5-2016

Clinical Social Work Interventions for Nursing Home Residents with Depression

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for Nursing Home Residents with Depression

by

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MSW Clinical Research Project

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's of Social Work

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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.

Abstract

The populations of older adults is growing. Nursing home residents, in particular, are some of the most vulnerable members of society. Depression is more common in nursing home residents than it is in older adults who live in the community. Clinical social workers are trained to be psychotherapists, and it is important for these professionals to know which types of therapy are most effective for nursing home residents with depression. This systematic literature review was designed to sample the most recent research on psychotherapeutic interventions that are effective in addressing depression in nursing home residents. Specific search criteria were chosen along with inclusions and exclusions. For this review, 10 research studies were analyzed. The results fell into four categories of interventions: reminiscence therapy, CBT, BE-ACTIV, and other interventions. The similarities and differences in the studies and the interventions that were tested are discussed. Based on this systematic literature review, reminiscence therapy and CBT are the most effective types of therapy for nursing home residents with depression. The clinical social work practice and policy implications are presented. The limitations of this study are also highlighted along with suggestions for future research in this area.

Acknowledgments

Thank you to my research chair, Dr. Robin Whitebird. Your input, guidance, patience, as well as your calm and steady manner helped get me through this project. To my committee members, Carol Ashwood and Rebekah Elling, thank you for reviewing my work and giving me your professional input to improve it. It was invaluable.

- To my family, your unconditional love and support are immeasurable. I am so grateful!

  To my Mom, thank you for your encouragement and wisdom, for making me laugh, for listening to me when I need someone to listen, and for letting me be your "family social worker."

  To my Dad, you are one of main reasons I became a social worker! Thank you for being my inspiration and for cheering me on along the way.

  To Nathan, I can't believe you're coming to my graduation even though you'll be here again less than a month later. You're so sweet, Little Nathie! Thanks for being so proud of me and my career change. It really means a lot to me!

  To Lauren, you have been a great cheerleader while I've been in grad school, and you did a great job making sure I knew I could do it. Thanks for your grad school advice. I made it!

  To Mr. T., every picture your parents post of you puts a smile on my face, and the joy the pictures bring helped me get through the stressful times in my last year of grad school. Auntie El can't wait to see you in June, little dude!

- To my friends outside of school, I'm excited I'll have more time to see you and talk to you very soon! Thanks for hanging in there with me even when I haven't been around much.

- To my MSW friends, classmates, and professors, you have made my giant career change so very enjoyable! I learned from each and every one of you, and I will miss seeing you regularly. Thank goodness texts and social media that will make communicating after graduation easy.

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The population of older adults is growing and, with that, so does the need for long term

care for those who need it later in life. Ortman, Velkoff, and Hogan (2014) state, "In 2050, the

population aged 65 and over is projected to be 83.7 million, double its estimated populations of

43.1 million in 2012" (para. 2). Nursing homes provide one option for long term care to those

whose care needs are great. About 1.4 million people live in approximately 16,000 nursing

homes across the U.S. (Sahlins, 2010). Sahlins (2010) explains that nursing home residents are

some of the most vulnerable individuals in our population due their medical needs as well as

their lack of financial resources or lack strong family support. Social workers are aptly prepared

to work with vulnerable populations including nursing home residents.

In the elderly, depression is one of the most common mental health issues (Yeung, Ching,

& Chung, 2010). The reasons that make nursing home residents particularly vulnerable also lead

to an increased risk of depression. "Levels of depression among older people in residential and

nursing homes have been found to be much greater than that in the community," and reported

prevalence rates range from 22% to 52% (Goudie, 1998, p. 189). Depression is a serious health

problem in older adults which affects overall well-being and can slow down recovery from

illness (Goudie, 1998). Goudie (1998) states that depression is not a "normal" part of aging, and

it needs to be recognized and caught in the early stages when therapeutic interventions are likely

to be most effective.

"Clinical social workers . . . diagnose and treat mental, behavioral, and emotional

disorders, including anxiety and depression (Bureau of Labor Statistics, 2014, "Clinical Social

Workers," para. 1). However, nursing home social work is not clinical in nature. It is mainly

about conducting resident assessments which are required to comply with long term care

regulations. In the best cases, nursing home social workers are trained to screen for depression

in residents but do not directly treat depression. Clinical social workers, though, are able to

address residents' depression with psychotherapy. The aim of this project is to investigate the

interventions clinical social workers use to effectively treat depression in nursing home residents

when it is identified as an illness to be addressed.

Literature Review

Older adults living in nursing homes are a vulnerable population, and if they live with an

untreated depression in a nursing home, their vulnerabilities increase. Social workers employed

by nursing homes in the U.S. work with this population daily, but they are often not trained nor

do they have the capacity in their workloads to provide depression interventions to the nursing

home residents with whom they work. Nursing homes that offer psychological services to their

residents typically contract mental health practitioners to come into the facility on an "as-

needed" basis to work with residents individually (Grabowski, Aschbrenner, Rome, & Bartels,

2010). Clinical social workers make up a large majority of these practitioners and should be

versed in the therapeutic interventions that are supported by research. Regulations that affect the

practice of nursing home social work are the primary reason social work in nursing homes is not

clinical. Therapy for residents with depression is an important health care service nursing homes

provide, and clinical social workers provide therapy.

Depression in Nursing Home Residents

Choi, Ransom, and Wyllie (2008) report that previous studies found the prevalence of all

types of depression in nursing home residents ranged from 9 to 75%. Chronic illness, functional

impairments, cognitive decline, bereavement, and grief are predictive factors for nursing home

placement, and those same factors more often than not have co-occurring depression (Choi et al.,

2008). It follows that there are higher prevalence rates of depression in nursing home residents compared to community-dwelling older adults (Choi et al., 2008; Youdin, 2014). Choi et al. (2008) conducted interviews with 65 nursing home residents, and they reported their depression to be related to the transition and adjustment of moving to the nursing home.

The Minnesota chapter of the National Alliance on Mental Illness (NAMI, 2009) says the symptoms of depression in older adults present differently than symptoms in other age groups. In older adults, signs of depression include: memory problems, confusion, social withdrawal, loss of appetite, vague complaints of pain, inability to sleep, irritability, fixed false beliefs (delusions), and hallucinations (NAMI Minnesota, 2009). These symptoms are important for social workers to look for when working with the nursing home population.

Federal Laws on Nursing Home Social Work

The regulations that govern nursing homes dictate, in part, the job of a nursing home social worker. In the federal requirements for long term care facilities, there is a section titled Quality of Life which lists the requirements for social services. It states, "The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" (Electronic Code of Federal Regulations, 2015, "Quality of Life," part g). It goes on to state that "a facility with more than 120 beds must employ a qualified social worker on a full-time basis" (eCFR, 2015, "Quality of Life," part g). The bed number limitation is important to note since 70% of U.S. nursing homes have less than 100 beds (Bern-Klug, 2008).

