

1997 Grant Application • Latina/Latino Policy Research Program

CALIFORNIA POLICY SEMINAR
University of California2020 Milvia Street, Suite 412, Berkeley, California 94704
(510) 642-5514 • Fax (510) 642-8793 • CA.PolSem@ucop.edu • http://www.ucop.edu/cpsPROJECT TITLE AN INVESTIGATION OF DEPRESSION AMONG LOW-INCOME MEXICAN-ORIGIN LATINA
WOMEN: IMPLICATIONS FOR THE DESIGN AND IMPLEMENTATION OF PRIMARY-
CARE BASED INTERVENTION PROGRAMS.Principal Investigator(s) Johanna ShapiroCampus Address UCIMC, 101 The City Drive (Bldg 200, Rt 81, Rm 512)
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SUMMARY STATEMENT OF RESEARCH AND ITS POLICY RELEVANCE

Levels of depressive symptomatology in both U.S. born and immigrant Latino populations significantly exceed levels of non-Hispanic whites. In a state where almost one-third of all U.S. Latinos will reside by the year 2000, this should be cause for concern at policy-making levels. Further, shrinking mental health budgets and the advent of managed care makes it increasingly likely that a significant portion of the treatment of these patients will occur in primary care settings. The proposed research will study low-income, Spanish-speaking Mexican-origin Latinas to suggest educational outreach efforts to increase help-seeking from primary care settings by women not currently in treatment; and modifications in intervention protocols currently used by primary care providers to decrease treatment drop-out and improve patient compliance. The information from this study can be used by policy-makers to develop guidelines for community health clinics regarding appropriate culture-specific ways of promoting mental health within the Latino population of the state.

Project Timeline and Budget

Number of Months	<u>Twelve (12)</u>
Salaries (excluding benefits*)	\$ <u>12,708.00</u>
Supplies and Expenses	\$ <u>0.00</u>
Travel	\$ <u>864.00</u>
Other	\$ <u>11,330.00</u>
TOTAL	\$ <u>24,902.00</u>

*Grants are supported by state funds, therefore benefits are expected to be paid by investigator's home campus.

Please attach a detailed budget that specifically relates each item to project activities, as well as a timeline outlining the schedule for major project components, including the project's start/completion (reporting) dates.

Information Required

Please provide the following information about your project in a narrative statement, not to exceed ten double-spaced pages, attached to this application form:

- Description of the importance of the issue and relevance of the proposed work to state policy
- Research objectives
- Methodology

If you are seeking other sources of funding for this project, please specify those sources by name, the amount being requested, and the status of the requests. CPS requests notification if any other funds are awarded.

Attach to the proposal narrative an abbreviated (1- to 2-page) vitae for each participant. Please print all material on one side of the page only and keep supplemental material to a minimum. Submit 10 copies of this application form, the proposal narrative, and attachments (abbreviated vitae, budget, and timeline).

Proposals that do not follow this format will not be accepted and will be returned.

Principal Investigator's Statement

I understand and agree that if California Policy Seminar funds are awarded to this project, they are intended for project activities only; that upon completion of the study, the California Policy Seminar requires a report (which includes an executive summary) written specifically for a policy audience; and that dissemination of the report to state officials may be done by the California Policy Seminar. I also understand that I may present results in academic journals and other publications, with the requirements that I acknowledge CPS support, include a statement that the views and opinions expressed are those of the author(s) and do not necessarily represent those of the California Policy Seminar or the Regents of the University of California, and provide a copy of each publication to CPS. Accountings of expenditures and interim progress reports will be submitted as required by the California Policy Seminar, and unused funds will be returned to CPS. Failure to comply with these conditions may jeopardize funding.

Date

Johanna Shapiro Ph.D.
Signature of Principal Investigator

12/12/96

Date

Dayna Le Duc
Signature of Contracts and Grants Officer

DAYNA LE DUC
GRANTS OFFICER

STATEMENT OF THE PROBLEM: By the year 2000 there will be approximately 29 million Latinos in the United States; thirty-one percent of this growing population resides in urban California alone (1). Latinos are often considered an "epidemiological paradox" (2) because, despite frequent poverty, low educational attainment, and often immigrant status, in many respects (i.e., infant low birthweight and mortality, cardiovascular disease, strokes, cancer, drug- and violence-related deaths) they are as healthy or healthier than the non-Hispanic white benchmark (3). However, mental health problems, particularly depression, in this population are cause for concern. Studies suggest that levels of depressive symptomatology in both U.S.-born and immigrant Latino populations significantly exceed levels for non-Hispanic whites (4). Further, according to the American Psychiatric Association, about 18% of those experiencing depression in the U.S. are Latino, a rate double the percentage of Latinos in the general population (5). Low income, immigrant Latina women have been identified as suffering disproportionately from depression (6), although there is some controversy regarding this claim (Dr. Daniel Hayes-Bautista, personal communication, December 1996). Recent studies by two of this proposal's investigators of poor Latina women both with and without the stressor of a child with disabilities indicate between 33-49% of the samples above a screening cut-off for depression (7).

