How Important Is Intrinsic Spirituality in Depression Care?

A Comparison of White and African-American Primary Care Patients

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We used a cross-sectional survey to compare the views of African-American and white adult primary care patients (*N* = 76) regarding the importance of various aspects of depression care. Patients were asked to rate the importance of 126 aspects of depression care (derived from attitudinal domains identified in focus groups) on a 5-point Likert scale. The 30 most important items came from 9 domains: 1) health professionals' interpersonal skills, 2) primary care provider recognition of depression, 3) treatment effectiveness, 4) treatment problems, 5) patient understanding about treatment, 6) intrinsic spirituality, 7) financial access, 8) life experiences, and 9) social support. African-American and white patients rated most aspects of depression care as similarly important, except that the odds of rating spirituality as extremely important for depression care were 3 times higher for African Americans than the odds for whites.

KEY WORDS: **depression; spirituality; patient attitudes; African Americans.**
J GEN INTERN MED 2001;16:634–638.

Ethnic disparities in mental health service utilization, quality of care, and outcomes have been documented.[1,2] Patient, provider, and health system barriers all contribute to ethnic disparities in mental health care. Structural and financial barriers of access to mental health care for ethnic minority patients have been described; however, personal barriers, particularly cultural beliefs and preferences, are not as well understood. Despite an increase in positive attitudes toward help-seeking from professionals and increasing use of outpatient general medical services for mental health problems by African Americans, many studies show that African-American patients receive inadequate treatment for depression, perhaps as a result of an overemphasis of somatic symptoms by patients and under recognition by general medical providers.[3–6] Furthermore, studies show higher rates of attrition from psychotherapy and pharmacotherapy and lower referral rates to mental health specialists for African Americans compared to whites.[7,8]

Personal barriers of potential importance for African Americans identified in previous work include perceptions of stigma, mistrust of mental health professionals, and fears of psychotropic medication.[9–11] It is unclear whether use of spirituality, other active coping strategies, informal sources of support (family, friends, and church members) and help-seeking from clergy serve as barriers to mental health care.[12,13] While African Americans say they prefer counseling over medications for depression, few actually desire referrals to mental health specialists.[14–16] We hypothesized that African Americans would rate stigma, trust in health professionals, concerns about antidepressant medication, informal sources of support, and spirituality as more important aspects of depression care than whites.

METHODS

Study Design and Patient Selection

The study design was a cross-sectional survey of attenders of an urban university-based primary care clinic (a subset of a larger sample included in a study of minor depression). To be eligible for our survey, patients had to be English-speaking, between the ages of 18 and 64, African American or white, and able to give informed consent. Patients were asked to complete the 20-item Center for Epidemiologic Studies Depression Scale (CES-D) as a measure of depression symptom level, and those with scores of 11 or greater were included. These patients all completed a clinician-administered diagnostic evaluation using the Structured Clinical Interview for DSM III-R (SCID). Recruitment strategies were identical for African Americans and whites.

Patients recruited between September 1996 and August 1998 were asked to complete a self-administered questionnaire, designed by us, while at the clinic or by return mail. The 126 items included in the questionnaire were developed using comments grouped into domains from content analysis of focus groups with health professionals and depressed patients.[10] The study design, patient recruitment strategy, development of the importance questionnaire, and reliability and validity testing of the items and domains have been described in detail elsewhere.[11] We asked patients to rate each item on a 5-point scale according to its importance for high quality care for depression: 1, not at all important; 2, not very important; 3, somewhat important; 4, very important; and 5, extremely important.

Received from the Department of Medicine, The Johns Hopkins University School of Medicine (LAC, HTV, DEF, NRP), and the Department of Health Policy and Management, The Johns Hopkins University School of Hygiene and Public Health (LAC, DEF, NRP), Baltimore, Md; and The Western Psychiatric Institute and Clinic and the Department of Psychiatry, University of Pittsburgh School of Medicine (CB), Pittsburgh, Pa.

Presented in part at the 15th Annual Meeting of the Association for Health Services Research, Washington, DC, June 21–23, 1998.

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The patient questionnaire also inquired regarding demographic characteristics, lifetime experience with depressive symptoms, functional impairment, and past visits to mental health professionals.