Putting the number of beds aside, nursing homes are held responsible by regulations for the medically related psychosocial needs of their residents, but only the facilities of a certain size are required to employ a full-time qualified social worker (Bern-Klug, 2008). In the larger

nursing homes, the one social worker employed has a caseload of at least 120 residents. If 30%

of those residents are depressed, seeing each of them weekly for therapy would be a full time

job, and it would not leave time for anything else. As such, nursing home social work does not

include therapy for residents. Bern-Klug (2008) points out that a qualified social worker in a

nursing home may or may not have a bachelor's degree in social work because the law allows

people in the job to hold other human service degrees as well. Clinical social workers who

provide therapy to clients have master's degrees in social work.

To summarize, nearly three-fourths of the nursing homes in the U.S. are not required to

by federal law to have a qualified social worker. In the facilities that are required to employ a

qualified social worker, that employee may or may not have a social work degree or license

because it is not required. There is no mention of a master's degree in social work in the federal

regulations regarding nursing home social workers, and the practice of clinical social work is

what is taught in master's level social work programs. Nursing home social work is not clinical

in nature. Clinical social workers are trained in the psychotherapeutic interventions that can be

used to help people with mental illness. Ideally, nursing homes would be required at the federal

level to employ clinical social workers, but that is not the case.

State Laws on Nursing Home Social Work

The lack of specificity in the federal regulations translates to a wide variation by state in

the credentials needed to be a qualified social worker at a nursing home. A study by Bern-Klug

(2008) documented the state variations in nursing home social worker requirements. The federal

regulation indicates the importance of the quality of life and psychosocial health of nursing home

residents, and both of these are priorities for nursing home social workers (Bern-Klug, 2008).

With that said, no mention of nursing home social worker qualifications was found in the

administrative laws of 10 states. In seven of the remaining 40 states, people without a college

degree (of any kind) are allowed to work as social workers in nursing homes with more than 120

beds (Bern-Klug, 2008). On the other end of the spectrum, 16 states and the District of

Columbia have laws that say a qualified social worker is a person with a degree in social work

and a license (Bern-Klug, 2008). None of the states, though, require their nursing home social

workers to have a master's degree in social work. To reiterate, the responsibilities of nursing

home social workers are not clinical in nature.

Nursing Home Social Worker Responsibilities

As mentioned earlier, the federal law is clear on this topic; nursing homes "must provide

medically-related social services to attain or maintain the highest practicable physical, mental,

and psychosocial well-being of each resident" (eCFR, 2015, "Quality of Life," part g). Sahlins

(2010) points out that nursing home social workers spend much of their time filling out

paperwork tied to an assessment that is state and federally mandated for funding and regulatory

compliance of nursing homes. The Minimum Data Set (MDS) is the name of the assessment,

and it describes and tracks each resident's medical status including their functional abilities and

emotional concerns (Sahlins, 2010).

Although there is no regulation declaring who fills out the MDS, nursing home social

workers are frequently responsible for any or all of the sections having to do with demographics,

mood and behavior, psychosocial well-being, and customary routines (Sahlins, 2010). The U.S.

law regarding the requirements for long term care facilities states that assessments must be

completed within 14 days after admission, within 14 days after the facility determines there has

been a significant physical or mental change in the resident, and not less often than once per year

(eCFR, 2015). In addition, a quarterly assessment of each resident is required which happens not

less than once every three months (eCFR, 2015). A nursing home social worker whose job

includes performing assessments spends a lot of time filling out forms so that the facility remains

compliant with federal regulations.

That means nursing home social workers in facilities with more than 120 residents must

assess and complete paperwork for each resident at the times indicated to be compliant with the

law. Since compliance is tied to federal funding for many nursing homes, it is understandable

that the nursing home social worker's highest priority is likely resident assessments. With

assessments and the paperwork involved as part of their responsibilities, there is not time to do

therapy with residents who have mental illness even if the nursing home social worker has a

master's degree in social work (which is not likely since it is not required). Nursing home social

work is not structured to be clinical social work.

Clinical Social Work Definition

It may be helpful to more thoroughly define clinical social work. The National

Association of Social Workers (NASW, 2015) states:

> Clinical social work is a specialty practice area of social work which focuses on the
>
> assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other
>
> behavioral disturbances. Individual, group and family therapy are common treatment
>
> modalities. Social workers who provide these services are required to be licensed or
>
> certified at the clinical level in their state of practice. Clinical social workers perform
>
> services in a variety of settings including private practice, hospitals, community mental
>
> health, primary care, and agencies. NASW advocates for clinical social workers through
>
> the legislative and regulatory process. (para. 1)

Clinical social work is therapy, psychotherapy, and counseling, and clinical social workers are therapists. Currently, it is not required that nursing homes in the U.S. employ clinical social workers.

Therapy for Depression in Older Adults

Freud was pessimistic about therapy with older adults because the "mass of material to be dealt with would prolong the treatment indefinitely" and "the lack of hope for the future would militate against the motivation or opportunity for change" (Woolfe, 1998, p. 142). Progress away from Freud's attitude is evident in the UK. The under-detection of mental illness in older adults is a key issue the UK government is addressing in light of the growing population of the elderly (Hill & Brettle, 2006). The government in the UK found that depression in people age 65 and older is particularly under-diagnosed in residents in nursing homes, which may be attributable to a general tendency for mental health issues in older adults to be regarded as a normal part of aging rather than as treatable illnesses (Hill & Brettle, 2006). As previously mentioned, depression is not normal for older adults. Similarly, depression is not expected for nursing home residents.

Goudie (1998) states that depression in older adults is less often diagnosed by general practitioners than in younger people, and when it is diagnosed, treatment of any kind is infrequent. Psychotherapy is not offered as often as a treatment option to older people (Goudie, 1998). This behavior of health professionals seems to be linked to negative beliefs about older people not responding to treatment (Goudie, 1998). "Many social workers in training are unmotivated to engage in a psychotherapeutic relationship with an older adult" (Youdin, 2014, p. 50). This may be based on a conception that an older adult is unable to change and set in his or her ways (Youdin, 2014). This mindset is similar to that of Freud. A study by Woolfe (1998) on

therapists' attitudes toward working with older people resulted in a recommendation to give

greater attention to the existence of age bias in counseling.

Whether or not an age bias exists in the delivery of care, Hill and Brettle (2006) found in

a systematic review of 47 papers that counseling with older adults is effective especially for the

treatment of depression, anxiety, and for improving individual well-being. In their review of

literature, therapy outcomes in older adults are consistent with those in younger groups (Hill &

Brettle, 2006). According to Baldwin (2010), "age is no barrier to psychological interventions

for depression: for moderate depressive disorder, they are as effective as medication" (p. 61).

This is strong evidence that counseling works for older adults who are depressed. Clinical social

workers should be aware that therapeutic interventions with this population are successful.

Youdin (2014) highlights several types of psychotherapy that can be used with older

adults: cognitive behavioral therapy (CBT), narrative therapy, and reminiscence therapy. CBT is

an effective evidence-based therapeutic orientation for the treatment of depressive disorders

(Youdin, 2014). CBT focuses on the relationship between thoughts, feelings, and behaviors, and

it teaches the client to modify maladaptive thinking and replace it with positive thinking

(Youdin, 2014). Similarly, the maladaptive feelings and behaviors become positive feelings and

behaviors (Youdin, 2014). Narrative therapy is based on the idea that life stories provide

meaning. Enabling the clients to reauthor their stories allows them to explore different narrative

outcomes (Youdin, 2014). Reminiscence therapy is a strength-based strategy that allows clients

to connect with their past positive experiences and memories to help them problem solve in the

present (Youdin, 2014). These are some of the interventions that psychotherapists use with older

adults.

