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The Relationship between Depression and Social Ties

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PUBL 9802: Research Paper in Health Studies

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THE RELATIONSHIP BETWEEN DEPRESSION AND SOCIAL TIES

Introduction

Imagine having an illness that stripped away your identity, had the ability to impair or destroy valuable relationships, and left you crippled with sadness and anxiety (Canadian Mental Health Association [CMHA], 2010b; Public Health Agency of Canada [PHAC], 2010b). It would be overwhelming, to say the least. Added to that is the fact that the rates of relapse are high for this illness, and for some sufferers death is inevitable (Beattie, Pachana & Franklin, 2010; CMHA, 2010b; Jhingan as cited by Rajkumar, Thangadurai, Senthilkumar, Gayathri, Prince & Jacob, 2009). Tragically, those who cannot cope with this illness may commit suicide, if they do not die from related physical causes (Alexopoulos, 2005; Beattie et al., 2010; Bephage, 2005; Chew-Graham, 2010; CMHA, 2010b; Gilmour, 2010; Golden, Conroy, Bruce, Denihan, Greene, Kirby, et al., 2009). The name of this illness? Depression.

Depression as a Public Health Concern

Depression is an elusive mental illness. Three million Canadians will experience depression in their lifetime from various causes (CMHA, 2010b). But, there is no single cause for this condition. Researchers indicate that chemical imbalances in the brain, medications, physical conditions, psychosocial and socio-economical factors may be among the potential causes of depression (Alexopoulos, 2005; Beattie et al., 2010; Butcher & McGonigal-Kenney as cited by Costa, 2006; Chew-Graham, 2010; Cicirelli, 2009; Cyr, 2007; Grundy, 2006; PHAC, 2010c; Yohannes & Baldwin, 2008).

Depression is a critical mental illness that has destroyed the lives of many Canadians. It leads to self neglect, poor self esteem and thoughts of self harm (Barg, Huss-Ashmore, Wittink, Murray, Bogner & Gallo, 2006; Bonnewyn, Shah & Demyttenaere, 2009; Buck, 2008; Louch,

2009; Loughlin, 2004; Yohannes & Baldwin, 2008). It is a serious public health concern, not only because of the devastating impact depression has on the individual, but also because of the effects it will have on their loved ones and the community as a whole (Barg et al., 2006; Boyle, 2005; CMHA, 2010a; Hauenstein & Peddada, 2007; PHAC, 2010c; St John, Blandford & Strain, 2006). Public health care professionals need to educate individuals and families worldwide on what depression is and how it affects those involved (World Health Organization [WHO], 2010). Furthermore, public health care professionals need to reduce the stigma associated with depression which may lead to proper assessment and treatment (WHO, 2010).

Prevalence of Depression in the General Canadian Population

In Canada depression is a major public health concern since approximately 67% of the population expressed having suffered from some form of this illness (CMHA, 2010b). Depression will be the second cause of morbidity worldwide by 2020, following cardiovascular disease (Barg et al., 2006; Buck, 2008). Moreover, depression is the third most common disorder for which individuals seek assistance from their General Practitioner (GP), acknowledging that it limits their ability to reach their maximum potential (Barg et al., 2006; Buck, 2008; Chew-Graham, 2010; Fyffe, Brown, Sirey, Hill & Bruce, 2008; Mackereth & Appleton, 2008; Rajkumar et al., 2009). Additionally, many GPs see depression in the community as a result of personal stress, social stress and lifestyle choices (Chew-Graham, 2010; Mackereth & Appleton, 2008; Rajkumar et al., 2009).

Effects of Depression on the General Canadian Population

The cost that depression has on an individual is difficult to place. Morbidity and mortality of depression, family dynamics and economic losses are some of the effects that depression has on the general population. These losses and their subsequent costs will be explored.

Morbidity

Over half of the Canadian population suffers from depression (CMHA, 2010b). Or, to put that in another perspective, depression accounts for approximately 34% of mental illness hospital admissions (Mood Disorder Society of Canada, 2009). Those living with depression often report: feelings of worthlessness and helplessness, disinterest in previously enjoyed activities, a change in appetite, lack of energy and poor concentration (PHAC, 2010c). On a positive note, the majority of Canadians believe that treating depression with professional help will alleviate depressive symptoms (CMHA, 2010b).

In some circumstances, secondary mental illnesses occur as a result of depression. Research indicates that anxiety disorders, personality disorders and substance misuse can occur alongside depression (Costa, 2006; PHAC, 2010b). Other secondary medical conditions which may occur, but are not limited to depression include: autoimmune disorders, chronic pain, infectious diseases, insulin resistance, cancer and cardiovascular disease (Chew-Graham, 2010; Costa, 2006; Dahle & Ploeg, 2009; Gilmour, 2010; Yohannes & Baldwin, 2008).

Mortality

Individuals with mood disorders, such as depression, are at a high risk of suicide (PHAC, 2010b). In 2006, there were 3,512 deaths in Canada as the result of suicide (Statistics Canada, 2010a). Approximately 90% of Canadians who commit suicide have a diagnosable mental illness (Mood Disorder Society of Canada, 2009; Shah & Bhat, 2008). The most common methods of suicide are firearms, hanging, drowning, asphyxia, and overdose which is the most frequent and easily accessible practice (Alexopoulos, 2005; Bonnewyn et al., 2009). Men are more likely to have more violent suicides, such as by firearms, and women are more likely to commit suicide

by less violent methods such as drug overdoses (Alexopoulos, 2005; Bonnewyn et al., 2009; Flood & Buckwalter, 2009).

Relationships

As previously mentioned, depression affects not only the individual suffering from this mental illness, but also the lives of their loved ones. 86% of Canadians polled believe that depression, as well as anxiety, may have a strong impact on their personal relationships with others (CMHA, 2010b). Depression puts strain on families and friends, and in some cases leads to divorce (Bonnewyn et al., 2009; Chew-Graham, 2010; CMHA, 2010b; Dahle & Ploeg, 2009; Proctor, Hasche, Morrow-Howell, Shumway & Snell, 2008). For many individuals, of any age, bereavement, relationship concerns, unemployment, moving and financial stress can cause, or exacerbate, depression (Alexopoulos, 2005; Buck, 2008; Godfrey, 2005; Grundy, 2006; Yohannes & Baldwin, 2008). Caregiver stress and burnout is also another effect of depression on a relationship (Fulmer et al., 2005).

Economic Impact

There are two significant ways in which depression costs the Canadian people, economically speaking. The loss of productivity by businesses and the cost of health care due to depression constitute an exorbitant cost to Canadian taxpayers. If depression were to be dealt with adequately by health care professionals, these costs could be reduced, and the individual suffering from depression could again become a productive member of society (WHO, 2010).

First, gaining or maintaining employment with a mental illness can be daunting (Alexopoulos, 2005; Buck, 2008; CMHA, 2010a; Shields, 2006; Yohannes & Baldwin, 2008). Seventy-eight percent of Canadians feel that mood disorders, particularly depression, can have a strong impact on workplace success (CMHA, 2010b). Individuals may have gaps in work history

and limited employment, lack confidence, fear and be anxious about going to work, as well as experience discrimination and stigma due to their mental illness (CMHA, 2010a). Absenteeism results in loss productivity and overall ineffectiveness of the employee suffering from depression. (PHAC, 2010b). In 1999, the cost of loss of productivity from depression in the workplace was 1.6 billion dollars in Canada (Baba, Galperin & Lituchy, 1999).

Second, health care costs have skyrocketed due to the increase in mental health care issues (PHAC, 2010b). Hospitalizing someone with a mental illness will cost 170,820 dollars per year (Mood Disorder Society of Canada, 2009). The use of pharmaceuticals to treat depression is astronomical (PHAC, 2010b). Canadians spent approximately 1.16 billion dollars on antidepressants in 2007 which averages out to $ 35.00 per capita (Mood Disorder Society of Canada, 2009). Worldwide, antidepressants are the eighth top medication sold (Mood Disorder Society of Canada, 2009). The amount of money spent on treating depression could be better utilized by public health professionals in educating the Canadian people on this mental illness and preventing it before it accumulates to a devastating level.

Prevalence of Depression in Canadian Older Adults

Depression and Aging

Depression can strike an individual at any age. While not all older adults will experience depression, this subset of the population – and especially frail older adults, is at greater risk. However, depression is not considered to be a normal part of the aging process (Barg et al., 2006; Beattie et al., 2010; Bephage, 2005; Bonnewyn et al., 2009; Casado, Quijano, Stanley, Cully, Steinberg et al., 2008; Costa, 2006; Cyr, 2007; Dahle & Ploeg, 2009; Grundy, 2006; Greaves & Farbus, 2006; Louch, 2009; Pitkala, Routasalo, Kautiainen & Tilvis, 2009; Proctor et al., 2008; Shah & Bhat, 2008; Yohannes & Baldwin, 2008).

Advances in medicine and accessible health care have greatly contributed to today's older adults living longer and healthier lives than past generations. For most, successful aging is the norm; however, for those who do experience depression, it has a profound impact on their wellbeing, health, and independence.

The Facts

In Canada, currently 20% of older adults suffer from depression (Government of Canada as cited by Dahle & Ploeg, 2009). Statistics Canada (2010b) reports that only 10.6% of older adults are actually diagnosed with depression. Let us also consider that older adults reside in a variety of settings. Approximately 5% to 10% of community dwelling adults may have a serious episode of depression which may require treatment (Mood Disorder Society of Canada, 2009). For those residing in Long-Term Care (LTC) institutions 80% to 90% of older adults have depression or psychosis (Mood Disorder Society of Canada, 2009). It is also unfortunate to note that adults over the age of 65 years have the highest rate of hospitalizations for mood disorders than any other age group (Mood Disorder Society of Canada, 2009).

The Challenges

Researchers are challenged when trying to assess depression in older adults for a number of reasons. First, researchers believe that statistics under represent the magnitude of this public health issue, that depression is under reported in this population due to stigma, and, that the lack of a clinical diagnosis of depression contributes to the belief that depression is just a part of the aging process; all of which places excess burden on those affected (Barg et al., 2006; Beattie et al., 2010; Bephage, 2005; Bonnewyn et al., 2009; Casado, Quijano, Stanley, Cully, Steinberg et al., 2008; Costa, 2006; Cyr, 2007; Dahle & Ploeg, 2009; Grundy, 2006; Greaves & Farbus, 2006; Louch, 2009; Pitkala, Routasalo, Kautiainen & Tilvis, 2009; Proctor et al., 2008; Shah & Bhat,

2008; Yohannes & Baldwin, 2008). Second, when selecting participants it is difficult to gauge who will accurately represent the population in question (Barg et al., 2006; Dong & Simon, 2008; Fulmer et al., 2005; Pitkala et al., 2009; Riolo, Nguyen, Greden & King 2005). Several researchers questioned whether or not participants understood what they were being asked as cognitive impairment was a concern (Acierno et al.; Dahle & Ploeg, 2009; Dong & Simon; Pitkala et al., 2009). For researchers and practitioners, it is difficult to assess depression in the older population as many things can mimic depression, including: pulmonary conditions, age related changes, medication side effects, reluctance by the older adult to discuss depression, agitation and memory loss which in some cases is mistaken for dementia rather than a significant sign of depression (Beattie et al., 2010; Chew-Graham, 2010; Cyr, 2007; Yohannes & Baldwin, 2008).

