

## Attitudes toward Seeking Treatment for Depression among Community Dwelling Elders in a Western City in the United States

Frances Wilby MSW<sup>1\*</sup> and Amanda Barusch<sup>2</sup>

<sup>1</sup>Assistant Professor, College of Social Work, University of Utah, USA

<sup>2</sup>Professor, Dept. of Social Work & Community Development, University of Otago, New Zealand

### Abstract

**Background:** A fraction of older adults who experience depression seek professional treatment. We know a good deal about the adverse consequences of untreated depression, but considerably less about attitudes toward treatment as they are perceived by the elders themselves.

**Purpose:** This study was conducted to examine attitudes towards professional treatment from the perspectives of older adults living in the community with clinically significant depressive symptoms as measured by the CES-D.

**Method:** Twenty five respondents from a random sample of 91 reported significant levels of depressive symptomatology. Among the 25, only eight indicated that they would seek treatment. The remaining 17 participants were asked to delineate their reasons for not seeking treatment.

**Results:** Their responses suggest that belief in the efficacy of treatment and self-identification of depression are necessary, but not sufficient, to establish willingness to seek treatment. Additionally, results suggest that the foremost barrier to treatment for older adults with depressive symptoms may be their own attitudes; their ideas, values, and feelings.

**Keywords:** Attitudes toward treatment; Depression; Mental illness; Barriers to treatment

### Introduction

Despite its life-threatening consequences, depression among older adults is undertreated in many nations [1-4]. One study of community dwelling elders in a Dutch community found that only 4.9% who experienced significant depressive symptoms received treatment for their condition [5]. Feinson and Popper [6] documented underutilization of outpatient services by older adults in Israel and the United States. A U.S. study reported that only 11% of "high utilizers" of primary care services received adequate treatment for depression, 34% received inadequate treatment and 55% received no treatment [7]. Unutzer et al. [8], reported that only 12% to 25% of older people in the U.S. study with significant depressive symptoms received treatment. And more recently, research has indicated that even though older adults are more frequently diagnosed with depression, they still do not receive adequate treatment [4,9]. This under-treatment has been attributed to both systemic and attitudinal barriers.

Focused on the service delivery system, providers and mental health researchers often attribute underutilization to systemic barriers, such as lack of resources and specific training for physicians to adequately diagnose and treat depression in the elderly [4,5,10-12], lack of adequate reimbursement to physicians for depression treatment [4] shortage of culturally competent mental health professionals [13,14], lack of public knowledge regarding services available [14] and the limited duration of primary care visits [4]. Further, as Harman et al. [15], noted, Medicare's limited coverage for mental health care leaves many older adults unable to pay for treatment. But the pervasiveness of underutilization across diverse cultural and service delivery contexts suggests that systemic barriers may not be the only factor; directing attention to attitudinal barriers [4].

Attitudinal barriers to treatment include provider misconceptions. For instance, physicians may view depression as a normal part of aging. Physicians may share some of the stigmatized views toward depression

in older adults just as the adults themselves do [4]. To further confound the problem, depressive symptoms in adults aged 65 and over do not always meet DSM criteria for major depression, but fall into the category of "sub-syndromal" depression [16,17].

Older adults' attitudes towards depression can also inhibit help seeking [18]. Support for this view is found in a survey of 588 geriatric patients in which depressed older adults who attributed their symptoms to age were significantly less likely to report believing it was important to discuss their depression with their physicians [19]. Older adults may also see depression as a moral failure [4] and a recent study indicated that even those with a history of depression may not rank it among their most important problems [20]. Additionally, religious views have been found to impede access to mental health treatment when older adults believe that prayer and adherence to religious traditions can heal depression [9].

Stigma surrounding mental illness in general and depression in particular is a significant factor in help seeking and treatment compliance [4,18,21]. In a classic study of older adults' utilization of mental health professionals, [22] asked participants in a congregate meal program whether they would seek professional help if they experienced symptoms of depression. The majority (72%) indicated they would not. Results also suggested that general attitudes towards mental illness were associated with responses regarding the likelihood of help seeking.

