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# Mental Health Aspects of Diabetes in Elders from Diverse Ethnic Backgrounds

## **American Indian Elders**

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# Background

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- ❑ 5–10 Million indigenous people in the continental United States at the time of first European contact 500 years ago.
- ❑ 1900 – Census count of only 237,000 Native Americans due to infectious disease, deprivation, and genocide.
- ❑ 1880's – 1934 Era of suppression and repression of Native American cultures. American Indians (A/I) are confined to “reserved” lands.
- ❑ Indian Self-Determination and Education Assistance Act of 1975 and the Indian Health Care Improvement Act of 1976 enacted by Congress.

# Influences on Native American Cultures

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- Forced Assimilation
- Boarding Schools
- Removal of Indian children from families and adoption by White families. (Ended by the Indian Child Welfare Act of 1978.)
- Historical relationship with land bases.
- Unique relationship with the federal government.
- Relocation programs of 1950's.

# Influences on the Older American Indian Cohort

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- Did not immigrate from another place
- Many Nations paid for health care, education and social programs, in perpetuity, with ceded land by treaty.
- Tribal affiliation and historical relationship with the federal government.
- World view influenced by unique reality of tribal, familial and spiritual history.

# Access to Health Care

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- Perception of and reaction to a hostile environment, including:
  - Health care system and providers
  - Diabetes diagnosis
  - Coping with depression
  - Recognition of memory loss
- Complex system of health care delivery:
  - Medicare/Medicaid
  - Indian Health Service
  - Compacting and contracted services
  - Tribal health services
  - Veterans Administration

# Demographics

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- ❑ 62% of American Indians do NOT live on-or-near reservation land.
- ❑ The number of older American Indians is expected to nearly double between 2000 and 2020 (Rhoads, 2003), many of whom live in urban areas.
- ❑ There are 28 non-governmental and non-tribal programs providing clinical services to American Indians and Alaska Natives in urban areas.

# Diabetes Relative Risk

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- ❑ Over 98% of diabetes in AI/AN, including children, is Type 2 diabetes, and associated with insulin resistance. (Other ethnicities: 10-15% Type 1 and 85-90% Type 2.) (Attico & Pauk, 1998)
- ❑ The Strong Heart Study (SHS, 1988, 1992, 2003)
  - ❑ 4,549 AI men and women ages 45 to 74, on-or-near reservations.
  - ❑ Rates of Diabetes from the SHS:
    - ❑ Arizona – Men, 65%      Women, 71%
    - ❑ Dakotas – Men, 32%      Women, 43%
    - ❑ Oklahoma – Men, 36%      Women, 41%

# Diabetes Relative Risk (cont.)

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- ❑ Strong Heart Study (cont.)
  - ❑ Impaired glucose tolerance was predictive of a high risk of developing diabetes.
  - ❑ 4 years later SHS participants with impaired GTT developed diabetes at a rate of 30-50%.
  - ❑ Rates of kidney disease and dialysis are much higher than other ethnic populations.
  - ❑ Very few AI receive kidney transplants.

(SHS, Data Book, 2003)

