

2019

# A Qualitative Study of Native American Older Adults and Elderly Depressive Symptoms and Protective Factors

Kristen K. Pyke

*University of Montana, Missoula*

Let us know how access to this document benefits you.

Follow this and additional works at: <https://scholarworks.umt.edu/etd>



Part of the [Clinical Psychology Commons](#)

---

## Recommended Citation

Pyke, Kristen K., "A Qualitative Study of Native American Older Adults and Elderly Depressive Symptoms and Protective Factors" (2019). *Graduate Student Theses, Dissertations, & Professional Papers*. 11456.  
<https://scholarworks.umt.edu/etd/11456>

This Thesis is brought to you for free and open access by the Graduate School at ScholarWorks at University of Montana. It has been accepted for inclusion in Graduate Student Theses, Dissertations, & Professional Papers by an authorized administrator of ScholarWorks at University of Montana. For more information, please contact [scholarworks@mso.umt.edu](mailto:scholarworks@mso.umt.edu).

Running head: A QUALITATIVE STUDY OF NATIVE AMERICAN

A QUALITATIVE STUDY OF NATIVE AMERICAN OLDER ADULTS AND ELDERLY  
DEPRESSIVE SYMPTOMS AND PROTECTIVE FACTORS

By

KRISTEN KAYLIE ANN PYKE

BA, Syracuse University, Syracuse, NY, 2015

presented in partial fulfillment of the requirements  
for the degree of

Master of Arts

in Clinical Psychology

The University of Montana  
Missoula, MT

May 2019

Approved by:

Scott Whittenburg, Dean of The Graduate School  
Graduate School

Gyda Swaney, PhD, Co-Chair  
Psychology Department

Christine Fiore, PhD, Co-Chair  
Psychology Department

Laurie Walker, PhD  
Department of Social Work

© COPYRIGHT

by

Kristen Kaylie Ann Pyke

2019

All Rights Reserved

Pyke, Kristen, M.A., May 2019

Clinical Psychology

## A Qualitative Study of Native American Older Adults and Elderly Depressive Symptoms and Protective Factors

Co-Chairperson: Gyda Swaney, PhD

Co-Chairperson: Christine Fiore, PhD

Research of depression in Native American older adults and elderly has been limited. The research that has been done has typically fallen into three domains: exploring the frequency of depression (Carleton et al., 2013), identifying or developing culturally competent measurement tools (Ackerson, Dick, Manson, & Beals, 2018), and determining the protective factors that reduce the effects of depressions. More specifically, Kaufman et al. (2013) found that spirituality was beneficial in reducing depression; however, this varied by tribe within their sample. Whitbeck et al. (2002) found that perceived social support among elderly Native Americans was a protective factor for the individuals displaying depressive symptoms. The study is a secondary analysis of a qualitative data set of a larger study which focused on community-based participatory research, Resiliency in Native American Older Adults (Wallace & Swaney, 2006). The study examined 11 archival interviews (8 females and 3 males) with older adult and elderly Native Americans from the Northwest. The participants were from 50-79 years with a mean age of 62 years. The interviews were analyzed using a qualitative methodology, specifically a Grounded Theory approach. My research questions include: a) Do Native American older adults and elderly discuss symptoms of depression? b) If so, how do they discuss symptoms of depression? c) Additionally, if they report experiencing symptoms of depression do they report experiencing suicidal thoughts? d) If they report depressive symptoms, including suicidal thoughts, do they also identify any protective factors that may reduce the effects of depressive symptoms? Several participants indicated having some symptoms of depression; however, the number of symptoms that they discussed varied among each participant. The depressive symptoms that participants discussed identified included depressed mood, fatigue, difficulty in sleeping, suicidal ideation, lack of concentration, overeating and these symptoms mapped well onto the DSM 5 diagnosis of MDD. The core categories that were identified within protective factors included, culture, social support, and self-regulation. In conclusion, the research examining depression and protective factors among these individuals was beneficial to understanding what older adults have experienced, how they managed, and what they described helped them through difficult times. Despite the presence of many challenges evidenced in the interview transcripts, descriptions provided numerous examples of resilience throughout commentary.

## A Qualitative Study of Native American Older Adults and Elderly Depressive Symptoms and Protective Factors

### **Background of Native Americans**

There are 5.2 million Native Americans within the United States of America (U.S.; U.S. Census Bureau, 2012). In comparison to the general population (323.1 million) this is exceedingly small. According to the U.S. Census Bureau (2012) there are 567 federally recognized tribes. Many of these Native Americans have multiple cultures and customs that are attributed to either one or multiple tribes. Even though there are so many recognized tribes there are many tribes that are not receiving services through the federal government. Moreover, about 78% live off of the reservations meaning they also do not receive services (U.S. Census Bureau, 2012). Indian Health Services (IHS) is the predominate way that many Native Americans receive health care. Burwell, McSwain, Frazier, and Greenway (2014) noted that in IHS serves approximately 2.1 million Native Americans. Compared to the overall population of Native Americans the number of individuals that are currently being served is less than half of the overall population of Native Americans. Additionally, the researchers also noted that 31 percent of the Native American population was 15 years or younger (Burwell et al., 2014). Burwell et al., (2014) also noted that six percent of the population is older than 64 years old. Burwell et al., (2014) stated that the life expectancy rate for Native Americans from birth is 73.7 years. Whereas the life expectancy from birth for the general population is 78.1 years. This is an unusual proportion because many children are being born, however, not many Native Americans are living long lives. These rates are different compared to the general population which has lower rates of younger children, however, the general population tends to live longer. This may be due to the leading causes of death for older individuals. Burwell et al., (2014) added that the

two leading causes of death for Native Americans for all ages was diseases of the heart and malignant neoplasms. The leading causes of death for ages 45 to 54 years old were diseases of the heart and malignant neoplasms. The leading causes of death for Native Americans aged from 55-64 years old were malignant neoplasms and diseases of the heart. The two leading causes for death for Native Americans aged 65 years and older were diseases of the heart and malignant neoplasms. In addition, the leading cause of death for Native American males were diseases of the heart and malignant neoplasms. Whereas for Native American females the two leading causes for death were malignant neoplasms and diseases of the heart. The two leading causes of death are the same for male and female Native Americans and for older individuals, however, they order varies depending on your age and/or sex. Not only are the causes of death concerning for these older individuals but the rates at which they are passing away is concerning. Burwell et al., (2014) mentioned that the death rates for the overall Native American population for all causes was 32,867 per 100,000. They added that the death rates for Native American individuals aged from 45-54 years old for all causes were 4,625 per 100,000. In addition, the researchers also noted that the death rates for Native American individuals aged 55 to 64 years old for all causes were 5,332 per 100,000. The death rates for Native Americans individuals aged 65 years old for all causes were 15,086 per 100,000. Compared to the general population some of these rates vary, however, it is concerning and worth noting that many of these Native American individuals die younger than the general population. Furthermore, Burwell et al., (2014) mentioned that the suicide rates for all Native American individuals was 336 per 100,000. Additionally, males had higher rates of completed suicide compared to females in all age groups. Specifically, males aged 15-24 years old, which peaked at 58.7 deaths per 100,000, was 2.9 times higher than females of the same age, which also peaked during the same age range (20.2 deaths per 100,000). This is

alarming amount of Native American individuals and is higher than the general population. Native Americans have a variety of reasons as to why they may not be living as long as the general population. These reasons include lack of medical and mental health services, and higher risk of death by diseases. Native American's environment and genetics are impacting the life expectancy of Native Americans. Parker, May, Maviglia, Petrakis, Sunde, and Gloyd (1997) found that the predominate diagnosis found in Native American populations were substance use disorder specifically alcohol, major depressive disorder, and generalized anxiety disorder. This is important information because it shows that Native Americans either feel incredibly anxious or substantially depressed which can lead to an alcohol substance use disorder. In summary, health factors are important when considering the impact of them on Native American populations. However, one must also take into consideration how each tribe varies from each other when working with different Native American groups from your own.

Other researchers (Paniagua & Yamada, 2013; The National Tribal Behavioral Health Agenda, 2016) have noted that there are additional factors to consider when working with Native American's like socioeconomic status, education and lack of traditional language. However, they noted that the most important thing to consider when working with Native Americans is the variation in cultures across the different tribes. When considering working with Native Americans and doing research with Native Americans, one must always consider how the tribes are different and the specific customs that vary from one another. Additionally, Sue and Sue (2003) mentioned that it is important to consider familial structures that are present within Native Americans families. This is important to note because some Native American tribes may have matrilineal or patrilineal customs. These varying customs can impact how specific individuals within the Native American tribe contribute to the overall maintenance of the tribes. The

researchers also mentioned that the government plays an important role in how Native Americans view themselves. As discussed prior, 2.1 million Native Americans receive services from the U.S. government, however, the Native Americans may become constrained by the U.S. government because of this aid. Some reservations are allowed to use the aid they receive from the government in varying ways they see fit, however, not all Native American reservations receive the same luxury. This kind of constraint from the U.S. government can impact how the tribe functions and what decisions are able to be made from the tribe without the government becoming involved. Overall, there is a significant effect of culture on Native American tribes and this should be taken into consideration when working with or doing research with specific Native American tribes.

In summary, there are many factors to consider when working with or doing research with Native Americans. Some of the most important factors include mental and physical health, environment, and varying cultures across tribes. When working with Native American groups one must consider multiple factors, so they can try to understand that specific Native American tribe they are trying to help or research. Throughout this paper many factors will be considered and applied to the research that will be conducted, so that one can better understand the many aspects that affect these Native American tribes.

### **Historical Trauma**

Historical trauma is defined by Brave Heart (2003) as “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” (p.7). This is important to consider when doing research with Native Americans because all Native Americans are continuously affected by historical trauma.

Historical trauma is believed to affect Native Americans regularly because of the U.S. government policies that have been enforced upon Native Americans.

Whitbeck, Adams, Hoyt, and Chen (2004) operationally defined historical trauma by developing two scales by focus groups; the Historical Loss Scale and the Historical Loss Associated Symptom Scale. Both scales were developed from focus groups with respected elders (aged 55 years and older) in two upper Midwest reservations. The Historical Loss Scale frequency scale measured how often Native Americans thought about loss of land, language, traditional spiritual ways, family due to relocation and boarding schools, self-respect, trust in whites because of broken treaties, culture, respect from children, people to early death, and respect by children for traditional ways. Many of the components that Whitbeck et al. (2004) conceptualized historical loss into multiple categories. Some of the categories that Whitbeck et al. (2004) examined are discussed below.

**Land and relocation.** Native American land loss happened because of different policy changes that were made from the U.S. government. Native Americans often fought to maintain their lands; however, it was not always successful for the Native American individuals. Waghelstein (2001) reported that the U.S. fought its first war as an independent nation in the 1790s because Americans homesteaders wanted to expand their land base to the northwest. Since then Native Americans have been constantly fighting against the U.S. government to remain on their homelands. Unfortunately, the relocation of many tribes was forced upon them by the U.S. government's policy change. Walters, Beltram, Huh, and Evans-Campbell (2011) reported that in 1830 the Indian Removal Act was signed into law, which forced some Native American tribes to move from their homelands to lands not yet claimed by the U.S. government areas west of the Mississippi. The Choctaw Nation were first to be removed in 1831. They were relocated to

Oklahoma and many of them suffered from disease, exposure and starvation on the trail of tears. Shoemaker (2003) discussed the impact the general Land Allotment Act had on Native American tribes, which stated that 90 million acres of land were lost. She also indicated that tribal nations traded with U.S. government for medical and educational services. However, many treaties were broken by the U.S. government throughout the treaty process and large amounts of land were simply taken from the Native American tribes.

**Families, boarding schools, and language.** Brave Heart and DeBruyn (1998) described the Boarding School Era as forced assimilation of Native Americans children into the dominant culture. Native Americans had the choice to attend boarding schools when it started in 1870s; however, the boarding schools became required in the 1890s. Native Americans children were forced to attend boarding schools, where they were stripped of their cultural identity. If parents refused to comply to the U.S. government, they were threatened by the Indian agents with incarceration, loss of food and supplies. Walters et al. (2011) reported that many children who were forced to attend boarding school were most often located thousands of miles away from their families. The children were often punished if they spoke their language, and traditional practices. Walters et al. (2011) also stated that the children were taught western mannerisms and English, so they would become assimilated into the mainstream culture. Horejsi, Craig, and Pablo (1992) also reported that boarding schools were a way to destroy Native American's cultures and replaced it with dysfunctional behaviors, such as severe punishment towards their own children. The children ended up with a lack of attachment with their own children, which could have led to abuse and neglect. In addition, Brave Heart (2003) would agree with these authors and added that parents who have experiences intergenerational trauma from boarding schools are more likely to be authoritarian parents, who are uninvolved and non-nurturing. Brave

Heart (2003) discovered that lack of quality parenting is correlated with higher substance use by their children. These parents then in turn affect their children who often times exhibit varying psychological symptoms, including suicide, depression, substance use, and anxiety.

Furthermore, Barsh (1980) added that many Native American children have been taken away from their parents and placed in foster care. Unfortunately, an unusually high proportion of Native American children have been fostered by white families and stripped of their cultural identity. Since an unusually large number of Native American children were placed with white families, many Native American children became adults and did not know their culture background. However, they are bullied, and discriminated against as Native Americans. Brave Heart (2003) reported that many Native American parents and Native American children were affected by the Boarding School Era and exhibit a variety of psychological symptoms because of the historical trauma that they have experienced. Native Americans have been influenced heavily by boarding schools.

In addition to boarding schools, U.S. policy has had a profound influence on Native American languages. Gray (2012) found that only one person in a tribe of 2,636 members was fluent in their language. Whereas, Weaver and Brave Heart (1999) added that men (47.1%) reported higher fluency than women (28%) in their traditional language. The researchers also stated that men reported higher fluency in their parents (94.1%) in contrast to women (76.5%). This is a substantial drop in fluency rated within two generations and this drop is seen throughout Indian country. Many Native Americans do not know their culture and language and it has severely impacted the way they view themselves.

