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The Prevalence of Depression among Older, African American Women

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Abstract

This study explores the prevalence of depression among older African American women as depression has been targeted as a major health problem among older African American women. According to the DSM-5 diagnostic system, depression is defined as a disturbance in mood, characterized by sadness, and is associated with other psychological and physical symptoms that adversely affect a person's functioning at work, at home and in social contexts. Although controversy surrounds the classification and the reported prevalence of late life depression, most of older female adults in community surveys, report depressive symptoms. Due to the magnitude of the problem, gerontological practitioners must increase their endeavors to explicate the phenomenon of depression. Greater focus needs to be placed on theory development and research related activities to increase knowledge of depression and interventions. To date, little research has been conducted on depression among older African American women. It is important to explore depression in older women for several reasons. First, the higher prevalence rate of depression among older women, relative to older men, needs to be adequately explained. Second, demographic information reveals that older women comprise much of the senior population in Western countries, and this trend is expected to continue. Finally, given that the preponderance of research on late life depression has been carried out with both sexes, existing research has neglected to investigate gender-related influences as a potential source of depression among older women. The implications of the findings for practice, policy, and research are also explored.

Keywords: depression**,** elderly, treatment, women, health, and research.

1.0. Introduction

Depression is a major debilitating mental health issue within the United States and around the world (Ammerman, Altaye, Putnam, Teeters, Zou, & Van Ginkel, 2015). Although, depression can affect individuals from across nationalities, cultures, and genders, it is one of the most common mental health issues among the older adult population (Li, Pang, Chen, Song, Zhang, & Zheng, 2011).

If left untreated, depression can lead to detrimental thoughts and behaviors such as suicidal ideations and attempts (Lo, Lin, Gagliese, Zimmermann, Mikulincer, & Rodin, 2010). Depression may occur as a major depressive disorder (MDD), the most severe form, or minor depression or depressive symptoms (Ammerman, et al., 2015). According to the Diagnostic and Statistical Manual of Mental Disorders, MDD is an illness characterized by five or more symptoms, which must be present for two or more weeks (Ammerman, et al., 2015). These symptoms include: depressed mood; an inability to find pleasure from pleasurable activities or events (anhedonia); a significant change in weight or appetite; changes in sleep patterns; decreased concentration; decreased energy; inappropriate guilt or feelings of worthlessness; psychomotor agitation or retardation; and suicidal ideation (Ammerman, et al., 2015). Of the listed symptoms, depressed mood or anhedonia must be present for a diagnosis of MDD (Barg et al., 2006).

MDD is usually associated with role impairment and substantial symptom severity; however, minor depression consists of fewer symptoms and is below the severity threshold for a clinical diagnosis, often resulting in many older adults' depression being undetected (Bschor, Bauer, & Adli, 2014). Although controversy surrounds the classification and the reported prevalence of late life depression, most of older female adults in community surveys, report depressive symptoms. Due to the magnitude of the problem, gerontological practitioners must increase their endeavors to explicate the phenomenon of depression. Greater focus needs to be placed on theory development and research related activities to increase knowledge of depression and interventions (American Psychiatric Association, 2019. To date, little research has been conducted on depression among older African American women. Moreover, due to the preponderance of research on late life depression has been carried out with both sexes, existing research has neglected to investigate gender-related influences as a potential source of depression among older women (Davey-Rothwell, Stewart, Vadnais, Braxton, & Latkin, 2017; Lo, et al., 2010).

Mental health problems such as depression are often a taboo topic across various cultures, thus it is a problem that needs major attention, especially among the African American communities, in which depression is seen as a luxury that African Americans cannot afford to have (Black, Gitlin, & Burke, 2011). Depression is a major problem among older African American women; however, they also tend to be understudied as members of a multiple minority and oppressed group (Hunn & Craig, 2009). As matriarchs and grandmothers in their families and communities, it is easy, with as much pressure that these labels and responsibilities hold for African American women, for depression to emerge and become a detrimental problem throughout their lifespan (American Psychiatric Association, 2019).

