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Implementing Group CBT for Depression Among Latinos in a Primary Care Clinic

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Depression in low-income Latino populations can be treated using group cognitive behavioral therapy (GCBT). However, effective delivery of GCBT for depression in primary care settings is often impeded by high dropout rates and poor homework adherence. In this study, we describe the structure, processes, and outcomes (including attendance, homework completion, and symptom measures) of GCBT for Spanish-speaking Latino patients with depression in an urban public sector primary care setting. For this study, 96 Latino patients in a primary care clinic participated in at least 1 session of GCBT. Although depressive symptoms among these patients, as measured by the PHQ-9, significantly decreased during treatment, attendance and homework completion were limited. Even with a strategy in place to allow patients to continue in treatment after missing several sessions, 23% of patients dropped out of therapy following their initial session, and approximately half of all patients completed less than 50% (or 8) therapy sessions. Homework was only completed 23% of the time it was checked. Greater session attendance prospectively predicted lower depressive symptoms over time. We discuss potential strategies to increase engagement, treatment effects, and symptom reduction for depression in primary care settings.

Even though depression continues to be a leading cause of disability for persons aged 1 to 44 (World Health Organization, 2008), it continues to be undertreated in racial-ethnic minority populations, including Latinos. Due to various factors including cost, lack of insurance, language barriers, and limited availability of culturally competent providers, Latinos are overall less likely to seek specialty mental health care than Whites (U.S. Department of Health and Human Services, 2001). Furthermore, Latinos are more likely to report mental health issues, such as depressive symptoms, to a primary care physician than to a mental health professional (U.S. Department of Health and Human Services, 2001). Unfortunately, primary care physicians are less likely to diagnose depression in Latinos (Borowsky et al., 2000), and when depression is identified and treated with evidence-based treatments, these treatments are often not delivered as tested in clinical trials (Shafran et al., 2009). Taken together, the primary care setting may be a critical link to identifying and addressing mental health problems and a way of ameliorating mental health disparities among Latinos.

Keywords: depression; CBT; Latinos; implementation; homework

Cognitive behavioral therapy (CBT) interventions for depression are generally efficacious but rarely available in low-income and public sector settings, and when they are, they are often not delivered as tested in clinical trials (Shafran et al., 2009). Our goal in this paper is to characterize the implementation of a group CBT intervention for depression among Spanish-speaking Latino patients treated in a public sector, safety-net primary care clinic. We describe the implementation of the intervention and report data on engagement and treatment outcomes. Our findings highlight potential methods of improving the delivery of CBT for Spanish-speaking Latino patients treated for depression in public sector primary care settings.

Implementation of CBT in Low-Income Settings

Randomized controlled trials (RCTs) have provided foundational information about the efficacy of CBT interventions in controlled lab or clinical settings (for an overview of psychosocial interventions for depression in primary care, see Linde et al., 2015; Westbrook & Kirk, 2005); however, the translation of evidence to practice has not always been clear. Comparisons of CBT outcomes in RCTs vs. naturalistic settings have been mixed, with some finding better outcomes in RCTs (Hans & Hiller, 2013; Kushner, Quilty, McBride, & Bagby, 2009; Westbrook & Kirk, 2005) and others finding no difference in outcomes (Merrill et al., 2003; Minami et al., 2008; Schindler, Hiller,

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& Witthöft, 2011). Of note, only one of these studies (Merrill, Tolbert, and Wade, 2003) reported sample ethnicity, and the values ranged from 89% to 92% Caucasian. In fact, real-world implementation of interventions for low-income minority populations has been shown to be very different from that of highly resourced interventions delivered in RCTs (Westen, Novotny, & Thompson-Brenner, 2004). For example, mental health interventions in clinical trials tend to have more fidelity checks and increased efforts to retain patients in treatment (Miranda, Chung, et al., 2003). Implementation rates of CBT tend to be highest in academic medical centers, where much of the research on CBT has taken place (McAlpine, Schroder, Pankratz, & Maurer, 2004). Patients in real-world, public sector settings are likely to differ in severity and/or comorbidity from research participants, as they have not been subject to the same types and levels of inclusion criteria as those within RCTs. In particular, the logistics and specifics of implementation in primary care settings serving low-income Latinos remains less understood (Organista, Muñoz, & Gonzalez, 1994).