**\*Corresponding author:** Frances Wilby MSW, Assistant Professor, College of Social Work, University of Utah, USA, Tel: (801) 585-9276; E-mail: frances.wilby@socwk.utah.edu

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This pilot study was conducted to examine the attitudes of community dwelling adults, aged 65 and over with significant depressive symptoms, towards mental health treatment. Its theoretical underpinning comes from the framework of stress and coping articulated by [23]. This model posits a feedback loop involving stressors, appraisals, and coping responses. In this case, depressive symptoms represent a stressor; the older adults' interpretation of those symptoms, an appraisal and help-seeking, one of many possible coping responses. The effectiveness of the coping response in alleviating the stressor feeds back, affecting the stressor itself, the individual's subsequent appraisals, and the likelihood of repeating that response. Attitudes toward seeking treatment can color the appraisal process and eliminate seeking treatment from an individual's repertoire.

## Materials and Methodology

### Design

The study employed a mixed method concurrent data collection strategy [24], combining standardized measures with a semi-structured qualitative interview. Standardized instruments allowed for valid and reliable measurement of depressive symptoms and cognitive impairment. The qualitative interview allowed for a deeper understanding of the experience of depression in this group and why they did or did not seek treatment [25].

### Sample

Participants were recruited from the voter registry of a western metropolitan area in the United States. 100 participants were recruited; among these, nine were eliminated due to cognitive impairment. Within the resulting sample of 91, just over one quarter of participants, 25 (27%) had significant depressive symptoms as measured by the Center for Epidemiological Studies-Depression Scale (CES-D). These 25 participants form the basis for this manuscript. The rate of depression in this study is comparable to other large scale studies done in the region [26].

### Setting

Interviews were conducted either in the participants' homes or in public spaces by second year MSW students who were trained in interview methods. If participants expressed discomfort related to interviewers coming to their homes, a public space, such as the library was suggested and agreed upon. Two participants chose to meet in public spaces. Minimal requirements included an electrical outlet for the tape recorder and comfortable chairs for the interviewer and interviewee. Interviewers made every effort to minimize distractions and interruptions.

### Human subjects procedures

The study was approved by the University of Utah Institutional Review Board. All ethical principles regarding human subjects in research were followed including: a) informed consent, b) assessment of risks and benefits, and c) fair recruitment procedures in the selection of research subjects. Separate consent forms were signed for the screening and in-depth interviews. Respondents were given a "thank you gift" of \$20 for their time.

### Instruments

All interviews began with the collection of general demographic information including age, gender, race, religion, education level, marital status, and income level. Cognitive impairment and depressive

symptoms were then addressed, followed by a guided conversation about depression.

### Cognitive impairment

Cognitive impairment was measured with the MMSE [27]. This instrument required participants to answer eleven questions that tested orientation, recall, attention, calculation, ability to copy a figure, and ability to follow verbal and written commands. Elders who score 24 or less are likely to have some type of organic brain syndrome [27]. Nine participants (9%) of the original 100 who scored at or below 24 on the MMSE were eliminated from further participation in the study.

### Depression

The Center for Epidemiological Studies Depression Scale [28] is a 20 item self report scale that measures depressive symptoms across four domains; depressed affect, positive affect, somatic symptoms and retarded activity and interpersonal relations [28]. Frequency of symptoms in the preceding week is reported on a four point scale consisting of 0 (rarely-less than 1 a day), 1 (some of the time-1 to 2 days), 2 (a moderate amount of time-3 to 4 days), or 3 (most or all of the time-5 to 7 days) [29]. Answers are summed, with potential scores ranging from 0 to 60. A score of 16 or above indicates significant depressive symptoms [28]. The CES-D has been shown to have a test-retest reliability of 81 [30].

### Guided conversation

In-depth semi-structured interviews, which we called "guided conversations," were conducted with the participants with significant depressive symptoms. Questions used in this analysis focused on help-seeking. They included:

1. Do you consider yourself depressed?
2. Have you ever talked with a professional about feeling depressed?
3. Please estimate the likelihood that you will see professional treatment for depression in the next year.
4. Do you think professional treatment can reduce or cure depression?

These questions were developed by the researchers to examine attitudes towards mental health treatment for depression. Interviewers were trained to prompt respondents for in-depth responses.

### Data Analysis

#### Quantitative data

Results of the CES-D were tabulated to determine the number of participants with significant depressive symptoms. Mean, median, mode, and range were also tabulated to examine the distribution of depressive symptoms in the depressed sample.