**Traditional ways and spirituality.** Irwin (1997) described different policies that restricted Native Americans from practicing their traditional ways and spirituality. In 1883, the

Indian Religious Crime Code was drafted. This law prohibited Native Americans from performing ceremonies under threat of imprisonment. However, the U.S. government restricted the practice of Native American traditional ways long before the passing of the Indian Religious Crime Code. The First Continental Congress Indian Proclamation in 1783, set the precedent to deny Native Americans of their religious rights by declaring the U.S. government had the sole power to control the affairs of Native Americans. the U.S. government passed the American Indian Religious Freedom Act in 1978 allowing Native Americans to practice their religion without threat of imprisonment. This act was passed in order to address past wrong doings by the U.S. government towards Native Americans.

**Political status.** Bruyneel (2004) believed when the U.S. government passed the Indian Citizen Act it was a way to assimilate Native Americans into the mainstream culture. The U.S. government passed the Indian citizen act in 1924, which gave citizen status to Native Americans. Native Americans became citizens of their tribe and citizens of the U.S. However, many Native American tribes opposed becoming citizens of the U.S. and often tried to repeal the notion. One tribal confederacy who refused out right were the Iroquois Confederacy (e.g. the Haudenosaunee Confederacy). The Haudenosaunee confederacy refused to become U.S. citizens because they knew that it was a form of assimilation and that they would lose many of their rights if they did become U.S. citizens (Bruyneel, 2004). The U.S. government has tried to take away Native American land and identity. Some tribes were severely affected by the different policies that the U.S. government put into effect disbanded some of those tribes and they were unable to recover from this impact. These different government policies have continued to affect Native Americans today and may result in different psychological symptoms from a historical trauma response.

In summary, Native Americans has been affected by U.S. government policy in a variety of ways and in which they are still being affected to this day. Native Americans were separated from their land, families, language, traditional ways, and spirituality because of U.S. government policy. Unfortunately, Native Americans may still be feeling the after effects of continuous change in U.S. government policy and these effects may be manifested as a historical trauma response. Brave Heart (2003) stated that responses to historical trauma can cause psychological symptoms, including self-destructive behavior, depression, suicidal thoughts and gestures, anxiety, anger and low self-esteem. This response may be present within many of the interviews that will be examined throughout this paper. Whitbeck et al. (2004) found within their sample that the perceptions of historical loss by Native Americans lead them to have emotional response similar to anger/avoidance and anxiety/depression from the Historical Symptom Scale. Some of the symptoms of depression that these Native American individuals are experiencing may be influenced by the historical trauma response.

### **Depression**

The American Psychiatric Association (2013) characterized major depressive disorder (MDD) as a person having a depressed mood most of the day, diminished pleasure or interest in most activities, significant weight loss or weight gain, insomnia or hypersomnia. The symptoms also include psychomotor agitation or retardation nearly every day, fatigue, feeling worthlessness or excessive guilt, diminished ability to concentrate, and recurrent thoughts of death or suicidal ideation. These symptoms must be present for at least two weeks and must include either a depressed mood or a loss of interest in almost all activities within that period (pp.160-161). An individual must have at least five out of the nine symptoms in order to qualify for an MDD diagnosis.

The American Psychiatric Association (2013) reported prevalence rates for MDD within the general population to be approximately 7%; however this varies depending on age. They also reported higher rates among females after adolescence. Additionally, some precursors include adverse childhood experiences, and first-degree family members having a diagnosis. Adverse childhood experiences and stressful life events potentially are risk factors for developing MDD. However, the incidence of adverse childhood experiences and stressful life events does not appear to be a useful guide in providing treatment. Furthermore, there is a two to fourfold increase in developing MDD within one's life if the individual has a first-degree family member who is diagnosed with MDD. The American Psychiatric Association (2013) also stated that the heritability of MDD is 40% and is more likely if one has the personality trait neuroticism. There is an increased risk of suicide with this disorder especially if the individual has had a history of suicide attempts or threats. Finally, there are marked differences between genders but there is little understanding as to why there is a difference between women and men. Women have a greater likelihood to develop MDD over their lifetime than men. Additionally, there are no distinct differences between cultures; however, MDD has the likelihood to be comorbid with a substance use diagnosis.

The diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) will be used as criteria when coding the interviews within the current study. The diagnostic criteria will be used in an effort to discover how Native American elders discuss depression symptoms.

### **Depression in Native Americans**

Depression is often conceptualized by the DSM-5 diagnosis. However, within Native American communities' depression can often be expressed in a variety of ways. Cohen (2008)

explains that many tribes view depression differently and each Native American tribe may have various descriptions of sadness, which is most closely linked to depression. Each description is fluid unlike the rigorous criteria in the DSM-5 MDD diagnosis.

Cohen (2008) also explains that most tribes do not like to be labeled and consider labels as bad omens. Depression is often conceptualized in multiple ways among Native American tribes. Manson (2000) also discussed the difficulty in conceptualize depression within Native American tribes. Shore, Manson, Bloom, Keepers, and Neligh (1987) reported that depression symptoms were perceived throughout their Native American sample. However, their sample of Native American individuals did not describe depression symptomatology. The researchers stated that it was peculiar that the symptoms of depression were present within the population; however, there was not a word for depression within the tribe. Since there is not a word for depression within many tribes, this research can be impactful in the way we conceptualize depression within Native American population.

Wilson, Civic and Glass (1995) stated that prevalence rates for Native Americans with depression were similar to prevalence rates for the general populations within primary care facilities. However, Manson, Shore, and Bloom (1985) reported 40% of Native American patients seen within community health facilities were diagnosed with depression. The researchers stated that within some Native American communities the rate of depression is four to six times the national average. Dinges, Atlis, and Ragan (2000) also stated that depression rates among Native Americans declines with age. The researchers found that within the Native American adolescent's population 58% were diagnosed with depression compared to adults (32-45%). The rate of depression in Native American adolescents is concerning and is often reflected in suicide rates among that group. Gray and McCullagh (2014) examined suicide and specifically focused

on Native Americans who live in Indian Country. They found that suicide is a major concern for Native American people aged 15-34 and that it's approximately 250% higher prevalence than general population. It is also the second leading cause of death behind accidental deaths in Native American populations. As stated above, Burwell et al. (2014) report that the suicide rates for all Native American individuals was 336 per 100,000. Additionally, males had higher rates of completed suicides compared to females in all age groups. Specifically, males aged 15-24 years old, which peaked at 58.7 deaths per 100,000, was 2.9 times higher than females of the same age, which also peaked during the same age range (20.2 deaths per 100,000). Dinges and Duong-Tran (1993) differentiated the age gap seen most often among Native American adolescents. Dinges and Duong-Tran (1993) reported that suicide in adolescents is most often seen in Native American adolescents aged 16-17 year-old compared to 14-15 year-olds. Cohen (2008) found that 32% of Native American elderly endorsed symptoms for depression. However, Gray and McCullagh (2014) stated that there is a low rate of suicide in Native American elderly populations. Burwell et al. (2014) reported that the suicide rates for both sexes aged 55-64 years were 9.6 per 100,000, for 65-74 years-old it is 7.8 per 100,000, for 75-84 years-old it is 5.8 per 100,000, and for 85 years and on it is 6.7 per 100,000. These rates drop slowly as Native Americans elderly age throughout their lifetime. These finding support the notion that suicidal thoughts may be present within this sampling population; however, the rates in the general Native American population are low.

Tucker, Wingate, and O' Keefe (2016) found that depressive symptoms were present only when there was a perception of discrimination among Native American participants. Whitbeck, McMorris, Hoyt, Stubben, and Laframboise (2002) would agree and found a strong association between discrimination and depressive symptoms. Whitbeck et al. (2002) also stated

that when Native American individuals are experiencing discrimination they are two times as likely to exceed the Center for Epidemiological Studies Depression Scale (CES-D) cutoff. Two measures often used when measuring depressive symptoms in Native Americans is the CES-D, in addition the Inventory to Diagnose Depression (IDD) is also used when researching with Native American populations.

In addition, researchers have examined which measures should be used to identify depression symptoms within Native American populations (Ackerson, Dick, Manson & Baron, 1990; Somervell, Beals, Kinzie, Boehlein, Leung, & Manson, 1992). Both groups of researchers identified the Inventory to Diagnose Depression (IDD) as a more consistent measure of depression symptoms; however, both groups of researchers agreed that more research needs to be done on the measure before concluding its superiority over the Center for Epidemiologic Studies Depression Scale (CES-D).

Center for Epidemiological Studies Depression Scale (CES-D) has been examined in relation to its sensitivity and specificity to the DSM-5 diagnosis of MDD. Stansbury, Ried, and Velozo (2006) found that the specificity of the CES-D was good, whereas the sensitivity to a depression diagnosis was moderate. The researchers also found that the positive affect questions did not lend support to a depression diagnosis and they suggest that the CES-D be modified. Carleton et al. (2013) also supported the notion that the CES-D be shortened, and the positive affect questions be eliminated. The researchers added that they had the lowest inter-item correlation on the CES-D with the clinical sample that they had tested. Furthermore, Carleton et al. (2013) reported that having a 14-item, three-factor model would be more congruent with the current diagnostic criteria of MDD. The CES-D has been examined multiple times with its contingency with the DSM-5 diagnosis of MDD; however, it is still used frequently in research

to get a broader understanding of individuals depressive symptoms. Researchers caution using the CES-D for a diagnosis of depression or MDD.

Many researchers (Kim, DeCoster, Huang & Chiriboga, 2011; Somervell et al., 1992) have examined using the CES-D with Native Americans. Specifically, they examined the factor model of the CES-D and how it maps on to the symptoms that Native Americans may present. Somervell et al., (1992) found that the four factors of the CES-D include depression, positive affect, somatic and retarded activity, and interpersonal. The researchers stated that a four-factor model can be utilized with the NA populations, however, the researchers added that combining positive affect and somatic and retarded activity may be better suited for the NA population. Additionally, the researchers mentioned that there was a high correlation between positive affect and somatic factors. In contrast, Dick, Beals, Keane, and Manson (1994) reported that the CES-D should be collapsed into three-factor model; however, somatic complaints and negative affect should be combined into one factor. In contrast, Billow (2008) identified a two-factor model, through her study of Native American older adults, which includes 1) depressive affect and somatic signs, and 2) positive affect. Her findings may be a consideration within the current research given the population being studied is the same.

Iwata and Buka (2002) also added that Native Americans are more likely to express positive symptoms. The researchers believe that Native American's wanting to maintain group harmony, so they are more likely to express positive symptoms. This research is interesting when comparing it to fellow researchers concerns about the utility of the positive affect scale. When considering the utility of the positive affect scale within the CES-D and the higher endorsement of these items with Native Americans it becomes concerning about its utility when doing research with Native Americans. However, the CES-D is often used when examining depression

populations, specifically Native Americans, and is widely used in research. Most researchers caution its use to diagnosis individuals with depression. For the purposes of this research study the CES-D will be used in conjunction with the DSM-5 diagnosis of depression when evaluating the transcripts.

### **Depression in Elderly**

Depression in elderly is often impacted by a variety of factors. Depression can often be influenced by psychosocial aspects of elderly's lives (van't Veer-Tazelaar et al., 2007; Hagedoorn et al., 2001). Depression is most often found within elderly who are also have a physical illness (Alexopoulous, 2005; Noel et al., 2004; Orfilia et al., 2006; Hagedoorn et al., 2001). Depression in elderly is also most often correlated with a stressful life event (Kraaij, Kremers, & Arensman, 1997). In regard to psychosocial effects on depression, Hagedoorn et al. (2001) reported an increase in distress among women when their husband and themselves were ill. The researchers found that within women their psychological distress was also affected by their husband's illness. Whereas within men their psychological distress was only affected by their own illness, not when their wives were also ill. The researchers found that spouse's illnesses, specifically within women, impacted their own psychological distress. Additionally, van't Veer-Tazelaar et al. (2007) discovered that elderly persons (>75 years-old) whom were diagnosed with depression were depressed because of aspects related to old age, including afraid of falling, and being alone within their house. These are some examples of psychosocial aspects that affect elderly depressive symptomatology. Depression in elderly can also often be correlated with physical illness. Orfila et al. (2006) found that women tended to live longer, however, they reported a higher prevalence of chronic conditions. Additionally, they were more likely to report depression symptoms than men. Furthermore, Noel et al. (2004) also found that

depression often happens in conjunction with other psychiatric and physical illness within older adults/elderly. The researchers found that as depression severity increased the quality of life and physical and mental function within older adults decreased. Additionally, depression severity made a larger impact on mental functioning status, disability and quality of life than medical illness comorbidities. Alexopoulos (2005) also discussed the connection between medical illness and depression, however, they also stated that stress is linked with medical illness and depression. Alexopoulos (2005) also discovered that the onset in elderly populations is less likely to be related to family history. Furthermore, the researcher found that later life depression often arises when faced with psychosocial adversity, chronic medical diseases and disability. These conditions have been found to influence depression within the elderly population. Additionally, stressful life events within an individual's past have shown to cause depressive symptoms. Kraaij, Kremers, and Arensman (1997) found that stressful and traumatic life events have impacted elderly persons' depressive symptoms. The researchers found that there was a significantly correlation between life events that occurred within late adolescents/adulthood and depression. However, the researchers discovered that events that occurred during late adolescents/adulthood did not account for all the high depression score. Additionally, the researchers identified that stressful life events that happened during late adolescents/adulthood and recent life events accounted for the high depression score on the measures. Stressful life events included, problems with friends and family, convicted and sentenced to jail, financial worries etc. Finally, the researchers mentioned that the depression seen within elderly populations can be accounted for past stressful life events in late adolescent/adulthood and recent events that have happened within the last year. Many variables can impact the onset of depression within elderly populations including, psychosocial aspects, physical illness, and

stressful life events. Some of these factors are seen within Native American populations, whom are expressing depressive symptoms.

