Overcoming Barriers to Care: Engaging Minority and White Individuals with Low Incomes and Depression in Evidence-based Treatments

Nancy K. Grote, Ph.D.

Research Associate Professor
University of Washington School of Social Work
Promoting Healthy Families Program

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Objectives

- Poverty, stress, and depression
- Underutilization of mental health services by women with low incomes, especially women of color
- Barriers to treatment engagement and retention
- What can we do to engage women of color with low incomes and depression in treatment?
- What can we do to retain them in a full course of treatment?
- Future directions

Poverty, Stress, and Depression

- **If you are an African American (AA) living in the U.S. today, your chances of being poor (living under the poverty line) are 1 in 4 or 25%** (US Census Bureau, 2000)

- **If you are Hispanic, your chances are about 1 in 4** (US Census Bureau, 2000)

Depression

- **Unipolar depression vs. bipolar depression (manic-depression)**

- **Unipolar** – 5 or more of the following sx have been present during the same 2 week period that cause significant impairment in functioning (social, job):

  depressed mood, loss of interest or pleasure; significant weight loss or decrease in appetite, insomnia or hypersomnia; psychomotor agitation or retardation; loss of energy or fatigue, worthlessness or excessive guilt; difficulty concentrating or making decisions; thoughts or attempt of suicide

- **Bipolar depression (manic-depression) –** presence of mania (with or without depression) that causes significant impairment in functioning (social, job)

  abnormally elevated, expansive or irritable mood for at least 1 week

  3 of the following sx present: inflated self-esteem or grandiosity; decreased need for sleep; racing thoughts; distractibility; increase in goal-directed activity; excessive involvement in pleasurable activities that lead to painful outcomes

DSM-IV, 1994

Poverty, Stress, and Depression

- **Poverty increases exposure to many acute and chronic stressors that increase the risk for depression** (Belle, 1990).
- **Poverty decreases access to resources that can buffer the impact of these stressors** (Belle, 1990).

Study of acute stress, chronic stress, and depressive symptoms

(Grote, Bledsoe, Larkin, & Brown, 2007)

Questions:

- **How can we better understanding the links between acute and chronic stress and depression?**
- **How can we engage and retain in treatment women who have multiple stressors, but few financial or social resources to deal with them?**

Study of acute stress, chronic stress, and depressive symptoms

(Grote, Bledsoe, Larkin, & Brown, 2007)

- **Sample of 97 African American and 97 White Ob/Gyn patients with low incomes**

- **Revision of the African American's Stress Scale:**

  (Watt-Jones, 1990)

  qualitative interviews with AA and White women with low incomes

Description of Acute Stressors

- **Acute (a time-limited event requiring a certain degree of life change)**

  death of family member, parent, child

  income decreased; got into debt; lost your job

  family member or partner arrested; friendship breaks up

  marriage, breaking up with partner, had a child, miscarriage, abortion

  you were the victim of a crime against your person

Description of Chronic Stressors

- **Chronic (a continuing demanding condition that does not change):**

being on welfare, being unemployed

family member or friend with emotional/financial problems

your partner lies to you, asks to borrow money from you

trying to find a dependable babysitter

chronic pain or disability

Description of Chronic Stressors

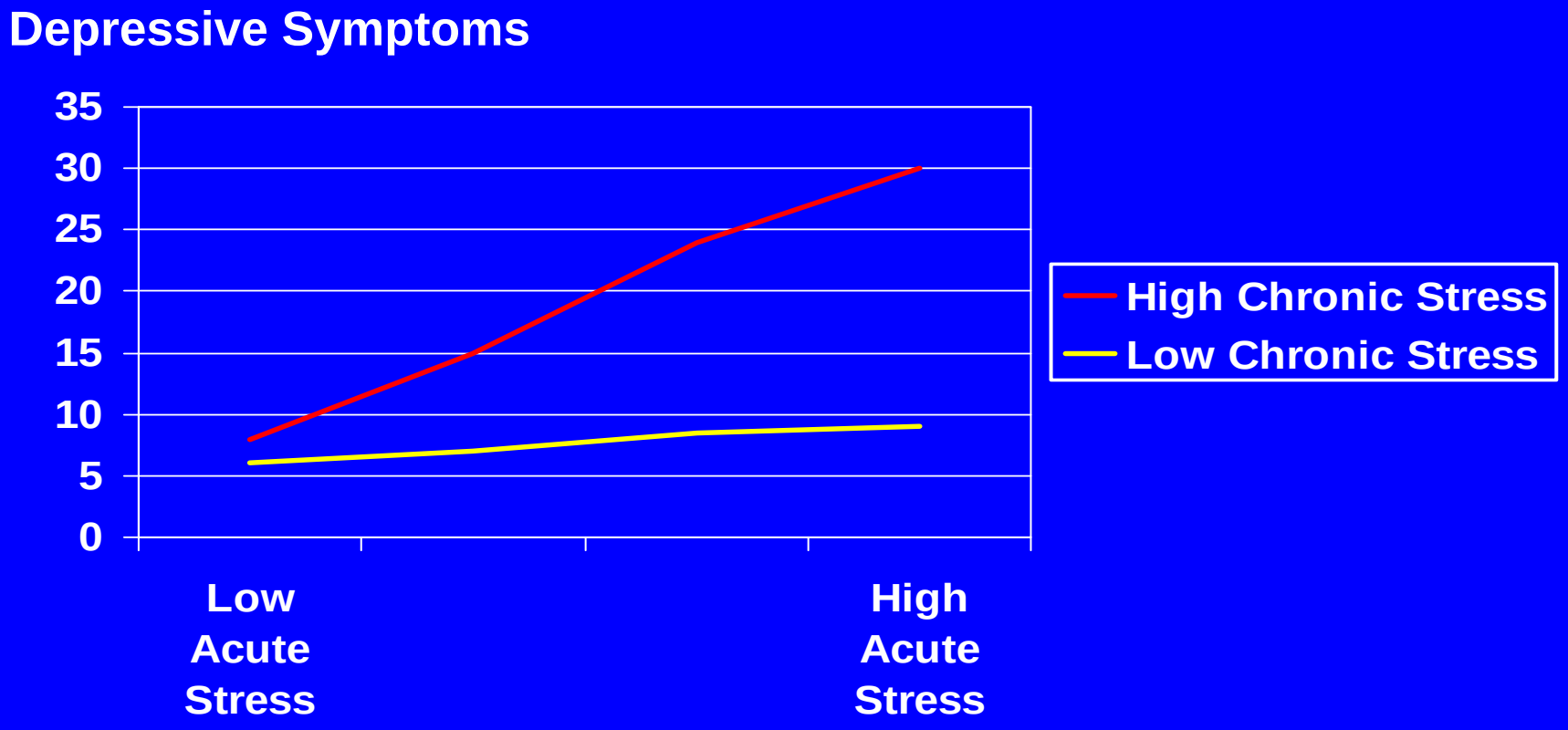
- African American women with low incomes reported more chronic stressors than white women with low incomes:
  - trying to get landlord to make repairs
  - living in a neighborhood with high crime
  - living in a violent neighborhood
  - living in an excessively noisy neighborhood
  - trying to make ends meet/running out of money
  - unable to afford a car
  - being the only parent
  - being approached/spoken to disrespectfully by someone discriminating against you