Effects of Depression in Older Adults

Depression in older adults is an often underestimated issue. Some health care professionals believe that depression is a natural part of the aging process because this population experiences a number of losses in later life (Beattie et al., 2010; Costa, 2006; Cyr, 2007; Dahle & Ploeg, 2009; Greaves & Farbus, 2006; Pitkala et al., 2009; Yohannes & Baldwin, 2008). The effects of depression on this population can be devastating.

Depression affects this population who feel hopeless over the events occurring in their lives, particularly the death of loved ones which, in turn, reminds them of their own mortality (Boyle, 2005; Pitkala et al., 2009; Rocchiccioli & Sanford, 2009). As a result of depression, the older adult may feel dependent upon others and excluded from life (Grundy, 2006; Rocchiccioli & Sanford, 2009). Many older adults become depressed and then begin to ignore their own physical need which leads to malnutrition and dehydration, resulting in complications or, in

extreme conditions, death (Dahle & Ploeg, 2009; Rocchiccioli & Sanford, 2009).When older adults become depressed their mood and sense of self worth is affected, and among those who have experienced losses the risk is even greater (Rocchiccioli & Sanford, 2009). Emotionally, the older adult often feels anxious, ashamed, hopeless and worthless, consequently self isolating themselves from their loved ones which has the potential to hinder social interaction as well as their ability to care for themselves independently, thereby compromising their health and safety (Beattie et al., 2010; Bonnewyn et al., 2009; Boyle, 2005; Newbern & Krowchuk as cited by Rocchiccioli & Sanford, 2009). Sometimes the loss and fear becomes overwhelming and suicide becomes an option (Alexopoulos, 2005; Beattie et al., 2010; Bonnewyn et al., 2009; Chew-Graham, 2010; Gilmour, 2010; Golden et al., 2009; Shah & Bhat, 2008).

Morbidity

Depression has the ability to influence the older adult both mentally and physically. Mentally, as with individuals in the general population, older adults may develop anxiety disorders, personality disorders and substance misuse habits (Costa, 2006; PHAC, 2010b). Physically, the morbidity related to depression includes, but is not limited to: autoimmune disorders, chronic pain, infectious diseases, insulin resistance, cancer and cardiovascular disease (Chew-Graham, 2010; Costa, 2006; Dahle & Ploeg, 2009; Gilmour, 2010; Yohannes & Baldwin, 2008). These can be particularly devastating in older adulthood as the rates of healing are compromised through age and the ability their body has to heal (Chew-Graham, 2010; Dahle & Ploeg, 2009; Gilmour, 2010; Yohannes & Baldwin, 2008).

Mortality

The mortality of depression is significant in older adults. In 2006 there were 483 suicides reported by those individuals aged 65 years and older, more than any other age group (Statistics

Canada, 2010a). Older men have the highest rate of suicide, at approximately 31 suicides per 100,000 people (Mood Disorder Society of Canada, 2009). Of these suicides 90% are from depression (Shah & Bhat, 2009). This mortality is the result of poorly treated depression (Bonnewyn et al., 2009; Chew-Graham, 2010; Cyr, 2007; Proctor, 2008; Proctor et al., 2008; Rocchiccioli & Sanford, 2009; Shah & Bhat, 2009; Yohannes & Baldwin, 2008).

Factors which increase the risk of suicide include, but are not limited to: secondary mental disorders, divorce, social isolation, functional limitations, change in employment and family discord which will be discussed later in the review of the literature (Alexopoulos, 2005; Bonnewyn et al., 2009; Chew-Graham, 2010; Dahle & Ploeg, 2009; Golden et al., 2009; Nicholson, 2008; Proctor et al., 2008). Most common methods of suicide in older adults are firearms, hanging, drowning, asphyxia and overdose which is the most common and easily accessible method (Alexopoulos, 2005; Bonnewyn et al., 2009). Suicide is the result of untreated depression making this population vulnerable (Alexopoulos, 2005; Bonnewyn et al., 2009; Chew-Graham, 2010; Dahle & Ploeg, 2009; Rocchiccioli & Sanford, 2009; Shah & Bhat, 2009; Statistics Canada, 2010a).

Depression in Older Adults as a Public Health Concern

One of the major reasons why older adults may become depressed in older life is due to changing social roles. For many, social supports change and networking becomes vital in order to maintain basic needs as one ages (Evans, 2009; Grundy, 2006). If these needs are poorly met, the older adult may begin to isolate due to various mental or physical impairments.

In times of distress, most individuals rely upon their social ties which include family members, friends, coworkers, neighbours, and other members of their community for physical, financial and emotional support (Alexopoulos, 2005; Beattie et al., 2010; Golden et al., 2009;

Green, Rebok & Lyketsos, 2008; Harrison, Dombrovski, Morse & Houck, 2010; Perrier, Boucher, Etchegary, Sadava & Molnar, 2010; Steed, Boldy, Grenade & Iredell, 2007). These social ties are important, and their presence has been linked to decreased likelihood of experiencing psychological distress and better health outcomes in older adults (Beattie et al., 2010; Bonnewyn et al., 2009; Golden et al., 2009; Green et al., 2008; Mood Disorder Society of Canada, 2009; Perrier et al., 2010; Voils, Allaire, Olsen, Steffens, Hoyle & Bosworth, 2007). Furthermore, the perception of having social ties is essential, meaning that the feeling of having many social ties available to help in a time of crisis is more important than the actual help provided (Evans, 2009; Golden et al., 2009; Green et al., 2008; Perrier et al., 2010). Unfortunately, for many older adults these social ties can be either limited or nonexistent. Furthermore, many older adults are isolated. In some cases, older adults are isolated due to physical disabilities which hinder their ability to socialize. These issues expand not only throughout community dwelling older adults, but also through those who are institutionalized. It is important to combat depression in older adults because the devastating rates of morbidity and mortality have destroyed lives beyond repair.

Depression in older adults may incrementally become a critical public health issue because baby boomers are aging quickly (Bonnewyn et al., 2009; Costa, 2006; Dahle & Ploeg, 2009; Flood & Buckwalter, 2009; Greaves & Farbus, 2006; Statistics Canada, 2010c). Canadians over the age of 65 currently constitute 1/8 of the population (Dahle & Ploeg, 2009). It is expected that by 2031 there could be as many as 9.4 million baby boomers which amounts to a staggering 25% of the Canadian population (Statistics Canada, 2010c). Furthermore, researchers indicate that people are living longer and, therefore, that the quality of life issues in older adulthood will transpire (Bephage, 2005; Boyle, 2005; Costa, 2006; Evans, 2009; Godfrey, 2005;

Hegerl, Althaus, Schmidtke & Niklewski, 2006; Pitkala et al., 2009; Proctor, 2008; Shah & Bhat, 2008; St John et al., 2006). Older adults who already make up the highest rates of depression will continue to become a major public health issue concern as they age into even older adulthood.

Purpose

The purpose of this paper is to explore the current body of literature on the effect of social ties, or lack thereof, as a cause or as an exacerbation of depression among older adults. The social supports, social networks and social isolation of older adults will be examined. For each type of social ties, its relationship to depression will be discussed to gain a clear perspective of the psychosocial needs of the older adults in order to combat depression in later life.

In the second half of this paper, the role of the public health care professional will be explored in the context of public health practice, policy and research. By examining each of these areas public health care professionals can increase the older adult's social ties in hopes of not only decreasing the prevalence of depression in older adults, but also by educating the key stakeholders in how to avoid depression in this high risk population in the future.

Methodology

The purpose of the review of the current body of literature is to explore the effects of social ties on older adults. In order to do so, the population needs to be defined, key terms selected, and search criteria reviewed.

The Population

The population being examined in the current body of literature are adults aged 65 years or older who reside in a variety of settings such as in the community, LTC settings, and hospitals, in both rural and urban settings. While it is recognized that there are various subsets with different characteristics, strengths, and needs within this group (e.g., 65-74 years, 75-84

years, and 85+ years), 65 years or more is used as it is the commonly used 'definition' of older adult.

Literature Search Methods and Criteria

Search Engines

The search engines utilized for this literature review included: Proquest, OVID, Blackwell Suite, Pubmed, Sage Publications and Ontario Scholars Portal. Search engines included only those with journal articles, not ebooks.

Key Terms

Several key words were utilized when searching for literature on older adults and depression. To describe the population *older adults, elderly adults* and *old age* were utilized. In order to adequately search for the psychosocial factors which cause depression in older adults, *social ties, social networks, social supports* and *social groups* were terms utilized in this search. To describe depression, and other related factors, the key terms used were *depression, isolation, loneliness* and *suicide.*

Search Criteria

There were several factors which were used to set limits on the literature search. First, only articles published after 2004 were utilized in order to ensure that the content being researched was current and, that the practices were current. Second, peer-reviewed, evidence-based journal articles were utilized to guarantee the scientific rigour and quality of the findings. Third, only journal articles that reported on qualitative or quantitative studies, mixed design, or provided a review of the relevant literature were considered therefore excluding summaries, editorials, or a opinion pieces.

Social Ties and Depression among Older Adults

Defining Key Concepts

Prior to discussing the relationship between social ties and depression within the selected vulnerable populations, the key concepts that will be explored in this paper, namely depression and social ties, will be defined. More specifically, social ties are operationalized as social supports, social networks, and social isolation.

Much of the current literature surrounding social ties and the older adult often use social supports and social networks interchangeably. For the purpose of this literature review both concepts will be defined separately, but will be used simultaneously.

Social Support

Social supports are individuals who provide one another with friendship, advice, companionship and dependence with regards to financial, physical or emotional needs. These types of relationships tend to focus on the quality and the content of the interactions (Friedman, Conwell & Delawan, 2007; Godfrey, 2005; Green et al., 2008; Grundy, 2006; Steed et al., 2007; Voils et al., 2007). They tend to be more intimate and sincere, offering more empathetic care. Social supports are developed over a lifetime and can include family, friends, coworkers, neighbours, etc. (Alexopoulos, 2005; Evans, 2009; Godfrey, 2005; Grundy, 2006; Steed et al., 2007; Voils et al., 2007). Lastly, researchers have indicated that these types of relationships have a more significant connection to health outcomes in terms of social connections than do social networks (Grundy, 2006; Voils et al., 2007).

Social Networks

In the context of this literature social networks are defined as the relationships that individuals have with others that may be within the environment of a group of individuals, an

agency or a membership to group facilities (Evans, 2009; Friedman et al., 2007; Grundy, 2006; Hawes, Webster & Sheill as cited by Mackereth & Appleton, 2008; Voils et al., 2007). At times they can be considered superficial with regards to their level of intimacy and moreso for information or entertainment purposes, and may also refer to a webbing of social relationships to the person in question (Evans, 2009; Grundy, 2006; Mackereth & Appleton, 2008; Voils et al., 2007).

