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Abstract

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Keywords

depression, psychotherapy, medication, pharmacology, African American adults, African American older adults

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Introduction

The marginalized populations in the United States continue to have poor access to mental health. Much research has shown that the African American population is one of the marginalized populations in the nation that are severely impacted by poor mental health and lack of adequate treatment. Numerous factors are linked to their poor attitudes toward mental health and treatment outcomes in this community; stigma based on cultural background contributes to their poor mental health condition. African American culture perceives depression as a stigma and a sign of weakness, believing it is necessary to 'uphold the image' of strength or resilience while invalidating one's psychological or emotional health [1]. Furthermore, it has been noted that stigma around mental illness has been identified as a barrier to engagement in mental health services. It is pointed out that those who identify as African Americans might manifest stigmatizing behavior in the future. In addition, it has been proven that the perception of African Americans about mental illness and the stigma related to mental illness may be a significant factor that impacts their utilization of mental health services [2,3,4].

African Americans continue to demonstrate distrust and mistrust in governance. Oppression and discrimination against African Americans for centuries was pronounced mostly during the slave trade era, adversely affecting how this population perceives mental illness, diagnosis, and treatment. Also, cultural differences significantly affect how this population seeks mental health support [5]. Cultural biases result from the limited number of African American mental health professionals, which limits accessibility to culturally competent mental health

services for this population: only 2% of psychiatrists, 2% of psychologists, and 4% of social workers in the United States are African American [6,7]. Due to the smaller number (about 2 percent) of American Psychologist Association members that are African American, some African American individuals may have concerns that other mental health practitioners may lack the cultural competence to provide therapy [8]. While working with this population, counselors must examine the fundamental historical, social, and cultural variables forming a client's beliefs concerning illness etiology, diagnosis, and intervention [9].

Many other factors related to systemic racism further exacerbated this population's accessibility to adequate mental health resources. Systemic variables such as the absence of quality access to health care, racism, and the environment in which individual lives affect this population's access to effective mental health services. It is well known that systemic oppression and racism lead to social inequities, poverty, and illiteracy among African Americans [7]. Studies have shown that African American older adults experience more psychological distress than their white counterparts because of lifelong exposure to and experience with racism, discrimination, prejudice, poverty, and violence [4,10]. Another factor that has contributed to triggering depression among African Americans is classism; a research study stated, "we found that classism appeared to be the most consistent predictor of mental health symptoms (i.e stress, well-being, depression) and that interaction of classism and racism was significantly associated with stress and well-being" [11].

African American older adults are 20 percent more likely to report severe mental distress than adult Whites. African American older adults living in poverty are two to three times more likely to report severe mental and emotional pain than those not living in poverty [12]. This

population is most likely to receive improper diagnosis and treatment, more likely to have depression for extended periods, and more likely to suffer enormous disability from depression.

Depression is a chronic mental illness; if left untreated, it can lead to other serious complications. “Depression (also known as major depression, major depressive disorder, or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working” [13]. In addition, it has been noted that depression can significantly impair a person’s ability to function; when this occurs, it is known as major depressive disorder (MDD) [7]. It is noted that depression among older African Americans is widespread and often undiagnosed and untreated [4]. Depression is a noteworthy issue among adults and older adults. The weight of depression is more pronounced among African American elderly, and it has been a significant public health concern, resulting in increased disability and morbidity. The effect of depression is not limited to mental and physical health, but also to an increased risk of cardiovascular disease [14]. In addition, the African American population does not have access to standard mental health services, resulting in inferior quality of mental health treatment [15].

Furthermore, a study was conducted to determine church-going African American adults’ attitudes and expectations about receiving formal depression care. The participants spoke about their concerns: stigma, trust, respect for autonomy, privacy, and confidentiality while receiving mental health services. The focus group spoke repeatedly about the critical role of spiritual leaders – pastors and other supportive individuals in the faith communities that they trust and could help encourage them to seek mental health services. The researchers emphasized that it is essential to note that much older African Americans prefer to use “talk therapy as the first line of intervention” [16]. The purpose of this systematic literature review is to answer the following

research question: In African American adults and older adults with major depressive disorder, do modified psychotherapy and faith-based resources, compared to medication management, improve stability over eight months?

