

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Abstract

According to the US Department of Commerce estimates, the older adult population will more than double by 2050, to 80 million (US Department of Commerce, 1995). Depression is very common among the older generation with 6.5 million diagnosed cases out of 35 million individuals aged 65 and above (NAMI, n.d). Many of these older adults with depression suffer from stigmas, both internal and external. The objective of this systematic literature review was to synthesize the information available on stigma related to older adults with depression. The databases SocINDEX, Social Work Abstracts, Pubmed, and were systematically searched (2010 to date). The search terms included older adult, depression, stigma, perception, medications, counseling, social support and therapy. Studies were screened according to pre-defined inclusion criteria. Criteria included articles on older adults with depression and related perceptions. Researcher chose to use studies that were both qualitative and quantitative, and both cross-sectional and longitudinal. Research was focused on the population sample of both men and women who were identified as older adults. This research found stigma (both public and private) to affect older adults with depression. Further findings were an under-diagnosis of depression, a low reporting of symptoms and a belief that depression is a normal part of aging. Future research is needed into stigmas and what causes them as well as into stigmas that plague older adults living in facilities. Also, more education is needed for those who work with older adults. The results of this study form the basis for a better understanding of the effect stigma has on older adults with depression.

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Perceptions of Depression in Older Adults

The number of older adults is increasing and so are those living with depression. It is imperative that perceptions around older adult depression be studied. According to the US Department of Commerce estimates, the older adult population will more than double by 2050, to 80 million. By that year, as many as 1 in 5 Americans could be considered an older adult (US Department of Commerce, 1995). Many losses accompany the aging process, which can include the loss of loved ones and independence. This causes many aging individuals to suffer from depression.

Depression has always existed but the term came to be in the 1970s. It was previously known as melancholia and manic-depressive insanity (Davison, 2006). Society has shifted towards greater understanding of depression; realizing people with the diagnosis are not insane. In recent years more attention has been given to this disorder.

Depression plagues individuals all over the globe. Depression is very common among the older generation with 6.5 million diagnosed cases out of 35 million individuals aged 65 and above (NAMI, n.d). Depression has been found to be the most common emotional disruption in this population (Smith-Ruiz, 1985).

Depression late in life increases the risk for cognitive decline. A study evaluating 23 community-based cohort studies found that participants with depression were 1.85 times more likely to develop dementia (Diniz et al., 2013). Depression is the highest risk for suicide in the older adult population (NAMI, n.d.). In a study of 1,444 individuals aged 65 and older, Lee et al. (2009) found more older adult persons with depression used emergency medical services.

It is believed 30 to 50 percent of the older adult population will experience depression (Dorfman, et al., 1995). Older adults with depression can become forgotten by their families and

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there is an increased risk of abuse, suicide and hasty institutionalization (Dorfman, 1995). Not detecting depression symptoms in this population can have devastating effects. Those aged 65 and older account for 18 percent of suicides in the United States (Yates, Van Orden, & Caine, 2012) even though many saw a physician within the past month (Rupel, et al., 2010).

Older adults can be at a higher risk for depression due to certain medicines or combination of medicines, damage to body image (e.g. loss of a limb, surgery, stroke or heart attack), fear of death, living alone, social isolation, other illnesses, chronic or severe pain, or loss of a loved one (Help Guide, 2014).

Depression in the older adult population can be difficult to detect because it can be confused with other diseases that surface later in life, such as dementia or memory loss. Also symptoms of depression are often confused with aging symptoms such as long face or a slouched posture (Evans & Mottram, 2000). As many as 11 percent of the older adult population with depression go unnoticed and therefore not treated (Dorfman, 1995). With women living longer than men, many end up living alone and therefore are at a higher risk for isolation and loneliness. According to USA today, 30 million Americans aged 65 and older were living alone in 2012. With the growing number of older adults and the desire for independence, that number can only increase.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (2013) the symptoms of depression, which could be mistaken for signs of aging, include: difficulty concentrating, remembering details, making decisions, fatigue and decreased energy, guilty feelings, worthlessness, helplessness, hopelessness, insomnia, early-morning waking, extreme sleepiness, irritability, restlessness, loss of interest, overeating or loss of appetite, persistent pains

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(that do not diminish with treatment); insistent sad, anxious, or "empty" feelings, suicidal ideations, and suicide attempts (American Psychiatric Association, 2013).