Results

- As predicted, chronic stress (b = .42***) accounted for more of the variance in depressive symptoms than acute stress (b = .25*) -- 16% vs 6.3%
- Chronic stress appeared to exacerbate the effects of acute stress on depression – for each unit increase in chronic stress there was a 2.6 unit increase in the effect of acute stress on depression

Chronic Stress Amplifies the Effects of Acute Stress on Depressive Symptoms

(Grote, Bledsoe, Larkin & Brown, 2007)



Poverty, Stress, and Depression

- **Unipolar depression vs. bipolar depression (manic-depression)**
- **Individuals living in poverty have a twofold increased risk of depression, controlling for age, race, sex, or history of depression** (Bruce, Takeuchi, & Leaf, 1991).
- **1 in 4 mothers living in poverty were depressed during their childbearing and childrearing years** (Scholle et al., 2003; Siefert et al., 2000) **vs. 1 in 8 women with middle class incomes**

Underutilization of Mental Health Services

- **Women of color with low incomes and depression rarely seek or receive treatment in mental health settings (13%).**
  (Miranda et al., 1998; Siefert et al., 2000)
- **Data from Surgeon General (2001) and Wang et al. (2005)**
  - **Emergency room and inpatient service use** (Snowden, 2001)

The Risks of Untreated Depression

- **The course of depression becomes recurrent in 50 - 70% of new cases** (Kupfer, 1991).
- **The risk of recurrence rises with each successive episode.**
- **The severity of subsequent episodes tends to increase.**
- **Public health burden of maternal depression and adverse effects on child mental health and development**
  (DHHS, 1991; Field, 1992)

Barriers to Care

- **Practical**
- **Psychological**
- **Cultural**

Putting it into context – an ecological model of barriers to treatment engagement and retention

An Ecological Model of Barriers to Treatment Engagement and Retention

Distal Influences ----> **Proximal Influences** ----> **Rx Adherence** ----> **Rx Outcomes**

Community Barriers

violence, safety concerns
lack of support services
unemployment; poverty
lack of access to M.H. services

Helping System Barriers

bias or cultural insensitivity in environment, procedures, providers
lack of evidence-based treatments
lack of diversity in clients & staff
provider overload and burn-out

Social Network Barriers

negative attitudes toward RX
social network strain

Client Barriers

practical- time, financial, transportation, child care
psychological - stigma, low energy, negative RX experiences
cultural – women's view of depression
multiple stressors/coping strategies
strong self-reliance

Practical Barriers to Care

- **“By the time I meet with my teenager’s parole officer, go to work, take care of my other kids, nurse my ailing grandmother, and take 2 buses across town to get here, I don’t have time in my life for treatment.”**

Practical Barriers to Care

- **Costs – 40% AAs and 52% Hispanics lack health insurance in the US** (US Census Bureau, 2003)
- **Access**
  - **Inconvenient or inaccessible clinic locations**
  - **Limited clinic hours**
  - **Transportation problems**
- **Competing Obligations**
  - **Child care and social network**
  - **Loss of pay for missing work**
  - **Dealing with chronic stressors**

Practical Barriers to Care: Recommendations

- **An engagement strategy needs to help with costs of transportation and childcare, offer flexible scheduling in an accessible location.**

- **Depression treatment needs to incorporate the use of phone therapy** (Simon et al., 2004).

Psychological Barriers to Care

- **Stigma**
- **Stigmatizing treatment settings**
- **Previous negative experiences with treatment**
- **Therapist characteristics, including race/ethnicity**
- **Burden of depression**

Psychological Barriers to Care: Stigma

- **“I don’t want to be that person to get the medication and be called “DEPRESSED”; my sister had to live with that label – she has panic.”**
- **“My mother was depressed when I was growing up. They locked her up in the hospital and treated her like she was crazy. I promised myself that I would not get depression like my mother.”**

Psychological Barriers to Care: Stigma

- **Depressed individuals may choose to avoid the shame of stigma (e.g., crazy, violent, defective) by not seeking treatment or discontinuing treatment prematurely** (Link & Phelan, 1991).

- **In a study of perceived stigma among low-income, depressed AA and white women in an Ob/Gyn clinic:** (Scholle et al., 2003)

  - **51% of these women reported worrying about what their family or friends would think about their depression**

  - **40% said they were embarrassed to discuss their depression with anyone**

Psychological Barriers to Care: Recommendations -> Stigma

- **An engagement strategy needs to address the stigma of depression by providing accurate information about depression** (Anderson et al, 1986; K. Davis, 2003)

- **Depression is a medical illness; it is not the woman's fault; it does not mean she is crazy; there are effective treatments that can help her feel better**

  (Weissman, Markowitz, & Klerman, 1984)

Psychological Barriers to Care: Stigmatizing Treatment Settings

- **"I feel that this therapy in the Ob/Gyn clinic is better – it's not so out in public; and it's connected with my doctor's visits."**
- **Recommendations:**
  - **help-seeking and depression treatment in primary care settings** (Miranda et al., 1998)
  - **school-based mental health services** (Catron & Weiss, 1994)
  - **Supermarket Psychotherapy** (Swartz et al., 2002)

Psychological Barriers to Care: Negative Experiences with Mental Health Care

- **"When I saw a therapist, it felt like she was just "doing her job" and she didn't care. I didn't feel I could be natural or comfortable, so I quit."**
- **"I don't want the therapist to report my depression to CYF (child protective services) because they might take my baby away."**
- **"My therapist told me to leave my baby's father who has problems with heroin."**

Psychological Barriers to Care: Recommendations -> Negative Rx Experiences

- **An engagement strategy needs to focus on:**

  1) a woman's previous negative experiences with mental health care

  2) what she wants in a therapist, including her feelings about racial/ethnic differences between them

  (Thompson et al., 2004)

- **The therapist needs to show true warmth and acceptance.**

- **The therapist needs to differentiate her role from that of caseworkers in other social agencies.**

Psychological Barriers to Care: The Burden of Depressive Symptoms

- **"Sometimes I may wake up and say, "I want to change my appointment. I don't want to go out into the world today."**
- **Recommendations:**
  - **Inquire about the burden of depressive symptoms and how they might interfere with coming for treatment.**
  - **Blame the depression, not the woman.**
  - **Emphasize flexible scheduling of appointments**
  - **Incorporate the use of phone therapy** (Simon et al., 2004)