In summary, federal regulations state that all nursing homes must offer social services but, depending on size, nursing homes are not all required to employ a qualified social worker. In addition, depending on the state where the nursing home is located, that employee's required credentials range from a degree in social work with a license to no college degree at all. Because nursing home social workers are not required to have a master's degree in social work, the job responsibilities do not include the practice of clinical social work which would address the needs of residents living with mental illnesses like depression. Therapy works for older adults with depression, and this is important for both nursing home social workers and clinical social workers to know so that residents who are depressed can get the treatment they need. The purpose of this study is to explore the effective clinical social work interventions for nursing home residents who suffer from depression.

Conceptual framework

People who work with older adults who live in nursing homes are serving one of the most vulnerable populations in our society. In their work, social workers give priority to those who are most vulnerable because they are the people who cannot easily find help anywhere else. The first part of the conceptual framework for this project is the ethical framework of the social work profession. Three of the six core values of social work are particularly relevant to this project: service, social justice, and dignity and worth of the person (NASW, 2008). Together, these three values mean that social workers respect the inherent worth of each person and work toward a primary goal of helping people in need which addresses social problems and challenges social injustice (NASW, 2008). By working with vulnerable older adults in nursing homes, social workers put these values into action.

The 10 principles of Social Work for Social Justice expands upon the social justice value. "Priority for the Poor and Vulnerable" is one of the 10 principles of Social Work for Social Justice (School of Social Work, 2010). It states that the way the most vulnerable members are doing is a basic moral test for any community, and those at most risk should be a priority (School of Social Work, 2010). Depressed older adults in nursing homes should be a priority for social workers, and that is the second mainstay of the conceptual framework for this project.

The final part of the conceptual framework for this project is the principle of "Human Dignity" also from the 10 principles (School of Social Work, 2010) as well as the NASW Code of Ethics (NASW, 2008). This principle states, "Dignity of the human person is the ethical foundation of a moral society," and it continues to say that whether the life and dignity of each human person is threatened or enhanced is the measure of every institution (School of Social Work, p. 1). If mental health practitioners believe their services are better spent on younger people, this practice threatens the dignity of older adults. The stigma associated with mental illness in our society also continues to threaten the human dignity of those living with mental illness. Nursing home residents who are depressed fall into both of these categories, and the principle states, "Social workers act to prevent and eliminate domination of, exploitation of, and discrimination against any person or group on any basis" (School of Social Work, p. 1). Vulnerable populations can easily be forgotten by society, yet social workers know these people deserve the same respect given to anyone else. There is inherent worth in every human being.

Overall, nursing home residents with depression are worth the attention of mental health practitioners, and they should be prioritized by social workers because they are vulnerable. These ideas together sum up the conceptual framework for this project.

Method

The research method that was used in this study is a systematic literature review. Systematic reviews identify and analyze existing research studies so that an aggregate of knowledge from the studies selected can be presented. For this project, a systematic review identified effective clinical social work interventions for nursing home residents with depression. Petticrew and Roberts (2006) say that a systematic literature review is "a method of making sense of large bodies of information, and a means of contributing to the answers to questions about what works and what does not" (p. 2). They go on to explain that reviews are important because individual studies are frequently valued more than what is deserved (Petticrew & Roberts, 2006). The overarching goal of a systematic review is to summarize the findings from previous research studies where those studies were the result from the literature search performed in the current research project. The goal of this project is to provide a summary of recent study results that identify types of therapy which measurably improve depressive symptoms of nursing home residents.

Search Terms and Databases

SocINDEX with Full Text, Social Work Abstracts, and PsycINFO were the databases used for the literature search. The search engine for SocINDEX with Full Text and Social Work Abstracts is EBSCOhost, and both of these databases were selected at the same time in one EBSCOhost search. The following search terms were used: "nursing home" or "long term care" or "skilled nursing facility" AND "therapy or counseling" AND "depression." In the EBSCOhost search, the term "depression" was previously identified as a subject field, and therefore that subject designation was selected for that term. The other search terms did not have a field option selected. PsycINFO uses the ProQuest search engine, and the search terms varied

slightly from the EBSCOhost search. The first two search terms remained the same, but the third

was changed to "major depression." In PsycINFO, "major depression" is a subject heading in

the database, and that is the reason it was used in place of "depression" in the previous search.

Sample

The study population in this project is older adults who live in nursing homes and have

symptoms of depression. "Older adult" is defined as age 65 and up. In PsycINFO, the "Aged

(65 years and older)" limitation was selected. Residents of nursing homes, long term care

facilities, and skilled nursing facilities are considered the same for this study. Because

subsyndromal depression (a.k.a. minor depression or dysthymia) is also of concern in nursing

home populations, the definition of depression for this project was not limited to mental

disorders according to *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.;

DSM-5; American Psychiatric Association, 2013).

Types of Studies

This project limited the search results to empirical quantitative research studies that were

peer-reviewed and published in English. Quantitative study results include information on the

effectiveness of therapeutic interventions to address depression in nursing home residents, and

that is the goal of this project.

Inclusion and Exclusion Criteria

Research studies published between January 2005 and December 2015 were included

from SocINDEX with Full Text, Social Work Abstracts, and PsycINFO according to the search

criteria described. In February of 2016, articles were searched and collected. As shown in the

flow chart in Appendix A, 21 articles from Social Work Abstracts and SocINDEX with Full Text

met the initial search criteria as well as 48 articles from PsycINFO for a total of 69 articles. Of those 69, 10 articles met criteria to be included in this systematic review.

The titles and abstracts of the articles from the initial search were scanned for the first exclusion, and articles that were excluded from the research review included: studies focused on older adults with dementia or Alzheimer's disease; studies that used a pharmacological intervention; studies focused on caregivers; articles focused on specific medical conditions; and studies focused on medical interventions. It is more difficult to measure therapy effectiveness when a study participant has cognitive deficiencies hence the significant exclusion of studies focused on dementia. The first exclusion left 14 articles after duplicates were accounted for. The articles were printed and read in detail at which time a second exclusion was necessary. The four articles eliminated this time included: one study with participants who were not nursing home residents, one study with participants with severe and persistent mental illness, and two research studies that were not experimental or quasi-experimental designs.

Data Analysis

The final systematic review consisted of 10 research studies. A list of the included article authors and titles can be found in Table 1. As each of the 10 articles was read for the first time, an article analysis form was filled out to extract information on the research question, sample, intervention, statistical analysis, findings, and areas for discussion. An example of a completed form can be found in Appendix B. Additional notes were tabulated in subsequent readings.