Cohen, Kennard and Pitt (1994) surveyed young people's attitudes toward their older counterparts and found they are generally negative. They described the older adults according to their physical appearance or "wrinkled, white hair, grumpy, arrogant and intolerant of others" (p. 736). They also saw them as having a diminished role in society and being mentally incompetent. A common finding formed out of 12 interviews was that the older generation was "discontented and dissatisfied" (p. 737). Similarly, another study of 89 youths found that older adult depression was viewed as "just being old" (Rupel, 2010).

Of the many stigmas, there are two types of stigma that arise from perceived and actual perceptions from inside the individual, or self-stigma and from society, or public-stigma (Latlova, Kamaradova & Prasko, 2014). Research shows that removing stigma from diseases, such as depression, can improve the quality of life for those living with it (Corrigan & Penn, 1999). Therefore, with the rapidly growing older adult population plagued with depression much assistance will be needed to handle their symptoms. Depression if not properly diagnosed and treated, can increase the demand of caregivers, illness, and toll on health services (Evans & Mottram, 2000).

It is imperative that social workers become competent in the older adult population and the issues with which they are faced. Even if social work professionals do not have an interest in working with this population there is a good chance they will come in contact with them in the work setting, as the population booms. By social work professionals and students alike becoming competent in the older adult population, the commitment to cultural competency and diversity

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will be met. Age is a form of diversity and oppression. “Social workers should seek education and understanding on social diversity and oppression” (Workers, 2008 P.1).

By seeking education and understanding, social workers can also stay true to the principle of service, or goal of helping people in need and addressing social problems (Workers, 2008). But above all, social workers strive to combat social injustice and these stigma, and lack of proper treatment of older adults, discussed above are an example of this. “Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people” (Workers, 2008, P. 1). The older adult population is one that is oppressed, but often overlooked. There is a great deal known about depression, yet there is still much to discover.

This research study will seek to answer the question, "How do perceptions about depression among older adults affect the services they seek or receive?" These services include counseling, therapy, medications, and social support. Understanding this question will allow us to assess this growing phenomenon of older adult depression and the factors surrounding it. Therefore the stigma can be lessened, so as to assist them.

This research study follows a systematic literature review method. The intention of the research study was to deliver a comprehensive summary of current literature relevant to this research question. The summary compiled, analyzed and assessed the literature located. The literature was categorized by topic and quality. The research was compiled and organized so as able to be easily reviewed and duplicated.

Conceptual framework

Research theory utilized in this systematic review is stigma theory. Stigma theory was used to frame and guide the research. The population specified in this research was individuals

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aged 65 and older. Stigma is defined as a separation of individuals from one another based on a socially agreed upon decision that some people or groups are less worthy than others. Stigma often leads to stereotypes, prejudice, and discrimination (Link & Phelan, 2001).

Recent research shows that individuals fear and avoid those with mental illness (Stuart & Arboleda-Florez, 2000). There are public and personal stigmas against the older adult population as well as against depression. This research strived to conclude whether the perceptions gained from stigma effect the individuals' actions (e.g. use of services, seeking assistance, mortality, etc). Furthermore, negative attitudes and experiences of rejection and discrimination continue to affect the quality of life for persons with mental illness (Katsching, 2000). Stigma can also explain low service use, inadequate funding and delayed progress toward recovery (Markowitz, 2001).

This research follows the application of the research regarding stigma coined by Erving Goffman (1963). Goffman's research has been used as a framework in the past to explain stigma of mental illness in general and medical stigmatized groups such as HIV and Leprosy. The World Health Organization (2002) has recognized that stigma and discrimination involved with mental disorders are strongly connected with suffering, debility and economic loss. Link & Phalen (2001) and Quinn & Chaudoir (2009) echoed Goffman's study of stigma by speaking on the impact different stigmas have on decreased finances, mood, and health decline.

An interview with Dr. James Hullet, Senior medical director at OptumHealth Behavioral Solutions published by everyday HEALTH stated that "our culture has a rigid definition of what constitutes appropriate behavior, and there is a social stigma associated with depression." According to Dr. Hullett, social stigmas about depression often translate to inaccurate

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stereotypes, such as lack of willpower, out of control emotions, danger to others; defect, as well as antisocial behavior (Bowers, 2012).

Stigma framework was found to be a good fit to guide the retrieval of information and the course the research followed. The reason is that the framework is derived from personal stories. Also, the framework gets at the questions the researcher is trying to answer. Granted the research is dated, but still very relevant. The framework addresses stigma which is the backbone of the research that was completed.

