

CHRONIC DISEASE AND MINOR DEPRESSION

Patient and Family Perceptions

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Purpose

- ▣ To conduct research to adapt a chronic disease self-management program among Latinos in Florida
- ▣ Presentation focuses on nine focus groups
- ▣ Analysis is ongoing
- ▣ Results should be considered preliminary – haven't been verified by CAB



Depression

- ▣ 4th leading cause of disability worldwide
- ▣ 27 lost work days per year
- ▣ Lifetime prevalence 17%
- ▣ Importance of general health care
 - 153% increase in use of that sector – i.e., primary care
- ▣ Co-occurrence rates of depression with cardiac disease, arthritis, diabetes, HIV, stroke – 10-30% (Davidson 2006; Stafford 2007)
- ▣ Increased morbidity and mortality if depression untreated (Katon 2003)



The Importance of Minor Depression

- ▣ Definition: 2-4 symptoms with impaired functioning
- ▣ 5-15% primary care patients worldwide
- ▣ Increases MORTALITY after myocardial infarction
- ▣ In Latinos, twice as prevalent as major in primary care
- ▣ Predictor of onset of first episode of major depression
- ▣ Death in people with diabetes and...
 - Major Depression – 2.3 odds
 - Minor Depression – 1.67 odds



Tomando Control de su Salud

- ▣ Chronic Disease Self Management Program
 - 14 hour Self Management Intervention
 - Components:
 - ▣ Theoretical principles of self efficacy
 - ▣ Designed to facilitate group interaction and participation
 - ▣ Session Topics:
 - Problem solving re: pain, fatigue, isolation, etc.
 - Exercise/physical activity
 - Use of medications
 - Communication with providers, family, others
 - Nutrition
 - Action Planning



Phase One Qual Research

- ▣ Focus groups with patients and families
 - Patients must meet criteria for minor depression and have one of three chronic diseases (hypertension, diabetes, cardiovascular disease)
 - Family members are nominated from patient focus group members
 - ▣ Family members must have some level of caretaking experience for group participation
- ▣ Semi-structured interviews with health care providers, promotores, and community-based organization leaders



Phase One Completion to Date

- 5 focus groups with patients
 - 3 with males
 - 2 with females
- Males face stigma associated with depression, so decided to divide patient groups by gender and have a male moderator
- 4 focus groups with family members
 - Genders combined
 - Mixed genders did not inhibit discussion among family members



CBPR

- Seven out of nine focus groups were led by community members with assistance from research team
- 2 male groups were conducted by professional researcher
 - No available male moderator at the time of the groups
- Community members handled recruitment and screening
- Participate in weekly research team meetings



Analysis

- Identification of emergent themes
 - Compared between AIs and FM groups
 - Community-research team reviewed extensive field notes
 - 2 bilingual research staff coded the focus group transcripts to improve reliability of data
 - Results were reviewed at weekly team meetings as each transcript was completed
- Still on-going - next steps
 - Review final results along with community-research team
 - Verification check - CAB



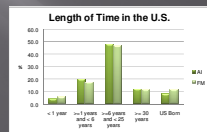
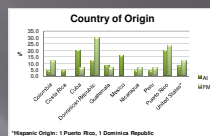
Gender Breakdown by Group

	Patient Groups (N = 4)	Family Groups (N=4)
Males	15	4
Females	10	13
Total	25	17



Demographic Data

	AI n=25		FM n=17	
	n	%	n	%
Age (mean/SD)	49.12 (8.4)	---	38.82 (14.6)	---
Gender				
Males	15	60.0	4	23.5
Females	10	40.0	13	76.5
Highest Level of Education				
Less than high school	4	16.0	2	11.8
Some high school	1	4.0	1	5.9
High school graduate or GED	11	44.0	9	52.9
Vocational school or some college	4	16.0	2	11.8
Graduate School/Professional	5	20.0	3	17.6

