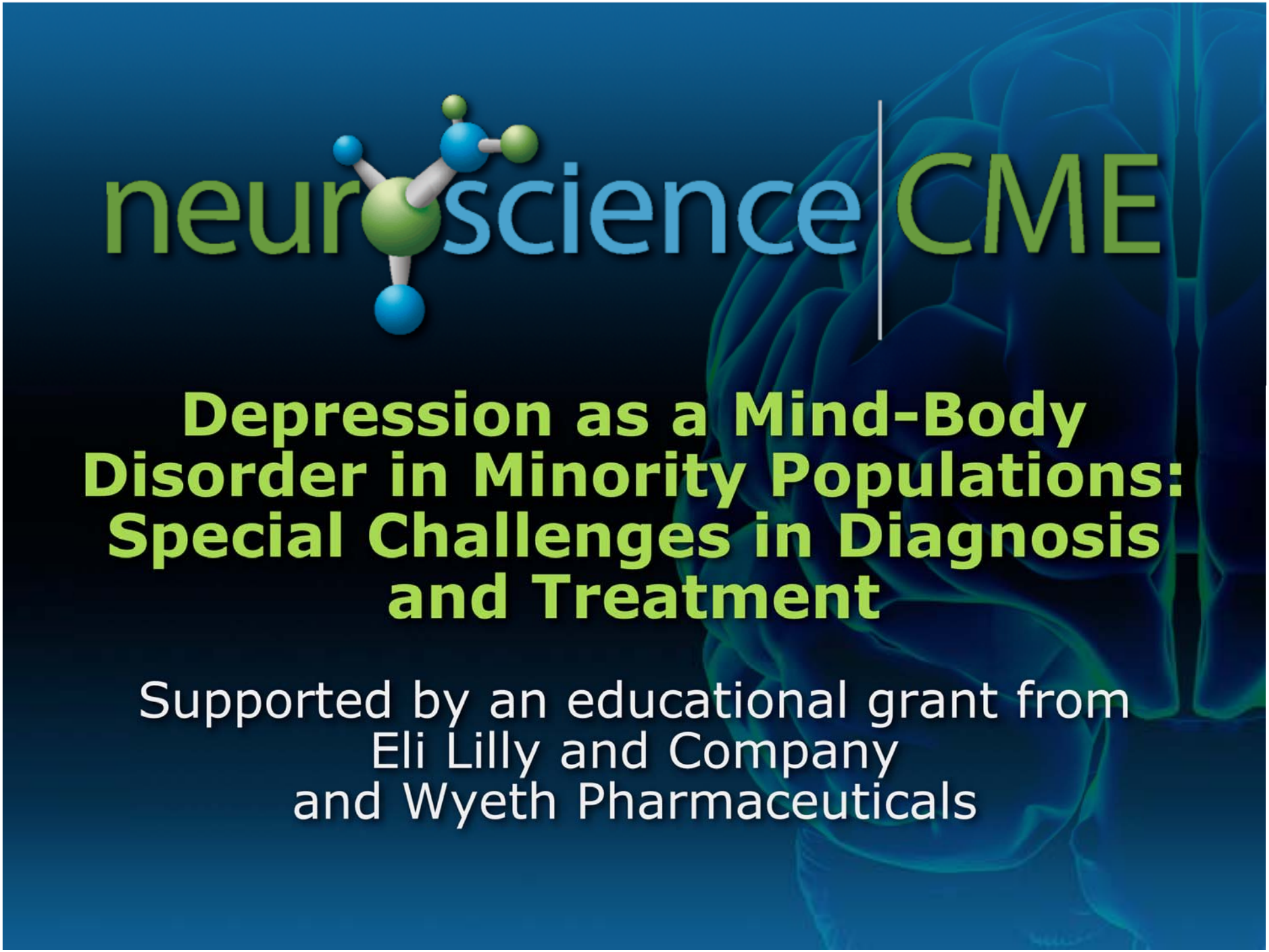
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Depression as a Mind-Body Disorder in Minority Populations: Special Challenges in Diagnosis and Treatment
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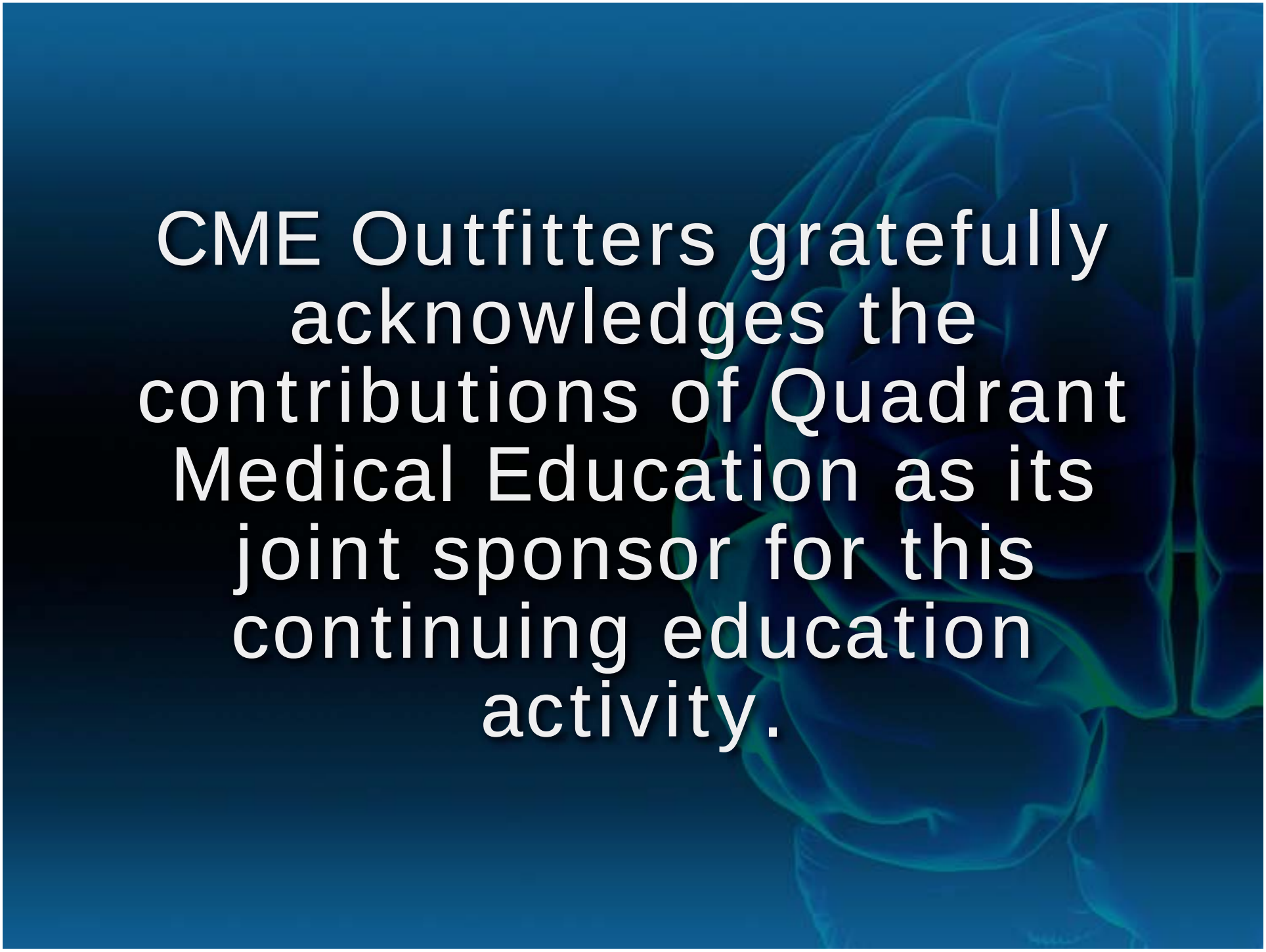
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Learning Objective 1

