Treatment of Depression in African American Primary Care Patients

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Introduction

Depression is a common and costly psychiatric condition, affecting nearly 18.8 million American adults or about 9.5 percent of the U.S. population in a given year (National Institute of Mental Health [NIMH], 2003), and the functional disability associated with this condition is comparable to or worse than many chronic medical conditions such as arthritis, diabetes, and hypertension (Broadhead, Blazer, George, & Tse, 1990; Wells et al., 1989). Individuals suffering from depression seek help as frequently from their primary care physician (48%) as from mental health specialists (49%) (Narrow, Regier, Rae, Manderscheid, & Locke, 1993). However, depression frequently goes unrecognized and untreated in primary care settings (AHCPR Depression Guideline Panel, 1993). In this report we examine depression in African Americans, focusing specifically on the prevalence of this disorder, mental health treatment, and the effectiveness of evidenced-based psychotherapy and medication for African Americans with depression.

Prevalence of Depressive Disorder in African Americans

Numerous community-based studies have documented higher rates of depressive symptoms among African Americans than among Whites, although these differences were eliminated when socioeconomic status was controlled for (see Neighbors and Williams for a review: 2001). However, recent epidemiological studies of community-based samples have found few racial differences in the prevalence rates of depressive disorders. In the first national study of psychiatric disorders in the United States, the Epidemiologic Catchment Area Study (ECA), Kessler and colleagues (1994) found that African Americans had lower rates of mental illness than Whites in all major diagnostic categories (including major depression). Similarly, in a recent replication of this survey (Kessler et al., 2003), African Americans had comparable rates of major depression in the past 12 months and lower rates of lifetime major depression when compared to Whites. Brown, Ahmed, Gary, and Milburn (1995) found a slightly higher rate (3.1%) of major depression in a community sample of African Americans than that reported in the ECA Study (2.2%) (Weissman, Bruce, Leaf, Florio, & Holzer, 1991), and in contrast to other epidemiological studies of

depression, they found no gender differences in the rates of major depression. Finally, no racial differences were found in rates of major depression or severity of depressive symptoms once gender and income were controlled for in a large sample of African American, Asian American, and White primary care patients (Jackson-Triche et al., 2000). These findings indicate that while higher depressive symptoms are associated with lower socioeconomic status, African Americans experience clinical depression (i.e., depression for which treatment is indicated) at rates that are similar to Whites.

Treatment Seeking Among African Americans

Despite similar rates of depression among African Americans and Whites, disparities in treatment for depression are significant, particularly in the mental health sector (Snowden, 2001), with African Americans typically having significantly lower rates of treatment seeking than Whites (Sue, 1988; Sue, Fujino, Hu, Takeuchi, & Zane, 1991), higher drop-out rates from treatment (Sue, Zane, & Young, 1994), and greater use of emergency care (Hu, Snowden, Jerrell, & Nguyen, 1991). However, this disparity is not as great in general medical settings, in which African Americans have been found to discuss mental health problems as frequently as Whites (Ford, Kamerow, & Thompson, 1988). Further, in the NIMH ECA Study, among patients with major depression African Americans were more likely than Whites to report that they received care for depression solely in the general medical sector (Cooper-Patrick, Crum, & Ford, 1994). More recent work suggests that this pattern of underutilization may be changing. Using data from the Baltimore Epidemiologic Catchment Follow-up Study, *Cooper-Patrick, Gallo, Powe, Steinwachs, Eaton, and Ford* (1999) found that mental health service utilization had increased for both African Americans and Whites. This increase was greatest among African Americans who sought care in the general medical sector. In addition, Bosworth, Parsey, Butterfield, McIntyre, Oddone, Stechuchak, and Bastian (2000) found that when access to care is equitable (i.e., in the Veterans Affairs Medical System), African American women veterans expressed a greater desire for mental health services and comparable use of services when compared to Whites.