CBT With Latinos

Latinos are the fastest-growing ethnic group in the U.S. and are disproportionately of low-income backgrounds (Steppler & Brown, 2016). Psychosocial interventions such as CBT for depression have been shown to be effective for Latinos (Miranda, Azocar, et al., 2003; Miranda, Chung, et al., 2003). There are a variety of models and interventions for addressing depression in primary care, and group cognitive behavioral therapy (GCBT) is one approach that can help reach larger numbers of patients with fewer provider resources. GCBT is a good fit for Latino patients served in public sector settings because it is easily standardized and, in a group format, can be administered to large numbers of patients, using less time and fewer resources than other treatment therapies (Oei & Dingle, 2008), while offering support from other group members throughout the course of treatment (Balabanovic, Ayers, & Hunter, 2012). In primary care settings, CBT can be especially advantageous for Latino patients because they tend to prefer psychotherapy to psychopharmacology (Dwight-Johnson, Lagomasino, Aisenberg, & Hay, 2004).

Barriers to Engagement

Although effective, because of barriers at both the system and patient levels, GCBT may not always be utilized. At the system level, GCBT is often not available in primary care settings—or when it is, it is not often available in non-English languages or tailored to the appropriate educational level of the patients (Villalobos et al., 2016). At the patient level, most Latinos with mental disorders do not utilize treatment relative to their need (Alegria et al., 2014; Cabassa, Zayas, & Hansen, 2006). At the system level, when they do receive care it is often via primary care and in public sector settings (Dwight-Johnson & Lagomasino, 2007). Systemically, clinics have generally not adapted their services to reduce barriers to treatment.

Implementation of psychosocial interventions for depression aimed at low-income Latino populations served in urban primary care settings appears to be especially marred by challenges related to patient retention and delivery of the full intervention (Zayas, McKee, & Jankowski, 2004). Patient-level barriers specific to low-income populations are inflexible employment schedules, stigma, and difficulty grasping concepts due to low literacy and education levels. In a trial of CBT in primary care, Miranda, Chung, et al. (2003) reported that psychologists spoke to low-income women an average of 10.2 times (SD = 12.2) before they attended a therapy session. These women were provided with transportation and child care reimbursements to enable attendance. This level of outreach is not feasible in most public sector clinics, where a sizable portion of Latinos receive care, due to resource and time constraints. Even after that outreach, only 53% of those assigned to CBT received 4 or more sessions and 36% received 6 or more sessions. For women who were referred to community partners instead of CBT, only 17% attended at least 1 session (Miranda, Chung, et al., 2003).

Once in treatment, engagement, as measured by session attendance, is low among low-income Latinos compared to non-Latino populations (Organista et al., 1994). Given that session attendance is vital for learning and practicing the skills taught in CBT, it is important to understand how this variable relates to outcomes. Homework completion is another engagement factor that is a critical ingredient in CBT, but homework completion rates have not been reported specifically for Latinos with depression, nor do we understand the relationship between homework and outcomes in this population. It is important to learn more about patients' dosage of treatment as measured by attendance and homework completion, since we know those elements are related to improved outcomes in the general population (Kazantzis, Whittington, & Dattilio, 2010; Neimeyer, Kazantzis, Kassler, Baker, & Fletcher, 2008). Nevertheless, few studies investigate the implementation, process, and outcomes associated with GCBT offered to Latino patients with depression in public sector primary care settings. This information can help us understand how evidence is translated into practice, identifying barriers to ideal implementation, especially as the evidence and support for integrated care proliferates (World Health Organization, 2008).

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