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Mental Health Stigma in Depressed Latinos over the Course of Therapy: Results from a Randomized Controlled Trial

Anahi Collado, Ph.D.¹, Michael Zvolensky, Ph.D.², Carl Lejuez, Ph.D.³, and Laura MacPherson, Ph.D.⁴

¹Department of Psychology, University of Kansas- Lawrence- Cofrin Logan Center for Addiction Research and Treatment; ²Department of Psychology, University of Houston; ³Department of Psychology, University of Kansas; ⁴Greenebaum Comprehensive Cancer Center, University of Maryland

Abstract

Objective: The current study examined the course, correlates, and predictors of mental health stigma among depressed, Spanish-speaking Latinos that were receiving treatment. This population faces significant disparities in mental health treatment and carries high levels of mental health stigma.

Method: The study utilized data generated from a randomized clinical trial ($N = 46$) that evaluated the efficacy of Behavioral Activation and Supportive Counseling for depression among Latinos.

Results: Mental health stigma decreased over time; these decreases were more pronounced among individuals who were randomized to Supportive Counseling. Mental health stigma was positively associated with depressive symptoms and therapeutic alliance over time. Mental health stigma was not related to treatment attrition.

Conclusions: These preliminary findings indicate that mental health stigma continues to be relevant among individuals who are actively participating in treatment. Receiving mental health treatment may be sufficient to dispel some of the stigmatizing views endorsed by underserved clinical populations.

Keywords

Stigma; Latinos; Behavioral Activation; Supportive Counseling; therapeutic alliance; treatment attrition

Mental health stigma refers to the negative social evaluation associated with a psychiatric label (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007). The role of mental health stigma as a deterrent to seeking treatment for individuals needing such services has been well documented (Corrigan, 2004; Livingston & Boyd, 2010), particularly among ethnic

minority populations (Clement et al., 2015). Latinos, who represent the largest U.S. ethnic minority group, have confronted marked mental health treatment barriers and disparities historically (Derr, 2015). Among Latinos, Spanish-speakers have been particularly encumbered by low rates of treatment access, utilization, retention, and greater depressive symptom severity (Keyes et al., 2012; Sentell, Shumway, & Snowden, 2007). Research has demonstrated that mental health stigma significantly underlies these disparities above and beyond socioeconomic indicators and health insurance status (Gary, 2005; Interian et al., 2010; Nadeem et al., 2007; Vega, Rodriguez, & Ang, 2010). Common mental health stigma-related fears in this population include being negatively perceived by others and believing that problems are personal and should not be disclosed (Alvidrez & Azocar, 1999; Santiago-Rivera et al., 2008).

Even after individuals initiate treatment, mental health stigma is related to greater levels of attrition and non-adherence (Livingston & Boyd, 2010; Sirey et al., 2001). In one primary care investigation, depressed Latinos who were receiving treatment endorsed less mental health stigma than those who did not receive treatment, although mental health stigma continued to impact treatment adherence and depressive symptoms negatively (Vega, Rodriguez, Ang, 2010). Fortunately, research suggests that mental health stigma may be amenable to intervention. For example, data have shown that mental health stigma decreased from pre- to post-treatment among individuals who received treatment for substance use disorders (see Livingston, Milne, Fang, & Amari, 2011, for a review). Strikingly, there is presently a lack of empirical work that focuses on mental health stigma among individuals in psychological treatment other than for substance use.

Altogether, reports of high levels of mental health stigma among depressed Spanish-speaking Latinos, coupled with reports of elevated depression symptom severity in this population (Aponte-Rivera et al, 2014), and the limited research that exists on how mental health stigma impacts medically-underserved communities in the U.S. receiving psychosocial treatments,, indicate the need to understand the construct's course and correlates. Therefore, the current study focused on elucidating the course of mental health stigma among Latinos during depression treatment and its association with 1) early treatment termination, 2) depressive symptoms, and 3) therapeutic alliance.