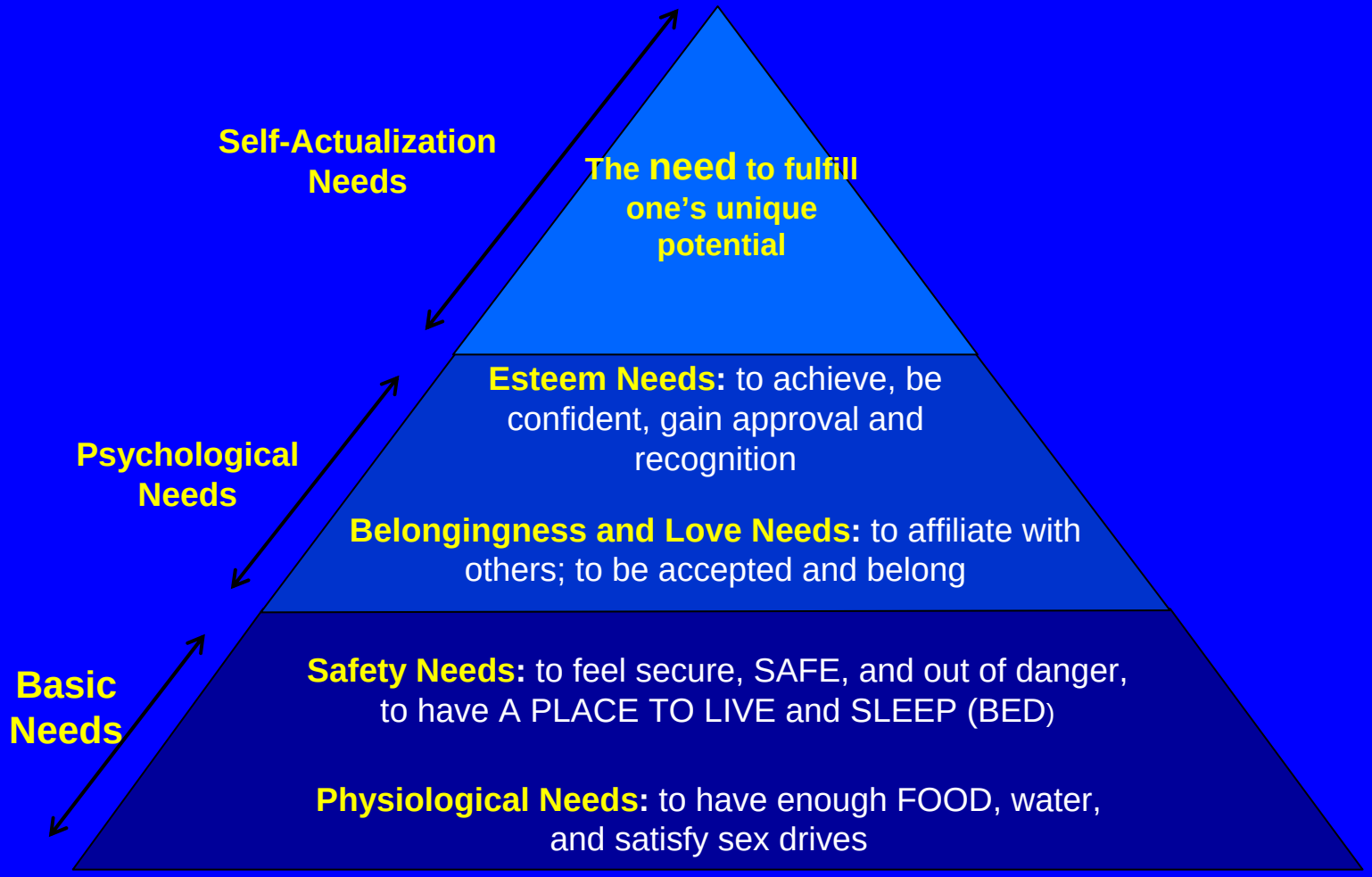
Cultural Barriers to Care: The Culture of Poverty

- **“No one can understand what my depression is like ‘til they have walked in my shoes and had no money.”**
- **“My therapist seemed overwhelmed by all my practical problems, so how could she help me?”**
- **“I don’t see how just talking about something can change it. How is me talking about losing my job going to get me another job?”**

Cultural Barriers to Care: Maslow's Hierarchy of Needs (1970)

- **Self-Actualization Needs**
- **Psychological Needs**
- **Fundamental Needs**

Maslow's Hierarchy of Needs, 1979



Cultural Barriers to Care: Recommendations -> the Culture of Poverty

- **An engagement strategy for women with low incomes and depression will require a scope broad enough to conceptualize their depression as critically linked with multiple social problems and chronic stress.**

- **Therapy must involve not just talking about problems, but advocacy -- helping her address her problems in a pragmatic way. Add a case management component.**

Cultural Barriers to Care: The Culture of Race

- **Clinician insensitivity to how African American women may manifest depression (somatic symptoms) or explain depression in spiritual or cultural terms**

  (Brown, Abe-Kim, & Barrio, 2003)

- **Clinicians may see only the negative in the lives of minority women & may fail to operate from a "strengths perspective."**

  (Saleebey, 1997)

- **2 kinds of bias**

Cultural Barriers to Care: The Culture of Race

And though you're poor it isn't poverty that
concerns you
and though they fought a lot
it isn't your father's drinking that makes any difference
but only that everyone is together and you
and your sister have happy birthdays and very good Christmasses
and I really hope no white person ever has cause
to write about me
because they never understand
Black love is Black wealth and they'll
probably talk about my hard childhood
and never understand that
all the while I was quite happy.

-- from "Legacies" by Nikki Giovanni

Psychological Barriers to Care: Does Race of Therapist Matter?

- **Thomas and associates observed that African Americans have a long history of suspicion toward and mistrust of medical research and view prevention and treatment services within the context of contemporary racism**
  (Corbie-Smith et al., 2002; Freimuth, et al, 2001)

Psychological Barriers to Care: Does Race of Therapist Matter?

- **“Sitting in front of a white therapist isn’t necessarily like she thinks she is better than me, BUT there are some white people who think they can look down on you and show favoritism to people of their nature and culture and treat you any kind of way.”**

- **“No, I don’t think it matters.”**

Cultural Barriers to Care: The Culture of Race

- **Clinicians may fail to appreciate the personal resources that African American women with low incomes have relied on to cope with stress.**

- **Spirituality and religion are often important psychological coping mechanisms and sources of resilience in Latina and African American women.**

(Mays, Caldwell, & Jackson, 1996; Miranda et al., 1996)

Psychological Barriers to Care: Does Race of Therapist Matter?