Identify manifestations of depression in minorities

Learning Objective 2

Apply culturally sensitive approaches to involve minority patients in the diagnosis and treatment of depression

Learning Objective 3

Create goal-directed therapy plans to treat depression in minority patients

Moderator:
Rakesh Jain, MD, MPH

Director, Adult and Child Psychopharmacology Research

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Associate Clinical Professor of
Neuropsychiatry and Behavioral Science

University of South Carolina
School of Medicine

Consulting Associate, Division of Child
and Adolescent Psychiatry

Department of Psychiatry

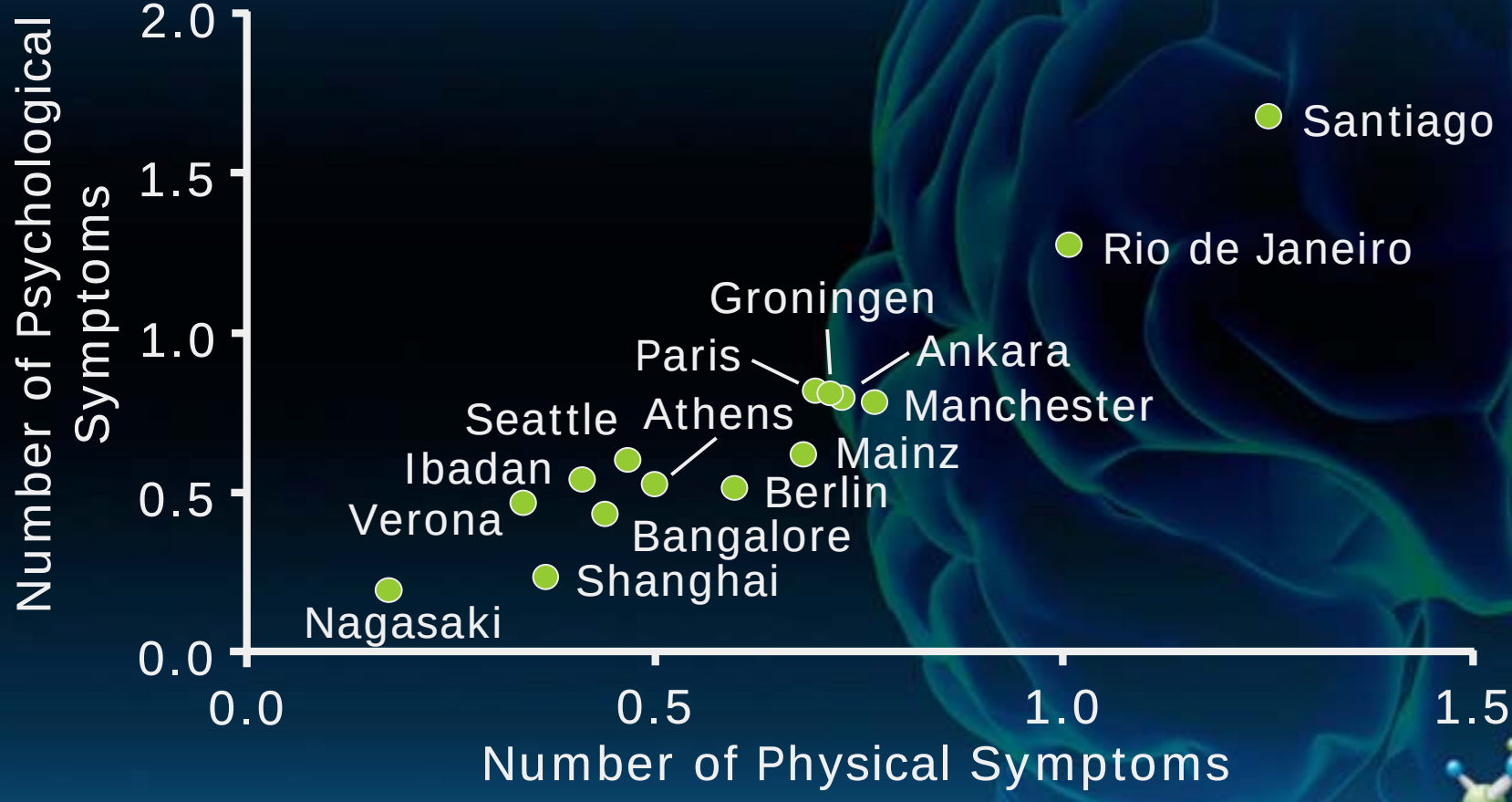
Duke University

Role of Ethnicity, Culture, and Race in Diagnosis and Treatment of MDD

Ethnic/cultural factors may influence:

- Likelihood of seeking medical help
- Clinical presentation
- Course/chronicity of MDD
- Metabolism of the medication
- Treatment response
- Treatment adherence

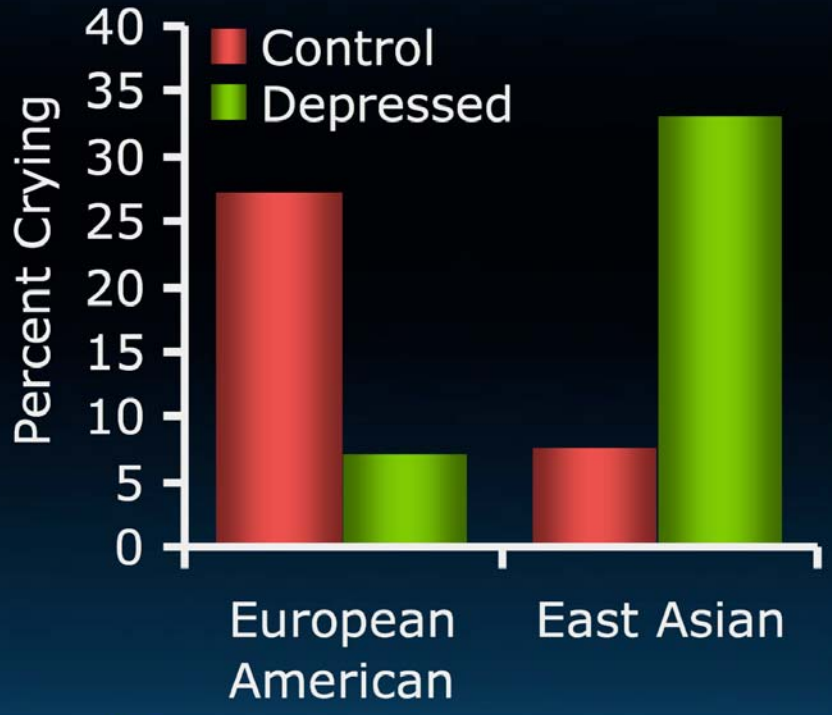
Ethnic and Cultural Differences May Influence Clinical Presentation of MDD

