Psychotherapeutic interventions for depressed, low-income women: A review of the literature

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Abstract

Low-income women have very high rates of depression and also face a number of unique barriers that can prevent them from seeking, accepting, engaging in, or benefiting from psychotherapy treatment. Untreated depression often leads to deleterious psychological consequences for these women and their children, and may also diminish a woman’s ability to improve her economic circumstances. We reviewed the literature on psychotherapeutic interventions for depressed, low-income women, identifying a number of practical, psychological, and cultural barriers that often prevent them from engaging in psychotherapy. Next, we assessed the degree to which established intervention programs help women overcome these barriers. The data suggest that it is quite difficult to engage depressed, low-income women in psychotherapy, but that a number of standard psychotherapy approaches do show promise. However, we found that many of the currently available interventions fail to fully address the barriers that prevent this population from engaging in treatment. Moreover, the impact these interventions have on engagement and attrition rates or clinical improvements is often inadequately reported. We provide preliminary recommendations for clinicians who work with low-income women as well as suggestions for bolstering the literature base.

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1. Introduction

Prevalence of major depression and other mental health disorders is significantly higher in low-income individuals than in the rest of the population and this difference is even more prominent for chronic depression (Lorant et al., 2003). However, low-income individuals are less likely to be diagnosed (American Psychological Association (APA), 2001) or to seek (Grote, Swartz, & Zuckoff, 2007) or receive a full course of guideline-concordant depression treatment (Greeno, Anderson, Shear, & Mike, 1999). Although direction of the causal relation between socioeconomic status (SES) and mental illness remains contested, poverty is one of the most consistent predictors of depression (Belle & Doucet, 2003). Importantly, among welfare populations, mental illness has been identified as a significant barrier to successfully moving from welfare to working and living independently (APA, 2001; Lennon, Blome, & English, 2002; Siefert, Bowman, Helfin, Danziger, & Williams, 2000).

Mental health problems also have been linked to increased risk for poor general physical health, as well as specific medical illnesses such as somatic complaints, that typically follow a chronic course and are therefore especially costly (e.g., Abbass, Kisely, & Kroenke, 2009). The US healthcare system is at a critical juncture, with burgeoning national healthcare costs and the impending entrance of millions of previously uninsured low-income Americans into the healthcare system with the Obama administration's March 2010 passage of transformative healthcare legislation. These events increase the importance of finding and disseminating efficacious mental health treatments that can not only directly ease psychological pain, but that also have the potential to reduce overall healthcare costs and improve economic opportunity for low-income Americans.

Although low-income individuals face significant chronic stressors that often diminish their motivation or ability to obtain proper mental health treatment, the few large-scale depression treatment trials that have been conducted with low-income women indicate that standard depression treatments (psychotherapy and medication) can be effective if individuals complete a full course of treatment (e.g., Miranda, Chung, et al., 2003). The major focus of this review is therefore on identifying and understanding the barriers that prevent low-income women from fully engaging in psychotherapy treatment, so that they can be reduced. Because (1) low-income adults and those who rely on public assistance are disproportionately represented by women (APA, 2001), (2) the poverty rate of 37% for single women with children is higher than that of any other demographic group in the United States (US Census Bureau, 2007a), (3) depression strikes women at twice the rate it does men (Culbertson, 1997; Kessler, 2001), (4) depression is most common among women of childbearing and childrearing years (Lazear, Pires, Isaacs, Chaulk, & Huang, 2008), and (5) women are typically the primary caregiver for children who are also negatively affected by parental depression (Goodman & Gotlib, 1999), this article reviews psychotherapy treatments for low-income women with depression. We focus our attention on psychotherapeutic interventions and not medication treatment, because many childbearing women are unable or unwilling to take these medications, and because psychotherapy has been identified as the treatment of choice for individuals from a variety of ethnic groups (Miranda, Azocar, Organista, Dwyer, & Areane, 2003).

