Final Report

Managing Depression in African Americans:

Consumer and Provider Perspectives

Sponsored By the Mental Health Association of Allegheny County

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Introduction

The purpose of this project was to examine pathways to depression care and perceived barriers to care among African Americans who have experienced a recent depressive episode. The framework for developing specific aims and focus group questions is informed by collaborative models of care. The foundation of collaborative models of care lies in a shared understanding between consumer and provider of the nature of the problem, and agreement on treatment options and treatment plans [1]. With this in mind, we examined factors influencing the provider-consumer encounter by evaluating the sociocultural meaning of depression for both consumers and providers. Expanding our knowledge about consumers' perception of depression, its treatment, and life circumstances that may influence treatment-seeking behavior will enable us to inform providers about the culturally meaningful perceptions of depression consumers bring to the encounter. Given that prior research has suggested that providers and consumers often focus on different elements of care [2, 3], it is particularly important to examine the congruence between consumers and providers on perceptions of depression and its treatment. Information regarding consumers' perceptions of depression and its treatment, and divergence between consumers and providers can help us to develop more effective collaborative approaches for engaging depressed African Americans in treatment.

Background

This project represents a collaborative effort between members of the academic community, a mental health advocacy agency, local private foundations, and local county government. It represents an initial effort by these diverse stakeholders to identify and address the mental health needs of African Americans in a way that can inform service delivery, health policy, future research, and funding initiatives.

The project examined pathways to depression care and perceived barriers to care for adult African Americans. This study sought to identify barriers to depression care confronted by African American adult consumers.

Four specific aims were addressed.

The study was comprised of six focus groups: three with consumers and three with providers.

Providers and Consumers Surveyed

The study was comprised of six focus groups that included three of which contained African American adults who had experienced a depressive episode within the last six months (consumers), with the remaining three comprised of a variety of health-care professionals (providers). Providers and consumers were asked similar questions, designed to identify the following:

- Cultural factors
- Differences in perspective
- Successful engagement
- Intervention

Four Specific Aims

1. Identify culturally meaningful factors that influence African Americans' perceptions of depression and treatment-seeking behavior.
2. Identify congruence and/or lack of congruence between providers and consumers on perceptions of depression and factors influencing treatment-seeking behavior.
3. Identify the most salient factors that providers need to understand to effectively engage and treat depressed African Americans.
4. Identify the most salient, modifiable factors influencing consumers' perceptions of depression and treatment-seeking behavior that may be the target of intervention strategies at either the individual or community level.

Method & Strategy

We conducted three focus groups with African American consumers who'd had a recent episode of depression and three focus groups with providers of depression care to African Americans.

Both consumers and providers were asked similar questions about the following:

- nature of depression,
- typical depression coping strategies,
- pathways to care,
- barriers to obtaining care,
- social and cultural contributions to symptom expression, and
- help-seeking.

Providers were asked additional questions regarding perceived barriers to providing effective care for the African American consumers they serve.

Each group was comprised of approximately 10 - 13 participants.

A total of 41 consumers and 30 providers participated in the focus groups.

Consumer Perspectives

Focus Group Composition

Members of consumer groups were African Americans who had experienced a depressive episode within the past six months. They varied in age from 23 to 70, and approximately one-third of the participants were male. The majority of participants had at least a high school education, but more than half of the participants were unemployed. Most consumers had health insurance.

Most consumers had recurrent episodes of depression, with the majority reporting that they'd experienced at least three or more periods of depression in their lifetime. Most had also received mental health treatment in the past, about half within the past 6 months. The type of treatment received varied and included group or individual counseling (34%), medication (26%) or combined medication and counseling (40%). Most (75%) had received treatment from mental health specialists (psychologists, social workers, mental health counselors, psychiatrists).

Table 1

Demographics & Clinical Characteristics	
Mean Age	46.8
% Female	68
% ≥High School Education	75
% Employed Full/Part Time	39
% Prior Mental Health Treatment	85
% Mental Health Treatment in Past 6 Months	50
% ≥ 3 Depressive Episodes	72
% with Health Insurance	80

Consumer Perceptions of Depression

When asked "How can you tell when you are depressed?," consumers most frequently identified the clinical symptoms of depression (e.g., sadness, loss of interest, change in weight or appetite, problems sleeping, fatigue, feelings of worthlessness) and diminished functioning as evidence of a depressive episode. Others made note of the cognitive aspects of depression such as memory loss and pessimistic thinking. For some, other affective or emotional states such as anxiety, anger, feeling stressed, overwhelmed, stuck, or out of control signaled depression. Several participants, for whom substance abuse had been a problem, stated that wanting to use drugs again let them know that they were feeling depressed.

