Depression-Related Disparities Among Older, Low-Acculturated US Latinos

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Older Latinos with depression report higher levels of impairment and are more persistently ill than non-Hispanic white older adults, yet they have lower rates of guideline-concordant treatment. Cognitive and problem-solving psychosocial modalities are emerging as key treatment considerations for older Latinos.

As the population increases and people live longer than previous generations, a significant number of older people will need treatment for mental disorders. Depression is one of the most prevalent mental disorders among older adults, including ethnic and racial minorities, and is a leading cause of disease burden and disability in the US and abroad. Part of this burden is attributable to the fact that depression is often comorbid with medical conditions, it impairs cognition, and it leads to significant disability with an increased risk of suicide and all-cause mortality.

Late-life depression is defined in this article as unipolar depressive syndromes that older adults experience, typically around age 60 or older: major depression, dysthymic disorder, adjustment disorder with depressive features, and clinically significant depressive symptoms or minor depression. The prevalence of depression is 15% to 20% each year for older adults; for major depression, prevalence is 1% to 4% in the general population and up to 14% in nursing home residents. The prevalence of minor depression is 4% to 13%, while dysthymic disorder occurs in about 2% of the older adult population. For people living in long-term-care settings, the rates of minor depression or clinically significant symptoms of depression range from 17% to 35%. Although depressive disorders are less frequent in older adults than in those who are younger, older adults report higher levels of depressive symptoms than their younger counterparts, and symptom remission is less likely in the elderly. As with younger adults, the course of depression in older populations is marked by exacerbations, remissions, and chronicity—60% of older adults who recover from a major depressive episode have a subsequent episode, and up to 40% of depressed older adults can experience relapse and chronicity. Thus, even subthreshold or subclinical levels of depression that do not necessarily meet DSM-IV diagnostic thresholds can be disabling. Greater disability is associated with higher prevalence of depression and risk among the elderly. Those with complete impairment in a least 2 domains of living are at highest risk for major depression (up to 31.5%). The mechanisms implicated in the relationship between disability and depression include both individual (eg, heightened sensitivity to acute and chronic stress, biological pathways such as increased proinflammatory and cortisone activity) and external factors (eg, environmental stress exposure).

Depression-related disparities among older, low-acculturated US Latinos

Latinos represent the fastest-growing segment of the older adult population. With an increase from 6% in 2006 to 18% in 2050, they will account for the largest racial/ethnic minority group over age 65 by 2028. Among adults aged 50 and older in need of depression treatment, less than half access services. Considerable evidence exists that older US racial and ethnic minorities experience significant mental health disparities in depression burden and access to quality mental health treatment. Older minorities with depression report higher levels of impairment and are more persistently ill than non-Hispanic white older adults, yet they have lower utilization of mental health care. A comprehensive review by Fuentes and Aranda found that of 1068 articles, only a handful of depression treatment studies actually reported racial- or ethnic-specific outcomes pertaining to older minorities. Although there has been an increase in the proportion of Americans who are treated with antidepressants, older minorities report higher rates of depression-related disability and longer duration of the depression, and they are less likely to receive any type of therapy or guideline-concordant depression care.

Older Latinos have up to double the rates of clinically significant depression compared with both
whites and blacks in similar population-based studies. Prevalence for major depression is higher (about 28%) among minority patients in urban settings. Although immigrant young Latinos have better mental health outcomes than US-born Latinos for select disorders, older immigrant and low-acculturated (ie, limited English-speaking and retaining country of origin beliefs, traditions, communication patterns, and help-seeking behaviors) Latinos tend to be at higher risk for depression. Yet, the situation is compounded by the fact that older Latino immigrants report low service utilization despite elevated rates of dysthymia and anxiety disorders. Correlation data indicate that elevated depression rates in older Latinos are associated with female sex, older age, low income, low social support, high stress, chronic financial strain, functional decline, and low acculturation.

**What new information does this article provide?**

Older Latinos with depression report higher levels of impairment and are more persistently ill than non-Hispanic white older adults, yet they have lower rates of guideline-concordant treatment. Cognitive and problem-solving psychosocial modalities are emerging as key treatment considerations for older Latinos.

**What are the implications for psychiatric practice?**

Personalized and culturally congruent psychosocial care should include assessment of cultural preferences for the following: (1) language of treatment encounters, (2) discussions regarding medication effects, (3) inclusion of family and social networks in treatment goals, (4) case management and brokering of community-based services, and (5) collaboration with primary care physicians regarding treatment for comorbid medical conditions.

Improving the quality and coordination of care for high-need, high-cost populations is a crucial component for addressing health care disparities among vulnerable populations. Health care reform efforts should address the needs of racial and ethnic minorities, who are disproportionately represented among economically disadvantaged populations. Latinos and African Americans are 6 times more likely than whites to be dually eligible for Medicaid and Medicare. Although health-related advancements have been made, especially in the area of life expectancy, health disparities among older Latinos persist. Compared with non-Hispanic whites, older Mexican Americans have a high incidence of diabetes and obesity in conjunction with low access to primary care, and they are more functionally impaired, have lower rates of physical activity, and report more disabilities.