#### Qualitative data

Interviews were recorded and transcribed, then subjected to iterative thematic analysis by two social workers and one gerontology student. Coding categories were checked by two members of the team, who separately coded a sample of interviews then met to discuss areas of disagreement. This process was repeated until an acceptable level of agreement (80%) was achieved in independent coding of a random sample of interviews. Because of the semi-structured nature of the interview, it was fairly easy to achieve an acceptable level of agreement

between the coders. NVivo 7 software was used for cross referencing and examining associations between records.

## Results

### Quantitative data

25 (27%) of the sample had significant depressive symptoms (scores of 16 or greater) as measured by the CES-D. 20 were female and 5 were male. Scores ranged from 16 to 37 with the mean score of 21. The two most commonly occurring scores were 17 and 37 with 3 participants each.

The personal characteristics of the sample are presented in Table 1. The sample was well educated with 95% having a high school education or better and 32% being college graduates. The general population in the region with a high school education is 86.8 % and a bachelor's degree or higher 28.4 %. Sixty percent (15) had incomes of \$30,000 or less which is reflective of the overall population of those 65 and older in the U.S. and eight percent (2) were at or below poverty level which is slightly lower than the U.S. population over 65 as a whole [31].

### Qualitative data

Results for the qualitative data, including the emergent themes of why people would not seek treatment are given below. Results for each of the 4 questions in the semi structured interview are discussed.

#### 1. Do you consider yourself depressed?

Fourteen (56%) of the 25 participants self-identified as depressed when asked "Do you view yourself as depressed?" Marilyn1 aged 73 responded, "I think when things go wrong I get depressed – a lot of things go wrong nothing seems to go into place you get depressed. I am not worth why bother. Susan aged 77 reported, Yes, I think a great deal of mine is chemical imbalance. I think a lot of it is circumstance too. Despite having scores of 16 or higher on the CES-D, nine respondents did not view themselves as depressed, and two were unsure.

A chi-square analysis was conducted to examine the association between self-identification and willingness to seek treatment. Among those who saw themselves as depressed, six (43%) indicated they would seek treatment. Among those who did not identify themselves as depressed, only two (22%) indicated willingness to seek treatment. This effect was statistically significant ( $p < 0.05$ ) and results are presented in Table 2.

The process of appraisal is an integral part of any coping process, so an older adult who does not consider him or herself depressed is unlikely to seek help for the condition [23]. In this study, most of those with significant depressive symptoms did consider themselves depressed (56%), and within this group a majority indicated that they would not seek treatment. Our analysis suggested that self-identification is associated with willingness to seek care, but this aspect of the appraisal process is not sufficient in itself to move people to seek treatment.

#### 2. Have you ever talked with a professional about feeling depressed?

Nine of the 25 respondents had a history of depression and five (20%) had received mental health services prior to the study. Of the five who had received treatment in the past, 3 (60%) indicated they would not seek treatment again. They felt that treatment did not help them, or that they could not establish a therapeutic alliance with the provider.

#### 3. Would you seek treatment?

Most of the sample (sixteen respondents or 64%) said they would

not seek treatment; eight (32%) indicated that they would; and one (4%) was not sure. None of the participants with significant depressive symptoms were receiving treatment for depression. All but three of these respondents were women, and this group had a mean CES-D

Participants (N=25)			
Participant Characteristics		N	%
Age			
	65-69	4	16
	70-74	10	40
	75-79	4	16
	80-84	5	20
	85-89	2	8
	90+	0	0
Gender			
	Female	20	80
	Male	5	20
Marital Status			
	Widowed	7	28
	Married	10	40
	Separated	0	0
	Never Married	0	0
	Divorced	8	32
	Other	0	0
Race			
	White	23	92
	Hispanic	0	0
	Asian American	1	4
	Black/African American	0	0
	Native American	0	0
	Other	1	4
Education			
	Grade School or Less	0	0
	Jr. High or Middle School	2	8
	High School	8	32
	Business or Trade School	5	20
	Some College	5	20
	Graduate/Professional School	5	20
Religion			
	Catholic	1	4
	Protestant	0	0
	LDS	20	80
	Jewish	0	0
	None	1	4
	Other	3	12
Income Level			
	Below \$10,000	2	8
	\$10,000-\$19,999	7	28
	\$20,000-\$29,999	8	32
	\$30,000-\$39,999	2	8
	\$40,000-\$49,999	2	8
	\$50,000 and above	4	16
Self described health status			
	Excellent	2	8
	Very good	8	32
	Good	6	24
	Fair	7	28
	Poor	2	8