Low-income women face a myriad of serious and chronic life stressors that may hinder their psychological functioning. Typical challenges include finding food and shelter, working multiple jobs or surviving on public assistance, experiencing above average rates of crime and community violence, serving as the exclusive caregiver for their children, and social isolation (Boyd, Diamond, & Bourjolly, 2006). Physical or sexual abuse is almost a standard experience for low-income women (Miranda & Green, 1999), with lifetime prevalence rates of domestic violence as high as 67% in a study of women receiving welfare benefits (Tolman & Rosen, 2001). These challenges likely contribute to the elevated depression rates in this population, but they also may preclude a woman's ability or motivation to seek, remain in, or benefit from psychotherapy. In the context of a clinical chart review, younger women and those with more severe depression symptoms were less likely to respond to treatment and most likely to drop out (Organista, Muñoz, & González, 1994). Even with treatment, depression is likely to recur in up to 85% of individuals (Mueller et al., 1999), with each successive episode increasing the likelihood and severity of a subsequent depressive episode (Soim et al., 2000). Together, these data suggest that in many cases, individuals most in need of depression treatment are the least likely to seek or benefit from it, and they point to the urgency of improving depression outreach and treatment for low-income women with numerous risk factors. The reduced motivation and increased hopelessness characteristic of chronic depression could make the difficult task of improving one's economic circumstances seem insurmountable.

Beyond depression's direct impact on a woman's psychological functioning, its long-term effects on her children's development can be significant (Goodman, 2007). The effects of maternal depression have been documented beginning in early infancy and include excessive crying, depressed behaviors, and cognitive delays (see Goodman & Tully, 2006 for review). These negative effects are hypothesized to occur through a combination of several mechanisms, which interact with each other to increase risks to a child: “the heritability of depression; innate dysfunctional neuroregulatory mechanisms; exposure to negative maternal cognitions, behaviors and affect; and the stressful context of the children's lives” (Goodman & Gotlib, 1999, p. 458). Infants and very young children of depressed mothers are especially likely to experience impaired parenting (Lovejoy, Graczyk, O'Hare, & Neuman, 2000), perhaps because the mother–child bond was formed only or primarily in the context of a depressive episode. As children age, conduct problems, academic challenges, and a variety of internalizing disorders are common in the offspring of depressed women (Halligan, Murray, Martins, & Cooper, 2007; Lovejoy et al., 2000). Furthermore, once established, deficits in a child's psychosocial functioning do not improve simply because the mother's depression is treated (Forman et al., 2007), highlighting the importance of prevention and early intervention efforts with depressed mothers. However, even for women with chronic, difficult to treat depression who were enrolled in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, statistically significant improvements in both psychopathology symptoms and diagnoses for their children occurred when a mother's depression remitted. However, unless the mother experienced at least a 50% reduction in depressive symptoms, no improvements were found in child outcomes; in fact, psychiatric diagnoses for the children whose mothers did not meet this benchmark increased during the three-month observation period (Weissman et al., 2006).

Obtaining and maintaining employment is the primary method available to those hoping to improve their financial circumstances. However, it is likely that a woman who concurrently faces stressful daily life and is combating depression will be less able to seek additional education or job training opportunities that would allow her to improve her economic circumstances. In an attempt to help
more families achieve this economic self-sufficiency, the US government overhauled its welfare benefits program through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which created the Temporary Assistance for Needy Families (TANF) program. TANF is intended to reduce dependency on government assistance by “promoting job preparation, work, and marriage” (Center on Budget and Policy Priorities [CBPP], 2009). The large majority of welfare recipients now receive a maximum of five total years of public assistance, and beneficiaries lose their benefits if they are not employed after two continuous years of assistance. These welfare reforms bring urgency to improving depression treatment for low-income women. Currently, only 40 percent of families who are eligible for TANF benefits (based on their poverty status) actually receive them, usually because they cannot find or maintain employment (CBPP, 2009). Low-income individuals typically have little education and only qualify for low-wage, low-skill service labor that is highly competitive. Competing with other prospective employees, consistently working up to one’s potential, or simply putting forth the effort required to obtain employment can be quite difficult for someone who is suffering from depressive episodes that impair energy and that increase despair and hopelessness (Lennon, Blome, & English, 2001). Several government-sponsored programs have been created alongside TANF to help ease the transition from welfare to work, but treating the high rates of depression and other mental illness in their participants may be critical to their success. One study evaluating efficacy of an education and job training program for low-income, teenage mothers found that those services were only effective for non-depressed women (Quint, Bos, & Polit, 1997), highlighting the importance of pairing depression treatment with other educational and psychosocial government services when designing programs for women with multiple challenges.

Treating the high rate of chronic, recurrent depression in low-income women will remove one important barrier to improving their economic circumstances. In order to create efficacious psychotherapy interventions for this population, the barriers to engaging and treating depression in low-income women must be identified, understood, and addressed.

1.1. Objectives

The goals of this article are to review the extant literature on psychotherapeutic interventions for low-income women, specifically identifying: (1) the variety and types of adaptations researchers have used to enhance psychotherapy (methodology and treatment protocol) for depressed low-income women, and (2) those adaptations that demonstrate the greatest efficacy for this population, leading to improvements in: (a) engagement, (b) persistence in treatment, and (c) clinical outcomes.

