

# Depression in Latinos: A Focus on Overcoming Barriers

## Needs Assessment

Depressive Disorder (MDD) is a highly common and treatable disorder. It affects more than 17 million American adults annually, has a per annum cost of more than \$2 billion and is one of the most burdensome and prevalent disorders in the world. It is expected to be the second highest cause of disease burden worldwide by 2020. [1,2,3] Patients with MDD experience long-lasting problems in daily functioning and sense of well-being, comparable to or worse than patients with chronic illnesses. [2]

Once identified, depression can almost always be successfully treated either by psychotherapy, medication or both. Unfortunately, depression is underdiagnosed and undertreated, especially in primary care. [2, 4, 5] Primary care clinicians are most likely to see patients when they first become depressed; yet only one-third to one-half of people with depression are correctly diagnosed in primary care. [2]

MDD is particularly burdensome for Latinos, an umbrella term referring to a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. Latinos, who account for 45.5 million US residents and are the nation's largest and fastest growing ethnic group, consistently report more depressive symptoms than other ethnicities, but are among the least likely to receive a depression diagnosis and, if diagnosed, remain poorly treated. [6, 7,8,12] While about 50 percent of Latinos who do receive some level of depression treatment receive it in a primary care setting, fewer than 13 percent receive guideline-based care that would be considered adequate, about half the rate compared to non-Latino whites. [6, 10]

Clinically speaking, just being Latino is a risk factor for MDD, although the risk for depressive symptoms is similar to that among non-Latino whites. [7,9] Cultural and social factors and the absence of emotional social support in Latino communities can amplify stressful life events, which tend to be higher in Latinos. [8] In addition, stigma associated with depression therapy, including antidepressants, is greater in Latinos than other ethnicities, negatively impacting treatment adherence; and among Latinos, simply being treated for depression is seen as implying "more severe illness, weakness or failure to cope with problems, and being under the influence of a drug." [11] These stigmata are significant concerns among Latinos, limiting the discussions with their clinicians about depressive symptoms, treatment adherence, follow-up visits and specialty referral, playing a part in low diagnosis and treatment rates of MDD. [11, 12]

Another, and in some ways, more significant culprit in sub-optimal diagnosis and treatment of MDD in Latinos is a practice termed "statistical discrimination (SD)." Different than more observable forms of discrimination, e.g. affective bias and cognitive stereotyping, SD occurs when a physician uses general information about an ethnic (or other) group in the absence of individual data to make clinical decisions. [12] SD alone does not necessarily create gaps in treatment; however, when clinical uncertainty arises due to poor physician/patient communication, too much weight can be placed on these group-based generalizations. Consequently, in the case of MDD, depressive symptoms are not recognized and treatment is not prescribed. [12] Unfortunately, communication, especially about depression, is historically challenging for primary care physicians. The training PCPs receive in medical school in recognizing and treating depression is often inadequate. [13] Additionally, family physicians often don't

recognize depression as a “real illness,” since it often exhibits no empirically detectable symptoms; and many lack the communication skills necessary to elicit the type of information required for a diagnosis, especially in Latinos who are generally reluctant to discuss depression, for reasons described above. [11,13] Finally, the perception that diagnosing and treating depression is significantly more time consuming than other physical concerns lead some PCPs to avoid discussion of depression altogether. [14,15]

MDD is a significant problem for enlisted military personnel returning from combat areas and their families. Since September 11, 2001, approximately 1.5 million American troops have been deployed in support of the War on Terror, with the majority seeing more than one tour of duty. [20] Most of those deployed to Iraq and Afghanistan report exposure to multiple life-changing stressors, leading to a finding by the US Army that about 17 percent of soldiers deployed in Iraq screen positive for MDD. [21] Of the 88-94 percent of enlisted personnel who access their military-provided primary care physician, 22 percent present with psychological health issues. [27] Wartime experiences often challenge a person’s ability to easily reintegrate into civilian life following deployment since survival strategies used in combat environments are disruptive to interpersonal and family functioning. [19,20] A soldier’s family also experiences unique stressors when a soldier is deployed, which, in many cases, leads to depression; and, because the spouse, in effect, becomes a single parent, the added duties and responsibilities can interfere with seeking help for depressive symptoms or medication adherence. [20,22] The stress associated with deployment (extended separations, increased workloads, shifting demands, and unstable deployment schedules) is difficult to manage under any circumstances, and even more so when the service member is deployed to combat zones where loss of life and injury are real possibilities. [20] The distress and anxiousness induced by uncertainty about how to respond to other family members’ needs can also lead to MDD if left unchecked. The strain of separation weighs heavily on both the deployed soldier and the spouse/caretakers left behind. Should the soldier be injured and placed at a treatment facility far from his or her base (a very common occurrence), the spouse struggles to meet the soldier’s needs and the needs of the family. In addition, should death become a factor, the family must leave on-base housing within six months, creating further disruptions. [20]

The soldier and family are often so affected by the stressors surrounding deployment that even a joyous occasion such as the reunion of an absent parent or spouse back into the family leads to complicated emotions for everyone involved. [20] The convergence of these stressors creates ideal conditions for the development of significant emotional problems for military personnel and their families. [20, 22]

