Challenges in Assessment and Identification of Depression Among Older Adults: Implications for the Native American Community

by Rebecca Donaldson

In our society, changes in older adulthood are consistently framed in terms of loss and deficiencies. This paper examines the prevalence and nature of depression among the elderly, and how depression relates to the developmental stage of older adulthood. Mental health concerns, particularly depression, are widespread among older adults. Focusing on the Native American elderly, a disproportionately impoverished minority population with a disproportionately high rate of older adult depression, this paper uses a multicultural lens to examine the different experiences of depression among older adults, and the resulting implications for service delivery. Increasing knowledge in the professional community has important implications for increased coordination and improved services for older adults suffering from depression.

Older adulthood is a life stage filled with many physical, cognitive, emotional and psychological changes. In present-day American society, such changes in older adulthood are consistently framed as leading to losses of roles and abilities. Our society's emphasis on youth and devaluing of age and experience is reflected in our attitude towards older adults. Fry (1986) conceptualizes our view of the aging process as "a gradual, downward trajectory with ever-increasing levels of inadequacy, impairment, and physical and psychological decline" (p. ix). Bearing this in mind, it is not surprising that our society sees high rates of mental health issues, particularly depression, among the elderly (Ruiz, 1995, p. 6). Research estimates that 15 percent of older adults demonstrate clinically significant symptoms of depression (Bower, 1991). Many studies demonstrate, however, that such decline is not inevitable. Research suggests that various environmental, biological and socio-cultural factors and experiences of stress can influence older adults' likelihood of experiencing depression (Chaisson-Stewart, 1985; Fry, 1986). The Bio-Psycho-Social-

Cultural model's focus on a person's subjective experience of events acknowledges the individualized experience of depression and the need for multifaceted solutions to this prevalent problem (Fry, 1986, p. 2). Understanding the factors and experiences contributing to high rates of depression among the elderly is critical if our society hopes to improve quality of life for older adults.

Despite the prevalence of depression among this population in our society, older adult depression is among the most vaguely defined mental health problems in regard to cause, origin and assessment (Fry, 1986, p. 114). Given the influence of environmental factors, it is important to examine the occurrence of older adult depression within a framework that acknowledges cultural influences in the subjective experience of aging. Ironically, current inadequacies in assessing older adult depression are particularly evident in our failure to consider or examine the complex influence of socio-cultural factors on depression. This discussion will examine these current challenges in understanding depression by focusing on the impact of depression among the Native American elderly, a disproportionately impoverished minority group.

THE NATURE AND EXTENT OF OLDER ADULT DEPRESSION

Characteristics and Prevalence:

Data suggests that depression is the most common mental illness among the 12.3 percent of people over age 65 experiencing mental health problems that require intervention (Ruiz, 1995, p. 6). The physical and mental health of the elderly must be examined in an environmental or ecological context. The effects of environmental and psychological factors on health seem particularly evident among the elderly because they have fewer material and emotional resources to assist them (Coe, 1983, cited in Fry, 1983, p. 1). There is little question that older adults may face challenging biological, cognitive, psychological and social changes. Normal biological changes, however, generally do not explain the onset of late-life depression (Blazer, 2002, p. 27). Similarly, normal changes associated with aging can result in psychological stress, through the loss of social support, for instance, which may in turn contribute to depression. Again, however, research generally suggests that normal psychological or emotional changes associated with aging do not cause depression.

Research has shown a number of factors to correlate with high rates of depression. These factors can be understood best through the Bio-Psycho-Social-Cultural perspective, which suggests four categories that interact and thereby influence an individual's behavior and experiences. A discussion of the

various biological, psychological, social and cultural factors that may influence one's experience of mental health illuminates the degree to which depression is a multifaceted and multi-causal phenomenon (Chaisson-Stewart, 1985). Our framework for understanding depression must truly examine and integrate these various factors to provide a comprehensive understanding of this complex problem facing older adults.

In regard to biological factors, a strong correlation exists between physical illness and depression. Such findings are particularly relevant for the elderly because of the frequency, and chronic and debilitating nature, of illness experienced among this population (Manson & Brenneman, 1995, p. 284). Suffering from physical illness, particularly chronic or serious illnesses including arthritis, cancer, chronic lung disease or heart disease, is a characteristic shared by many older adults experiencing depression. It is also important to note that the subjective meaning of an illness, or losing certain abilities to failing health, is relevant to mental health. A disease or disability that destroys a person's self-image, making a person more prone to frustration or feelings of hopelessness, holds great meaning to that individual and may put him or her at risk for depression (Fry, 1986, p. 5).