There was considerable discussion about the difficulty recognizing depressive symptoms initially, and it was not uncommon for consumers to report that they'd experienced several episodes before they knew something was "wrong."

The most prominent theme in discussion of the causes of depression concerned relationships. The nature of relationships with parents (both as adults and in early childhood), with partners, children, friends, and the loss of relationships through death, conflict, and divorce were discussed extensively as precipitants of depression. For parents, the stress of raising children was also viewed as a cause. Further, many women expressed particular concerns about single parenthood and its impact on mood and functioning. There was considerable emotionally laden discussion about how early childhood trauma can set the stage for adult depression. Harsh physical punishment had a negative impact on many consumers, leaving them feeling vulnerable and sad and often blaming themselves for this reaction.

As one person aptly stated:

"I tried marriage twice, but at the time I had no idea that some of my feelings and behaviors were based on depression. It wasn't actually until my mother died and it got so much worse, that it was obvious to me that something was wrong. I happened to pick up one of those little cards, where you check off the feelings you're having…I checked off nine out of ten…whoa. I had no idea I had depression."

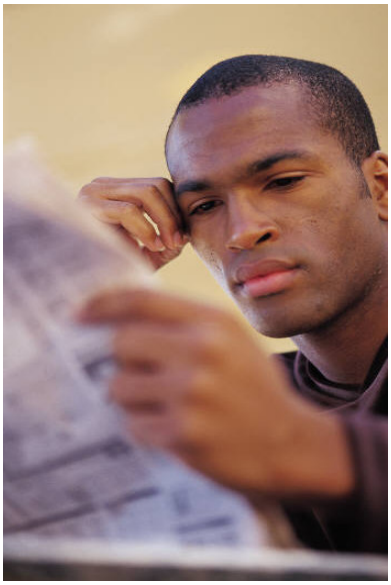
Consumer Perceptions of Depression

Many of these consumers also struggled with trying to balance these experiences with what they believed to be the positive aspects of strict discipline, i.e., fostering respect for parents and authority, teaching children "*right from wrong*," etc. Some consumers had witnessed family violence, or had been the victim of physical or sexual abuse. Clearly, their early trauma contributed to longstanding problems with trust, relationships, depression, and for some, prior substance abuse. The stress of coping with the demands of day to day life and limited resources, (i.e., jobs, money, housing) were also viewed as contributing to depression directly, and indirectly through their impact on relationships and daily functioning.

Coping Strategies of Depression

A recurring theme throughout discussion of the causes of depression was that of culturally acceptable coping strategies. Many consumers saw their life experiences as very similar to others in their neighborhoods, and viewed their depression as an inappropriate reaction to the stress that many African Americans experience, i.e., "*everyone had to deal with difficult things*". It appeared that many experienced a sense of shame because they weren't able to "*deal with things*," which often led to "*keeping things inside*" although it was acknowledged that this was harmful. Thus, feeling depressed triggered negative views about themselves and their ability to function in a culturally acceptable way as well as concerns about how others would view them. The group discussion reflected the struggle many experienced; the positive aspects of African American coping, which emphasizes surviving in spite of adversity, and its negative impact on those who are vulnerable.

Recognizing Depression



As previously noted, most consumers had experienced several episodes of depression, and this chronicity was viewed as leading to difficulty recognizing it as a mental health problem. As one consumer stated:

"…*it had been there so long it just was just a part of me. It's just the way that I was. I built a comfort zone for myself within my house, and that was my safe place, actually in my room. Everything I needed and wanted was around me, and I didn't have to leave it. And when I needed something from the kitchen or some other place, I had the kids go do those things for me so I didn't have to go outside and deal with people.*"

Many stated that they'd gotten used to having feelings of depression, and only considered doing something about it when symptoms got "*real bad*." Again, the recognition of depression was viewed as critical to learning how to cope with it. Interestingly, there was quite a bit of discussion acknowledging that getting help for depression can effect how long it lasts. Help-seeking strategies included prayer, support groups, medication, and counseling. However, drawbacks included problems with medication changes, ineffective treatment, and lack of availability of counseling when needed.