Analyses

For this analysis, we ranked the importance of the 126 items (according to mean scores and the percentage of patients rating the item as extremely important) separately by ethnicity. Spearman's rank correlation coefficient tests were used to compare rankings according to mean score and the percent of patients rating the item as extremely important. In a previous paper, we described 7 domains that were identified using reliability and discriminant validity testing of the top 30 items for the overall sample: 1) health care providers' interpersonal skills (10 items); 2) primary care provider recognition of depression (2 items); 3) treatment effectiveness (6 items); 4) treatment problems (3 items); 5) patient education and understanding about treatment (2 items); 6) intrinsic spirituality (4 items); and 7) financial access (3 items).[11] When we conducted a confirmatory factor analysis on the top 30 items separately by ethnicity, 2 additional domains were included: 1) life experiences and 2) social support. Items from the life experiences domain were included among the top 30 items for each ethnic group, while items from the social support domain were identified among the top 30 items only for whites. Cronbach's αs for the 9 domains range from 0.81 to 0.92.

For each item, we dichotomized responses as extremely important versus the other 4 categories (not at all important, not very important, somewhat important, and very important). This cut point was chosen because a high percentage of the overall sample of patients rated the items as extremely important. We also conducted analyses using ratings dichotomized as very or extremely important versus the other 3 categories. We then used logistic regression to quantify the associations between the importance ratings of various aspects of care by ethnicity, adjusting for age, education, marital status, and employment status in multivariate models.

RESULTS

Of the 97 individuals approached, 76 patients completed the questionnaire. The average age of patients was 34.8 years. The sample was 72% women, 36% African American, 64% white, 29% married, 32% college graduates, and 49% employed full time. These individuals are similar to the overall clinic population with respect to gender and ethnicity. The mean score on the Center for Epidemiologic Studies Depression Scale was 22.2. Fifty-four percent of the patients reported definite impairment in functioning related to their symptoms, and another 24% reported that they felt impaired "sometimes." Over half the patients reported having depression in the past, and 46% of the sample had visited a mental health professional sometime in the past. The SCID diagnoses of most of these individuals were minor depression and dysthymia. Compared to whites, African Americans were less likely to be married, college graduates, or employed full time. There were no statistically significant racial differences in depression symptom level or history of mental health service use, although whites were somewhat more likely to have no disorder or to have major depression by the SCID than African Americans (Table 1).

Spearman's rank correlation coefficient test showed that the rankings by mean score and by percentage of patients rating the item as extremely important were highly correlated (r_s = .86, P < .0001). Table 2 shows the top 30 aspects of depression care from 9 domains identified by the percentage of by African-American and white patients rating the item as extremely important. A total of 39 items are shown because the top 30 items from each ethnic group are included. Compared with whites, African-American patients gave higher ratings to all items related to spirituality. For example, African Americans rated having faith in God, being able to ask God for forgiveness, and prayer among the 10 most important aspects of depression care. In contrast, these aspects of care were ranked 25th, 28th, and 31st among whites. In adjusted analyses, the odds of rating these items as extremely important were 3 to 4 times higher for African Americans than whites. There was less racial disparity in the rankings of other aspects of depression care, including trust in health professionals and the use of informal sources of social support. Neither whites nor African Americans ranked concerns about stigma among the top 30 items. African Americans rated treatment problems (having to stay on medications a long time and having medications fix, rather than cover up, depression) as more important than whites, although the differences did not reach statistical significance. Analyses using the percentage of patients rating the item as very or extremely important versus the other responses resulted in similar findings.

DISCUSSION

Patient views regarding the importance of various aspects of depression care were similar for African Americans and whites, except for the importance of spirituality. African-American patients in this study were more likely than whites to rate spirituality as an extremely important aspect of care for depression. Research linking religious involvement with psychological well-being among African Americans indicates that prayer is an important means of coping with serious personal problems.[17] Of note, the aspects of spirituality rated as extremely important were of a private and intrinsic nature, reflecting active coping with depressive symptoms such as feelings of guilt and hopelessness. In contrast, items related to public religiosity, such as church attendance and social support from church members, were not rated among the top 30 items.