2. Method

2.1. Defining low-income

Each year, the US government sets poverty standards and thresholds that are used to allocate social services and to determine the proportion of citizens living in poverty. However, instead of using these (relatively) arbitrary standards, all literature addressing depression treatment for individuals at or near these federal poverty levels is reviewed in this article.

2.2. Identification of studies

The literature was systematically reviewed in September 2009, using all relevant electronic databases, including PsycINFO, PUBMED, MEDLINE, and CINAHL, to search for research articles published between 1980 and 2009. Searches were completed using combinations of the following key words: SES, poor, low-income, poverty, impoverished, social class, public health clinic, depressed, depression, psychotherapy, therapy, counseling, treatment, and intervention. Articles were selected for inclusion in this review if they were written in English and (1) described intervention or prevention programs for low-income women with a primary diagnosis of major (unipolar) depression or depressive symptoms, or if they were (2) conceptual or theoretical discussions of psychotherapy treatment for low-income women, undertaken with the primary purpose of identifying, elucidating, and/or overcoming barriers to treating depression in this group. This review includes all relevant interventions that use some form of “talk therapy” to reduce a client’s depressive symptoms and improve psychosocial functioning, including traditional individual and group psychotherapy models, as well as individual and group interventions that are psychoeducational in focus (cf. Nathan & Gorman, 2002). After identifying articles that met either inclusion criterion (1) or (2) above, we manually searched the reference sections to identify additional articles relevant to psychotherapy treatment for depressed, low-income women. Journal articles were excluded if they simply discussed the prevalence, causes, correlates, risk or protective factors for depression in this population; made recommendations based solely on archival data; focused primarily on men, minors or elderly individuals; or discussed depression in the context of a major medical disorder (e.g., cancer or HIV). Forty-two peer-reviewed articles met these criteria and are therefore included in the analysis below.

2.3. Analysis

We divided the articles into two categories, Type I (preliminary studies or conceptual papers) and Type II (intervention or outcome studies). Type I studies are explorations of methods for improving psychotherapy for low-income women, including empirically-based focus groups1 or pilot studies2 and articles that simply provide rational suggestions3. Type II studies include eleven intervention studies that reported outcome data.

2.3.1. Step 1

Suggestions for improving psychotherapy for low-income women are summarized based on a review of all of the Type I studies. Following Grote et al. (2007), these suggestions are broken down into practical, psychological, and cultural barriers of concern to researchers and practitioners who work with depressed, low-income women.

2.3.2. Step 2

The Type II studies are outlined and outcomes are described briefly (See Table 1). We assess each intervention to determine specific accommodations it has included to address practical, psychological and cultural barriers to treating depressed, low-income women, and we assign a simple “yes” or “no” ranking that designates whether these accommodations led to adequate (i.e., meaningful) reductions in these three types of barriers. For the studies that provided sufficient information, we calculated average treatment gain effect sizes, Cohen’s d (Cohen, 1987; Thalheimer & Cook, 2002). If multiple outcome measures were reported (e.g., BDI and CES-D scores), we calculated the average effect size of these measures. Additionally, in an attempt to accurately judge the methodological rigor of these

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1 “Empirical” focus groups with several members of the target population, who engage in discussion with researchers to more fully understand a phenomenon, in this case to identify and overcome barriers to treating low-income women with depression.

2 Small scale or pilot studies used to test an intervention’s feasibility and preliminary efficacy; these typically lead to intervention improvements that will be tested more fully in a future clinical trial.

3 Suggestions are not based on empirical data, but are instead generated rationally by individuals with significant research and/or clinical expertise with this population.
studies, we adapted and combined research quality indicators from The Cochrane Collaboration (Higgins & Green, 2009) and The Jadad Scale (Jadad et al., 1996). Those indicators deemed useful for understanding the quality of depression treatment programs for low-income women were assessed for each study (See Table 2). Again, a simple “yes” or “no” ranking system was utilized, with 1 or 0 points awarded, respectively. If an article reported either the average number of sessions subjects attended or the total number of participants who terminated treatment prematurely, reported attrition data were considered adequate. Adequate outcome data were characterized by the presence of sufficient detail to calculate depression symptom effect sizes (i.e., post-treatment standardized mean differences between intervention and control groups). If the published article included no mention of a given quality indicator, it was assumed to be missing from the study design and was therefore awarded 0 points. A simple sum of study quality metrics provides an overall Methodological Rigor Score (MRS) of 0–7 for each study.