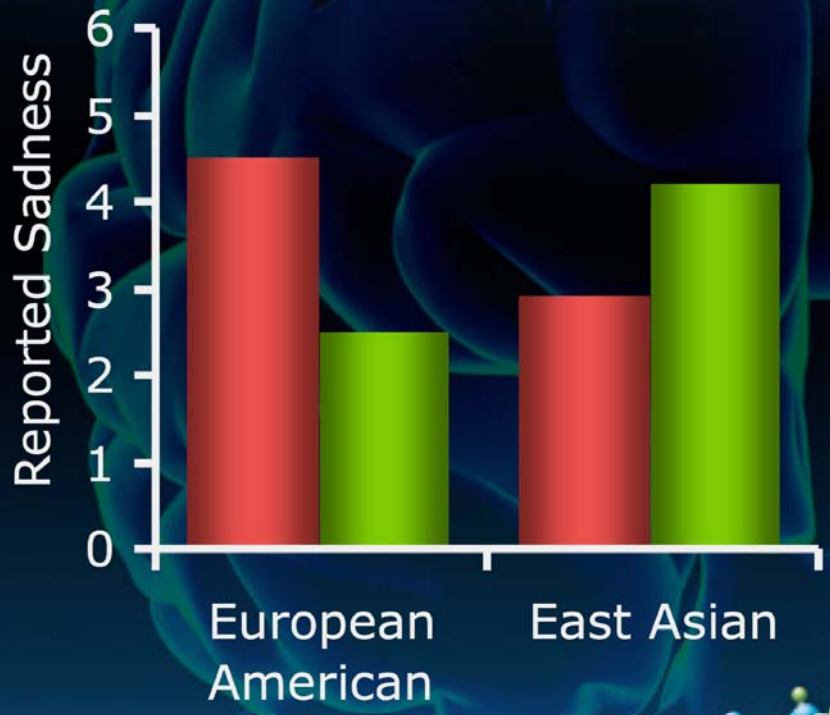


Simon GE, et al. *N Engl J Med* 1999;341:1329-1335.

Ethnic and Cultural Factors May Influence Emotional Reactivity in Depressed Individuals

Percentage of participants crying or reporting sadness during a sad film clip (N = 56)



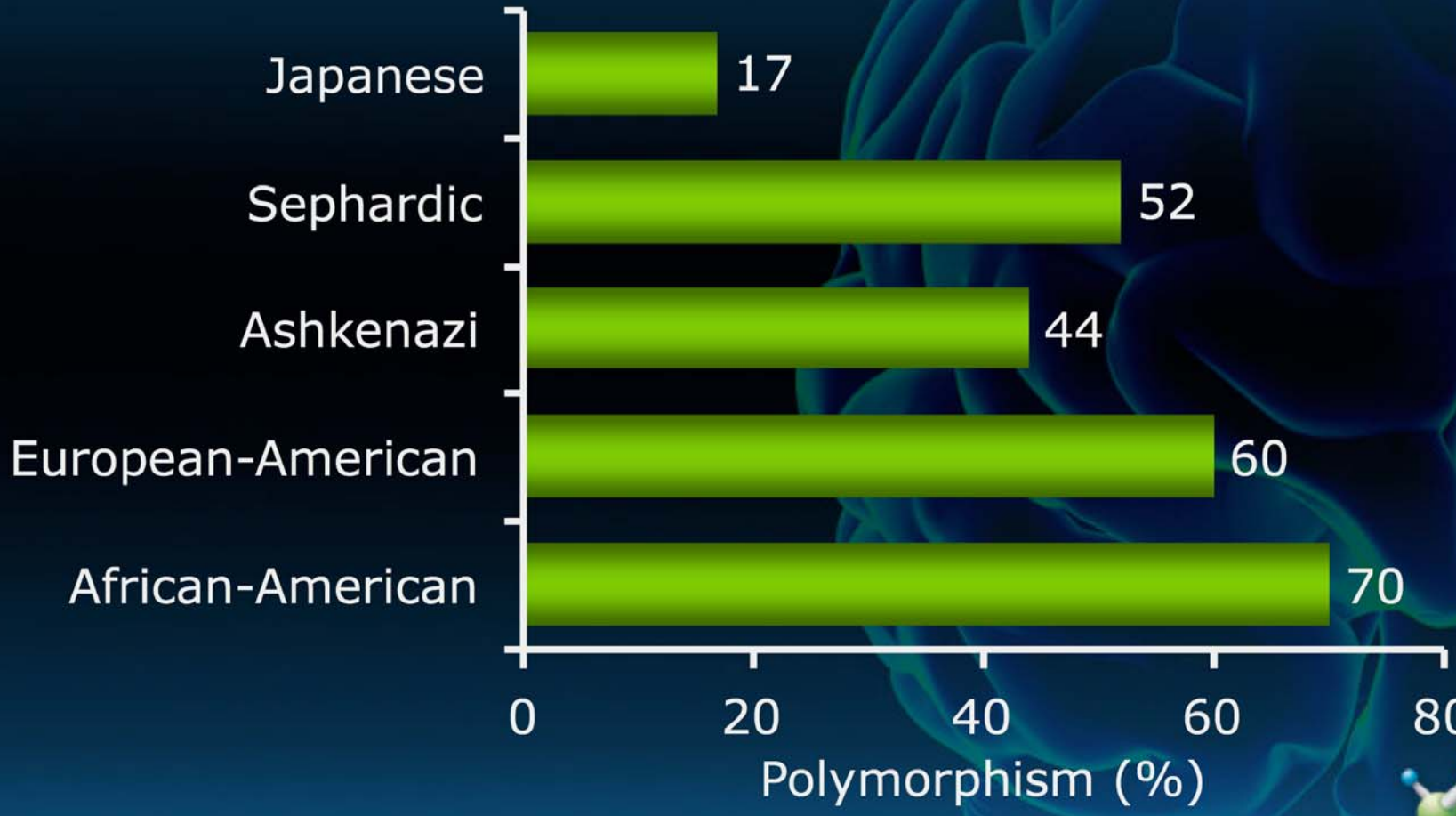


$p < .05$

Chentsova-Dutton YE, et al. *J Abnorm Psychology* 2007;116:776-785.