Table 1. Characteristics of Study Participants

	Total, % (*N* = 76)	African American, % (*n* = 27)	White, % (*n* = 49)
Demographics			
Age			
18–34	55	48	59
35+	45	52	41
Gender			
Female	72	70	74
Male	28	30	26
Marital Status			
Married	29	11	39*
Never Married	54	59	51
Separated/ divorced/widowed	17	30	10
Education			
High school or less	39	53	12*
Some college	28	20	44
College graduate	32	27	44
Employment status			
Unemployed	35	59	22*
Employed part-time	16	15	16
Employed full-time	49	26	61
Depression status			
CES-D Score			
11–15	21	15	24
16–21	36	44	31
22+	43	41	45
Ever depressed in the past			
Yes	56	48	61
No	44	52	39
SCID diagnosis			
None	16	4	23
Dysthymia	19	22	17
Minor depression	63	74	56
Major depression	3	0	4
Currently impaired by depressive symptoms			
Yes	54	48	57
Sometimes	24	24	23
No	22	28	19
Ever visit mental health professional			
Yes	46	33	53
No	54	67	47
Most recent visit to mental health professional (*n* = 35)			
<1 month ago	11	11	12
1–6 months ago	9	22	4
7–12 months	0	0	0
>12 months ago	80	67	85

* χ^2, *ldf*, P < .01. *None of the other comparisons were significant at the* P < .05 *level.*

Limitations of this study include its small sample size from 1 geographic area, the nonrandom selection of patients, and the heterogeneity of depressive diagnoses and symptoms. The sample was also younger, more educated, and had a higher prevalence of previous mental health treatment than many other primary care samples. Additionally, the whites in our sample were more educated, and the African Americans, less educated, than national averages. Although we adjusted for educational status in our multivariate analyses, there remains the potential for residual confounding of the relationship between race and importance ratings because of socioeconomic status and other unmeasured characteristics. Nonetheless, the study contributes to the literature because little work has been done previously to compare African-American and white primary care patients' priorities for treatment of depression.

Our focus on spirituality was guided by our previous qualitative research as well as by other literature regarding the importance of spirituality to African Americans. Because of the strength of the association and its consistency across several items in the same domain, it is unlikely that the findings related to spirituality and race occurred by chance. Because we performed 39 individual regression analyses, several other significant findings might have resulted by chance alone.

Research indicates that patients want their physicians to address issues of faith and spirituality in the course of their treatment, and that patients with strong spiritual and religious tendencies are receptive to physicians referring them to pastoral counselors or praying with them.[18] However, primary care physicians cite lack of time and inadequate training as the most important barriers to discussing spirituality with patients.[19] Not much is known about how, when, and with whom patients would like to discuss their spiritual needs in the context of medical care. Some authors suggest that physicians routinely use a spiritual needs assessment with patients—asking patients whether or not they consider themselves to be religious or spiritual, how important faith is in the patient's daily life, whether or not the patient belongs to a community of faith, and how the patient would like the physician to address these issues in their health care.[20] Physicians might also try to ascertain whether patients' religious views and coping styles are healthy and facilitate adjustment or whether these views are dysfunctional, contribute to psychopathology, or impede patients' ability to benefit from medical care. If physicians feel their patients require more spiritual care than they are able to provide, referrals could be made to pastoral counselors with patients' consent.

This exploratory study suggests that acknowledgment of spirituality within the context of care of depression may be particularly important for African Americans. Future research should use larger samples of primary care patients to compare attitudes toward the inclusion of spirituality in depression care between African Americans and whites and to identify the range of appropriate ways for health professionals to address the spiritual needs of their patients who place a high value on spirituality.

Table 2. Percentage of African Americans and Whites Rating Aspects of Depression Care as Extremely Important (EI)