Keywords For the PICOT Mnemonic

African American, adults, older adults, depression, psychotherapy, pharmacology, intervention, medication. Table 1 below summarizes the eligibility criteria for the study in line with PICOT.

Population – African American adults and older adults with MDD

Intervention – Modified psychotherapy

Comparison – Medication or Pharmacology intervention

Outcome – Improve stability

Time/Type – Time: 8 months. Types of studies: Systematic Review

Table 1. Inclusion and exclusion criteria for participants

Inclusion Criteria	**Exclusion Criteria**
Participants must be: • African Americans • Adults over 18 years old • Diagnosed with mild to severe depression.	Participants cannot be: • Other races • Less than 18 years old • Using pharmacology intervention • Has other mental health diagnoses

Methods

This study was approved by the University of the Pacific Institutional Research Board (IRB protocol number IRB2023-85). This systematic literature review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [17]. The search strategy includes utilizing the following electronic databases: MEDLINE, (PubMed), Cochrane, and relevant gray literature (government reports), and other related articles. To obtain

the maximum potential of the search engine for this project title, this study utilized a Boolean Search process that contains some combinations of different elements of probability conjunctions and phrases to limit, broaden, and define the search result to the highest possible specificity to the project title (African American AND Blacks) AND (Adult NOT Men NOT Women) (Psychotherapy OR Therapy OR Intervention) AND (Depression OR depressive disorder OR mental illness). See Table 1 for more details on inclusion and exclusion criteria. The PubMed search engine produced 1,935 results (articles). The results were further filtered with AND / OR to obtain more specific relevant results thereby eliminating irrelevant articles. Cochrane was also used for this search. The search produced 116 results; it was discovered that 98 of the articles obtained were already in PubMed, thereby eliminating duplicates. The number of articles obtained was later reduced to the most relevant articles to form the basis for the systematic review of this study, see Fig. 1.

Several articles were reviewed for this study, but only five contain sampling data about mitigating symptoms of depression among African American adults and older adults. All the information gathered by various authors and researchers corroborates one another. All five studies had intervention groups while four used control sampling and only one used an active control group. The participants were screened for depression, and they recorded a high success rate of intervention. In four of the five studies, all participants belonged to the African American racial group. In the fifth study, participants had diverse racial and ethnic backgrounds (48% African American, 27% non-U.S.- born Hispanic, 15 % U.S.-born Hispanic, and 10% non-Hispanic white). Furthermore, of the five sources utilized, three had American older adults ages 55 and over; the fourth source had an age range from 30-65, while the fifth source had ages 18 and over. All research studies were published in different years: one in 2013, two in 2014, one in

2017, and the last one in 2021. Four of the sources used the Patient Health Questionnaire (PHQ - 9) assessment tool to measure depression for individuals diagnosed with mild to severe depression; only one source used the Center for Epidemiologic Studies Depression Scale (CES-D) and Quick Inventory of Depression Symptoms (QIDS).

Results

Using a PRISMA flowchart, Fig.1 below shows a clear and graphic representation of the process by which the articles reviewed for this research were selected.

