Depression and Older Native Americans

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Abstract

This paper reviews recent research on the prevalence of depression in older adults and especially older Native Americans. Information on the importance of considering acculturation and general life satisfaction in this population is described. The paper concludes with several recommendations for treatment and counseling.
Depression and Older Native Americans

Most of the current information on mental health and aging is based on the needs of the average older male, but the majority of older people are female, especially after the age of 80. Little attention has been given to ethnicity and its effect on the mental health status of older people. We know that members of multicultural groups in the U. S. have lower life expectancies than whites. We also know that mental health status is affected by ethnicity, gender, and age, but we have few details on the exact relationships (Hersen & Van Hasselt, 1996).

Mental disorders occur more frequently with advancing age. Risk factors include genetics, gender, ethnicity, socioeconomic and environmental factors, health-related behavioral patterns, health care utilization patterns, psychosocial stress and coping resources, and factors related to cultural change, such as acculturation, modernization, and migration (Birren, Sloane, & Cohen, 1992).

Although mental disorders are more common in old age, feelings of well-being are also positively associated with aging. Thus, today there is a more positive formulation of aging than in the past, when it was thought that the losses experienced in aging lead to an inevitable increase in the likelihood of mental disorders. Loss could include the loss of loved ones, the loss of social role, the loss of occupation through retirement, and the loss of socioeconomic status. We now know that these losses do not necessarily cause mental disorders, and the majority of older adults are satisfied with their lives.
Prevalence of Depression in Older Adults

Society has perpetuated the myth that depression is a natural consequence of old age so much that older people often believe it themselves. However, research shows that the incidence of major depressive episodes in adults over age 65 who live in the community is somewhere between 1% and 4%, which is lower than in young and middle-aged adults. As you might expect, rates of depression are higher in some subgroups, such as older adults who are ill or frail, where the rate is from 10% to 15%. Another 9% to 30% of older adults have some symptoms of depression but not enough to be diagnosed with clinical depression. Overall, depression is the most common psychological disorder found in older persons (Dick & Gallagher-Thompson, 1996). Still, the great majority of older adults are not depressed, so there is no reason to think that aging in itself causes or is associated with depression.

The diagnosis of depression in older adults is more difficult than with younger age groups, because many older people do not label or describe their negative feelings as depression. Instead, they often report symptoms which the counselor may see as metaphors for depression, such as feelings of worthlessness, demoralization, hopelessness, or despair. Behavioral symptoms (such as low energy, agitation, or psychomotor retardation) and somatic symptoms (such as difficulty sleeping, decreased appetite, weight loss, and loss of interest in sex) may be due to unrecognized medical problems, to chronic illness, or to the side effects of medications (Hersen & Van Hasselt, 1996), so a thorough intake interview is essential.
Typically, referrals to mental health professionals follow the older person's visit to a primary care physician. Depressed older adults often have increased health complaints, even in the absence of known medical problems. Sometimes older adults present with a depressed mood that may be obvious to an interviewer but will often be denied by the patient. Unfortunately, the majority of older adults who are depressed are not referred for treatment by physicians. This is partly due to confusion of depressive symptoms with "normal aging." Since some physicians themselves may think it is normal for people to be depressed, they may not discuss the depression or refer the person to a mental health professional.

Older Native Americans and Acculturation Stress

The emotional impact of the disruption of the Native American way of life may have a significant affect on Native American elders, and predispose them to mental disorders. Acculturation stress is the stress felt by Native Americans who have difficulty adjusting to the dominant culture, or who feel pulled between their allegiance to their traditional culture and the dominant culture. The current psychiatric diagnostic manual recognizes acculturation stress as a problem which may be the focus of clinical attention, but it is not considered a mental disorder (APA, 1994).

Those Native Americans who maintain tribal identity have fewer problems in general (and this is likely true with mental disorders too). Native American elders are more likely to have traditional values, and if they stay enmeshed in tribal culture (for example, by living on a reservation near their relatives) they may experience less acculturation stress than younger people. The most extreme acculturation stress
would likely be felt by Native Americans who try to maintain their
traditional tribal values and activities while also trying to be successful
in the dominant culture. For example, Native Americans who were
reared with traditional values on a reservation who then move to a city to
find work may be expected to experience significant acculturation stress.
Anxiety or depressive symptoms may result from this stress.