Table 1

Included Articles

Author(s)	Title
Chueh, K., & Chang, T. (2014)	Effectiveness of group reminiscence therapy for depressive symptoms in male veterans: 6-month follow-up.
Hyer, L., Yeager, C. A., Hilton, N., & Sacks, A. (2009)	Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care.
Karimi, H., Dolatshahee, B., Momeni, K., Khodabakhshi, A., Rezaei, M., & Kamrani, A. A. (2010)	Effectiveness of integrative and instrumental reminiscence therapies on depression symptoms reduction in institutionalized older adults: An empirical study.
Konnert, C., Dobson, K., & Stelmach, L. (2009)	The prevention of depression in nursing home residents: A randomized clinical trial of cognitive-behavioral therapy.
Lutwack-Bloom, P., Wijewickrama, R., & Smith, B. (2005)	Effects of pets versus people visits with nursing home residents.
Meeks, S., Looney, S. W., Van Haitsma, K., & Teri, L. (2008)	BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes.
Meeks, S., Van Haitsma, K., Schoenbachler, B., & Looney, S. W. (2015)	BE-ACTIV for depression in nursing homes: Primary outcomes of a randomized trial.
Myskja, A., & Nord, P. G. (2008)	"The day the music died": A pilot study on music and depression in a nursing home.
Wang, J. (2005)	The effects of reminiscence on depressive symptoms and mood status of older institutionalized adults in Taiwan.
Wu, M., Sung, H., Lee, W., & Smith, G. D. (2015)	The effects of light therapy on depression and sleep disruption in older adults in a long-term care facility.

Results

The purpose of this systematic review was to identify psychotherapeutic modalities that measurably improve depression symptoms in nursing home residents. Of the 10 articles that were identified in the literature search, three (30%) tested reminiscence therapy interventions with nursing home residents. Two articles (20%) tested interventions identified as CBT or a

form of CBT (GIST) with nursing home residents. Two studies (20%) were authored by the

same primary researcher and both tested the same behavioral intervention developed for nursing

home residents called BE-ACTIV. The remaining three studies tested interventions that are not

central modes of psychotherapy: music sessions (10%), volunteer visits with a dog (10%), and

bright light therapy (10%).

All 10 studies (100%) in this systematic review used participants who were nursing home

residents, age 70 or older (when rounded to the nearest year). Five studies (50%) screened the

participants for depression and required a minimum score on a depression scale to determine if

they should be included in the study. The other 5 studies (50%) did not require their participants

to exhibit depression symptoms to qualify for the study. More than half of the studies (60%,

n=6) were conducted outside of the U.S. in the following locations: Taiwan, China (30%, n=3),

Iran (10%, n=1), Canada (10%, n=1), and Norway (10%, n=1).

Nine studies (90%) were either experimental or quasi-experimental designs as per the

review exclusion criteria. The study which used music sessions as the intervention was deemed

a "natural experiment" (Myskja & Nord, 2008, p. 32). It did not include a control group in the

design, and therefore did not meet the research method requirement of this review.

As stated in the systematic review literature search criteria when the terms "dementia" or

"Alzheimer's disease" appeared in the title or abstract of articles, those articles were excluded

from this review. Half of the research included in this review (50%, n=5) screened for cognitive

impairment of the nursing home resident participants using the Mini-Mental State Examination

(MMSE). The MMSE is a rapid screen to measure an individual's cognitive ability, and it is

used often in long term care settings (Hyer, Yeager, Hilton, & Sacks, 2008; Karimi et al., 2010;

Meeks, Van Haitsma, Schoenbachler, & Looney, 2015). One study (10%) used the Short

Portable Mental State Questionnaire (SPSMQ) to measure mental functioning. The remaining

four studies (40%) in this review did not measure cognitive impairment in their sample of

nursing home residents with a standardized measure. Two of the four did not control for

cognitive impairment at all, and the other two controlled for it by researcher assessment of "no

obvious cognitive impairments" (Wang, 2005) and ability "to respond to interview questions"

(Wu, Sung, Lee, & Smith, 2014). One of the two studies that did not control for cognitive

impairment at all was the study about music sessions. In the study by Myskja and Nord (2008),

over half of the study participants lived in areas of the nursing home for people with dementia.

This is another reason the music sessions study did not meet the requirements of this review.

The majority of the studies in this review (90%, n=9) used some form of the Geriatric

Depression Scale (GDS) to measure depression as the dependent variable at baseline and post

intervention. The types of the GDS that were used as study measures included the shortened 15-

item GDS (50%, n=5), the full 30-item GDS (30%, n=3), and the TGDS or the Taiwan version of

the GDS (10%, n=1). The Montgomery Aasberg Depression Rating Scale (MADRS) was the

other depression symptom measurement that appeared in this set of research studies. Various

other study measurements appeared in the articles, but the measures of depression mentioned are

of primary interest to this project's purpose.

Reminiscence Therapy Studies

The three reminiscence therapy interventions varied in design, but each study in this

category (Table 2) focused on participants recalling important events and memories which can

be used to address present problems.   Two of the interventions were in group format, and one

was individual therapy.

Table 2

Reminiscence Therapy Studies

Authors	Title	Sample	Intervention	Findings
Chueh, K., & Chang, T. (2014)	Effectiveness of group reminiscence therapy for depressive symptoms in male veterans: 6-month follow-up.	21 male residents from a Taiwan veterans' nursing home; mean age 82 years	GRT: 4 weeks of structured content group reminiscence therapy twice weekly for 60 minutes. Control: 4 weeks of typical daily nursing home activities	GRT reduced depressive symptoms for a 6-month period.
Karimi, H., Dolatshahee, B., Momeni, K., Khodabakhshi, A., Rezaei, M., & Kamrani, A. A. (2010)	Effectiveness of integrative and instrumental reminiscence therapies on depression symptoms reduction in institutionalized older adults: An empirical study.	29 residents from the largest nursing home in Iran; mean age 70.5 years	3 different experimental groups, each 6 weekly 90 minute group sessions: 1) Integrative reminiscence therapy per manual. 2) Instrumental reminiscence therapy per manual. 3) Control social discussion group.	Integrative reminiscence therapy significantly reduced depression compared to control, and instrumental reminiscence therapy reduced depression but not significantly.
Wang, J. (2005)	The effects of reminiscence on depressive symptoms and mood status of older institutionalized adults in Taiwan.	55 residents from 5 long-term care facilities in southern Taiwan; mean age 75.9 years	Reminiscence therapy: 4 months of individual meetings weekly. Control: Only pre-and post- data collection meetings.	Reminiscence therapy significantly reduced depression in the treatment group.

Karimi et al. (2010) tested two different types of group reminiscence therapy (GRT),

called integrative and instrumental, against a social discussion group which served as the control.

An intervention manual was followed to conduct the two types of reminiscence therapy, and all

three groups were led by a master's level therapist who was supervised by a clinical

psychologist. Each of the six weekly group sessions had a different theme: 1) family history, 2)

life accomplishments, 3) major turning points of life, 4) history of loves and hates, 5)

experiences of suffering, and 6) meaning of life and belief (Karimi et al., 2010). To distinguish

between the two types, Karimi et al. (2010) state:

Integrative reminiscence is a process that promotes acceptance of self and others, conflict

resolution and reconciliation, a sense of meaning and self-worth, and the integration of

the present and past. Instrumental reminiscence involves remembering past plans and

goal-directed activities, recalling how one coped with past problems, and drawing from

past experience to solve the present problems. (p. 882)

The other group reminiscence therapy study intervention was led by "one therapist with

extensive experience and training in group counselling and reminiscence therapy" (Chueh &

Chang, 2014, p. 379). The study by Chueh and Chang (2014) used eight group sessions that

were modified versions of sessions from another research study, and each group session focused

on a different topic. The control group in this study participated in the typical daily activities of

the veterans' nursing home. Session topics included: 1) greeting each other and sharing war-

related memories, 2) increasing participants' awareness of feelings about their two forced

displacements and helping them to express feelings, 3) identifying positive past relationships and

how to apply positive aspects to present relationships, 4) recalling life histories and stories, 5)

recalling issues of life transitions, 6) gaining awareness of personal accomplishments and

identifying personal goals, 7) identifying positive strengths and goals, and 8) conducting an

overview of all sessions followed by a farewell (Chueh & Chang, 2014).