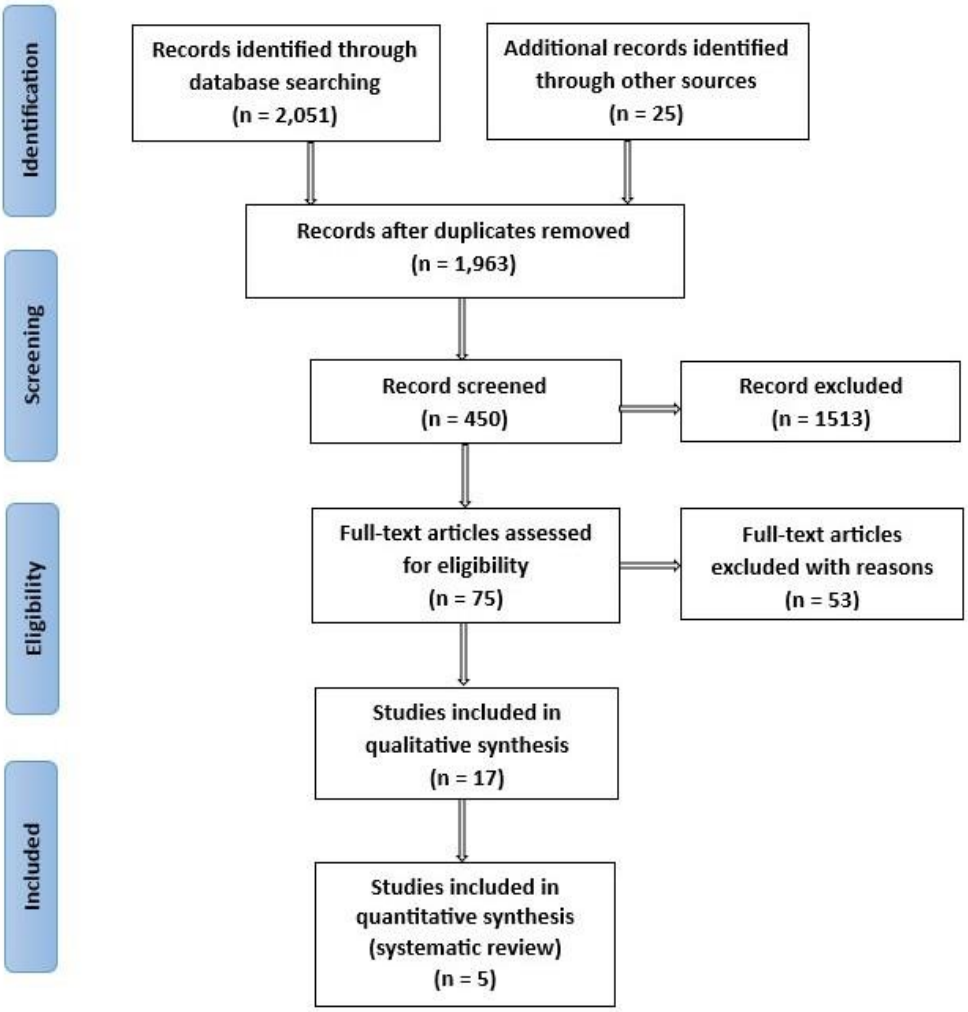

Figure 1. PRISMA flow diagram

Table 2 below summarizes and compares all five studies' methodology and statistical results. In looking at the statistical significance of each study in the table, we find the following:

Authors	Year	Modified Program	Age range	Assessment tool	Initial Participants	Final Participants	Intervention Duration	Facilitators	Success Rate	Statistical Method	*p* Value
Gitlin et al	2013	BTB	55 / +	PHQ -9 / CES-D	208	160	8 months	Social workers	Approx 70%	T-test	0.470
Szanton et al	2014	BTB	55 / +	PHQ 9	208	208	8 months	Social workers	88%	χ^2 / T-test	0.093
Pizzi et al	2014	BTB	55 / +	PHQ 9	703	129	8 months	Social workers	71.9%	T-test	0.310
Dalencour et al	2017	Faith-based	18 / +	PHQ -9	1,246	947 (48% AA)	8 months	Unknown	54 % (AA-FBO)	Wald-χ^2	0.051 (AA)
Ward et al	2021	OHDC / CWD	30-65	CES-D /QIDS	132	132	6 months	Unknown	Effective- OHDC	CI – 95%	N/A

Table 2. Methodologies of Five Articles with Statistical Analyses

The Gitlin et al. study evaluated a modified program, Beat the Blues (BTB), their null hypothesis was not rejected because the p-value, 0.470 being greater than 0.05 (statistically insignificant), meaning a home-based intervention alleviates depressive symptoms and improves the quality of life in older African American [18].

The Szanton et al. study reported a p-value of 0.093 - more significant than 0.05 - revealing that nonpharmacologic intervention can reduce depressive symptoms in both African Americans with and those without financial strain [19].

The Pizzi et al. study analysis revealed a p-value of 0.310. Thus, the null hypothesis is not rejected because the p-value is more significant than 0.05. In the study, based on cost-effectiveness, again BTB intervention proves to be an effective treatment for depression in older African American adults [20].