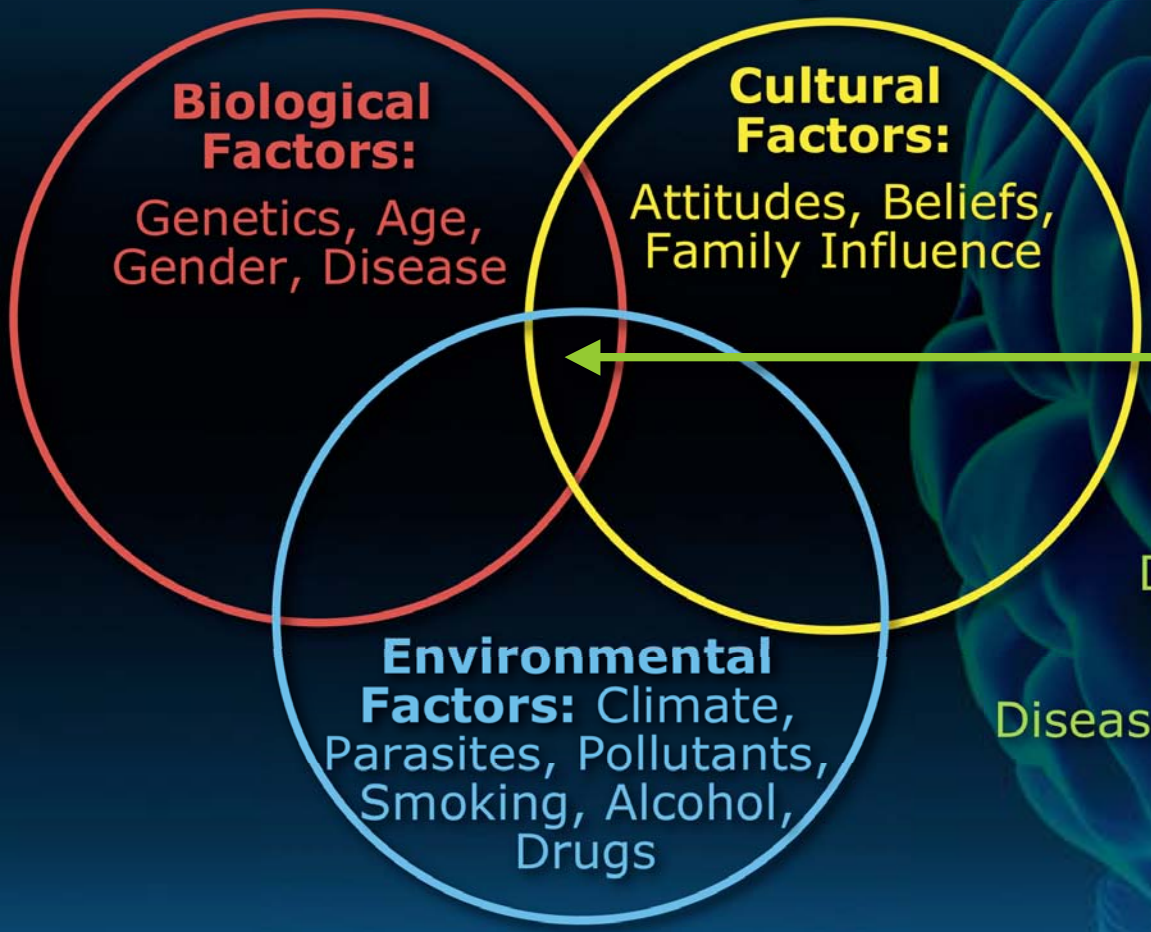
Neurobiological Relevance of Ethnicity

Percentage of “long” 5HTTPR allele in different populations



Lin KM, et al. *J Clin Psychiatry* 2001;62:13-19.

Factors Related to Ethnicity May Influence Medication Response

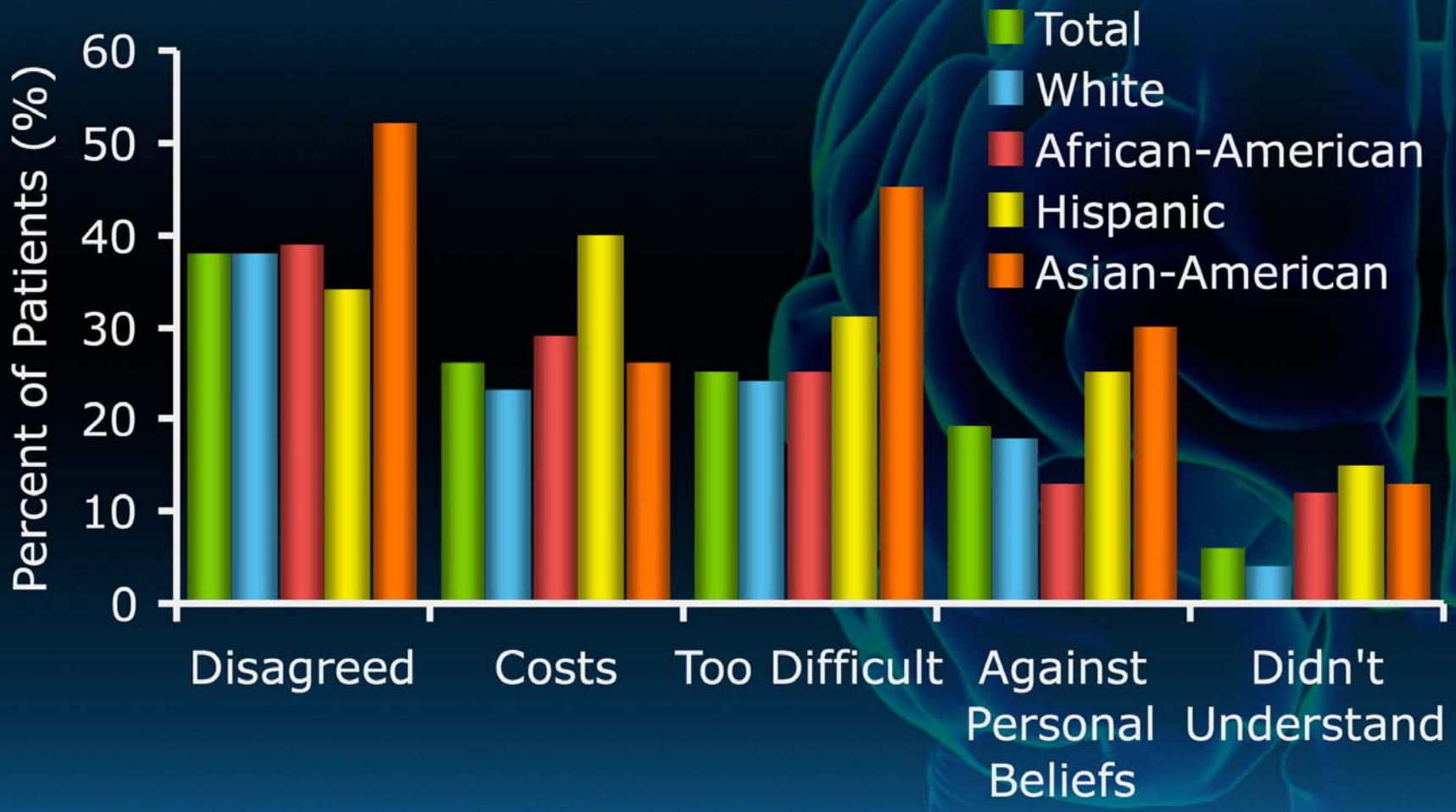


Variability in:

Drug Metabolism
Drug Receptors
Drug Response
Disease Progression Proteins

Harris PA. *J Manag Care Pharm* 2004;10:S2-S7.

Factors Related to Ethnicity May Influence Treatment Adherence



Harris PA. *J Manag Care Pharm* 2004;10:S2-S7.

Conclusion

- Proper ethnic/cultural perspective may result in:
  - Improved rate of correct diagnosis of MDD in minorities
  - Fewer unnecessary diagnostic procedures and less delay of appropriate treatment
  - Enhanced therapeutic alliance
  - Appropriate selection of treatment modalities
  - Improved treatment results due to better response, adherence, and appreciation of the side effects of medication

