DEPRESSION PREVENTION, SUICIDE PREVENTION IN ELDERLY ASIAN AMERICANS

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Rationale: *Early recognition of depression and prompt treatment can reduce the prevalence of severe depression and suicide, but little information about the prevention of depression is known. An educational approach for depression prevention certainly may meet the need of the vulnerable population experiencing mild or subclinical depression. The preventive approach will certainly help them avoid the stigma of psychiatric treatment as well as accommodate economic realities. We studied whether depression can be prevented from proceeding to the severe form for vulnerable individuals, especially the Asian American elderly.* Method: *Elderly Asian Americans were recruited and divided into two groups; experimental subjects attended psychoeducational class once a week for 8 weeks, while controls were placed in an 8-week waiting period. The educational program was based upon the manual,* Depression Prevention Course *by Munoz, which emphasizes cognitive behavioral approaches. Each session consisted of 30 minutes of a video educational program and 30 minutes of discussion.* Result: *After 8 weeks in the educational program, HAM-D scores of the experimental group were significantly lower than the control group.* Conclusion: *Based upon our study result, the psychoeducational program appears to exert significant preventive effect for subclinically depressed Asian American elderly. It is worth exploring this approach on a larger scale.*

The prevalence of suicide has been higher among elderly Japanese and Japanese Americans because suicide is an acceptable way out of problem situations. As Asians grow older, the prevalence of physical illness, feelings of depression, and dysfunctions to the extent that they are not able to be as productive may cause some to think of suicide. Of course, those who

do think of suicide are in the minority, and those who actually commit suicide are an even smaller group.

Together with these tendencies towards illness, depression and suicide as Asians age, there's also the high-perceived stigma of mental illness labeling. Thus, many conservative Asians and Asian Americans will not see a psychiatrist, even if psychiatric problems are severe. This was evident when we opened the Asian Clinic in Los Angeles and found that many of the patients were seriously and chronically mentally ill. Fully 85 percent of them were referred by a social worker, the police, or other outside sources rather than self- or family-referred. This, of course, contrasts to the figure for European Americans which is just the opposite, namely 85 percent being self-referred, and only 15 percent referred by the authorities.

In order to cope with the double problems of 1), the high-perceived stigma of mental illness labeling and 2), the need for multiple sources of help for aging Asians and Asian Americans, we suggest an educational experience might be better accepted in the community.

DEPRESSION PREVENTION, SUICIDE PREVENTION

The prevalence of suicide in Asian Americans in the United States, Japan, and China is higher among the elderly than among European Americans and in Europe, with the notable exception of Hungary which has the highest rate of suicide in the world (1). The prevalence of suicide among Asian Americans in the United States is highest among the Japanese American elderly, especially males. As was noted in the GAP Report about ethnic minority suicide, the rate of suicide among elderly Chinese women is higher than for the males (2). This is an exception in that in every other ethnic group, the prevalence of suicide among the elderly males is higher than among the females. For example, the prevalence of suicide among elderly European Americans is 32 per 100,000 for males and 7.45 per 100,000 for females ages 65 to 74; 46 for males and 6 for females per 100,000 ages 75-80; 53 for males and 5 for females per 100,000 ages 85 and over; a sharp contrast with few European American females committing suicide in their old age.

A few years ago, a study of the records of Los Angeles County Coroner's office compared suicide among elderly Asians and among elderly European Americans (3). We had hypothesized that the elderly Asians committed suicide because of cultural conflict; that is, that they maintained the cultural beliefs of traditional Asia and their children acculturated very rapidly and adopted the American values. We were surprised to find that our hypothesis was incorrect, that the elderly Asians committed suicide, not because they were out of touch with their offspring (89.6 percent were either living with or in close touch with their offspring in contrast to only 60.4 percent of European Americans). Instead, we found that elderly Asians committed suicide when they were physically ill or depressed, or both physically ill and depressed.