Wang (2005) tested an individual reminiscence therapy where the therapist and

participant met weekly for four months. The principal researcher, who holds a PhD in

gerontological care and has experience in conducting reminiscence therapy, trained research

therapists (Wang, 2005). Researchers met 1:1 with treatment group participants to do

unstructured individual reminiscence (Wang, 2005). The control group of participants was

measured for depression twice, at the beginning and at the end of four months with no

intervention in between measures. The study by Wang (2005) is the only of the three in this category that did not screen for depression symptoms as a requirement for nursing home residents to participate in the study.

      All three reminiscence therapy studies showed an improvement of depression symptoms in nursing home residents in the treatment group as compared to the control. In Chueh and Chang (2014), the participants' depression scores as measured by the TGDS decreased significantly at all three post-tests: 1-week, 3-month, and 6-month. In Karimi et al. (2010), both types of reminiscence therapy reduced depression symptoms (measured by GDS 15-item) compared to control at the post-test immediately following the intervention, and the integrative reminiscence therapy significantly reduced depression symptoms. Individual reminiscence therapy in the study by Wang (2005) significantly reduced the GDS 15-item scores in the treatment group from pre-test to post-test as compared to the control group.

CBT Studies

      The two studies in the CBT category (Table 3) both used primary concepts from CBT in the interventions that were tested. The basic premise of CBT is that thoughts, feelings, and behaviors are all linked. Also, changing negative thinking affects emotions and behaviors. The intervention used by Konnert et al. (2009) was a group therapy intervention. Hyer et al. (2009) tested an intervention called Group, Individual, and Staff Therapy (GIST) in their study. The GIST intervention included group therapy sessions, individual therapy sessions, and involvement of a staff or coach chosen by each individual study participant.

Table 3
Cognitive-Behavioral Therapy Studies

Authors	Title	Sample	Intervention	Findings
Hyer, L., Yeager, C. A., Hilton, N., & Sacks, A. (2009)	Group, individual, and staff therapy: An efficient and effective cognitive behavioral therapy in long-term care.	25 residents from a veteran's nursing home in Central New Jersey; mean age 79 years	GIST: 15 weeks of structured CBT-based weekly 75-90 minute sessions (13 group sessions with coach at 2 of those, 2 individual sessions). TAU: 15 weeks treatment as usual of daily nursing home activities	GIST is more effective for depression than TAU (treatment as usual).
Konnert, C., Dobson, K., & Stelmach, L. (2009)	The prevention of depression in nursing home residents: A randomized clinical trial of cognitive-behavioral therapy.	64 residents from seven nursing homes; mean age 81 years	CBT: 7 weeks of structured group CBT therapy twice weekly. TAU: treatment as usual of daily nursing home activities	A CBT intervention is beneficial for residents with subsyndromal depression compared to TAU.

The three primary components of the GIST intervention are behavioral activation, increasing positive mood, and modifying behaviors (Hyer et al., 2009). The intervention implements these main objectives by leading the participants through: 1) individual positive goal selection, 2) weekly open group sessions that have the same agenda each week and focus on goals, 3) behavioral activation of positive or meaningful goals, and 4) social support (Hyer et al., 2009). Experience mapping is also a part of the group sessions, and it is a facilitated problem solving method which helps participants identify the thoughts/feelings/behaviors associated with the problem (Hyer et al., 2009). The GIST invention did not follow a manual, but it was adapted for use with older adults from the group, individual, and family treatment (GIFT) program developed by Friedman and colleagues (Hyer et al., 2009). It is unclear who lead the GIST group sessions and who conducted the individual therapy sessions. The control group in this study received treatment as usual (TAU) at the nursing home which consisted of daily activities consisting of socialization, games, and special events.

Konnert et al. (2009) is the only study in the CBT group that did not screen for depression in its participants prior to entrance into the study. The intervention used was called "Coping with Stress in Seniors," and it was adapted from prior research (Konnert et al., 2009). CBT group leaders were doctoral-level clinical psychology students who received training and supervision from clinicians with much experience in CBT and clinical gero-psychology (Konnert et al., 2009). Each group session was structured similarly, and the topics covered included: 1) constructing a mood diary, 2) coping with stress, 3) the relationship between thoughts and mood, 4) techniques for changing thoughts, 5) identifying and scheduling pleasant events, 6) planning for stressful events, and 7) preventing the blues (Konnert et al., 2009). The control group in this CBT study was treatment as usual (TAU) at the nursing where participant resided (Konnert et al., 2009). Since participants were recruited from seven different nursing homes, TAU varied.

Both CBT studies improved depression symptoms compared to the control. The 15-week GIST intervention resulted in significantly lowered GDS 15-item scores compared to the control group (Hyer et al., 2009). The group CBT intervention tested by Konnert et al. (2009) significantly reduced the participants' GDS scores at all three post-tests: immediately after, 3 months, and 6 months.

BE-ACTIV Studies

Meeks is the primary researcher on both of the BE-ACTIV studies (Table 4) included in the systematic review. The BE-ACTIV stands for Behavioral Activities Intervention, and it is a behavioral intervention designed to treat depression in long term care residents (Meeks et al., 2008). There are four essential components of BE-ACTIV: individual weekly meetings with the depressed participant and mental health practitioner; involvement of and collaboration with nursing home staff from the activities department; systematic assessment by staff of pleasant

events; and assessment and removal of barriers via behavioral problem solving and weekly

communication between the mental health practitioner and activities staff (Meeks et al., 2008).

Table 4

BE-ACTIV studies

Authors	Title	Sample	Intervention	Findings
Meeks, S., Looney, S. W., Van Haitsma, K., & Teri, L. (2008)	BE-ACTIV: A staff-assisted behavioral intervention for depression in nursing homes.	1st pilot: 5 residents from one nursing home, 2nd pilot: 20 residents from 6 nursing homes; mean age of both groups 75.4 years	BE-ACTIV: 10 weeks of Behavioral Activities Intervention individual therapy weekly for 30-40 minutes. Control: unclear.	BE-ACTIV led to increased activity level and more rapid improvement in depression and mood than did treatment as usual.
Meeks, S., Van Haitsma, K., Schoenbachler, B., & Looney, S. W. (2015)	BE-ACTIV for depression in nursing homes: Primary outcomes of a randomized trial.	82 residents from 23 nursing homes; mean age 75.16 years	BE-ACTIV: 10 weeks of Behavioral Activities Intervention individual therapy weekly. Control: weekly research staff visits for 5-30 minutes.	BE-ACTIV resulted in better Major Depressive Episode diagnostic recovery and more likely full remission than TAU. Both groups improved depressive symptoms and functional outcomes similarly

In 2008, Meeks et al. conducted two pilot studies. The purpose of the first pilot was to

design the manual for the BE-ACTIV intervention. The second pilot was a randomized pilot to

determine feasibility and efficacy of BE-ACTIV (Meeks et al., 2008). "A principal innovation

of BE-ACTIV is the use of a collaborative relationship between a mental health therapist and

activities staff members" (Meeks et al., 2008, p. 106). The BE-ACTIV manual that was

developed contains two versions: one for the mental health practitioner, and one for activities

staff members (Meeks et al., 2008). The manual is a session-by-session guide that specifies

goals for each session (Meeks et al., 2008). The randomized pilot included a control group, but

it was not clear how the residents in the control group were treated. The primary researcher, a

licensed clinical psychologist with 15 years of experience providing mental health care to

nursing home residents, was the mental health practitioner in both pilots (Meeks et al., 2008).