Rahn Kennedy Bailey, MD, FAPA

Chairman of Psychiatry

Executive Director of Elam MHC

Meharry Medical School

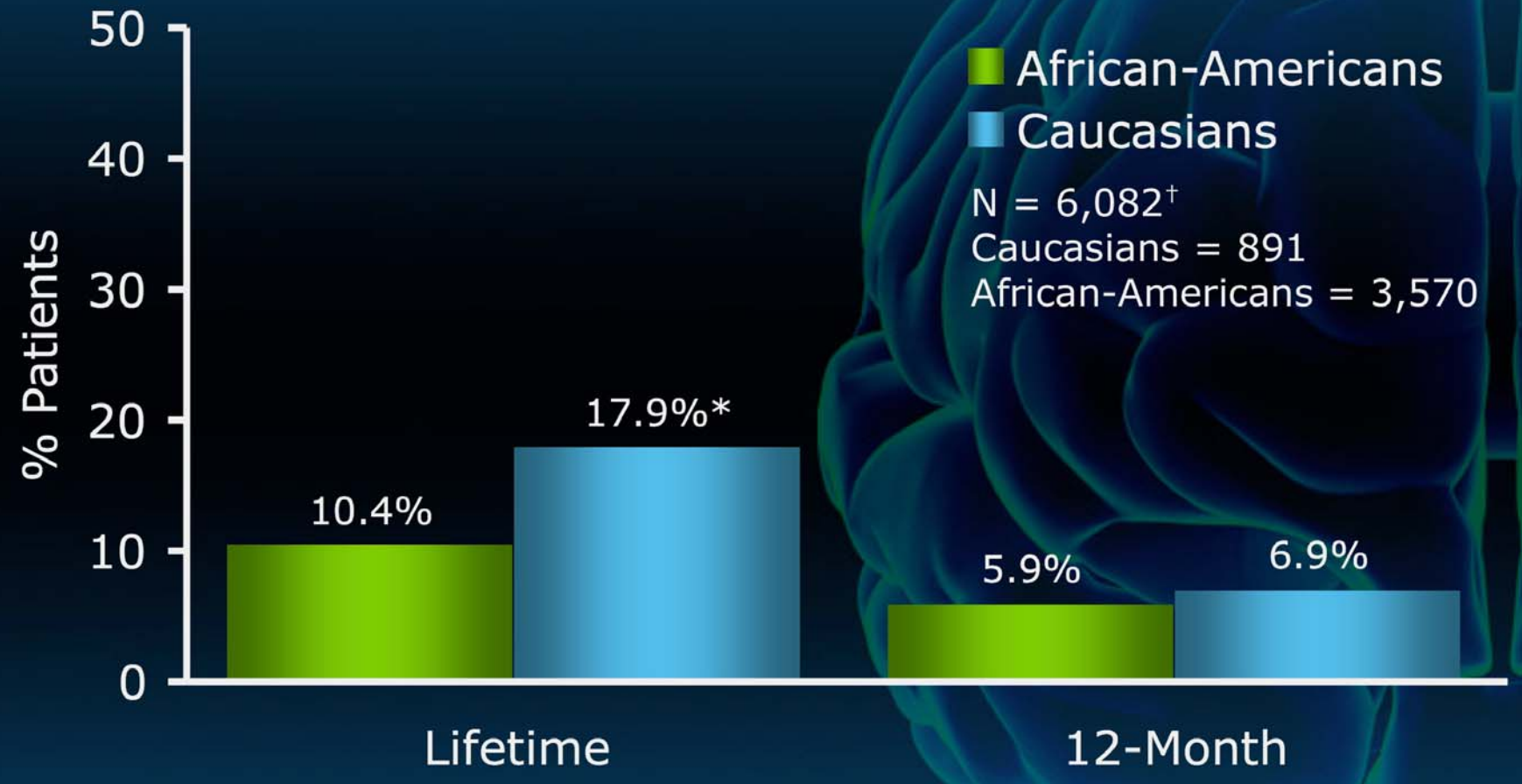
Vice Speaker, House of Delegates

National Medical Association

Deputy Representative, Black Caucus

American Psychiatry Association

Estimated Prevalence in the African-American Population

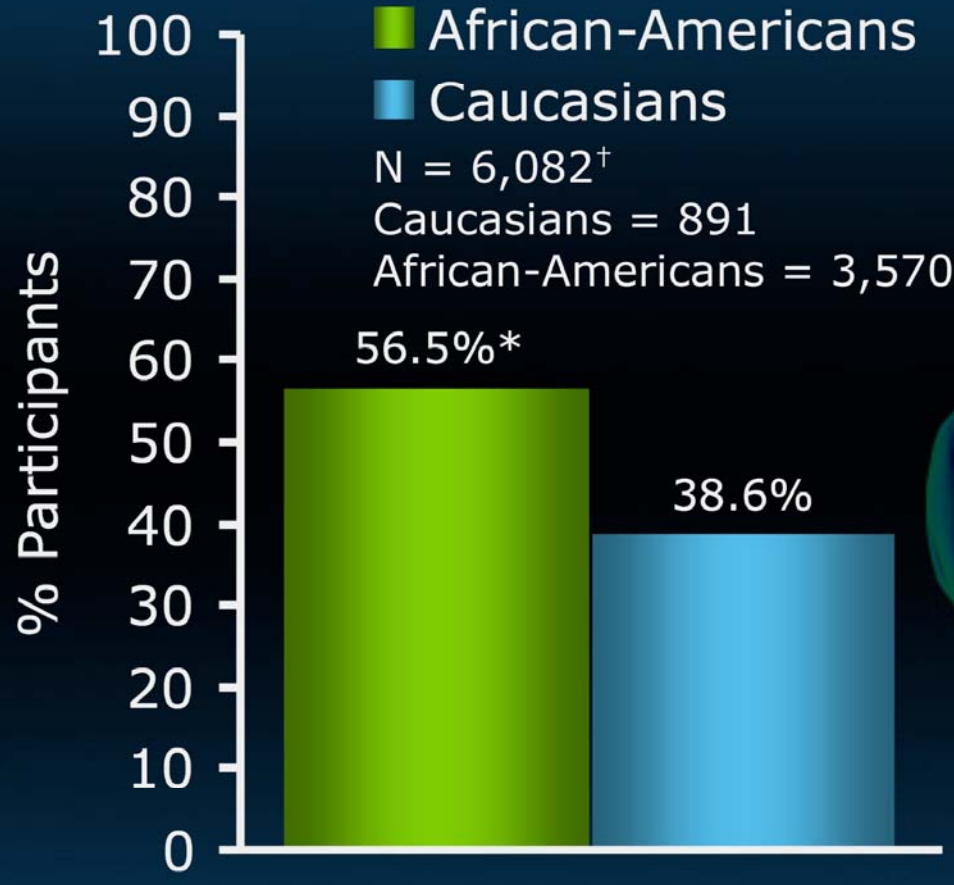


* $p = .001$

† This study also included a population of 1,621 Caribbean Blacks

Williams DR, et al. *Arch Gen Psychiatry* 2007;64:305-315.

MDD Persistence in African-Americans



In addition:

Relative to Caucasians, African-Americans were more likely to rate their depression as severe or very severe and more disabling

* $p = .001$

† This study also included a population of 1,621 Caribbean Blacks

Williams DR, et al. *Arch Gen Psychiatry* 2007;64:305-315.

Assessment Issues in African-Americans

- Some assessment issues to consider in the African-American population include:
  - Misdiagnosis of depression in African-Americans
  - The stigma surrounding depression in the African-American community
  - African-American attitudes and beliefs toward depression
  - Disparities in access to mental healthcare
    - Financial barriers
    - Lack of African-American providers
    - Geographical distribution of point-of-care settings

US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD; 2001.