Goffman (1963) describes stigma in symbols, responses, rules, types and deviance. It was looked at in terms of how individuals try to pretend they do not have depression due to stigma, or “symbols.” Goffman (1963) states that skin color is a stigma symbol, as is a hearing aid, cane, shaved head, or wheelchair. Stigmatized people often use symbols as “disidentifiers” in order to try to pass as a “normal.” For instance, if an illiterate person is wearing ‘intellectual’ glasses, they might be trying to pass as a literate person. This use of stigma as “disidentifiers” can also be described as a concealable stigmatized identity, or an identity that can be kept hidden from others but that brings with it social depression (Quinn & Chaudoir, 2009).

Then, how society responds to aging individuals with depression (responses) and what causes aged individuals with depression to not go along with stigma (rules). According to Link and Phelan (2001) there are many situations that involve stigma. Stigma processes can affect various areas of people’s lives, so stigmatization probably has an intense effect on opportunities in life i.e. earnings, housing, criminal involvement, health and life (Link & Phelan, 2001). Living with stigma involves identity issues, self-definition treatment, relationship outcomes and the social context in which people live (Quinn & Chaudoir, 2009).

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Social workers and other professionals working with older adults that live with this stigma face unique challenges. It is unknown how many older adults are living with this stigma that couples the illness of depression. When older adults hide their symptoms of depression, this could make it challenging for some social workers to recognize their depression and could cause the recovery process to last longer. If clinicians can address the stigma that couples older adults with depression, perhaps the symptoms of depression during aging can be a solution for improving the quality of life for this population.

Types of stigma was used as a category but veered from what Goffman (1963) proposed. Goffman proposed the stigma types of physical, group identity and character traits. Character traits are those that cause society to see an individual as weak, treacherous, etc. (mental illness, prison).

Goffman also discusses physical stigma (handicaps), and stigma of group identity (age, race). Physical stigma and group identity stigma was not used. These are stigmas this population feels but are not relevant to the research. Since the research is specifically focusing on the stigma married with depression in the older adult population the character traits remained as a category along with public and individual stigmas (i.e. family, person, and professional).

Goffman (1963) believed that stigma is caused by people “deviating” from the norms. Nonetheless, he developed theories in which deviance could be functional and acceptable in society. Deviance was discarded as it was not seen as relevant to the researcher.

This framework was a guide in gathering of data. Data was gathered that follows this framework in that it was derived from the idea of stigma. Research that follows the inclusion criteria, as mentioned, was categorized into: types, rules, responses to and symbols of stigma.

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Methodology

The method utilized in this research is called a systematic review. This is a literature review focused on a research question that tries to identify, assess, select and combine all high quality research evidence relevant to that question. The purpose of a systematic review is to provide a thorough summary and assessment of current high quality literature relevant to a research question.

A systematic review involves a detailed search of the empirical literature for relevant studies (White & Schmidt, 2005). The methodology of this type of review involves a specific inclusion criteria comprised of a chosen number of educational databases and key search terms. The systematic review involves data abstraction using an impartial and apparent approach for research synthesis, with a goal of minimizing bias (White & Schmidt, 2005).

Search strategy

The search used electronic databases. These databases included: SocINDEX, Social Work Abstracts, Pubmed, and PsycINFO. The terms used to conduct this research were older adult, depression, older adults, stigma, perception, medications, counseling, social support and therapy. Articles were selected by reviewing abstracts of literature located followed by review of full articles. Researcher tracked the number of articles screened, amount rejected, and those used in study.

Inclusion criteria

The systematic review identified articles on older adults with depression and related perceptions. Researcher chose to focus on professional, family and individual perceptions of stigma. Although much research has been completed on depression and the symptoms, limited research has been completed on the perceptions society has on older adult depression and the

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effects it causes. Articles were used from the year 2010 to 2015, to narrow and define the research collected to the most current work.

Articles were used internationally as to attend to how various cultures treat depression. Also, to assess what causes other countries older adults to be contented. Researcher chose to use studies that were both qualitative and quantitative, and both cross-sectional and longitudinal studies. Research was focused on the population sample of both men and women who were identified as older adults. Studies including younger persons' attitudes toward older adults were not ruled out.