Meeks et al. (2015) used the same BE-ACTIV intervention as established in Meeks et al. (2008), and the intervention manual developed in 2008 was the manual used to conduct the 2015 intervention. The mental health therapists were clinical psychology doctoral students who completed a seminar and practicum on the BE-ACTIV intervention (Meeks et al., 2015). The control group received treatment as usual at the nursing home where they resided (participants were recruited from 23 nursing homes) as well as weekly visits with research staff to collect self-rated mood data (Meeks et al., 2015).

The BE-ACTIV studies measured the GDS for participants in the treatment and control groups before and after the intervention. The statistical results presented in each of the studies, though, did not focus on the GDS scores. It is clear from tables in each of the studies that GDS scores were lower after the BE-ACTIV intervention compared to the control group, but it is not clear if the differences were statistically significant. Both of the BE-ACTIV studies screened participants for depression to determine entrance into the studies.

Other Intervention Studies

The other intervention studies (Table 5) were as different from each other as they were from any of the other categories of studies. The volunteer visits with a dog intervention was conducted on an individual basis, and the music sessions and bright light therapy interventions took place in groups.

Table 5
Other Intervention Studies

Authors	Title	Sample	Intervention	Findings
Lutwack-Bloom, P., Wijewickrama, R., & Smith, B. (2005)	Effects of pets versus people visits with nursing home residents.	68 residents from two nursing homes; mean age 69.9 years	2 experimental groups, each 3 times per week 15-20 minute individual visits: 1) trained volunteers with dogs 2) trained volunteers without dogs	Dog visits did not reduce depression.

Myskja, A., & Nord, P. G. (2008)	"The day the music died": A pilot study on music and depression in a nursing home.	72 residents from a Norway nursing home; mean age 86.6 years	Music Sessions: 6 weeks of structured group music sessions twice weekly for 45 minutes. No Music: no music sessions.	Depression measure shows a significant decrease in the music therapy condition compared to no music therapy.
Wu, M., Sung, H., Lee, W., & Smith, G. D. (2014)	The effects of light therapy on depression and sleep disruption in older adults in a long-term care facility.	84 residents from a long-term care facility in Taiwan; mean age 80 years	Bright Light Therapy: 4 weeks of group light box sessions three times per week for 30 minutes. Control: usual care including 30 minutes in activity room without light box.	Light therapy reduced depression significantly in the treatment group.

The intervention tested in the study by Lutwack-Bloom, Wijewickrama, and Smith (2005) was volunteer visits with nursing home residents. The treatment group participants were visited by a two person team of volunteers who had a therapy dog with them, and the control group participants were visited by a team of volunteers without a dog. The volunteer visitors in the study were college students who completed an orientation covering the scope and length of the visits in an effort to assure as much as possible that all of the visits were comparable (Lutwack-Bloom et al., 2005). The nursing home residents were not screened for depression before they were chosen as study participants. Lutwack-Bloom et al. (2005) showed equal reductions in GDS scores of the nursing home residents in the treatment group and control group. This study did not indicate visits with a dog effected depression symptoms.

The study by Myskja and Nord (2008) was deemed a "natural experiment" by the researchers (p. 32). The music therapy aide at the nursing home took an 11-week leave of absence after holding open group music sessions twice a week for residents for a full year with only a few one week absences (Myskja & Nord, 2008). The music sessions were designed for residents with dementia using four sequences as outlined in a previous music therapists' work: 1) focus attention, 2) regulate arousal, 3) dialogue, 4) conclusion. Nursing home resident participants were not screened for depression as a prerequisite for the study. The study measured

participants' depression symptoms via the MADRS before the music aide returned and again six

weeks after music sessions resumed (Myskja & Nord, 2008). There was no control group in the

study by Myskja and Nord (2008). The depression scores of participants decreased significantly

from the no music session measure to the measure when music sessions resumed.

Wu, Sung, Lee, and Smith (2014) tested an intervention called bright light therapy. The

intervention was administered to a group of participants via a light box generating 10,000 lux

(Wu et al., 2014). Research assistants delivered the bright light therapy and observed the group

participants (Wu et al., 2014). Study participants were not screened for depression before the

study. The control group received only usual care which included the same amount of time in

the activity room without the light box that the treatment group had with the light box (Wu et al.,

2014). The bright light therapy resulted in a decrease of the participants' GDS 15-item scores

from pre-test to post-test, but the difference was not significant.

Discussion

This systematic review found 10 research studies that tested interventions to address

depression in nursing home residents. Half of the studies focused on reminiscence therapy and

CBT interventions, and all five of them showed reductions in the depressive symptoms of

nursing home residents. Two studies tested the BE-ACTIV intervention, but the direct effects of

BE-ACTIV on depression as measured by a reliable depression scale were unclear. The study

that tested volunteer visits with a dog did not show improvement in depression symptoms. There

is some evidence that music sessions reduce depressive symptoms in nursing home residents, but

the music sessions study did not qualify for this review due to both its method and its study

population. Lastly, the Bright Light therapy study showed a reduction in depression symptoms,

but it is not a psychotherapeutic intervention.

The five CBT and reminiscence therapy intervention studies included in this review tested an intervention that significantly reduced depression in nursing home residents as indicated by a version of the GDS (GDS 30-item, GDS 15-item, or TGDS). The results of these five studies are consistent with the literature that suggests CBT and reminiscence therapy are effective interventions for older adults with depression (Youdin, 2014). Four of the five studies used group therapy as the primary method to implement the treatment, and only one of the four used a blended group and individual therapy method. CBT and reminiscence therapy are both modes of therapy in which group member and peer support would augment the therapeutic effects of the therapy. Clinical social workers should keep in mind that CBT and reminiscence therapy are effective for addressing depression when working with this population.

The BE-ACTIV intervention was an unexpected finding in this review, and it was the focus of two of the articles in this study. BE-ACTIV seemed promising because it was designed exactly to meet the objective of this study: to reduce depression in nursing home residents. BE-ACTIV, however, did not show a clear significant reduction in GDS depression scores in the population tested. An important concept that both of the BE-ACTIV studies emphasized is the necessary participation of both a mental health practitioner and the nursing home staff in the intervention's implementation. This model is designed to give the nursing home resident multiple avenues of support during the treatment of their depression. The involvement of the nursing home staff in depression interventions led by mental health practitioners should be kept in mind for all types of depression treatment in nursing homes. BE-ACTIV, though, needs to be studied further to determine whether it is an effective intervention that improves the depressive symptoms of nursing home residents.