**The call for personalized and culturally congruent psychosocial care**

Psychosocial interventions that address the clinical complexity and the interplay of depressive symptoms with long-term–care conditions are critical. With all of the advances in geriatric psychiatry, we find that fewer than 50% of older adults who are taking antidepressants achieve remission of late-life major depression. Nevertheless, studies have found that differences in remission rates were not clinically significant between older and younger (middle-aged) patients. Comorbidity can negatively influence the diagnosis of depression and initiation of treatment as well as treatment response. Unfortunately, undertreatment or nonadherence to treatment may be due to barriers to care. Personalizing the care of older patients with depression has emerged as a unifying concept in geriatric psychiatry. Predictors of response to depression treatment range from clinical to psychosocial factors. Because older Latinos have heightened exposure to predictors of poor outcomes, it is important to target predictors that are modifiable, such as self-care strategies and behaviors, problem-solving, and self-efficacy, with referrals to primary care for follow-up evaluations. Three specific issues emerge that influence personalized care: coping styles, the mind-body connection, and potential stereotypes. Avoidant coping styles are particularly noxious and directly related to increased levels of depression. It may be important to address patients' decisions “to avoid” taking another medication, or waiting until situations worsen before taking any action (an avoidant coping orientation).

Similarly, mental health disparities go hand in hand with medical disparities among older Latinos—the mind-body connection. For example, older Latinos receiving Medicare are one-third as likely as whites to undergo hip replacement surgery for severe osteoarthritis, which may reduce pain and improve physical function. And, because chronic pain is associated with increased depression symptoms in later life and increased risk of suicide, multiple disparities tend to be confounded in this older population, leading to a “double jeopardy,” situation.

Social networks and cultural values of older Latinos are often romanticized and the subject of much speculation and assumptions. This may lead to dashed hopes or misplaced expectations, and therefore depressive reactions. Personalized care in the proposed interventions would address
circumstances in which expectations about family support are re-framed or re-interpreted to avoid blame or distress.

As noted earlier, mental health disparities persist for older Latinos, particularly those who exhibit low-acculturation. Geriatric patients may fail to identify the need for care, lack knowledge of depression care services, avoid seeking care or remaining in care because of stigma, fear addiction to medications, or believe that symptoms of depression are part of the aging process or a natural consequence of failing health. Individual explanatory models of depression are likely to be influenced by the cultural background of the patient and his or her community and prior experience with illness and use of services.

Latinos are likely to explain depressive symptoms by the “wear and tear” hypothesis (chronic worry and suffering over life stressors, or sufrimiento) associated with loss of a significant other, medical problems, and personal attributes. Factors that also play a role in Latinos’ hesitancy to seek treatment may be interpersonal (feelings of rejection by loved ones), and spiritual (punishment or abandonment by God). Specific interventions should focus on sociocultural considerations to address symptom presentation, including preferred providers and patient-provider relationships. Latinos tend to somaticize psychological distress and rely on culture-bound assessments and cures for psychiatric illness that are rooted in a holistic view of wellness—the mind-body-spirit world. Moreover, older Latinos tend to prefer mental health treatment by their primary care physician than by a mental health specialist. This preference may not be different from what we find with non-Latino groups, but it may be accentuated in older Latinos, given the authority imbued onto the family physician, the stigma attached to seeking psychiatric care, and less availability of mental health care. Although medications are prescribed, these older patients frequently raise multiple concerns regarding taking too many medications or becoming “addicted” to pharmacological treatments.

Clinical Tips and Implications for Treating Depression in Older US Latinos

- Consider that older Latinos may have had no prior—or only episodic—experience with mental health care and, consequently, may not fully comprehend the role of psychiatry.
- Assess whether depressive symptoms are regarded by the older adult as an inevitable part of aging or poor health, chronic suffering, or other culturally bound attribution of symptoms.
- The tendency to over-somatize symptoms of depression may be accentuated in older Latinos because of low health literacy and holistic views of the mind-body-spirit connection.
- Fears of institutionalization, stigmatization, and discrimination to medications are salient concerns for older Latinos and thus need to be addressed to optimize treatment adherence.
- Language proficiency and preferences may differ with regard to face-to-face encounters, print and internet media, and contacts with family caregivers.
- Respect for authority and deference toward the physician (and other formal health-care professionals) play a role in clinical inquiry and decision-making; making a conscious effort to balance the power dynamics can improve communications and serve to strengthen the patient–physician relationship.
- Psychotherapies are emerging as important depression treatments for older Latinos; cognitive-behavioral therapy and problem-solving therapies as well as collaborative care show the most promise.
- Care management is generally key ancillary service for ongoing psychosocial, economic, and environmental stressors and strains that are typically heightened in this population.
- Inclusion of family members and significant others generally helps improve outcomes; involve the patient’s support system with his or her permission to achieve optimal care.

References:
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