3. Results

3.1. Step 1: summary suggestions based on Type I studies

Although the primary aim of each of the reviewed studies was to discover or describe ways to improve psychotherapy for impoverished women, the studies utilize a variety of theoretical approaches, target different symptoms, and focus on different subsets of women (e.g., prenatal or African American women) to gather this information. Analyzed together, these articles converge on a range of adaptations to traditional methods of psychotherapy that have been proposed to enhance clinical outcomes for the entire population of low-income women.

3.1.1. Practical

3.1.1.1. Encouraging attendance. A number of logistical challenges must be addressed to enable low-income women to attend depression treatment. First, psychotherapy should be provided free of charge. Many low-income individuals do not have health insurance or have policies that do not sufficiently cover mental health treatment (Lennon et al., 2001), and they are unlikely to be able to pay for psychotherapy when they cannot even afford basic necessities. To increase the likelihood that women who juggle multiple time commitments and financial constraints will attend therapy sessions, reimbursement for treatment and transportation costs should be considered (Abrams & Curran, 2007; Muñoz & Mendelson, 2005). These women are often the primary or sole caretakers for their children and childcare should therefore also be offered or covered (Miranda & Green, 1999). It may seem untenable to consider providing these costly accommodations at a time when decreasing inflation in healthcare costs is a key domestic priority. However, given the close relationship between depression, poverty, and medical illness, as well as the high societal costs that correspond with each of them (e.g., Simon et al., 2001; Stewart, Ricci, Chee, Hahn, & Morganstein, 2003), finding a way to make these investments to reduce practical barriers to mental healthcare may be prudent.

This population is confronted with a variety of ongoing life stressors, sometimes making a “typical” weekly psychotherapy schedule infeasible (Beeber et al., 2007). Additional suggestions to increase attendance include using reminder calls ahead of appointments, using flexible scheduling and understanding and tolerating the need for missed appointments (Satterfield, 1998), and offering in-home sessions (Beeber et al., 2007; Hauenstein, 1997; Satterfield, 1998) or telephone appointments (Grote, Bledsoe, Swartz, & Frank, 2004a) when needed.

3.1.1.2. Location. Mental health treatment is traditionally not offered in or near low-income neighborhoods, making care-seeking inconvenient. Further, the typical “workday” hours of clinic operation are not conducive to the inflexible work schedules of the service jobs low-income individuals occupy (Beeber et al., 2007; Grote et al., 2004a; Miranda & Green, 1999). Because this population relies heavily on public transportation, which requires a significant time commitment, increasing access to care in the communities where these individuals reside is an important initiative. Offering psychological care in public health clinics, particularly OB/GYN clinics where women are already attending prenatal or other medical appointments, is another possibility. Providing mental health care in collaboration with primary care or in another medical setting increases the likelihood that depression will be diagnosed. It can also lead to improved attendance rates and reduced stigma, both because services can be combined with other medical visits and because mental health treatment was recommended by a trusted medical care provider (Grames, 2006; Grote et al., 2004a; Grote, Bledsoe, Swartz, & Frank, 2004b; Grote et al., 2007; Hauenstein, 1997; Miranda & Green, 1999). Providing mental health care in a woman’s home can reduce practical barriers and lead to increased attendance, and some women may consider it a more acceptable treatment option (Beeber et al., 2007; Hauenstein, 1997; Satterfield, 1998). However, several studies that offered participants a choice of therapy location found that a clinic setting was preferred to in-home care (e.g., D’angelo et al., 2009; McKee et al., 2006). Reasons women refused in-home visits include reduced privacy and anonymity, a desire to get out of the house and socialize, and “concerns about the safety of the therapists...[and] opposition of boyfriends or husbands” (McKee et al., 2006, p. 77). An intervention program must therefore carefully evaluate the treatment preferences of its target population before determining treatment location.

3.1.1.3. Addressing other life stressors. Depression is not the only challenge that low-income women face and simply offering standard psychotherapy treatment to women who have a number of serious life stressors is insufficient. Case management (CM) should be considered to help “optimize client functioning” and maximize the benefits of psychotherapy (National Association of Social Workers, 1992). CM originated in the social work tradition and aims to assess the full scope of a client’s needs in order to provide a package of social services (e.g., access to food, shelter, and employment opportunities) that is more effective than any of these services would be in isolation. By offering therapy as one of several services, a provider demonstrates a more complete understanding of the extent of a client’s challenges, thereby increasing his or her credibility (Grote et al., 2007). When other challenges that exacerbate depression symptoms and experiences are tackled, an individual can focus more fully on improving her psychological functioning, also increasing psychotherapy’s utility (Grote et al., 2007). Ideally, CM also teaches a woman to access resources and advocate for herself in the future when additional similar challenges are likely to arise (Cunningham & Zayas, 2002).

