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BACKGROUND: *Few studies examine older African Americans' beliefs and attitudes toward depression, yet this population is more likely than other ethnic groups to be underdiagnosed and undertreated for depression.* ***OBJECTIVE:*** *To examine the beliefs and attitudes about depression in a sample of community-dwelling older African Americans.* ***STUDY DESIGN:*** *A qualitative approach embedded within a survey design was used. The sample included 51 community-dwelling African Americans older than age 60 who were recruited from a northeast state. Participants' descriptions of the meaning of depression were analyzed using editing analysis style.* ***RESULTS:*** *Four major themes emerged from the data: (a) Keeping the Bully Out, (b) God Will Provide, (c) Losing Control, and (d) That's Not Me.* ***CONCLUSIONS:*** *These data can assist mental health nurses in understanding older African Americans' beliefs and attitudes toward depression. Culturally sensitive educational programs, reminiscence interventions, and suggestions to assist with screening for depression in this population are discussed.* ***J Am Psychiatr Nurses Assoc, 2007; 13(4), 230-236. DOI: 10.1177/1078390307305926***

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Late-life depression is a public-health problem in the United States with tremendous health and economic implications. According to the National Institute of Mental Health (2003), an estimated 2 million of America's 35 million older adults have a depressive illness, and another 5 million have subsyndromal or minor depression. The consequences of untreated depression in older adults include increased mortality, suicidal ideation, and decreased functional abilities (Cook, Pearson, Thompson, Black, & Rabins, 2002; Fröjdh, Håkansson, Karlsson, & Molarius, 2003). Studies examining the effect of depression on health care costs found that depressed elderly patients also have significantly higher health care costs than do nondepressed elders, regardless of chronic morbidity (Katon, Lin, Russo, & Unutzer, 2003).

Depression is a general term that is often used for a variety of mood disturbances that can differ in symptom presentation, duration, and frequency. Therefore, it is important for researchers to distinguish between the different diagnostic definitions of depression. Major depressive disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV), is characterized by the presentation of (a) five or more major depressive symptoms listed in the DSM-IV criteria, each of which lasts at least 2 weeks, and (b) depressive symptoms that include depressed mood and/or loss of interest and pleasure. A depressed mood that is a result of drugs, alcohol, medications, or a medical condition is not considered a major depressive disorder (American Psychiatric Association, 2007). Diagnostic criteria for dysthymia disorder include depressed mood for most of the day and for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

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Additional diagnostic criteria include the presence of two of the six symptom criteria listed in the DSM-IV with no episode of major depressive disorder (MDD) present during the first 2 years of symptom presentation. Depression not otherwise specified (NOS) allows for classification of a less severe form of depression and includes disorders with depressive features that do not meet the criteria for major depressive disorder, or dysthymic disorder. This classification includes minor depression and recurrent brief depressive disorder (American Psychiatric Association, 2007). Late-onset depression is defined as major or minor depression diagnosed with first onset after age 60 (U.S. Department of Health and Human Services, 2001).

Although late-onset depression may be a common illness among older adults, few receive adequate treatment. It has been shown that older adults who died because of suicide visited a primary care physician within a month before their suicide (Conwell, 2001). Additionally, it has been reported that misdiagnoses often occur in minority groups (Snowden, 2001). According to the Surgeon General's 2001 report *Mental Health: Culture, Race and Ethnicity*, the disparities affecting mental health care of minorities are the result of their having less access to mental health services, receiving poorer quality of care, and being underrepresented in mental health research. Specifically, African Americans are more likely than other ethnic groups to be underdiagnosed and undertreated for depression (Das, Olfson, McCurtis, & Weissman, 2006).

There is a call for more aggressive screening, identification, and treatment of depression in older African Americans (Skarupski et al., 2005). Recent studies have shown that older African Americans are less likely to be identified as depressed (Gallo, Bogner, Morales, & Ford, 2005) and that they find counseling and antidepressant medication less acceptable than do Whites (Cooper et al., 2003). Furthermore, there is a need to gain an understanding of the barriers that prevent the treatment of depression in this population. In a review of the literature conducted by Das et al. (2006), major barriers to diagnosis and treatment in the African American population were identified as stigma about the diagnosis, clinical presentation of somatization, comorbid general medical problems, and difficulties with the patient–physician relationship.