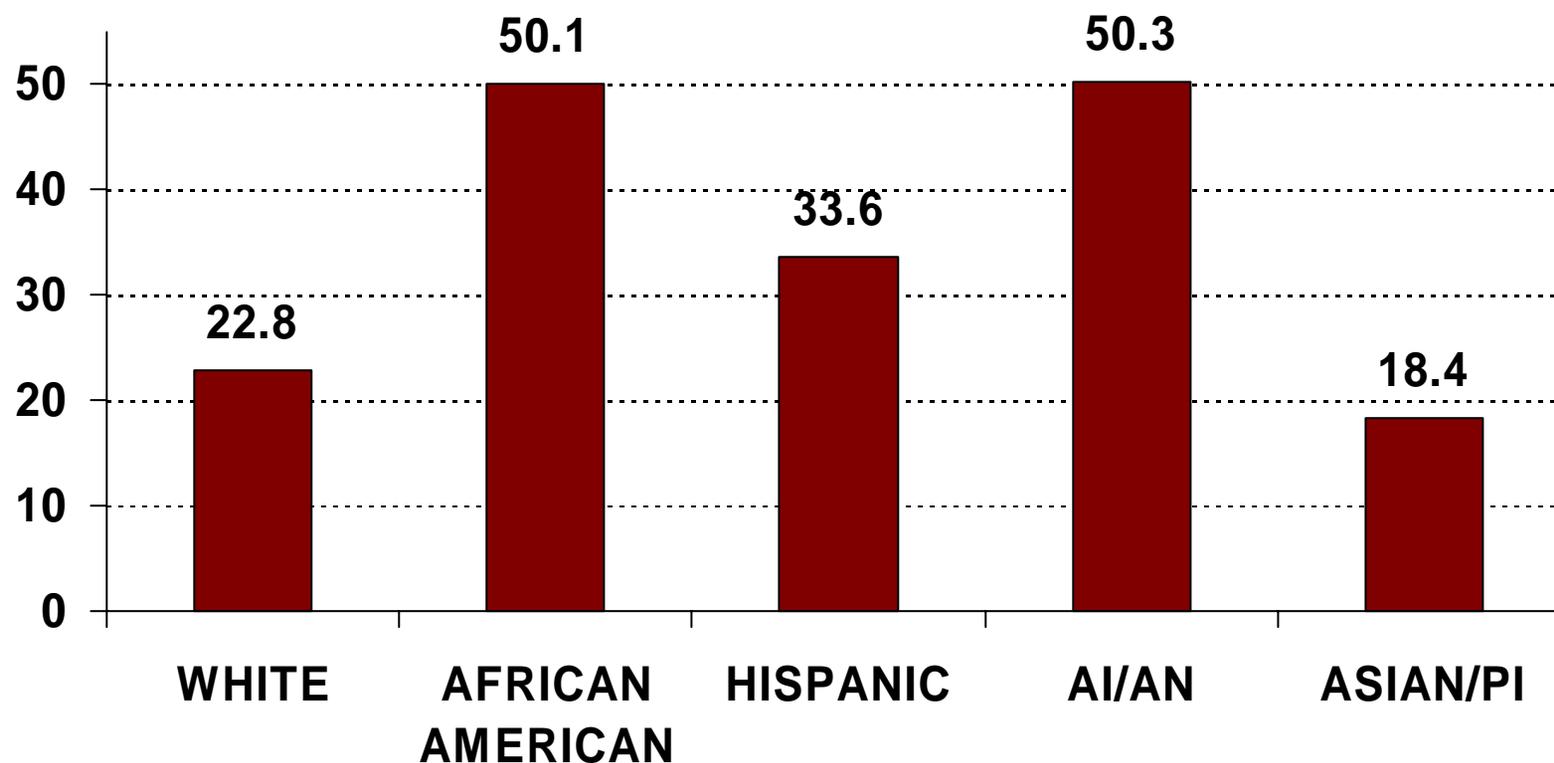
# AI Diabetes Relative Risk

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- ❑ One urban study of hypertension in older AI (in the Pacific Northwest) reported that the most frequently reported co-morbid conditions with HBP were:
  - ❑ Type 2 diabetes
  - ❑ Alcohol Abuse
  - ❑ Depression
  - ❑ With higher rates for diabetes and depression
- ❑ The same study reported that the number of health problems was the most important factor associated with end organ\_disease screening. (Rhoads, 2003)

# AI: Diabetes-Related Death Rate\*, 1999

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\*Per 100,000

# Urban AI Death Rates from Diabetes

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- ❑ Diabetes is the 5th highest cause of death for AI ages 45-64, and the 4th highest for AI 65 years and older.
- ❑ Ages 45-64 death rates from diabetes:
  - ❑ All Races – 20.7 (per 100, 000)
  - ❑ Urban AI – 40.0
- ❑ Ages 65 and over, death rates from diabetes:
  - ❑ All Races – 117.0 (per 100,000)
  - ❑ Urban AI – 162.5

Urban Indian Health Institute, Seattle Indian Health Board, 2004

# Assessment of Diabetes Risk Factors for AI

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- Family History of Type 2 diabetes
- Impaired fasting glucose
- Impaired glucose tolerance
- History of gestational diabetes
- History of delivery of a macrocephalic infant (> 9 lbs.)
- Obesity (> 125% of IBW)
- Hypertension
- History of renal disease in parents
- Very high or very low birth weight

(Attico & Pauk, 1998)

# AI: Culturally Appropriate Diagnosis and Assessment

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- Screening blood sugar levels for AI elderly should be done at least every three years, and annually for those at higher risk.
- Elders who are overweight and sedentary should have a fasting blood sugar at least annually.
- Regular retinal screening for retinopathy is recommended.
- Regular screening for kidney disease is recommended.