Native American Elders and Mental Health

In 1990 about 6.5% of the American Indian population was age 65
and older, and the size of this group is growing. There are many
social conditions which affect the mental health of Native Americans.
Lower socioeconomic status is associated with higher levels of stress and
fewer coping resources in general. Combining lower social class, higher
levels of stress, and older age results in a greater risk for mental disorder
for most ethnic minority elderly. This occurs partly through the
mechanisms of discrimination and exclusion. Racial discrimination
reduces income potential, which means reduced income in old age. So
economic stress increases the likelihood of stress which could contribute
to the development of mental disorders in old age.

Regarding the effects of stress, there are really two sides to the
equation: stress and resources. With enough stress, anyone would
develop disorders, but with enough resources, just about anyone can
cope with a large amount of stress. Social support mediates the
negative effects of stress, thereby reducing susceptibility to stress-related
disease (and mental disorders). The main supports for ethnic minority
groups usually include family, church, and community. The extended
family and kinship systems of Native Americans are very important
mediators of social and psychological stress. Although many Native
Americans lack extensive financial resources, this may be compensated in part by having extensive family and social resources.

A study of mental health and life satisfaction among the elderly (Johnson, et al., 1988) found that Native Americans had mental health scores comparable to the scores of Whites and African Americans, and better scores on average than Hispanics. However, the life satisfaction scores of the Native American elderly were lower than Whites and African Americans, and similar to those of Hispanics. Even so, the Native American elderly scored well above the median of the scale on life satisfaction.

Another study on elderly Native Americans by the same authors (1986) found a relatively high level of life satisfaction (64%). There is a positive association between life satisfaction and mental health in older Native Americans. These results suggest that although elderly Native Americans may be less satisfied with their lives than Whites or African Americans, the majority of them are fairly satisfied, and they did not report more symptoms of mental illness (Stanford & Du Bois, 1992).

The most common mental health problem among Native Americans is alcoholism. Native Americans are ten times more likely to die due to alcoholism than members of the general population (Griffith, 1996). Although there is a lack of adequate data on the prevalence of mental disorders in Native Americans, depression is probably more common than in members of the general population. The suicide rate of Native American adults is over twice as high as that of the general population, and the rate of suicide of young adult Alaska Natives is ten times the national average (U. S. Congress, 1986).
There is very little data on the rate of mental disorder in the older age group of Native Americans. One Indian Health Service study showed that visits to IHS for mental disorders was lowest among those age 65 and over, and the diagnosis of organic brain syndrome was highest among this group. There was low utilization of services for depression and anxiety. A similar low rate of utilization of services for treatment of alcoholism is thought to be partly due to the high mortality rate of alcoholics (Stanford & Du Bois, 1992).

Recommendations for Treatment

The goals of treatment for depression include decreasing symptoms, reducing risk of recurrence, increasing quality of life, and improving medical health status. The two major types of treatment are biological therapy (primarily medications) and counseling or psychotherapy. Many patients with severe acute depression (about 60%) improve with antidepressant medication (NIH, 1991). Although there is little research specifically on the use of such medications with people over age 65, overall the antidepressants seem to be equally effective in older adults. However, it may take longer to see a response in older adults (six to 12 weeks). Medication compliance by elderly people is a problem; it has been estimated that 70% of patients fail to take 25 to 50% of their medication (NIH, 1991).

Counseling or psychotherapy is an essential adjunct to treatment by medication, and in some cases it is sufficient to resolve the depression. Several controlled research studies indicate the moderate and durable effects of psychotherapy. Cognitive behavior therapy, behavior therapy, interpersonal therapy, and short-term psychodynamic therapy all seem to be about equally effective with older adults who are
in relatively good health. One problem is that many elderly people do not see themselves as depressed and reject referral to mental health professionals. Special efforts may be needed to engage these clients in treatment. Community-based programs such as senior centers, nutrition programs, and volunteer services can play an important role in a comprehensive approach to intervention.

Psychotherapy typically includes addressing the client's stated concerns, and identifying the client's maladaptive thoughts, feelings, and behaviors. Most psychotherapies for depression try to move the client from inactivity to busyness; from isolation to togetherness with other people; and from rumination on problems to distraction or a focus on more the positive aspects of the client's life.

Service systems need to pay more attention to the cultural context of mental health problems of the minority elder patient, including Native Americans. Depression can be expressed in different ways, depending on definitions of mental health, adjustment, and happiness, and on cultural norms for acceptable behavior. More research is needed to determine how Native American elders experience and express depression, and on what treatments for depression are most effective with them. For example, psychosocial treatments involving the family, group, and social network may be more effective than treatments which focus on the identified patient. The extended family could share the burden of the diagnosis, enhance the patient's compliance with treatment, and promote recovery from the depression.
References