Further evidence related to perceiving depression as a weakness was gathered in a study that examined differences in the indicators of depressive symptoms among a sample of community-dwelling African American and Caucasian older adults. Participants were asked if they thought depression to be a personal weakness. Results showed that 41% of the African American sample answered yes, compared to 36% of the Caucasian sample (Mills, Alea, & Cheong, 2004). No known qualitative studies that specifically asked older African Americans to describe their beliefs and attitudes toward depression were found in the literature. Increased knowledge and understanding of how older African Americans perceive depression could assist mental health nurses with overcoming the identified barriers to identification and diagnosis of depression in this population. The purpose of this article is to present the results from a qualitative study that examined older African Americans' beliefs and attitudes toward the term *depression*. The primary research question that guided this inquiry was as follows: What are older African Americans' beliefs and attitudes toward depression?

METHOD

Research Design

A qualitative approach embedded within a survey design was used to gain insight into older African Americans' beliefs and attitudes toward depression. In this design the researcher collects more in-depth contextual data from a subset of the participants within a larger quantitative study to gain insight into more complex issues and interventions (Polit, Beck, & Hungler, 2001). The contextual data described in this article were collected from a subset of participants from a larger quantitative study that tested the effects of a reminiscence intervention on depression and life satisfaction in older African Americans (Shellman, Moody, Smith, Hewitt, & Martin, 2005). In field research, questions often evolve as part of the research process. As the recruitment process began for the larger reminiscence study, data collectors noted a general hesitation among the population to participate in a study about depression. This observation, in addition to information provided by senior center directors and church leaders confirming that their members may not admit to feeling depressed, led to this inquiry to gain insight into older African Americans' attitudes and beliefs toward depression.

Procedure

Approval for the study was obtained from the university's internal review board. African American

research assistants were trained to conduct culturally sensitive interviews and participated in the protection-of-human-subjects training required by the university. African American research assistants were selected to collect the data because shared group membership has been described as a way of facilitating discussion and disclosure of sensitive topics (Jackson, 1991), and inclusion of researchers who belong to the ethnic group being studied has the potential to reduce the threats to a valid research process (Porter & Villarruel, 1993). The purpose and procedures of the study were explained to the participants before obtaining consent. The consent form was read to each participant and signed before data collection began.

Inclusion criteria for participation in the study included being born in the United States, being 60 years of age or older, and dwelling in the community. The age of 60 was chosen because that is the membership requirement for the senior centers. A purposive sample ($N = 51$) completed the questionnaire through verbal interviews administered by the data collectors. To better understand African Americans' beliefs and attitudes toward depression, the participants were asked three open-ended questions as part of the quantitative data collection for the larger study: (a) Describe for me in detail what the word *depression* means to you; (b) Tell me everything you know about feeling depressed; and (c) How do you feel about someone who is depressed?

Participants

In qualitative research, participants are selected to maximize appropriate information relevant to the research question (Crabtree & Miller, 1999). For this study, the sample was purposively selected to obtain rich information regarding community-dwelling older African Americans' beliefs and attitudes toward depression. Participants included older African Americans recruited from senior centers, churches, and senior-housing sites in a northeast urban setting who were willing to discuss their thoughts pertaining to the word *depression*. All participants were born in the United States; 62% reported that they were born and raised in the South. The mean age of the sample was 71.3 years ($SD = 8.2$). Seventy percent of the participants were female, 47% lived alone, and the mean number of years that participants had attended church was 50.7 ($SD = 21.6$).

TABLE 1. Meaningful Segments

You can control it	God will provide
It's like a bully	Couldn't walk
Down and out	They are weak
Just pray	Not me
Never happened to me	Not God's fault
No energy	Not sleeping
They can't cope	Don't allow myself
No pick-me-up	Can't do anything
It comes at you	You can keep it out
It is always there	No control
Despair	Can't function
Loss	They don't pray

DATA ANALYSIS

The participants' descriptions of the meaning of depression were interpreted using editing analysis style, as described by Crabtree and Miller (2001). In editing analysis style, the researcher must enter the contextual data without a template, free from preconceptions (Crabtree & Miller, 1999). To assist with this separation, the researcher begins by carefully questioning any preconceptions that may exist. In this study, before data collection began, the researcher examined presuppositions about depression in this population and how they could influence this study. The next process involved debriefing the data collector so that any biases and presuppositions could be examined and discussed before collecting data.

In this type of qualitative analysis, the researcher reviews the text, looking for meaningful segments that are related to the research question. The segments are rearranged, and the data is reduced and interpreted. Once the meaningful segments (see Table 1) are identified and reviewed, a categorization scheme is developed. Each of the categories is explored for patterns and themes. This is called the connecting phase of the analysis. The themes described in this article are the result of connecting patterns found in the categories identified by the researcher.