When Dr. Felice Lieh Mak gave her lecture on the occasion of her receiving the Asian/Asian American Award from the American Psychiatric Association, she mentioned the prevalence of suicide in the People's Republic of China (1). A very large and systematic study of 118,800,000 people found that the prevalence of suicide among elderly Chinese women was high. The figures were 19.6 per 100,000 (1). Since the overall rates in rural areas are nearly three times higher, but the gender ratios are about the same, the author suggests because of the "relatively low status of women, the deeply frustrating constraints on their life chances, and cruelty towards them, suicide, and the threat of suicide, is one of the few traditional levers of domestic power and forms a protest that Chinese women have available." This certainly suggests that there is a need for suicide intervention to prevent suicide among those who have second thoughts or wish to find a different way of life.

Treatment in Asia is different from treatment in the United States. In the United States we have a well-developed system of mental health delivery, which may have ups and downs historically, but nonetheless has been comprised of mental health teams with psychiatrists, psychologists, psychiatric social workers and nurses. Recently, marital-family counselors have been added to a group of professionals offering therapy. Thus, the

number of professionals available for help is much greater in the United States. In contrast, Japan, with a population of 150 million, has approximately 10,000 psychiatrists. We, with a population of 250 million in the United States, have approximately 40,000 psychiatrists. In addition, of course, we have psychologists, psychiatric social workers, nurse counselors, and marital-family counselors. Thus, attitudes about mental illness and therapy are less rejecting in America. We do still have an unacceptably high perceived stigma. Education must be continued. The HCFA initiative was an excellent beginning. There were brochures for the patient for the primary care physicians and others giving expert views of depression, its diagnosis, treatment and prevention. This needs to be done also for people with anxiety disorders, schizophrenia and other psychiatric problems.

In addition, fees for therapy are greater in the United States than in Japan. Thus, the average Japanese psychiatrist sees patients very briefly, diagnoses the condition and prescribes medication. The sale of medication becomes then an augmenting source of income. The main point I wish to make about the comparison of America and Japan is that we have many more resources for the therapy of depressed patients compared to Japan, a highly industrialized Asian nation. The rest of Asia, which is in the process of industrializing, has even fewer resources. Medication augmented by psychotherapy is available only to the relatively few individuals who have overcome the perceived stigma of mental illness labeling and sought care from physicians and mental health professionals. We definitely need alternative resources for the many who will not seek treatment from physicians or mental health professionals.

EDUCATION VERSUS THERAPY

Because of the high-perceived stigma of mental illness labeling, we believe that education in the community offers those subjects, who are not diagnosed as patients, an alternative way of coping. This eliminates the stigma of mental illness labeling and also offers an opportunity for the subject to be "educated" for their own potential benefit and for depression prevention.

Thus the cognitive-behavioral/educational approach rather than therapy would be more culturally acceptable in Asia. This is why we decided to use the approach initially devised by Ricardo Munoz at the University of California, San Francisco and studied in his work with English-speaking, Spanish-speaking and Chinese-speaking adults (4).

This is a report of an ongoing study in three Asian American communities in Los Angeles: a) Chinese Americans, b) Korean Americans, and c) Japanese Americans. For the purposes of this study, videotapes were made adapting the Munoz materials to be culturally sensitive. The videotapes made for the study were of psychiatrists covering the lessons in the material originally devised by Munoz. For the Chinese group, Drs. Yang Dai, Ming Ao and Shoujie Zhang made videotapes, each approximately 30 minutes long. The classes included eight lessons and also a videotape of the relaxation instructions. The Korean videotape was made by Dr. Christopher Chung videotaped the lessons in a manner appropriate to the Korean subculture. The Japanese videotapes were made by Dr. Sadanobu Ushijima, Professor and Chairman, Department of Psychiatry, Jikei University School of Medicine in Tokyo, Japan, during his visit to the UCLA Neuropsychiatric Institute.

These videotapes have been used in the community with elderly Asians. The initial aim was to find Asians from the age of 50 to 70. The reason for trying to find elderly Asians below the age of 71, was our concern about the ability to learn as one grows older. However, we obtained the groups as they were available. The age groups varied from 76.5 ± 8.8 in the Chinese group, 66.4 ± 10.7 (66.7 ± 7.9 in control group) in the Koreans, and 53.8 ± 7.7 (57.4 ± 9.8 in control group) in the Japanese.