It is important to explore depression in older women for several reasons. First, the higher prevalence rate of depression among older women, relative to older men, needs to be adequately explained. Second, demographic information reveals that older women comprise most of the senior population in Western countries, and this trend is expected to continue. The studies of Black et al. (2011) found that elevated depressive symptomatology that interferes with day-today functioning among older adults is a major public health problem, which is often under-recognized and under-treated (Freeman, 2013). Hence, significant gaps in information and knowledge about late life depression exist. For example, current research findings reveal a contradictory pattern concerning prevalence in which there is a marked decline in diagnosable depression (i.e., major depression and dysthymic disorder) with a simultaneous presence of elevated levels of depressive symptomatology among older females (Freeman, 2013; Glasheen, Colpe, Hoffman, & Warren, 2014). The following sections of this study will subsequently explore the course of major depression among African American females characterized by exacerbations, remissions, and chronicity. The implications of the findings for practice, policy, and research are also explored.

2.0. Literature Review

An extensive review of the relevant literature showed that Mental illnesses affect about 20 to 30 percent of older adults living in the community American Psychiatric Association, 2019; National Alliance on Mental Illness, 2015). Depression is the most common mental health problem, with as many as 330 million people experiencing it at any given time (Glasheen, et al., 2014). About 14 to 16 percent of older adults in primary care settings are reported to suffer from clinical depression, while more than half suffer from minor depression (Ammerman, et al., 2015; Barg et al., 2006). It is predicted that by the year 2020, major depressive disorder, which is currently the fourth most common disorder among women will be the second highest cause of disability, behind heart disease, worldwide (Barg et al., 2006; Freeman, 2013).

The depression rate for men is reportedly 6.7 percent, while the estimate for women is 12.3 percent (Ammerman, et al., 2015). Some studies have shown that the difference in rates between depressed men and women diminish with age (Nolen-Hoeksema, 2012; World Health Organization, 2014a), while others have shown that it is more common in women, regardless of age (Bluth, Campo, Futch, W. & Gaylord, 2016; Warner, & Brown, 2011). Although it is more prevalent in women than in men, it may be overly prevalent in older African American women, as the estimates among this group has not been widely reported in the literature and is difficult to gauge. Depression is often underdiagnosed, misdiagnosed, or dismissed as a normal part of aging among older adults and such underreporting is more common in African American communities (Ammerman, et al., 2015; Bschor, et al., 2014; Davey-Rothwell, et al., 2017).

According to Steffens, Fisher, Langa, Potter, and Plassman (2009), the prevalence rates of depression are dependent on person-related and methodological factors. The person-related factors relate to the inclusion/exclusion for cognitive impairment, the racial/ethnic composition of the sample, and the research setting, such as an outpatient clinic, an inpatient hospital, a nursing home, and a non-institutionalized community setting. Some methodological factors are selected measures for depression: how symptoms are counted that may be attributable to either depression or another medical issue, the strategy employed to assess depression among more severely cognitively impaired adults, and the kind of instrument used, such as the depression screen, the structured diagnostic interview, or the symptom checklist (Ammerman, et al., 2015). Another factor is whether the sample is representative of the older adult population by including different age groups, from the youngest-old to the oldest-old (Bluth, et al., 2016). The estimates may also be affected by the limitations in generalizability, the inconsistency of the rates, and whether there are enough racial/ethnic minorities in the samples. Hunn and Craig (2009) argued that comorbidity also plays a role because those with multiple illness diagnoses tend to have higher rates of depression and be more at risk for depressive symptoms.

Specific to older African American women, they face not only a double burden of being older and being a racial/ethnic minority (Steffens, et al., 2009), but as women, they also face what has been described as a "triple jeopardy" (Spence, Adkins, & Dupre, 2011). According to the triple jeopardy hypothesis, which derives from the double jeopardy hypothesis, the health of African American women declines significantly late in life due to their multiple disadvantaged statuses (Spence et al., 2011). However, using the triple jeopardy hypothesis to predict the health of this group has often yielded inconsistent support (Min, 2005; Spence et al., 2011).