Latinos make up about 13 percent of the armed forces enlisted personnel and about five percent of military officers, with those numbers expected to rise in the coming years as the Department of Defense increasingly targets Latinos in recruiting efforts. [16,21] The percentages, however, are deceiving since about a quarter of Latinos in military service are assigned to front-line combat or hazardous duty occupations. [18]

While no studies are known to analyze diagnosis and treatment rates of MDD in Latino vs. non-Latino combat veterans, it is logical to surmise that similar disparities established in civilian population exist in combat veterans, especially since about half of personnel who have depression don’t seek help from a provider and only half of those receive minimally adequate treatment – statistics mirrored in civilian populations. [6,19] And while Latinos in the military face additional stressors, their families encounter the same cultural and social stigmata as their fellow civilians, including communicating about depressive symptoms with providers. [11,12,13,19] In addition, Latino families who have been displaced to live near a military base (along with the deployed family member) can experience acculturative family distancing

(AFD), a phenomenon shown to be most prevalent in Latino families who are rapidly removed from daily reinforcement of Latino culture and exposed to continuous, first-hand contact with other groups. [23] AFD is associated with higher psychological distress and greater risk for clinical depression in Latinos, especially those who have emigrated from another country. [23] As the Department of Defense offers US citizenship for military service, immigrant Latino military families are becoming more common. [24]

Systemic complications, such as trying to access care or help by navigating the bureaucracy of government, automated messages, or the confusing myriad of available service providers can create an added point of stress and frustration. Resources designed to serve family members as well as combat veterans are difficult to locate. When MDD is diagnosed it is also a barrier, since it isn't usually considered combat-related injury if it develops after the soldier returns home, in addition to the social and cultural factors experienced by Latinos mentioned earlier. When combined with communication difficulties, few succeed in locating needed assistance, resulting in untreated depression in combat veterans and families. This lack of support is a barrier to care, especially in Latinos who are reluctant to seek care or communicate with providers about depressive symptoms. [22]

Opportunities to identify and treat depression in Latinos are missed in military treatment facilities and by the non-military primary care providers who care for families. Inadequately trained providers, who could better recognize the presentation of depression and be trained to use culturally-appropriate strategies to elicit information to aid in diagnosis, inadvertently allow high-risk patients to pass through undetected. [19, 20, 26]

Undiagnosed and untreated MDD in combat veterans and families can lead to a cascading series of events, including drug use, suicide, marital problems and unemployment, which can be amplified by concomitant post traumatic stress disorder (PTSD) or traumatic brain injury (TBI) resulting from combat exposure, as noted in a report by the RAND Corporation in June 2008. [19] According to the RAND report, Latinos are more likely to develop combat-related MDD than other ethnicities. [19] Of the 300,000 combat veterans suspected of having MDD and/or PTSD, approximately 75,000 are Latino, based on the rates of Latinos in the military and deployed to combat or hazardous areas. [16,18,21] Since military rates for the underdiagnosis and undertreatment of depression are similar to those found in civilians, fewer than 10,000 Latino combat veterans are receiving minimally-adequate care [6,10,19]. It can be presumed that similar or lower rates are indicative for family members, for reasons outlined above.

The RAND report acknowledges the military health system's lack of qualified providers who are needed to address all the mental health needs of returning combat veterans and their families. It cites a strong need for training of primary care providers in recognizing and responding to the symptoms of combat-related depression or problems with separation and reintegration. [19] Lewis-Fernández, *et al.* noted that primary care physicians are poorly trained in culturally-specific presentation and communication strategies to recognize MDD in Latinos, and that such [training] would improve diagnostic rates and actively promote adherence to effective treatments. [26] The RAND report also acknowledges the need for relevant and timely education for current and future health professionals who care for combat-veterans and their families. [19] Finally, the American Psychiatric Association's (APA) report notes a shortage of Veterans Administration-sponsored mental health services for families of veterans. [20] While isolated examples exist, they are plagued by the shortage of properly trained community-based and military providers noted in the RAND report. [19,20]

## The Educational Gap

About half of returning combat veterans are not being diagnosed and are not receiving even minimal care for major depression. The combat-related and other stressors which contribute to MDD and barriers to appropriate care are highest among Latinos in the military and their families. Cultural and social factors coupled with traditionally poor communication skills between Latino patients and primary care providers creates clinical uncertainty regarding a depression diagnosis and/or treatment, and missed opportunities to diagnose and appropriately treat MDD are at unacceptable rates. As DoD and VA funding plateaus or declines relative to mental health services, a significant increase has been realized in Latino soldiers and their families who are in need of these services. While the burden will most certainly fall to local communities, primary care health providers are ill equipped to recognize and appropriately meet these mental health needs. The unfortunate result is underdiagnosis, misdiagnosis and undertreatment of MDD by healthcare providers in Latinos who serve in the military and their family members in accordance with the most current, evidence-based clinical guideline.

The RAND report, the APA report and the Department of Defense acknowledge a gap in the number of properly trained providers, especially in primary care, to meet present and future needs. Each outlines that community-based primary care providers should receive specialized training in recognizing and responding to the mental healthcare needs of soldiers and their families. When combined and strengthened with strategies to diagnose and treat MDD in Latino populations, including culturally-appropriate communication, this type of training will reduce the disparities created by cultural, social, professional and systemic barriers, increasing the number of Latinos who are diagnosed and receive appropriate treatment for MDD.

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