Disparities in Access to Healthcare

- Nearly one-fourth of African-Americans are uninsured, which is 1.5 times more than Caucasians[1]
- Rate of employer-based covered health insurance for African-Americans is 53% vs. 73% for Caucasians[2]
- A relatively high proportion of African-Americans live in the rural South
  - Evidence indicates mental health professionals are concentrated in urban areas and less likely to be found in the most rural area counties of the US[3]

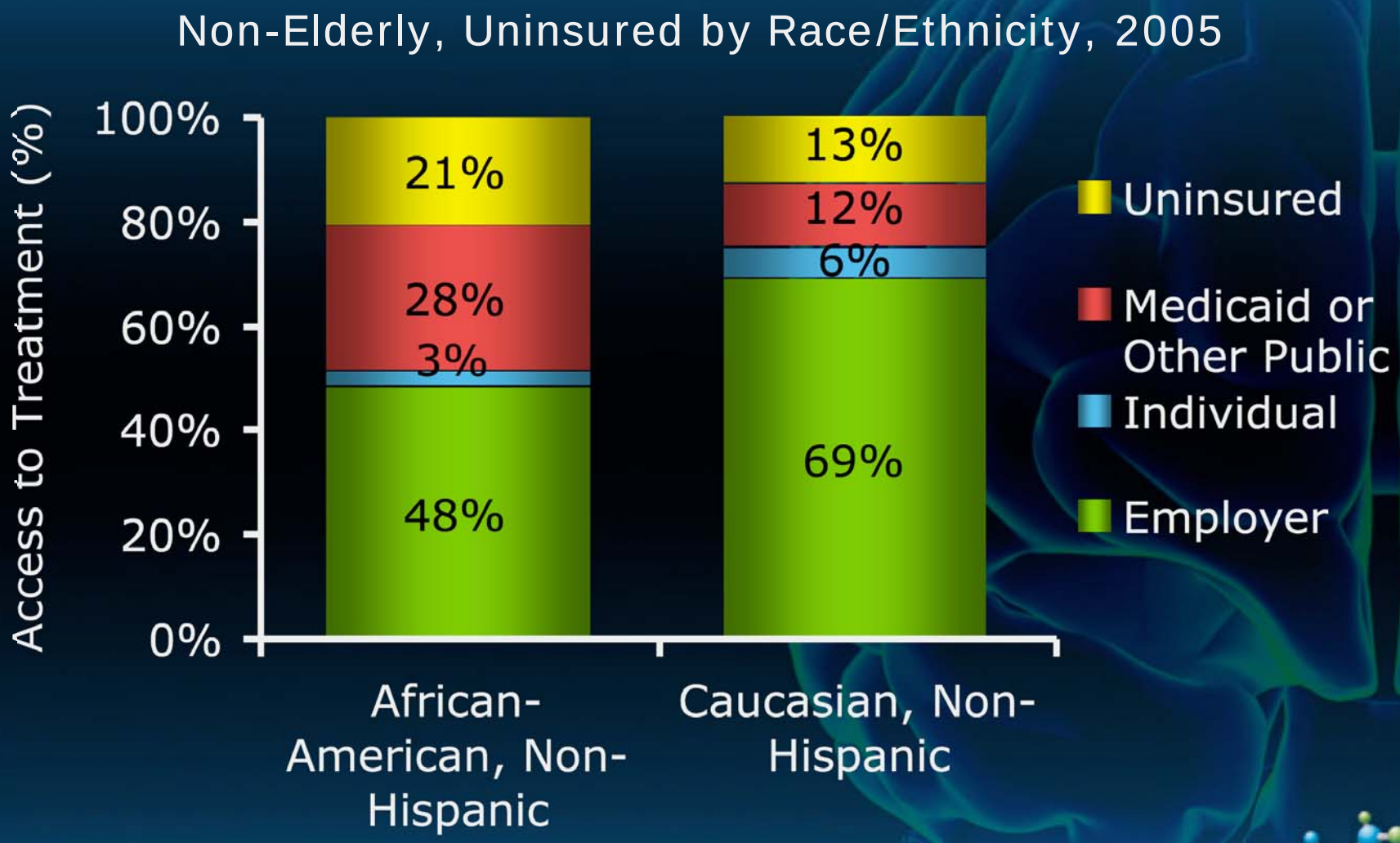
1. Brown ER, et al. *Racial and ethnic disparities in access to health insurance and health care.* Los Angeles, CA: UCLA Center for Health Policy Research and The Henry J Kaiser Family Foundation; 2000.
2. Hall M, et al. *Ann N Y Acad Sci* 1999;896:427-430.
3. Holzer CE, et al. Effects of rural-urban county type on the availability of health and mental health care professionals. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States*. Rockville, MD: Center for Mental Health Services; 1998.

Treatment Disparities

- Treatment of 13,065 patients with depression were examined in a state Medicaid study covering years 1989-1994[1]
  - African-Americans were found to be less likely than Caucasians to receive appropriate care for depression
  - African-Americans were less likely than Caucasians to receive an antidepressant when their depression was first diagnosed (27% vs. 44%) and less likely to receive SSRIs
- A study which analyzed data from a community-based study (1986-1996) that followed patients aged 65 and older found that:[2]
  - Older Caucasian community residents were nearly two times (in 1986) and four times (in 1996) more likely to use an antidepressant than older African-Americans

1. Melfi CA, et al. *J Clin Psychiatry* 2000;61:16-21.
2. Blazer DG, et al. *Am J Psychiatry* 2000;157:1089-1094.

Access to Treatment



Data from The Henry J Kaiser Family Foundation. *Key Facts: Race, Ethnicity and Medical Care;* 2007. Publication Number: 6069-02.

Comorbidities in African-Americans

- Diabetes
  - 13.3% of all African-Americans aged 20 years or older have diabetes[1]
  - African-Americans are 1.8 times more likely to have diabetes as non-Hispanic whites[1]
  - Depression is a risk factor for development of type 2 diabetes[2]

1. American Diabetes Association. African American and Diabetes Facts. Available at: http://www.diabetes.org/communityprograms-and-localevents/africanamerican/facts.jsp. Accessed May 22, 2007.
2. Eaton WW, et al. *Diabetes Care* 1996;19:1097-1102.

Comorbidities in African-Americans (cont.)

- Obesity
  - African-American (non-Hispanic) adults in the US are considerably more overweight and obese than Caucasian (non-Hispanic) adults[1]
- Hypertension
  - In 1999 report, 35% of African-Americans had hypertension, which accounted for 20% of African-American deaths in the United States - twice the percentage of deaths among Caucasians from hypertension[2]

1. American Obesity Society. AOA Fact Sheet. Available at http://www.obesityusa.org/subs/fastfacts/Obesity_Minority_Pop.shtml. Accessed May 22, 2007.
2. Cooper RS, et al. *Sci Am* 1999;280:56-63.