Pathways to Depression Care

We asked a number questions to determine how African American consumers cope with depression, use social support, and determine that treatment is needed. We also asked what treatments were perceived as effective, and what factors contributed to seeking treatment and staying in treatment.

While prior research has shown that many African Americans use informal sources of support first [4-6] for personal and mental health problems, our findings provide further insight into the concerns that consumers have about this type of help seeking. When asked "How do you cope with depression?" there was some discussion about going to family and friends for support, increasing pleasurable activities, prayer, and least often, seeking mental health treatment. However, when asked who they talked with first about problems with depression, most of the discussion was about how family and friends can act as deterrents to getting help for depression. Indeed, a number of consumers indicated that they talked with no one about their depression. Consumers noted that there is still a great deal of stigma associated with depression, and many family members and friends don't understand that depression is a treatable illness. Some thought that parents and other family members might be unwilling to discuss the consumer's depression because their behavior likely contributed to it, and they might feel guilty. Friends were often viewed as unhelpful because they could be judgmental, disinterested, or might tell others.

How do you cope with depression?

Seeking Help

Consumers were least likely to seek treatment when they thought they should be able to handle depression on their own or when seeking treatment was viewed as showing weakness. Recognition of depression was also important. Therefore, consumers reported being less likely to seek help early in a depressive episode and when the symptoms were mild. Access to care was also an influence; when consumers were not aware of available treatment or did not have money or insurance, they tried to handle depression on their own

When asked whether there were treatments that could help with depression, consumers emphasized the development of trust with their provider as critical to getting the most out of treatment. Many also discussed the need for the treatment approach to be tailored or adapted to the consumer's style to maximize effectiveness. For example, some consumers preferred providers who were more directive, i.e., giving advice and answering questions, others said they worked best with providers who listened carefully and helped the consumer to work things through at their own pace, and still others wanted "*facts*" not talk.

The latter preferred providers who discussed the biology of depression, how drugs worked, and who provided written information. They noted that having this information, or the "*facts*" helped them to regain a sense of control.

One woman describes her experience as follows: "*My girlfriend, when she found out that I had admitted myself to the hospital, she came down and said, "What are you doing in here? You don't need to be in here….you're not crazy! I was like, "Well I'm not here because I'm crazy. I'm here because I need help for myself. I want to make myself better." That is one of the things that keeps people from getting help. They are afraid of what somebody else is going to say or think.*"

Types of Treatment

No specific type of treatment was identified as ideal for depression. Instead, the relational context was most important in determining whether or not a treatment was helpful. Thus, consumers who had received effective treatment talked about how a trusting relationship with their provider evolved, allowing them to address difficult and often painful issues, and ultimately how they experienced a sense of loss when they terminated treatment. Conversely, "*bad*" treatment experiences were discussed in terms of concerns about medication side effects, fear of being used as a "*guinea pig*," lack of cultural sensitivity on the provider's part, and mistrust of the provider.

Consumers reported being most likely to seek help for depression when they either had experienced or anticipated developing a relationship with a provider that was characterized by trust, openness to the client's treatment preferences, and cultural sensitivity. Additionally, prior experiences with effective treatment and a need to regain control and improve functioning were conducive to seeking treatment again. However, it was evident that many consumers viewed treatment as appropriate only when symptoms became severe, or when suicidal thoughts or thoughts of hurting someone were experienced.

What's the ideal treatment for depression?

Major Deterrents to Seeking Treatment

The major deterrents to seeking treatment included: concerns about confidentiality, stigma, adverse effects of medications and previous experiences with ineffective treatment. Many women were concerned that if they sought treatment they might be hospitalized and their children would have no one to care for them. Similarly, women were also concerned that their children might be taken away from them if they sought treatment for depression. This was particularly the case for women involved with various social service agencies. In light of the above-mentioned concerns, it is not surprising that when asked "Who do you prefer to go to for treatment?", no clear preference emerged. Instead, consumers reiterated the above issues as contributing to their reluctance to seek treatment. Preferences for mental health professionals and clergy were comparable. Other types of providers were not discussed.