As stated earlier, depression among older African American women is understudied and poorly understood (Hunn & Craig, 2009). There are several reasons for this. Many studies examining depression have focused on samples with mostly white older adults (Nicolaidis, Timmons, Thomas, Waters, Wahab, Mejia, & Mitchell, 2010; Sriwattanakomen, McPherron, Chatman, Morse, Martire, Karp, …Reynolds III, 2010). Health care, long-term care, and social services are underutilized by African Americans in general due to factors such as lack of awareness, limited financial resources, a mistrust of the research process, the existence of language barriers, discriminatory practices, lack of education, and insensitivity of institutions toward diverse groups (Bschor, et al., 2014; World Health Organization, 2014a).

African Americans are more likely to seek the care of a primary care provider, as opposed to a mental health specialist (Barg et al., 2006), yet the diagnosis of depression by primary care providers is more prevalent among Whites than African Americans (Sriwattanakomen, et al., 2010). Further research is needed to examine the factors associated with depression among older African American women. This study will focus on community-dwelling older African American women because, as Nicolaidis, et al. (2010) stated, so much of the available literature is about men. Sriwattanakomen et al. (2010) reported that due to the different social worlds in which they live, recognition of the importance of specifically examining risk factors among this population is growing. Additionally, Warner and Brown (2011) state that previous quantitative research lacks a direct examination of the way in which race/ethnicity and gender intersect in the health of older Americans, especially utilizing longitudinal data, instead often viewing the social constructs separately.

The purpose of this study is to explores the prevalence of depression among older African American women as depression has been targeted as a major health problem among older African American women., identify gaps in the literature and add to the knowledge base about depression among this population of color, and develop a framework for future studies investigating mental health issues among diverse populations.

Specifically, the research questions addressed in this study will probe (a) the relationship between age and depression, (b) the influence of social support on depression, (c) the relationship between religion and depression, (d) the relationship between caregiving and depression, (e) the influence of physical health on depression, and (f) the joint impact of age, social support, religion, caregiving, and physical health on depression.

Answering these questions will have a significant influence on the way mental health services are provided to this population and the way in which research is implemented in the field of social work through practice and policy. The way social work researchers are trained and educated will have to be adjusted to include these factors, based on the findings of this study and other similar studies. Knowledge of these relationships may help researchers create targeted interventions designed to reduce the prevalence of depressive symptoms in older African American women (Glasheen, et al., 2014). Although there have been many studies comparing older Black and White populations, the focus of this study will specifically be on the factors of older, community-dwelling, African American women.

2.1. Sociohistorical Background of African American Older Adults

Historical events ranging from the Great Depression to World War II and changes in Black-White race relations have influenced older African Americans (DuBois, 1965). African American older adults typically experienced a childhood and adulthood dominated by the World Wars, the Great Depression, the end of segregation, and an increase in civil rights. The experiences of African American and Caribbean older Black adults have differentially impacted their belief systems and quality of life (Thomas, 2012). The impact of racial discrimination on the quality of life of African Americans has been subject to extensive investigation (March, Luchsinger, Teresi, Eimicke, Findley, Carrasquillo, & Palmas, 2014). African American older adults have experienced discrimination and prejudice at the institutional, political, and economic levels (Dubois, 1965; Taylor, Chatters, & Jackson, 2007).

Discrimination can take two forms. De jure discrimination refers to discrimination mandated by law, while de facto discrimination, although not mandated by law, is sanctioned by societal customs and accepted practices (March, et al., 2014). De jure discrimination was prevalent under the Jim Crow laws (1876-1965), while de facto discrimination is the ongoing prejudices toward and treatment of African Americans by Whites to which the authorities tend turn a blind eye (Thomas, 2012). In addition, African American older adults have tended to experience extensive economic hardships throughout their lives (Mair, 2010). Prior to World War II, nearly threequarters of African Americans lived in Southern agricultural areas and worked in the fields for meager wages (Snell-Rood, Feltner, & Schoenberg, 2019). Beginning in the 1940s, many migrated to Northern cities where they faced living conditions that included overcrowding, crime, drugs, and discrimination (Sternberg, & Lee, 2013). Furthermore, African Americans have suffered high unemployment, underemployment, and periodic layoffs (Ammerman, et al., 2015; Thomas, 2012).