Aspect of Care	African Americans, %EI (*n* = 27)	Whites, %EI (*n* = 49)	Unadjusted OR* (95% CI)	Adjusted OR† (95% CI)
Intrinsic spirituality				
Having faith in God	81	39	6.94 (2.24 to 21.47)	3.89 (1.11 to 13.52)
Asking God to forgive you	70	33	4.75 (1.71 to 13.18)	2.81 (0.88 to 8.94)
Prayer	67	24	6.16 (2.19 to 17.30)	3.72 (1.15 to 12.08)
Being able to thank God	63	35	3.10 (1.16 to 8.25)	1.45 (0.46 to 4.54)
Reading scripture to feel better	48	20	3.62 (1.29 to 10.10)	1.77 (0.53 to 5.89)
Recognition of depression				
PCP recognizes your depression‡	70	63	1.37 (0.50 to 3.78)	1.30 (0.37 to 4.58)
PCP believes your symptoms	63	71	0.70 (0.25 to 1.90)	0.60 (0.17 to 2.08)
Patient education and understanding				
Knowing what to expect	67	59	1.37 (0.51 to 3.68)	3.13 (0.84 to 11.57)
Having information about treatment	63	63	0.98 (0.37 to 2.61)	1.37 (0.43 to 4.35)
HP gives you information‡	62	50	1.60 (0.60 to 4.22)	1.66 (0.51 to 5.44)
Health professionals' interpersonal skills				
Trust HP to act in one's best interest	69	81	0.51 (0.17 to 1.56)	1.10 (0.24 to 4.87)
HP listens to you	59	63	0.84 (0.32 to 2.21)	1.00 (0.31 to 3.25)
HP judges you	54	49	1.21 (0.46 to 3.15)	1.06 (0.34 to 3.24)
Having one HP who knows all about you	50	42	1.40 (0.53 to 3.65)	1.49 (0.46 to 4.82)
HP understands your problems	48	67	0.45 (0.17 to 1.17)	0.79 (0.24 to 2.55)
HP approaches you as an individual	48	49	0.96 (0.37 to 2.47)	0.71 (0.22 to 2.25)
HP gives you support	48	53	0.82 (0.32 to 2.10)	0.63 (0.20 to 1.99)
HP treats you like a "guinea pig"	46	33	1.76 (0.66 to 4.68)	1.64 (0.51 to 5.22)
Getting guidance from HP	37	35	1.07 (0.40 to 2.85)	0.84 (0.26 to 2.71)
Feeling comfortable with HP	31	59	0.30 (0.11 to 0.84)	0.41 (0.13 to 1.28)
Treatment effectiveness				
Counseling restores functioning	63	58	1.21 (0.46 to 3.20)	1.03 (0.32 to 3.30)
Medications restore functioning	58	72	0.52 (0.19 to 1.42)	0.77 (0.23 to 2.54)
Medications are effective	56	71	0.51 (0.19 to 1.37)	0.74 (0.23 to 2.40)
Counseling helps with problems	50	65	0.54 (0.20 to 1.44)	0.60 (0.19 to 1.92)
Able to talk about life experiences	48	27	0.71 (0.19 to 2.59)	1.05 (0.24 to 4.53)
Talking about what bothers you	41	38	1.14 (0.43 to 3.00)	1.49 (0.47 to 4.70)
Treatment problems				
Medications are addictive	70	73	0.88 (0.31 to 2.50)	1.05 (0.30 to 3.64)
Medications make you feel drugged	70	56	1.84 (0.67 to 5.04)	1.76 (0.54 to 5.77)
Medications make you feel worse	59	75	0.48 (0.17 to 1.32)	0.70 (0.21 to 2.28)
Having to stay on medications a long time	54	27	3.14 (1.15 to 8.53)	4.78 (1.37 to 16.68)
Medications should fix, not just cover up	52	58	0.76 (0.29 to 1.98)	0.74 (0.24 to 2.29)
Meds take long to work	44	23	2.69 (0.97 to 7.42)	2.97 (0.88 to 10.01)
Access to mental health care				
Affording mental health treatment	56	63	0.72 (0.27 to 1.88)	0.62 (0.18 to 2.06)
Having mental health Insurance	41	59	0.47 (0.18 to 1.23)	0.58 (0.17 to 1.94)
The system is a hassle	30	35	0.79 (0.28 to 2.18)	0.64 (0.19 to 2.15)
Life experiences				
Being able to talk about relationships	41	33	1.37 (0.51 to 3.64)	1.89 (0.56 to 6.32)
Being able to talk about loved one's death	27	31	1.10 (0.40 to 3.00)	1.52 (0.45 to 5.16)
Social support				
Having a friend to talk to	33	21	1.90 (0.65 to 5.48)	2.38 (0.67 to 8.37)
Being able to interact with people	33	31	1.10 (0.40 to 3.00)	2.08 (0.56 to 7.63)

* *Odds of African Americans compared to odds of whites rating the item as extremely important.*
† *Adjusted for age, education, marital status, and employment status.*
‡ *PCP, primary care provider; HP, health care professional.*

This work was partially supported by research grants from The Commonwealth Fund, the Robert Wood Johnson Foundation, and the National Institute of Mental Health (U01-MH454443). Dr. Cooper was a Picker/Commonwealth Scholar and a fellow in the Robert Wood Johnson Foundation Minority Medical Faculty Development Program during the time this work was conducted.

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