Finally, the three factors identified as most important in influencing consumers' decision to seek treatment included the following:

1. readiness to make changes and "*get back to normal*" followed by
2. availability of effective treatment, and
3. having a trusting relationship with their provider.

Confidentiality, stigma, adverse effects of medications, and previous experiences of ineffective treatments are major deterrents to seeking treatment.

Table 2	
Provider Characteristics	
Mean Age	49.8
% Female	60
% African American	53
% Mental Health Specialists	34
% General Medical Provider	21
% Clergy	18
% Other -Case Management -Drug & Alcohol -Homeless Outreach	27
Mean Years in Practice	19.2
Service Sector % Mental Health % General Medical % Faith Based % Social Service % Multiple	 36.6 6.7 23.3 10.0 23.3

Provider Perspectives

Focus Group Composition

As shown in Table 2, the provider groups were quite diverse and included mental health providers, general medical providers, clergy, case managers, drug and alcohol specialists, and mental health counselors serving the homeless. Provider groups included males and females, African Americans and whites, and ranged in age from 34 to 76. This was an experienced group of providers, who worked in settings that included public, community, and hospital based mental health clinics, faith-based agencies, social service agencies, and private practice. A number of providers worked in multiple settings.

Perceptions of Depression and its Treatment

"How do you determine that a person has depression?"

Providers were asked a series of questions regarding:

- perceptions of depression,
- effectiveness of treatments for depression,
- and pathways to depression care

that were similar to those posed to consumers. When asked "How do you determine that a person has depression?" providers typically identified clinical symptoms of depression and impairment in functioning.

The presence of psychosocial stressors, medical comorbidity, and recent substance abuse were also used as possible indicators of depression. In addition, many providers concurred that for many clients, the recognition of depression was not straightforward, and arriving at a diagnosis of depression was an evolving process. This process usually involved educating the client about the nature of depression. Consistent with consumer perceptions, the existence of significant psychosocial stressors was viewed as a major cause of depression. Providers also emphasized the need to take into account contextual factors such as:

- early childhood trauma,
- experiences with discrimination and oppression,
- and spiritual crises

as contributing to depression in African Americans.

To a lesser degree, medical illness, substance abuse, and "*chemical imbalance*" were viewed as precipitating depression. Depression was described as a disorder of variable length, and chronicity was dependent upon the type of depression and the impact of the client's social, psychological and economic circumstances.

Pathways to Depression Care

We wanted to know providers' views about how consumers cope with depression, so we asked:

"Who do people talk with first about their problems with depression?"

There was a great deal of agreement that people typically seek out people they trust, be they clergy, friends, family, or health professionals. However, there was also acknowledgment that concerns about stigma might deter consumers from talking about depression. In fact, providers also thought that talking with family members could often act as a deterrent to seeking treatment. Providers stated that some consumers were not comfortable talking with anyone about their depression and some chose to "*self-medicate*" rather than seek support. Providers also noted that sociocultural factors had an impact on seeking help and that providers must become aware of these and develop mechanisms for addressing them.

Although mental health professionals were mentioned as someone consumers might talk with first if they had a trusting relationship, it was clearly evident in this discussion that providers did not think that most African American consumers viewed mental health treatment as a first step in coping with depression. Providers indicated that consumers were more likely to handle depression on their own when they were concerned about the appropriateness of care available, particularly if they'd had prior treatment and "*it didn't work out*," or they know someone who had a negative experience with treatment. They noted that patients might also be more likely to try to "*just get through it*" when experiencing excessive stress, problems with childcare, or when symptoms were viewed as mild.

As one provider stated "…someone said something earlier about treating the person versus a situation in the community. And I don't know why we ask that question. It's not a matter of either or. It's a matter of both and. I think too often clinicians tend to just focus on the individual when they can really play a major role and make some changes in the community and need to. If we're really caring about people, we need to look at the community situation. But at the same time, here is an individual who needs some help right now. And so you've got to deal with that. At the same time, your work with that particular person can serve as a springboard to looking at these larger community issues.".

Approaches to Treatment

In order to determine what steps providers took to engage African American consumers in treatment, we asked providers:

"What do you do once you have determined that someone has depression?"