The Dalencour et al. study on faith-based intervention for African Americans had the 0.051 p-value: the null hypothesis was not rejected since it is more significant than 0.05 - the use of depression care provided by Faith-Based Organizations (FBO) in combination with the services provided by traditional health providers may reduce depression for African Americans [21].

Ward et al. in their clustered randomized controlled trial, allocated participants to intervention groups, employing either the Oh Happy Day Class (OHDC) or Coping with Depression (CWD). Both of these in-person intervention programs spanned a duration of twelve weeks. The subsequent post-intervention statistical analysis revealed that participants with the OHDC interventions demonstrated a more pronounced reduction in depression symptoms within the African American population, with a 95% confidence interval. Thus, the OHDC intervention was deemed more "efficacious" compared to the group utilizing CWD [15].

The major findings of each of the five studies are summarized in Table 3.

Authors / year	Major Findings of Each Study
Gitlin et al. (2013)	Home-based intervention alleviates depressive symptoms and improves the quality of life in older African Americans.
Szanton et al. (2014)	Nonpharmacologic intervention can reduce depressive symptoms in both African Americans with and those without financial strain.
Pizzi et al. (2014)	Based on cost-effectiveness, BTB intervention proves to be an effective treatment for depression in older African American adults.
Dalencour et al. (2017)	Faith-based organizations (FBO) in combination with the services provided by traditional health providers may reduce depression for African Americans.
Ward et al. (2021)	Oh Happy Day Class, a modified program showed a greater reduction in depression symptoms.

Table 3. Significant Findings in the Five Articles

Discussion

Depression is a severe mental illness that could lead to other mental conditions like anxiety and panic disorders. It has been established that African American adults and older adults in the United States respond poorly to pharmacologic intervention in treating depression due to numerous factors [15]. Many modified evidence-based practices have proven to be effective in providing intervention for the African American population, especially adults. This population of both adults and older adults prefer using psychotherapy over the standard pharmacology treatment for their depression [20, 22].

Gitlin et al. reported that home-based intervention could reduce depression among older

African Americans [18]. Their research was built on a previous trial of the BTB intervention. PHQ-9, a standard tool for screening depression, was used along with randomized trial sampling. The initial participants were 208 African American older adults aged fifty-five and over, and the final participants were 160 individuals, with 79 and 81 for the intervention and control groups, respectively. The two groups were assessed at two different durations: four and eight months. The researchers discovered that the treatment group felt better and had improved mood stability with a 70 percent success rate; the rest, 30 percent, would need booster sessions to get well. The intervention was effective, and improvement was observed in individuals, but the active components of the treatment needed to be clarified. Also, the intervention was conducted in just one senior center, with a small sample and few percentages of men, and there was a wide withdrawal gap between the treatment and control groups – participants dropped to 182, with 89 and 93 for treatment and control group respectively at four months.

Ward et al. in their 2021 study corroborated with Gitlin et al. about the efficacy of modified EBP on depression intervention for African American adults [15,18]. Researchers used randomized sampling. The sample size was 132 individuals diagnosed with depression – mild to moderate. The age range was 30-65, with three-quarters (74%) of the participants being women. The treatment groups were both OHDC and CWD. OHDC was initially designed for Whites but was modified to suit the cultural beliefs of the African American population. The CWD group attended 2-hour twelve sessions, while the OHDC group had 2.5-hour twelve sessions. The participants' mental and physical health status were examined for six and twelve weeks and three- and six-months post-intervention. Based on the results obtained, more sessions of OHDC and fewer sessions of CWD were shown to reduce symptoms of depression. Both interventions were effective; individuals reported a decline in depressive symptoms from mild to moderate symptoms. On the other hand, the sample was small, with many missing data; the research samples were also limited to one city.

Delancour et al. in their study reported that African Americans and Hispanics in Los Angeles could benefit from FBO [21]. The initial screening comprised 947 individuals aged eighteen and above; 48% of the initial population were African Americans, and 52 % were Latinos. It was surprising to the researchers to find that 54% of the people who benefited from FBO were African American. Furthermore, one-third of the individuals who were FBO beneficiaries also reported benefiting from traditional mental health services, a finding that was also reported by other researchers [16,18]. From the researchers' standpoint, FBO promotes traditional mental services and does not contradict mental health services; the healthcare providers and FBO would need to work hand in hand to provide mental health services to these populations to improve mental health services outcomes. However, the assessment was based on self-report, with the study done in just two communities in Los Angeles and involved only one type of FBO [21].

