

Listening to the Voices of Older African Americans:

New Directions in Supporting Mental Health

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Objectives

- The Mental Health Disparities Maze
- A different lens for understanding and addressing disparities
- Strategies of Urban African Americans in coping with distress
- Implications for Health Disparities research

Mr. H

- 82 yrs old, single, urban dweller

- Lives with other renters

HEALTH PROFILE:

- 7 chronic conditions

- Self-rated health is poor

FUNCTIONAL PROFILE

- Ambulation difficulties

- ADL difficulties

- Bathroom/stairs inaccessible

- Meal prep, shopping, and travel difficulties

ADAPTIVE PROFILE

- Use of adaptive equipment

- Strong social network

- Very active



Why Focus on Urban African American Elders?

- Understand the specific experiences and adaptive mechanisms of this particular cohort who are embedded in a unique historical, socio-political-economic-cultural context
- A model for understanding human adaptation in general
- A model for addressing health disparities

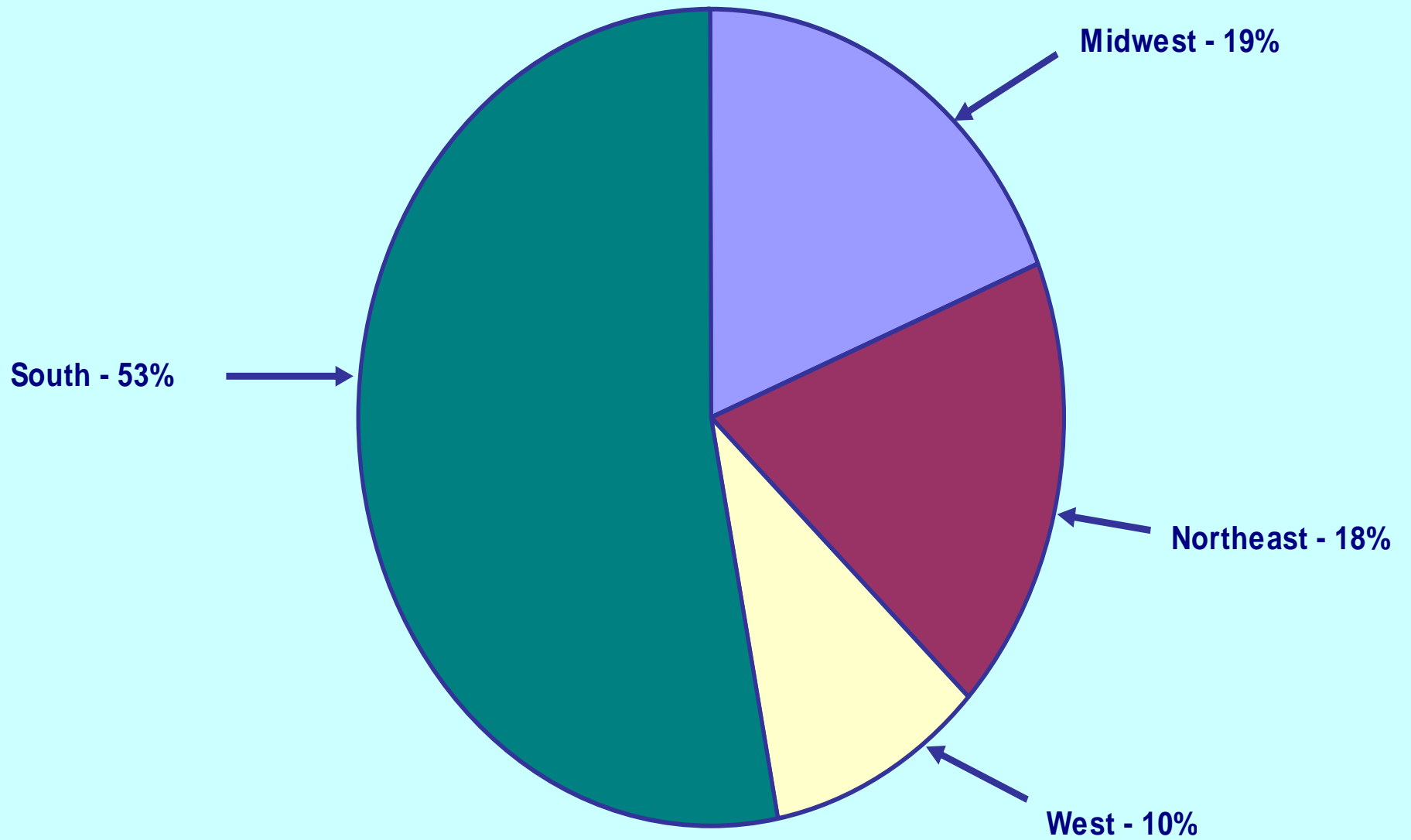
The Demographics



Black/African American Elders

- Ethnic minority elders projected to be 40% of older US population by 2040
- By 2050, African Americans will represent 12% of older adult population
- Increasing heterogeneity
 - Caribbean, African, Migratory patterns (South to North)