### **Depression in Native American Older Adults and Elderly**

Depression in Native American elderly persons have far less research than in the general population. Jackson and Chapleski (2000) noted that depression in Native American elderly is overlooked in research and that there needs to be more examination into the reasons why Native American elderly have depressive symptoms. Some researchers have examined the utilization of IHS services with individuals who are diagnosed with depression. John (2004) reported that IHS services are difficult to reach if one does not live on a reservation and they are also severely underfunded which makes it difficult to acquire services at the IHS locations. Novins, Beals, Croy, and Manson (2008) reported that 51.3% of individuals diagnosed with depression have utilized IHS services in the past. John (2004) also mentioned that if one tries to acquire services at IHS for depression they might not be culturally sensitive. The researcher also mentioned that somatic symptoms may manifest more so within Native American populations than with the general population. John (2004) reported that depression is the most prevalent health problem among Native American elderly. Goins and Pilkerton (2010) investigated the comorbidity between depression and other difficulties that Native American elders have experienced. The researchers found that an increase of depression symptoms was correlated with higher comorbidity scores, which included, poorer physical health, old age, and interpersonal mastery. They found a high score of comorbidity between depression symptoms and physical conditions that elderly are experiencing. The researchers also mentioned that Native American elderly tend to not live as long as the elderly in the general population. The comorbidity between depression and poorer physical health was also explored within elderly persons in the general population

and the research has shown that there is a correlation within both cultures. Finally, Chapleski, Kaczynski, Gerbi and Lichtenberg (2004) found that stressful life events have a connection with depression in Native American elderly persons. Additionally, the researchers noted that the short-term effects of stressful life events impact the mental health of Native American elderly. The researchers also discovered that poor physical health affects depression. Furthermore, Chapleski et al. (2004) found that prior depression emerged as the strongest predictor of continuing depression. Furthermore, these findings are like the dominant cultures findings about stressful life events having an impact on depression symptoms. Previous research in other cultures has shown that poor physical health and stressful life events can have an impact on elderly persons within the general population. Some research examining Native American elderly populations have also shown to have similar results compared to the general population (Jackson & Chapleski, 2000). However, there are more aspects that influence depression in Native American elderly population that need to be further examined to get a better understanding of what depression is in Native American elderly populations. Additionally, there may also be protective factors that may prevent Native American elderly from developing depression that have yet to be examined.

### **Resilience**

Bonanno (2004) stated that resiliency is the ability to maintain stable psychological and physical functioning when dealing with a highly distressing event. Additionally, Stout and Kipling (2003) stated that resilience is when an individual “spring backs for adversity” regardless of the emotional, psychological, and physical distress. Zautra, Arewasikporn, and Davis (2010) defined resilience as the adaptive response to adversity, with a focus on recovery, sustainability, and growth. For the current study, I will be using Wallace and Swaney (2009)

definition of resiliency which is defined as a process of adaptation. The researchers further explain that within resiliency there is both a presence of adversity and positive adaptation that utilized within the individual regardless of the adversity.

Resiliency factors vary depending on the group that is being researched. Russell and Richards (2003) identified resiliency factors in lesbian, gay, and bisexual (LGB) individuals as movement perspective, confronting internalized homophobia, expression of emotions, successful witnessing, and a LGB community as resource. These factors may be similar to other marginalized groups and should be considered in conjunction with the current research. According to Wells (2009) resilience factors in older adults are strong social ties, low household income, good mental, and physical health. These resiliency factors should be considered in conjunction with the participants of the current study because the participants are older adults. Additionally, Black and Lobo (2008) found that resiliency factors in family are positive outlook, family member accord, flexibility, family connection, spirituality, family time, financial management, and support networks. These resiliency factors that fall within familial level should also be examined in conjunction with the current study examining Native American older adults.

Masten (2001) argued that resiliency is an adaptation that occurs naturally among ordinary human adaptive responses. She added that resiliency is one of our many adaptation processes that we develop as children. Rutter's (1985) definition matches Masten's (2001) but he also believed that resiliency depended upon the individuals' assessment of the situation and tools they had to adapt to any given situation. Chawla, Keena, Revec, and Stanley (2014) found that children who played in naturalistic environments (e.g., wooded areas, green fields, etc.) developed resilience more frequently than children that did not. Southwick, Morgan,

Vythilingman, and Charney (2005) observed that resiliency factors in adolescent youth were increased when adolescents had a resilient mentor who supported them. These resilience factors in youth can be found in adults who have also experienced adverse events. However, one must take into consideration Masten's (2001) argument that resilience factors are common and ordinary. Ardel, Landes, and Vaillant (2010) researched the long-term effects of heavy combat on veterans and their overall well-being. They found that the more resilient veterans experienced personal growth when they had been faced with severe stress and crises. In contrast, non-resilient individuals exhibited negative physical and psychosocial health consequences. Additionally, Bonanno (2004) reported that positive emotion and humor is often used in conjunction with a negative event and individuals who display these positive functions tend to adjust better over time. Wingo, Wrenn, Pelletier, Gutman, Bradley, and Ressler (2010) found among their sample of highly traumatized African Americans, those subjects that displayed resilience factors experienced fewer depressive symptoms than those who did not exhibit resilience factors. Their research shows that many individuals who experience trauma may be able to combat the negative effects from the trauma if they are resilient.

Zautra, Arewasikporn, and Davis (2010) stated that resilience can be identified at both the individual and communal levels. Resiliency will be examined more specifically at the individual level; however, given that Native Americans tend to be a collective, resiliency within the community itself may also be identified within the current study. In addition, Ahmed, Ratele, and Bawa (2009) examined resiliency factors that may lessen the use of violence in communities. The resiliency factors that are focused on to decrease violence are also factors that should be focused on when learning to create a cohesive community for Native Americans. The researchers found that resilience factors like efficacy, supportive relationships, and communal

cohesion are important components to decreasing the use of violence within community. Wells (2009) identified a supportive family as a predictive factor of resilience among older adults.

These three levels, individual, familial, and communal, can be applied to working with Native Americans to increase resiliency among Native American clientele.

### **Resilience with Native Americans**

Many researchers (Cross, 2003; HeavyRunner & Morris, 1997; LaFromboise, Hoyt, Oliver, & Whitbeck, 2006; Stiffman, Brown, Freedenthal, House, Ostmann, & Yu, 2007; Stout & Kiplin, 2003; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002) have examined resilience and how Native Americans exemplify this phenomenon. Most often they have identified culture as being a highly contributing factor to resilience among Native Americans. Cross (2003) stated that culture can be used as a source of healing for Native Americans. Additionally, Stout and Kiplin (2003) stated that culture is an important part of resiliency in Native Americans and it is learned through ceremonies and parent-child interactions. The researchers go on to discuss how culture affects the way a Native American interacts within the world and how a Native American continues to formulate their identity. Whitbeck et al., (2002) found that Native American individuals that participated in cultural practices were less susceptible to depressive symptoms and less effected by discrimination. Additionally, HeavyRunner and Morris (1997) discussed the importance of tribal identity, oral tradition, spirituality, elders and ceremonies to be important components to resiliency within Native American individuals. LaFromboise et al., (2006) found that community, culture, and family were protective factors among their sample of adolescent Native Americans. However, the researchers identified perceived discrimination as a risk factor that can negatively affect the resilience of Native American youths. Additionally, Stiffman et al., (2007) found that Native

American adolescents who lived on the reservation had less perceived individualized strengths than the Native Americans who lived in urban communities. The researchers also found that Native American adolescents who lived on the reservation discussed more tribal strengths than individual strengths. Overall, it appears that research is finding that culture is important to consider when examining resiliency among Native American.

### **Resilience and Depression among Native Americans**

Resilience in Native Americans elderly populations specifically targeting depressive symptoms has not been examined as frequently as depression in Native American elderly. For example, Kaufman et al. (2013) found that spirituality had a benefit in reducing depression. However, Kaufman et al. (2013) found that it differed depending on the tribe. In addition, Rybak and Decker-Fitts (2009) reported several spiritual practices (e.g., pow wow, sweat lodge, smudging, and story-telling) Native Americans participate in that have been beneficial in protecting themselves from the negativity of the world.

In addition, Grandbois and Sanders (2012) stated that elders discussed cultural resilience as a community with cohesive families that combined to create a strong support system. Whitbeck et al. (2002) found that perceived social support was a protective factor among Native American elderly who might display depressive symptoms. Whitbeck et al. (2002) reported that Native American elderly that participated in traditional practices, liked speaking their language, and attended pow wows were less likely to exhibit depressive symptoms. In addition, the researchers stated that the traditional practices can vary (e.g., beading, hunting, understanding cultural traditions) and can have a positive influence on the individual. Bals, Turi, Skre, and Kvernmo (2011) found that cultural factors resulted in a significant decrease in negative externalizing and internalizing symptoms in Native American adolescents. From the above we

can see that cultural factors are important protective factors among Native American individuals who are at risk for experiencing depression. However, more research needs to be completed to get a better understanding of how these protective factors and resilience can continue to ameliorate depressive symptoms among Native Americans.

### **The Current Study**

A review of the literature thus far has provided support for an increased need for research in the Native American older adult and elderly populations, specifically in depression symptomology and protective factors. The current study explored how one sample of Native American older adults and elderly conceptualized depression and potential protective factors against depression. Major depressive disorder (MDD) is characterized as having a depressed mood most of the day, diminished pleasure or interest in most activities, significant weight loss or weight gain, insomnia or hypersomnia. The symptoms also include psychomotor agitation or retardation nearly every day, fatigue, feeling worthlessness or excessive guilt, diminished ability to concentrate, and recurrent thoughts of death or suicidal ideation. These symptoms must be present for at least two weeks and must include either a depressed mood or a loss of interest in almost all activities within that period (American Psychiatric Association, 2013, p.160-161). The current study took a qualitative approach in order to immerse ourselves within the data. Additionally, the current study examined the data from a westernized viewpoint. However, the current research included individuals who identify as being Native American into the data analysis process to decrease the westernized viewpoint that could potentially overshadow the Native American cultural presence.

### **Method**

The current goals of the study are to explore

- A) Do Native American older adults and elderly discuss symptoms of depression?
- B) If so, how do they discuss symptoms of depression?
- C) Additionally, if they report experiencing symptoms of depression do they report experiencing suicidal thoughts?
- D) If they report depressive symptoms, including suicidal thoughts, do they also identify any protective factors that may reduce the effects of depressive symptoms?

### **Participants**

The data from these participants were collected from the Native American Resilience Project (NAR; Wallace & Swaney, 2009). The current study included 11 Native American adults (8 females and 3 males). The participants were aged from 50-79 with a mean age of 62 years. The participants were living on a reservation in the Northwest United States. In the original study the participants were recruited through senior centers on the reservation, flyers, newsletters, local papers, radio advertisements, word of mouth, and flyers posted at powwows.

Approximately 18% of the participants were married and the other 82% were single (27%), divorced (27%), or widowed (27%), and 55% of the participants lived with their spouse or other family members. Over 60% of the participants earned less than \$25,000 a year. For more demographic information, please see the Table 1 below.

### **Materials**

**Transcripts.** Transcripts from the 11 participants were analyzed using the NVivo 12 qualitative software. There were also colored markers provided and worksheets that were filled out for the first interview that is coded. Additionally, a computer was also used with the NVivo qualitative software downloaded onto it.

**Procedure**

The Research Team gathered and together read their own individual copy of participants' interviews, beginning with Participant #1. We read the interviews fully before starting to code. Colored pens were provided and together we identified sentences that answer the research questions. We color coded the first interview together. The subsequent interviews were coded using NVivo 12 software, while we were all together in one room on one computer that was projected onto a overhead. Once the passages, sentences, and words are identified that answer the question then we re-examine what has been previously found for underlying concepts that were not previously explored. Throughout this process, we continued to update our conceptual understanding of what the data is describing. The concepts were continuously compared to each other so that the underlying themes would become present throughout the coding process. The codes were further grouped into categories, including words or phrases that the Native American older adults and elderly used to describe depressive symptoms. Furthermore, the core categories started to emerge as we continued to move on to other interviews. Finally, we looked back at the categories that have been found and examined them in order to identify core categories that had developed from the data in order to answer the research questions.

**Research Team**

A qualitative data analysis was conducted by a research team consisting of students, a faculty member, and a primary researcher. The students are both undergraduate and graduate students at the University of Montana. All members of the Research Team did completed the Collaborative Institutional Training Initiative (CITI), which is an on-line human subject protection course, specifically the Social and Behavioral research course. This course teaches researchers about privacy and confidentiality, informed consent, ethical principles, and the

definition of research. One of the primary researchers from the Native American Resilience project, Dr. Gyda Swaney, will be participating on the research team throughout the analysis.

**Primary investigator.** I will be the primary investigator of this research study. Currently, I am a fourth-year doctoral student in the clinical psychology program. I am a part of the Mohawk tribe from Akwesasne, New York. I am interested in returning to my home reservation to provide treatment to my people. I am interested in depression and suicide research because of the incidences that I have witnessed on my home reservation. I am particularly interested in NA older adult populations because this group has not been researched as heavily as other NA age groups. It is also important to consider given the lower incidence rates of suicide in this age range when compared to the general population. However, there are higher incidence rates of depression within this age range. Furthermore, there is much speculation on the incidence rates of depression within Native American older adults and elderly because of the difficulty in measuring depression symptoms in NA populations. When measuring NA populations, one must consider the use of westernized measurements tools on this population, which may create bias in data that is collected from this population.

**Presence of Native American's perspectives.** Additionally, two Native American graduate students were recruited to provide an outside perspective on the coding process periodically throughout the coding process in order to minimize coding bias. We met regularly throughout the coding process to maintain a low level of coder bias. Specifically, they assisted in identifying the themes or concepts within the data are answering the research questions.

**Research assistants.** Three undergraduate research assistants were part of the coding process. These students were recruited through the InPsych Scholar program. All three students

identified with being Native American and assisted in the data analysis. Native American research assistants were needed to provide an additional cultural perspective on the data analysis. Having multiple coders reduces the likelihood of coder bias (Sipes, 1976). The coders met frequently throughout the process to collectively agree on concepts and themes that emerge throughout the analysis.

### **Data Analyses**

The current study used a qualitative methodology to analyze the archival data. Corbin and Strauss (2015) describe qualitative research as being flexible and open to possibilities.

Qualitative research builds on the coders continued interaction with the data and the concepts that are being explored. A Grounded Theory approach was employed. Creswell (2012) describes Grounded Theory as using a process or action to generate or develop a theory based on the data. The researcher develops a theory or an explanation from the data of a group of individuals. The theory is therefore grounded in the data and is discovered by investigating every aspect of the data that was collected.

**Coding.** Using Corbin and Strauss (2015) and Charmaz (2006) suggestions the research team will read the whole interview before starting to code any part of the interview.