**Table 1:** Personal Characteristics.

Self-Identified as Depressed	Would you seek treatment?			
	Yes	No	Unclear	Total
Yes	6	8	0	14
No	2	6	0	8
Not Sure	0	2	1	3
Total	8	16	1	25

Chi-square 9.189(4),  $p < .05$

**Table 2:** Self-identification of Depression and Willingness to Seek Treatment.

score of 24, with a range from 16 to 37. Among respondents who did not consider themselves depressed, two indicated that if they were depressed they would seek treatment.

Four themes emerged from this question as to why participants would not seek treatment: the determination to “go it alone,” the belief that their symptoms were not bad or important; dissatisfaction with past treatment experiences; and religious beliefs. Although most respondents only mentioned one reason, two cited two and one listed three reasons for not seeking treatment.

“Going it alone” The most common response, cited by eight respondents, was a determination to “go it alone,” and solve their problems without assistance. For instance, when asked why she would not seek treatment, 65 year old Sarah said, “I think it is up to yourself.” Similarly, 81 year old Martha said, “I keep that to myself. I talk to myself.” The stigma associated with mental illness and depression was occasionally reflected in respondents’ concern for privacy. Some did not want others to know about their difficulties with depression. As 75 year old Henrietta said, “People don’t need to know if I have a problem or not.” Similarly, 72-year old Claire responded, “I don’t think it is anyone’s business but my own.”

Taken to an extreme, this preference for “going it alone” led to severe withdrawal. This was the case for June, aged 70, who said that when she was depressed, “No, I no talk to anybody.” Similarly, 67 year old Beth said, “A lot of time I won’t even answer my phone. Bad days cocoon, lock the door don’t answer the phone.”

“It’s not that bad” minimization or denial of symptoms

Five respondents took the position that their symptoms were not severe enough to merit professional intervention. This was expressed in statements such as 81 year old Carl’s, “I am not depressed anyway. I don’t know what other people feel, but I am not that depressed.” Beverly, aged 78 said, “It hasn’t lasted that long. I think most people have days when they feel blue.” Similarly, 81 year old Ethyl, whose CED-D score was 24, said, “I am okay. I get up in the morning and live my life. It is ok.”

Sometimes it was hard to tell whether respondents were denying their symptoms or reframing them. For instance, Arthur, aged 72 was asked what he did when he was feeling down. His response was, “I don’t feel down. To feel down I would be defeated. And I don’t want to be defeated. I can’t be defeated. You have to live with yourself, and if your self is defeated what are you going to do? Commit suicide? Wrong.” John aged 81, suggested that his advanced age militated against seeking treatment: “I think it’s too late in life to worry about it, so I probably wouldn’t, no.” When asked to reflect on the causes of depression, John did not deny that he was depressed, saying, “I think well, mostly I think self-esteem problem, but that is the biggest thing I think. Then I think a lot of comparing yourself to other people never makes you feel too good. So, other than that I guess it could be a lot of things. You can look back and realize you should have had kids even though I have a wonderful step daughter I adopted, but other than that that is probably

what would make me depressed”. But he minimized his long-standing symptoms saying, “I am not that depressed anyway.” Given his gender and his age, John is at relatively high risk for suicide, which makes his comments especially poignant.

## Dissatisfaction with prior treatment

Nine of the 25 respondents had a history of depression and five had received mental health services prior to the study. Three members of this group expressed dissatisfaction with services they had received. John had a long history of treatment for depression and was not satisfied with his current mental health provider. He said, “I just never had any luck with it. I mean, maybe in some cases it does work but for me it didn’t seem to help. Sarah, aged 71 said, “Yes I went to a counselor years ago, after I had gone through a serious depression, but after a few times and having to always wake him up to tell him the time was up, I decided to not go anymore. I thought he gave me a lot of “gobbledygook.” Finally, Sarah concluded that, “He just wasn’t with me.” Generally, these respondents reported having left treatment with a sour taste in their mouths.