African American Population by Region



Source: U.S. Census Bureau, Census 2000

Regional Demographics

- In Philadelphia, African Americans represent the largest racial/ethnic minority group (35%) of the older adult population.*
- By 2015, the largest proportion of the elderly in Philadelphia will be African American, followed by Hispanics & Asian groups.*
 - The minority will become the majority

*Glicksman, & Norstrand, 2004

Cohort Experiences of Older African Americans

Adapted from Stanford University
Ethnogeriatric Curriculum



1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
<p>Urban migration</p> <p>NAACP formed</p>	<p>Harlem Renaissance</p>	<p>WW II: segregated troops; factory work in North & West</p>	<p>Civil Rights Movement & Law</p>	<p>Declining Affirmative Action</p>
<p>Ku Klux Klan active</p>	<p>Klan marched on Washington</p>	<p>Desegregation in plants, schools, and military</p>	<p>Dr. Martin L. King, Jr. led non violence then killed</p>	<p>Black Muslim movement</p>
<p>WWI and the "Red Summer"</p>	<p>Depression</p>	<p>Montgomery Bus Boycott ; Jackie Robinson</p>	<p>Affirmative Action</p>	<p>Rodney King trial</p>

Significance

- Highest users of health services and long-term care
- Multiple social structural jeopardies:
 - low income, low home ownership, high unmet housing needs, greater exposure to risk factors for mental illness (violent crimes, homelessness, incarceration)
- High rates of disability and health problems that are disabling

The Mental Health Paradox



Risk for Depression

- African American elders have higher prevalence than Whites of chronic conditions that are risk factors for distress/depression
 - Stroke, Diabetes, Heart disease, Cancer
- African Americans have greater functional disability, also a risk factor for depression
- Yet, African Americans have lower rates of depressive symptoms than Whites even when compared to other groups with the same level or even greater impairment

Rates of Distress/Depression

- Subsyndromal forms of depressive illness more common than major depression
 - Prevalence rates from 15% to 17% (Blazer, 2002; Beekman, et al., 1995).
- Rates higher among older adults with physical health problems and functional disabilities or who receive home care
 - Prevalence rates from 25% to 33% plus (Bruce et al., 2002)

Rates of Distress/Depression

- Early studies show rates for African American elders from 7% (Eaton & Kessler, 1981) to 18.3% (Stallones et al., 1990)
- Recent research - rates vary across settings
 - Primary care 17%
 - Home care 30%
 - Community 21%
 - Rehabilitation 30%

(Bruce, et al., 2002; Miller, et al., 2004; Skarupski et al., 2005; Kurlowicz et al., 2005)

Rates of Distress/Depression

- Philadelphia survey of African American (N = 98,870) and White (N = 156,935) elders 60 years of age or older found:
 - 48% of African Americans versus 33% Whites reported fair to poor health
 - 34% of older African Americans reported no depressive symptoms (Geriatric Depression Scale) compared to 43% of Whites;
 - 50% of older African Americans reported 1-3 depressive symptoms compared to 42% Whites,
 - 17% African Americans reported 4+ symptoms compared to 15% Whites ($p = .017$;

Pennsylvania Health Management Corporation, 2004

Mental Health Paradox Continues

- Black patients more likely than white patients obtain mental health care from primary care provider
 - Less likely to be diagnosed
 - Less likely to be given anti-depressant medications
 - African Americans derive same benefits as Whites from depression treatment
 - Preference for “talk” versus pharma therapies
- Use of anti-depressant use increased among White but not Black patients

(Gallo et al., 2005; 1998)