**Initial coding.** The Team's first review identified all sentences, passages, and phrases that describe any of the diagnostic criteria for MDD include having a depressed mood most of the day, diminished pleasure or interest in most activities, significant weight loss or weight gain, insomnia or hypersomnia. The symptoms also include psychomotor agitation or retardation nearly every day, fatigue, feeling worthlessness or excessive guilt, diminished ability to concentrate, and recurrent thoughts of death or suicidal ideation. These symptoms are present for at least two weeks and include either a depressed mood or a loss of interest in almost all

activities within that period (American Psychiatric Association, 2013, p.160-161). The Team's second review identified all sentences, passages and phrases that describe protective factors.

***Focused coding.*** Words and short phrases were identified that answer the research questions. Those words or short phrases that describe depression include; for example, "I guess I don't like to be alone too long. Then I start thinking about, about other things I guess." Secondly, those words or phrases that might include protective factors might include, "Well, you know, talking to the Elders around here, too, that helps, too, because they know a heck of a lot than we do because they've lived longer." The concepts were constantly updated depending on the data which changed depending on the concepts found within the other interviews. Overall, the coders updated their conceptual understanding as they move forward in the data. The concepts were always compared to each other to understand the underlying themes present within the interviews.

***Axial coding.*** The codes (words, short phrases) were then grouped into categories. The categories included the words or phrases that the older adults and elderly Native Americans used to describe their depressive symptoms. Furthermore, these categories also included the words or phrases these individuals used to describe protective factors. NVivo 12 allows us to look at how the focused codes are related, connected, or overlap with each other and group in categories.

***Selective coding.*** Through this process the core categories emerged and were identified. The core categories are culture, social support, and self-regulation. These core categories emerged from the codes and categories that developed after the analysis.

This process was continued until no new codes are found within the interviews, which is called saturation. Saturation was reached after 11 interviews were analyzed. The data has reached saturated, when no new codes or themes are likely to be found within the subsequent

interviews. After the interviews, have reached saturation, the researcher re-examines axial codes and how they fit into different categories. Guest, Bunce, and Johnson (2006) examined interviews in order to get a better idea when saturation is likely to occur. They found that 92% of the codes were found within the first 12 interviews. The researchers discovered that after the first 12 interviews, codes were found more infrequently in the remaining sets of data. The data are then examined to see how they fit into the overarching core categories of data.

**Criteria of rigor.** Lincoln and Guba (1985) describe four criteria that needs to be considered when analyzing qualitative data. These include: Credibility, Transferability, Dependability, and Confirmability. Credibility is described as the researcher being confident about the results that they found within the study. This is similar to internal validity in quantitative studies. Procedures to achieve credibility would be prolonged engagement, persistent observation, peer debriefing, negative case analysis, referential adequacy, and member checking. Some of these procedures were utilized within the research team during coding of the data. Specifically, prolonged engagement, peer debriefing, and member checking. Prolonged engagement involves investing a sufficient amount of time with the group and peer debriefing involves discussing the investigators hypothesis with a peer who is willing to question the investigators justification for their hypothesis. Additionally, member checking includes presenting the conclusions that were drawn from the data to the group whom originally participated in the study and receiving additional input about the conclusions drawn.

Transferability is when the researcher provides a detailed description of the data so that readers can apply this data to other situations if they feel the need. This is similar to external validity in quantitative research. The procedure used to facilitate this is to provide a thick description, with detailed information about the process that the researcher went through to

arrive at the conclusion. This will be done within the methods and results section within this paper. This process is not the researcher's task it is the reader's task to come to the same conclusion from the researcher's detailed account of the data.

Dependability is when the research can be replicated and the results will still arrive at the same conclusion. Dependability can be achieved by continuously monitoring and documenting everything that the researcher is doing, so that if a reader wanted to replicate the study they would have the ability to do so.

Confirmability within the data happens when there are no biases affecting the overall findings within the data. The results of the data are solely based on the data itself and not the researchers bias. The procedure often used to decrease confirmability would be to have somebody audit the data. This researcher had another graduate student audit the data in order to increase the confirmability of the data. This will provide the researcher with an understanding about whether there is bias within the conclusions of the data.

**Analysis of research questions.** Depression in Native American older adults and elderly has not been examined with a qualitative data analysis approach. Some research studies (Chapleski et al., 2004; Goins and Pilkerton, 2010; Jackson & Chapleski, 2000; John, 2004 ) have briefly examined depression among Native American older adults compared to their general population counterparts (Burwell, McSwain, Frazier, & Greenway, 2014) but this research has not examined how depression is discussed among Native American elderly. Little research (Chapleski et al., 2004; Jackson & Chapleski, 2000) speaks to the results that are likely to be found within the present study.

Currently, the first question that will be asked is whether Native American elderly discuss symptoms of depression. The first question needs be answered before the following two

questions can be further examined. If Native American elderly do discuss symptoms of depression, then how they discuss symptoms of depression can be examined. Following this analysis, the presence of suicidal ideation or suicidal thoughts will be explored within the data. That will be again be explored by examining phrases, sentences, and words that express the presence of suicidal ideation, suicidal thoughts, and/or suicide attempts. Finally, if they do discuss suicidal ideation or suicidal thoughts, what protective factors do they utilize to prevent them from completing the act. Passages, sentences, and phrases will again be examined and noted if they have to do with protective factors that prevented the individual from completing suicide and/or making it through a depressive episode.

### **Analysis**

#### **Initial Coding**

Charmaz (2006) discussed initial coding as going throughout each interview and identifying; word-by-word, line-by-line, and incident-by-incident. The InPsych research team comprised of NA undergraduate students Jacinda Morigeau, Stephan Chase, and Alyse Laststar and NA graduate students Ashton Smith and Matthew Croxton who checked and coded the data.

The interviews were an archival data set that had been collected from a previous study (Wallace & Swaney, 2009). The interview questions that were asked in the original study were focused on coping skills that these individuals utilized throughout their lifetime. These questions were beneficial in understanding the protective factors that these individuals had developed throughout their lifetime. However, when we examined depression symptoms it was difficult to find codes that discussed depressive symptoms throughout these interviews. This will be discussed further in this document below.

Throughout this process the researchers read through the interviews and identified words, sentences, and passages which are associated with symptoms of depression and protective factors. We coded these interviews through NVivo 12 which allowed us to differentiate the codes into a variety of categories that were related to symptoms of depression and protective factors. Questions related to the data were frequently assessed throughout this process and were continually discussed amongst the research team. This was utilized in order to continuously assess for what categories were emerging from the data and whether those categories fit within the data. This process combined the use of initial coding and focused coding to further identify and narrow down specific codes that fit within the different categories that emerged from the data. These codes were reduced from larger paragraphs to sentences that explained the symptoms of depression and protective factors. The data was first broken down into the four component parts based upon the four questions that were asked by this researcher (i.e., discussing symptoms of depression, symptoms of depression, suicidal ideation, and protective factors). Moving through the interviews the research lab team read through the interviews and identified words, sentences, and paragraphs which coincided with each of the four questions within NVivo 12 and categorized them into the corresponding categories.

Upon completion of the paragraph identification the larger passages were reduced to shorter and similar codes that were grouped into the four categories (i.e. yes/no depression, symptoms of depression, suicidal ideation, protective factors/coping mechanisms). The principle investigator and research lab team further discussed emerging themes, implicit actions/meanings, and significance of points made throughout the interview and how these fit within the four categories. The categorization of the DSM-5 and difference between protective factors and coping were discussed throughout this process. We decided that since this research study was

focusing on protective factors among these individuals, we would focus our attention on protective factors instead of coping mechanisms and therefore did not code for coping.

The principle investigator and research lab continuously discussed the individuals experience with depressive symptoms and what they look like in this population. Similarities and differences with the DSM-5 and these NA responses were discussed among the research team and principle investigator. We discussed the research along with the approach that was taken when examining the individual's responses.

Upon completion of initial coding of the interviews, additional analysis was conducted using QSR NVivo 12 to search the document for codes that we may have missed during the initial coding. A word frequency search was completed on each of the 11 interviews to ensure that we did not miss any codes. Following the results of the word search, the results were discussed among the research team. No new categories were discovered in this step.

### **Focused Coding**

The initial coding had produced multiple codes that the principle investigator and research team had further differentiated into categories. Charmez (2006) discussed the next process of qualitative analysis as focused coding. Focus coding further differentiates the initial codes by identifying short phrases that answer each of the research questions. Charmez (2006) has discussed how focused coding is more directive, and selective. She further discusses how focused coding compares your initial codes with each other to start to lead to more focused codes, categories, and subcategories. The principle investigator and research team further discussed the importance of each four categories. The research team compared the codes within the categories and discussed the importance of codes, so that we could further identify adequate and useful focused codes.

The principle investigator and research team further developed the focused codes by comparing codes within the same interview (e.g., allowing extending family to help them through a tough time to data regarding belief in extending family) using the initial codes from the interview. Comparison of between interviews data led to the development of more focused codes (e.g., family, social support, etc.). Categories (e.g. protective factors, depression, etc.) and subcategories (e.g., family, social support, etc.) were further developed throughout this process.

Based upon the data, the research team and the principle investigator organized the focused coding into the following categories: within yes/no depression: symptoms of depression, depressed mood, fatigue, lack of pleasure, psychomotor retardation, sleep, thinking, weight loss or gain, worthlessness, suicidal ideation, suicide attempt, acceptance of circumstances, avoidance, culture, family, friends, hobbies, imagining, independent, laughter/humor, live in both worlds, nature, pets, school, sense of security, spiritual beliefs, strength, support to and from others, learning, thinking, values and beliefs, and working. These codes were compared to each other in order to further develop the categories and understand the underlying connections that are made between the codes. The following core categories were defined as social engagement, self-regulation, and culture. See the diagram A for further reference. Further refinement of these codes had led to the categories in which they are grouped.

### **Selective Coding**

Charmez (2006) discussed the emergence of codes within the data following focused coding. Charmez (2006) stated that the focus of selective coding is to further understand your data and the findings are meant to be integrated. Selective coding is meant to further understand your categories by utilizing your focused coding to develop a theoretical understanding of your

data. The principle investigator focused on creating categories that encompassed the subcategories that were developed through the process of analyzing the data.

The participants answered a series of questions throughout the interviews. The information related to depression and protective factors was identified and highlighted throughout the interviews (e.g. sentences, passages, and paragraphs). The information was shortened and labeled with the respective nodes/codes within the interviews. The nodes/codes were further differentiated among each other into categories that answered the four questions. The categories were further broken down into subcategories within their respective categories. For example, protective factors were further broken down into working, family, and culture. The depression category was differentiated from protective factors and examined in a similar manner to protective factors. The core category components were derived from the codes that emerged throughout this process. Finally, quotes from the interviews were selected to provide support for the categories and core categories that emerged throughout this process.

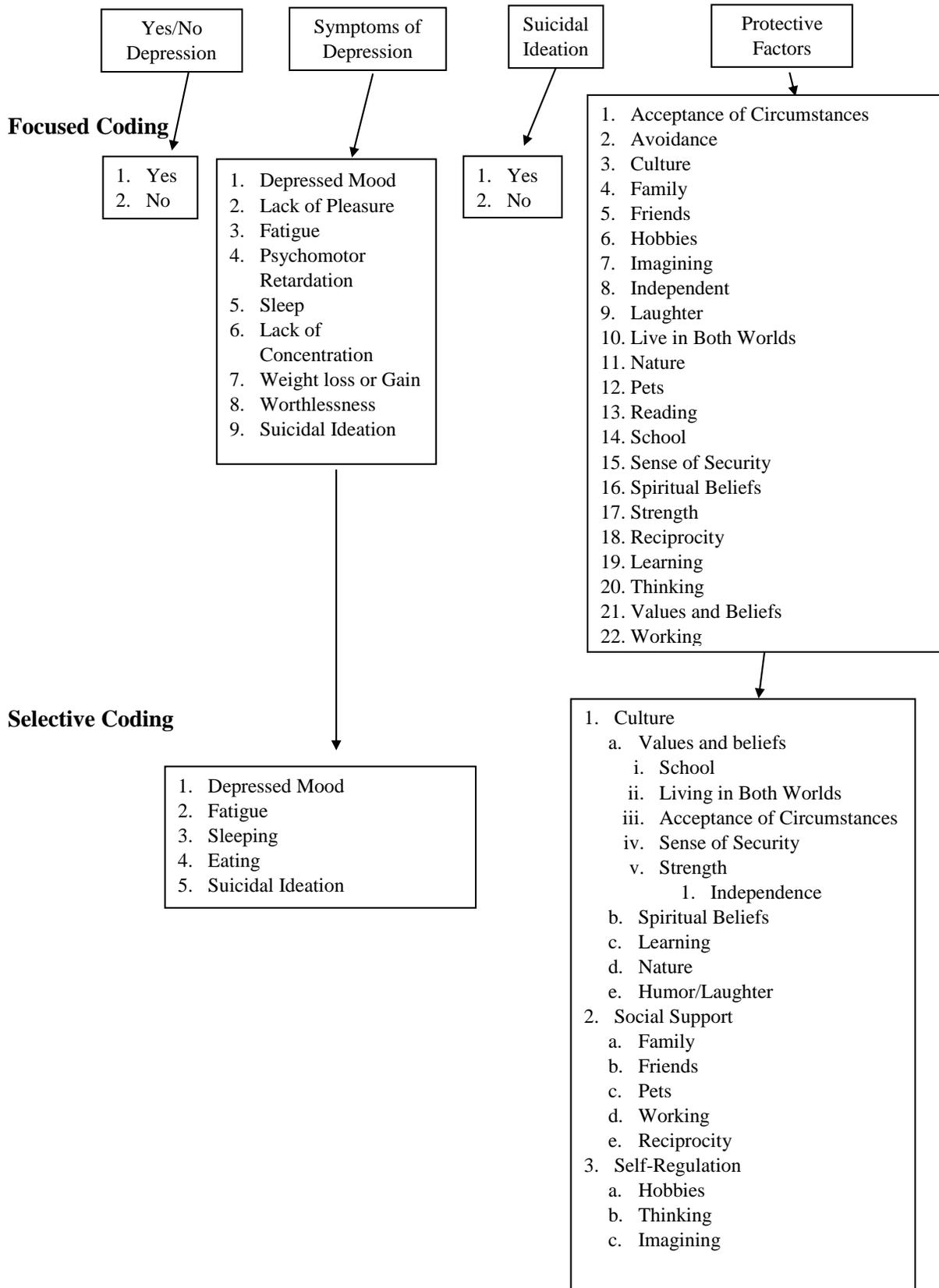
### **Axial Coding**

Charmez (2006) discussed how axial coding has received criticism and the lack of use amongst researchers. Furthermore, Charmez (2006) reiterates their point by discussing the lack of attention spent on axial coding in Corbin and Strauss (2015) latest edition of their grounded theory text. The primary investigator utilized axial coding as making connections between the codes and developing subcategories among the present codes. The categories and subcategories will be discussed in the following section.

