Effective Treatment of Depression in Older African Americans: Overcoming Barriers

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Objectives

- To review the epidemiology of late life depression
- To discuss racial/ethnic disparities in late life depression
- To describe the depression care process
- To examine evidenced-based treatment of depression in older adults
Overview of Depression

- The leading cause of disability worldwide
- 4th leading cause of total disease burden
- 16.2% lifetime prevalence in the United States (conservative estimate)
- 6.6% 12 month prevalence in the US
Late-Life Depression

- Depression is the most prevalent psychiatric diagnosis among the elderly
- Prevalence in adults aged 65 and older in 2004:
  - 17% of women
  - 11% of men
- Depression in elderly leads to increased disability, morbidity, and risk of suicide, poor adherence with medical treatments, increased mortality from medical illnesses
Late-Life Depression by Setting

- Prevalence of major depression in older Americans
  - Community Settings (1-3%)
  - Primary Care Settings (5-9%)
  - Institutional Settings (12-30%)
- Depression is more prevalent among younger adults, but older adults are less likely to be identified and treated
Diagnosing Depression in Older Adults

- Depression should not be considered just a normal part of aging
- Depression in older adults may look different than in younger adults
  - More anxiety and anhedonia symptoms
  - More physical health problems
  - More ambivalence about life
  - “Sadless depression”
- Depression can be confused with dementia
  - “Pseudodementia”
Challenges in Late-Life Depression

- Depression can be confused with the effects of multiple illnesses and the medications used to treat older adults
- Comorbidities are the rule, not the exception
- Advancing age results in loss of support systems (death of spouse, siblings, retirement, relocation), which increase the risk for depression
Disparities in Treatment Engagement and Retention

- Older adults seek mental health treatment less than any other age group
- 50% of adults over 65 are in need of mental health services, only 20% receive treatment
- Older adults prefer psychotherapy to pharmacotherapy, but are rarely follow up when given a referral to therapy
Barriers for African Americans Older Adults with Depression

- African American older adults are less likely to receive an accurate diagnosis of depression compared to White older adults
- African American older adults are less likely to receive empirically supported treatments for depression compared to White older adults
Barriers for African Americans

- African American older adults suffer more psychological distress due to racism, discrimination, poverty, violence, etc.
- African American older adults often have fewer psychological, social, and financial resources for coping with stress than White older adults
Comorbidities in Older Adults

- **Late-Life Depression**
  - Doubles the risk of cardiac diseases
  - Increases the risk of death from medical illness
  - Reduces the ability to rehab from medical illness
Prevalence of Major Depressive Disorder in Chronic Disease

- Parkinson's: 51%
- Cancer: 42%
- Diabetes: 27%
- CVA: 23%
- CAD: 17%
- MI: 16%
- HIV: 12%
- Alzheimer's: 11%
Challenges in Elderly Underserved, Low Income Populations

- Poor access to care
- Disability
- Mild Cognitive Impairment
- Dealing with Social Adversity
Depression in the Elderly and Suicide

- Increased risk of suicide in elderly
- Suicide rate in people ages 80 to 84 is twice that of the general population
- Suicide in people age 65 and older is a major public health problem
Myths about Treating Late Life Depression

- Mental health treatment is not effective
- There is no cure for depression
- Antidepressants are addictive and like street drugs
- There are too many side effects with antidepressant medications
African American Older Adults

- More likely to deal with depression through:
  - Informal support networks
  - Church
  - Primary care physicians
    - Depression in African Americans is less likely to be detected in primary care than it is in whites
Cultural Coping Strategies

- **Self-reliance**
  - Keeping busy
  - Staying active in the community
  - Cooking and cleaning
  - Self-medicating – alcohol and nicotine
- **Pushing through the depression**
- **Denial**
- **Relying upon God**
Racial/Ethnic Disparities Among Older Adults

- African Americans seek treatment at half the rate of Whites
- Attend fewer sessions when they do seek treatment
- Tend to terminate treatment prematurely
- Limited research shows African American older adults with depression are less likely:
  - To be in treatment
  - To intend to seek treatment in the future
  - To have ever sought mental health treatment for depression
Barriers to Treatment