Disparities in Recognition and Treatment in the Primary Care Sector

Even though African Americans are more likely to receive care in the primary care sector, disparities exist in both the recognition of depression and its treatment. Such disparities underscore the continuing need to make identification of depression and treatment within the primary care sector responsive to racially and ethnically diverse populations. Primary care practitioners face the challenging task of considering the interplay of physical and psychological symptoms in their diagnostic and treatment decision-making. This process may be even more complex when treating African Americans because of increased rates of certain medical conditions and the common expression of psychological distress through somatic symptoms. Researchers have

found that a focus on somatic symptoms and physical functioning is common among depressed African Americans (Adebimpe, 1981; Brown, Schulberg, & Madonia, 1996). However, this clinical presentation may contribute to lower recognition of depression because physicians' detection of depression is higher when patients report psychological distress and impaired psychosocial functioning (Coyne, Schwenk, & Fechner-Bates, 1995). For example, Borowsky and colleagues (2000) found that primary care physicians were less likely to detect mental health problems in Latino and African American women when compared to White women.

Physical illness is a risk factor for depression (AHCPR Depression Guideline Panel, 1993), and this may be particularly salient for African Americans because of substantially higher rates of morbidity, mortality and disability associated with such conditions as diabetes, heart disease, and cancer (U.S. Department of Health and Human Services, 2000). In fact, Kosch, Burg, and Podikuju (1998) found that detection of anxiety or depression by primary care physicians was higher among White women when compared to African American women, a difference that was most pronounced when African American women had a comorbid medical condition. Additionally, the presence of psychiatric disorders such as depression and anxiety may increase the morbidity associated with chronic medical conditions because individuals with these psychiatric disorders are less likely to receive regular medical care (Cooper-Patrick, Crum, Pratt, Eaton, & Ford, 1999). Even when recognized, some studies have found that African Americans are more likely to receive inadequate treatment for psychiatric disorders in the primary care sector (Green-Hennessy & Hennessy, 1999; Skaer, Sclar, Robison, & Galin, 2000; Wang, Berglund, & Kessler, 2000). In contrast, Rollman and colleagues (2002) found that while treatment of depression was sub-optimal among primary care physicians, there were no racial differences in adequacy of depression treatment. However, primary care physicians were more likely to provide counseling for depression among White patients.

Factors Influencing Treatment Seeking Behavior

A number of salient barriers to mental health care for African Americans have been identified in recent work. These include perceptions of stigma, beliefs that stress and life experiences are the cause of depression, beliefs that reliance on personal coping strategies is most appropriate for managing depression, mistrust of healthcare professionals, and concerns about the effects of psychotropic medications (Brown, Taylor et al., 2003; Cooper et al., 2003; Cooper-Patrick et al., 1997; Millet, Sullivan, Schwebel, & Myers, 1996). In addition, knowledge about depression treatment and preferences for counseling over medication may affect treatment engagement (Dwight-Johnson, Sherbourne, Liao, & Wells, 1999). The development of a collaborative relationship with the primary care physician may also be an important factor that can facilitate an individual's willingness to begin treatment (Brown, Taylor et al., 2003). In fact, Cooper-Patrick, Gallo, and colleagues (1999) found that African

American primary care patients' satisfaction with mental health treatment was significantly associated with the treating physician's participatory decision-making style. When compared to Whites, African Americans rated their physicians as being less participatory, except when they saw African American physicians. As primary care practitioners work to reduce disparities in the recognition and treatment of depression in African Americans, it will be important for them to be cognizant of sociocultural factors that may influence expression of depressive symptoms and styles of coping with depression (Brown, Abe-Kim, & Barrio, 2003). Additionally, the development of a trusting relationship and awareness of an individual's preferred decision-making style can help facilitate treatment acceptance and adherence.

Effectiveness of Evidenced-Based Treatments for African Americans

Despite a growing body of literature documenting the effectiveness of treatments for depression within the primary care sector (see Schulberg, Katon, Simon, & Rush for a review: 1998), only a handful of studies have enrolled sufficient numbers of ethnic minorities to enable the evaluation of treatment response in these groups. However, the published studies summarized below report promising findings regarding the effectiveness of depression treatments for African Americans and other ethnic minorities.