Social Isolation

Social isolation exists when individuals do not have social networks or supports (Alexopoulos, 2005; Loughlin, 2004; Nicholson, 2008; Proctor et al., 2008). This occurs because individuals may be isolated due to physical or mental impairment, geography, economic status or language within the perspective of this body of knowledge. Individuals may purposefully isolate themselves, or be victims of isolation (Nicholson, 2008; Rocchiccioli & Sanford, 2009).

Depression

Depression is defined as a mental health diagnosis within the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association [APA], 2000). There are several types of depression including, but not limited to: Major Depressive Disorder, Postpartum Depression and Major Depressive Episode, the latter being explored in this body of knowledge. Major Depressive Episodes, or Episodic Depression, are usually considered to be situational crises caused by a psychosocial issue and alleviated in a short time frame. One is considered to have depression if he has five or more depressive symptoms that persist for more than two weeks (APA, 2000). These include, but are not limited to: depressed mood, anhedonia, change in weight or appetite, change in sleep pattern, decreased concentration, decreased energy,

inappropriate guilt or feelings of worthlessness, psychomotor agitation or retardation or suicidal ideation (APA, 2000).

With regards to psychosocial factors, the Diagnostic and Statistical Manual of Mental Disorders states that these factors may trigger or exacerbate a mental disorder (APA, 2000). This may mean that psychosocial factors may cause depression, and or, necessitate a secondary diagnosis depending on the psychopathology and the individual factors involved with said person (Proctor et al., 2008). Unfortunately, psychosocial depression reviews garner less attention in research and in practice (Cicirelli, 2009; Proctor et al., 2008).

Review of the Literature

In order to provide a clear depiction of the social issues associated with depression in the older adult, social supports and networks will be discussed simultaneously, followed by social isolation. Within each section, the social issues and their link to depression in the older adult population will be explored. To conclude each section there will be a discussion of the benefits of social ties when combating depression.

Social Supports and Social Networks

From birth everyone ages. Over the course of an individual's lifetime he will endure many changes, struggles and emotions. The older adult is no exception. In older adulthood many changes occur, maybe more than in any other age group. These changes occur quickly and often without any notice.

Role changes. Often one of the most difficult life stressors which most older adults incur are roles changes (Barg et al., 2006; Friedman et al., 2007; Grundy, 2006; Loughlin, 2004; Mellor, Firth & Moore, 2008; Pitkala et al., 2009; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). For some older adults seeing their children off to post secondary education can

be daunting and stressful (Barg et al., 2006). In this instance, the change in the parental role is offset by an increase in stress and anxiety worrying about their loved ones (Barg et al., 2006). Similarly, when their children marry and leave their previous family life there is a sudden and noticeable minimizing of the parental role, a role which they had maintained for decades (Barg et al., 2006). Consequently, the older adult may feel a sense of abandonment (Barg et al., 2006; Friedman et al., 2007; Grundy, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). The older adult may feel as though he has fewer family contacts as well, leaving him feeling lonely (Dahle & Ploeg, 2009; Friedman et al., 2007; Rocchiccioli & Sanford, 2009; Steed et al., 2007).

Around the time that their children leave the proverbial nest older adults also enter into retirement and lose an additional role as an employee or as an employer, someone who is considered to be a contributing member to society (Barg et al., 2006; Friedman et al., 2007; Godfrey, 2005; Grundy, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). As a result of these changes and challenges the older adult may feel a sense of loss and a void that needs to be filled (Barg et al., 2006; Friedman et al., 2007; Grundy, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). With these changes there often comes a loss, or lack, of daily interaction with coworkers. These roles changes are not the only issues which occur. A change in relationships also takes place as the older adult ages.

Friendships and relationships. Maintaining ties with other individuals is a component of successful aging (Godfrey, 2005; Loughlin, 2004; Solomon & Peterson as cited by Mellor et al., 2008; Rocchiccioli & Sanford, 2009; Steed et al., 2007). While older adults may experience

altered roles, they may also experience altered relationships with friends. These have the potential to increase their sense of loneliness.

Friends and neighbours move away to be close to their adult children, to downsize, or to enter a LTC facility (Boyle, 2005; Steed et al., 2007). This move may cause a lack of daily interaction for the older adults, leaving them feeling lonely and at times isolated (Alexopoulos, 2005; Boyle, 2005; Godfrey, 2005; Steed et al., 2007). This can be a particular challenge as they are faced with fewer friendships (Dahle & Ploeg, 2009; Friedman et al., 2007; Godfrey, 2005; Rocchiccioli & Sanford, 2009; Steed et al., 2007). The older adult may feel a void as well because there are fewer individuals his own age who can relate to his life situation (Dahle & Ploeg, 2009; Friedman et al., 2007; Rocchiccioli & Sanford, 2009; Steed et al., 2007). Researchers have indicated that friends are essential in old age for companionships, emotional support and morale (Godfrey, 2005). They have the ability to reduce feelings of loneliness better than family members can (Godfrey, 2005). Without these social ties, the older adult is left without confidants and report more psychological distress and higher rates of depression than those older adults with confidants (Prince et al. as cited by Godfrey, 2005). Furthermore, it is shown that friends can act as a buffer and reduce the excess risk for depression in older adulthood (Godfrey, 2005).

This can be stressful because the older adult is not always aware or capable of coping with these changes. Therefore, the older adult has fewer social supports which places him at risk for depression.

Death and dying. These, unfortunately, are not the only stressors which older adults undergo. They are the beginning of a long line of struggles to overcome. Other issues which occur are the unfortunate death of loved ones (Cicirelli, 2009; Ward, Mathias & Hitchings,

2007). Friends, siblings, and spouses become ill and die (Barg et al., 2006; Cicirelli, 2009; Friedman et al., 2007; Godfrey, 2005; Grundy, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). The death of siblings can be particularly difficult for the older adult due to a loss of a lifelong closeness which often intensifies in older adulthood (Cicirelli, 2009).

This loss brings about two issues for the older adult. First, they are faced with bereavement (Alexopoulos, 2005; Bephage, 2005; Buck, 2008; Cicirelli, 2009; Godfrey, 2005; Grundy, 2006; Monk, Germain & Buysse; Perrier et al., 2010; Pitkala et al., 2009; Yohannes & Baldwin, 2008; Ward et al., 2007). When an older adult loses a spouse there are changes in wellbeing and in social participation (Buck, 2008; Li, 1007). Furthermore, when an older adult loses a spouse there can be accompanying fears and anxieties about financial security, safety and freedom, leading to sleep deprivation which is a common symptom of depression (Bephage, 2005; Boyle, 2005; Godfrey, 2005; Monk et al., 2009; Ward et al., 2007). For the older adult, bereavement can be a particular challenge because research indicates that the loss of a sibling has the potential to last for decades (Cicirelli, 2009). Furthermore, there is a sense that the family unit is no longer intact (Cicirelli, 2009; Ward et al., 2007). The concern which researchers have with bereavement in older adults is that it not only may lead to bereavement depression but also the individual may experience worthlessness, psychomotor retardation, apathy and sad mood (Bephage, 2005; Buck, 2008; Godfrey, 2005; Perrier et al., 2010; Ward et al., 2007).

Second, when a death occurs they are reminded of their own immortality (Barg et al., 2006; Bephage, 2005; Boyle, 2005; Cicirelli, 2009; Pitkala et al., 2009; Rocchiccioli & Sanford, 2009). Researchers believe that death fear can often occur with the death of a loved one (Cicirelli, 2009). When an older adult loses someone close there is a fear of death and

vulnerability which looms over him (Cicirelli, 2009; Ward et al., 2007). The older adult feels helpless as well as threatened with his existence (Cicirelli, 2009). Furthermore, the older adult may have difficulties coping as he cannot recover lost loved ones (Cicirelli, 2009). Death fear is an emotional reaction to one's own perceived mortality and one's helplessness in the face of this threat (Cicirelli, 2009; Godfrey, 2005).

During the first year of bereavement approximately 10 to 20 percent of spouses will develop depression which may persist if it is left untreated (Alexopoulos, 2005; Casado et al., 2008; Proctor, 2008). The prevalence of depression continues during the second year of this grieving process (Alexopoulos, 2005; Buck, 2008). While older adults may not experience depression to the same degree as a widowed younger adult, the rates of depression are approximately the same throughout all ages (Alexopoulos, 2005). There are, however, ways to cope with this type of loss should the older adult choose to do so.

Social groups. When life changes occur, be it role changes or a death in the family, older adults reply upon other individuals for support. When older adults endure these age related changes some fill the void by increasing their social supports and social networks through groups (Friedman et al., 2007; Grundy, 2006; Loughlin, 2004). Many require the use of various social networks to assist them with social needs such as companionship or information sharing (Friedman et al., 2007; Loughlin, 2004). Unfortunately, some older adults are not aware of these resources and, therefore, do not utilize them. They do, however, have the potential to assist the older adult to combat the struggles and changes which they are currently facing.

The groups that the older adults are involved with may provide information such as health related interests, sports, hobbies or social gatherings (Paluck, Allerdings, Kealy & Dorgan, 2006). By not having, or not utilizing, these social networks the older adult is at higher

risk for loneliness and social isolation (Friedman et al., 2007; Godfrey, 2005; Golden et al., 2009; Loughlin, 2004; Nicholson, 2008). While these networks may benefit the older adult, they are not always easily accessible. Physical and mental illness, geographical location, and lack of transportation are a major hindrance (Acierno et al., 2010; Friedman et al., 2007; Godfrey, 2005; Loughlin, 2004; Mellor et al., 2008; Nicholson, 2008; Rosenbloom, 2009). If these issues were corrected, researchers suggest that more social groups would be utilized in the community (Acierno et al., 2010; Friedman et al., 2007; Loughlin, 2004; Mellor et al., 2008; Nicholson, 2008; Rosenbloom, 2009). When community groups are not accessible, older adults can, however, rely upon community services to assist them in their daily life.

Community services. Older adults need to maintain their independence and activeness in the community. Currently, the goal for older adults in community health is to keep them in the community to avoid the use of LTC facilities (Loughlin, 2004). There are many community resources which help the older adult to maintain an independent lifestyle and to provide them with one-on-one services (Friedman et al., 2007; Loughlin, 2004). These, however, do not come without challenges.