- Ageism
- Shame/Stigma
- Cultural Barriers
- Fear/Distrust of the Treatment System
- Lack of Knowledge
- Lack of Insurance/Financial Barriers
- Transportation
- African Americans have greater negative attitudes toward seeking treatment (in some studies)
Depression Care Process

Step 1: recognition and diagnosis
Step 2: patient education
Step 3: treatment
Step 4: monitoring
Step 1: Recognition and Diagnosis

- The clinician suspects that a patient may be depressed
  - Patient may self-identify
  - Patient may present with somatic complaints
  - Clinician may use screening tools
- Formal assessment must be done to confirm the diagnosis
Step 2: Patient Education

- Clinician and staff education patient about depression and the care process
- Engage the patient
- Determine patient preference for treatment
Patient Education

- EXTREMELY IMPORTANT
- Stigma and lack of education will lead many people to avoid treatment
- Information about what depression is (and is not)
- Steps involved in treatment
- How antidepressants work – common questions and answers
- What to expect from psychological counseling
Step 3: Treatment

- Clinician and patient select the appropriate management approach
- Three Phases of Treatment
  - Acute – aims to minimize depressive symptoms and achieve remission
  - Continuation – tries to prevent return of symptoms during current episode
  - Maintenance – focus is to prevent lifetime return of new episodes
Treatment for Depression in Elderly

- Medication
- Psychotherapy
- Electroconvulsive therapy (ECT)
Antidepressant Medications

- Medications are equally effective in older adults
- SSRIs are well tolerated
  - May take longer to start working
  - May need to start at lower doses in elderly
- Tricyclic antidepressants
  - Orthostatic hypotension – increased risk of falls
  - Urinary retention
  - Less well tolerated at effective doses
  - Anticholinergic effects
  - Cardiac side effects
Antidepressant Medications

- **SSRIs**
  - Fluoxetine
  - Sertraline
  - Paroxetine
  - Citalopram/Escitalopram

- **SNRIs**
  - Venlafaxine/Desvenlafaxine
  - Duloxetine

- **Other Antidepressants**
  - Mirtazapine
  - Bupropion
Psychotherapy

- In general, many African Americans prefer psychotherapy (*in theory*) to medication
- Referral and follow through is often difficult
- Access to effective therapy is limited in underserved populations
  - Limited providers
  - Insurance limitations
Psychotherapy Preference

- Although preferred, few older African Americans use this option
- 50% copayment for outpatient psychotherapy under Medicare
- Less practical – weekly appointments
Electroconvulsive Therapy

- Extremely effective in older adults
- Barriers include access/availability
- Effective when medications are contraindicated, or when there has been limited response to medication
- Stigma regarding ECT limits availability of this therapy
Step 4: Monitoring

- The clinician and support staff monitor compliance with the plan and improvement in symptoms/function
- Modify treatment as appropriate
- Goal is remission
Stepped-Care

- Aims to provide the most effective but least intrusive treatment appropriate to an individual's needs
- Assumes that the course of the disorder is monitored and referral to the appropriate level of care is made depending on the person's difficulties
- Each step introduces additional interventions
- Higher steps normally assume interventions in previous steps have been offered and/or attempted
The Stepped-Care Model

- **STEP 1**: All known and suspected presentations of depression
- **STEP 2**: Persistent subthreshold depressive symptoms; mild to moderate depression
- **STEP 3**: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression
- **STEP 4**: Severe and complex depression; risk to life; severe self-neglect

- **Focus of the Intervention**: Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
- **Nature of the Intervention**: Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions

Low-intensity psychological and psychosocial interventions, medication and referral for further assessment and interventions

Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions
Conclusions

- Late life depression is a major public health problem that must be addressed
- Racial/ethnic disparities exist in the diagnosis and treatment of late life depression
- Late-life depression is treatable and recovery is possible
- Specific treatment of depression should be tailored to fit the unique needs of African American older adults


Questions/Comments

THANK YOU!

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