The history and culture of African American older adults has been profoundly affected and defined by the group's disadvantaged status in the U.S.; persistent racism and the continuing effects of discrimination have contributed significantly to adverse living conditions among them (Williams, Haile, Gonzalez, Neighbors, Baser, & Jackson, 2007). Empirical studies have found associations between racism and several socioeconomic and health disparities among African Americans (Williams et al., 2007). Even as the African American population ages, economic disparities remain prevalent. Despite growing and costly programs for the aged (Sternberg, & Lee, 2013). African American older adults have about half the financial resources of older White adults. For example, older single African American women are three times as likely to be impoverished as older single White women (U.S. Department of Health and Human Services, 2018). In 2015, 40% of older African American women lived alone and in poverty, while only 17% of older White American women lived under these conditions (Snell-Rood, et al., 2019).

Ethnic diversity within the Black population has grown substantially over the past several decades (Williams et al., 2007). The issue of ethnic heterogeneity has been largely ignored, as race and ethnicity have been viewed as interchangeable (Thomas, 2012). Caribbean Blacks living the U.S. form a small group with the dual status of being Black and immigrant (March, et al., 2014). They do not fit neatly into U.S. race classifications which have expanded from 5 to 15 classifications in the 2010 US Census: White, Black, Hispanic, American Indian, Asian Indian, Chinese, Flipino, other Asian, Japanese, Korean, Vietnamese, Native Hawaiian, Guamese, Samooan, Pacific Islander (Humes, Jones, & Ramirez, 2011).

3.0. Gender and Depression

In the U.S., research has consistently shown that women are twice as likely as men to experience depression; recent prevalence estimates reported from the National Comorbidity Replication Survey (NCS-R) found 16.6% of all U.S. adults experience major depressive disorder at some point during their lifetime (Nolen-Hoeksema, 2012). Among U.S. adult women, 20% reported experiencing major depressive disorder sometime during their lifetime, compared to 12.9% of men. Major depressive disorder experienced during a one-year period was reported by 8.5% of women and 4.7% of men. Furthermore, women of childbearing age, i.e., those between the ages of 18 and 45, comprise most women afflicted by depression (National Alliance on Mental Illness, 2015; Nolen-Hoeksema, 2012).

It is noteworthy, the methodology used to examine differences across populations and individuals has limited the study of depression inventories. The expression of one's gender or sex-role has been influenced by social forces that interact across time and sociopolitical climate (World Health Organization, 2014a). Bluth, et al. (2016) defined gender as a method of social categorization. This categorization system was thought to use biological sex differences to create different social categories for men and women. Furthermore, Walby, Armstrong, and Strid (2012) explained the concept of gender identity as a person's visceral, cognitive, and behavioral response to the social meaning of being "male" or "female." This explanation builds upon the assumptions that people are aware of the social categories that accompany gender, and that they accept or reject their assigned categories. Warner and Brown (2011) asserted that the social meaning of one's gender affects all relationships with self and others. These definitions of gender identity and gender role highlight the complex nature of socialized rules and beliefs associated with gender. The dynamics of gender shape one's attributions, thoughts, and assumptions.

Prevalence data provides a vehicle through which to begin the investigation of the link between feminine gender roles and depressive symptomology. The epidemiological rates of depression are predictable. Researchers have noted high female-to-male ratios for diagnosed depression across cultures and generations (Bluth, et al., 2016; Nolen-Hoeksema, 2012; World Health Organization, 2014a). They found rates of depression to be higher in women than in men, whether the assessment was made based on patients' self-report or clinicians' decisions.