- **" When I first met you I wondered " how could you as a white woman help me?" But you really listened and cared about me and my problems. You believed in me and didn't judge me."**

- **Race/ethnicity matters, but so do other therapist characteristics - interpersonal warmth and acceptance.**

(Comas-Diaz & Greene, 1994; Miranda et al., 1996; Thompson et al., 2004)

Cultural Barriers to Care: The Culture of Race

- **"My relationship with God and my church got me through the worst times; He gave me strength and told me to "get moving"; people prayed with me and for me; I rely on Him to get me through the day; I know He's taking care of me."**

- **"Now I know I can work with you because you understand my faith and the importance of my church community to me."**

Cultural Barriers to Care: The Culture of Race

- **Clinicians may fail to appreciate or know how to work with the strong self-reliance African American women show.**

  (Mays, 1995)

- **Clinicians may fail to affirm the important role of mothering.**

Cultural Barriers to Care: The Culture of Race

- **Many women of color with low incomes have experienced trauma – such as childhood physical and sexual abuse or domestic violence in adulthood** (Miranda et al., 1998).
- **They have coped adaptively by relying on themselves when they could not count on others to be there for them.**

  (Mickelson et al, 1997)
- **Though adaptive, strong self-reliance has been linked with difficulties in engagement and retention in psychotherapy.**

  (Tyrell et al., 2001)

Cultural Barriers to Care: Recommendations -> the Culture of Race

- **An engagement strategy for AA women with low incomes will need to take into account their views and explanations of their depression.**
- **An engagement strategy needs to show an appreciation of the personal and cultural resources AA women have relied on to cope with their problems.**
- **Their strengths need to be incorporated into the therapy and the therapist needs to reach out to them (intrusive?).**

(Tyrell et al, 2001)

Previous Successful Engagement Practices:

- **Carol Anderson -- The psychoeducational approach**
- **Jeanne Miranda – neutral rx settings; intensive outreach, optional psychoeducation, free transportation and childcare, culturally sensitive clinicians; good results**
- **Mary McKay – engagement during phone intake: 1) exploring barriers (e.g., practical, psychological, cultural) and 2) problem-solving the barriers; good results**

The Pre-Treatment Engagement Interview

(Grote, Zuckoff, Swartz, Bledsoe, & Geibel, under review)

- **Principles of Ethnographic Interviewing:**
  - **The goal to understand the perspectives, experiences, and values of a person from a different culture without bias**
  - **The interviewer adopts a one-down position as learner**
  - **The interviewee feels safe to tell her story without fear of judgment**
- **Principles of Motivational Interviewing**
  - **The goal is to enhance the client's motivation for rx by exploring and resolving ambivalence about rx**
  - **Honoring both sides of the ambivalence about rx and the therapist**
  - **Asking permission before giving information to client**

The Pre-Treatment Engagement Interview

(Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007)

- **First Part (45 minutes) -- We asked about:**
  - **Her perception of her depression experience, including stigma**
  - **Acute and chronic stressors linked with her depression**
  - **Her strengths and coping mechanisms, especially spirituality**
  - **Previous negative experiences with mental health care**
  - **What she wants out of a therapist – does race matter?**
  - **Practical barriers – transportation, child care, scheduling**
- **Second Part (15 minutes) -- We provided:**
  - **Psychoeducation, problem solve the barriers (practical last), affirm, hope**
- **Story of Tammy**

The Engagement Interview: Empirical Findings

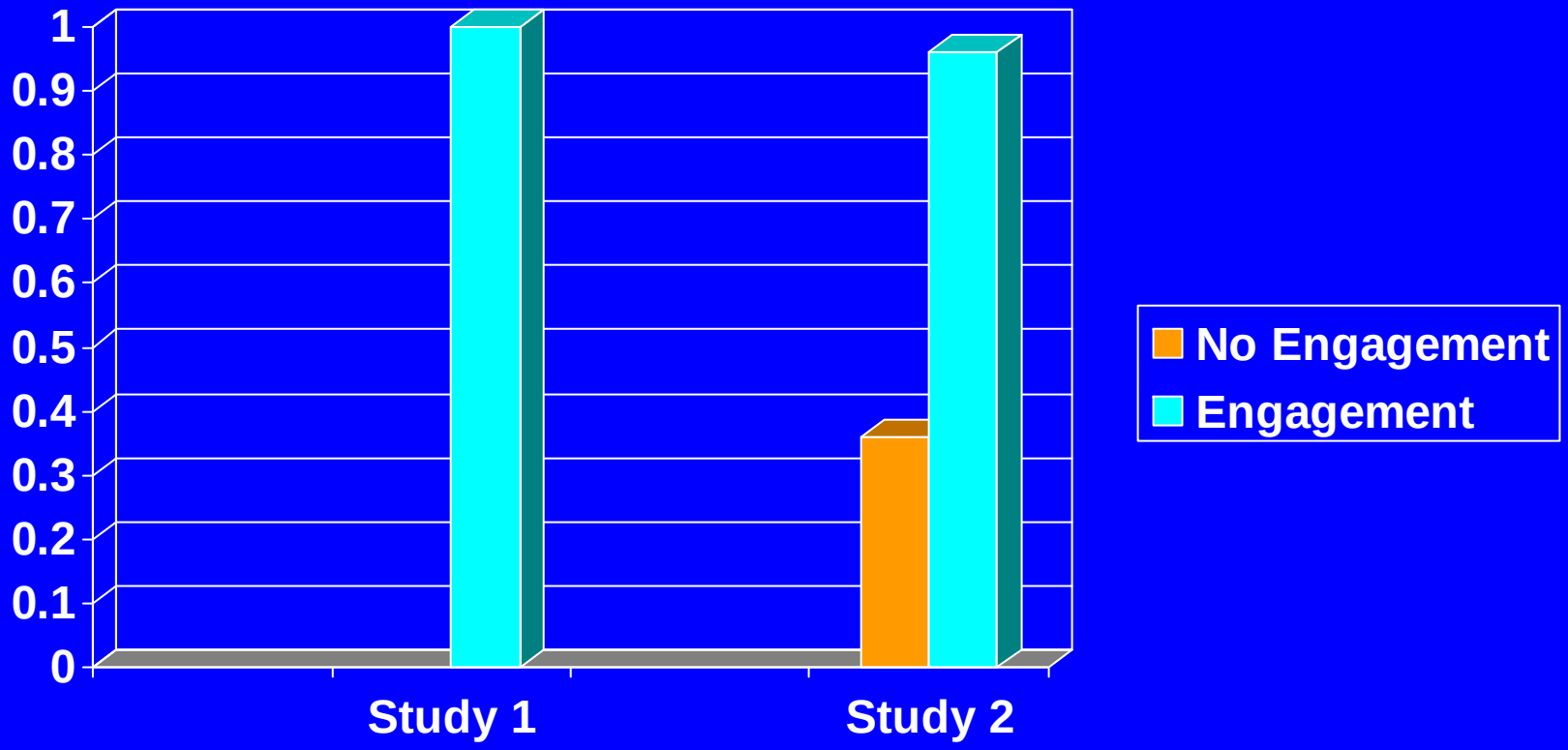
- **Sample = pregnant African American and White women with low incomes and depression receiving prenatal care in an Ob/Gyn clinic; women not seeking depression treatment**
- **Study 1 – Feasibility Study**
  - **N = 12 women; 9 (75%) were African American**
  - **Engagement Interview and 8 sessions of Interpersonal Psychotherapy (IPT)**
  - **IPT is an evidence-based depression treatment with a collectivist orientation**

The Engagement Interview: Empirical Findings

- **Study 2 – Randomized Pilot Study**
- **53 (66% African American) women randomly assigned to 2 conditions:**
  - **28 women = no engagement and referral to a community mental health center located at Ob/Gyn clinic**
  - **25 women = engagement interview and referral to Interpersonal Psychotherapy provided in Ob/Gyn clinic**
- **Results: % attending at least 1 treatment session**

% Attending at least 1 Treatment Session

(Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007)