(SHS, 2003)

# AI: Culturally Appropriate Management of Diabetes

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- ❑ “Now you are a REAL Indian”
- ❑ Medications – In the SHS, more males and females with diabetes received oral medication than received insulin, less than 0.5% received both oral medication and insulin, and more women than men received treatment. (SHS, 2003)
- ❑ Elderly AI may be resistant to self-monitoring glucose levels due to vision and sensory impairment (especially fingers) and loss of dexterity.

# AI: Culturally Appropriate Mgmt. of Diabetes - Diabetes Health Education

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- ❑ Health education should utilize a “health promotion” approach rather than a “disease model”, and be carefully evaluated for cultural relevance. (Neligh, 1990)
- ❑ Peer AI educators are being successfully used to provide community education for fitness, wellness programs, weight control programs, indigenous cooking classes and self-management programs.
- ❑ One-on-one counseling combined with AI group education/discussion seems to be most effective.
- ❑ The importance of AI counselors, AI peer educators, and AI member groups cannot be overstated

# AI: Depression Relative Risk

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- ❑ Little is known about the mental health status of older AI in Tribal or community populations, and limited research exists for depression in AI. (Manson, Ackerson & Brenneman, 1989; LaFromboise, 1988)
- ❑ “Acculturation Stress” resulting from forced acculturation and attempted forced assimilation is hypothesized to be a causative factor in development of depression in older AI. (Kunitz & Levy, 1986; Leighton, 1971; LaFromboise, 1988)
- ❑ A strong association is suggested between the burden of medical illness and disability, and depression in rural and urban Indians age 55 years and older. (Lichtenberg, Chapleski, and Youngblade, 1997)

# AI: Culturally Appropriate Diagnosis and Assmt. of Depression

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- ❑ Difficulties in assessment of AI for depression:
  - ❑ Prevalence and expression of symptoms of depression in older AI may vary widely depending upon cultural values.
  - ❑ Cultural labeling of different emotions is variable.
  - ❑ Conceptual language differences.
  - ❑ Cultural incongruence with DSM IV criteria for the diagnosis of depression. (Manson, Shore, & Bloom, 1985; Hendrix, 1999)

# AI: Culturally Appropriate

## Diagnosis and Assmt. of Depression

- ❑ Depression may be more common in AI women than in AI men. (Baron, et al, 1989)
- ❑ A 12-item version of the Center for Epidemiological Studies Depression Scale (CES-D) has been utilized effectively among urban, rural off-reservation, and reservation residing AI aged 55 years and older. (Chapleski, Lamphere, Jankowski, Dwyer, and Lichenberg, 1997)
- ❑ The MMPI and Cornell Medical Index have been found to be culturally invalid for use with AI. (Chapleski, et al, 1997)
- ❑ The Geriatric Depression Scale (GDS) is widely used , and may be inappropriate for use with older AI, resulting in withdrawal from the relationship by the AI elder. (Hendrix, 2004; Miller, 2001)

# AI: Culturally Appropriate

## Treatment & Intervention for Depression

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- ❑ Information may be obtained by discussing specific symptoms (for example, loneliness, sleep problems, activities, low energy, sadness, etc.), rather than “depression”. (Kramer, 1991; Hendrix, 2001)
- ❑ Depression, alcoholism, violence and anxiety may be functional reactions to the real experiences of genocide, oppression, racism, and cultural alienation, and should be treated as cultural Post Traumatic Stress Disorder. (Duran & Duran, 1995)
- ❑ Depression may be experienced as a spiritual imbalance as well as a physical imbalance, and the services of a healer and/or spiritualist may be required in addition to allopathic medical intervention.
- ❑ Older AI may be especially resistant to taking anti-depressant medication.

# AI: Cognitive Loss and Dementia - Relative Risk

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- Very little is known.
- Alzheimer's disease may be less common among AI.
- Diabetes has been linked with depression and functional disability, and other research has linked depression to the eventual development of dementia.
- As the AI population live longer it is anticipated that dementia and memory loss will become more prevalent due to extremely high rates of diabetes, and possibly depression.
- Most likely prevalence will increase in the vascular dementias associated with multi-infarct dementia and stroke.