The most common themes discussed included educating consumers about depression and trying to work with them to develop an agreed upon approach to treatment. Consideration of the many social and contextual issues that are associated with their depression was also viewed as important. It was emphasized that providers should be aware that clients' concerns and contexts would vary; there is no singular "*African American experience*." Professional people may experience isolation and discrimination that an unemployed mother or a person struggling with substance abuse will not. There may be commonalties in their experiences, but providers must be cognizant of the uniqueness of each person's situation and how it affects them.

Limitations in Providing Services

While providers seemed well aware of the complexity of issues facing their African American clients, many expressed frustration at the limitations they faced in providing services. Clients often presented with multiple problems, many of which providers could not assist with. The lack of continuity of care particularly between mental, general medical, spiritual, and social services were salient concerns, and the need for greater integration of these services was viewed as critical if African American consumers are to be adequately served. There was also some discussion about the need for outreach for more marginalized consumers (e.g., homeless families, substance abusers, etc.). Finally, development of a trusting relationship was seen as critical to helping clients initiate or adhere to treatment.

When providers were asked to identify effective treatments for depression, no particular treatment modality emerged. Medication, psychotherapy, combined medication and psychotherapy, were all viewed as potentially effective. Instead, providers focused on the importance of utilizing a treatment approach that allowed the provider to consider the social issues and spiritual concerns that clients may present with. It was emphasized that a provider's understanding of clients' cultural background and current life circumstances were viewed as critical to delivery of any treatment.

Clients often presented multiple problems.

Developing Trusting Relationships

Providers noted that the development of trusting relationships with African American clients might be experienced as challenging for both provider and consumer. The historical and continuing experience of discrimination and oppression in many spheres of life by African American people was viewed as contributing to their caution in developing trusting relationships with healthcare providers, particularly for mental health problems.

Considerable concern was expressed about how medication was prescribed, with some providers indicating that medications are sometimes "*pushed*" on consumers with apparently little consideration given to psychosocial treatments. Conversely, general medical providers indicated that they were increasingly asked to treat depression, and were frequently limited to pharmacologic treatment because of lengthy waiting lists for mental health treatment. The increasing "popularity" of treating depression with medications was also addressed. Providers expressed concern that consumers often did not receive appropriate education about the prescribed medication(s) and possible side effects. Medication monitoring was perceived as frequently inadequate, and this likely contributed to poor adherence. Without adequate information, clients were more likely to expect a quick response and discontinue medication when this did not happen.

One psychotherapist noted:

"....in addition to education, we have to work really hard at giving African Americans a different experience with therapy, because that is not something that they buy into easily and engage in. But if their experiences become different, then their perceptions will, in turn, be different…they will be *able to see that…`this is a resource that can truly help me' So on top of the education we ourselves need to present differently and give them these experiences."*

Seeking Treatment

When asked "What factor(s) influence a person's decision to seek treatment?" providers indicated that the stigma of mental illness and experiencing crises or stress that they can no longer manage independently were the most important factors in determining help-seeking behavior. Also, identification of depression and referral by people or agencies with whom the consumer had a trusting relationship was viewed as important in getting people into treatment. It was noted that often these relationships exist with non-mental health providers (e.g., shelter workers, friends, clergy) and that more public education efforts should be geared toward helping the public and a variety of other service providers identify depression.

Providers were also asked whether their views about the appropriate ways to treat depression in African Americans differed from those of their agency or institution. In response to this, the discussion focused almost exclusively on the need for training in cultural competence. Although many stated that their agency recognized the need for cultural competence, in practice, actual training was often optional. Discussion focused on the importance of understanding African American cultural values, behavioral and attitudinal norms, culturally acceptable expressions of distress, and help-seeking. Providers seemed to feel strongly that inadequate understanding of these factors, or lack of comfort addressing cultural differences could negatively influence both the diagnostic and treatment process. While it was acknowledged that addressing these issues could be challenging, some providers described the positive treatment outcomes that had occurred as a result of their agency's willingness to improve cultural awareness of providers and staff.

What factor(s) influence a person's decision to seek treatment?

