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

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Learning Objective 1

Identify manifestations of depression in minorities
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
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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

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)

$p < .05$

Neurobiological Relevance of Ethnicity

Percentage of “long” 5HTTPR allele in different populations

- Japanese: 17%
- Sephardic: 52%
- Ashkenazi: 44%
- European-American: 60%
- African-American: 70%

Factors Related to Ethnicity May Influence Medication Response

Biological Factors:
- Genetics, Age, Gender, Disease

Cultural Factors:
- Attitudes, Beliefs, Family Influence

Environmental Factors:
- Climate, Parasites, Pollutants, Smoking, Alcohol, Drugs

Variability in:
- Drug Metabolism
- Drug Receptors
- Drug Response
- Disease Progression Proteins

Factors Related to Ethnicity May Influence Treatment Adherence

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
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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
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

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\(^3\)

Treatment Disparities

Treatment of 13,065 patients with depression were examined in a state Medicaid study covering years 1989-1994¹

- 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

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Access to Treatment

Non-Elderly, Uninsured by Race/Ethnicity, 2005

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Access to Treatment (%)</th>
</tr>
</thead>
</table>
| African-American, Non-Hispanic | 21%  
  | Uninsured | 28%  
  | Medicaid or Other Public | 3%  
  | Individual | 48%  
  | Employer | |  
| Caucasian, Non-Hispanic      | 13%  
  | Uninsured | 12%  
  | Medicaid or Other Public | 6%  
  | Individual | 69%  
  | Employer | |

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\(^2\)

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\(^2\)

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Efficacy/Tolerability and Patient Adherence Are Essential for Sustained Recovery

- Increased Severity
- Euthymia
- Symptoms
- Syndrome
- Treatment phases
- Acute (6 to 12 wk)
- Continuation (4 to 9 mo)
- Maintenance (≥ 1 yr)

- Time

- Minimum Amount of Recommended Treatment

- 50% stop medicine
- ≈70% of patients no longer on medication
- 50% stop medicine

- Response
- Remission
- Relapse
- Recurrence

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.
4. Reesal RT, Lam RW. *Can J Psychiatry* 2001;46(suppl 1):21S-28S.
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

Remission Lowers Risk of Relapse/Recurrence

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

* 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

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

STAR*D Clinical Study Results

Remission Rates

Level 1 (1 Failure) 11.9 weeks
Level 2 (2 Failures) 8-10 weeks ≤ 14 weeks
Level 3 (3 Failures) ≤ 14 weeks

Monotherapy
Combination treatment

% Remission

Low Treatment Resistance High

10 20 30 40

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?