The Picture is Confusing

- African Americans (particularly elders with impairment, chronic health conditions) have lower rates of depressive symptoms yet a significant number are distressed
- Wide variation in prevalence rates based on region, neighborhood, gender, urban-rural, setting (e.g, primary care, home care, community)
- Unclear if differential rates due to differential symptom presentation (somatic versus dysphoric mood), differential and/or missed diagnoses, view of reporting as complaining
- African Americans who are depressed/distressed are under treated
- Unclear as to preferred coping strategies, preferred treatment approaches, definition of depression, factors contributing to depression

Persistent STICKING POINTS

- Continued comparison with Whites:
 - Unable to explain differences
 - Comparisons based on domains derived from and relevant to dominant group
 - Ignores extreme heterogeneity within cultural groups, vast regional differences
 - Differences reflect measured and unmeasured differences and processes not yet well understood
- Lack of understanding of historically and culturally grounded practices that inform self-care/health practices

Persistent STICKING POINTS

- Historical (and current) unethical research as collective cultural framework of older African Americans
 - Mistrust of pharmacological and preference for “talk” research
 - Use of mental health statistics as a tool to promote segregation and racism
 - Tuskegee, Holmes Prison experiments
 - Historical mistreatment of African Americans in medical texts
- Under recruitment of African American elders, particularly men

Looking Through a Different Lens

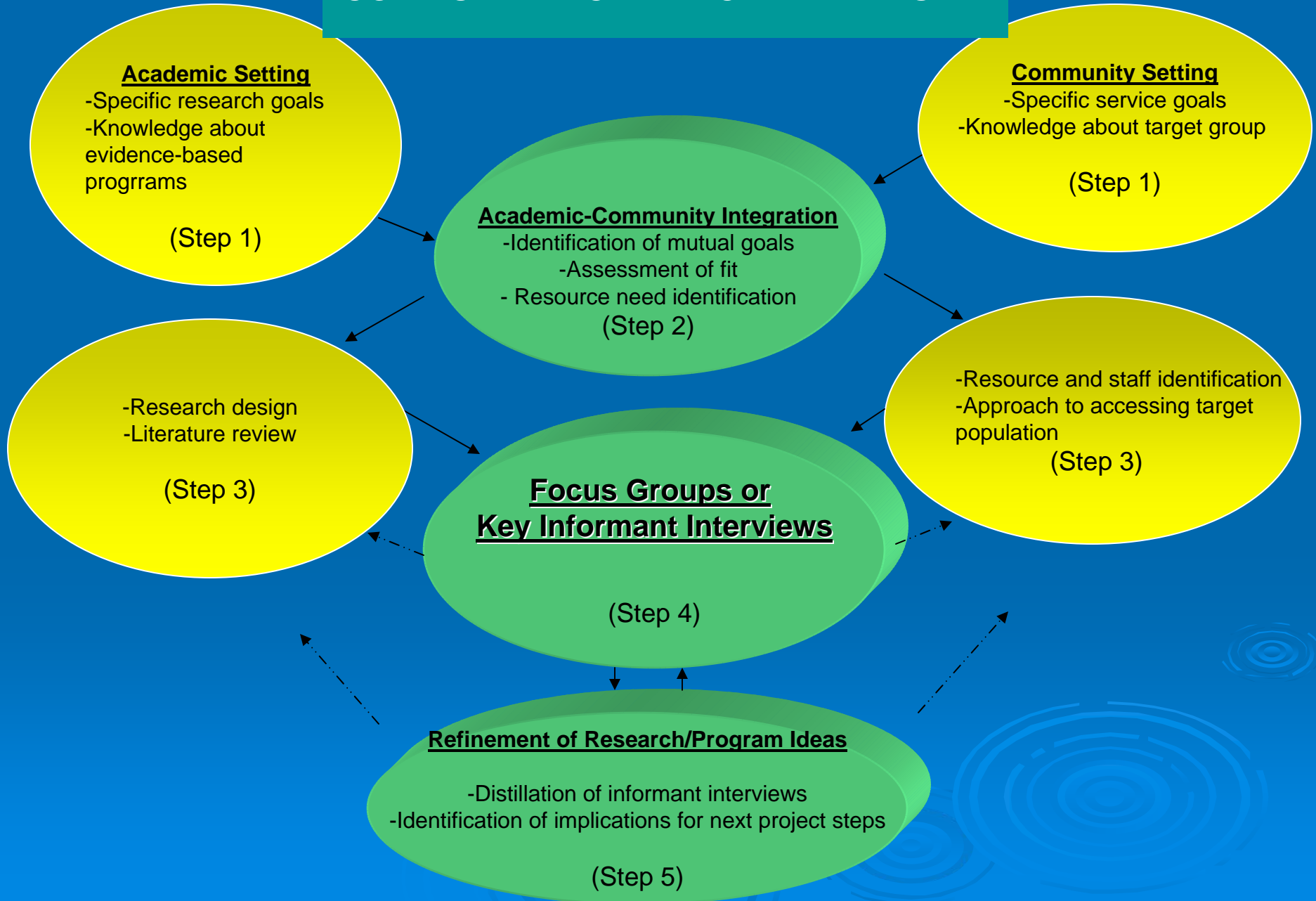


Community-based Participatory Research

“A collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change...”