# AI: Culturally Appropriate Diagnosis & Assmt. for Cognitive Loss & Dementia

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- It is not likely for an older AI to present to a health care provider complaining of “memory loss”.
- The most common presenting behaviors of dementia in AI in one study were:
  - #1 – “difficulty understanding instructions”
  - #2 – “not recognizing people they know”
  - 1/3 of the participants exhibited restlessness and agitation all the time. (John, Hennessey, Roy, & Salvini, 1996)
- The least common behaviors (same study) were:
  - #1 – Wandering/getting lost
  - #2 – Dangerous behaviors to self or others.
- There is currently no culturally appropriate/congruent instrument to measure cognitive function in AI groups. (Jervis & Manson, 2002)

# AI: Culturally Appropriate Treatment & Intervention for Cognitive Loss & Dementia

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- Some AI cultures normalize forgetfulness and confusion as part of the aging process.
- Intervention may not be needed or wanted.
- Symptoms of cognitive impairment may be seen and valued as preparation for crossing from this world to the next.
- Many AI families tend to value the interdependence of family and community as much as the autonomy of the individual.
- Some cultural values that affect caregiving and decision-making in the AI family may be:
  - Non-interference
  - Individual freedom
  - Non-directive communication
  - Non-infantilizing of elders

(Hendrix, 2001; Ogrocki, Welsh-Bohmer, & Allen, 1997)

# AI: Culturally Appropriate Treatment & Intervention for Cognitive Loss and Dementia

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- Interventions should be the result of collaboration between families and health care providers.
- “Caregiver burden” may be culturally unacceptable, but caregiver stress is felt significantly. (Henessey & John, 1996)
- Culturally appropriate caregiver training, respite care programs, and family support programs should be developed by health care systems providing services for older American Indians.

# AI: Key Informant

## Interview Results, Diabetes

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- The term “diabetes” is used, and diabetes is considered a “White man’s disease”, partially brought on by commodity foods provided to AI by the federal government upon confinement to reservations.
- “‘Big belly societies’ developed as activity decreased and cultural value shifted away from the (more active) warrior societies”.
- The first resource an AI elder with newly diagnosed diabetes is likely to turn to is family members and “other Indians with diabetes”.

# AI: Key Informant

## Interview Results, Diabetes (cont.)

- A “cure” is not anticipated. “The cure is really the healing and the healing is in the mind”.
- Faith in God, spirituality, and religious faith may be used in acceptance of diabetes.
- Denial may be used as a coping strategy, “until that doesn’t work anymore”.

# AI: Key Informant

## Interview Results, Depression

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- It is generally difficult for AI elderly to talk about “depression” or other feelings – not currently a cultural value.
- Depression is talked about as “feeling down”, “feeling blue” or “not feeling good”.
- Depression may be expressed as feeling “overwhelmed”, that they “have no control over their lives”, or they “may develop a meanness”.
- “Older Indian people and younger people go to the elders” and some will “turn to Indian religious leaders” for counseling.

# AI: Key Informant Interview Results, Recommendations for Health Care



## Providers for Care of AI with Depression

- Explain that “others are going through the same thing”.
- Start with indirect approaches (for example, talking about symptoms to draw out and educate).
- Have small groups (6-8 people).
- Education and counseling should include the entire family.
- Counselors should “see where the individual is coming from” and “meet them there” – “the physical and spiritual in transformation”.

# AI: Key Informant Interview

## Results, Cognitive Loss and Dementia

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- The term “dementia” is not used and not known. There may be a stigma with mental illness misperception.
- Cognitive loss is normalized as “you lose your memory when you get old”.
- Cognitive loss is recognized by AI family members when “elders become confused”, “begin forgetting important events”, “do not recognize relatives” or “forget medications”.

# AI: Key Informant Interview Results,

## Cognitive Loss and Dementia (cont.)

- ❑ Elderly AI with cognitive loss were described as consistently expressing feelings of “fearfulness” or “loneliness”, and that they were not likely to talk about these feelings with “a young person”.
- ❑ Family members may approach the issue of memory loss by asking, “Is there something bothering you?”
- ❑ There is not much specific knowledge about dementia in the community, and the informants recommended a “non-fear-based” educational approach.