Theoretical saturation is often reached when there are no longer any new codes that are found within the data. The data reaches saturation when no new codes or themes are likely to be

found within the subsequent interviews. The data was reexamined to further break them down into the following categories: focused coding into the following categories: within yes.no depression: symptoms of depression, depressed mood, fatigue, lack of pleasure, psychomotor retardation, sleep, thinking, weight loss or gain, worthlessness, suicidal ideation, suicide attempt, acceptance of circumstances, avoidance, culture, family, friends, hobbies, imagining, independent, laughter/humor, live in both worlds, nature, pets, school, sense of security, spiritual beliefs, strength, support to and from others, learning, thinking, values and beliefs, and working. The decision to stop examining further interviews was made by the primary researcher and research team after there were no new codes or themes found within the data. This was reached at interview nine, so the research examined two more interviews to make sure that no new themes were found in the subsequent interviews.

**Initial Coding**



## Results

### Depression

One of the questions that we originally sought to answer throughout this process was discussing whether this group of Native American older adults discussed symptoms of depression. Within the sample several individuals discussed symptoms of depression and one individual discussed a diagnosis of dysthymia throughout their lifetime. Many of the participants symptoms included having a depressed mood, fatigue, sleep, suicidal ideation, and weight loss. Throughout the coding none of the individuals discussed symptoms relating to a lack of pleasure, difficulty concentrating, psychomotor retardation or feeling worthlessness.

The participants discussed their symptoms of depression in a variety of ways. Within our research team we discussed the possibility that many of these individuals may have had a depressed mood and that they expressed it by feeling angry and upset. Feeling angry is often found in child and adolescents who have a depressed mood. The individual from interview 4 (female, 53) discussed feeling angry at her mother after her passing when she was a child:

I was really angry... and I blamed her for a long time being a child and not understanding what cancer was...I said I'm really mad at you MOTHER'S NAME for leaving the planet...

Another participant, a individual from interview 6 (female, 53), discussed having a depressed mood after her son was taken away from her and her difficult decision to give him to the social worker:

It's kind of like a, take the baby so you don't hurt my Mom, you know, or something like that, you know, I don't know. But there wasn't a day that went by that, or his birthday when it'd come up, you know, that I'd think of him or...cry for him sometimes.

Another example of depressed mood from this participant was when she discussed feeling lonely and how often start thinking about her past that would make her sad:

I don't know. I guess I don't like to be alone too long. Then I start thinking about, about other things I guess. Makes me sad, you know, and I don't want to... Maybe I think about the past too much, I don't know.

Both of these participants discussed their symptoms of depression and how they were impacted by the situations around them. Other participants were more direct in discussing how they felt down, that they would cry, or that they felt depressed. Each participant discussed having a depressed mood in a variety of different ways that were unique to their own experience.

Another symptoms of depression that was often discussed was feeling fatigued or having a lack of energy. An individual from interview 11 (female, 59) discussed how her daily hassles have impeded her ability to complete daily tasks and how she often has a lack of energy. "No, I don't think so, if I have enough energy to get my house clean, picked up... I just do what I can and when I can't do anymore, I just sit down." This woman discussed how her lack of energy has decreased her ability to be able to clean her house and get different chores done around the house. Furthermore, this women discussed previously in the interview how she was in an accident that caused her to not feel hungry. This made it difficult for her to live and how she had to push through that feeling.

A couple participants discussed having a difficulty sleeping and how that negatively impacted their life. An individual from interview 3 (female, 64) discussed how losing her son negatively impacted her life and the difficulty she had sleeping afterwards:

Plus I had to um, get on um, I couldn't sleep so I had a combination sleeping pill and depressant. I took that for about about (sic) a month...And then finally got some rest...

Additionally, another individual from interview 8 (female, 59) discussed having a difficult life and how she had trouble sleeping “I used to have a hard time sleeping but now I have just calmed—probably my age...”

Furthermore, the next symptoms that participants discussed was weight loss or weight gain. A participant who was the interview 4 (female, 53) discussed feeling depressed and how they would often eat because they had to “Actually I was really depressed for a while and I feed my body physically.” They individual further discussed how she would often eat because she should eat instead of her wanting to eat. This is an interesting way of describing what was going on with this participant during that time and how she was struggling with feeling depressed.

Finally, the last symptom of depression that was found was suicidal ideation. An individual from interview 2 (female, 50) discussed having thoughts of suicide in the past:

Ah, God. ‘Cause that saved me from suicide...It saved me from, um—‘cause I can honestly say, suicide, if I’ve thought of suicide, I think ah my grandkids don’t stop me from it, ah, but being able to talk to Creator is the thing that stops me from—ah because I won’t be able to see Creator if I do that.

This individual discussed a protective factor that saved her from completing suicide. She stated that her family was unable to save her from suicide; however, her religion, god or creator, was able to save her from completing suicide.

Throughout the process of this analysis it has become apparent that many individuals discussed protective factors throughout their explanations of how their depressive symptoms impacted them throughout their lifetime. Additionally, there were many individuals that did not discuss symptoms of depression; however, they discussed protective factors that positively impacted their life and helped them through difficult times.

### **Protective Factors**

The final question that we wanted to answer throughout this analysis was to identify protective factors that these individuals utilized to decrease the impact of depressive symptoms. The individuals discussed multiple symptoms that we divided into three separate core categories. The three core categories are social engagement, self-regulation, and culture. All three of these core categories will be further discussed.

**Culture.** The first core category that was identified through selective coding was culture. Culture was the name picked to encompass the following categories because of the different components of culture that each of these subcategories radiate. An example of culture for one individual from interview 3 (female, 64) was when she explained the importance of talking to her elders provides her strength. “Well, you know, talking to the Elders around here, too, that helps, too, because they know a heck of a lot than we do cause they’ve lived longer.” She further discussed the impacts of her culture and how culture has continued to give her strength throughout her life. The subcategories that were picked to fit within this core category were

chosen after careful deliberation between the primary researcher and the research team. The subcategories are as follows: values and beliefs, spiritual beliefs, learning, nature, and laughter/humor. Each of these subcategories describe a component of culture that was found within these Native American individuals interviews. This core category was found frequently among individuals within the current study and further emphasizes the importance of culture as a protective factor among these individuals.

The first subcategory that will be discussed within the core category culture is values and beliefs. The values and beliefs subcategory of culture envelopes five distinct subcategories. The following subcategories which are encompassed within values and beliefs are school, living in both worlds, acceptance of circumstances, sense of security, and strength. An individual from interview 1 (female, 51) discussed the importance of understanding her values and beliefs regardless of her stressors. “Um so I have stressors but you know what they just don’t matter, I think today I know what’s important in life and that’s what I am going for. I’ve not altered my values or anything like that.” She discussed the importance of having her values guide her regardless of her stressors that may be in her life. Another example of values would be an individual from interview 11 (female, 59) and her discussion of the importance of having a value and belief about what family should look like and how family will continue to guide them throughout life.

I mean, you have got to have, and see, that, you talk about you need, you need something. And we didn’t have that nurturing and caring and family ties. And I feel right now if children do not have the unity of family, they do not have that loving care from some place, then that is why they are on the streets, that’s why they are faking, that is why they are looking- they don’t know. There is not a doubt in my mind.

For her, family ties was an important value and belief that she had and she thought that if you did not have that similar belief you would end up on the streets. She believed that family ties provided one with a stable life. Furthermore, this interviewee discussed the importance of caring for others and supporting others, especially her children. She continued to discuss how caring for others, especially her family, provided her with strength and how that was an important value. This first subcategory that is distinct within the value and belief subcategory is school. School was important to a couple of interviewees that discussed the importance of getting an education.

Ah, I'm a very strong-willed person. I'm ah religious to an extent, I'm not a, a terrific church-goer, but I do pray all the time and do practice the Indian religion. I have sup— certain superstitions which probably would not fit ah regular religion, but ah they're okay with the Indian religion...and ah I think you just having a strong will and a good education, I think, was I was the third member of our tribe, I think to graduate from college...

This individual from interview 7 (male, 72) discussed how important it was for her to get an education and how that was formulated within her own belief system. This person is discussing the importance of school; however, she is also discussing how she was a strong individual and how that propelled her to be one of the few people who had a college degree from her tribe. Both of these distinct subcategories fall within value and beliefs; however, these categories often overlap with each other and are important to these individuals. One individual from interview 1 (female, 51) discussed their belief about living in both worlds and how that belief came to be from her parents.

well, I guess they gave me a lot of history they gave me a lot of history about, about our people, about our tribe, about what happened when white people came, they gave me a

lot of stories that happened in my family and said look this is the only way you are going to make it through this, this is the way that that you're going to be able to make some impact that you're going to be able to live in this world but you have to have an education, you have to learn how to deal with both, and this is the way you'll do it and so I trusted them so that's what I did.

For this individual, living in both worlds was a necessity for survival and how it wasn't an original belief. She stated that her parents taught her multiple things throughout her lifetime and this was one of them. Additionally, she talked about how going to school was something that her parents felt like she had to do in order to survive in a world that wasn't her own.

Acceptance of circumstances was another distinct subcategory within values and beliefs. An individual from interview 2 (female, 50) discussed how she accepted being overweight after she gained all of the weight she lost back. "...Ah, let's see I tried, ah that stomach, stomach thing-a-ma-jiggy, and lost 80 pounds and gained it back and—so I just have decided ah, even then I guess, that I was just going to be this way." She discussed how she slowly grew to accept herself and her difficulty with weight. She stated that she learned to accept herself as she is and that other people need to learn accept her too. This belief of accepting one's circumstances was something that she learned to do after trying many different approaches to dealing with her weight. She learned to accept her circumstances with her weight and grew more as an individual throughout the process, which became a protective factor.

Another distinct subcategory within values and beliefs is sense of security. An individual from interview 6 (female, 53) discussed she had a pretty good childhood growing up and how that belief transcended throughout her life.

No I, I think I had a pretty good childhood there. We were always happy, always well fed. You know, we always did something, we always rode horses all the time. And certain times of the year, um, my Dad and them, you know, like, Fall time, you know, they'd all get ready and would go camping across the river maybe for about a week two weeks. Go hunting and get deer meat, fish...can all that, you know, and for the winter, you know. Then during the summer that's what they did. Cut wood so we'd have wood for the winter, you know. All year long we had something to do, like now be out picking berries and stuff for the winter, you know.

She discussed having a sense of security among her family and how the different activities created it. She further explained how the sense of security she found within her family was something she wanted to impart onto the young people within her community. She discussed that not having somebody to talk to while growing up and going through difficulties made her want to support others around her and provide for her community members.

Finally, the last distinct subcategory that falls within values and beliefs is strength, which also encompasses independence. An example of both of these beliefs was discussed from the individual in interview 11 (Female, 79). She discussed the importance of believing in herself and how she will survive because of that belief.

And that is what ROMANTIC PARTNER saw in his mother and father, and I wasn't going to be treated that way. I was attracted to him-whatever did it, I don't know, like I said... But I married him and I had all of these children by him and they were going be raised more like I was then he was. I was gonna...yea and I was going to leave ROMANTIC PARTNER...not once, but several times...and I always had enough confidence in myself that whatever happens some way somehow I will survive.

She reported feeling confident in who she was, and she knew that if she left her partner she would be survive because she had been doing it for so long. She discussed the importance in having a belief in oneself and being independent can empower and individual. She provided a wonderful example of how these two categories can coincide with each other. These distinct subcategories that fall within value and beliefs further emphasize who these individuals are and how they make up one's own culture.

Another important protective factor within culture was spiritual beliefs. Native Americans within this sample discussed the interconnectedness they had between God and their Native American spiritual beliefs within the subcategory spiritual beliefs. Spiritual beliefs are encompassed within Native American practices and beliefs. An individual from interview 2 (female, 50) discusses how she would often read her prayer book and use sweet grass or sage in conjunction with each other when she was struggling with her anxiety symptoms. "yeah, that's what I do a lot of, actually is ah, I use my prayer books and I use ah sweet-grass, and um, sage, and pray in the morning and the evening—is how I been handling it." She goes on to further discuss how her faith became an important aspect of her life and how she uses it to overcome difficult challenges. Furthermore, this individual in interview 2 (female, 50) also discussed the importance of being able to talk to her parents even though they have passed away.

I guess being able to talk to my parents, even though they're deceased. I think I can talk to my parents. I ask them to help me everyday, I ask them to help my grandkids go the right way, um, I ask for, even though I still have a problem with ROMANTIC PARTNER, I still ask his parents to help him.

The spiritual belief that her parents will continue to be with her regardless of their physical presence has helped her through difficult aspects of her life. She discussed the importance of this

connection regardless of their lack of physical presence within this world. This spiritual belief that others are with her regardless if they are physically present is an aspect of this women's culture that we find occasionally across a variety of Native American tribes. Furthermore, another individual from interview 11 (female, 79) discussed the importance of God for her and how she feels like she wouldn't have been able to persevere if it wasn't for God.

And it's just a matter of time before Gods says 'ah, I've had enough of all this', and brings revelations. And its here, so. And, and I'm sure there isn't a doubt in my mind that if it weren't for God, the strength of knowing that there was a here-after, eternal life that (I) wouldn't have survived or fought or cared about anything.

Throughout most of her interview she discussed the impacts that her spiritual beliefs had on her life and how they got her through difficult times, like a terrible car accident. She discussed the negative implications of her accident and the how it affected her will to live, however, as time went on she learned to live with the changes in her life and continue to preserve because of her spiritual beliefs.