From Community Health Scholars Program, funded by WK Kellogg Foundation found in
The Examining Community-Institutional Partnerships for Prevention Research Group:
Developing and Sustaining Community-based Participatory Research Partnerships:
A Skill-Building Curriculum, 2006. www.cbprcurriculum.info

COMMUNITY-ACADEMIC PARTNERSHIP



Men's Focus Group Led by Dr. John Groce

Why participate in research?



Lessons Learned

- Culture of mainstream mental health research misses the inside perspective
 - Involvement of “insiders”
 - What questions should we ask and how
 - What is the give back
 - Starting an open, honest dialogue
 - Full personal disclosure
 - Who am I
 - Why am I conducting this research
 - What will I do with the information you give me

Men's Focus Group Led by Dr. John Groce

What do you think about when you hear the
word “research”



Why Participate in Research? Emerging Topics

➤ Generativity

- Leaving behind lessons learned
- Desire for voices to be heard, have a meaning, make a difference
- Chasm between young and old and responsibility of elder


➤ Get it straight:

- Aging plus gender plus misunderstanding/lack of knowledge of African American experience

➤ Tension of Mistrust but Understanding Importance:

- Distrust of medicine/pills, experimentation as solution
- Historical events and experiences profoundly influence continued mistrust.

Implications for Mental Health and Health Disparities Research

- Confidentiality – what happens if I tell you my story; who hears my story and what is done with it
 - Desire for full disclosure – straight talk
 - What and why
 - How will I learn of results
 - How will study help my community
- 

Identifying and
Understanding Adaptive
Strategies, Relationship to
Depressive Symptoms, and
Health Disparities



Emerging Evidence from Comparative Quantitative Study

Gitlin et al., in press, Journal of the American Geriatrics
Society



Study Aims

- Identify whether predictors of depressive symptoms differ for African American and White older adults with functional difficulties
- Evaluate whether control-oriented strategies moderate effect of functional difficulties on depressed mood over time

Inclusion Criteria

- Ambulatory community-living adults
- 70 years of age or older
- Do not receive OT/PT/Home modification services
- Functionally vulnerable:
 - Difficulty performing ≥ 2 IADLs
 - Difficulty with 1+ ADL tasks
 - Use of mobility device
 - Pain
 - Difficulty with bathing, transferring
 - 1+ falls

Morris et al, *TG*, Functional Vulnerability Index, Hebrew Home for the Aged

Sample Characteristics by Race (N = 313).

Characteristic	AA (n= 145)	White (n = 168)	χ^2	Z	p value
Age (Mean, SD)	77.60 (5.06)	80.31 (6.34)		-3.87	.001
Gender (%)			4.73		.030
Male	13.1	22.6			
Female	86.9	77.4			
Marital Status (% married)	13.1	22.6	6.31		.177
Living arrangement (% alone)	59.3	64.9	1.03		.311
Education (%)			10.60		.005
< HS	29.7	41.1			
HS	40.6	23.8			
> HS	29.7	35.1			

Characteristic	AA N=145)	White (n = 168)	χ^2	Z	p value
Difficulty paying for basics	2.72 (1.00)	2.3 (1.06)		-3.46	.001
# of Health Conditions (M, SD)	6.93 (2.65)	6.97 (2.81)		-.29	.772
Diabetes (%)	31.9	16.1	10.9		.001
Heart Disease (%)	42.1	35.9	1.23		.267
Stroke (%)	11.8	8.4	1.01		.315
Cancer (%)	2.8	14.3	12.7		.001
Anti-depression medications (%)	8.3	19	7.48		.006
Functional difficulty (M, SD)	2.26 (.55)	2.10 (.54)		-2.60	.009
Social support (Mean, SD)	21.91 (4.86)	19.17 (5.99)		-4.23	.001