QUALITATIVE RIGOR

According to Lincoln and Guba (1985), qualitative rigor emerges from credibility, auditability, and fittingness. Credibility, or trustworthiness, of the data was ensured through training of the research assistants, periodic debriefing, and prolonged engagement. During training, the research assistants were asked about their beliefs and attitudes toward depression so that they could set potential biases

aside and clearly document the participants' beliefs and attitudes. Prolonged engagement, or spending time within the culture, allows for trust to develop and adds depth to the overall understanding of the subject. The researcher and research assistants had spent time developing relationships before the study began. Auditability, or the ability of another investigator to follow the decision trail of the researcher from the beginning of data analysis to the end, was achieved by asking an experienced researcher not involved in the study to review the decision trail from highlighting meaningful segments to evolution of the themes. The fittingness of a qualitative study refers to how well the results fit into a context other than that from which they were generated. Fittingness of the study was addressed by seeking out older African Americans willing to provide their thoughts about depression. It is important to keep in mind that the results from this study reflect the beliefs and attitudes of this particular group of older African Americans. Other subgroups within the African American population may have different views regarding depression.

RESULTS

The depth of data can affect the sample size of qualitative studies. Some participants in this study kept their descriptions brief. Even though saturation was reached before the final sample size of 51, the researcher made the decision to include more interviews to ensure saturation and richness of the data. Analysis of the 51 descriptions of the participants' perceptions of depression resulted in four major themes that described the essence of their descriptions: (a) Keeping the Bully Out, (b) God Will Provide, (c) Losing Control, and (d) That's Not Me. The following are descriptions of the four major themes that emerged from the contextual data. The themes are represented by participant quotes.

Keeping the Bully Out

The participants repeatedly described depression as something bad yet something one can keep out of the body and mind. For example, one participant stated the following:

> I hope and pray that I never become depressed. You can control it—it's like a bully. You have to keep it out. If you let God in, you can keep the bully out.

The bully (depression), as described by some of the participants, keeps coming at you. Some people can handle this and others cannot. One participant described people who are depressed as weak. This state of weakness is the time the bully is let in.

> People who are depressed cannot handle what is given to them. It is not God's fault. He would not give you anything you couldn't handle. They [people who are depressed] are very weak.

God Will Provide

There was a definite sense among the sample that God played a role in keeping the bully out. This second theme represents the role of faith in keeping depression out of the participants' lives. Participants revealed that they felt praying and turning to God in times of distress would keep the bully out. For example, one participant stated,

> God is a beautiful person. He is good all the time if you let Him. He shows the way. If you don't let Him show you the way, you will become depressed. You will let the bully in.

Many times during the interviews, participants referred to God, faith, and praying. One participant stated, "I don't allow myself to get depressed. I pray to God that I never get that way." It is also interesting to note that during the interviews, many participants became animated, and they were observed to feel very strongly about what they were saying. For example, it was common for the participants to point toward the sky in reference to God as they described their beliefs toward depression.

Losing Control

The third major theme, Losing Control, surfaced when the participants revealed their thoughts about what depression means to them. One of the participants described feeling depressed after the death of a child and stated, "I felt the situation was out of my control, something was taking over." Many descriptions revealed loss of physical function as losing control. For instance, some participants described "not being able to do things," "can't function," and "someone who can't walk" as depressed. In the following description, the participant described a time of feeling depressed:

> I was depressed for about 1 year when I got sick. I couldn't walk, the doctor couldn't find anything wrong with me. I felt like I lost control over my body. But I was determined, so I prayed every day and exercised and walked again.

It was also revealed through the transcripts that the participants viewed depression as something one could control, but other illnesses such as diabetes or hypertension were beyond personal control. For example, one participant stated, "You can't control something like diabetes, but you can control depression."

That's Not Me

Although the participants were very willing to describe their thoughts about what depression means, most were sure to make it clear that depression or feeling depressed did not pertain to them. For instance, in one interview, a participant said,

> I don't feel that I am a person to go through depression. I lost my parents, I've lost jobs, and I got divorced. I don't get depressed because I can cope and take what is given to me.

Although the interviewer posed the question "what does depression mean to you?" a majority of the descriptions were given in terms of "they." In the following example, a participant reported,

> They get depressed because they can't handle things. They haven't done the best that they can, they didn't push themselves. It means someone is weak. This has never happened to me.

Five participants refused to discuss their beliefs and attitudes toward depression, providing additional data that supports this theme. Statements such as "never been depressed, I can't help you," or "I don't know anyone that is depressed," provide information about the stigma associated with depression. The participants felt it was important to let the data collectors know that not only had they never been depressed, they did not know anyone who was depressed either.