Gender role expectations may influence clinical decisions in important ways. It is in the inherently social environment of psychotherapy where a host of clinical decisions and general perceptions of depressed individuals may be mediated by gender role expectations. These expectations, for instance, may impact the diagnostic process so that women are perceived as depressed in the absence of objective indicators (Bluth, et al., 2016). One might argue that more women are diagnosed, and sometimes misdiagnosed, with depression because men and women present themselves very differently in treatment. That is, women appear to report more symptoms, present themselves with more affective intensity (Davey-Rothwell, et al., 2017) and experience more emotional distress than men (Nolen-Hoeksema, 2012). However, this argument does not account for findings from research on clinical judgment. For example, women were diagnosed with depression twice as often as men were, even when male and female patients were matched for level of severity.

One camp of researchers contends that the diagnostic label of depression may be more readily applied to women because stereotyped descriptors of females imply emotional maladjustment (Hunn, & Craig, 2009; Davey-Rothwell, et al., 2017). This contention is termed the gender role hypothesis of depression (Bluth, et al., 2016). The gender role hypothesis has gained support through empirical research that has established an overlap between descriptions of women's gender role and descriptions of depressive features (Soares, 2017; World Health Organization, 2014b). Indeed, one researcher has characterized the similarity between pathologized stereotypic feminine characteristics and depressive symptoms as "striking" (Davey-Rothwell, et al., 2017). Others discuss depression as a "caricature" of the traditional feminine role, where women are socially rewarded for qualities like helplessness and passivity (Snell-Rood, et al., 2019; Soares, 2017).

4.0. Age and Depression

In the United States and in other Western countries, the elderly is the fastest growing population, and many suffer from depression. Depression is one of the most common mental disorders of advanced age and contributes to medical illness and disability in late life, as well as increasing the risk of institutionalization, all-cause mortality, and suicide (World Health Organization (2014a). The emphasis placed on the growing elderly population is driven by the unprecedented growth in the 65 years and older group of citizens. Between 2000 and 2010, the number of older Americans increased by 3.7 million or a 12% increase (Li, et al., 2011).

The growth in the aging population is greatest in the over 85 age group (Lo. Et al., 2010). By 2030, it is estimated that 20% of the population will be 65 years of age or older. The "Baby Boomers", persons born after World War II, contribute to the increase in the number of older people (Bluth, et al., 2016; World Health Organization, 2014c).

Depression is the most common mood disorder in older adults (World Health Organization, 2012a). The risk factors include being female, divorced or separated, low socioeconomic status, and poor social support, and a recent unexpected or negative event. Retirement and loss of a spouse are examples of life situations possibly affecting the elderly client. Research indicates that older adults who are isolated or ill are more likely to be depressed but may be less likely to seek care (Mair, 2010). A study by Soares (2017) indicates clinically significant depression affects 15 to 20 percent of elderly individuals in the United States.

Depressive disorder is not a normal part of aging. Emotional experiences of sadness, grief and temporary "blue" moods are normal, but persistent depression that interferes with ability to function is not. Depression can and should be treated, just as medical illnesses are treated. Untreated depression delays recovery from this disability itself and may worsen the outcome of other illnesses as well. Depression is a potentially debilitating condition that often is unrecognized or under-treated in the elderly (American Psychiatric Association, 2019; Warner & Brown, 2011).

Clinical depression negatively affects functional status, quality of life and mortality (Freeman, 2013). Although elders compromise only 12 percent of the U.S. population, this population accounted for 16% of suicide deaths in 2011 (Centers for Disease Control and Prevention, 2012). Clinical depression is a psychiatric diagnosis of Major Depressive Disorder (MDD) or dysthymia (a chronic, less acute form of MDD) and may remain\ undiagnosed for years (Soares, 2017). The Global Burden of Disease Study reported that depression will increase and be ranked second after heart disease all over the world by the year 2020 (National Alliance on Mental Illness (2015).