Characteristic	AA (n= 145)	White (n = 168)	χ^2	Z	p value
Spiritual self-efficacy (M, SD)	4.28 (.56)	3.81 (.72)		-6.30	.001
Personal Agency (M, SD)	19.36 (3.39)	17.71 (3.59)		-4.03	.001
Control strategy use (M, SD)	3.4 (.45)	3.17 (.54)		-.42	.001
Baseline CES-D (M, SD)	12.35 (9.64)	16.36 (11.38)		-3.10	.002
% <u>≥</u> 16	31%	49%			
12 Month CES-D (M, SD)	11.39 (9.40)	15.81 (11.20)		-3.52	.001
% <u>≥</u> 16	27%	44%			

Control Strategy Use by Race (N = 313)

<u>Control Strategies</u>	Mean (<i>SD</i>)		χ^2	<i>p</i>
	AA (<i>n</i> = 145)	Whites (<i>n</i> = 168)		
I try to learn as much as possible about ways of handling my physical health problems.	3.71 (.60)	3.42 (.84)	12.0	.002
I try to make changes to my home to help me stay independent.	3.00 (1.12)	2.66 (1.19) ^a	7.87	.020
I try to do things to make myself feel safe in my daily activities at home.	3.39 (.90)	3.10 (1.04) ^a	8.28	.016
I pace myself so I do not get too tired.	3.29 (.96)	2.95 (1.07)	10.17	.006
I am willing to use special equipment such as grab bars or utility aids to help me stay independent.	3.71 (.60)	3.49 (.76) ^a	8.03	.018
I am willing to ask others for help if I need it.	3.19 (1.01)	2.96 (1.04)	8.43	.015
When I decide to do something about a health or physical problem, I'm confident I'll succeed.	3.20 (.93)	2.99 (.96) ^b	4.54	.103
I think about how important it is to stay healthy.	3.83 (.49)	3.76 (.64)	.59	.746

^a N = 167 ^b N = 165

Cross-sectional Regression Analyses

- Functional difficulty associated with depressive symptoms in both African American ($B=5.3$, $p < .001$) and White ($B=3.7$, $p < .05$)
- Lower spirituality associated with depressive symptoms for both African American ($B=-5.0$, $p < .01$) and White ($B=-5.6$, $p < .001$).
- Living alone associated with depressive symptoms in Whites only ($B=-4.6$, $p < .01$).

Test for Moderation

Dependent Variable = 12-month CES-D Score

Block 1 = Treatment assignment; demographics, anti-depression meds

Block 2 = Baseline CES-D

Block 3 = Baseline Functional difficulty

Block 4 = Baseline Social support; spirituality; personal agency, control strategy use