Limitations of Treatment

In addition to knowledge about African American culture, providers thought it important for practitioners to be aware of the limitations of mental health treatment. Helping the client to gain a clear understanding of how the provider's service might or might not help was seen as a first step in the development of realistic treatment expectations and a trusting relationship. While it was acknowledged that not all African Americans "*are religious or go to church*," spirituality was viewed as an important aspect of psychological well-being for many African Americans. Focus group members thought it important that providers work to foster an environment where clients would feel comfortable discussing these concerns. Finally, providers noted the importance of understanding the impact of racism and discrimination on African Americans. These effects begin early, often in childhood, and not only influence the opportunities and choices a person has, but from a psychological perspective, can have a profound impact on how people view themselves, and their relationships with others.

Spirituality was viewed as an important aspect of psychological well-being for many African Americans.

Barriers to Treatment

Several barriers to providing effective care for depressed African Americans were identified. Primary among these was the need for accessible, community-based care. Limitations imposed on treatment through financial reimbursement mechanisms and the fragmented structure of medical and mental health services were also viewed as major barriers. A number of providers also thought that their agency was not knowledgeable or open to addressing clients' spiritual concerns, often an important consideration among African Americans. It was also noted that a client's expectations about treatment could also serve as a barrier.

Impact of Racism and Discrimination on the Psychological Well-being of African Americans

Consumers and providers were largely in agreement that the experiences of racism and discrimination were associated with depression. Such experiences were viewed as creating psychological distress, and affecting the individual's sense of self-worth.

Racism and discrimination were viewed by both groups as contributing to significant social and economic inequities, as well as unfair treatment in the legal system, all of which were believed to contribute to depression in African Americans.

The impact of racism was viewed as:

- starting in childhood,
- affecting the individual's view of themselves,
- their aspirations,
- and their relationships with other African Americans.

Consumers viewed racism and its impact on the social and economic status of African Americans as contributing to conflict, violence, and substance abuse in African Americans. Many emphasized the need to increase the awareness among African Americans of constructive ways of coping with oppression. Providers also discussed the impact of racism on the mental health of African American men. They felt strongly that African American men were less likely to seek mental health care, and when care was sought, were often poorly served by the mental health system.

Both consumers and providers concurred that although these experiences typically had a profound impact on the lives of African Americans, mental health services are often not provided in a manner that facilitates the discussion of these issues. Providers may lack sufficient awareness of the impact of oppression, and/or do not have adequate training and skills to address it.

Both consumers and providers agreed that racism and discrimination were associated with depression

Congruence Between Consumers and Providers on Perceptions of Depression and its Treatment

One of the major aims of this project was to examine whether consumer and provider perceptions of depression and its management differed. Consumers and providers concurred that identifying the clinical symptoms of depression and changes in functioning were key in determining the presence of a clinical syndrome. While provider comments indicated an awareness that recognition of depression was difficult for many consumers, discussion in the consumer groups suggested that the difficulty recognizing depression is a major problem, and that providers may underestimate this. A major contributing factor to this difficulty are consumers' endorsement of culturally sanctioned views about coping with adversity, and expressions of distress. Consumers' clearly struggled considerably with the distress associated with their depression, and their belief that they "*should*" be able to handle things.

Major Causes of Depression

Psychosocial stressors were viewed as a major cause of depression.

Both consumers and providers viewed psychosocial stressors as a major cause of depression. In addition, providers noted medical comorbidity and substance use as causes of depression. While providers focused on psychosocial stressors generally, consumers focused more specifically on interpersonal stressors. Thus, much of their discussion focused on relationships with significant people in their environment. Prominent themes included loss and conflict in relationships, single parenthood, and for many, early childhood trauma. Like providers, consumers identified lack of resources and psychosocial stressors as causes of depression, but less emphasis was given to these factors.

Both consumers and providers expressed many of the same themes in terms of pathways to depression.

In terms of pathways to depression care, consumers and providers expressed many of the same themes. Both groups agreed that trust between provider and consumer is important, that treatment must be viewed as culturally relevant, and that many consumers seek treatment only when depression is severe. Both groups readily acknowledged the limitations of mental health treatment, expressed concerns about the adverse effects of medication, and addressed the complexity of social and economic needs that many consumers present with. However, providers focused on the need to deliver the appropriate treatment or "*package*" of services, while consumers emphasized the development of trusting, helpful relationships with people in their social network, as well varied service providers as critical to getting care for depression.