POLICY QUESTION #1: Does the state have a compelling interest in maintaining the mental health of its population? It is self-evident from both a legislative and an ethical perspective that the state must maintain a stake in the health and wellbeing of its constituents. As the largest and fastest growing ethnic group in the state (8), Latinos should be able to lay claim to a sizable portion of state resources allocated in this area, especially for a condition where data substantiate a high risk status, such as depression.

The existing research literature does suggest a significant segment of the Latino population particularly at risk for affective disorder. Admittedly, there is considerable controversy about the accuracy of cross-cultural diagnosis of mental disorders generally(9), and about the definition and

meaning of depression in the Latino population in particular (10,11). Factor analytic studies suggest a somewhat different constellation of symptom clusters for Latinos than for non-Hispanic white samples (12); as well as different factor loadings for male and female Latinos, and for Hispanics from different countries of origin (13). However, despite ambiguities in screening outcomes, it is probably true that, at the least, some form of dysphoria or demoralization is being measured in the above studies (14), as well as true clinical depression. Coupled with evidence of underutilization by Latinos of formal mental health services (15), as well as the existence of actual and perceived barriers to accessing health care in general (16), these findings point to serious costs to the state in terms of decreased individual wellbeing and productivity, negative impact on family function, medical expense due to disability, and increased mortality. It is in the state's interest to promote programs which properly educate Latinos about depression, as well as provide appropriate treatment modalities.

Of related concern is that there are well-documented negative consequences for children growing up with a mother who is depressed. There is ample evidence that maternal depression heightens the child's own risk for depression (17, 18). Depression in Latina mothers may not only put the child at risk for depression, but it may affect her parenting in ways that increase the child's risk of other behavior disorders, e.g., conduct problems (19). Since the state has an enormous interest in the wellbeing and functioning of future generations, the parenting implications of depression must also be seriously considered.

For a variety of reasons, including the perceived stigmatization among Latinos of seeking help from a mental health facility (20), and the pervasive somatization of depressive symptoms among unacculturated immigrants (21), many low SES Latinos tend to seek treatment for depressive symptomatology through community health clinics and private physicians. This consumer tendency fits well with newly emergent managed care guidelines that specify primary care physician responsibility for at least limited management of common mental disorders, i.e., depression (22).

Increasingly, the primary care physician will be the first line of defense in the treatment of depression for the state's Latino population (as well as most other patient populations). The responsibilities of the primary care physician in this context are to accurately diagnose the patient, to educate the patient about her disease, to intervene therapeutically, and to provide continuity follow-up. Education is especially important since research suggests a low level of accurate knowledge about mental illness in many Latino patients and family members (23).

POLICY QUESTION #2: Should the state encourage the provision of limited mental health care by primary care physicians to all patients, and in particular to Latino patients suffering from depression? The answer, from a cost-effectiveness standpoint, is probably yes, but only if the appropriate training and ancillary support services are available. For example, the consequences of a missed diagnosis of somatized depression to the health care system can be costly in terms of time spent by physicians and lab tests used to determine possible causes for complaints that have no physical basis. Further, when patients are dissatisfied or confused by treatment, the result is increased attrition rates, with attendant consequences of prolonged dysfunction, elevated utilization of medical services, and more frequent hospitalization.

In Orange County, the advent of a managed care Medi-Cal system (Cal-OPTIMA) has meant that County Mental Health will be forced to do more and more triage, as their focus increasingly becomes acute crisis intervention and maintenance of severely chronically ill patients. A logical option for overburdened county facilities would be more extensive reliance on community health clinics to provide diagnosis and treatment of common psychological disorders, such as depression.

In point of fact, the primary care physician may not always be optimally equipped to render care to Latino patients who have either major depressive disorder or subsyndromal depression. Many cultural, linguistic, and socioeconomic factors exist complicating the clinical care of Latino patients. Thus we need research on Latino populations whose findings will have implications for the specific kinds of

treatment recommended in the case of depression or depressive symptomatology. For example, depending on patient perceptions of causality and expectations for intervention, psychotherapy, which has been criticized for cultural insensitivity (25), may not be as relevant for this population as for a middle-class, non-Hispanic white population; or its form and focus may need to be altered to make sense to and meet the needs of the population being served (26). Similarly, family, friend, and community factors may be more important as elements of a treatment plan for Latino patients than for non-Hispanic whites (27).