Organista and colleagues (1994) found significant pre- to post-treatment symptom reductions in an open trial of cognitive-behavioral therapy for depression in low income and ethnic minority public sector primary care patients. Miranda and Munoz (1994) found that a cognitive behavioral course was effective in reducing depressive symptoms and missed physician appointments in a sample of African American, Latino, and White primary care patients with minor depression. These outcomes were maintained by patients through the one-year follow-up. Brown and colleagues (1999) found comparable reductions in depressive symptoms in African American and White primary care patients enrolled in a randomized clinical trial comparing interpersonal psychotherapy (IPT) or medication (nortriptyline) with physicians' 'usual care.' Both the IPT and medication conditions were more effective than 'usual care'. However, African Americans had less improvement in self-reported physical and psychosocial functioning than Whites. In addition, African Americans had lower drop-out rates from the psychotherapy condition and higher attrition rates from the medication condition. Miranda, Azocar, Organista, Dwyer, and Arean (2003) conducted a randomized trial to examine the effectiveness of supplementing traditional cognitive behavioral therapy (CBT) for depression with clinical case management in low-income Latino, African American and White primary care patients. They found that patients receiving CBT along with supplemental case management had better treatment retention rates than those who received CBT alone. Clinical outcomes for African Americans and non-Spanish speaking Whites were similar in both conditions. However, supplemental case management was superior

to CBT alone in terms of clinical outcome for Spanish-speaking patients. In a second randomized clinical trial evaluating the effectiveness of psychotherapy versus medication treatment in young minority women (White, African American, Latino), Miranda, Chung, Green, Krupnick, Siddique, Revicki, and Belin (2003) found that both medication and psychotherapy were superior to referral to community mental health services in reducing depressive symptoms. In addition, more women engaged in an adequate duration of medication than psychotherapy, and clinical improvement was greater for medication. Finally, Wells and colleagues (2000) enrolled a diverse sample that included Latinos, African Americans, "other minority," and Whites in a randomized controlled trial of Quality Improvement (QI) programs in managed care practices for depressed primary care patients. QI programs significantly improved mental health outcomes, quality of care, opportunities for depression treatment, and retention of employment for depressed patients, while medical visits did not increase. When outcomes for minorities were examined (Miranda, Duan et al., 2003), researchers found that African Americans and Latinos who received the QI intervention had significantly better clinical outcomes than those in the control condition; Whites showed similar clinical improvement in both conditions. However, although White participants had higher rates of employment following the intervention, African Americans and Hispanics did not.

Summary and Conclusions

Recent epidemiological studies show that African Americans have comparable rates of depressive disorders when compared to Whites (Kessler et al., 2003; Kessler et al., 1994). Further, African Americans are more likely to seek help for depression from primary care practitioners (Cooper-Patrick et al., 1994). However, disparities in the recognition and treatment of depressed African American primary care patients have been reported. Recognition of depression in African American patients by primary care practitioners is lower when compared to Whites (Borowsky et al., 2000; Kosch et al., 1998), as are rates of evidenced-based care (Wang et al., 2000). Although one study found no differences in the care for depression provided African American and White primary care patients (Rollman et al., 2002), the authors noted that care was sub-optimal for all patients and that African Americans were less likely to be counseled by their primary care physician. The latter finding is consistent with that of Cooper-Patrick, Gallo, and colleagues (1999) who found that African Americans reported that their White primary care physicians had a less participatory decision-making style. Development of a collaborative relationship is important because it may well influence an individual's willingness to engage in depression treatment and adhere to treatment recommendations.

Results of several recent randomized clinical trials conducted within primary care settings indicate that evidenced-based psychotherapy (e.g., interpersonal psychotherapy, cognitive-behavioral psychotherapy), pharmacotherapy and quality

improvement efforts are effective in treating depressed African American primary care patients. Of equal importance, however, are the cultural and contextual adaptations needed to make these interventions effective for diverse populations. These included incorporating patients' spirituality as a coping method in psychotherapy (Organista et al., 1994); including experts on the treatment of ethnic minorities on the treatment team; making information about treatment of ethnic minorities available to primary care practitioners (Miranda, Duan et al., 2003); providing translation services to non-English speaking patients (Miranda, Azocar et al., 2003); providing childcare services, transportation; and using intensive outreach to engage and retain impoverished women in treatment (Miranda, Chung et al., 2003).

Finally, as we continue to place emphasis on improving the mental health of African Americans it is important that we include the primary care sector in these efforts because it is a major source of care for African Americans with depression and other psychiatric disorders. Although the findings of several depression treatment trials are indeed promising, additional research and physician training will be critical to develop effective ways of helping physicians recognize depression in diverse populations and to treat it effectively. Additionally, health policy changes will be needed to provide the appropriate financing necessary for outreach efforts and other ancillary services needed to provide care effectively to African Americans and other minorities.

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