5.0. Depression and Treatment

Primary care practitioners and mental health practitioners report that depression in the elderly often goes unrecognized and untreated. Major depression is disabling, highly prevalent, and adversely affects daily function and quality of life (Black, White & Hannum, 2007). Depression in the elderly can contribute to increased health care costs and medical co-morbidities. Delivering effective psychotherapeutic treatment to this population is important to decrease depressive symptoms, improve quality of life and prevent premature death/suicide (Freeman, 2013; Glasheen, 2014).

It is worth to note that psychotherapy is as effective as antidepressant medication for mild-to-moderate geriatric depression. More than 25% of depressed older adults prefer to be treated with psychotherapy rather than with pharmacotherapy, and an additional 5% to 10% require psychotherapy in addition to antidepressant medication (Snell-Rood, et al., 2019). Interpersonal psychotherapy improves adherence to treatment because it provides a supportive environment and education for the various treatment modalities. Interpersonal Psychotherapy (IPT) is recommended in many depression treatment guidelines therefore, it is important to understand the intervention from a real-life perspective (Bailly, & Roussiau, 2010; Williams & Maslow, 2016).

IPT is a structured, time-limited therapy specifically developed for the treatment of depressive disorder (Caron, & Weissman, 2006). The therapeutic process involves guiding the client through a systematic progression of events where depressive symptoms are explored and psychoeducation about depression, relationships and responses is provided. Both the format and the content of IPT are especially suitable for elderly patients (Cuijpers, Geraedts, van Oppen, Andersson, Markowitz, & van Straten, 2011). Research attests to the utility of psychotherapy for depressed older adults Successful outcomes are promoted as elders find opportunities for education, development of new skills and improvement in or resolution of interpersonal problems (Cuijpers, et al., 2011; Finkenzeller, Zobel, Rietz, Schramm, Berger, 009).

Reviews of research on IPT indicate that this intervention is a practical, effective intervention for the elderly patient with depression (Caron, & Weissman, 2006). The efficacy of ITP in the treatment of acute depression has been demonstrated in several studies (Hinrichsen, & Clougherty, 2006). Interpersonal Psychotherapy (IPT) helps the clients to identify and explore the social and interpersonal issues in their lives. These issues relate to and maintain their depressive symptoms (Miller, 2009). In the beginning therapy sessions, the therapist and client agree upon a focus from a problem area in the client's life.

In the following sessions, strategies are developed to deal with the identified problem areas. This is a practical, effective intervention for treatment of the elderly patient with depression (Miller, & Reynolds, 2006). IPT combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone (Cuijpers, et al., 2011; Miller, 2009).

Based on current guidelines, problem-solving therapy or IPT combined with pharmacotherapy is considered the most appropriate intervention for major depression (Cuijpers, et al., 2011). State-of-the-art pharmacologic and psychotherapeutic techniques are the preferred management strategies (Miller, 2009). Major depression in late life is a common condition and treatment is effective for most elders but not all. Approximately 80% of older adults with depression improve when they are treated with medication, psychotherapy, or a combination of the two. However, 20% of depressed elderly do not recover with psychotherapy and pharmacotherapy (Caron & Weissman, 2006; Miller, 2009).

6.0. Implications for Practice

A gerontological explosion is anticipated, with the number of older adults expected to increase exponentially in the coming years (Black, et al., 2007). During this time, more and more older women will be seen by clinical social workers (Min, 2005). Social workers must be informed and able to understand the unique characteristics of older adults and their families (Mair, 2010). Depression will continue to be an important issue for clinical social workers, and for health care providers and policy makers (Spence, et al., 2011). Practitioners will need to be able to meet the unmet the needs of the older adult population while identifying the best practices for treating this illness (Li, et al., 2011). With such a consistent growing rate in elderly population, racial/ethnic minorities are expected to increase by more than 200% over the next few decades (Min, 2005). Culturally competent practitioners will be in high demand to meet the needs of the evolving mental health market (Black, et al., 2007; Williams & Maslow, 2016).