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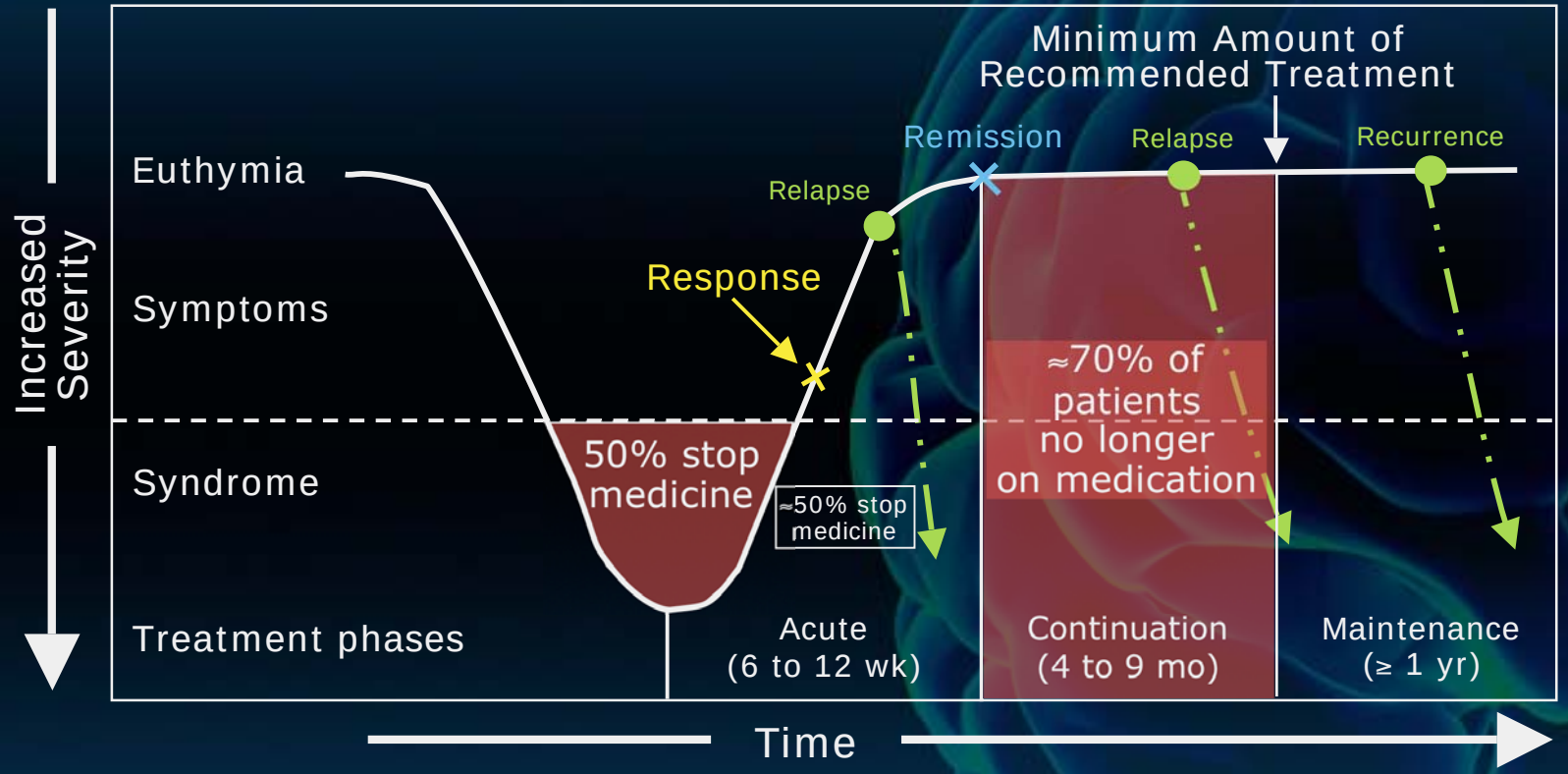
Chief, Division of Mood Disorders

NIMH Depression Trials Network Research Program

Co-Principal Investigator

University of Texas Southwestern Medical Center

Efficacy/Tolerability and Patient Adherence Are Essential for Sustained Recovery



Kupfer DJ. *J Clin Psychiatry* 1991;52:28-34. *Clinical Practice Guideline No. 5: Depression in Primary Care, Vol. 2.* Agency for Health Care Policy and Research; 2000. Streja DA, et al. *Am J Manag Care* 1999;5:1133-1142. Russell JM, et al. *Am J Manag Care* 1999;5:597-606. Melfi CA, et al. *Arch Gen Psychiatry* 1998;55:1128-1132. Lin EH, et al. *Med Care* 1995;33:67-74.

Remission of All Symptoms Is the Goal of Treatment

- Remission of symptoms has been the standard goal for more than a decade[1-4]
- Resolution of emotional and physical symptoms[5-6]
- Restoration of full capacity for functioning[5-6]
  - Return to work
  - Resume hobbies/personal interests
  - Restore personal relationships

1. *Clinical Practice Guideline No. 5: Depression in Primary Care, 2: Treatment of Major Depression;* 1993. AHCPR publication 93-0551.
2. American Psychiatric Association. *Am J Psychiatry* 2000;157(suppl 4):1-45.
3. Anderson IM, et al. *J Psychopharmacol* 2000;14:3-20.
4. Reesal RT, Lam RW. *Can J Psychiatry* 2001;46(suppl 1):21S-28S.
5. *DSM-IV-TR. 4th ed*. Washington, DC: American Psychiatric Association; 2000.
6. Rush AJ, Trivedi MH. *Psychiatr Ann* 1995;25:704-705, 709.

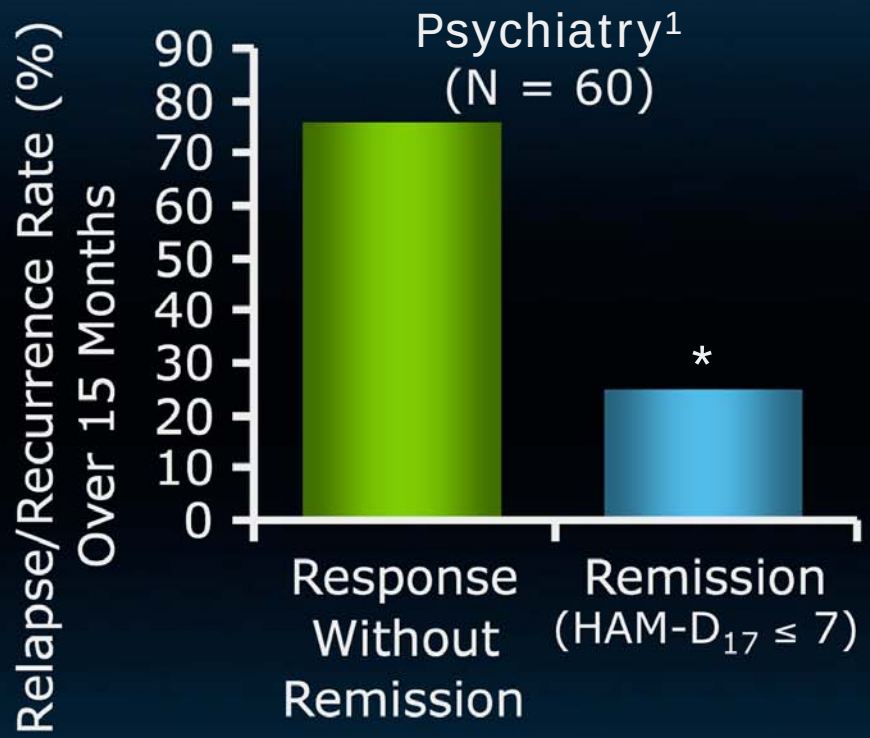
Why Should We Bother About Remission?