Block 5 = Baseline Function X Control Strategy use

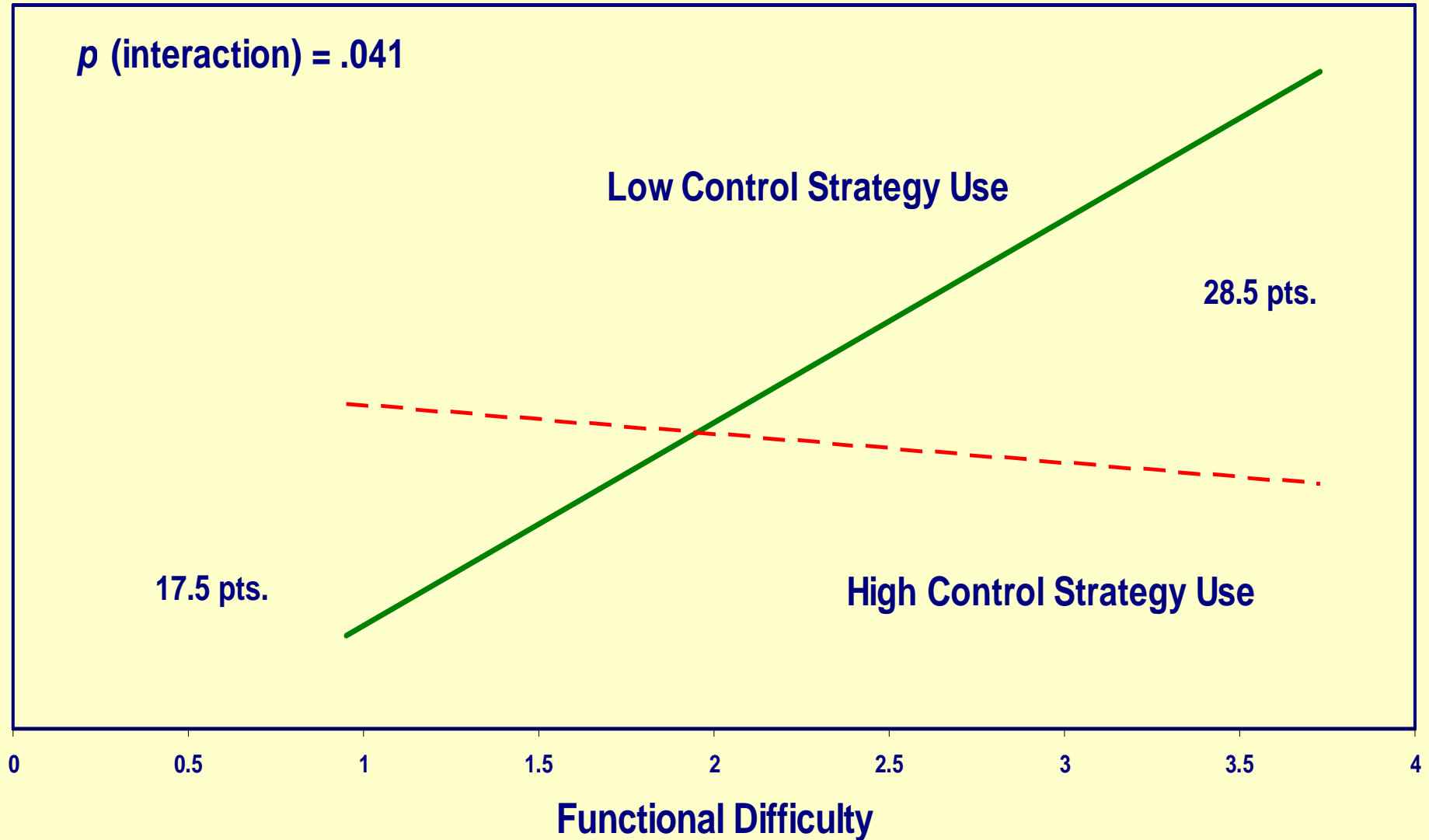
Baron and Kenny, 1986; Kraemer et al., (2002). Mediators and moderators of treatment effects in randomized clinical trials. *Archives of General Psychiatry*, 59, 877-883.

Moderation Effect of Control Strategies by Race at 12-Months CES-D Scores (N = 274).

Predictors	African Americans (n = 128)			Whites (n = 146)		
	B	CI		B	CI	
		Lower	Upper		Lower	Upper
Living arrangement	.69	-2.27	3.64	-4.48**	-7.60	-1.36
Baseline CES-D	.39***	.22	.57	.64***	.48	.80
Spiritual self-efficacy beliefs	-4.81**	-8.13	-1.49	-.66	-3.35	2.03
Functional difficulty by control strategy	-6.39*	-12.50	-.27	2.60	-2.08	7.28
	R² = .40			R² = .58		

* p < .05 ** p < .01 *** p < .001

Moderation Effect of Control Strategies for African American Older Adults



Critical Findings

- Health disparities
- Functional limitations associated with depressive symptoms for both African American and White elders but different predictors
- Depressive symptoms untreated among African American and White elders with functional difficulties
- African American elders use wider range of adaptive strategies than Whites
 - Social support
 - Spirituality
 - Control-oriented strategies

