Examining differential treatment effects for depression in racial and ethnic minority women: a qualitative systematic review

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CRD summary
This review found that interventions that allow patient choice of medication and/or psychotherapy, combined with case management and community support, are associated with optimal clinical benefits for low-income minority women with depression. Treatment effectiveness varied across ethnic groups. Given the clinical variability of the studies and methodological limitations in the review process, the author's conclusions should be regarded as unreliable.

Authors' objectives
To compare the effectiveness of treatments for depression in women from racial and ethnic minority groups.

Searching
MEDLINE, PubMed, EMBASE, CINAHL, PsycINFO, Academic Search, Social Sciences Citation Index, the Cochrane CENTRAL Register, the Cochrane Depression, Anxiety and Neurosis Group's Controlled Trials Register and CRISP (to identify ongoing studies) were searched from 1970 to 2005; the search terms were provided. In addition, internet searches using Google Scholar were conducted. The reference lists of retrieved articles were also examined.

Study selection
Study designs of evaluations included in the review
Randomised controlled trials (RCTs), observational studies and case series were eligible for inclusion.

Specific interventions included in the review
Studies of antidepressants or psychotherapy were eligible for inclusion. Psychotherapy included cognitive-behavioural therapy (CBT), interpersonal therapy (IPT) and any type of psychotherapy adapted for minority populations, either in individual or group format, and with or without case management or a religious intervention. The interventions included antidepressants (paroxetine/bupropion, nortriptyline, or unspecified treatment combined with support for treatment adherence), psychotherapy (group and individual CBT alone or combined with case management, IPT, or behaviour therapy), multifaceted quality improvement or collaborative care interventions, and case management. The control interventions included usual care and referral for community mental health care.

Participants included in the review
Studies that included women from racial and ethnic minorities aged over 17 years and diagnosed with depression were eligible for inclusion. These were defined as women self-identifying as African American, Native American, Latina or Hispanic, or Asian American (including Pacific Islanders) diagnosed with depression by Diagnostic and Statistical Manual of Mental Disorders (DSM) III and IV criteria. Studies could either focus predominantly on this population, or provide separate analysis by race and ethnicity.

The review included studies of African Americans, Latinos and Asians, mostly aged over 40 years (range: 18 to 74). Most had low socioeconomic status. All of the studies also included whites and some included men.

Outcomes assessed in the review
The inclusion criteria were not specified in terms of outcomes. The review reported changes in the symptoms and rates of depression (measured by depression scales and psychiatric questionnaires), adherence to treatment, and differential responses to treatment between racial groups.

How were decisions on the relevance of primary studies made?
Two reviewers selected the studies for inclusion. The author did not state whether they made decisions independently, or how any disagreements were resolved.
Assessment of study quality
The author did not state that they assessed validity but quality-related items such as blinding and use of intention-to-treat analysis were reported in the tables.

Data extraction
The author did not state how the data were extracted for the review, or how many reviewers performed the data extraction.

Methods of synthesis
How were the studies combined?
The results of the individual studies were not synthesised: the findings from each included study were reported.

How were differences between studies investigated?
Differences between the studies were not formally investigated.

Results of the review
Nine studies (5,027 participants, approximately 1,023 women from racial and ethnic minorities) were included in the review. There were six RCTs, one retrospective observational study, one case series and one study in which the design was unclear.

Three of the studies had fewer than 30 participants, and drop-out rates were generally high (where reported).

CBT and behaviour therapy both reduced depression scores at 16 weeks among low-income Puerto Rican women. The behaviour therapy group maintained longer-term improvement (1 RCT, n=26).

Older minority patients randomised to a multifaceted collaborative care intervention (psycho-education, psychotherapy or medication, plus monitoring) had significantly lower depression severity and less health-related functional impairment over a 12-month follow-up than those receiving usual care (1 RCT, n=1,801).

Quality improvement interventions (patient choice of nurse-supervised medication or CBT plus a treatment manual) improved appropriate care and decreased the likelihood of self-reported depression in depressed minority groups (1 RCT, n=1,269).

Medication or CBT was more effective than mental health service referral in reducing the symptoms of depression in low-income and minority women (1 RCT, n=267).

Addition of case management to group CBT improved outcomes among Spanish-speaking patients, but the reverse was true among African American patients (1 RCT, n=134).

Both CBT and culturally-adapted CBT reduced depression scores among African American women, but only from severe to moderate intensity. The effect was greater in the culturally adapted CBT group (1 observational study, n=22).

Other data were reported in the publication.

Authors' conclusions
Optimal clinical benefits for low-income minority women with depression are associated with interventions that allow patient choice of medication and/or psychotherapy, combined with case management and community support. There appear to be differential responses to treatment across ethnic and racial groups.

CRD commentary
The author's objectives and inclusion criteria were wide and imprecise. A number of relevant sources were searched for eligible studies but no attempts were made to locate unpublished studies (other than ongoing studies), hence the review might be subject to publication bias. Since details of the review process were not reported, it is unclear whether methods were used to reduce the potential for reviewer bias and error at the study selection and data extraction stages. A formal quality assessment was not conducted, although the author referred to the Jadad criteria and reported some quality-related details in the tables. The overall validity of the included studies remains unclear. Most of the included studies failed to provide separate data on ethnic minority women and, therefore, appear unsuited to answer the clinical questions of the review. It was frequently unclear which findings were statistically significant and, where results were described as significant, no estimates of effect or p-values were reported. It was also unclear which comparisons were based on subgroup analysis and which on randomised comparisons. In addition, no attempts were made to synthesise findings across the studies. Given the clinical variability of the studies and the methodological limitations of the review process, the author's conclusions should be regarded as unreliable.

Implications of the review for practice and research

Practice: The author stated that collaborative care models for ethnic minority women with depression should include clinicians trained to provide culturally appropriate care, case management, education about depression and patient choice of treatment. Treatment options should include medication with nurse support for treatment adherence and both individual and group psychotherapy.

Research: The author stated that further research is needed. This should address: differential treatment effects in minority groups; strategies to increase treatment compliance; treatment strategies in low-income minority women; strategies to address medical, psychological and social issues simultaneously and the cost-effectiveness of such approaches; the prevalence of depression in middle-to-upper class minority female populations; whether DSM diagnoses are relevant in minority populations; and the use of multidisciplinary interventions involving primary care, specialist, traditional and religious practitioners.

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