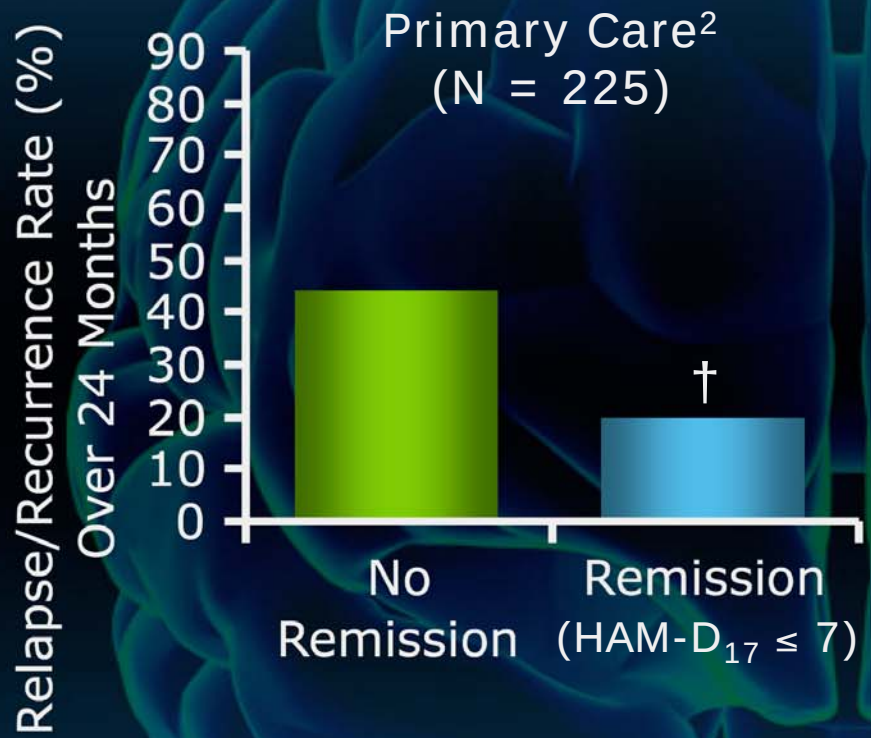
- Better is not well
- Aim for recovery
- Aim towards some target
  - Symptom-free status
  - Return to previous levels of functioning
- Aim not only away from illness
- Remission is the new standard

Thase ME. *J Clin Psychiatry* 1999;60:3-6.
Hirschfeld RMA, et al. *JAMA* 1997;277:333-340.

Remission Lowers Risk of Relapse/Recurrence

> 90% with residual symptoms had mild-to-moderate somatic symptoms[1]





* $p < .001$ between treatment groups

† Odds ratio = 0.32 (95% CI 0.18-0.54) for major depression during 24-month follow-up for remitters vs. nonremitters at 3 months

1. Paykel ES, et al. *Psychol Med* 1995;25:1171-1180.
2. Simon GE. *Bull World Health Organ* 2000;78:439-445.

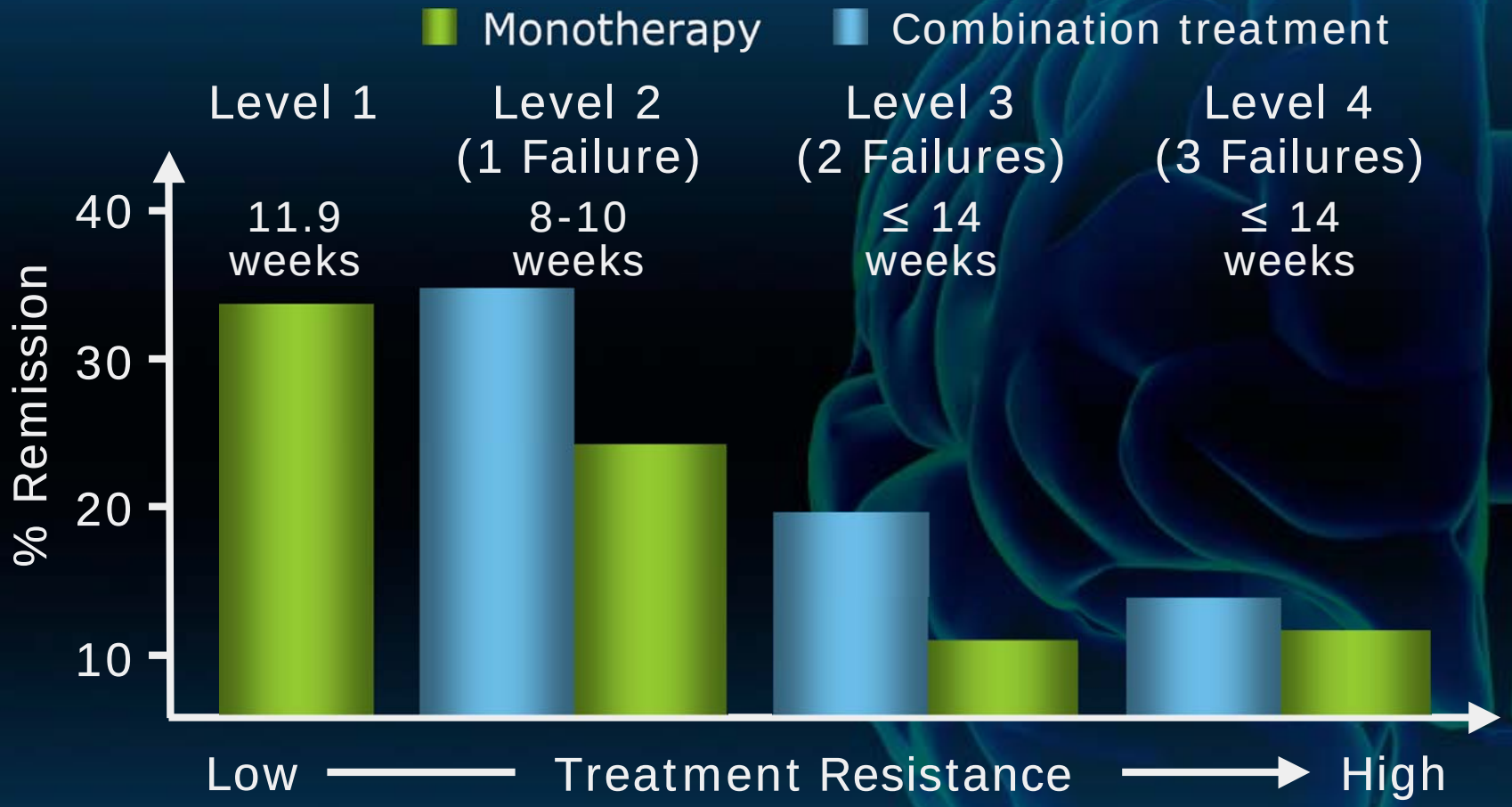
Considerations when Treating Depression

- Treatments
  - Selecting first-line therapy
  - Sequence or combination if treatment is unsuccessful
  - What decisions are made when modifying treatment
- Monitoring the patient
  - What symptoms to monitor
  - How to monitor symptoms
  - How to monitor patient progress

Trivedi MH, et al. *J Clin Psychiatry* 2001;62:158-163.
Trivedi MH, Baker SM. *J Clin Psychiatry* 2001;62:27-33.
Trivedi MH, Kleiber BA. *J Clin Psychiatry* 2001;62:22-29.

STAR*D Clinical Study Results

Remission Rates



Trivedi MH, et al. *Am J Psychiatry* 2006;163:28-40. Trivedi MH, et al. *N Engl J Med* 2006;354:1243-1252. Rush AJ, et al. *N Engl J Med* 2006;354:1231-1242. Fava M, et al. *Am J Psychiatry* 2006;163:1161-1172. Nierenberg AA, et al. *Am J Psychiatry* 2006;163:210-216. McGrath PJ, et al. *Am J Psychiatry* 2006;163:1531-1541.

Treatment Strategies in Patients with Partial Depression and Nonresponders: Definitions

- Maximize dose and duration
  - Use higher doses and longer trials
- Multi-neurotransmitter effects
- Switching
  - Substitution of one antidepressant for another
- Augmentation
  - Use another pharmacologic agent to enhance antidepressant effect
- Combination
  - Concomitant use of ≥ 2 antidepressants to achieve therapeutic effect
- Atypical antipsychotics
  - Efficacy after two treatment failures
- Somatic treatments
  - After 2 or 3 treatment failures?

Crismon ML, et al. *J Clin Psychiatry* 1999;60:142-156.
Trivedi MH, Kleiber BA. *J Clin Psychiatry* 2001;62(suppl 6):22-29.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