Although less than 25% of older adults with mental illnesses receive treatment, it is still important for social workers to know about the various types of treatment (Council on Social Work Education, 2013). Psychosocial treatments, any treatment not involving medication or medical procedures, will need to be adjusted and provided to this population to meet their specific mental health needs (Zalaquett & Stens, 2006). Social workers will also need to be aware of current treatments for depression such as cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), brief dynamic therapy (BDT), reminiscence therapy (RT), group therapy, maintenance therapy, and family therapy (Williams & Maslow, 2016; Zalaquett & Stens, 2006).

Currently, there is a significant workforce shortfall within the field of gerontological social work (Eldercare Workforce Alliance, 2012). There is a huge demand for more geriatric social workers, but not enough to supply this demand, which will increase to 45% by 2015 (Council on Social Work Education, 2013). By the year 2020, an estimated 60,000 to 70,000 social workers will be needed in this field (Council on Social Work Education, 2013). However, less than 10% of that estimate is currently available (Council on Social Work Education, 2013). The shortage of geriatric social workers is also a barrier to treatment of depression among older adults (Council on Social Work Education, 2013). The need for more social workers in gerontology will continue to rise and is estimated to reach 109,000 by 2050 (Eldercare Workforce Alliance, 2012).

Although about 75% of licensed social workers have older adult clients, many have not received the proper training or education to adequately address their needs, and only about 9% identify aging as their specific field of practice (Council on Social Work Education, 2013). From 2009-2010, 5% of all social work graduates specialized or completed coursework in aging, on average (Eldercare Workforce Alliance, 2012). Moreover, geriatric social workers are more likely to be closer to their clients' ages or reaching retirement age, which will create even more of a demand for geriatric social workers in the future (Council on Social Work Education, 2013). There also is a call for more diversity, in terms of racial/ethnic backgrounds, of these geriatric social workers (Council on Social Work Education, 2013).

This research illustrates the urgency for social workers to study the nature of depression among older adults. Often resulting from depression, older adults have the highest rates of suicide (Zalaquett & Stens, 2006). Statistics have shown that up to 75% of older adults who commit suicide visited a primary care professional about a month before their death (American Psychological Association, 2013). Additionally, there is a need to explore the factors associated with depression among older African American women.

The current state of gerontological research has huge implications for the way practitioners will practice, how policies will be implemented, how behavior and theory will be tied together, and how research will be conducted in the future. With this, social workers have a professional and ethical responsibility to address the mental health issues of populations that the National Association of Social Workers' Code of Ethics classifies as "vulnerable, oppressed, and living in poverty."

Socio-cultural competence should be an essential component in social work practice and the psychosocial assessment. Historically, socio- cultural factors have been approached by focusing only on one aspect (e.g., socio-economic status) or stereotypical views of racial and ethnic minority groups. When inundated with a myriad of socio-cultural factors for each ethnic group, the social worker is often overwhelmed with these details and has difficulty integrating this information to help the client (Mahoney, Carlson, & Engretson, 2005). This study's significant finding on mental health beliefs as significant predictors for MTHU provide a context for social workers to develop skills to become effective cultural brokers for their clients in the larger ecological system.

A cultural broker assists with bridging or mediating between groups or persons of different cultural backgrounds to advocate on behalf of another individual or group (Black, et al., 2011). Clients are experts about their history (e.g., ethnic identity, religiosity) and their beliefs regarding mental illness and solutions guide the decision-making process. Both clients and clinicians have beliefs, values and behaviors that stem from their respective cultural heritage as well as personal experiences. Social workers must understand and practice the tenets of effective cross-cultural communication (Nolen-Hoeksema, 2012) to advocate for their clients within the labyrinth of social welfare policies and services. As an effective cultural broker, the social worker can build trust, work with diverse communities, and assist clients in accordance to their needs, and not the dominant culture's mandates. This is to avoid stereotyping, a view that all individuals within a cultural group think and behave in an identical fashion (Mahoney et al., 2006; Nolen-Hoeksema, 2012).

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