* Less than 1/3 of phone intakes show for 1st rx session

Engagement Interview Observations

- **Most women did not want anti-depressant medication.**

  (Brody et al., 1997), Cooper-Patrick et al., 1997)

- **Clinicians were culturally sensitive, but race of clinician did not make a difference in terms of who was engaged or amount of engagement.**

- **What did matter:**
  - **Clinicians had experience & liked working with the women**
  - **Convenient, non-stigmatizing, diverse treatment setting**

    50% patients were African American

Engagement Interview Observations

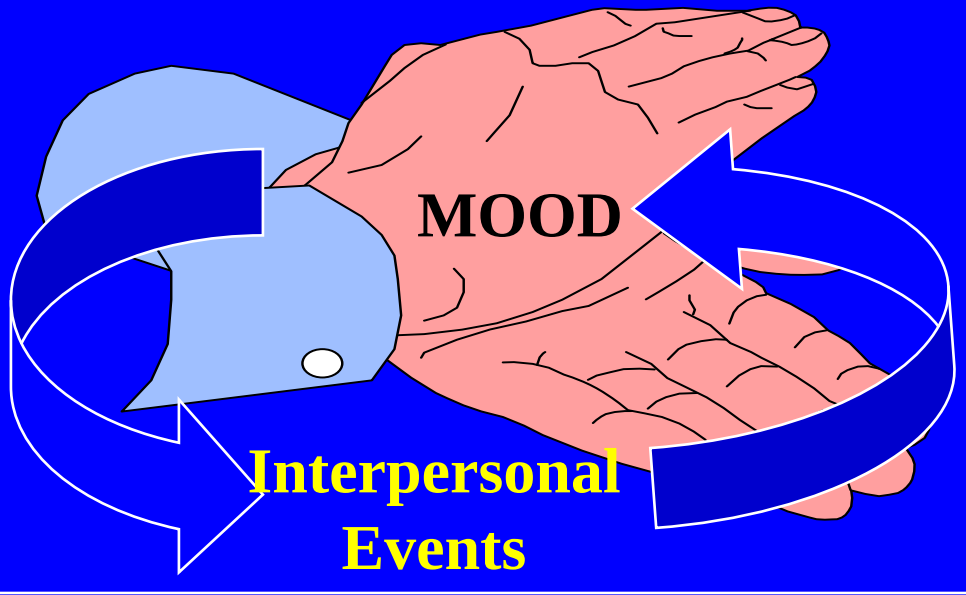
- **Similar promising indications:**
  - **Pilot data (Swartz et al., under review):**
  - **11 mothers with depression (whose children were receiving mental health treatment) participated in an engagement session before treatment**
  - **11 out of 11 (100%) attended an initial treatment session**
- **Remoralization: instills hope that this treatment will "work"**
- **Seems to "jump start" treatment & set the framework**

Introduction: What is Interpersonal Psychotherapy (IPT)?

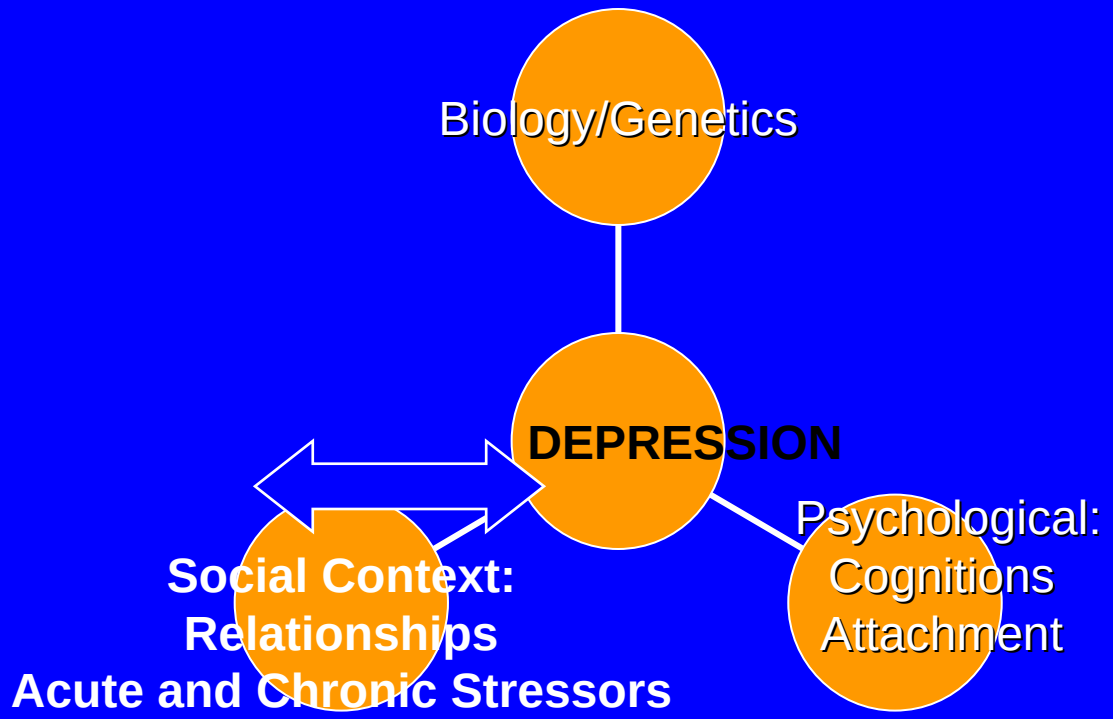
- Time-limited (12-16 weeks) individual psychotherapy for depression
- Structured, manualized treatment that has been used in research protocols
- Demonstrated efficacy for acute and maintenance treatment of depression in many studies
- Therapists like it: “it makes sense”

Introduction: What is IPT?

- Goals: symptom alleviation & improved social functioning
- Builds on empirical findings that interpersonal (IP) difficulties are linked to depressed mood & that depression impairs IP functioning



Introduction: The bio-psycho-social formulation of depression



IPT:
The Four Interpersonal Problem Areas

- Grief (complicated bereavement)
- Role Dispute
- Role Transition
- Interpersonal Deficits/Sensitivities

Goals of IPT (Weissman 2000)

- Symptom Relief from depression
- Improved Interpersonal Functioning
- Not aimed at character change

Treatment Retention:

Interpersonal Psychotherapy

(Grote, Bledsoe, Swartz, & Frank, 2004)

- **Modifications to Interpersonal Psychotherapy:**
  - **Engagement Interview before treatment**
  - **Full course of IPT in 8 vs. 16 sessions + follow-up sessions**
  - **Broader systems orientation**
  - **A specialized case management component** (Miranda et al.,2003
  - **Phone therapy if needed**

  - **Flexible scheduling of sessions in an Ob/Gyn clinic**
  - **Free bus passes and provision of child care on premises**
  - **Intensive outreach**
  - **Reminder letters and phone calls**
  - **Culturally sensitive clinicians and environment**

Treatment for depression during the perinatal risk period

→ BRIEF IPT -------

IPT Continuation and Maintenance

GOAL

- Reduce antenatal depression

GOAL

- Prevent depressive relapse post-rx-> 6 months postpartum

Overview of the Randomized Pilot Study

- **Hypothesis 1 – Culturally relevant IPT-B will lead to more treatment engagement and retention than usual care.**