Learning was another subcategory encompassed with culture. An individual from interview 11 (female, 79) discussed how she learned her cultural practices from her grandparents and how they continued to be incorporated throughout her life. She discussed described how learning was a spiritual practice that was done with her grandparents.

And I remember grandpa and grandma LAST NAME at place when I was a little girl. They use to go hunting, and grandpa would go hunting on the weekends or certain times of the year and I was just a little kid, and they would, a group of them would go up in the mountains to get food, ya know....deer and stuff. And then, uh, grandma last name they

always had a garden, and she always had us picking and, and doing things like that...weeding...all of that stuff... Right. And learning to can and freeze, not freeze because they didn't freeze in those days. And then they had, the creek that ran down there, and I remember, grandpa had a, um, a place where he use to go and they'd come home from their hunting trips and they'd go out there and they'd be in the cold water and go into the tee-pees or into the hut...and it was a sweat hut and not being very old at the time, and now they do that now more than they ever did through my period of life there.

She described being taught these different practices when she was younger, however, she saw them as being spiritual as she became older. The practices that she described provided her with a sense of belonging that she didn't feel like she had throughout her childhood. She further describes her childhood in the following statement...

And my mother was married to a, a LAST NAME, and I have a FIRST NAME LAST NAME who was, works for the tribe. Who worked for the tribe, she retired now...And she is a half-sister. And then I have a half-brother and a half-sister. My mother married a LAST NAME. And so, I have a half-brother and a half-sister there. So, we didn't see much of family ties like I say, I was the oldest of all of these children...My mother had eight children...And to be accepted for not feeling like a handicap to them. I always felt like I was there because there wasn't any place to put me. Um, that I felt inadequate, never really—Grandma LAST NAME use to make me feel, you know, pretty comfortable.

She did not feel like she had a sense of belonging within her own family, however, she felt like she did when she was with her grandparents. She stated that the sense of belonging from her grandparents that she felt along with the learning of these practices, they provided her with a

protective factor that influenced the way that she approached her life as she got older. She also discussed the connection to nature that her grandparents tried to instill on her at a young age and how that is a component of her culture. She eloquently discussed the importance of learning from her grandparents, and nature that her grandparents tried to instill in her at a young age.

Furthermore, an individual from interview 5 (male, 65) discussed the importance of nature on his life and how that was a protective factor for him.

I don't know I just love it up there in the woods being there, same way with my buddy that just died he always liked it in the woods he didn't like the crowds. We would get way up there on the hill, up there past the canal. There was a house up there in the woods it made me feel good, too; family got their family plot right there up in Ronan. But the way he like to be by himself in the woods all the time they let him his family let him be buried up there. Up on the hill there in his own kind of own little private plot there well he always liked didn't like crowds and he always liked to be by himself working all the time he was right up there in the wood by the trees. I thought that was really nice.

For him, the woods are a place for him to feel comfortable and place he could go to if he felt like he needed it. After some time it became a protective factor for him and he started to realize how important it was to him. Additionally, he discussed how it wasn't only him who viewed the woods as a protective factor but also his friend who passed away. Nature falls within the culture because for some individuals it is a cultural component. This was displayed from the individuals from interview 11 (female, 79) and interview 5 (male, 65).

Finally, the last subcategory of culture was laughter/humor. The subcategory encompasses multiple instances where individuals had to use laughter to cope with difficult subjects that they were talking about throughout the interview. Many individuals would often

laugh after they discussed a difficult situation that they have experienced. An individual from interview 3 (female, 64) diverted her attention from the interview after discussing her brother completed suicide. The individual from interview 3 (female, 64) said “look at those birds over there I didn’t even notice them. (laughter).” For some interviewees they had similar instances within their interview and it’s important to note that for these individual’s laughter was a way to take a break from the seriousness of the interview. The seriousness that many of these individuals faced was combatted by laughter and incorporating laughter into their lives, which is a part of their culture. Each subcategory has a important implication for culture and how these subcategories are interwoven throughout the culture of these individuals.

**Social support.** The second core category that was identified through selective coding was social support. Social support was the name picked to encompasses the following subcategories because of the importance of social interaction within each of these subcategories. Each one of the subcategories discussed the importance of social interaction with the individuals who described the importance of these subcategories. This category comprises of the following subcategories: family, friends, pets, working, and support to and from others. The subcategories were identified to fit within his core category after careful consideration of the focused codes that comprised of each of the subcategories.

Family was a subcategory within social support that was present within many of the individual interviews as a protective factor. An individual in interview 1 (female, 51) discussed how her extended family helped her when she was stabbed from a romantic partner:

Yeah, I think it was successful I think, um, in the beginning I don’t think I could cope with the horror of it for starters, um and as I checked out I guess my extended family checked in and helped me through that so in that way it was effective, I had a lot of people around me

who loved me who circled me with their love with their strength and helped me through that, a lot of friends.

The women continued to discuss how her family has always been there for her during difficult times and during times of growth. She stated that she believed her family should be around her, and further discussed the impact her family had on her life. Many individuals had expressed similar stories of support from their family as protective factors.

Another protective factor that was within the core category, social support, was the subcategory friends. Many individuals discussed the impact that friends had on their lives and how important it was to have the connection to others as a protective factor. The following individual from interview 10 (female, 62) discussed the difficulties she faced while living in her aunt's house. She stated that her aunt would care more about her own son than her and she often felt underappreciated in the house and that she felt wanted when she went to spend time with her friends.

Um hmm...I could...I...I could...I could go to my friends' homes and I could...I got along really well, I had a lot of wonderful support from my girlfriends' families and my girlfriends.

She discussed the importance of having the support from her friend and how that support helped her through the difficult time at her aunt's house. She further discussed how she felt like she could be herself at her friend's house and was cared for by her. This example shows how powerful friendship can be in these individuals lives and how they gave this participant the strength to be herself in a situation where she had to limit herself. She discussed the importance

of friendship as a protective factor in her life. This category falls within social support because of the interaction that is engaged in when one visits with another individual.

Furthermore, pets was another subcategory in the core category of social support. Only a few participants discussed the importance of pets on their lives. One participant from interview 10 (female, 62) discussed how the importance of her grandmother and her pets, specifically her cats, provided her with strong solid support throughout her life.

Well, I, I think my grandmother was a very strong influence in my life and so I always just focused on her and her life. And then I had animals, and I loved cats, and I always had cats.

This participant added that she had a difficult childhood. She stated that she was constantly moved around from household to household because she came from an unhealthy family and her only sense of strength and support was from her grandmother and her pets. She added that these two things provided her with strength through her difficult childhood. Many of these individuals mentioned multiple sources of support that continued to give them strength throughout their lifetime.

Moreover, working was another subcategory that we decided, as a research team, should be within the core category of social support. We decided to have working as a subcategory within social support because of each participants discussion of importance of social connection that often happened when they worked. An individual from interview 2 (female, 50) discussed how working was a coping mechanism for her but became a protective factor as time went on throughout her life. She discussed how she started helping children and people around her to cope with getting a divorce.

Ah, I got into working with the Head Start kids, ah, just kinda go to work and, ah, any volunteer things that came up with the Tribes for what, cooking at the wakes, and, ah, cooking for the Elder's dinners; just kinda got, got into working.

She stated that she got into working and it helped her through the tough time she was experiencing. Another individual from interview 5 (male, 65) discussed the importance of working for him after he got in trouble.

I had a guy that they sent me out to work for. He was a farmer, you know, bucking bails and doing, out on his farm, doing jobs. He thought a lot of me. Every time I'd go back. I'd get to come back, like I said, I'd turn around and get in trouble and go back, but he was always, coming right down there, and get me and take me back out to work.

He mentioned the importance of working. However, he added that the connection he had with this older gentleman made it easier to deal with being away from his family. It was a coping mechanism and became a protective factor. Working and interacting with a role model became a source of strength for him when he was younger and getting in trouble. Many individuals discussed the difficulties that they have faced throughout life. However, participants describe that sometimes the connection these people make is enough to deal with the struggles that they are facing.

Finally, reciprocity is the last subcategory within the core category of social support. This subcategory encompasses individuals who received support to and from others, and how reciprocity is integral within Native American culture. Reciprocity is a way for individuals to feel a sense of belonging and connectiveness from others within the Native American community. An individual from interview 6 (female, 53) discussed a sense of belonging that

she's felt when she helped others, and how she wished she had the support that she gives to others when she was younger.

That's why now-a-days I keep telling all these young people, you want to talk you, can come over and see me, and it's been good, you know. There has been some that come over here...and confide in me, and, you know, shock me sometimes, you know, oh man, they really have these problems these old people, you know. And it's good to have somebody to talk to. Cause like when I was growing up I didn't have anybody to talk to, you know. It was like my family they were so strict and everything, and... It's like if you said something, you know, you don't talk about that now, you know, there's a time and place for this, you know so...The time never did come.

This woman discussed the importance of being somebody that younger people can talk to and provide support and guidance to as well. She described the way that she gives back and protects herself from the despair that she feels over not having anybody to talk with is by giving back to the younger people. She also mentioned that she uses this as a way to cope with her grief with her son being taken from her after she gave birth. These individuals discussed different instances of social support, which are important reminders of how crucial social connections with others, and, how others can continue to support us throughout our lifetime.

**Self-regulation.** The third core category that was identified through selective coding was self-regulation. The research team and primary investigator discussed the importance of self-regulation that these individuals have maintained throughout their lifetimes. These individuals have discussed social connection and culture as being important factors in their life. However, there were some participants who discussed using individualized tactics that they decided to use when they were alone and unable to interact with others. They identified coping mechanisms that

they started to utilize when they first were struggling, that became protective factors as they became older.

Hobbies is a subcategory within the core category self-regulation. We decided to integrate hobbies into self-regulation because some individuals discussed the importance of engaging in hobbies to keep themselves occupied when others are not around to entertain. This individual from interview 2 (female, 50) discussed how she does jigsaw puzzles when her son and grandchild are not visiting. “I do when I’m alone, if my, if my son and my grandchildren are gone, is I do, ah, jigsaw puzzles. I can get lost in those for hours and hours and hours.” This woman discussed the importance of doing puzzles when her family was no longer visiting her and how it is enjoyable for her. She utilizes her hobby of putting together puzzles as a protective factor.

The next subcategory in self-regulation was identified as thinking. This category encompasses the importance of thinking about other topics or concentrating on something else for a while. This individual from interview 8 (female, 59) discussed the importance of getting out of her own head when she was having distressing thoughts. “I like to dream...it gets...instead of doing them—my mind—gives it, my mind it, uh, maybe it keeps from going, from letting my mind do the, the ‘don’t go there.’” She discussed how thinking about other things protects her from having troubling thoughts, and helps her make it through distressing moments. This use of thinking is often used to self-regulate one’s thoughts so that individuals can make it through a distressing moment or thought.

The final subcategory within self-regulation is imagining. This category describes how individuals will utilize their imagination as a protective factor. For this individual from interview

1 (female, 51), she was alone frequently, and she had to learn how to entertain herself. In order to do, that she had to develop a imagination that could keep her entertained for many hours.

I developed a really good imagination. I learned how to read I read everything I could lay my hands on, and I just kept my mind active; learned how to do a lot of things with my hands, and, um,(I) learned how to entertain myself, and learned how to be alone.

She learned how to be alone in order to cope, however, it turned into a protective factor to protect her from the loneliness that she often felt when she was living isolated from others. She utilized these skills so that she could live by herself. The individuals utilized different protective factors that helped them get through difficult situations throughout their lifetime. These protective factors are categorized as self-regulation because they are protective factors that they utilized to self-regulate in a variety of situations.

The protective factors that were discussed throughout the interviews were crucial for these individuals for survival. Each individual had a different subset of protective factors that were important to them. However, many of them had similar protective factors that were seen across each of the interviews that protected them from the difficulties that they faced throughout their lifetime. These individuals showed how resilient they were regardless of the obstacle that was thrown their way.

### **Discussion**

The current research study found that Native American older adults discussed symptoms of depression throughout their interviews. These individuals discussed depressive symptoms without being prompted by the interviewer, given it was an archival data set looking at coping. Symptoms that were discussed presented a range, with findings showing a stronger somatic

emphasis. Furthermore, the participants discussed suicidal ideation and one individual had attempted suicide in the past. However, these interviews show that Native American older adults are resilient individuals who discussed protective factors more frequently in comparison to depression symptoms. These Native American older adults discussed situations where they utilized different coping mechanisms to manage their symptoms of depression. Some of these included, talking to family members, participating in hobbies, and changing one's thoughts. They continued to utilize these coping mechanisms throughout their life, which in turn appeared to help them to develop protective factor(s) that they could utilize in times of need. The protective factors that they utilized became the foundation for their resiliency throughout their lifetime.

The current study found that the Native American older adults who had participated in the study had discussed symptoms of depression and were more likely to describe symptoms that were more somatic in nature compared to more cognitive symptoms. Research has found that depression is heavily prevalent among Native American individuals (Cohen, 2008; Manson, Shore, & Bloom, 1985). Additionally, O'Neil (1996) described depression in Native Americans as loneliness within her sample of Native American older adults. She discussed the three factors that are utilized to conceptualize how depression presents within her sample as feeling bereaved, feeling aggrieved, and feeling worthless which lead to loneliness. O'Neil (1996) argued that some individuals in her study fit the DSM-IV diagnosis of depressive disorders, however, she believed that you should consider her theory of pathological loneliness when working with Native American older adults because it may better conceptualize what Native American older adults are going through more accurately. When compared to the current study, pathological loneliness could be utilized to further understand this group of individuals and how their culture may impact their symptoms of depression. O'Neil (1996) conceptualization should be considered

when working with Native American older adults and further researchers. In the current study, given that Native American older adults' presentation of depressive symptoms and DeLeanne O'Neill (1996) work, could be used to cue health professionals to explore depression when they might not otherwise consider it. This is important information for mental health clinicians as well, since presentation of somatic symptoms may also challenge diagnosis and treatment. However, as with many Asian families, (Lee & Mock, 2005), this knowledge may guide more fruitful assessment and intervention earlier in health care access.