Activities of daily living, nutrition, ambulation and exercise are among some of the top care needs of the community dwelling older adult (Friedman et al., 2007; Loughlin, 2004). The resources available to older adults in the community include, but are not limited to: meals on wheels, homemakers, home health care nurses and aids, physical therapists and occupational therapists (Friedman et al., 2007; Loughlin, 2004). Other social networks include transportation services which can take older adults to adult day care and support groups in order to assist in enhancing their psychosocial needs to build social networks (Acierno et al., 2010; Boyle, 2005; Dahle & Ploeg, 2009; Loughlin, 2004; Mellor et al., 2008; Rosenbloom, 2009). These aids are of

particular use when older adults are having difficulties thriving in their homes because of growing dependence on others (Boyle, 2005; Rocchiccioli & Sanford, 2009). The older adult feels hopeless and helpless when these needs are not being attended to, and often fear having to go to a LTC facility as a result (Dahle & Ploeg, 2009). These services assist the older adult in maintaining their independence in the community, help to rehabilitate the older adult to return to their baseline functioning, and provide a sense of social interactions for the homebound older adult as well (Acierno et al., 2010; Boyle, 2005; Dahle & Ploeg, 2009; Loughlin, 2004; Mellor et al., 2008; Rosenbloom, 2009).

In some circumstances these services are not offered in their geographical area, or the supply does not meet the demands of the declining older adult's health status (Friedman et al., 2007; Godfrey, 2005; Loughlin, 2004; Mellor et al., 2008). Some older adults become frustrated by the system and refuse to have care provided to them which further limits their social network connections putting them at increased risk for isolation (Nicholson, 2008; Rocchiccioli & Sanford, 2009).

LTC facilities. As older adults change so do their physical and mental statuses. In some cases, older adults who are not able to maintain their independence in the community must reside in LTC facilities (Dahle & Ploeg, 2009; Steed et al., 2007). While these facilities are government regulated and make every effort to meet the health and emotional needs of their clients, they can pose a perceived threat to the social ties of the older adult (Dahle & Ploeg, 2009; Steed et al., 2007). In some circumstances, older adults may be institutionalized due to a lack of adequate social ties (Rocchiccioli & Sanford, 2009).

It is reported that approximately 15 to 25% of older adults living in LTC institutions have symptoms of major depression while another 25% of older adults report having less severe

symptoms of depression (Dahle & Ploeg, 2009). Depression is higher in women than in men by a ratio of 2:1 (Canadian Psychological Association as cited by Dahle & Ploeg, 2009). There are several causes of depression in these LTC facilities as indicated by researchers. When older adults first make the transition into the LTC facility, they believe that they will continue to have the support of their family and their friends that they had when they resided in their home (Dahle & Ploeg, 2009; Godfrey, 2005; Steed et al., 2007). After making this transition it became increasingly clear to some residents in Dahle and Ploeg's 2009 study that these ties would be compromised due to a lack of their ability to visit friends from their previous neighbourhood, and that their families would make fewer and infrequent visits thereby creating a feeling of loneliness and a void from a life once lived.

Many of the older adults in these health care facilities are challenged as they find it increasingly difficult to expand their social network within the restraints of the LTC facility (Dahle & Ploeg, 2009). Older adults indicate that a decrease in their own as well as others' cognitive and physical functioning lessened their ability to socialize (Dahle & Ploeg, 2009; Green et al., 2008; Pitkala et al., 2009; St John et al., 2006). Others fear that they themselves will become ignored, unable to remain independent, and reliant upon others.

Cognitive and functional decline are not the only reasons why older adults are hesitant to expand their social ties in LTC facilities. Fearing that nothing would be kept private by the other residents they were reluctant to get close to anyone else (Dahle & Ploeg, 2009). Research has shown that communicating with others who share similar life experiences can be helpful with problems and stressors. Older adults who are hesitant to make these network connections are at further risk for depression (Dahle & Ploeg, 2009; St John et al., 2006).

Older adults in LTC facilities also sense a lack of autonomy because they feel as though they can no longer care for themselves as well as they had in the past (Boyle, 2005; Dahle & Ploeg, 2009). Some of their new social ties include the health care professionals with whom they have routine, personal contact. However, doubting the genuineness of the relationship, they feel hesitant about sharing private information with these caregivers (Dahle & Ploeg, 2009). Most older adults report keeping their feelings, particularly of depression, to themselves as they find that their family, friends and health care staff, do not necessarily want to discuss it which creates even more of a burden on the older adult (Boyle, 2005; Dahle & Ploeg, 2009; Godfrey, 2005). This can be detrimental to the health of the older adult as this depression and hopelessness in the institutionalized are major risk factors for suicide (Boyle, 2005; Costa, 2006; Mechakra-Tahiri, Zunzunegui, Preville & Dube, 2009).

Lack of Social Supports and Networks Effect on Depression

As previously explored, when the older adults' social supports and networks are compromised it has an effect on their mental health and often leads to or exacerbates depression. The symptoms of depression often felt from the lack of social ties focus moreso on the perception of the older adult's individual self, rather than secondary disorders, as experienced with social isolation.

Common feelings experienced by the older adult are related to depression, including loneliness, hopelessness and helplessness, worthlessness, shame and guilt (Beattie et al., 2010; Bonnewyn et al., 2009; Boyle, 2005; Dahle & Ploeg, 2009; Godfrey, 2005; Golden et al., 2009; Greaves & Farbus, 2006; Pitkala et al., 2009; Proctor et al., 2008; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009; Steed et al., 2007). Furthermore, older adults feel a void as a result of changes in their lifestyle (Barg et al., 2006; Bonnewyn et al., 2009; Boyle, 2005;

Grundy, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rocchiccioli & Sanford, 2009). These feelings which the older adult experiences have the ability to lead to a decline in cognition which, in turn, can lead to disability and an increase in health and social services utilized by the older adult (Alexopoulos, 2005; Costa, 2006; Greaves & Farbus, 2006; Loughlin, 2004; Pitkala et al., 2009; Ryan et al. as cited by Dahle & Ploeg, 2009).

Social Ties as A Way to Combat Depression

A change in social ties can be overwhelming for the older adult. Depression, whether it is caused or exacerbated by this lack of a social outlet has the ability to hinder their mental health. Researchers do not always paint such a devastating picture. In fact, there has been research findings discussing the importance of these social ties as a way to combat depression.

Many older adults, although depressed, socialize and become involved either in their community or with those individuals who help to maintain their independence within the community. For those older adults who can mobilize volunteering becomes an outlet for social interaction and increased personal wellbeing (Godfrey, 2005; Li, 2007; Mechakra-Tahiri et al., 2009). Volunteerism has the ability to reduce stress and assists the older adult to focus on positive emotions as indicated in Li's 2007 study on bereavement. This allowed the widowed not only to gain and access support, but also to contribute meaningful skills and relationships to others in light of their decreased social ties and their own depression (Costa, 2006; Li, 2007). Researchers suggest that individuals try to expand their social networks when they fear that these social ties are becoming compromised, at least in older adults who have insight into their depression (Li, 2007). Furthermore, researchers indicate that having strong family ties, social ties, interests in the community as well as coping mechanisms can be a major defensive coping mechanism in later life (Fulmer et al., 2005; Grundy, 2006; Steed et al., 2007).

There is a strong sense of making a contribution and giving back, as expressed in previous research. This, however, is not the only way for older adults to cope with depression caused by a lack of social ties. Many older adults feel as though attending church can help them to combat their depression. This sense of community creates a positive and uplifting atmosphere and allows the older adult to make a contribution to their place of worship (Dahle & Ploeg, 2009; Fyffe et al., 2008; Mechakra-Tahiri et al., 2009). Feeling as though they are caring for others is a way to cope with their sadness (Dahle & Ploeg, 2009; Mechakra-Tahiri et al., 2009). Researchers state that religious activity is correlated with lower depression scores which may indicate that this is a positive coping mechanism, particularly for older adult women (Dahle & Ploeg, 2009; Fyffe et al., 2008; Mechakra-Tahiri et al., 2009). Social ties in this environment have multiple purposes. Not only do they have a sense of community within the church, but they also can connect with God which makes the older adult feel less alone, particularly in the face of many challenging situations which the older adult may experience in life (Dahle & Ploeg, 2009; Fyffe et al., 2008; Mechakra-Tahiri et al., 2009).

Social Isolation

Isolation comes in many forms. For some, geographical locations restrict their social interaction. For others, personal isolation by their own choice or the choice of others from mistreatment does occur. The most upsetting of all isolations is being trapped in one`s own body and not being able to live the life once enjoyed. These can be detrimental to the health of the older adult and have dire consequences as a result.

Geographical isolation. Another challenge to creating and maintaining social networks for older adults is their geographical location (Barg et al., 2006; Evans, 2009; Friedman et al., 2007; Godfrey, 2005; Loughlin, 2004; Nicholson, 2008). Some researchers believe that where

you age has an effect on how you age based on your environment, particularly in terms of one's social supports and networks (Evans, 2009). The current issue faced by rural communities is a lack of formal social network services which may isolate them in terms of their health and psychosocial needs (Evans, 2009). This may be the result of younger adults leaving small communities for urban centres (Evans, 2009; St John et al., 2006). Consequently, rural support systems may look different than urban support systems based on the composition of the populations (Evans, 2009; St John et al., 2006).

Many older adults have to travel to attend social activities and services (Paluck et al., 2006; St John et al., 2006). Those living in rural areas have a lack of access to resources, including medical and psychosocial (Friedman et al., 2007). Friedman et al. (2007) state that it is difficult for older rural adults to have regular contact with others as there are no, or limited, venues such as coffee shops, restaurants, stores, arenas and recreational clubs for them to socialize. Rural adults face this particular challenge of expanding their social networks when combating depression (Friedman et al., 2007). Conversely, some reports suggest that in light of the fact that they may have to travel a distance for these social ties, the older adults may actually have more frequency in attending social events than their urban neighbours (Evans, 2009; Nicholson, 2008; Paluck et al., 2006; St John et al., 2006). Personal experience has clearly demonstrated that there is a very strong sense of camaraderie among rural residents who pull together in both good and lean times. It is this sense of inter dependence that builds a sense of trust and dependence among other older adults as well in these rural areas (Evans, 2009). However, the rate of depression in rural older adults, particularly among those who live alone, is high compared to the rest of the rural population (St John et al., 2006); this is further evidenced

by higher rates of suicide and emergency room visits in rural settings (Friedman et al., 2007; Mechakra-Tahiri et al., 2009).

Researchers suggest that despite issues which may arise from having fewer social ties rural adults have an easier time integrating into social networks than urban adults (Evans, 2009). Also, rural individuals experience a feeling of neighbourliness, creating friendships which urban inhabitants do not (St John et al., 2006). According to Evans (2009) urban older adults do not have to be as personal when interacting with others and can remain anonymous. Furthermore, urban older adults feel as though they have less personal space and their privacy is limited (Evans, 2009). Findings suggest that in some cases rural older adults have a more positive perception of their social supports than urban older adults do, even in light of the fact that rural older adults often have poorer health and socio-economic statuses (Alexopoulos, 2005; Evans, 2009; Grundy, 2006; St John et al., 2006).

Self Isolation and loneliness. Loneliness is the result of not having the desired quality or amount of social interaction (Godfrey, 2005; Green et al., 2009; Nicholson, 2008; Steed et al., 2007). For the older adult, this is a common experience which is caused by different factors. Researchers indicate that there are three different themes of social loneliness (Barg et al., 2006; Golden et al., 2009).