Psychological factors influencing an older adult's risk for depression may include his or her mental health history. Some researchers have suggested that as many as 50 percent of elderly medical patients require psychological care as urgently as medical care (Fry, 1986, p.1). Both extensive anxiety and depression are associated with greater clinical severity, chronicity and poor recovery prognosis (Lynch et al., 2000, p. 268). Personality factors can serve as risk or protective factors as well. For instance, a strong sense of control over one's life and circumstances is negatively correlated with depression among older adults and thus perceiving control serves as a protective factor. Similarly, an individual's ability to reinforce oneself through the use of mood regulation skills, or the ability to control one's cognitive or emotional reactions to certain stimuli, negatively correlated with depression in a study of adults (Wong et al., 2000).

In regard to social factors, feelings of social isolation and lack of social support correlate high rates of depression (Blazer, 2002, p. 284). Alternatively, social support and feeling connected serves as a protective factor for individuals. Levin (1960) identified loss as the primary category of stressors for older adults, influencing self-esteem and mental health. Such findings are particularly relevant to the elderly population, as the loss of important relationships through the death of friends or a spouse is common and may lead to feelings of hopelessness (Fry, p. 5). One study suggested that 60 percent to 80 percent

of depression in the elderly is precipitated by a major event, almost always involving loss (Post, 1968, cited in Chaisson-Stewart, 1985). Similarly, feelings of social isolation and lack of support, often stemming from disconnection with family, may also have an important impact on mental health.

Sociocultural factors affecting depression among older adults include the attitude of the individual and their society or cultural group toward aging. For instance, members of lower socioeconomic status groups tend to express greater fear of poverty and abandonment than members of higher socioeconomic groups (Fry, 1986, p. 5). Sociocultural factors also can relate to social support, in that individuals' cultural norms may influence how much support they receive from their families. Sociocultural norms also might determine one's expectations of the support he or she should receive from family, which may impact positively or negatively that person's feelings of self-worth and value.

UNDERSTANDING ELDERLY VS. NON-ELDERLY DEPRESSION

Our understanding of depression among older adults is based on a framework designed for a non-elderly population (Bower, 1991, p. 310). Lewisohn, Biglan, and Zeiss (1976) suggested five classes of depression symptoms: 1) *dysphoria*, or feelings of sadness and apathy; 2) *behavioral deficits*, such as decreased verbal or physical activity; 3) *behavioral excesses*, such as intense feelings of guilt; 4) *somatic symptoms*, such as headaches; and 5) *cognitive expressions of extremely low self-esteem or negative expectancies* (cited in Fry, 1986, p. 80). Researchers and professionals typically understand depression among older adults by these standards. Though the elderly demonstrate hopelessness and loss of interest similar to younger depressed populations (Blazer, 2002, p. 39), numerous symptoms of older adult depression, which are not conceptualized in the model of major depression, are difficult to differentiate from normal aging symptoms. For instance, depressed older adults generally complain about discrete medical symptoms rather than classic symptoms of depression (Bower, 310, 1991). Findings have emphasized the importance of adjusting the younger client-based model of depression to understand older adult depression. Attempts to incorporate changes can be seen in the development of the Geriatric Depression Scale, which emphasizes psychological and cognitive symptoms, differing from the non-elderly-focused Beck's Depression Inventory by (Fry, 1986, p. 101). However, additional adjustments to such measurements of depression, to best reflect nuances in the experiences of elderly versus non-elderly depression, are needed.

DEPRESSION IN THE CONTEXT OF "NORMAL" OLDER ADULTHOOD

In examining depression among older adults, it is important to understand the context in which depression occurs. Keeping the challenges of older adulthood in mind, assessment tools must establish criteria for what level or range of functioning is considered normal. It is important to reiterate that close to 15 percent of older adults in the United States, who do not meet the criteria for major depression as based on the younger-client model of depression, demonstrate "clinically significant" symptoms of depression (Bower, 1991, p. 310). This is also true of 25 percent of older adults living in acute medical facilities (O'Riordan et al, 1988, cited in Blazer, 2002, p. 21). More research comparing the characteristics and prevalence of "clinically significant" depression symptomatology to major depression among the elderly is critical if professionals hope to fully understand the ways in which older adults experience depression. We also must acknowledge that our perceptions of aging directly affect our conceptualization of mental health in older adulthood. Specifically, our ideas about aging determine what level of negative effect or depression should be considered problematic. Some research demonstrates that depression is under-diagnosed (Bower, 1991), suggesting the normalization of older adult depression in our society, consistent with our idea of old age is a sad and "depressing" time.