We hypothesized that there would be a significant decrease in mental health stigma over the course of both treatments. We expected that higher levels of mental health stigma pre-treatment would be associated with a greater likelihood of treatment attrition and with greater levels of pre-treatment depressive symptomatology. We also predicted that there would be a positive association between mental health stigma and depressive symptoms over the course of treatment. Conversely, we expected an inverse relationship between mental health stigma and therapeutic alliance across treatment. To our knowledge, this is the first study to track stigma changes over the course of psychotherapy, examine its relation to psychiatric symptoms and therapeutic alliance over time, utilize a depressed clinical sample, and focus on a much underserved sub-population in the US, such as Spanish-speaking Latinos.

Method

Data for this study were collected as part of a RCT that was designed to evaluate Behavioral Activation and Supportive Counseling on depression among Latinos. Primary outcome data from the RCT indicated that depression decreased over the course of both treatments, but that individuals who received BATD showed more pronounced depression reductions (citation not included for the review process). The present study's goals are significantly different from the original RCT questions by examining the course of mental health stigma during SC and BATD as well as the correlates of mental health stigma including treatment dropout, depressive symptoms, and therapeutic alliance.

Procedures

All procedures were approved by the University of Maryland's Institutional Review Board. The study sample was recruited from July 2013 to June 2014 primarily through community organizations and radio stations serving the Spanish-speaking community of the [area]. Eligible participants had to: 1) be a minimum of 18 years of age, 2) Latino/a, 3) report Spanish-language preference, 4) meet criteria for Major Depressive Disorder, 5) not meet criteria for substance abuse or dependence, bipolar or psychotic disorders, 6) not be receiving psychotherapy, and 7) if taking antidepressants, demonstrate three or more consecutive months of use.

Treatments

We used the most current version of the Spanish BATD manual, which consists of 10 sessions (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011; Maero, Mathot, & Principi, unpublished manual). Participants were also randomized to receive a 10-session SC treatment protocol. The SC manual was modeled after Novalis, Rojcewicz, and Peele (1993). For more information, please refer to (Collado, Calderón, MacPherson & Lejuez, 2016).

Researchers have supported the use of both treatments among Latinos. Advocates of behavioral activation indicate that scheduling and completing activities could empower Latinos to perceive greater control over their lives because they oftentimes confront marginalizing situations (e.g., poverty, racism) over which they have little control (Comas-Díaz, 1981; Miranda, Azocar, Organista, Dwyer, & Areane, 2003). Others have proposed that behavioral activation's attribution of depression to individuals' environmental context in contrast to internal factors, such as faulty cognitions and biological factors, may decrease mental health stigma (Kanter, Santiago-Rivera, Rusch, Busch, & West, 2010; Santiago-Rivera et al., 2008). SC, on the other hand, was selected as a credible control condition based on the extant qualitative data that has consistently suggested that Latinos reference supportive talk, comfort, and catharsis as the most salient benefits of psychotherapy (Karasz & Watkins, 2006). In addition, the therapy's rationale is based on *desahogo* or the expectation among Latinos that therapeutic improvement is caused by relief through *venting* or getting things off one's chest while obtaining support (Cabassa, Lester, & Zayas, 2007; McCabe, Yeh, Garland, Lau, & Chavez, 2005; Interian & Díaz-Martínez, 2007).

Materials and Measures

Demographic Characteristics.—A demographics questionnaire was developed to assess the sample's characteristics.

Mental Health Stigma.—Participants completed the *Stigma Checklist Questionnaire* (SCQ) (Vega, Rodriguez, & Ang, 2010), which was designed to measure low-income, Spanish-speaking Latinos' fears and perceptions of receiving treatment for depression. The questionnaire consists of 7 items that assess for fears surrounding others' (e.g., relatives) judgments if they learned that the participant was depressed and/or receiving treatment. The measure also assesses for participants' own stigmatized views of individuals who are depressed and/or receiving treatment. Participants were asked to answer "yes" or "no" for each item and scores ranged from 0 to 7, with higher scores representing greater levels of mental health stigma. The internal reliability of the SCQ was reported at .69 and in the current study, Cronbach's alpha ranged from .66 to .70. The SCQ was administered prior to the first, fifth, and tenth sessions.