First, older adults feel that loneliness is a natural part of aging often caused by one's change in roles and surroundings (Golden et al., 2009; Steed et al., 2007). Researchers suggest that older adults find that family, friends and neighbours are the best defence against isolation as they are the most important members of their social groups (Godfrey, 2005; Steed et al., 2007). Isolation in this circumstance occurs as a result of the older adult not adjusting to these changes and not adjusting their social network and, consequently, suffering from social isolation. Older

adults do not wish to believe that these changes have occurred and, therefore, do not make adjustments (Barg et al., 2006; Godfrey, 2005; Golden et al., 2009; Steed et al., 2007). Older adults must make the decision not to be lonely because it is their responsibility to create their own happiness, as voiced by some older adults in Barg et al.'s 2006 study.

Second, some older adults feel that lonely people withdraw and are the cause of their own personal loneliness and social isolation (Barg et al., 2006; Golden et al., 2009). When older adults withdraw they believe that they then become less productive and less likely to socialize (Barg et al., 2006; Golden et al., 2009). Widows are at greatest risk for social isolation due to bereavement (Golden et al., 2009). When an older adult loses a partner or spouse the risk of depression is increased (Mechakra-Tahiri et al., 2009; Steed et al., 2007). Older adults make the choice to cut themselves off from other individuals (Barg et al., 2006; Golden et al., 2009). Some older adults feel hopeless due to their isolation and give up (Golden et al., 2009). Researchers indicate that older adults who feel hopeless are more likely to self harm (Golden et al., 2009).

And third, loneliness leads to depression as a result of minimal to no personal relationships (Barg et al., 2006; Golden et al., 2009). Loneliness is a subjective experience, and often results when an individual lacks a satisfying relationship (Nicholson, 2008; Pitkala et al., 2009). When this feeling of loneliness is not addressed it can lead to a depressive state for the older adult (Barg et al., 2006; Golden et al., 2009). Sometimes this isolation occurs as a result of fear of personal safety and can further exacerbate depression (Mellor et al., 2008). Other times, this isolation occurs due to loss of relationships due to a loss of physical function, chronic illness and bereavement (Wenger et al. as cited by Godfrey, 2005). This depression caused by isolation can become so extreme that the older adult may experience increased physical ailments or even

turn to suicide (Golden et al., 2009). Social isolation has been studied and researchers indicate that it has prognostic significance in terms of depression (Pitkala et al., 2009).

Elder mistreatment. Isolation occurs in many forms. For some older adults, social supports and social networks that are offered are not always accessible. Furthermore, social supports can be challenged when those who they rely upon mistreat them. Older adults can depend on their family and friends for a number of things including physical, emotional, financial and social support (Fulmer et al., 2005; Grundy, 2006). But, when the caregiver fails to provide the older adult with these basic needs or to protect them from harm, mistreatment or abuse occurs (Fulmer et al., 2005). This is often a difficult area for researchers to investigate as caregivers are often included in the assessment and older adults are afraid to report any mistreatment (Fulmer et al., 2005).

Neglect is the most common form of elder mistreatment (Fulmer et al., 2005). For the dependent older adult this neglect could be the caregiver not paying for home care services, or failure to provide appropriate home care (Fulmer et al., 2005). For example, an older adult may have had an accident or surgery requiring home care to help increase his physical mobility. If the required home care is not provided, the older adult cannot return to his previous level of functioning (Fulmer et al., 2005). These services, lost due to elder mistreatment, may include important treatments and information regarding their health which could contribute to their improved physical and emotional well being (Fulmer et al., 2005). This takes away basic needs from the older adult which can lead them to decompensate physically and result in depression because they may not be able to reach their previous level of functioning (Fulmer et al., 2005).

Elder mistreatment can occur socially when a caregiver fails to provide the dependent older adult with social stimulation (Fulmer et al., 2005; Grundy, 2006). This psychological

neglect could include giving the elder the silent treatment, or not providing him with companionship or information (Fulmer et al., 2005; Grundy, 2006). Other more extreme forms of psychological neglect include leaving the older adult alone for long periods of time, or ignoring him (Fulmer et al., 2005). As a result, the older adult's social supports are cut and isolation occurs resulting in loneliness. This is a particular challenge as many older adults rely upon their family and friends for various forms of support (Fulmer et al., 2005; Grundy, 2006; Steed et al., 2007). Many older adults are homebound and the only contact that they have is with family members or community services to assist them in their home. They count on these caregivers to provide them with support. When this support is not present, they often become dependent and vulnerable to depression (Dong & Simon, 2008; Grundy, 2006; Proctor et al., 2008).

While social ties are an important component of healthy aging, not all social ties are healthy for older adults. While this paper focused on more extreme experiences of negative relationships (i.e., abuse and neglect), older adults are just as susceptible to other forms of conflict-laden relationships that may also have a negative impact on their well-being.

The public health issue here is that someone is actively taking away their connection to the community which compromises their mental and physical health. When this issue is made known to authorities there is much time and money spent counselling the older mistreated adult (Fulmer et al., 2005). Researchers have concluded that older adults who have a sound social network are less likely to be at risk for elder mistreatment (Dong & Simon, 2008).

Physical isolation. Poor health also can limit one's contacts (Grundy, 2006; Nicholson, 2008; Rocchiccioli & Sanford, 2009). By being limited due to a physical disability, their personal characteristics and personal autonomy are restricted as is their quality of life (Alexopoulos, 2005; Bephage, 2005; Boyle, 2005; Chew-Graham, 2010; Costa, 2006; Godfrey,

2005; Grundy, 2006; Hegerl et al., 2006; Loughlin, 2004; Mellor et al., 2008; Nicholson, 2008; Pitkala et al., 2009 Proctor, 2008; St John et al., 2006; Rocchiccioli & Sanford, 2009). Distress is inevitable for the older adult.

Among those older adults who live alone some are found to have higher levels of social distress and physical disability which can lead to depression (Godfrey, 2005; Loughlin, 2004). Researchers state, however, that an older adult who has poor mobility but strong social ties to rely upon is less depressed (Butcher & McGonigal-Kenney as cited by Costa, 2006; Grundy, 2006; Mellor et al., 2008; Rocchiccioli & Sanford, 2009). Not all older adults are so lucky. Researchers state that homebound older adults may be vulnerable to poor health outcomes such as depression due to their disability and lack of social interaction (Alexopoulos, 2005; Loughling, 2004; Nicholson, 2008; Rocchiccioli & Sanford, 2009). Unfortunately, many older adults are limited to their physical health and in turn experience what is known as Geriatric Failure to Thrive (GFTT), in extreme circumstances (Rocchiccioli & Sanford, 2009).

GFTT is a profound response to the lack of social interaction for the older adult. Extreme outcomes occur when the losses and challenges become so difficult that they experience a loss of function and feel dependent and excluded from life (Rocchiccioli & Sanford, 2009). When older adults are limited due to physical and social losses, they begin to feel a loss in decision making, cognition and functional status (Costa, 2006; Godfrey, 2005; Rocchiccioli & Sanford, 2009). As a result, their health further declines and they begin to give up on life (Rocchiccioli & Sanford, 2009).

Social Isolation and Depression

Social isolation is associated with adverse effects on the health and well being of older adults (Mackereth & Appleton, 2008; Mellor et al., 2008). The lack of social ties is a component

of isolation. The symptoms of depression, which were previously discussed as a result of a lack of social ties, may persist in the older adult who is isolated. The symptoms of depression which are caused or exacerbated by isolation can, however, be more detrimental to the older adult's health as they have the ability to affect their mental and physical wellbeing.

Mental illness. The perception of social isolation stems from geographical location, elder mistreatment, and an inability to thrive which either leads to or further exacerbates depression or depressive symptoms. While older adults may feel common symptoms of depression from a lack of social ties, they may also experience secondary mental health conditions which cause depression and this perception of being isolated (Alexopoulos, 2005; Bonnewyn et al., 2009; Boyle, 2005; Mellor et al., 2008; Rajkumar et al., 2009; Rocchiccioli & Sanford, 2009). These have the ability to severely disable the older adult.

Anxiety is a common secondary diagnosis which accompanies depression in the older adults. Anxiety has the ability to cause the older adult to lose a sense of control on their mental wellbeing (Barg et al., 2006; Mellor et al., 2008; Rajkumar et al., 2009). They often fear being alone or isolated particularly when living in a rural area, or being mistreated by caregivers. In other cases the older adult may experience neuroticism, extraversion or introversion which occurs or is exacerbated through depression and loneliness (Barg et al., 2006; Roelofs et al. as cited by Beattie et al., 2010; Rajkumar et al., 2009). Researchers believe that older adults report depressive symptoms when they are distressed, such as stressful life events including loneliness and isolation (Proctor et al., 2008; Rajkumar et al., 2009). It is suggested that older adults are vulnerable to depression not only due to a lack of a social ties but also their inability to face these challenges effectively (Grundy, 2006). These issues are of particular concern when the older adult is experiencing social isolation (Grundy, 2006). Individuals with an inadequate social

support system can put older adults at risk for functional decline and disability which may in turn lead to an increased use of health and social services, if not institutionalization (Alexopoulos, 2005; Evans, 2009; Greaves & Farbus, 2006; Loughlin, 2004; Mellor et al., 2008; Pitkala et al., 2009; Rocchicciolo & Sanford, 2009; St John et al., 2006; Yohannes & Baldwin, 2008).

A change in cognition is also of concern to health care professionals. Researchers state that those individuals who are severely depressed lack the ability to care for themselves in part due to isolation (Grundy, 2006). As a result, they neglect their nutrition, hygiene, and their functional abilities, particularly as previously discussed in failure to thrive (Rocchicciolo & Sanford, 2009). Due to this inability to care for themselves, their cognition declines, putting them at risk for dementia (Alexopoulos, 2005; Costa, 2006; Pitkala et al., 2009; Proctor, 2008; St John et al., 2006). There is also an increased risk of developing dementia if an older adult lives alone (Grundy, 2006). Some older adults can develop dementia when depressed (Alexopoulos, 2005). Some of those older adults with reversible dementia suffer from a cognitive impairment (Alexopoulos, 2005; Pitkala et al., 2009; Proctor, 2008; St John et al., 2006).

Physical illness. In some extreme cases the older adult may exhibit depression through physical decline whether it is due to a secondary physical illness, exacerbation of a present physical illness or, in the worst case, death. Researchers conclude that living alone is associated with physical health disadvantages (Alexopoulos, 2005; Green et al., 2008; Greaves & Farbus, 2006; Grundy, 2006; Mechakra-Tahiri et al., 2009; Mellor et al., 2008). Those living alone have a higher chance of functional decline (Green et al., 2008; Greaves & Farbus, 2006).

Researchers indicate that those individuals, particularly older adults who have depression, are at increased risk for cardiovascular diseases which are linked to stress related depression (Barg et al., 2006; Beattie et al., 2010; Chew-Graham, 2010; Cyr, 2007; Gilmour, 2010; Grundy,

2006; Mellor et al., 2008). An elevated blood pressure caused by stress has been associated with depression in older adults. This stress has been caused by changes in the older adult's roles and interaction with others (Mellor et al., 2008).