Analysis

The Systematic literature review used a qualitative type of analysis. Based on the unique inclusion criteria described in the methodology, the research was tracked. Each article which fit the criteria was documented using the table below and categorized by type of findings and quality. The literature that fit the inclusion criteria was documented as to where it was located (e.g. SocIndex, Pubmed).

The locations were also further broken down into how many articles were retrieved from these locations and how many were discarded. Once literature was compiled and organized into categories, it was assessed and documented according to quality. Also, the results were assessed related to the quality of the studies completed leading to those conclusions.

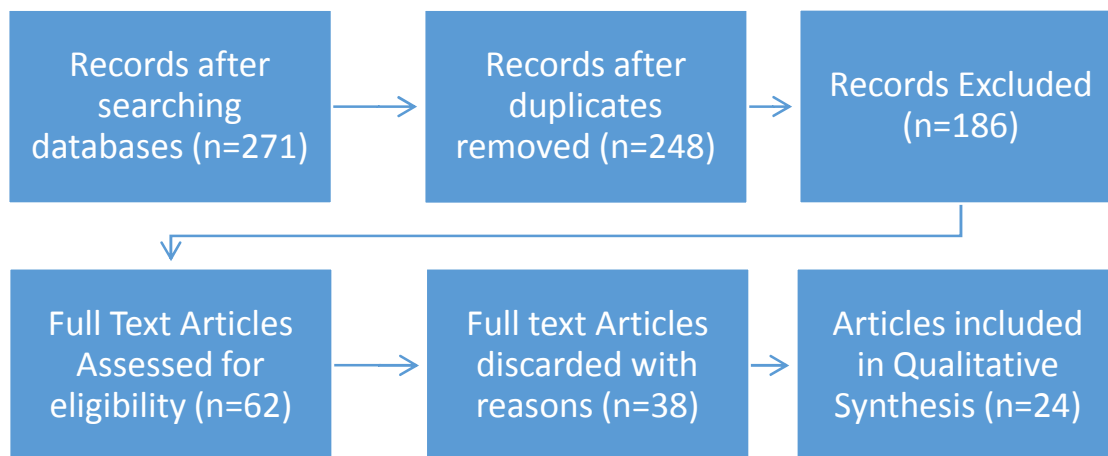
Articles were rated to assess the quality of the articles that were located. These articles were given a rating from one to five. Higher scores were given to articles with comparison groups, higher sample sizes and those with quantitative designs. Articles with comparison groups were automatically scored as a five, even if they had a smaller sample size or a qualitative design. Furthermore, next importance was placed on the sample size. If sample was over 100, a

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higher score was awarded. Themes were extrapolated from the literature. From these themes, quality was discerned by awarding higher credibility depending on the amount of studies that had more scores of fours and fives.

Data Abstraction

Once the articles were selected that met the inclusion criteria, they were read and data abstracted. The full table is in Appendix A. Researcher focused on the type of research completed, sample characteristics, findings, and measures. This assisted the researcher in assessing the findings and conceptualizing recurring themes.



An abbreviated table showing the themes that arose is located below the flow chart. The flow chart is shown to describe the exclusion process researcher followed during the data abstraction process.

Table

Theme(s)	Author(s)/Year(s)	Score	Comparison Group	Findings
<i>Stigma</i>	Pattyn et al., 2014	3	No	Public stigma appears to prevent respondents from viewing informal care as important.
<i>Stigma</i>	Latalova et al., 2014	3	No	Stigma interferes with treatment with mental illness and is more pronounced in men