Rutter (1993) proposes examining life transitions in terms of the new challenges faced and the ways in which occurrences and negotiations are influenced by strengths from the past. Such life-cycle models emphasize the role of environment throughout the life span, suggesting that historical events, environmental variables, societal expectations and value orientations influence an individual during the life course (Bigot & Munnichs, 1978, cited Fry, 1986, p. 6). Life cycle frameworks allow for an understanding of intra-generational similarities and intergenerational differences, as well as offering one's past experiences as an explanation for why different individuals react differently to seemingly similar occurrences (Rutter, 1993). Most comprehensively, the Bio-Psycho-Social-Cultural model provides an important framework for understanding how specific and complex factors interact to influence an individual's behavior and experience. Helping us understand complexities, this model also makes clear why single-entity problems among the elderly are rarely encountered, and that many interactions between behavioral, organic and cognitive process interactions exist in

the lives of older adults. The Bio-Psycho-Social-Cultural model's focus on a person's subjective experience of events acknowledges the individualized experience of depression. Additionally, this framework facilitates a multifaceted and strengths-based understanding of how older adults, as individuals, cope with depression.

THE ROLE OF CULTURE IN UNDERSTANDING OLDER ADULT DEPRESSION

Looking at differences across cultures is particularly important in our examination of the developmental context in which depression occurs. In examining American society from a multicultural perspective, there are a number of general cultural differences that should be acknowledged. First, some theorists suggest that general similarities of values exist within American minority cultures, which differ from mainstream societal values. These include the values of harmony with nature, reciprocity, traditional medicine, respect for elders and family commitment, among others (Padgett, 1995). Despite such similarities, much heterogeneity exists within the United States, including among minority groups, which results in different health and mental-health care experiences and outcomes for different populations. Specifically, variance exists in distribution of disease, the need for and seeking of health care, attitudes toward self-medication and the role of the health-care provider or healer, help-seeking and compliance, and response to health care professionals, among others (Padgett, 1995, p. 24). Secondly, one must consider how depression fits into the norms and values of a different culture. For instance, research has shown that minority elderly are much more likely to seek help for a physical problem and fail to mention relevant emotional or mental problems. This example not only emphasizes the importance of professionals understanding cultural differences to work effectively with different populations, but this has important implications for program planning and implementation.

More research is needed to examine the various socio-cultural influences on risk factors and experiences of depression among older adults. A great deal of past research has focused on homogenous populations and thus can only be cautiously generalized to ethnically or socioeconomically diverse populations. Few studies focus on differences between racial or ethnic groups in examining specific issues around depression, and those that do rarely examine the differences between elderly and non-elderly depressed populations. As a result, research that looks at mental health issues among the ethnically diverse elderly is not extensive. The quantity of research on socio-cultural factors in depres-

sion among the elderly must be expanded, and the scope of such research must be extended as well. In particular, more research must be done examining service use patterns among minorities, to plan future intervention and treatment programs that can be successful (Manson, 1995). Additionally, research must not only look at differences between minority and non-minority elders but also address the needs and characteristics of specific minority populations in America today. While some similarities of values may exist between American minority cultures (Padgett, 1995, p. 25), different minority cultures, whether defined by racial, ethnic, socio-economic, gender or sexual orientation status have different specific needs and strengths.

OLDER ADULT DEPRESSION WITHIN THE NATIVE AMERICAN COMMUNITY

Mental health research has failed to adequately examine the Native-American community, particularly older adults. Manson and Pambrum (1979) say regarding gerontological literature, "The elderly in question are usually white, seldom black, and never Indian" (cited in Thompson, 1994, p. 91). Thompson emphasizes that this tendency in literature has not changed a great deal in the past two decades. Though research on mental health among Native Americans is sparse, existing studies demonstrate that depression is the most commonly occurring mental-health problem among older Native Americans (Ruiz, 1995, p. 11). In fact, the Native-American elderly experience significantly higher rates of depression than non-Native-American elderly (National Indian Council on Aging, 1981; General Accounting Office, 1977, cited in Manson, 1995, p. 138). Considering how epidemically high depression rates are among older Americans, the surpassing rate of depression among Native Americans is particularly alarming. The Bio-Psycho-Social-Cultural model provides an essential framework for understanding the experience of depression among individuals in the Native American community.