POLICY QUESTION #3: What can the state do to ensure that primary care physicians are well-prepared to deliver care to depressed Latino patients? Primarily, the state can support programs that train minority or bilingual physicians (provided this is perceived by Latino patients as an active therapeutic variable); as well as promote educational efforts that encourage early detection and treatment and model programs which demonstrate effective patient management.

But how does the state know what kinds of physicians are most desirable; what types of educational efforts will be most effective; and what sorts of primary care-based programs will be most successful in attracting and keeping Latino patients in treatment? In California, the state government has already responded in part to these concerns by establishing cultural competency guidelines for Medi-Cal health plan contractors, based on the recommendations of a series of expert panels (24). This research proposal seeks to build on these efforts by examining depression from an "inside out," emic perspective, in order to identify and utilize potential cultural mediators of mental illness, and to ensure that the growing consolidation of health care services into managed care systems will not lead to a "one size fits all" approach.

PROJECT OBJECTIVES: The objectives of this project are several. First, the study will be able to produce in-depth qualitative and quantitative data about the nature of depression and expectations regarding treatment from a culturally sensitive perspective. Secondly, recruitment of three different

subject pools (described below) will allow us to address several aspects of the conceptual framework identified by Rogler et al (28, 29) as critical to understanding and responding to mental health issues of the Latino community. Third, the data will provide insights into both benefits and deficiencies of current treatment protocols for depression when used with Latina patients. Fourth, the data produced will be useful in helping design treatment protocols and community-based programs for use in primary care settings that will support early detection, culturally appropriate intervention, and reductions in treatment drop-out for depressed Latina women.

SUBJECTS AND RECRUITMENT STRATEGIES: A total of 180 subjects will be recruited from the greater Los Angeles metropolitan area. Sixty Latina women between the ages of 18-65 diagnosed with depression who have sought care because of poor health at a community health clinic will be recruited. Patients for the first group will be identified by their physicians at the community health clinic and referred to the study PI and the project's research assistant, who will contact them by phone and request their participation in the study.

The community health clinic to be utilized in subject recruitment is the University of California Irvine Family Health Center. Located in downtown Santa Ana, California, it is a 2600 square foot facility full service outpatient clinic. The clinic is situated in a federally designated medically underserved area, and virtually all users fall below poverty level. Approximately two-thirds of the patients are insured either through the CalOPTIMA (managed care Medi-Cal) program, or through the Medically Indigent Services program, both of which utilize state funding to reimburse the cost of care. The remainder of the patients are uninsured and self-pay.

The clinic has a patient volume of approximately 16,875 visits in a 6 month period. Of these visits, over 83% are made by Latinos, and of these 58% are women, and a further 70% of these are estimated to be from Mexico. Using the American Psychological Association figures, we estimate that roughly 18% of these patients will exhibit depressive symptomatology. We should then have 1024 visits by depressed

female Mexican Latina patients. Using a standard estimate of 1.75 visits/patient/6 months, this translates into a potential pool of approximately 585 Latina patients with depressive symptoms.

Sixty women will comprise an "untreated" sample, who score above the criterion cut-off of 16 on the Center for Epidemiological Studies Depression Scale (CES-D), but who are not currently in treatment (provisions in the research protocol will be made to encourage these women to obtain medical or psychological treatment, and to provide crisis intervention to any subject who appears suicidal). A third cohort of sixty Latina women will be recruited who do not have significant depressive symptoms, but who will provide a normative social context within which to understand perceptions of depression in the Latino community. This latter cohort is believed to be crucial to the study because of the anticipated importance of community and social support in early intervention and treatment.

Subjects for the second and third groups will be recruited by drawing on a previously identified sample of 100 low-income, Spanish-speaking Latina women who participated in a recent study of two of the investigators (33 of these women met or exceeded the screening cut-off for depression), as well as a previously used methodology of peer nomination (including a nominal finder's fee). These potential subjects will also be contacted by a project research assistant and requested to participate in the study. All subjects will be offered a \$10 fee for their participation.