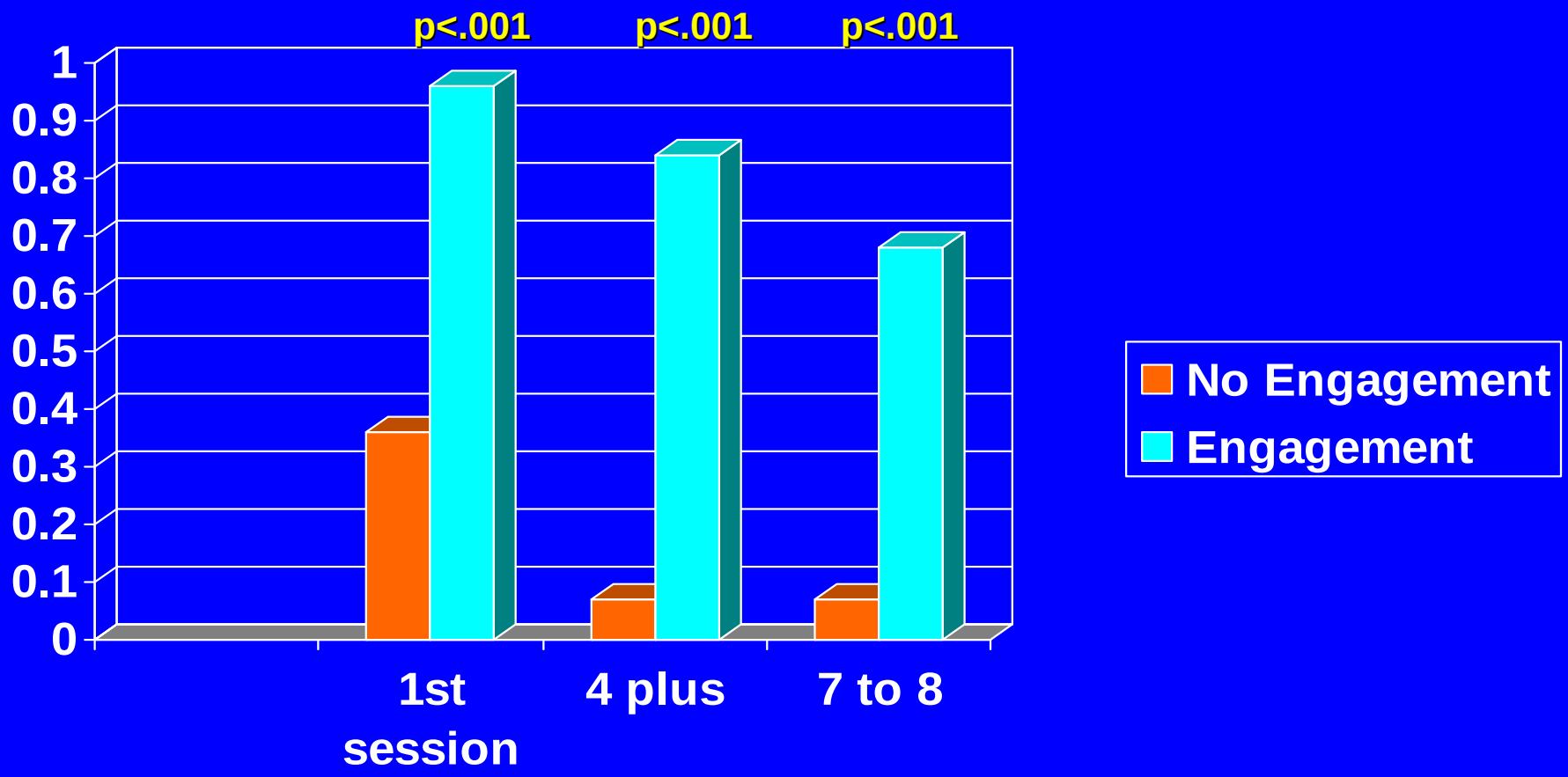
- **Hypothesis 2 – Culturally relevant IPT-B will be more effective than usual care in reducing depressive and anxiety symptoms and improving social functioning at post-rx and 6 months postpartum**

- **53 eligible, pregnant women were randomly assigned to:**

  - **Usual care = Referral to a community mental health center on same floor a Magee Ob/Gyn clinic (n=28)**

  - **Engage = Engagement session and referral to brief Interpersonal Psychotherapy (8 sessions) provided in office on same floor as Magee Ob/Gyn clinic (n=25)**

Results for Rx Engagement and Retention:
% Attending 1 - 8 Treatment Sessions



- Less than 1/3 of phone intakes attend 1 Rx session in community mental settings
- Modal (typical) number of Rx sessions attended in community mental health = 1

Use of Case Management (CM) Services

- 50% of women in brief IPT (12 out of 24) received CM services
- on average, they received 2 referrals to social service agencies
- 66% of those who received referrals reported successfully following through
- clinical observations:

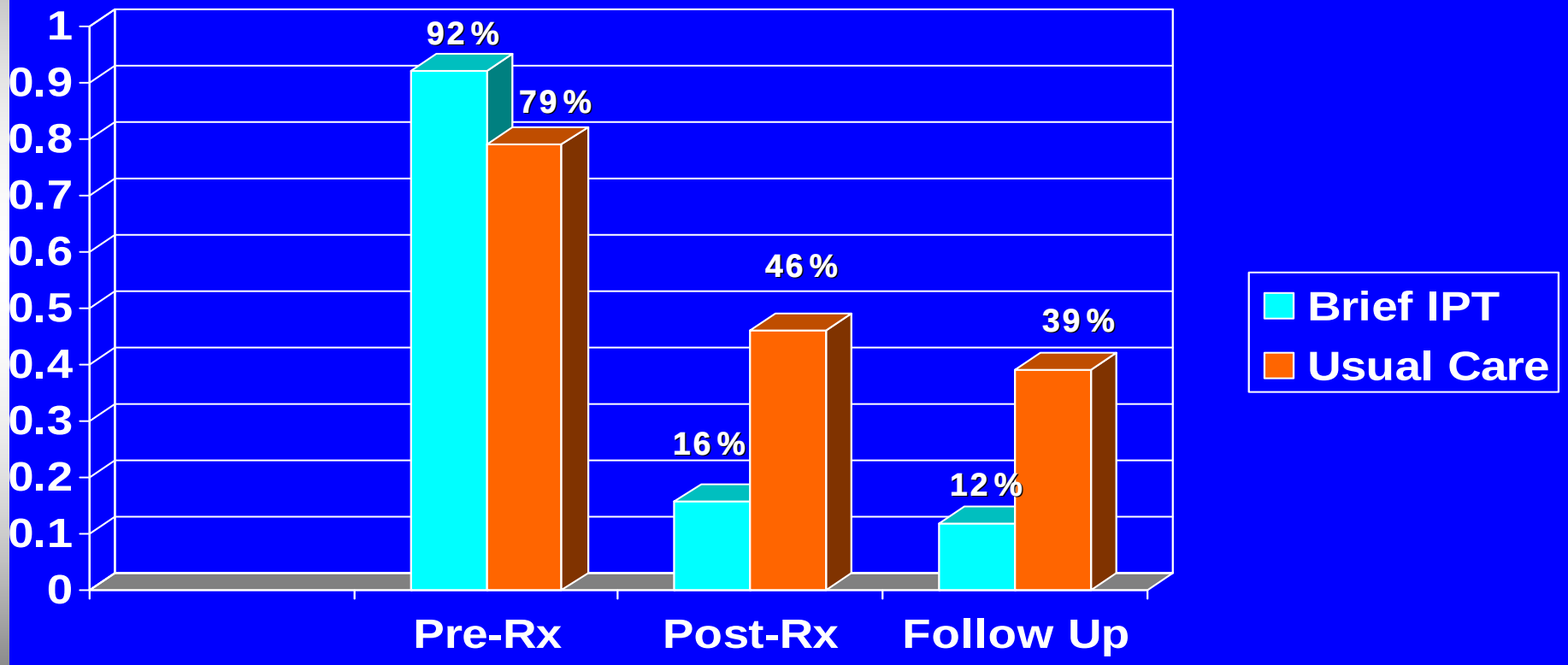
  1) focusing on CM took little time away from an IPT focus