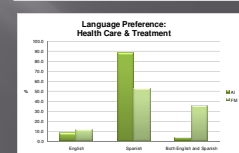


**Percent may not add to 100% due to missing values. AI: Afflicted Individuals; FM: Family Members



Demographic Data

	AI n=25		FM n=17	
	n	%	n	%
Marital Status				
Married/cohabiting with a partner	17	68.0	12	70.6
Single, never married	4	16.0	3	17.6
Separated/divorced	4	16.0	2	11.8
Income				
Unknown	1	4.0	4	23.5
Less than \$10,000	10	40.0	5	29.4
\$10,000 - \$39,999	14	56.0	6	35.3
\$40,000 - \$79,999	0	0.0	2	11.8
Type of Chronic Illness				
None	0	0.0	7	41.2
Cardiovascular Disease	4	16.0	0	0.0
Diabetes	14	56.0	4	23.5
Hypertension	15	60.0	3	17.6
Other	9	36.0	5	29.4



**Percent may not add to 100% due to missing values. AI: Afflicted Individuals; FM: Family Members



Demographic Data

	AI n=25		FM n=17	
	n	%	n	%
Minor Depression Present				
No	0	0.0	8	47.1
Yes	25	100.0	8	47.1
Access to MH Provider				
No	19	76.0	-	-
Yes	6	24.0	-	-
Health Insurance Coverage				
None	14	56.0	10	58.8
Yes, private insurance	1	4.0	3	17.6
Yes, Medicaid, Medicare, or other government assisted insurance program	9	36.0	4	23.5
Yes, other	1	4.0	0	0.0

**Percent may not add to 100% due to missing values. AI: Afflicted Individuals, FM: Family Members

Themes

- Risk of Depression
 - Debilitating effects of chronic illness
 - Economic difficulties (e.g., unemployment, general expenses, etc.)
 - Structural barriers
 - Difficulties of living with AI may lead to depression in family members
- “Simplifying one’s life. Help them [AIs] to understand and to calm down sometimes. The very depression that they suffer from...because depression breeds depression. If you see your family member or someone’s whose finger hurts, it hurts you, too. And if they suffer, you suffer.”

Themes

- Chronic Illness
 - Inability to work due to chronic illness
 - Mood swings
 - Difficulties doing things AI used to in past (work, recreation, etc.)
- “I’m going to give you an example. I like to dance, and I can’t hear music play because I start moving! I love music, without having a drink or anything. So, it would be like taking this away from a person who is sick. ‘Well, you can’t eat this, you can’t eat that. And that’s what things come to, that feeling where they say, ‘Why did I have to get this disease?’”

Themes

- Acculturation stress
 - Isolation of families and friends – not the same as home country
 - Food and dietary habits change
 - Cultural difference (language, they way things are done – system difference)
 - Unable to find jobs in their profession (jobs in general and professional jobs)
- “So, it is emasculating for him, to see that I am the only one working. My husband was an attorney in Colombia, but here, the language difference is a very big barrier. So, we’ve found ourselves...It’s been worse for him. He hasn’t been able to adapt to the way things are here. And I think that the diabetes and all of his other health problems have caused him to fall into depression.”

Themes

- Recommendations for Tomando
 - More education on diet, self-management, etc. requested
 - Skills to help AIs and family members cope with chronic illness and depression
 - Strategies for family members to support/help AIs
 - Leaders should include health professionals and lay educators
 - Support groups for AIs and family members

Themes

- Recommendations for Tomando
 - Sensitivity of certain topics (e.g. reduced sexual relationships/libido) should be observed
 - Infusion of cultural foods and traditions (e.g. music, social interaction)
- “I would say, in my case, people that have perhaps, already gone through...they should be given the opportunity, people who have overcome this situation. People who have experienced this and overcome it so that they can help others because if you don’t know about this, if you don’t live it, you just don’t know.”

Methodological Issues

- ❑ Working with community moderators
- ❑ Relying on community members for recruitment and screening
- ❑ Stigma surrounding depression in Latino community
- ❑ How to recruit patients who meet both criteria