DISCUSSION

The findings from this qualitative investigation shed light on older African American's beliefs and attitudes toward depression. In this study, participants perceived depression as something that can be controlled through their faith, something that is associated with negative connotations such as viewing depression as "a bully"—not an illness but a personal weakness. This suggests that underdiagnosis and undertreatment may be related to African American elders' failure to seek care for depression because they do not view it as a medical problem but as a personal weakness that can be overcome.

Participants' views that depression is something terrible that is always there ready to come into the body and mind is reflected in the theme of Keeping the Bully Out. According to these respondents, depression is always "knocking at the door," and it is the stronger person who turns to God and keeps the bully out. These results support the work of Mills et al. (2004), in which African American older adults perceived depression to be a personal weakness.

The theme of Losing Control reinforces older African Americans' belief that depression is something one can control. One participant stated, "People can control depression, either they let it in or keep it out." On the other hand, diabetes was mentioned as something one cannot control, reinforcing the belief that depression is not an illness but a weakness. This finding points to the need for depression education for this population and supports the work of Zylstra and Steitz (1999) that suggests older African Americans are less knowledgeable about depression than are Whites. The reasons for the lack of knowledge regarding depression could be related to mistrust of health care providers as well as few community resources available for this population. Scholle and Kelleher (2003) demonstrated that African American women are less likely to discuss depression with a health care provider and prefer education about mental health from less traditional sources such as churches.

Blank, Mahmood, Fox, and Guterbock (2002) found that although Black churches in the South had many health programs for their community, few programs existed that linked churches with mental health providers. Community participatory programs that provide culturally appropriate education through partnerships between church communities and gerontological mental health nurses could assist in increasing knowledge about depression as an illness, not a personal weakness, and encourage positive behaviors regarding screening and seeking treatment for depression.

Religiosity has been reported to be associated with well-being in African American elders (Cummings, Neff, & Husaini, 2003; Jang, Borenstein, Chiriboga,

& Mortimer, 2005) and as a protective factor to prevent depression (Taylor, Chatters, & Levin, 2004). Whereas participants in this study stated that turning to God would assist them in maintaining control over adversities and that their faith was an important part of their coping mechanisms, there may be a negative side to this belief that warrants further discussion. For example, throughout one of the interviews, as a participant discussed depression and her life, she started to cry, stating, "I am not depressed, God will provide. There are people worse off than me." The participant's crying and sadness did not correspond with what was said during the interview. This example represents evidence that African Americans with strong religious beliefs minimize mental health problems and do not seek treatment or admit to feeling depressed. The ability of gerontological mental health nurses to recognize the role of religion among African Americans cannot be underestimated. Although the relationship between religiosity and mental health in African Americans is complex, assessing the elder's religious beliefs can assist in the identification of depression and promote mental health.

As evidenced by the theme That's Not Me, in this study, it was common for the participants to describe depression in terms of someone else's problem. One elder refused to participate, stating, "I have never been depressed, so I can't help you." In a study conducted by Thompson, Bazile, and Akbar (2004) in which focus groups were conducted to examine views of psychotherapists, participants described mental illness as a shame and embarrassment. Because emotional distress is looked on with embarrassment, African American older adults many times present with somatic complaints and increased physical impairment rather than emotional complaints. Primary-care physicians may misidentify symptoms of depression if they are not presented as mood alterations (Snowden, 2001). These findings have implications for nurses working in the community, who are often the elders' first contact with health care. Therefore, nurses may benefit from additional training regarding the stigma associated with depression and therapeutic approaches such as the use of reminiscence and screening methods to identify depression in this population. For example, inquiries about life events and losses through the use of reminiscence may facilitate the development of a trusting relationship (Shellman, 2004; Shellman et al., 2005) and foster a therapeutic discussion about feelings of depression. Additionally, framing questions within an appropriate cultural framework and in terms of somatic complaints and physical disability may help to identify symptoms of depression in this population.

Findings from this inquiry represent a contextual and population-specific exploration of depression. Themes emerged from the data that provide valuable information for gerontological mental health nurses about the way that African American older adults may think and feel about depression. This information, however, is only the first step to better understanding the complexities of identifying depression in African American elders. Partnerships with churches and senior centers are needed to conduct research that identifies specific somatic complaints and physical disabilities that may indicate underlying depression in this population.

Furthermore, research to determine the role that religious beliefs play in the recognition of depressive symptoms and as a coping mechanism to promote mental well-being will assist nurses to work with their patients to identify and manage depressive symptoms and improve quality of life.

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