Finally, consumers and providers differed somewhat on their views about the "*most important factors*" that influence a depressed person's treatment behavior. Consumers clearly value their self-determination, they identified the need to get well and stay well as an important motivating factor in seeking treatment. They often described this as a process that evolved over years and after varied treatment experiences. A trusting relationship with providers was the second most important factor, and was viewed as important in helping to facilitate the desire to change. Lastly, experiences with effective treatment of depression was key for many consumers in seeking help. In contrast, provider's viewed stigma and consumers' view that depression treatment is not culturally relevant as the most important factors influencing treatment seeking behavior.

Culturally Meaningful Factors that Contribute to Perceptions of Depression and Coping Behavior

Many of our findings about perceptions of depression, coping, and help-seeking strategies are consistent with published work on depression in non-minority populations. Experiences of early loss and trauma, initial difficulty in depression recognition, and concerns about stigma are not unique to African Americans. What we hope to highlight is how various factors, whether common across cultures or unique to African Americans, serve to pattern an individual's perceptions and their psychological and behavioral responses to clinical depression. Factors that are common across cultures may well have different meanings and salience in different groups, and may lead to different behavioral responses across cultures.

We found that a salient factor influencing perceptions of depression and coping strategies were the normative experiences of distress among African Americans. Many of our respondents viewed feelings of distress and depressive symptoms as normal reactions to adverse economic, social and political conditions experienced by many African Americans. Even when distressing experiences were highly personal, such as family and interpersonal conflict, respondents often identified others within their immediate social environment who'd had similar experiences. Often, their own symptoms were thus viewed as an aberrant reaction. This likely contributed to the difficulty that many participants had discerning when particular stressors exceeded their capacity to cope, and when formal help was needed.

Coping With Depression

Focus group participants clearly articulated how culturally informed and accepted views about coping with stress and distress had both positive and negative influences on their views of themselves and their coping behaviors. Resilience in the face of distress and often demoralizing life situations was commonly viewed as a strength of African American cultural values. Despite experiences of disabling depressive symptoms, many viewed acknowledgment of depression as an admission of "defeat," and saw this as contrary to a strong and healthy survival ethic predominant in African American culture. Many viewed the development of such resilience as a critical facet of African American identity; coming to terms with disabling and painful episodes of major depression was particularly challenging because it represented a threat to their sense of identity. For many who were able to use treatment effectively, finding a way to embrace adaptive aspects of culturally sanctioned coping behaviors while also acknowledging their psychological vulnerability was key to them using mental health treatment effectively.

…many viewed acknowledgment of depression as an admission of "defeat".

Relationships

The nature and impact of relationships was one of the most dominant themes in the consumer focus groups. Participants discussed the impact of relationships as causes of depression, their value in helping one to cope with depression, and also how significant others might serve as deterrents to getting appropriate treatment. Trusting therapeutic relationships were also viewed as a key element in effective treatments for depression. Participants' emphasis on relationships is congruent with cultural collectivism, an important value among contemporary African Americans. For those who hold this value, interdependence and collective responsibility are emphasized and the individual is encouraged to look beyond their personal needs and consider the needs of the group [7]. Our findings suggest that many participants struggled with ways to incorporate these values in ways that enabled them to maintain important social network ties, while also acknowledging that professional help was necessary for effective management of depression. Unfortunately, for many participants this conflict resulted in not discussing depression with anyone, while others were able to develop alliances with people who could be supportive of their efforts to get treatment for depression.

Negative Experiences

African Americans mistrust the medical system due to poor health care or negative experiences with medical and/or mental health care.

Finally, mistrust of the medical system was evident from participant's responses. Many had been exposed to poor health care or knew someone who'd had negative experiences with medical and/or mental health care. These individual and collective experiences very likely contribute to mistrust of the healthcare system generally, and pose an even greater challenge to the help-seeking efforts of African Americans with depression.