In the other interventions category, the only study that was designed well and showed a decrease in the depressive symptoms of nursing home resident participants was the bright light therapy study. Though it had positive results, light therapy is not psychotherapy. The study that tested music sessions as an intervention was not a quasi-experiment because it lacked a control group, and the majority of its participants had dementia. For both of these reasons, the music study should have been excluded from this review. Even though the music sessions study clearly showed a decrease in depressive symptoms when the music sessions resumed at the nursing home, the study did not hold up in terms of external validity when compared to the other nine studies in this review. Like the light therapy study, the study that tested volunteer visits with dogs as the intervention did not test a psychotherapeutic intervention. Not only that, but the dog visits did not show a decrease in nursing home resident depression.

Also to be considered, six of the seven studies in this review (CBT, reminiscence therapy, and BE-ACTIV interventions) were studies that measured the cognitive functioning of the participants at the start of the study (MMSE $\geq$ 13 in five studies, SPSMQ < 8 in one study). Research by Conradsson et al. (2013) showed that the GDS 15-item is most useful to assess depression in older adults when their MMSE score is 10 or more. Taking this into account, the depression results are questionable in Wang (2005) which tested individual reminiscence therapy with participants. The study by Wang (2005) used the researcher's personal assessment of the nursing home resident's cognitive ability and had a requirement that there were "no obvious cognitive impairments" in the each participant (Wang, 2005). The GDS 15-item scores in that study are questionable since the nursing home residents' MMSE scores are unknown.

This review shows that nursing home residents have depressive symptoms that can be treated whether or not they have been diagnosed with a depressive disorder. Hyer et al. (2008)

notes that major depressive disorder, dysthymia, minor depression, adjustment disorder with depression, and subsyndromal depressive symptoms are all clinically significant in nursing home residents. Konnert et al. (2009) specifically targeted nursing home residents who were at risk for depression rather than residents who were already diagnosed with depression, and the CBT intervention successfully reduced depression symptoms. The objective in Konnert et al. (2009) was an important one: to prevent depression in nursing home residents. Depression is not a "normal" part of aging, and it should be caught in the early stages when therapeutic interventions are likely to be most effective (Goudie, 1998). To maximize the quality of life for nursing home residents, every employee at a nursing home should keep preventing resident depression in mind while at work.

Implications for Social Work Practice

Based on this limited systematic literature review, CBT and reminiscence therapy are effective psychotherapeutic interventions to use with nursing home residents who are depressed. This is important information for clinical social workers and other mental health practitioner who meet with residents regularly for therapy. Although the social workers employed by nursing homes may not have clinical degrees, it is also important for them to be aware of the types of therapies that are effective. Concepts from these modes of therapy can be used in their work as well.

Knowing the signs of depression in older adults is key for social workers who work with nursing home residents. The symptoms include: memory problems, confusion, social withdrawal, loss of appetite, vague complaints of pain, inability to sleep, irritability, fixed false beliefs (delusions), and hallucinations (NAMI Minnesota, 2009). Knowing how depression symptoms in older adults differ from those in other age groups is also important.

When depression symptoms are observed in residents, nursing home social workers should advocate for early interventions so that it does not turn into diagnostic depression. The MDS regulatory assessment of each resident that is performed, more often than not, by nursing home social workers includes psychosocial and emotional assessments (Sahlins, 2010). As such, nursing home social workers are ideally positioned to work toward preventing depression in residents. Choi et al. (2008) point out that chronic illness, functional impairments, and cognitive decline are reasons for nursing home placement, and they also frequently have co-occurring depression. Every employee at a nursing home should know the signs of depression in older adults so that residents exhibiting depression symptoms can be identified early as needing help. Nursing home social workers can lead the way for other employees by putting this into their daily practice. Preventing depression in nursing home residents is as important as treating depression in nursing home residents.

Several of the core values of social work are the reasons social workers should work with depressed nursing home residents. The core value "dignity and worth of the person" means the inherent worth of each person should be respected (NASW, 2008). The social work value of service states that the primary goal of social workers is to help people in need (NASW, 2008). "Priority for the Poor and Vulnerable" says that those at most risk in communities should be the priority for social workers (School of Social Work, 2010). Depressed nursing home residents are people in need, and social workers should give priority to them because they are a vulnerable population that can easily be forgotten by society. Prioritizing the treatment of depression and working toward preventing depression in nursing home residents are two ways social workers can fulfill their ethical responsibilities with this population.

Implications for Policy

The emphasis on the involvement of a mental health practitioner in the BE-ACTIV intervention studies relates to the issue of nursing home social worker qualifications that was addressed in the background literature review of this study. The current role nursing home social workers play in resident assessments is important and should remain in place. To augment social work services at nursing homes, it should be a federal requirement that nursing homes in the U.S. add to their staff at least one clinically licensed social worker or psychologist so that there is a built-in resource to address issues like resident depression. A requirement like this would send a clear message to nursing home management and owners telling them that the mental health of nursing home residents is as important as their physical health, and it should not be ignored. Social workers should advocate for this change in the interest of the mental health of nursing home residents.

Changing laws pertaining to nursing home staffing is a policy change that would take a lot of time and effort, but there are smaller changes that can be made more easily. Education for all nursing home employees about depression in older adults is an example. Each employee should be able to identify depression symptoms in older adults so that residents who are displaying the symptoms can be identified as someone who needs to be assessed more thoroughly for depression. The nursing home staff should work as a team toward the prevention and treatment of resident depression. Developing the awareness of what depression in nursing home residents looks like is the first step.

The next step is making sure there is a clear procedure in place for what to do if a nursing home employee observes depression symptoms in a resident. A standard operating procedure should be in place at each nursing home that dictates the process that should be followed if

depression symptoms are observed in a resident. That procedure would dictate who to notify if

symptoms are recognized. It would also include how to determine if a mental health professional

should be called in to work with the resident to address his or her depression. Ideally, within

each nursing home, an important tenant of staff culture would be that the mental health of each

resident is as important as the physical health. Flagging residents for further assessment for

depression in this environment would become second nature, and getting the residents the help

they need to address their depression would follow.

Study Limitations

Systematic literature reviews are limited based on the search terms used to find the

studies that are included. This review not only used particular search parameters, but the

exclusion of articles where "dementia" and "Alzheimer's" appeared in the title or abstract

eliminated many studies from consideration.

A second limitation of this review is that the attrition of participants in each of the studies

was high and understandably so. Hospitalization, illness, and death were the most frequent

causes of participants not completing the post-tests. Chronic illness is often the reason older

adults are moved to nursing homes, so this limitation is inherent to the population of nursing

home residents. That said, it still limits the quality of the research than can be conducted with

this population.

Most of the studies in this review commented on the fact that their sample size was too

small, and that is the third limitation. Three of the studies which had the largest nursing home

resident sample sizes are in the other interventions category, and those studies were previously

described as either weak in design or using interventions that were not psychotherapeutic. If the

pilot study to develop the manual for the BE-ACTIV intervention is removed (n=5), the

remaining samples sizes ranged from 20 to 82. With attrition, the nursing home residents who completed the same studies dropped down to a range from 14 to 57. Larger sample sizes in research studies make the data analysis statistics more credible.