Researchers have stated that physical changes in the older adult can be caused either by depression due to isolation, or by physical age related changes which can lead to depression, making it difficult to differentiate between the two in older adults. Some studies have found that depression caused by loneliness has lead to neuroendocrine and inflammatory marker responses (Alexopoulos, 2005; Barg et al., 2006; Cyr, 2007; Suttajit, Punpuing, Jirapramukpitak, Tangchonlatip, Darawuttimaprakorn, et al., 2010). This can be detrimental to the health of the older adult as it can prolong wound care healing and exacerbate infections (Cyr, 2007). Older adults suffering from depression also experience high levels of medical comorbidity (Alexopoulos, 2005; Grundy, 2006). Researchers have stated that physical age related changes, such as arteriosclerosis, endocrine and immune changes can cause changes in the brain, such as the hippocampus and amygdala which can lead to depression and be further compounded with psychosocial changes (Alexopoulos, 2005). Finally, depression can be caused by hypercortisolaemia, increased abdominal fat, decreased bone density, type two diabetes and hypertension (Alexopoulos, 2005; Costa, 2006). Any physical disability which the older adult may be living with can cause or further exacerbate depression and lead to prolonged suffering (Alexopoulos, 2005; Beattie et al., 2010; Godfrey, 2005).

The older adult who forgoes self care due to depression negatively impacts his body system. Malnourishment and dehydration are two possible consequences of this self neglect (Rocchiccioli & Sanford, 2009). This causes organ systems to shut down leading to further

physical disability, illness or even death (Rocchiccioli & Sanford, 2009). If their own physical decline does not put them at risk for death, their choice to end their life has the potential to do so.

Suicide. Suicide is the most drastic and devastating response to depression and it is twice as frequent in older adults as in the general population, moreso in men (Alexopoulos, 2005; Golden et al., 2009; Voils et al., 2007). It encompasses the effects of both the lack of social ties and of isolation (Alexopoulos, 2005; Barg et al., 2006; Bonnewyn et al., 2009; Boyle, 2005; Chew-Graham, 2010; Government of Canada as cited by Dahle & Ploeg, 2009; Golden et al., 2009; Greaves & Farbus, 2006; Voils et al., 2007). Those older adults who attempt suicide related to a disruption in social ties, usually experience a comorbid mental health illness such as anxiety and obsessive personality disorders (Alexopoulos, 2005; Bonnewyn et al., 2009; Costa, 2006; Golden et al., 2009). Other older adults, unfortunately, may attempt or commit suicide because they feel as though there is no perceived reason to live, and do not feel as though they have support to care for themselves (Alexopoulos, 2005; Bonnewyn et al., 2009; Boyle, 2005; Godfrey, 2005; Golden et al., 2009). There has been corroborating evidence that suicidal ideation is high in older adults who perceive that they have little or no social supports (Bonnewyn et al., 2009; Dong & Simon, 2008; Godfrey, 2005; Golden et al., 2009). The public health care professional needs to keep in mind that those older adults with a history of suicide attempt and symptoms or a diagnosis of depression are at high risk for suicide in their older adult life (Alexopoulos, 2005, Bonnewyn et al., 2009; Golden et al., 2009). In some cases, older adults commit suicide due to the pain and suffering of chronic illness, but even then they do experience some level of isolation because of this. When an older adult attempts suicide he is more likely to die than an individual in any other age group (Alexopoulos, 2005; Golden et al., 2009).

Social Ties as A Way to Combat Depression Caused By Social Isolation

Activities which reduce isolation improve one's overall health (Mackereth & Appleton, 2008; Voils et al., 2007). Researchers suggest that if the older adult has an increase in social contacts, creativity and mentoring, then there is an increased chance of positive effects and mental wellbeing (Greaves & Farbus, 2006). This may be a challenge for those who are isolated, but with community support it is possible to occur.

In order to combat isolation, older adults need to be creative. For those older adults who may be isolated due to physical illness or due to geographical location, there are new and inventive tools to expand their social surroundings. Older adult use of the internet has been a popular new area of study. Researchers suggest the use of the internet as a way to combat depression as caused by social isolation (Alexopoulos, 2005; Mellor et al., 2008; Nicholson, 2008). This is a wonderful tool as it has the ability to increase social ties through websites, email, chat rooms, etc. and can reach those older adults who are isolated by geography, living alone or by physical disability (Alexopoulos, 2005; Godfrey, 2005; Greaves & Farbus, 2006; Mellor et al., 2008). Respondents in the Mellor et al. (2008) study reported that the internet allowed them to feel closer to their families through email thereby making them feel connected to their relatives. Also, they were able to interact with other people and exchange information on a range of topics, particularly those regarding health and hobbies (Mellor et al., 2008).

The use of the internet is a great tool for information exchange, but so are social groups. Researchers state that the response to depression in older adults caused by isolation is the worst in this population (Alexopoulos, 2005; Pitkala et al., 2009; St John et al., 2006). Creative tools are necessary to help older adults to combat depression. Many groups, particularly those in rural areas, focus on healthy lifestyle and prevention, as well as stress relief all of which have shown

to be effective in rural areas (Alexopoulos, 2005; Pitkala et al., 2009). These groups focus on a specific task, but also encourage unification of the members as well. The actual content of the group is not the point of these social groups, but rather the social cohesion and peer support that comes with it that helps depressed older adults to decrease their own isolation and improve their own social ties (Pitkala et al., 2009). There is a sense of empowerment and mastery involved with these social ties (Godfrey, 2005; Pitkala et al., 2009). Some researchers state that groups help to reduce mortality rates of older adults who are suffering from loneliness which in turn leads to a decrease in the cost of health services (Casado et al., 2008; Pitkala et al., 2009).

For those older adults who have social resources but suffer from depression caused by elder mistreatment there are several tactics which they may utilize. Community services, housing and funding programs can assist older adults to maintain their independence without the added burden of an abusive caregiver (Acierno et al., 2010; Rosenbloom, 2009). These services can also be effective for the older adult suffering from physical disabilities which limit their social ties. These resources cannot be utilized, however, if the appropriate use of public health practice, policy and research are not operated effectively.

Recommendations for Public Health Practice, Policy and Research

Social Support Networks: The Key Determinant of Health

Social ties are a fundamental factor within the realm of public health. Through health care research, the PHAC (2010c) has determined that there are several factors which drive the health status of Canadians; the most important of the 12 Determinants of Health is social ties. In addition, social environments also play a key role, particularly in the health status of older adults. It is essential to understand how this main determinant of health can improve the lives of older adults through public health workers.

Researchers have indicated that social ties are a determinant of successful aging (Evans, 2009; Golden et al., 2009; Green et al., 2008; Mellor et al., 2008). Assessing the type and quality of social ties and assisting to increase these ties of the older adult is an important role of the public health care professional. This determinant of health, particularly, helps public health care professionals to take a population health approach to the care of the older adult. This means that the root of depression in older adults has been found due to a lack of social ties and isolation. With this determinant of health known, professionals can now not only address the issue but also try to prevent this lack of a coping mechanism in the future. Health care professionals can improve the health status of the older adult by examining what makes them vulnerable to the lack of social ties and find ways to intervene. Through multidisciplinary resources within the community, such as family medicine practices, senior support groups, public health units, local health associations, and the media, different approaches may be evident to try and educate older adults about depression as well as to help provide appropriate treatment to the older adult should they already be depressed.

Public health professionals can help to improve the lives of older adults by increasing their social ties. This can be done in a variety of ways. First, it is important to set guidelines for practice for public health care professionals to follow when caring for older adults either in a societal or individual basis. Second, new policies can be created or improved in order to meet the needs of the older adult. Finally, research can assist in further identifying the needs of the older adult in terms of social ties and isolation which are often difficult to assess and determine based on the quality of the research study.

Individual needs and preferences for social interaction differ greatly – some may want to be surrounded by loved ones, while others are content to be on their own. That said, social ties

are known to be important resources for maintaining wellbeing and health. As it is the goal of public health care professionals to improve the overall health of the population, methods to enhance or promote social ties need to be among the tools in their toolkit. However, while health care professionals can encourage and make their clients aware of related resources, they cannot force their clients to make use of them. For this reason, it is important professionals tailor their suggestions to the individual needs of their clients, or their efforts may be wasted (e.g., if what is suggested seems inappropriate to the individual).

Public Health Practice

There have been goals and guidelines drafted in order to meet the needs of those living with mental illness. It is the role and the responsibility of the public health care professionals to follow through with these guidelines, making resources available, in order to reduce the risk of depression in older adults with poor social ties, in this instance. These guidelines which exist currently focus on mental illness in the general population, but can be applied to the more specific population of older adults as well.

What We Have

Currently, public health practice efforts related to social ties and depression among the older adults are focused on awareness, positive environments and collaborations.

Awareness. Depression in the elderly is poorly treated due to stigma and the lack of an appropriate diagnosis of depression (Beattie et al., 2010; Bephage, 2005; Bonnewyn et al., 2009; Casado et al., 2008; Chew-Graham, 2010; Costa, 2006; Cyr, 2007; Dahle & Ploeg, 2009; Grundy, 2006; Greaves & Farbus, 2006; Louch, 2009; Pitkala et al., 2009; Suttajit et al., 2010; Yohannes & Baldwin, 2008). One of the main goals in public health practice is to reduce the stigma associated with mental illnesses in Canada (PHAC, 2010a). This is a major barrier

because there is a lack of knowledgeable, experienced frontline health care providers, information, resources, understanding and interest about the depression in older adults (Bephage, 2005; Costa, 2006; United States Department of Health and Human Services [USDHHS], 2005). Many see older adults as disposable and often in western society older adults are not necessarily valued. Furthermore, some older adults suffer a poor quality of life, poor family relations as well as a lack of connection to their community and trust in health care providers (Bephage, 2005; Boyle, 2005; Costa, 2006; Godfrey, 2005; Hegerl et al., 2006; Pitkala et al., 2009; Proctor, 2008; Suttajit et al., 2010; USDHHS, 2005).

The Canadian Alliance for Mental Illness and Mental Health (CAMIMH) has set the standard for mental health in Canada (PHAC, 2010a). They outline a number of goals designed to improve the practice of health care professionals, mainly in public health. These goals include, but are not limited to: setting standards of practice for professionals, utilizing a framework which focuses on health promotion, service delivery and enhancing research and public education. Some of these have already been utilized while others remain to be implemented in public health care practice.