## Religious beliefs

Two respondents felt that they should be able to use faith to manage depressive symptoms. For instance, Mary aged 65 said, “You have to reach down deep and you have to be able to communicate with your heavenly father”. Joan, aged 89, said, “If you have any faith you won’t have to go to them kind of people (treatment providers)”. Some religious traditions view life on earth as a test, which must be endured. Taken to an extreme, this could intensify elders’ reluctance to seek help. This finding is consistent with the work of Zivin and Kales [9], who found that religious beliefs could impede access to formal depression treatment.

4. Do you think professional treatment can reduce or cure depression?

Although the majority of the sample (64%) said they would not seek treatment, most of the sample (seventeen respondents or 68%) indicated that they thought treatment was effective, four (16%) felt that it was not, and four (16%) were unsure.

To determine whether belief in the efficacy of treatment contributed to a willingness to seek treatment, we conducted a chi-square analysis, which is summarized in Table 3. None of the respondents, either who felt that treatment did not work or who were unsure about treatment’s efficacy, indicated willingness to seek treatment. Among those who felt treatment was effective, less than half (47%) reported that they might seek treatment ( $p < .05$ ). Several in this group indicated that while professional treatment might generally be helpful, it would not be effective for them.

## Discussion

Attitudes towards seeking treatment for depression have dramatic

Does treatment Work?	Would you seek treatment?			
	Yes	No	Unclear	Total
Yes	8	9	0	17
No	0	4	0	4
Unclear	0	3	1	4
Total	8	16	1	25

Pearson Chi-Square=1.023E1;  $p < .05$

**Table 3:** Views of Treatment Efficacy and Willingness to Seek Treatment.



Research Questions and Themes	Yes N %	No N %	Unsure N %
1. Do you consider yourself depressed	14 (56%)	9 (36%)	2 (8%)
2. Have you ever talked with a professional about being depressed?	5 (20%)	20 (80%)	
3. Would you seek treatment?	8 (32%)	16 (64%)	1(4%)
Themes			
Go it alone	8 (32%)	NA	NA
Symptoms aren't that bad	5 (20%)	NA	NA
Dissatisfaction with prior treatment	3 (12%)	NA	NA
Religious beliefs	2 (8%)	NA	
4. Do you think professional treatment can reduce or cure depression?	17 (68%)	4 (16%)	4 (16%)

**Table 4:** Qualitative Results and Themes.

impact on the quality of life of older community dwelling adults. This study illuminated some specific attitudinal barriers experienced by older adults living in the community who experience significant depressive symptoms. The results of the chi-square analysis suggest that self-identification of depression and beliefs in the efficacy of treatment are necessary, but not sufficient conditions for elders to seek professional help. The following attitudes were identified that contributed to the participants lack of willingness to obtain treatment.

The most common response was that respondents felt they should be able to handle their problems alone, an expectation that may not have been congruent with their personal abilities. Cognitive distortions, or discrepancies between their expectations of themselves and their actual abilities, are more common among those who are depressed than those who were not depressed.

Some respondents in this study alluded to the stigma associated with depression, preferring that others not be aware of their illness. As Corrigan [32], observed, stigma may discourage people with mental illness from seeking care from identified mental health professionals. This applies to older adults as well. For instance, one study noted that elderly patients will not seek services from a mental health provider even when a referral is made [4]. Concern for stigma may be reflected in the privacy concerns reported by respondents in this study. Depressed adults may experience a greater preference for privacy. This suggests the need for innovative methods to reach the depressed community dwelling elder that do not require them to accept the stigmatizing labels of “depressed” or “mentally ill.”

Minimization or denial of symptoms was seen among those who did not self-identify as depressed, even though they had significant depressive symptoms. This has been observed in other studies. Morano and DeForge [33], reported that older adults have a level of denial that results in not discussing their depression with others.

In the present study minimization and denial of symptoms prevented participants from planning to seek help. Although they were experiencing symptoms, they either relabeled them or minimized their importance. While cognitive reframing may control symptoms of mild depression, the failure to secure needed help could leave them at risk.

The belief that treatment is not effective may contribute to the hopelessness associated with depression. Hopelessness, defined in the classic work of Abramson and colleagues, involves, “an expectation that

highly desired outcomes will not occur, or that highly aversive outcomes will occur, and that one cannot change this situation” [34]. This is often observed among those suffering from depression, and has been linked with suicide in older adults [35,36]. We observed it in 71 year old Sarah. When asked, “What do you think makes a person depressed?” She said, “I think it is hopelessness. Hopelessness that it will never get any better; you will always be the same. And which I think sometimes really are in life-they won't get any better and won't change, and so if you can just accept it and go on and see the sunshine in life you know it is great. You can't always see the sunshine. If you try hard enough, at least you see glimpses of it here and there and I think it is well worth it.