Manson (1995) focuses on the ways in which extensive poverty, biological vulnerabilities to alcoholism and poor health interact to contribute to depression within the Native-American community. Though the mainstream American elderly population experiences extensive health problems, these statistics pale in comparison to the rate of health problems experienced by Native Americans. Pneumonia, diabetes, alcoholism and poor dental health are especially problematic in the Native American community. Particularly alarming, research estimates that 73 percent of the Native-American elderly are mildly to totally impaired in coping with the basics of daily living (National Indian Council on Aging, 1981, cited in Manson, 1995, p. 138).

Social isolation and poverty interact to result in the high rates of depression among the Native-American elderly. Barney (1995) emphasizes that, unlike urban dwellers, Native Americans living in rural reservation communities would not likely be reached through community mental-health center outreach programs, or other social and recreational services. The lack of access to public transportation further takes away from their ability to access services and information. Such effects of living in rural areas are seen among white populations as well. Similar to white populations, most Native Americans living in poverty are over age 75 and in rural areas. However, there is a much higher proportion of rural to urban Native Americans (1:1) than there are white Americans (1:3), thus making the problems of rural poverty more acute in the Native American community (Barney, 1995, p.136).

It is important to note that extensive diversity exists within Native-American communities. Socioeconomic and cultural differences often exist between those living in urban communities and on reservations, as well as among the several hundred Native-American tribal groups in North America today. Additionally, Thompson (1994) suggests that the influence of majority American culture has further diversified the Native-American community, as the impact made by majority culture has varied among tribal groups and among individuals within these groups (p. 93). Across the board, significant heterogeneity exists between American minority groups, and research design and conclusions must recognize this. Heterogeneity within different minority groups, whether among various tribes within the Native American community or different ethnicities within the Latino or Asian communities, also must be acknowledged.

Less is known about the impact of psychological factors on the experiences of older Native Americans. As one of the primary researchers in health-care issues among Native Americans, Manson expresses concern that despite much evidence of extensive need in recent years, little has been done to spur research and increase our understanding of mental-health issues in the Native-American community. Additional studies should focus on improving our understanding about service-use patterns, to provide a more rational base for planning of programs, treatments and interventions. Additional data on specific differences between Native Americans and the general population likely would suggest protective factors of Native Americans to be built upon, as well as risk factors of which to be aware. Additionally, studies are needed to address specific topics previously neglected in the literature on Native-American elderly, including research on the overall psychiatric status, differences in treatment or access to services within Native-American communities, or issues such as alcoholism that disproportionately affect Native Americans (Thompson,

1994, p. 92). Thompson (1994) also emphasizes the importance of examining mental-health implications for the Native-American elderly, as mainstream American culture and continuing poverty may result in some deterioration of the long history of respect for elders within Native-American communities (Thompson, 1994).

CONCLUSION

The concerns and goals for future research and planning regarding older Native Americans reflect to a large degree the across-the-board needs in relation to depression among older adults. Specifically, research in new arenas is needed as well as continuing research on the role of specific socio-cultural factors, as well as mental health issues. Criteria must continue to be established and refined in regard to "normal" versus depression-level functioning, taking into account the subjective and culturally influenced experience of depression among older adults. As discussed previously, this challenge exists in all areas of health and mental health in regard to the elderly, but is especially important with regard to depression, the most prevalent, but least understood, mental illness affecting older adults (Fry 1986, p. 114).

Though much progress in research has been made in recent years, increasing the knowledge of professionals working in geriatrics has important implications for the possibility of increased coordination and improved services for older adults suffering from depression. It is important to emphasize that *comprehensive* changes are needed in the way we plan and address the various needs of older adults. Older adults lack visibility in our society and thus their extensive physical, cognitive, social and mental-health needs are easily neglected. Finally, it is also important to elicit the thoughts, values and opinions of older adults in such service planning, as well. It must be kept in mind that older adults, like any group of individuals, likely will not benefit from a service unless it is tailored to fit the needs and desires of their community. The notion that services must fit the needs, characteristics and barriers to change of a particular community has significant implications given the diversity of race, culture, and socioeconomic status in our society. ■

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