Many researchers have examined the utilization of the CES-D with Native Americans for screening purposes (Kim, DeCoster, Huang & Chiriboga, 2011; Somervell et al., 1992). The continued examination of ways to effectively screen Native Americans for depression may be beneficial with knowledge of the potentially more present somatic presentation than cognitive among elderly in this population. Additionally, it may be beneficial to also consider O'Neill (1996) conceptualization of depression in Native American older adults when clinicians work with this population. Furthermore, continuing to examine ways that depression can be diagnosed among Native Americans and what symptoms are most prevalent is important to effective practice. More specifically, the core categories that were found among these individuals were culture, social support, and self-regulation. Previous research indicates that protective factors, specifically social support, is negatively correlated with depression symptoms (Burnette et al., 2016; Roh et al., 2015).

The use of culture, social support, and self-regulation that were identified in the current study provide valuable insight regarding how protective factors were discussed among Native American older adults in managing difficult life events. Many of these individuals describe going through difficult situations including boarding school, sexual assault, domestic violence, parent's

death at a young age, completed suicide of family members, and divorce. This connection to culture has been found among researchers (Cross, 2003; HeavyRunner & Morris, 1997; LaFromboise, Hoyt, Oliver, & Whitbeck, 2006; Stiffman, Brown, Freedenthal, House, Ostmann, & Yu, 2007; Stout & Kiplin, 2003; Whitbeck, McMorris, Hoyt, Stubben, & LaFromboise, 2002) and has shown to be vital in overcoming adversities that Native Americans may face. By teaching clinicians to support and provide guidance to their Native American older adult clientele by utilizing these coping approaches, we can continue to support our Native American older adult clients. Further research can evaluate what is most beneficial for Native American older adults who are working on their depressive symptoms.

Transcripts provided examples of how culture, for example, may assist with management of depressive symptoms in Native American older adults. In their discussions, participants would refer to how their spiritual beliefs or practices, for example, kept them strong in face of adversity. Particularly, an individual from interview 11 (female, 79) discussed the importance of God for her and how she feels like she wouldn't have been able to persevere if it wasn't for God.

And it's just a matter of time before Gods says 'ah, I've had enough of all this', and brings revelations. And its here, so. And and I'm sure there isn't a doubt in my mind that if it weren't for God, the strength of knowing that there was a here-after, eternal life that (I) wouldn't have survived or fought or cared about anything.

She further discussed the impact that God had on her throughout her life and how God helped her throughout the difficult parts of her life. She was able to preserve through the aftermath of a terrible accident because of her spiritual connection to God. Additionally, for example, the participants would mention how important humor/laughter was to overcoming adversities. As discussed previously, an individual from interview 3 (female, 64) discussed her brother

completed suicide and ended up diverting the attention away from the subject by mentioning the birds. She said “look at those birds over there I didn’t even notice them. (laughter),” she was unable to handle talking about her brother’s death, so she diverted the interviewer’s attention so that she no longer had to discuss the difficult subject. This is one way that Native American individuals can cope with difficult subjects, which is to make a joke or avoid it all together. Lincoln (1993) discussed how Native Americans have always utilized humor as a survival mechanism and bonding mechanism by laughing at themselves and others. Additionally, Lincoln (1993) discussed how humor has always been apart of Native American stories for at least 500 years. The impact of humor/laughing within Native American culture has benefited individuals who have struggled with adversities. Their reports show conscious connection of culture to coping with challenging life circumstances. Thus, they are using their own methods to cope with their challenging life circumstances. Their use of coping mechanisms like culture show resilience in face of challenges and illustrates persistence to withstand the difficulties that they faced throughout their lifetime. Thus, it may be worthwhile considering evaluation of the exploration of culture with Native American older adult clients. Freedom to explore their culture and utilize culture as a protective factor within therapy, may become a powerful tool for overcoming their depressive symptoms.

Furthermore, research has found that cohesive families and social support tend to be considered as protective factors among Native Americans (Burnette et al., 2016; Grandbois & Sanders, 2012; Roh et al., 2015; Whitbeck et al., 2002). Utilizing social support, as another protective factor, illustrated how keeping busy with social interactions or plans, would help distract them from their pain. Once again, social support as described provided rich examples of how beneficial it is to reach out for support when needed and receive it, as well as how these

individuals provided support for others. Thus, through such illustrations the interviewees provide evidence for fostering of social support among Native American older adults for health and well-being, and for overcoming the intensity of depressive feelings. Participants used social support by reaching out to family members and friends in times of need and asking for help, whether that be for support surrounding a traumatic event or guidance through difficult situations. Some individuals discussed how often they wouldn't need to reach out for social support because family members and friends would automatically provide support. Discussions evidenced that others would provide support by helping them care for their children and help with day to day tasks. One individual discussed how important this support was for her because she ended up "checking out" following a traumatic event and was able to begin processing what she experiences because she knew her family was supporting her. O'Neil (1996) discussed the impact that loneliness can have on a Native American older adult and how this loneliness that is influenced by facets in their life can cause them to have pathological loneliness. O'Neil (1996) argued that depressive symptoms are better categorized as pathological loneliness in her sample of Native American older adults. Through her research and the current research, we have discovered how important social support is for individuals struggling with depressive symptoms or pathological loneliness and how it can be impacted by social support.

Because the participants provided ample examples of the use of social support helped them to overcome difficulties that they experienced throughout their lifetime, understanding how to foster such protections is important. For example, clinicians could be sensitive to the importance of family in these Native American older adult individuals and should be sensitive to approaching topics regarding their client's families. Yet, fostering social support would involve broaching the topic of families. Doing so can be difficult with clients depending on how they

view their relationship with their family. Clinicians could sensitively explore their client's views towards their families whether it be positive or negative and examine how to establish positive healthy connections that encourage safety and wellbeing.

Finally, the last protective factor that was found within this group of Native American individuals is their use of self-regulation. Although lower in use, some participants did use what we called self-regulation techniques. Examples provided by participants include changing one's thoughts, imagining a different world, and participating in hobbies for satisfaction and distraction, like jigsaw puzzles. Self-regulation was described as utilizing individualized approaches to cope with depression symptoms, when they were unable to interact with others. In their descriptions, participants discussed how their hobbies, thinking, and imagining could get them out of their own head, and oftentimes help them process the varying distressing situations. The individuals utilized these approaches by getting into a different mindset or distracting oneself from the loneliness that they felt when nobody is around. These strategies were helpful to them because it provided them with an outlet to process what was happening around them and engage in an activity. Because this primary investigator was unable to identify any studies that identify self-regulation as a protective factor in Native Americans, caution should be exercised in applying this method clinically. Thus, clinicians should be sensitive when discussing the use of self-regulation techniques with their Native American clients, but perhaps allow for exploration of these techniques if it appears beneficial to the client.

Each of the examples offered by participants, illustrated wise, and insightful application of coping approaches that helped with management of depressive symptoms, adverse life circumstance, and challenges to healthy functioning. Although a qualitative study exploring depression in Native American older adults, future research could investigate the possible

therapeutic application and possible benefits with others experiencing depressive symptoms in aging Native American adults.

The Native American older adults in the current study provided vivid examples of resilience and perseverance through the difficult times in their lives. This study suggests there is potential to use a more strength-based approach focused on fostering positive coping when working with Native American older adults. Additionally, a focus on the development of resiliency skills may better serve Native people.

### **Limitations**

The limitations of the study are important to consider. Given the archival data set, possible bias due to qualitative interpretations, and homogeneity of sampling group are present. One primary limitation is that it was an archival data set that had questions that focused on coping rather than depression symptoms or protective factors. Thus, this data set provided transcripts that automatically tied the depressive symptoms that were mentioned to coping. This allowed the research team to discover answers to the questions regarding depression, however, we were unable to ask the individuals specific questions which limited our ability to gather further data.

Furthermore, primary investigator and research team have a potential for bias and may have misinterpreted the experiences of these individuals despite the primary investigator adherence to the grounded theory approach, especially given that it was an archival data set. We tried to limit our bias by following the grounded theory methods with multiple raters. However, we were utilizing the diagnostic criteria for MDD, which introduced bias into the data by using a westernized approach to mental health.

Additionally, the homogeneity of the participants lends us to believe that we would be unable to generalize these results across multiple tribes. Most individuals lived within the same area and identified as being a part of one tribe located in the northwest of the United States. Even though most identified as being from the same tribe many identified being members of more than one tribe. Furthermore, there were greater numbers of women represented within this sample in comparison to men. Despite the given limitations the current study represents the experiences of the Native American's that participated in the study and was beneficial to the current researcher. The current study will be utilized to understand their experiences and continue to be built upon to provide suggestions for future studies.

### **Conclusions and Future Study**

Suggestions for future studies include continued qualitative and quantitative research on depressive symptoms and protective factors in Native American populations. Firstly, continuing to utilize qualitative research to examine depressive symptoms and protective factors is incredibly beneficial in getting a full understanding of how depressive symptoms present and are represented within Native American populations. Depression continues to be difficulty faced by many Native Americans. By continuing to do research examining depression in Native Americans it can be crucial to understanding how to best treat Native Americans struggling with depression with the use of this research. Additionally, by utilizing qualitative research we can ask direct questions about everyone's personal experience and further understand exactly which protective factors they utilized throughout their life. Qualitative research provides us with a deep understanding about each individual experience and the difficulties they have faced. Furthermore, we can utilize qualitative research to better understand the Native American's experience and utilize this informaiton to tailor the experience they have with mental health

professionals. Furthermore, continuing to understand and research protective factors that Native Americans utilize can be helpful in strength-based approaches to psychotherapy.

Additionally, research that can further knowledge that will extend our work with communities and explore the role of protective factors that individuals endorsed in this study. Research could seek to provide empirical evidence for the benefits to fostering protective factors within communities that can demonstrate a decrease the impacts of negative life events.

Further research of the role and benefits of self-regulation as a protective factor could increase our understanding. Exploring whether multiple groups of Native Americans utilize this protective factor successfully for depression may provide stronger evidence for therapeutic role. Additionally, developing a measure that can more astutely assess the skills such as self-regulation, can then be utilized across different tribes. This would allow for empirical larger sample studies of the identified protective factors.

In conclusion, the research examining depression and protective factors among these individuals was beneficial to understanding what older adults have experienced, how they managed, and what they described helped them through difficult times. Despite the presence of many challenges evidenced in the interview transcripts, descriptions provided numerous examples of resilience throughout commentary. Overall, this current study provides us with an understanding of depression in Native American elderly, and what participants described as methods to overcome these difficulties. Finally, this work may allow us to consider therapeutic approaches that foster skills to cope, address and protect Native American clients from poor outcomes. However, more rigorous research should be conducted to confirm the benefits of such approaches, and consideration for the individual, and limitations given this preliminary study are of great importance.

## References

- Ackerson, L. M., Dick, R. W., Manson, S. M., & Baron, A. E. (1990). Properties of the inventory to diagnose depression in American Indian adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 29*(4), 601-607.
- Ackerson, L. M., Dick, R. W., Manson, S. M., & Baron, A. E. (1990). Properties of the inventory to diagnose depression in American Indian adolescents. *Journal of American Academy of Child and Adolescent Psychiatry, 29*(4), 601-607.
- Ahmed, R., Ratele, K., & Bawa, U. (2009) Satyagraha and resilience: From violence prevention to liberation. *Social Change, 39*(4), 550-567.
- Alexopoulos, G. S. (2005). Depression in the elderly [Seminar]. *The Lancet, 365*(9475), 1961-1970. doi:10.1016/S0140-6736(05)66665-2
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Washington, D.C: American Psychiatric Association.
- Ardelt, M., Landes, S. D., & Vaillant, G. E. (2010). The long-term effects of world war II combat exposure on later life well-being moderated by generativity. *Research in Human Development, 7*(3), 202-220.
- Bals, M., Turi, A. L., Skre, I., & Kvernmo, S. (2011). The relationship between internalizing and externalizing symptoms and cultural resilience factors in indigenous Sami youth from arctic Norway. *Int J Circumpolar Health, 70*(1), 37-45.
- Barsh, R. L. (1980). The Indian child welfare act of 1978: A critical analysis. *The Hastings Law Journal, 31*, 1287-1336.

- Billow, R. H., (2008). *Perceived discrimination and depressive symptomatology among Native American older adults* (Masters Thesis). Unpublished masters thesis, The University of Montana.
- Black, K., & Lobo, M. (2008). A conceptual review of family resilience factors. *Journal of Family Nursing, 14*(1), 33-55.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20-28.
- Brave Heart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13.
- Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian Alaska Native Mental Health Research, 8*(2), 56-78. doi:10.5820/aian.0802.1998.60
- Bruyneel, K. (2004). Challenging American boundaries: Indigenous people and the “gift” of U.S. citizenship. *Studies in American Political Development, 18*, 30-43.
- Burnette, C. E., Roh, S., Lee, K. H., Lee, Y. S., Newland, L. A., & Jun, J. S. (2016). A comparison of risk and protective factors related to depressive symptoms among American Indian and Caucasian older adults. *Health and Social Work, 42*(1), e15-e23.
- Burwell, S., McSwain, R. G., Frazier, C. F., & Greenway, K. (2014). *Trends in Indian Health: 2014 Edition*. Rockville, MD: Indian Health Service.
- Carleton, R. N., Thibodeau, M. A., Teale, M. J. N., Welch, P. G., Abrams, M. P., Robinson, T., & Asmundson, G. J. G. (2013). The center for epidemiologic studies depression scale: A

- review with a theoretical and empirical examination of item content and factor structure. *PLoS ONE*, 8(3), e58067.
- Chapleski, E. E., Kaczynski, R., Gerbi, S. A., & Lichtenberg, P. A. (2004). American Indian elders and depression: Short- and long-term effects of life events. *The Journal of Applied Gerontology*, 23(1), 40-57. doi:10.1177/0733464804263087
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Chawla, L., Keena, K., Pevec, I., & Stanley, E. (2014). Green schoolyards as havens from stress and resources for resilience in childhood and adolescence. *Health & Place*, 28, 1-13.
- Cohen, K. S. (2008). At the canyon's edge: Depression in American Indian culture. *Explore: The Journal of Science and Healing*, 4(2), 127-135.
- Corbin, J., & Strauss, A. (2015). *Basics of qualitative research techniques and procedures for developing grounded theory* (4<sup>th</sup> ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2012). *Qualitative inquiry & research design choosing among five approaches* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Cross, T. L. (2003). Culture as a resource of mental health. *Cultural Diversity and Ethnic Minority Psychology*, 9(4), 354-359.
- Dick, R. W., Beals, J., Keane, E. M., & Manson, S. M. (1994). Factorial structure of the CES-D among American Indian adolescents. *Journal of Adolescence*, 17, 73-79.