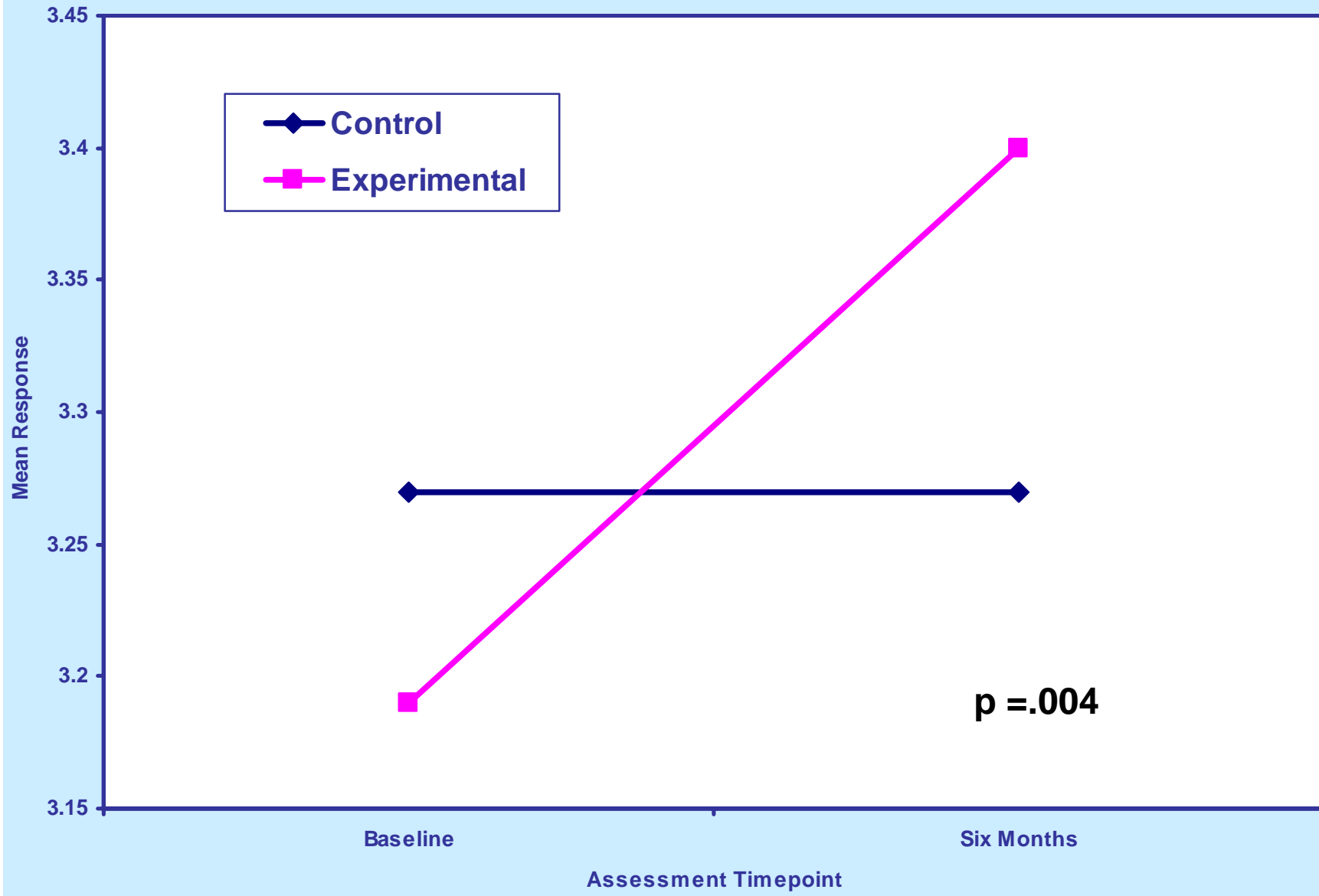
How do Control Strategies Buffer Depressive Symptoms?

- Maintain participation in meaningful activities
- Behavioral activation – active/effective ingredient in CBT
- Activity engagement may maintain reserve capacity to overcome health set backs

Why Do African Americans Use Control-oriented Strategies More than Whites?

- Control strategy use may be grounded in an historically-based cultural tradition of resiliency and pushing through adversity
 - Why do some African Americans not use these strategies?

Control-oriented Strategy Use



Evidence from Qualitative Research

-Semi-structured Interviews with 60 African Americans
Stratified by gender and level of functional difficulty:

Topics:

- Meaning of depression
- Relationship of neighborhood and depression
- Appraisals of well-being

In process

Mental Flexibility; Planning for the Future; Willingness to Use Devices

- Do you ever think about moving?
- “Not right now but I know eventually I probably will...because I’m getting older and like I said it’s a two-story..and steps.. Which some of the neighbors put in stair-glides...I don’t have that..so..I would like to stay there as long as I can. I’m using a cane right now and I’m able to get up and down.. I’m 60, I don’t know what’s going to happen if I live to be 80 or if I’ll be able to stay...I’d want a stair glide....”

Problem Solving, Adaptability to Harsh Situations

- Can you tell me why you stated that you are strongly attached to your neighborhood?

“One thing I think is the safety feature, you lock your doors now...if you see someone coming through, going to each door... you call up the other neighbors. I wouldn't open the door for everybody and sometimes you don't open the door. You know there's a lot of scamming, especially for older people...well we have a ramp because my husband is a double amputee, so they know there's older people. We have a dog too.”