Depression.—We administered the *Beck Depression Inventory-II (BDI-II)* (Beck, Steer, & Brown, 1996) at every session and at the follow-up. The 21-item inventory assesses the depressive symptom severity. Mild depression scores range between 14 and 19, moderate depression between 20 and 28, and severe depression between 29 and 63. The *BDI-II* Spanish version was evaluated in a sample of 470 Spanish community adults (Sanz, Perdígón, & Vázquez, 2003). Internal consistency in this study ranged from .86 to .91 across all 10 sessions. The questionnaire was administered at every session.

Therapeutic Alliance.—We assessed the strength of the therapeutic relationship using the *Therapeutic Alliance with Clinician Questionnaire (TAC)* (Neale & Rosenheck, 1995). The *TAC* consists of 9 items and its response choices are in a Likert scale format. Possible scores range from 0 to 54, and higher scores represent greater alliance. The Spanish version of the *TAC* (Bedregal, Paris, Añez, Shahr, & Davidson, 2006) was evaluated with depressed individuals and achieved high internal consistency ($\alpha = .96$). In this study, alpha coefficients ranged from .94 to .97 across the four sessions in which it was administered (sessions 2, 5, 8, and 10).

Data Analytic Plan.—We conducted bivariate correlations to assess potential covariates for our variables of interest. To account for the nested structure of the data, we used multilevel modeling (Hierarchical Linear Modeling [(HLM) (Raudenbush & Bryk, 2002)]. The nature of HLM allowed us to conduct intent-to-treat analyses, control for baseline scores of the dependent variable, include multiple assessment points while accommodating missing data, examine individual change over time, and include the average change and the individual variation around this average change. The selection of HLM is consistent with previous open label trials of clinical interventions (e.g., Spates et al., 2012; Neacsu et al., 2014) and with guidelines set forth by the Institute of Medicine (2011) that the data analytic approach maximizes information from small trials and facilitates obtaining results that are reliable and valid. To improve estimation of effects given the limitation of the study's small sample size, we used random effects and a Restricted Maximum Likelihood estimation.

We centered all variables, except for time, around the grand mean of respective scores to avoid multicollinearity. To examine decreases in mental health stigma over time, mental health stigma was specified as the outcome and time as the predictor (Model 1). Depressive symptoms and therapeutic alliance were specified as time-varying predictors (Level 1 variables) of mental health stigma, which was the outcome variable in both models (Models 2 and 3 respectively). HLM models included treatment condition as a Level 2 (time-invariant) variable. The models did not include other covariates. Finally, logistic regression analyses were conducted to evaluate the association between pre-treatment mental health stigma and early treatment termination (1 = completed treatment; 0 = did not complete treatment) and controlled for treatment condition.

Results

The primary outcomes paper includes a CONSORT diagram of the study (Collado, Calderón, MacPherson & Lejuez, 2016). Participants were between 18 and 74 years old (mean age = 35.91; $SD = 13.80$) and were living in the US for 4.07 years ($SD = 2.69$). The sample consisted of 39 females and seven males. Thirty-seven percent of participants reported earning a yearly income of less than \$14,999; 41% indicated being employed full time. Participants' mean education was a 10.93 grade level ($SD = 3.74$). Participants had a pre-treatment mental health stigma mean score of 2.30 ($SD = 1.90$). See Table 1 for means and standard deviations of the mental health stigma variable by treatment condition. Eighty-three percent of individuals ($n = 38$) endorsed at least one mental health stigma item at baseline. The pre-treatment mean score of depressive symptoms was 29.70 ($SD = 10.36$), indicating severe depression. Therapeutic alliance at the first administration (session 2) had a mean score of 47.58 ($SD = 11.50$) out of a possible score of 63. There were no differences in demographic and clinical variables between conditions (p -values $> .34$). Only one correlation was significant and showed that mental health stigma and age were inversely associated ($r = -.31$, $p = .045$).