It is tremendously important for the public to know that depression in some older adults is a major community health concern. Through public education, public health care professionals have been using social marketing tools to make the community aware of this devastating illness. The most important campaign to date is elder mistreatment which has been made known through various social marketing skills, and has been identified as a major barrier to psychosocial wellbeing in the older adults. This has been accomplished through television commercials and billboards on elder mistreatment and symptoms of depression (USDHHS, 2005). Posters, pamphlets and websites also discussed depression in older adults, and can be found in a variety

of locally utilized areas such as in doctors' offices, hospitals and seniors' centres (USDHHS, 2005). These resources help to indicate to older adults, to their families as well as to front line health care providers that depression in older adults is an important matter (USDHHS, 2005). By being knowledgeable that this exists, individuals can be aware of those around them who may be suffering. This may also encourage older adults to increase their social ties through various activities within their community (Golden et al., 2009; Green et al., 2008; Loughlin, 2004; USDHHS, 2005).

Positive environments. The key to improving social cohesion is to improve self esteem and self confidence in those individuals who are being targeted (Godfrey, 2005; Mackereth & Appleton, 2008; Suttajit et al., 2010). When older adults feel confident enough to go out and meet others they counteract the negative effects of social isolation (Alexopoulos, 2005; Blazer as cited by Barg et al., 2006; Mackereth & Appleton, 2008; Nicholson 2008). Public health practice has been focusing on creating positive environments for older adults. Many communities have centres for seniors, which are great meeting places that offer a variety of health promotion and primary prevention opportunities. Older adults may benefit from group based therapy rather than individual based interventions when it comes to learning about and utilizing social skills (Alexopoulos, 2005; Pitkala et al., 2009). Activities include, but are not limited to: mentoring, and creative activities such as crafts or cooking which are more likely to positively affect one's health and wellbeing (Alexopoulos, 2005; Greaves & Farbus, 2006). These can be utilized by public health care professionals in order to combat depression which is caused by a lack of social ties or isolation.

Collaboration. While the goal in public health is to stop depression in the older adults before it starts, it is unrealistic to think that this goal can be achieved solely through public

health. Public health care professionals can work in collaboration with those in primary health care facilities where older adults frequent in order to assess and treat depression (Alexopoulos, 2005; Bephage, 2005). Currently, the major barrier to receiving help in current health practices is the reluctance to discuss emotional issues, medical comorbidities, or life threatening illness which takes precedence (Alexopoulos, 2005; Bephage, 2005; Costa, 2006). Stigma may also be a barrier here as older adults are often reluctant to be treated for psychiatric disabilities (Alexopoulos, 2005; Casado et al., 2008; Costa, 2006). In some cases the onus is on the older adult who may resist reporting mental health concerns and rather focus on physical concerns instead as these are deemed to be more accepted in primary health care settings (Godfrey, 2005). Therefore, it is important to correct poor screening practices for depression among older adults, an area which will be discussed in the next section.

Where We Need To Go

In order for the practice of health care professionals to improve, there are several important areas which need to be addressed including awareness, stigma, assessment, and tracking.

Awareness. Health care professionals have a duty and an obligation to provide the best possible care to the clients whom they serve. Whether this professional works in a public or primary health care setting, this is still a standard to be upheld. The first ***step*** in bettering the care which is being provided is to examine one's own personal knowledge and understanding of the population being serving. Aging is daunting for most individuals and being reminded of one's own mortality can be terrifying (Godfrey, 2005). One's personal perspective has the ability to blur or bias the care that is provided to the older adult (Bephage, 2005). It is therefore important for the health care provider to understand how social ties, in this instance, can lead to depression.

This may make them aware of current struggles of their own loved ones or the clients with whom they work (Bephage, 2005). Through this personal education the provider will become more empathetic and be able to relate through their current struggles or their fears of the future. Being aware is the first step to professional development (Bephage, 2005).

Many individuals utilize continuing education which is particularly necessary in order to meet the needs of the aging population (Bephage, 2005). Eliminating stigma, understanding what depression means and looks like in the older adult population is key, as is understanding the various needs of this population (Bephage, 2005; Casado et al., 2008; Costa, 2006). As a result, research is needed to inform practices in these areas to ensure that it reflects the most current needs and understanding of appropriate interventions for this delicate population (Bephage, 2005).

Eliminating stigma. There are three types of stigma which persist. Public stigma is experienced by health care providers, employers and members of the community who have unfortunately developed untrue stereotypes about those who live with mental illness (Alexopoulos, 2005; Costa, 2006; USDHHS, 2005). Self stigma occurs when the individual applies negative stereotypes about mental illness to themselves (Alexopoulos, 2005; Casado et al., 2008; Costa, 2006; Louch, 2009; USDHHS, 2005). Institutional stigma exists when there are assumptions made about mental illness which are not necessarily correct and yet policies and funding are provided based upon this incorrect assumption (USDHHS, 2005). It is crucial to nip these perceptions in the proverbial bud.

Educating older adults with regards to stigma is of major importance. Many older adults who are isolated and not aware of what depression is do not want to associate themselves with a mental illness (Alexopoulos, 2005; Casado et al., 2008; USDHHS, 2005). The older adult must

learn about healthy aging and be proactive in this process. The first action in reducing stigma is being aware of one's own mental health status.

While depression in older adults is not well recognized due to a variety of factors, it is essential to discuss what depression is in older adults and what it looks like in order to reduce stigma. This is key if the general populace is to be educated about this mental illness. The first task in reducing stigma is to encourage those members in the community to contact older adults be they family, friends, or various community groups (Alexopoulos, 2005; Louch, 2009; Steed et al., 2007; Suttajit et al., 2010; USDHHS, 2005). This may help to bond or to unify members of the community in order to combat depression caused by a lack of social ties. Second, older adults benefit from giving and receiving peer counselling, support and mentoring (Alexopoulos, 2005; Greaves & Farbus, 2006; USDHHS, 2005). This provides them with self esteem and, in some cases, makes them feel as though they are giving back to the community (Bargs et al., 2006; Godfrey, 2005; Loughlin, 2004). Third, public health care professionals can work on social marketing to focus on older adults and their needs as they age (Barg et al., 2006; USDHHS, 2005). Fourth, health care professionals need to be aware of this issue and to provide appropriate assessment and intervention which is often difficult with the added stigma to this debilitating illness (Louch, 2009; USDHHS, 2005).

Assessment. In assessing and managing depression in the older adults there are three areas of appropriate assessment: psychiatric, psychological and social factors (Bephage, 2005). These three areas have proven to be important for the older adult as depression caused by social ties can affect each of these areas in their life. The physical health status of the older adult should also be assessed as many physical ailments can mimic, or lead to, depression (Bephage, 2005).

The tools which health care professionals utilize are also important. Current methods for assessing depression are made for younger people and have lead to a misdiagnosis when utilized on the wrong individual (Pachana as cited by Beattie et al., 2010). Depression needs to be assessed and addressed within social contexts and when visiting the GP (Proctor et al., 2008). The Geriatric Depression Scale is often considered the gold standard for assessing depression in older adults (Costa, 2006; Floor & Buckwalter, 2009; Louch, 2009). With any assessment or measure, however, the health care professionals who utilize it must do so appropriately, as results can be over- or under- exaggerated depending on how it is administered (Costa, 2006; Flood & Buckwalter, 2009; Louch, 2009).

Other ways to improve public health care practice would be to incorporate different service delivery models for those working within the community and the hospital setting. These include, but are not limited to: computer clinical decision supports which are utilized by telehealth services, adequate training of health care professionals, and management of depression with medical illnesses (Alexopoulos, 2005; Beattie et al., 2010; Casado et al., 2008).

Another effective tool, which may be utilized by public health care professionals is the Socio-cultural model of successful aging (Godfrey, 2005). This model focuses on the social wellbeing of the older adult, particularly with regards to depression, and focuses on transitions, life events and losses, as previously discussed in the literature review (Godfrey, 2005). When utilizing these tools it is also important to consider the social ties of the older adult. Collateral information could be provided by family, friends, and carers of the older adult (Bephage, 2005).

When the tools have been completed, and appropriate assessments been made, then the appropriate treatment can take place for the older adult. There are five appropriate approaches which health care professionals can take in order to improve their practice and the care of the

older adult population. It is important to note that a psychosocial approach is essential when dealing with depression in older adults, as in this case, depression is caused by a lack of social ties (Bephage, 2005). First, psychotherapy has shown to be effective because the older adult is encouraged to express his thoughts and emotions as caused by his change in social ties and isolation (Bephage, 2005). This can be of particular importance when the older adult discusses his feelings of loneliness and hopelessness (Godfrey, 2005). Psychodynamic therapy can also be of assistance as when the older adult explores the psychological reasons for his depression, particularly that caused by his many forms of isolation (Bephage, 2005). Cognitive behavioural therapy has also proven to be successful. Here, the older adult discovers his thought patterns which trigger depressed mood and develop positive thinking techniques as a way to combat these (Bephage, 2005). This is effective when the older adult feels alone and feels that he is unable to cope due to a strain in his social ties (Bephage, 2005).

The future of health care practice for depression in older adults is unclear. There are standards of practice which exist in order to assist health care professionals in meeting their goals. It is, however, incumbent upon the public health agency or the health care professional to meet these standards.

Tracking. As with any illness or disease, depression should be tracked and monitored within the community. This is not a current public health practice with depression in older adults, but it is a current health care goal. While depression is not contagious it is an illness which needs to be monitored and treated effectively. The Centre for Chronic Disease Prevention and Control of Health Canada is one partner working with the PHAC, who has been recognized as a potential partner under the CAMIMH's goals (PHAC, 2010a). These individuals could be of use as they

could create a national public health surveillance and reporting system, as outlined by the CAMIMH (PHAC, 2010a).

Public Health Policy

There are various existing standards and goals for mental illness in Canada to ensure that mental illnesses are a part of the national health and social policies in Canada (PHAC, 2010a). They wish to be the voice for everyone who is affected by mental illness (PHAC, 2010a). There are many bodies which outline policies for the appropriate treatment of those living with depression, particularly older adults, which is the focus of this paper.

What We Have

In order to meet the needs of the older adult suffering from depression, it is important to assess which standards are already a part of the Canadian standard in combating mental illnesses. Some of these standards are applied generally to everyone suffering from mental illness, but can be applied to older adults specifically.

Individual and family level. In order to first recognize that a problem exists the older adult must admit that an issue is present and be willing to change. Self help is a first necessary goal for the older adult to follow (PHAC, 2010a). Helping oneself towards recovery with mental health resources is a significant interpersonal skill (PHAC, 2010a).

Everyone needs support. In order to meet the needs of those affected by mental illness, it is necessary that the individual and his family be included in preparing the national policy on mental illness services, supports, and health promotion (PHAC, 2010a).

Community level. It is crucial to develop partnerships within the community to reach mental health promotion goals (PHAC, 2010a). Partnerships should focus on collaborative and cooperative opportunities to improve those health care systems which focus on mental illness

(PHAC, 2010a). Some of these mental health opportunities may include creating new models of health care service such as piloting, testing and disseminating information about new models of mental illness care and beneficial health practices (PHAC, 2010a).