Recommendations

Our findings indicate that the individual's perception of the social appropriateness of their depressive symptoms, and the appropriateness of seeking mental health treatment are critical factors influencing their utilization of mental health services. Our recommendations are therefore guided by a public health approach, we have identified modifiable factors that can be the focus of intervention directed toward the individual, provider and the community. These factors include:

1. Education and Training
2. Service Delivery Structure
3. Clinical Intervention
4. Research
5. Health Policy

1. Education and Training

Community-based education programs must be developed and implemented. The difficulty African American consumers have recognizing depression as a clinical condition that is treatable is clearly demonstrated in this study. Consumers are influenced by their own culturally informed beliefs, and by the beliefs and attitudes of trusted family, clergy, and friends who frequently are mediators of treatment seeking behavior. Educational efforts should first inquire about community perceptions of depression and its treatment, particularly medication. Instructional strategies can then be developed that address these perceptions and misconceptions in addition to providing "standard" information about depression. Education should target natural leaders within the community (i.e., norm and opinion shapers) and build on natural community links with the goal of empowering community members to acknowledge depression and to accept this as a treatable problem.

Education and training efforts should be targeted toward:

- General Public
- Mental health providers
- Non-mental health providers
- Community-based organizations
- Clergy/ Religious institutions
- Schools (Kindergarten through baccalaureate, professional schools)

2. Service Delivery Structure

- **Resources must be utilized (or new resources developed) that can help service systems and individual staff improve the treatment engagement process.**
- **Naturally occurring intersections between the medical, social, spiritual, and mental health sectors must be identified and used to facilitate better integration of health care.** The development of financial support for use of such mechanisms should be encouraged.
- **Methods for evaluating "community-mediated" client satisfaction with mental health services should be developed. Such methods will incorporate community expectations for mental health services.** Development of this assessment strategy is important given the impact community-based norms have on consumers' willingness to seek mental health care.
- **Mechanisms for building community-centered advocacy that focuses on setting expectations for mental health services and accessing mental health services should be identified.**

1. Both formal and informal health care providers must be educated and encouraged to accept community-centered mental health advocacy.
2. Methodologies that can incorporate community expectations for mental health services in formal and informal milieus should be developed.
3. Strategies to evaluate these methodologies should be developed.

RECOMMENDATIONS

Education and Training

Service Delivery Structure

Clinical Intervention

Research

Health Policy

3. Clinical Intervention

- **Develop and implement intake procedures that increase continuity of care.** There is sufficient evidence that commonly used intake procedures negatively affect pathways to mental health treatment for mental health treatment. Intake procedures must be carefully examined to identify barriers to treatment initiation, engagement, and retention.
- **Develop specialized outreach procedures to educate and treat depressed African American males.**
- **Identify culturally sanctioned coping strategies that contribute to appropriate care for depression.** Develop community-based and individually-focused intervention efforts that build on the adaptive aspects of these coping strategies
- **Consumers' motivation and resources for change should routinely be assessed and incorporated in the evaluation, treatment engagement, and retention process for depressed African Americans.** Focus group responses indicate that consumers value their self-determination. The need to get well and stay well is an important motivating factor in seeking treatment. Assessing this information will inform providers about where to begin with a particular consumer and may also serve help consumers begin to develop supportive networks that can reinforce their commitment to get well.

4. Research

- **Identify the critical elements influencing the treatment engagement process for depressed African Americans. In addition to treatment initiation, factors associated with "early" treatment seeking behavior, retention, adherence, and treatment completion should be identified.**
- **Research that identifies effective treatments for African Americans (both psychosocial and pharmacologic) should be conducted.**
- **Identify the key elements associated with successful community-based health and mental health programs that have achieved significant clinical outcomes and work to apply these to mental health demonstration projects.**

1. Design and implement studies that can determine the transferability of these strategies.

- **Research that evaluates mental health outcomes based on the availability of ancillary support should be conducted.**

5. Health Policy

- **Mechanisms to develop adequate financing of ancillary elements of the therapeutic process (e.g., outreach services) must be developed.** Focus group findings indicate that consumers value the development of trusting relationships, and that this is an important determinant of treatment seeking behavior. However, current systems for reimbursement of mental health services leave little time for clinicians to develop this type of relationship when treatment is initiated. The financial reimbursement system also devalues the implementation of consumer outreach, which may be critical for the identification of depression in African Americans, as well as initiation of and retention in depression treatment.
- **Community-centered advocacy should be used to encourage both legislators and insurance carriers to pay for ancillary services.**

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About Our Organization…

The Mental Health Association of Allegheny County was founded in 1959 to serve residents by:

- Providing them with a relevant mix of information, referral, advocacy and legal services.
- Helping individuals obtain quality behavioral health services that are both appropriate and culturally sensitive.
- Providing free and confidential services.

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