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<i>Stigma</i>	Sirey et al., 2014	5	Yes	Stigma associated with mental health referrals and services
<i>Stigma,</i>	Willby et al., 2011	5	Yes	Depressed older adults not socially isolated
<i>Stigma, Low reporting, Normal part of aging</i>	Lee and Dugan, 2014	4	No	Perception of mood affects service use
<i>Stigma, Low reporting, Normal part of aging</i>	Corcoran et al., 2013	4	No	Depression not associated with intent to use services
<i>Stigma, low reporting, normal part of aging</i>	Kitchen et al., 2013	5	Yes	Stigma/value placed on sufficiency and depression as normal
<i>Stigma, Low Reporting, Under-diagnosis</i>	Kravitz et al., 2011	3	No	Distrust physicians' competence and openness
<i>Stigma, Low Reporting</i>	Gum et al., 2011	4	No	½ of participants received no formal treatment
<i>Stigma, Low Reporting</i>	O Connor et al., 2010	5	Yes	Stigma Associated with mental illness and seeking mental health services
<i>Stigma, Normal part of aging</i>	Gellis, 2010	4	No	Lack of confidence in assessing depression , incorrect responses on depression quiz
<i>Stigma, Normal part of aging</i>	Ruppel, 2010	5	Yes	Older adult are viewed as just old
<i>Low Reporting, Under-diagnosis</i>	Garrido et al., 2011	3	No	69.5 percent of older adults with major depression did not get treatment
<i>Low Reporting, Under-diagnosis</i>	Albrecht et al., 2014	4	No	Depressive symptoms not associated with hospitalizations
<i>Low Reporting, Under-diagnosis</i>	Lee et al., 2012	5	Yes	Negative perceptions and depression seen as normal aging
<i>Low Reporting</i>	Holvast et al., 2012	3	No	High contact with mental health providers-less lonely and more social contacts
<i>Low Reporting, Under-diagnosis</i>	Voldby et al., 2010	2	No	Under diagnosis of depression. Reluctant to seek help
<i>Under-diagnosis</i>	Helvik et al., 2012	3	No	40 percent good perceived health. Coping resources associated with good health ratings

Findings

There were four main themes that arose from the articles reviewed. An overwhelming theme that arose is stigma relating to depression in the older adult population. Within the theme of stigma, the sub-themes of internal and public stigmas will be discussed. The following themes

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were also present in the literature: the feeling that depression is a normal part of aging, the overall under-diagnosis of depression and low reporting of depressive symptoms. Another subject that was alive within all of the themes was the importance family support has on older adult depression. This theme will not be discussed in depth as it is a theme that has ample research that has been completed.

Stigma

Twelve of the twenty-four articles that were reviewed in full focused on stigma. These articles were found to be credible with nine receiving a score of four or five. Following review of these articles discussing stigma, two sub-themes arose: self, or anticipated, stigma and public, or perceived, stigma.

Self-Stigma.

Self-stigma is defined as internalization of anticipated prejudices which cause individuals to develop negative feeling about themselves (Latalova et al., 2014). Sirey et al. (2014) found that of 735 older adults, those diagnosed with depression were significantly more likely to have high anticipated stigma. This subsection with anticipated stigma was 70 percent less likely to have a mental health referral (Sirey, 2014). Likewise, O'Connor (2010) found that anticipated stigma has a negative influence on attitudes and intentions toward seeking mental health services among older adults with depression. Similarly, in a study of 16 older adults in rural Wyoming it was found that perceived stigma was an overwhelming barrier to seeking treatment (Kitchen et al., 2013). Latalova (2014) also found self-stigma to be a barrier to older adults seeking treatment for depression.

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Public Stigma.

Public stigma is defined as the perception held by others that the individual is socially undesirable (Latalova, 2014). Following a study of 168 social work professionals, Gellis (2010) surprisingly found that their contact with older adults did not decrease their misconceptions. This population was found to have misconceptions about aging and depression alike (Gellis, 2010). A similar study of individuals aged 13-31 established that young adults hold a poor view of depression in older adults (Ruppel, 2010). Correspondingly, Pattyn et al. (2014) found that perceived public stigma appeared to prevent respondents from viewing informal care as important. On the contrary, a study of older adult service use, found that lack of mental health treatment was related to perceived public attitudes (Gum et al., 2011).

Low reporting of depressive symptoms

Ten of the 24 articles that were reviewed in full, focused on how older adults do not recognize depressive symptoms and therefore have a lesser chance of reporting to a medical professional or using mental health services. These articles were found to be legitimately credible with five receiving a score of four or five.

Lee and Dugan (2014) found that out of 9,547 older adults 30 percent had inaccurate perceptions of their mood symptoms. This study found that older adults are at risk of not seeking mental health care or receiving insufficient care (Lee and Dugan, 2014). Correspondingly, Garrido et al. (2011) found 65.9 percent of survey respondents diagnosed with depression did not receive any mental health services within the previous 12 months. By the same token, Gum et al. (2011) proved in a study of 144 older adults with depressive symptoms that 48 percent did not receive any formal treatment.

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Similarly, perception of need was not found to be a predictor of service use. Gellis (2010) also found older adults to be less likely to voluntarily report symptoms of depression. Furthermore, of the 65.9 percent diagnosed with depression, 33 percent voiced perception of need (Garrido, 2011). Likewise, a study by Albrecht et al. (2014) was completed of hospitalized individuals over age 65. This study established extreme discrepancies between reporting by those with depression and those without.