It is anticipated that subjects will be of a homogeneous background (i.e., Mexican-born, low-income, relatively low educational attainment, primarily Spanish-speaking, and in this country between 3 and 15 years) in order to reduce variance due to acculturative, sex, and country of origin factors (30-32). While an RO1 grant or large-scale epidemiological study could address differences of country of origin, birthplace, years in U.S. and gender, as well as compare a Latino sample to other ethnic and non-Hispanic white groups, such ambition lies beyond the scope of this project. It is also true that, in our previous two studies examining depression, neither demographics nor acculturation contributed to the variance of our depression measure (although because of contrary findings in the literature, we will

continue to incorporate variables from both areas). Further, it is our belief that not all research necessarily must include a “gold-standard” design of comparison to an non-Hispanic, white group.

SURVEY METHODS: The study will employ both quantitative and qualitative methodologies, and will be cross-sectional in nature. Since low literacy levels preclude the use of self-administered questionnaires, all data will be collected in an interview with the research assistant which will take place in the patient’s home. An explanation of the study’s purpose and voluntary nature will be provided and signed consent for participation will be obtained at that time. It is estimated that approximately two and one-half hours will be required for the completion of the study materials (see below for a description of information to be collected during the interview.) Although the entire interview will be tape recorded, no comprehensive transcription and translation of responses to open-ended questions are anticipated. The interviewer will use a combination of note taking and tape-sequence numbers to retrieve and transcribe/translate only key responses. Closed-ended questions and standardized tests will be prepared on optical character recognition (OCR) scannable forms for easy marking and scanning into a computer data base for statistical analysis. . A random subset of women in the treatment condition will participate in a 3 month follow-up focus group to assess improvement in symptomatology, and to gather suggestions about intervention and relapse prevention. A chart review of psychotropic medications used by these subjects will also be conducted at this time.

MEASURES: All subjects who agree to participate will be assessed using the CES-D (33), still considered the most reliable depression screening tool for use with Latino populations (34), as well as the Composite International Diagnostic Interview (CIDI), which has been cross culturally validated (35,36), and identifies major depressive disorder. Standardized instruments measuring pertinent demographic information, as well as dimensions related to family functioning (37,38), religiosity, acculturation (39-41), and social support (42,43) will be utilized. In addition, a structured questionnaire, with qualitative as well as quantitative items, will be developed for use with the entire sample.

The interview segment of the study will be designed based on data from two focus groups and will address the following questions:

1) Attributions regarding the nature of depression. Do Latina patients think social factors, health problems, biochemistry, and/or genetics play a role in causing or exacerbating their symptoms? What are perceived differences between depression, nervios (44), and susto (45,46)? Patients' understanding of the causality, severity, heritability, and stigma of mental illness will have important implications for educational and treatment approaches.

2) Expectations for treatment. What kind of individual (family member, friend, pastor, physician, mental health professional, curandero) do Latina patients think is best suited to treat this illness? Are there unique cultural factors that might affect the structure of treatment? For example, does the patient expect to be treated primarily within the doctor-patient dyad, or is it important to involve family members (based on the concept of *familismo*) (47) or other special individuals (based on the concept of *compadrazgo*) (48)? What OTC and prescription medications (both from the U.S. and Mexico) are patients using and what are patients' subjective impressions of medication benefits and side effects? What do patients think is required to prevent their symptoms from returning? What alternative or complementary approaches might be developed to a) encourage compliance with standard treatments of depression (i.e., antidepressant medication, cognitive therapy) b) treat depressive symptoms that are not responsive to standard therapies.

3) Barriers to treatment. What are perceived and actual barriers to treatment for depressive symptoms, either at mental health facilities, physician offices or community clinics? (i.e., access problems for financial, transportation, childcare and other reasons; incompatibility with other treatment options; mistrust of providers; stigma associated with mental health interventions or facilities, etc.). What community outreach programs can be designed to overcome barriers and make treatment more accessible?

4) Expectations for physician. How important is the character of the physician (i.e., the *simpatia* (49) and *personalismo* (50) expressed by the physician) in the treatment of Latina patients? Do Latina patients think they improve more quickly when the provider speaks their language (51, 52) and/or is Latino/Latina himself/herself (53)?

ANALYSIS PLAN: An analysis of the qualitative data will be used to address the questions raised above. In addition, a correlational analysis will be employed to address relationships among the standard measures, for example, whether or not there are group differences in social support, family function, and acculturation. Wherever possible, thematic information uncovered through qualitative analysis will be quantified and incorporated in the correlational analysis. For example, the analysis may reveal that attributions regarding the nature of depression vary with levels of acculturation or that the expectations patients have about the treatment of depressive symptomatology are related to such demographic measures as age.