  2) including CM made IPT more meaningful and relevant

Treatment Outcomes:
Pre- to Post-Rx and Follow Up (6 months pp)

- Diagnoses of major depression
- Depressive symptoms
- Social functioning
- Intent-to-treat analyses

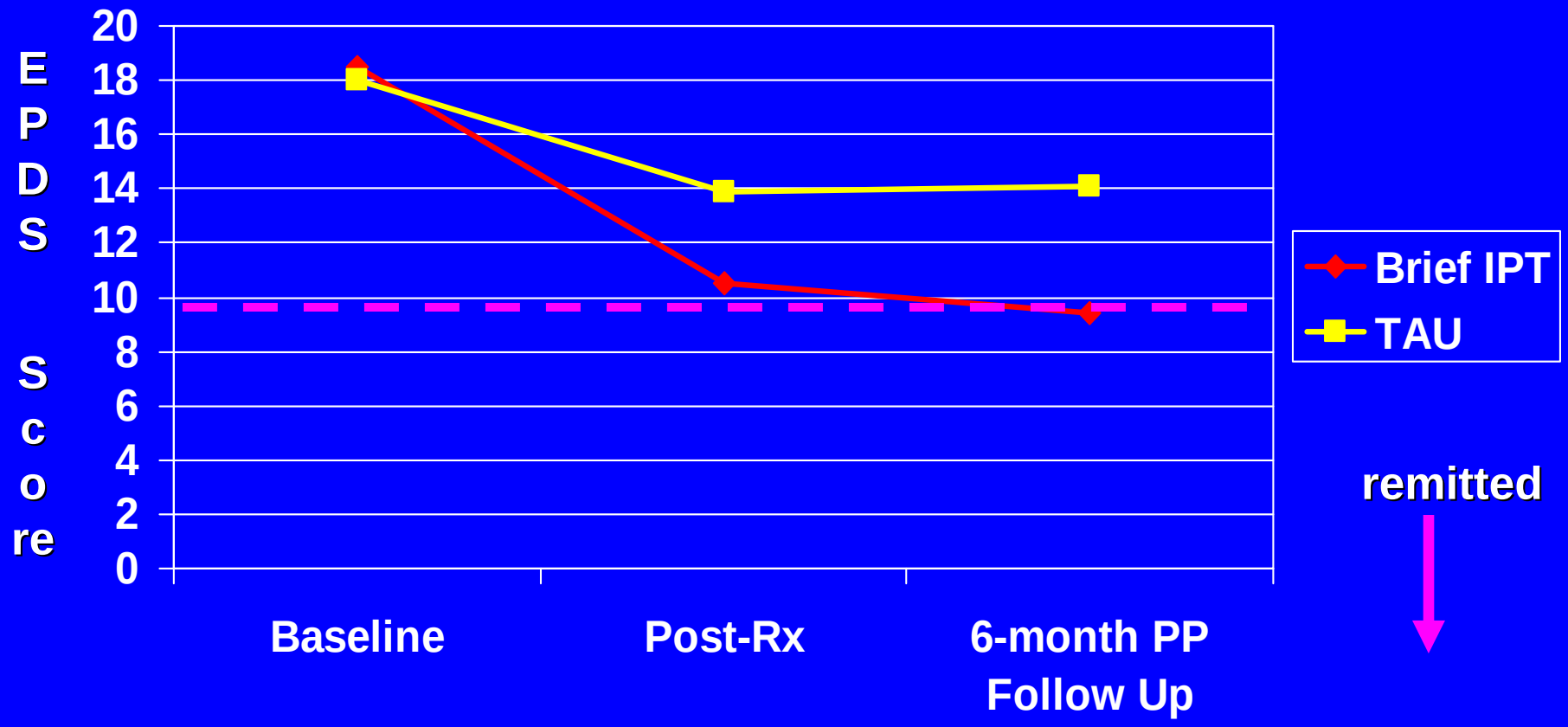
% with Major Depression Diagnoses



Pre – Post-Rx: p<.05 **Pre – F/U: p<.05**

Maternal Depressive Symptoms

(EPDS < 10 = normal functioning)