Szanton et al. reported on the efficacy of using BTB to provide intervention for older African American adults experiencing financial distress [19]. The research used a sample of 208 individuals aged fifty-five and over with depression with mild to severe symptoms. PHQ-9 was used as a screening tool. The treatment group had one hour per week – 10 sessions, substituted by biweekly sessions for four months. The study showed that therapeutic intervention could alleviate depression with /without financial distress. It is believed that the intervention did not have side effects like medication; also, what an individual learned could be applied after the intervention, with a high retention rate – of 88%, and the intervention was relevant to the older African American population. On the other hand, the research was limited to one geographical location, which may not represent the entire nation.

Pizzi et al. revealed that the BTB psychotherapy intervention could alleviate depression in older African Americans as compared to pharmacology intervention [20]. 129 African American older adults aged fifty-five and above were recruited for the trial – intervention and control groups. The study used a randomized sampling method with a PHQ-9 assessment tool. The participants were assessed at baseline at four months and eight months after program completion. The study revealed that the exorbitant price of providing pharmacology cost range from $20,500 -$76,500 (quality-adjusted life year [QALY]) in a year compared to $146 per month ($1,752 per annum) for the BTB program. BTB has proven dependable and cost-effective in managing depression in African American older adults compared to pharmacological intervention. Also, it is observed that services can be effectively delivered remotely or face-to-face with individuals. On the contrary, the sample size was small; also, the control group witnessed improved mood symptoms in quality-adjusted life, most likely because of their involvement in the trial since they were able to receive complete treatment after four months; therefore, the study may not reveal how economically / financially advantageous to use BTB versus pharmacology.

Study Limitations

Several limitations of our study must be acknowledged. First, we utilized only three search engines that were readily accessible: PubMed (MEDLINE- PubMed), Cochrane, and government reports. Studies reporting issues other than mental health issues in the adult and older adult African American population may have investigated depression or depressive disorders and thus were not part of our analysis. Additionally, our search may not have employed the most optimal keywords to generate an ideal sampling of papers. Our search included keywords “African American AND Blacks” AND “Adult NOT Men NOT Women”, “Psychotherapy OR Therapy OR Intervention” AND “Depression OR depressive disorder OR mental illness”. Furthermore, validated checklists were not used to assess study quality which

may result in selection bias.

Conclusion and Recommendation

The literature reviewed has contributed to various modified EBP psychotherapies that could be used to alleviate depression among African American older adults. The BTB program is a cognitive behavioral therapy initially designed for Whites but modified to meet the culture and beliefs of the African American population. The modified intervention has become widely accepted and used among African Americans experiencing mild to severe depression. A nonpharmacologic intervention approach can alleviate depressive symptoms among individuals with a financial burden [19]. The study referred to past studies arguing that heavy taxes for low socioeconomic status can hinder social support. Further research is needed to determine if knowledge of BTB could be used to mitigate the impact of stressors and improve depressive symptoms. Individuals who participated in the intervention did see improvements, but the main ingredients/elements of the treatment are uncertain. Further research is needed to understand the components and mechanisms of the intervention [18].

It has been shown that there was little available data on the degree to which the African American population depends on mental health services provided by FBO, the type of FBO intervention provided, and how this intervention is connected to the use of traditional mental health services [21]. On the other hand, a more recent study acknowledged that this is the first clinical trial of 'Oh Happy Day Class' (OHDC), and more research needs to be done to examine its comprehensive impact [15]. Another study had earlier stated that since the intervention lasts for eight months, it might not represent the actual result that compares the cost of BTB intervention versus pharmacological cost. Further research on the health utilities index (HUI-3) would be needed for more comprehensive information [20].

The result of all the studies about this population does not break down the different demographic profiles of African Americans since the culture varies from one African country to

another. Furthermore, each African country is made up of many cultures, and as such, treatment for individuals will vary based on individuals' cultural backgrounds. It is recommended that further study should include the African American population from ancestry nations to obtain a more reliable outcome that reflects the diversity among African Americans.

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