The basic plan was to have the experimental and control groups evaluated at the outset. Then after eight weeks of classes showing the videotapes, group discussions of the videos, and lessons presented to the subjects in written form, evaluation of both the experimental and control groups was repeated. The control group was then given four lessons after which a reevaluation was performed. This was because we wanted the

control group to feel they had received something. As approved by the UCLA Human Subject Protection Committee, each subject signed a very elaborate informed consent.

RESULTS

It was found that there was a significant difference in the Hamilton Depression Rating Scale comparing the experimental group and the control group in the Korean and Japanese studies. As to the Chinese group, the first group of 20 subjects were all given the experimental condition. This is because of a misunderstanding by the volunteer who recruited the subjects in a church group for the elderly. They were all told they would have the eight classes (and thus be in our study in the experimental group). The results with the 20 elderly Chinese, all of whom received the experimental conditions, were much older than we had anticipated. Their age ranged from 61 to 89 years with the average age being 76.5. It is of considerable interest that a group of very elderly Chinese were able to learn from the videotapes and group interactions with Drs. Yang Dai, Ming Ao and Shoujie Zhang. At present, we are recruiting another group of 20 subjects, half of whom will be in the experimental group and half in the control group, and hope to have these results later this year.

DISCUSSION

We have briefly presented our research on depression prevention and suicide prevention in Los Angeles. Our results have been favorable in that the experimental group in the Korean and Japanese subjects had significantly lower Hamilton Depression Rating Scale scores. This was despite the fact that none of the subjects were clinically depressed, thus making improvement more difficult to accomplish.

We hope to follow the subjects, both experimental and control on an annual basis and follow them for perhaps as long as five years.

The title of this article is "Depression Prevention, Suicide Prevention." We are aware of the need for multiple ways to prevent depression and suicide. Indeed, our study is a preliminary exploration of the feasibility of depression prevention and suicide prevention in elderly Asian American

subjects. Since not every depressed individual is a suicidal risk and since not every person who is seriously depressed and suicidal will seek help because of the high stigma of mental illness labeling, we are aware that there still remains a need for basic education about depression. The best approach has been exemplified by the Agency for Health Care and Policy and Research (AHCPR) publications on Depression in Primary Care (5). It is frustrating that the information is there and yet not utilized. How to most appropriately disseminate the information and to persuade those who need help to seek help? Even in times of disaster, for example, the great earthguake in Kobe in 1995 when hundreds of thousands of people were impacted, one wonders how many of them were depressed and suicidal and might have benefited from mental health professional help.

Our efforts were specifically focused on elderly Asians because of the high prevalence of suicide among the elderly Japanese males and females and among Chinese females. It is probable that in this group especially, there are problems related to the high prevalence of death among peers, increasing prevalence of physical illness and depression so that the combined impact may become cumulative. We do not assume that our efforts will have a major impact on the Asian American community, however, we hope that our videotapes and lessons will benefit the Chinese, Korean and Japanese communities.

CONCLUSION

Our preliminary results have shown that our videotapes and classes with psychiatrists from China, Japan and Korea have improved the level of symptoms in nonpsychiatrically diagnosable community subjects in Los Angeles. We are currently in the process of completing the experimental and control groups in the Chinese study. Of special interest are our results with the Chinese American group whose ages were 61 to 89 years, who improved on the Hamilton Depression score despite the fact that they had very few symptoms and were not clinically diagnosable as being depressed.

We have collaborative studies in Asia, specifically planned in Guangzhou with Dr. Lin Gu-Hui, and in Shanghai, perhaps with Dr. Ming Yuan Zhang or Dr. Kaida Jiang. In Japan, Dr. Sadanobu Ushijima and his colleagues at Jikei University School of Medicine are planning a series of studies including elderly community subjects and patients who have been treated for major depression with appropriate medication and treatment. The experimental group will have videotapes and class instruction. Later, perhaps we'll be able to arrange collaborative studies also in Korea.

In the future, the depression prevention videotapes and instructional materials may be a part of an educational program to help community subjects cope more appropriately and adequately before they become psychiatrically ill.

ACKNOWLEDMENTS

This study was supported in part by the National Research Center on Asian American Mental Health (NIMH #R01 MH44331). This article is based on a presentation given at the 149th Annual Meeting of the American Psychiatric Association, New York, May 4-9, 1996.

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