PREVIOUS EXPERIENCE. Dr. Shapiro has been Principal Investigator on several grants examining the relationship between ethnicity and family functioning. She has also been co-PI on two NIH Supplements to study health and well-being in Latina women. Dr. Blacher is currently Principal Investigator on a longitudinal NICHD-funded research project begun in 1982 studying families of children with severe disabilities. Recently, she has recruited two additional samples of urban African-American and Latino families to investigate the effects of culture and ethnicity on family adaptation and health. Recent studies of these two investigators are notable for the extraordinarily high rates of depression the Latina women interviewed. Fully 49% of a sample of 148 Latina mothers of children with retardation scored at or above the clinical cut-off for depressive symptomatology (7). A control sample of mothers without a child with disabilities had significantly lower levels of depressive symptomatology, but were still higher than expected (e.g., 15% falling in the very high risk range).

Dr. Sandoval has been a practicing family physician for over fifteen years, with a special interest in the treatment of depression in Latinos. He is active in local community outreach, and has made many professional presentations on cultural diversity and underserved populations. He is a recipient of a Certificate of Recognition from the California Senate, as well as numerous other awards for outstanding service and dedication to the community. Dr. de la Rocha is a medical anthropologist with special expertise in health issues among Latino migrant and farm workers.

ANTICIPATED CONTRIBUTIONS OF THE PROPOSED STUDY: The anticipated contributions of the proposed project are several. We will be able to provide state agencies with data that can elucidate culture-specific ways of promoting mental health within the Latino population. The study will produce additional information based on patient report and community informants about how primary care physicians can best to educate patients and the community in general about depression; and how they can develop efficient and effective treatment plans that respect the cultural expectations of patient and family. This approach will lay the groundwork for developing therapeutic approaches that negotiate the sensitive but critical territory between folk medicine, biomedicine, and cultural sensibilities (54).

REVISIONS: LATINA DEPRESSION INTERVIEW

1) Have you ever heard the term depression when talking about someone's emotional/physical state?
YES NO

If YES, go to #2. If no, provide a brief description of depression (ie., cries a lot, has no energy, poor appetite, poor sleep, feels there is nothing enjoyable in life, feels sad), then say:

Do you have a name for these problems? If yes, what is it?
Then go to #3

AFTER EACH OF THE FOLLOWING QUESTIONS, ALWAYS ASK: Within your own community, have you heard other ideas (relevant to the question) that are different than what you've just told me? ie., if the subject says, "I think depression is caused by stress," you should ask: "Are there other ideas about what causes depression that you have heard from friends or relatives?"

2) In your own words, what does it mean when someone is depressed?

3) What causes depression?

(PROMPTS: problems at home or at work, chemical imbalance in the brain, stress, sudden fright; also - "Can the stress of caring for a child with disabilities cause, or contribute to, depression?" If yes, in what ways?)

4) Are there any types of people who are more likely to become depressed than others? If yes, who?

5) When someone is depressed, do they sometimes have other kinds of illnesses as well? If yes, ask what kinds.

6) How long does an episode of depression usually last?

(PROMPTS: days, weeks, months, years; comes and goes)

7) Can depression sometimes go away by itself?

8) What can you do to treat depression? (make depression better)

(PROMPTS: go to a doctor, take medication (what kinds), use herbal remedies (what kinds), talk to your spouse, friend, or family member, go to a curandero, go to a counselor, talk to a priest or pastor, exercise, pray, keep busy)

9) Are people who are depressed more likely to commit suicide?

If yes, why do you think this is?

10) Are women more likely to become depressed than men; or men than women; or is it the same? If one group is mentioned as more likely, ask why.

11) Out of 100 women, how many do you think might be depressed? Out of 100 men? (I'm trying to get at prevalence - maybe this is not the best way to ask the question).

12) Can children and teenagers become depressed?

13) Does depression tend to run in families? Do you know of anyone in your family who has been depressed? If yes, who? when? how was this person treated?

14) History of depression: How would you compare the way you are feeling now with how you were feeling when we last spoke? (better, worse, about the same). What about at other periods in your life: have you felt depressed or down? If yes, when? how did you get better?

15) Has caring for a child with disabilities made it easier or harder to deal with feelings of depression, or is this not relevant? If easier/harder, in what ways?

16) Do you think your husband understands that you are depressed?
Yes No (if "no," go to #19).

17) If yes, what is his reaction?
(PROMPTS: Supportive, negative, ignores the problem)

18) What does he do/suggest to make you feel better?

19) Who has been most helpful in making you feel better?
(identify person by role, ie., friend, relative, priest, etc.)
If "no one," STOP.

20) What did this person do to make you feel better?