Depression as normal part of aging

Five of the twenty four articles that were reviewed in full focused on the internalized stigma that older adults feel related to belief that depression is a normal part of the aging process. These articles also looked at public attitudes and beliefs. These articles were found to be exceedingly credible with four receiving a score of four or five.

Lee and Dugan (2014) name this as a significant issue within the older adult depressed population. Likewise, Kitchen (2013) emphasized belief in the normality of late-life depression. The age group of 75 to 90 years old had stronger beliefs that depressive symptoms were normal compared to 60 to 74 year olds (Kitchen, 2013). Similarly, Corcoran et al. (2013) published that older adults studied shared this feeling. Correspondingly, a study of young adults yielded this theme as an overwhelming view held by this population (Ruppel, 2010). A study completed by Gellis (2010) found the social workers interviewed to be generally under-educated regarding depression and aging, therefore leading to this misconception. This view of the normality of depressive symptoms is present in these articles, in the older adult population themselves as well as their younger counterparts.

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Under-diagnosis

Seven of the 24 articles that were reviewed in full, focused on how older adult depression often goes un-diagnosed or under-diagnosed. The majority of the articles in this theme were found to be not as credible with two articles receiving a score of four or five.

Kravitz et al. (2011) found that 25 percent of older adults with clinically significant depression went un-diagnosed. A similar study established that a number of older men with depressive symptoms were un-diagnosed, therefore un-treated (Voldby et al., 2010). Albrecht et al. (2014) also discussed the issue of underdiagnosed depression authors discovered in hospitalized older adults. Likewise, Lee et al. (2012) corroborated this finding of under-detection of older adult depression. Similarly, Garrido (2011) and Helvik et al. (2012) discuss a clear link between individuals with depressive symptoms under-diagnosis and un-perceived need for care. A corresponding study established that 70 percent of older adults with depressive symptoms had recently seen a general health practitioner, yet 30 percent had not discussed these symptoms with their practitioner (Holvast, 2011).

Discussion

This research raised four resounding themes regarding depression in the older adult population: stigma, low reporting, under-diagnosis and the normality. This research is very timely and important for social work clinicians. As discussed above, the population of older adults is rapidly increasing. The U.S. Census Bureau (2010) projection that the population age 85 and over could grow from 5.5 million in 2010 to 19 million by 2050 supports the US Department of Commerce (1995) estimates of the older adult population more than doubling by 2050. Clinicians should be aware of and study older adult depression.

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Social work practice with older adults and their families is increasingly recognized by the profession as a major field of practice in a wide range of health care and community-based settings (Beckman et al., 2006). The population is growing and, as research shows, is experiencing depression coupled with stigma. This research argues that anticipated and perceived stigmas cause older adults to be less likely to discuss their symptoms with healthcare providers. Anticipated stigma causes older adults to be less likely to request mental health services (Sirey, 2014) and has a negative influence on attitudes and intentions toward seeking mental health services among older adults with depression (O'Connor, 2010). Therefore, it can be assumed that if these providers are not hearing about the depressive symptoms, it is less likely that these individuals get diagnosed with depression.

This can be due to confusion with other medical conditions such as dementia or memory loss (Evans & Mottram, 2000). A link was discovered in the research located. The stigma that many older adults feel is related to the feeling that depressed feelings are a normal part of aging and are therefore not discussed with others. Therefore it can be hypothesized that if stigma is addressed, then depression treatment will increase. It is unknown how many older adults have depressive symptoms, yet this research overwhelmingly shows that there is an under-diagnosis and reporting of symptoms.

This research corresponds with the idea brought about at the beginning of this study: social workers become competent in the older adult population and the issues with which they are faced. With the ever growing population of older adults, social work professionals will come in contact with them in the work setting. Clinicians should seek education and understanding to stay true to the principle of service, or goal of helping people in need and addressing social problems (Workers, 2008). Social work clinicians strive to combat social injustice and these

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stigma, and lack of proper treatment of older adults, discussed above are an example of this.

“Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people” (Workers, 2008, P. 1). This education is increasingly important due to the evidence that clinicians hold misconceptions and lack of education on the older adult population and on depression (Gellis, 2010).

Implications for Social Work practice

This research leads to the argument that expanded training is needed for those who work with older adults (Gellis, 2010). Additionally, social work clinicians and healthcare professionals require tools and education into identification of depression symptoms in the older adult population, due to those who do not disclose depressive symptoms they are feeling.