➤ “...so I keep my doors locked especially when I’m inside I make sure both doors are locked and if people come to see me after 6:00 and its dark, before I open the door I put on the porch light first, see because I want to know who’s standing out there and it’s not because I’m afraid of people but by me being by myself.. Maybe I just like to be careful.”

Miniaturization of Life Space

- I guess strongly attached...I know this is going to sound silly to you but the walls are very thin and they smoke pot and I can smell it and if anybody was to come in my house while they're smoking pot...by the walls being so thin, they would think its me smoking it. And I haven't said anything about it for the simple fact that she has twin sons and her sons are about 6'5 and 300 pounds a piece so therefore I said to myself well as long as they don't bother me, I will not bother them so I have not said anything about it.. You know.. And really haven't bothered me but it annoys me, that smell annoys me.”

Do you ever get depressed? What would you say to a friend who was depressed?

- I keep going, and what have you. And I guess I don't allow myself time to you know, to be bothered by a whole lot of stuff.
- "I'll say get among people, and do and find something to do."
- "You have to talk to someone who is in your groove."

Emerging Adaptive Mechanisms

COGNITIVE:

- Self-talk (e.g., saying to self “snap out of it,” or “got to move on”)
- Cognitive reframing (e.g., could be worse; I’m still living; they didn’t kill me yet)
- Holding on to religious beliefs
- Cognitive comparisons (e.g., not as bad as it could be; not as bad as it was for parents)
- Minimization of problems
- Readjustment of expectations
- Don’t “claim” it as a problem

Emerging Adaptive Mechanisms

BEHAVIORAL:

- Prayer
- Purposeful business (keep on keeping on)
- “..Talk to someone in your groove”
- Purposeful involvement with friends, activities
- Do versus “complain”
 - “This is how it is but I’m not complaining.”

An Emerging Dynamic

- Sources of strength and modes of coping in response to and reinforced by historical, health, societal and community forces
- Modes of coping are immediately adaptive but do they contribute to minimization of symptoms and misdiagnoses?

Implications For Depression Treatment from Emic and Quantitative Perspectives

- Predictors of depression and adaptive mechanisms may be race/culture specific
- Depression prevention interventions may need to be tailored to address risk factors unique to different race/ethnic groups
- Develop/test programs that support culturally-appropriate forms of adaptation
 - Behavioral activation therapy
 - Skill-building in task simplification
 - Interventions that address Mind-body-spirit

THREE IMPLICATIONS
FOR UNDERSTANDING
AND ADDRESSING
MENTAL HEALTH AND
HEALTH DISPARITIES



LOOKING BACK TO MOVE FORWARD

- Health disparities are complex reflecting deeply rooted historical, socio-political and economic forces that play out in specific behavioral choices and preferred coping responses of individuals
- Race and ethnic origins are broad indicators of complex social and behavioral patterns that have historical basis
- Must understand the historical and current context of peoples lives and embrace the complexity

THE IN-SIDE PERSPECTIVE

- Academic-community partnerships a must
- In-depth/in-side knowledge of target community:
 - Preferred modes of coping/treatments
 - Specific concerns impacting mental health and health
 - Crime, drugs, neighborhood deterioration, HIV/AIDS
- Involvement of community leaders and members of targeted group
- Naming and framing of study/program to resonate with cultural perspective of target group

NEW CULTURE OF RESEARCH

- Understanding stance of targeted group
- Establishing trust
 - Bridge cultural divides between clinic and community; between researchers and target community
- Mixed methodologies – emic perspective and comparative large scale studies
- Different ways of involving target group
 - Identifying/refining the questions we should be asking
 - Member checks – did we get it right?
 - Naming and framing programs/approaches
- Give back
 - Overcoming the research time line
 - Closing the gap
 - Sharing what we learn through the preferred ways of the target group

"The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death."

~ Guiding Principle for Improving Minority Health, CDC

Key Collaborators

- Lynn Harris, Executive Director, Center in the Park Senior Center
- Janice Burke, Ph.D., OTR/L, Co-investigator, NIMH In Touch qualitative study
- Nancy Chernett, MPH, Project manager for the NIMH In Touch qualitative Study
- Tracela White, Ph.D., Coder for In Touch qualitative study
- Marie Dennis, Ph.D., research analyst for quantitative study
- Walter Hauck, Ph.D., statistician