Federal level. Creating strategies to deal with depression is a current task for the government of Canada. The Mental Health Commission of Canada (MHCC), as developed and supported by the Government of Canada, has assisted in creating a strategy which deals with reducing stigma related to mental illness (Health Canada, 2009). If the stigma is reduced, particularly for those older adults living with depression, many more cases of depression are likely to be reported in this population and therefore treated effectively (Beattie et al., 2010; Bephage, 2005; Bonnewyn et al., 2009; Cyr, 2007; Dahle & Ploeg, 2009; Grundy, 2006; Greaves & Farbus, 2006; Louch, 2009; Pitkala et al., 2009; Suttajit et al., 2010; WHO, 2010; Yohannes & Baldwin, 2008). The MHCC supports mental health research, but also ensures that primary health care, home care, and acute care sectors deliver adequate mental health services to those who need it (Bephage, 2005; Health Canada, 2009). This national standard is of particular interest to older adults as public health care professionals can work towards ensuring that appropriate standards of practice are upheld in the community and the various levels of the health care system. Furthermore, they monitor mental illness trends in the population and raise awareness of mental illness through social marketing (Health Canada, 2009).

There are many resources for depression, which are created and supported by the federal government: The Mental Health Promotion Unit, Health Canada, The Canadian Mental Health Association, Canadian Psychiatric Association, The National Network for Mental Health, The Canadian Psychological Association and The Mood Disorders Society of Canada (Health Canada, 2009). Many of these resources share the same goals and work in unison to promote the

health of Canadians based on their particular needs, and do make particular note of depression among older adults.

Where We Need To Go

These guidelines need to focus public health measures on improved social ties of older adults in order to combat depression in later life. By doing so the risk of depression among older adults is decreased. So what's the next step in public health care policy?

Policies which increase social ties and decrease social isolation for older adults are needed. These should be created in young adulthood and carried throughout older adulthood in order to avoid depression. This, however, is not always possible. As a result researchers have suggested that policies which encourage the use of social ties are necessary for the older adult to create a reserve of social resources and to improve their quality of life (Bephage, 2005; Boyle, 2005; Costa, 2006; Godfrey, 2005; Golden et al., 2009; Green et al. 2008; Grundy 2006; Hegerl et al., 2006; Pitkala et al., 2009; St John et al., 2006). The hope is to avoid a bad death, as some researchers have put it (Green et al. 2008; Grundy 2006). These social ties usually come in the form of health promotion activities such as skill building, coping skills, family ties and connections to community resources some, any, or all of which are needed to prepare the older adult for life (Grundy, 2006). Grundy (2006) also suggests that policies are needed to provide the older adult with safe social environments which also encourage policing.

While these are not unreasonable steps to be taken by public health professionals, other key stakeholders are certainly needed. For example, the Government of Canada provides funds to the provinces and territories for community centres that promote and facilitate social engagement. Bodies for seniors, such as the Ontario Seniors Secretariat (2010) and the Ontario

Society (Coalition) of Senior Citizens' Organizations (2010) may also be involved in informing policy and work with the government to prioritize needs.

Public Health Research

In order to improve and increase the current body of public health research on social ties and their effect on depression in older adults, it is essential to examine the current body of research that exists and to determine what should be done in the future. There are specific goals set out by the Government of Canada which will help to guide current research. Recommendations made by researchers based on current studies will also assist to set the standards for future health care research.

What We Have

Research guides practice. Currently, there are certain criteria present which guide mental health research in Canada. These will be discussed as they regard to mental illness, particularly with depression and the older adult.

Research standards for mental health in Canada. In order to ensure that research in Canada is conducted to the best of its ability, there are certain guidelines which must be followed that are set out by the CAMIMH (PHAC, 2010a). The first is to guarantee that there is a national research agenda for mental health (PHAC, 2010a). For researchers, this would include identifying the most important issues to research with regards to mental health and the older adult. Second, there needs to be public awareness and education on the importance of mental health research in order to support the cause (PHAC, 2010a). Following this support, the third step is to ensure that there is adequate funding for mental health research and, that those researchers are supported in their work (PHAC, 2010a). Once the work is ready for dissemination, policy makers must be made aware of evidence-based research and incorporate it

into national standards of care (PHAC, 2010a). Much support is needed by the community from consumers as well as key stakeholders in order to ensure that this research is being utilized for the good of those individuals who require it the most (PHAC, 2010a).

Where We Need To Go

There are certain expectations for mental health research. Some of these goals are created by bodies with a special interest in mental health such as the CAMIMH (PHAC, 2010a). Other expectations are made by mental and public health researchers. Gaps and areas for future research were identified by health care researchers in order to improve their research. First, and foremost, the most appropriate research tools and methods must be utilized. Second, it is necessary to conduct more research on depression and the older adult, as this is a poorly assessed and treated mental illness for this age group (Bephage, 2005; Casado et al., 2008; National Institute of Mental Health [NIMH], 2010). For example, work could target identification of which groups are at the highest risk, what their needs are, and what interventions have been successful (NIMH, 2010).

Utilizing the proper research tools and methods. Research conclusions, while valid, are only as effective as the study itself. There are many flaws which occur in a research study and many researchers have identified ways to improve in the future. The most commonly voiced concern is the design.

Researchers utilize a variety of different research designs to assess or test their interventions. One common mistake may be the use or fusion of designs. In this literature review there were several mixed method designs. The issue with these is that they may make researchers question the validity of the results (Mellor et al., 2008).

Sample size is another common problem. Most often, sample sizes that are too small and not random can limit the interpretation and generalize the findings of the study (Evans, 2009; Loughlin, 2004; Paluck et al., 2006). Instead, larger sample sizes are needed to assess the prevalence, such as in Loughlin's (2004) study when they explored depression and its relation to social supports. Furthermore, small sample sizes may lead to sampling error (Evans, 2009). In addition, many of the studies performed were quasi experiments which may threaten their external validity. As a result, more random sampling needs to occur (Evans, 2009).

When selecting participants it is difficult to gauge who will accurately represent the population in question (Barg et al., 2006; Dong & Simon, 2008; Fulmer et al., 2005; Paluck et al., 2006; Pitkala et al., 2009; Riolo et al., 2005). One issue experienced by researchers in Pitkala et al.'s (2009) study as well as Barg et al.'s (2006) study was that participants involved in the intervention wanted to change their lives for the better, and may not have represented the older adult population at risk for decreased social supports. Another common issue experienced by researchers was the level of cognition of the older adult (Acierno et al., 2010; Dong & Simon, 2008). They questioned whether or not participants understood what they were being asked as cognitive impairment was a concern in the studies focusing on elder mistreatment and failure to thrive (Acierno et al., 2010; Dong & Simon, 2008; Pitkala et al., 2009; Proctor, 2008).

When the methods of data collection were analyzed several researchers noted that their approach to gathering information may have had faults. For example, Acierno et al. (2010) noted that the questions in their surveys were not open ended and did not allow any explanation. Another issue Acierno et al. (2010) confronted was that their survey included data from the family members rather than the older adults. It is pivotal to ensure that the data being collected comes from the source being examined.

Treatment and intervention research. Depression in older adults is poorly treated. Researchers indicate that older adults who are at increased risk for inappropriate medication treatment including the incorrect use of prescriptions, are less likely to be treated with psychotherapy and have a lower quality of general health status (Alexopoulos, 2005; Chew-Graham, 2010; Fyffe et al., 2008; Yohannes & Baldwin, 2008). These occur as a result of poorly recognized depression in the older adult population. While medication, when used correctly, can be of use for the older adult, in the case of poor social ties as a cause for depression, psychotherapy may be the best intervention in order to identify what is missing from the life of the older adult (Alexopoulos, 2005; Buck, 2008; Chew-Graham, 2010; Costa, 2006; Louch, 2009). This, however, is not a current practice, but would be beneficial, research states (Costa, 2006).

Social ties research. In the area of social supports and social networks, more research on their link to depression is needed. Social factors, as they relate to depression, have been ignored in research to date (Boyle, 2005).

It is also clear that older adults suffer from depression in a variety of settings- such as community settings, LTC facilities, and hospitals. Work may be needed to determine whether the same relationship between lack of social ties and depression exists across settings to avoid a 'one size fits all' approach to intervention. For example, previous research indicates that those who live in LTC and hospital settings may experience cognitive and functional decline alongside depression, so it is necessary for researchers to differentiate the role of social ties in these circumstances (Proctor et al., 2008).

Social isolation research. In the literature review presented in this paper, there were several areas of isolation explored. Each area has its own research needs and will be discussed in relationship to the older adult.

With regards to geographical isolation, there is little known about older adult males and their perceived mental health issues (Mellor et al., 2008; Paluck et al., 2006). Most of the research has been focused on older adult females, and it would be of interest to explore males' social relationships, if any, within the community setting (Paluck et al., 2006). If public health care professionals knew of the struggles of the male population in rural areas, an appropriate assessment and related interventions could be completed to reduce their social isolation within their community settings. Another issue in rural isolation is that there is a lack of literature on the effects of rural and urban social support differences as a marker of successful aging (Evans, 2009; Mellor et al., 2008). It would be of interest to study what services are effective to both of these populations in order to help to create appropriate interventions and services (Evans, 2009).

Social isolation, due to elder mistreatment, was another difficult theme which needs to be further explored in research as a cause of depression in older adults. Acierno et al. (2010) states that elder mistreatment is difficult to determine at times, as older adults are reluctant to discuss it. Therefore, research on the effects of appropriate interventions may be hindered. Furthermore, future studies need to collect data from the older adult only, as many articles include family members which may not create a proper presentation of the population (Acierno et al., 2010). If public health care professionals were aware of the struggles that older adults experience through elder mistreatment, they would be able to better understand their situation and not only combat their mistreatment by loved ones but also improve their social ties thereby breaking this chain of isolation.

Summary

Depression among older adults is a public health issue, particularly because it is underreported and undertreated. Some older adults are at increased risk for depression, especially considering their lack of social ties which is a known cause of this mental illness. Social ties are successful coping mechanisms which have been shown to reduce depression and to minimize the impact on the lives of older adults.

Unfortunately, this public health issue has the potential to continue to grow exponentially as baby boomers age and become the largest age group of the population in Canada; by 2031 they will make up 25% of the Canadian population. It is the responsibility of public health care providers to reduce depression in older adults by increasing social ties through public education and awareness. It is also the responsibility of varying health care providers to meet the needs of this population and the community to ensure that they are well supported through this difficult aging process.

In order to reduce depression in older adults through enhancing social ties, collaboration is needed among key stakeholders groups. There are a variety of things that public health care professionals can do in terms of practice, policy and research in order to address this major public health concern. Some of these standards are currently set by the Government of Canada, and are to be upheld by public health care professionals. Other recommendations for public health practise are voiced by researchers. However, these things cannot be accomplished without the support of the key stakeholders and the general public, particularly those older adults who are affected by depression.

No one should suffer from this debilitating illness, and it most certainly is not a rite of passage as many believe. No one deserves to have their identity stripped away or their life

destroyed. No one deserves to suffer a greater part of their lifetime with a debilitating illness when they could enjoy their golden years. Some do not live through this illness, and those who do may suffer again one day. Depression is an illness with a major price tag which no one can afford.

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