Mental Health Stigma over the Course of Treatment (Model 1):

Mental health stigma showed a linear decrease over time ($\beta = -0.10$, $SE = 0.04$, $p = .02$). There was a significant interaction between condition and time ($\beta = 0.13$, $SE = 0.06$, $p = .03$), such that individuals who received SC showed greater decreases in stigma relative to those in BATD.

Mental Health Stigma and Depressive Symptoms (Model 2):

There was a positive, significant relationship between mental health stigma and depression over the course of treatment ($\beta = 0.04$, $SE = 0.02$, $p = .02$). There were no differences in depressive symptoms as a predictor of mental health stigma between SC and BATD ($p = .55$).

Mental Health Stigma and Therapeutic Alliance (Model 3):

Greater mental health stigma was associated with greater therapeutic alliance over time ($\beta = 0.05$, $SE = 0.02$, $p = .01$). There was no difference in therapeutic alliance as a predictor of

mental health stigma between BATD and SC ($p = .21$). Please refer to Table 2 for HLM results.

Mental Health Stigma and Early Treatment Termination:

Mental health stigma was not related to early treatment termination ($p = .34$). There was no effect of treatment condition on treatment attrition ($p = .45$).

Discussion

The current study found that mental health stigma decreased over the course of both BATD and SC. Interestingly, neither psychotherapy directly targeted mental health stigma, which suggests that receiving treatment may be sufficient to dispel stigmatizing views in clinical populations. The study also demonstrated that individuals in SC showed more pronounced decreases in mental health stigma relative to individuals in BATD. Additionally, greater therapeutic alliance was related to greater levels of mental health stigma across conditions. Results also indicated that greater mental health stigma at baseline was not related to treatment dropout across treatments. Finally, depressive symptoms and mental health stigma were positively related over the course of treatment.

The finding that psychotherapy may decrease mental health stigma is consistent with previous research (e.g., Livingston et al., 2011), with some notable exceptions (e.g., Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). In the study conducted by Link and colleagues (Link et al., 1997), men diagnosed with co-occurring psychiatric and substance use disorders ($N = 84$) did not demonstrate changes in different measures of mental health stigma (perceived rejection, discrimination experiences, and perceived need for secrecy) after completing community or residential substance use treatment and despite improvements in depression symptoms and abstinence. Overall, the mixed findings may be a result of the differences in the sample's clinical severity, sample characteristics, number of treatment sessions offered, and/or study design.

The finding that SC led to greater decreases in mental health stigma relative to BATD requires additional investigation. One possibility is that SC allows individuals to *vent* (*desahogarse*), which is highly consistent with Latinos' expectations and views of therapy (Cabassa, Lester, & Zayas, 2007; McCabe et al., 2005; Interian & Díaz-Martínez, 2007). The present study's results suggest that therapists using BATD (and other more structured treatment modalities) may consider allotting time for *venting* in this population as others have previously suggested (e.g., McCabe et al., 2005). Lejuez and colleagues (Lejuez, Hopko, Levine, Gholkar, & Collins, 2005) include a case example in which BATD and *venting time* were seamlessly integrated in treating a depressed Latina client. Another possibility is that attitudes about depression and its treatment could have accounted for these findings. Future research may formally assess for discrepancies between treatment expectations and actual treatment as a predictor of mental health stigma. In addition, post-treatment in-depth interviews may elucidate the mechanism by which mental health stigma levels decreased.