- Dinges, N. G., Atlis, M. M., & Ragan, S. L. (2000). Assessment of depression among American Indians and Alaska Natives. In R. H. Dana (Ed.), *Handbook of crosscultural and multicultural personality assessment* (pp. 623–646). Mahwah, NJ: Lawrence Erlbaum.
- Dinges, N. G., & Duong-Tran, Q. (1993). Stressful life events and co-occurring depression, substance abuse and suicidality among American Indians and Alaska Native adolescents. *Culture, Medicine and Psychiatry, 16*, 487-502.
- Goins, R. T., & Pilkerton, C. S. (2010). Comorbidity among older American Indians: The native elder care study. *Journal of Cross-Cultural Gerontology, 25*(4), 343-354.  
doi:10.1007/s10823-010-9119-5
- Grandbois, D. M., & Sanders, G. F. (2012). Resilience and stereotyping: The experiences of Native American elders. *Journal of Transcultural Nursing, 23*(4), 389-396.
- Gray, K. (2012). Linguists and tribe members work to restore native languages. *Diverse*. Retrieved from <http://www.diverseeducation.com>.
- Gray, J. S., & McCullagh J. A. (2014). Suicide in Indian country: The continuing epidemic in rural Native American communities. *Journal of Rural Mental Health, 38*(2), 79-86.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? : An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. DOI: 10.1177/1525822X05279903
- Hagedoorn, M., Sanderman, R., Ranchor, A. V., Brilman, E. I., Kempen, G. I. J. M., & Ormel, J. (2001). Chronic disease in elderly couples: Are women more responsive to their spouses'

- health condition than men? *Journal of Psychosomatic Research*, 51(5), 693-696.  
doi:10.1016/S0022-3999(01)00279-3
- HeavyRunner, I., & Morris, J. S. (1997). Traditional native culture and resilience. *Research & Practice*, 5(1), 1-6.
- Horejsi, C., Craig, B. H. R., & Pablo, J. (1992). Reactions by Native American parents to child protection agencies: Cultural and community factors. *Child Welfare*, 71(4), 329.
- Irwin, L. (1997). Freedom, law, and prophecy: A brief history of Native American religious resistance. *American Indian Quarterly*, 21(1), 35-55.
- Iwata, N., & Buka, S. (2002). Race/ethnicity and depressive symptoms: A cross-cultural/ethnic comparison among university students in East Asia, North and South America. *Social Science & Medicine*, 55(12), 2243-2252.
- Jackson, D., & Chapleski, E. E. (2000). Not traditional, not assimilated: Elderly American Indians and the notion of 'cohort'. *Journal of Cross-Cultural Gerontology* 15, 229-259.
- John, R. (2004). Health Status and disparities among American Indian elders. In K. E. Whitfield (Ed.), *Closing the gap: Improving the health of minority elders in the new millennium* (pp.27-44). Washington, DC: Gerontological Society of America.
- Kaufman, C. E., Beals, J., Croy, C., Jiang, L., Novins, D. K., & The AI-SUPERPFP Team. (2013). Multilevel context of depression in two American Indian tribes. *Journal of Consulting and Clinical Psychology*, 81(6), 1040-1051. doi:10.1037/a0034342
- Kim, G., DeCoster, J., Huang, C. H., & Chiriboga, D. A. (2011). Ethnicity and the factor structure of the center for epidemiologic studies depression scale: A meta-analysis.

*Cultural Diversity and Ethnic Minority Psychology*, 17(4), 381-396.

Doi:10.1037/a0025434

- Kraaij, V., Kremers, I., & Arensman, E., (1997). The relationship between stressful and traumatic life events and depression in the elderly [Short report]. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18(2), 86-88. Doi:10.1027/0227-5910.18.2.86
- LaFromboise, T. D., Hoyt, D. R., Oliver, L., & Whitbeck, L. B. (2006). Family, community, and school influences on resilience among American Indian adolescents in the upper Midwest. *Journal of Community Psychology*, 34(2), 193-209.
- Lee, E., & Mock, M. R. (2005). Asian families: An overview (3<sup>rd</sup> ed.). In M. McGoldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity & Family Therapy* (pp. 269-289). New York, NY: The Guilford Press.
- Lincoln, K. (1993). *Indi'n humor: Bicultural play in Native America*. New York, NY: Oxford University Press.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Manson, S. M. (2000). Mental health services for American Indians and Alaska Natives: Need, use, and barriers to effective care. *The Canadian Journal of Psychiatry*, 45(7), 617-626.
- Manson, S. M., Shore, J. H., & Bloom, J. D. (1985). The depressive experience in American Indian communities: A challenge for psychiatric theory and diagnosis. In A. Kleinman & B. Good (Eds.), *Culture and Depression* (pp. 331-368). Berkeley, CA: University of California Press.

- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227-238.
- Noel, P. H., Williams, J. W., Jr., Unutzer, J., Worchel, J., Lee, S., Cornell, J., ... Hunkeler, E. (2004). Depression and comorbid illness in elderly primary care patients: Impact on multiple domains of health status and well-being. *Annals of Family Medicine*, 2(6), 555-562. doi:10.1370/afm.143
- Novins, D. K., Beals, J., Croy, C., & Manson, S. M. (2008). Methods for measuring utilization of mental health services in two epidemiologic studies. *International Journal of Methods in Psychiatric Research*, 17(3), 159-173. doi:10.1002/mpr.255
- O'Neill, T. D. (1996). *Disciplined hearts: History, identity, and depression in an American Indian community*. Berkeley & Los Angeles, CA: University of California Press.
- Orfilia, F., Ferrer, M., Lamarca, R., Tebe, C., Domingo-Salvany, A., & Alonso, J. (2006). Gender differences in health-related quality of life among the elderly: The role of objective functional capacity and chronic conditions. *Social Science & Medicine*, 63, 2367-2380.
- Paniagua, F. A. & Yamada, A. M. (2013). *Handbook of multicultural mental health: Assessment and treatment of diverse populations (2<sup>nd</sup> ed.)*. San Diego, CA: Academic Press.
- Parker, T., May, P. A., Maviglia, M. A., Petrakis, S., Sunde, S., & Gloyd, S. V. (1997). Prime-nd: Its utility in detecting mental disorder in American Indians. *Int J Psychiatry Med.*, 27(2), 107-128.

- Roh, S., Burnette, C. E., Lee, K. H., Lee, Y. S., Easton, S. D., & Lawler, M. J. (2015). Risk and protective factors for depressive symptoms among American Indian older adults: Adverse childhood experienced and social support. *Aging & Mental Health, 19*(4), 371-380.
- Russell, G. M. & Richards, J. A. (2003). Stressor and resilience factors for lesbians, gay men, and bisexuals confronting antigay politics. *American Journal of Community Psychology, 31*(3/4), 313-328.
- Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *The British Journal of Psychiatry, 147*, 598-611.
- Rybak, C., & Decker-Fitts, A. (2009) Understanding Native American healing practices. *Counseling Psychology Quarterly, 22*(3), 333-342. DOI: 10.1080/09515070903270900
- Shoemaker, J. A. (2003). Like snow in the spring time: Allotment, fractionation, and the Indian land tenure problem. *Wisconsin Law Review, 729*, 729-788.
- Shore, J. H., Manson, S. M., Bloom, J., Keepers, G., & Neligh, G. (1987). A pilot study of depression among American Indian patients with research diagnostic criteria. *American Indian and Alaska Native Mental Health Research, 1*(2), 4-15.
- Sipes, R. G. (1976). A test for coder bias. *Behavior Science Research, 3*, 149-168.
- Stiffman, A. R., Brown, E., Freedenthal, S., House, L., Ostmann, E., & Yu, M. S. (2007). American Indian youth: Personal, familial, and environmental strengths. *J Child Fam Stud, 16*, 331-346.

Somervell, P.D., Beals, J., Kinzie, J. D., Boehnlein, J., Leung, P., & Manson, S. M. (1992). Use of the CES-D in an American Indian village. *Culture, Medicine and Psychiatry*, 16(4), 503-517.

Somervell, P.D., Beals, J., Kinzie, J. D., Boehnlein, J., Leung, P., & Manson, S. M. (1993). Criterion validity of the center for epidemiologic studies depression scale in a population sample from an American Indian village. *Psychiatry Research*, 4, 255-266.

Southwick, S. M., Morgan, C. A., Vythilingman, M., & Charney, D. (2005). Mentors enhance resilience in at-risk children and adolescents. *Annual Reviews of Clinical Psychology*, 1, 255-291.

Stansbury, J. P., Ried, L. D., & Velozo, C. A. (2006). Unidimensionality and bandwidth in the center for epidemiologic studies depression (CES-D) scale. *Journal of Personality Assessment*, 86(1), 10-22.

Stout, M. D. & Kipling, G. (2003). *Aboriginal people, resilience, and the residential school legacy*. Ottawa, ON: Aboriginal Healing Foundation.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice (4<sup>th</sup> ed.)*. Hoboken, NJ: John Wiley & Sons Inc.

Tucker, R. P., Wingate, L. R., & O'Keefe, V. M. (2016). Historical loss thinking and symptoms of depression are influenced by ethnic experience in American Indian college students. *Cultural Diversity and Ethnic Minority Psychology*, 22(3), 350-358.  
doi:10.1037/cdp0000055

The National Tribal Behavioral Health Agenda, (2016). *The national tribal behavioral health agenda*. Retrieved from <https://store.samhsa.gov/system/files/pep16-ntbh-agenda.pdf>.

U.S. Census Bureau. (2012, January). *The American Indian and Alaska Native population: 2010* (Issue Brief No. C2010BR-10). Washington, DC: T. Norris, P. L. Vines, & E. M. Hoeffel.

van't Veer-Tazelaar, P. J., van Marwijk, H. W. J., Jansen, A. P. D., Rijmen, F., Kostense, P. J., van Oppen, P., ... Beekman, A. T. F. (2008). Depression in old age (75+), the PIKO study. *Journal of Affective Disorders, 106*(3), 295-299. doi:10.1016/j.jad.2007.07.004

Wallace, K. A., & Swaney, G. I. (2009). *Resilience in Native American older adults: Two Studies*. [Qualitative dataset]. Missoula, MT: The University of Montana.

Walters, K. L., Beltram, R., Huh, D., & Evans-Campbell, T. (2011). Dis-placement and dis-ease: Land, place, and health among American Indian and Alaska Natives. In L. Burton, S. Matthews, M. Leung, S. Kemp, & D. Takeuchi (Eds.), *Communities, Neighborhoods, and Health: Expanding the Boundaries of Place* (163-199). New York, NY: Springer.

Waghelstein, J. D. (2001). The United States army's first war: War in the northwest territory, 1790-1795. *Small Wars & Insurgencies, 12*(2), 1-18.

Weaver, H. N., & Brave Heart, M. Y. H. (1999). Examining two facets of American Indian identity: Exposure to other cultures and the influence of historical trauma. *Journal of Human Behavior in the Social Environment, 2*(1-2), 19-33.

DOI: 10.1300/J137v02n01\_03

Wells, M. (2009). Resilience in rural community-dwelling older adults. *The Journal of Rural Health, 25*(4), 415-419.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology, 33*(3/4), 119-130. doi: 10.1023/B:AJCP.0000027000.77357.31

Whitbeck, L. B., McMorris, B. J., Hoyt, D. R., Stubben, J. D., & LaFramboise, T. (2002). Perceived discrimination, traditional practices, and depressive symptoms among American Indians in the upper Midwest. *Journal of Health and Social Behavior, 43*(4), 400-418.

Wilson, C., Civic, D., & Glass, D. (1995). Prevalence and correlates of depressive syndromes among adults visiting an Indian health service primary care clinic. *American Indian and Alaska Native Mental Health Research: Journal of the National Center, 6*(2), 1-12.

Wingo, A. P., Wrenn, G., Pelletier, T., Gutman, A. R., Bradley, B., & Ressler, K. J. (2010). Moderating effects of resilience on depression in individuals with a history of childhood abuse or trauma exposure. *Journal of Affective Disorders, 126*, 411-414.

Zautra, A. J., Arewasikporn, A., & Davis, M. C. (2010). Resilience: Promoting well-being through recovery, sustainability, and growth. *Research in Human Development, 7*(3), 221-238.

## Appendix A

Table 1

*Demographic Description of Participants (N = 11)*

<b>Characteristic</b>	<b><i>n</i></b>	<b>%</b>
<b>Age</b>		
50 - 60	5	45.5
61 - 70	4	36.4
71 - 80	2	18.1
<b>Marital Status</b>		
Married	2	18.1
Divorced	3	27.3
Widowed	3	27.3
Single	3	27.3
<b>Highest Education Level completed</b>		
Middle School	1	9.1
High School	3	27.3
Vocational Training	0	0
Some College	2	18.1
College Degree	4	36.4
Graduate, Medical, or Law Degree	1	9.1
<b>Annual Household Income (\$)</b>		
Did not report an income	1	9.1
Less than 7,500	4	36.4
7,500 -14,999	2	18.1
15,000-24,999	0	0
25,000-40,000	3	27.3
More than 40,000	1	9.1
<b>Living Status</b>		
Living alone	3	27.3
Lived w/spouse	2	18.1
Lived w/ children	4	36.4
Lived w/ spouse & child(ren)	0	0
Other living arrangements	2	18.2

*Appendix B*

Table 2

*Semi Structured Interview Questions*

What would you say have been the major life stressors in your life?
How have you coped with them? That is, what have you done in order to make it through the tough times? Was this a successful coping strategy? Is there anything that you would do differently?
What would you say are the minor, everyday hassles that you deal with?
How do you cope with these hassles?
What gives you your inner strength? Which of these is most important?
How have your sources of strength changed over your lifespan? Why do you think this has changed?
Some people identify certain factors as being important in overcoming stress. From your answers to my questions, it seems that _____ has been very important to you. Is this correct?
How does _____ help you deal with stress? That is, how does _____ work for you?