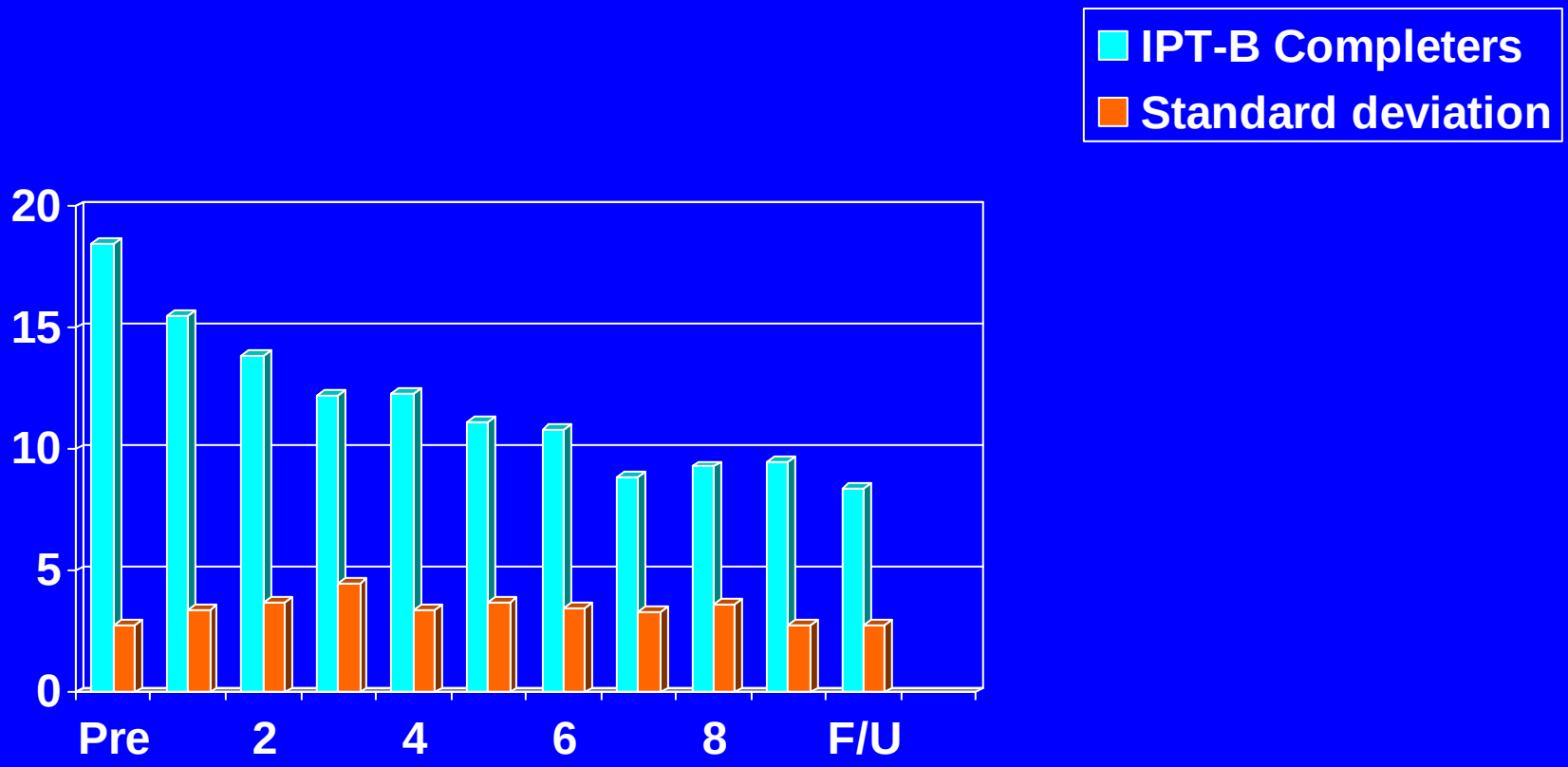


Pre-Post change: p< .01 Pre-Follow-Up: p<.001

Rx Results: EPDS Scores of Completers

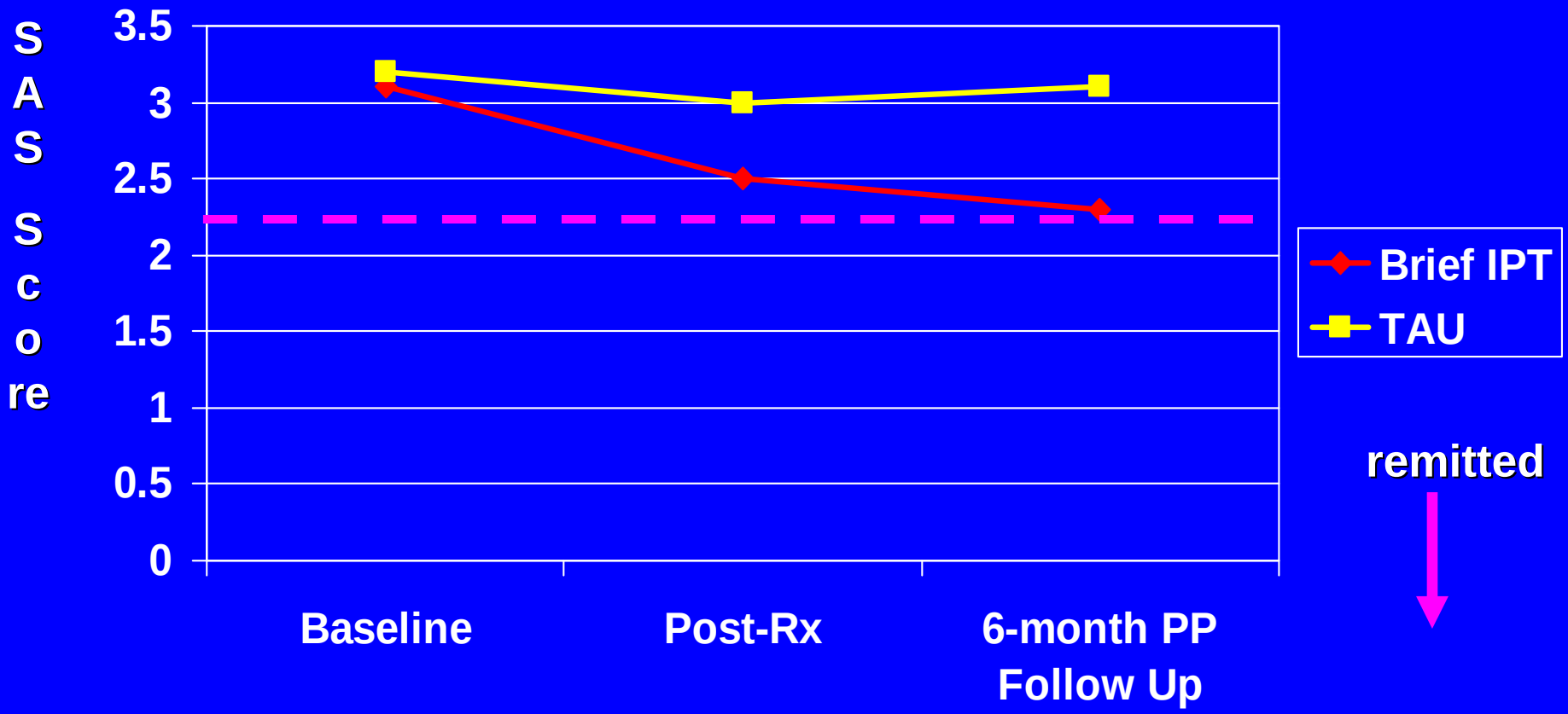
Pre- to Post-Rx and 6 month postpartum follow up

< 10 = normal range



Maternal Social Functioning

(SAS – Social and Leisure < 2.2 = normal functioning)



Pre-Post change: p< .05 Pre-Follow-Up: p<.001

Conclusions about Culturally Relevant IPT-B

- Findings suggest that culturally relevant IPT-B may reduce antenatal depression, prevent postpartum depressive relapse and improve social functioning in Black and White women on low incomes

- Observations:
  - Most women did not want anti-depressant medication.
  - Convenient, non-stigmatizing primary care setting serving a diverse female population on low incomes
  - Clinicians had experience & liked working with the women.

Where Do We Go From Here?

- **Cost effectiveness studies to promote health policy changes**

  1) compared to inpatient and emergency room costs
  2) productivity: depression-free days; child mental health outcomes

- **Training in engagement skills and culturally relevant Rx:**

  1) doctors, social workers and nurses in primary care clinics
  2) intake workers and clinicians in community mental health
  3) clinicians in school-based programs
  4) students in schools of social work and nursing

- **Limitations and Summing Up**