This present study's findings differ from those of meta-analytic reviews that have reported the adverse impact of mental health stigma on treatment dropout (e.g. Livingston & Boyd, 2010; Sirey et al., 2001). Our results, however, are consistent with a previous study that reported that mental health stigma was unrelated to premature termination in a sample of parents of Mexican-American children receiving psychiatric services (McCabe, 2002). The researchers indicated that mental health stigma could play a more significant role when it comes to seeking services, but not when deciding to continue such services. Despite the lack of relationship between early treatment termination and mental health stigma, it should be noted that in the current study 83% of participants endorsed at least one stigmatized view of depression or depression treatment. These rates indicate that mental health stigma continues to be elevated among individuals who enroll in treatment.

In the current study, greater therapeutic alliance was associated with higher levels of mental health stigma. One possibility for these results could be that when clients feel connected to their therapists, clients' perceptions of their therapists' views of them become more significant. This may be especially true in depressed individuals who may view therapists as a central form of social contact. Notably, previous research found increases in mental health stigma after viewing a cognitive behavioral therapy (CBT) web page relative to a control condition (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). The researchers hypothesized that CBT's emphasis on one's ability to change mood by targeting cognitive distortions and behaviors could have led participants to perceive that the public believes that depression is under their control and therefore faults them for their depressive state. Participants in the present study could have made similar attributions about their therapists' view of them. Further, mental health stigma and depressive symptoms were not associated at baseline but were related over the course of treatment. Future research should consider factors underlying the change in mental health stigma, including social isolation, rumination, and emotion regulation (e.g., Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009). An important note about these results is that in the original RCT, BATD was more beneficial than SC in showing greater reductions in depression. This finding may indicate that although mental health stigma is associated to various treatment correlates (as was the case in this study), it may not underlie reductions in depressive symptoms. The study should be interpreted in light of its limitations. The relatively small sample size and focus on Latinos and depression are factors that could limit the generalizability of our results. The small sample size precluded us from examining temporal relationships between stigma and depressive symptoms. Despite this small sample size, however, with 46 within-subject assessment points over time, the design was sufficient to detect effects. Nonetheless, future research is warranted to reproduce these findings with a larger sample size. Additionally, we did not use a differentiated measure of mental health stigma that could assess for various types of stigma including public, self, personal, or structural sources of stigma (Corrigan, Kerr, & Knudsen, 2005; Herek, Gillis, & Cogan, 2009; Corrigan & Watson, 2002). Finally, the SCQ achieved internal consistencies of .66 to .70 (relative to .69 in the manuscript that evaluated its psychometric properties), which may be associated with the scale's brevity.

Overall, this study contributes to a limited literature in describing the course, correlates, and predictors of mental health stigma among depressed individuals in treatment. A major strength of the study is its focus on a widely underserved US population who is in critical

need of treatment services. As the number of Latinos continues to grow, understanding treatment barriers, such as stigma, is crucial to curtail the discrepancies between the need for mental health services and treatment utilization.

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Table 1

Means and Standard Deviations of Baseline, Mid-Treatment, and End-of-Treatment Stigma Scores by Group

Total Stigma	Baseline	Mid-treatment	End-of-treatment
BATD	2.57 (1.65)	2.24 (1.48)	1.82 (1.72)
SC	2.04 (2.14)	1.36 (1.15)	1.00 (1.07)

Note. BATD: Behavioral Activation Treatment for Depression; SC: Supportive Counseling.

Table 2

Results of HLM Analyses

Fixed Effects Models	<i>B</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Model 1 - Mental Health Stigma				
Time	−0.095	0.040	−2.361	.023
Time * Condition	0.132	0.059	2.225	.031
Model 2- Mental Health Stigma and Depressive Symptoms				
Time	0.037	0.015	2.399	.021
Time * Condition	−0.019	0.030	−0.623	.550
Model 3- Mental Health Stigma and Therapeutic Alliance				
Time	0.052	0.020	2.577	.013
Time * Condition	0.005	0.041	1.272	.210

Note. Model 1 evaluated mental health stigma changes over time and between conditions. Model 2 tested the effect of depressive symptomatology on mental health stigma over time and between conditions. Model 3 tested the role of therapeutic alliance on mental health stigma over time and between conditions.