Correspondingly, education and support is needed for older adults on their depressive symptoms and that these feelings are not normal signs of aging, and therefore can be helped. Clinicians will also need to advocate for the older adult population living with depression and empower them to stand up against it. Likewise clinicians will want to teach the general population that depression is not a normality of aging and that it can lead to negative stigmas.

Perhaps formal education on depression and stigma surrounding the older adult population should be added into social work institutions. The reason is, as stated above, whether or not a clinician strives to work with the elderly population it is likely they will work with an older adult during their practice. On a similar note, other healthcare professionals (e.g. physicians, nurses, therapists) should receive education on depression in the older adult population as well as stigma.

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Summary

This systematic literature review set out to gather relevant information available from the past five years. This review aimed to identify, assess, select and combine high quality research evidence relevant to the research question, "How do perceptions about depression among older adults affect the services they seek or receive?" This systematic literature review completed these goals and therefore provides a simple compilation of research collected. This literature offers a narrowed look at the research available on the subject. Also, the importance of stigma was established, paving the way for future research on the topic.

Limitations and future directions

Although there is research completed on depression in the older adult population, and stigma linked with it, it is still quite limited and gaining recognition. Several of the studies located were heavily laden with information on the importance of support for the older adult living with depression. In light of the research on support for the older adult living with depression, it remains a common problem plaguing the older adult population. Future research should be completed on stigma and how to combat it or use it to assist in the treatment. Furthermore, it is well-known that when older adults receive support from family members and friends they are less likely to feel stigma and more likely to stick to their treatment plans (Lee, 2012; Kwag et al., 2011; Muramatsu et al., 2010; & Gur-Yaish et al., 2012). The importance of support is a commonly researched topic so was therefore not discussed in detail. Yet, there is no specific research on the reasoning behind this, or how to ensure this support for older adults with depression.

Further research direction should be placed on use of family members to combat this occurrence. It seems that these articles collected, do not discuss the history, type and degree of

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the older adults' depression. On a different note, a majority of articles are focused on older adults residing in their homes. Further studies would be useful into the different types and levels of stigma which plague older adults in different locations (e.g. assisted living facilities, skilled nursing facilities, and etc). Moreover, as derived from this systematic research, research is present on stigma that couples depression in the older adult population.

Additionally, future research should be completed on what causes this stigma and how to work with the older adults living with it. If clinicians can address the stigma that couples older adults with depression, perhaps the symptoms of depression, during the aging process, can be a solution for improving the quality of life for this population. In summary, depression in older adults is widespread, under-diagnosed, and therefore often untreated. Many older adults are plagued with stigma that couples depression and therefore do not disclose their symptoms or view them as normal. Further research is needed on the topic and education provided to those who work with the older adult population.

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Appendix A PERCEPTIONS OF DEPRESSIONS