Some respondents indicated dissatisfaction with previous treatment experiences, with Sarah, in particular, citing failure to establish a therapeutic alliance. Mechanic [4], suggests that even for those who seek treatment for depression, the treatment is often ineffective due to non-therapeutic doses or other provider errors.

While this may have been due to professional incompetence, it may also result from the negativity associated with depression. Personal negativity, often associated with depression has been linked with dissatisfaction, limited participation, and termination of treatment in chronically depressed patients. This finding clearly illustrates the impact of the feedback loop mentioned above. Having once proven ineffective, help-seeking is unlikely to be included among possible coping responses for those struggling with symptoms of depression.

Two participants in this study reported if they had a strong enough faith and a strong relationship with their God, they could overcome depression. They believed their faith was not strong enough, thus attributing their depression to a religious failure on their part. The view that mental illness represents a spiritual or religious failure is not uncommon [37] and has been linked to unwillingness to seek treatment [4].

**Limitations**

This random sample was drawn from the voter registry, so cannot be considered perfectly representative of community-dwelling older adults. The sample, although random, is also fairly small, so results must be interpreted as indicative of potential areas of research and not as a definitive estimate of population characteristics. In addition, the exclusion of individuals with cognitive impairment precludes any discussion of the role of this factor in help seeking in this population. Further, while the CES-D is an effective screening tool for depressive symptoms, it does not offer a definitive clinical diagnosis. Some respondents described may not meet DSM or related criteria for the disorder. Lastly, the sample was drawn from a western city with a fairly homogenous population; therefore the results may not be representative of community dwelling older adults in other areas.

**Conclusion**

The attitudes toward treatment identified in this study reflect participants’ ideas and feelings about why they were not willing to seek help. In applying the feedback loop of Lazurus and Folkman [23], these attitudes interfere with an adaptive coping response (seeking treatment) to the depressive symptoms (stressor). Ineffective coping responses, such as denying symptoms, do not alleviate the depressive symptoms (stressor).

A unique contribution to the literature offered by the study is that none of the participants referred to systemic barriers to explain their

unwillingness to seek treatment, such as transportation problems, disability, service limitations, or financial issues. Instead, they focused on attitudinal barriers. Attitudinal barriers may prevent the initiation of help-seeking, while systemic barriers may complicate the task once it has begun. The fact that, as we observed in the introduction, under utilization of mental health services is widespread across different cultures and service contexts adds support to the notion that systemic barriers represent only part of the problem. It is also important to note that the underutilization of mental health treatment in older adults is a long standing problem what we have been doing to reach this group is not working therefore some important aspect of the problem is being missed.

This does not necessarily imply that systemic barriers are not important. They undoubtedly prevent many older adults from receiving assistance. But we would suggest that attitudinal barriers must be overcome before older adults will begin to seek help for their symptoms. Thus, these results might inform community-based prevention efforts designed to help older adults who suffer from depression to make the first step towards receiving professional assistance.

## Implications for Practice

There are numerous implications for practice among geriatric nurses, geriatric social workers, mental health counselors, home health and hospice workers, and other disciplines working with older adults in community settings. These findings suggest that older community dwelling adults may benefit from interventions that help them identify their attitudes and how these attitudes affect their mental health and well being, rather than programs that emphasize access issues such as transportation and cost. Programs designed to be implemented in the home or in the community rather than in mental health centers and doctor's offices may benefit those older adults struggling with stigma and privacy issues. Religious leaders can be educated about older adults' beliefs regarding depression as a lack of faith and help their congregations understand the biological determinants of depression.

We have many older adults struggling with depression and experiencing a myriad of consequences including poor quality of life, co-morbid health conditions, and increased mortality risk. Although there has been an increase in the diagnosis of depression in older adults in the past 20 years, older adults continue to terminate prematurely, receive inadequate treatment, and suffer negative consequences from this disease. The challenge comes in health and mental health professionals tailoring their approaches to appeal to older adults. The current systems are not working the number of older adults not seeking and complying with treatment makes this clear.

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