The fourth limitation is that half of the studies in this review sampled the resident population at only one nursing home. The study that screened residents for participation from the most nursing homes (n=23) stated that even those results were region specific because all of the nursing homes were within a certain area. The remaining studies sampled anywhere from two to seven nursing homes. Because nursing home cultures vary from facility to facility, the studies that recruited participants from more than one nursing home have higher generalizability.

Implications for Future Research

Based on this review, it appears that the U.S. needs to catch up in conducting research to address depression in nursing home residents. Only four of the 10 studies were conducted in the U.S., and two of those four studies were authored by the same primary researcher. That said, the dementia exclusion in this study removed many articles from consideration, and it is unknown how many of those studies were conducted in the U.S.

Research to determine whether individual or group therapy is more effective for nursing home residents with depression would be valuable. In this review, five of the interventions were group therapy, three interventions were individual therapy, and one intervention was a combination of both methods (there were only nine total interventions since BE-ACTIV appeared in two studies). Group therapy is the most common method that appeared in this study, but it is unclear whether it is the most effective method to deliver therapy for this population. It is possible group therapy was chosen more often for the convenience of the researchers, and it is worth investigating what is most effective for the nursing home residents.

Further research should also be done to determine whether music therapy is, in fact, an effective intervention for nursing home residents with depression. The study that tested music sessions in this review was not designed well, and it did not hold up in comparison to the other studies. For that reason, the results of the study are questionable. Though there is evidence the music sessions intervention reduced depression symptoms, it is an intervention that should be investigated further using a quantitative experimental or quasi-experimental research design.

It would also be interesting to look into all the benefits of psychotherapy for nursing home residents with depression. The studies included in this review show that most interventions improved depression symptoms, but do other benefits exist? Is there a financial benefit? Goudie (1998) stated that depression in older adults can slow down recovery from illness. When illnesses of nursing home residents worsen, hospitalization is often the result. Are recovery times in the hospital shortened if depression in nursing home residents is already being treated?

Finally, a much broader review of literature on this topic would be beneficial. The biggest exclusion in this review was that of studies whose sample population was nursing home residents with dementia or Alzheimer's disease. That said, this review included four studies that did not measure cognitive impairment of the participants. Any of the participants in those four studies may be cognitively impaired. In one of the four studies, the majority of its participants had dementia. Even though it was a specific exclusion of this review, it was difficult to entirely exclude participants with cognitive impairment. It would be interesting to find out what other modes of therapy are introduced if the dementia exclusion were removed from this study's search criteria.

Conclusion

Because of federal regulations, nursing home social work is not clinical in nature but it is important work that serves one of the most vulnerable populations in society. Though they may not be employed by nursing homes, clinical social workers and other mental health professionals who work with nursing home residents need to know the interventions that work best with the population they serve. This limited systematic literature review showed that reminiscence therapy and CBT are effective for addressing depression in nursing home residents. Educating all nursing home staff on how to recognize depression in residents is a first step toward prevention and treatment of depression in residents. Nursing home residents are worth the attention of social workers, and the residents who are living with depression can be helped.

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Appendix A
Flow Chart of Systematic Review
Article Inclusion
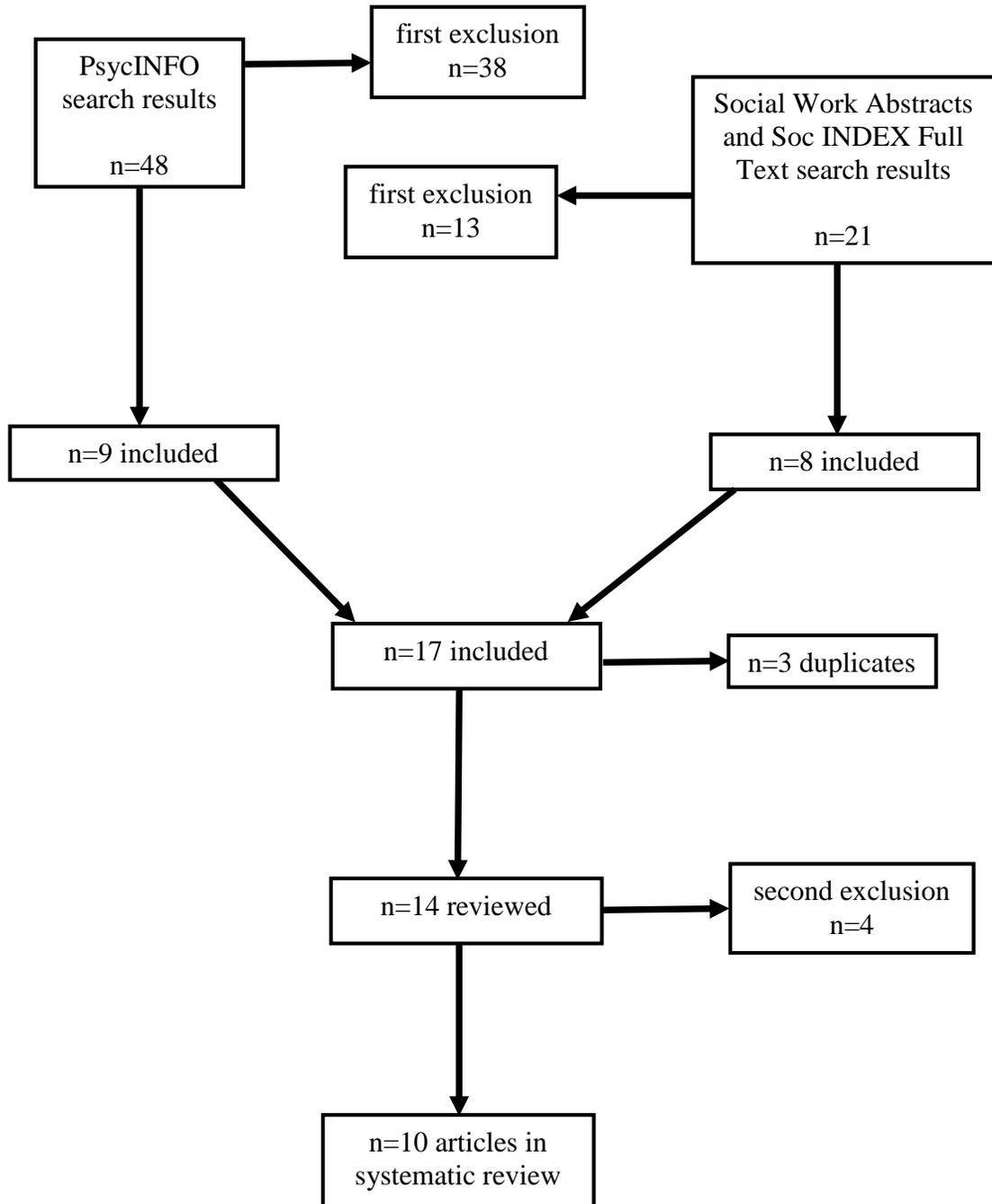
Appendix B
Example of Article Analysis Form