Author(s)	Year(s)	Research Design	Sample	Selection Criteria	Comparison Group	Findings	Measures	Score
Hyo Jung Lee and Elizabeth Dugan	2014	Quantitative/longitudinal	9,547 community dwelling older adults	2010 the Healthand Retirement	No	Perception of mood affects service use	Use of Mental Health Services and Depression	4
Albrecht et al.	2014	Quantitative/Prospective cohort study	750 older adults 65 and above	Maryland Hospital Patients	No	Depressive symptoms not associated with hospitalizations	Baseline Questionnaire Depression, MMSE, Social Network	4
Cohen-Mansfield et al.	2013	Questionnaire and interview	180 older adults over 60	Residents of NORC in Maryland	No	Depression not associated with intent to use services	Depression Scale, "How often would you say you feel lonely?" IADL	4
Corcoran et al.	2013	Qualitative/Quantitative-	13 studies -356 older adults 60 and above	primary care physicians or inpatient treatment	No	Negative perceptions and depression seen as normal aging	Meta-analyses and systematic reviews	2
Lee et al.	2012	Cross-sectional -Purpose Sampling Method	316 older adults 65 and above	7 Assisted Living Facilities in Kansas	Yes	Depression is under detected	Perceived Stress, Coping, COPE, Depression, Satisfaction	5
Frances Willby	2011	Qualitative/Quantitative	91 older adults 65 and above	Randomly Selected	Yes	Depressed older adults not socially isolated	Depression , Interviews, MMSE, Ways of Coping	5
Kitchen et al.	2013	Qualitative	16 older adults 56-63	Rural Wyoming community residents.	yes	Stigma/value placed on sufficiency and depression as normal	Semi-structured interviews	5
Susan Ruppel	2010	Qualitative	89 people (45:17-26 and 44: 13-31)	university in the southeast	Yes	Older adult are viewed as just old	Vignettes, Questionnaire	5
Latalova et al.	2014	Systematic Review	525 older adults	elevated depression scores (randomly allocated)	No	Stigma interferes with treatment with mental illness and is more pronounced in men	Discrimination, Depression , Internalized Stigma, and Stigma of Seeking Help	3
Kravits et al.	2011	Qualitative	116 people 25-64	Knowledge of depression	No	Distrust physicians' competence and openness	Focus Groups	3
Voldby et al.	2010	Qualitative	8 men 66-85	Meant diagnosed with depression in late-life	No	Under diagnosis of depression. Reluctant to seek help	Interviews	2
Hatfield et al.,	2013	Quantitative	735 older adults 65 and above	From internal and family medicine primary care offices	No	Social interaction a buffer between illness burden and depression	Depression, Support, Family Involvement, Criticism, and Illness	4
Gum et al.	2011	Longitudinal	144 older adults 65 and above	Depressive symptoms	No	½ of participants received no formal treatment.	In person initial interview and telephone follow up	4
Sirey et al.	2014	Quantitative	735 older adults	Admitted to meal program/ depression	Yes	Stigma can hinder mental health referral.	Memory, Health, Orientation and Stigma	5

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Author(s)	Year	Research Design	Sample	Selection Criteria	Comparison Group	Findings	Measures	Score
O Connor et al.	2010	Two stage Sampling Design	248 older adults 60 and above	Diagnosed with depression	Yes	Stigma associated with mental illness and seeking mental health services	PHQ-9, Discrimination , Stigma, Attitudes-Mental Health Treatment	5
Garrido et al.	2011	Secondary data analysis	1,681 older adults 65 and above	Collaborative Psychiatric Epidemiology Surveys 2001-2003	No	69.5 percent of older adults with major depression did not get treatment	MHC use, need for care, mental/physical illness, attitudes toward care, demographics.	3
Zvi D Gellis	2010	Quantitative	168 social workers	Sample from NASW New York Chapter (working with older adults)	No	Lack of confidence in assessing depression , incorrect responses on Depression Quiz	Depression Quiz, Confidence in Assessment of Common Clinical Problems and Facts on Aging Quiz II	4
Muramatsu, et al.	2010	Logistic regression analysis	6535 older adults 70 and above	Using ten year panel study 1993-2002	No	Functional limitations were major stressors associated with depression	Depression Scale, cognition/stress/IADL needs and assistance	4
Martin et al.	2011	Cross-sectional	163 older adults 66 to 106	Comparing physical abilities, mental health, nutrition, housing and environment	No	More support related to lower depression, less loneliness	Stress, Social Provisions, Physical Activity for the Older adult, Fatigue, Loneliness and Depression	3
Gur-Yaish et al.	2013	Quantitative	468 older adults	Process Effects on Functional Outcomes and Recovery	No	Service use in hospital setting	Self-report, Questionnaires at admission and discharge	4
Danielle R Jahn and Kelly C Cukrowicz	2012	Quantitative	98 older adults 60 and above	Health Sciences Center and Community Medicine Clinics	No	Depressive symptoms in participants with less functional impairment were not affected by views of health.	Depression Scale, IA DL, Health Survey and Hopelessness	4
Holvast et al.	2012	Cross-sectional Analysis of Depression and Anxiety	167 older adults 55 and above	With depressive disorder indicated by CIDI	No	High contact with mental health providers-less lonely and more social contacts	Depression, Anxiety, and CIDI	3
Helvik et al.	2012	Cross-sectional study	217 older adults 65-95	General community hospital patients hospitalized for at least 48 hours	No	40 percent good perceived health. Coping resources associated with good health ratings	Health scale, Lawton Scale, Self-maintaining, Anxiety, Depression , Coping and Mini Mental Status Exam	3
Pattyn et al.	2014	Qualitative	755 older adults	Representative sample of non-institutionalized adult general public	No	Public stigma appears to prevent respondents from viewing informal care as important.	Interviews, Devaluation, Discrimination, Social Isolation, Shortened General Health	3