3.1.2. Psychological

3.1.2.1. Importance of psychological care. It appears that low-income women require consistent, constant outreach and an unbalanced provider-client relationship in order to address practical barriers to mental health treatment. In addition, there are a number of psychological challenges that providers must help low-income women overcome. Providers may face significant difficulty convincing low-income individuals that depression treatment is as important as managing the acute stressors in their lives or that it can even be helpful (Jesse, Dolbier, & Blanchard, 2008). Low-income women may be more likely to rely on informal sources of care, such as family, friends or church groups, and only turn to primary care and
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample*</th>
<th>Treatment protocol</th>
<th>Control group</th>
<th>Depression inclusion criteria</th>
<th>Results</th>
<th>Clinical outcomes</th>
<th>Effect size (Depression Sx)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornas-Díaz (1981)</td>
<td>26 PR women living on US mainland and receiving gov’t aid; Mean age: 38</td>
<td>5 weeks group cognitive (CT) or behavioral therapy (BT)</td>
<td>Wait list control (WLC)</td>
<td>Referred for dep. TX by community agencies; BDI assessed at baseline</td>
<td>NA</td>
<td>Reduced depressive symptoms for both groups compared to WLC</td>
<td>Combined CT/BT: 2.17</td>
</tr>
<tr>
<td>Miranda, Chung, et al. 2003; Miranda et al., 2006</td>
<td>267 DC-area women attending gov’t programs for L-I families; 50% Latina, 44% AA, 6% White; Mean age: 29.3</td>
<td>8 weeks CBT, focusing on mood management, pleasant activities and improving interpersonal relationships, or medication or community referral</td>
<td>Community referral (CR)</td>
<td>MDD assessed by CIDI</td>
<td>CBT: 53% attended 4+; 36% attended 6+ sessions; Meds: 75% received 9+ weeks; 45% attended 24+ weeks; Community referral: 83% attended none</td>
<td>More likely to complete meds than CBT (75% vs. 36%); Meds more eff. than CBT up to 12 months; CBT and meds equally effective at 12 mo F-U; Both meds and CBT superior to CR</td>
<td>CBT vs. referral: 1.17</td>
</tr>
<tr>
<td>Miranda, Aroc et al. (2003)</td>
<td>199 L-I patients (67% women) referred to clinic from primary care; Mean age: 49.2; 39% Latino, 37% W/Other; 24% AA</td>
<td>12 weeks CBT: changing thinking, adding pleasant activities and improving interpersonal interaction or CBT + case management (CM)</td>
<td>CBT (w/o CM)</td>
<td>MDD dx, confirmed by SCID</td>
<td>CBT-CM: 76% completed 8+; CBT-only: 57% completed 8+</td>
<td>CBT-only: Reduced dep. sx at 6-mo F-U (Spanish/English speakers); CBT-CM: Reduced dep. sx only for Spanish speakers</td>
<td>Not Available</td>
</tr>
<tr>
<td>Lara, Navarro, Rubin, &amp; Mondragón (2003a,b)</td>
<td>134 L-I women with dep. sx in Mexico City; Mean age: 35.3</td>
<td>6 weeks group psychoed. sessions (GC) or 20 min. explanation &amp; psychoed. materials provided (MIC)</td>
<td>MIC (brief explanation/psychoed. materials)</td>
<td>Self-referral to groups; CES-D used to assess dep. sx; No dx required</td>
<td>NA</td>
<td>TX group felt the program had a stronger influence on life/problems</td>
<td>Not Available</td>
</tr>
<tr>
<td>Zayas, McKee, &amp; Jankowski, 2004; McKee, Zayas, Fletcher, Boyd, &amp; Nam, 2006</td>
<td>187 pregnant L-I minority women with low-risk pregnancies; 57% Latina, 43% AA; Mean age: 25</td>
<td>8 weeks CBT, 4 weeks child development psychoed. modules, biweekly social support building sessions (SSB) or Usual Care</td>
<td>Referral to usual clinic services; Non-depressed control</td>
<td>&gt;14 on BDI; No dx required</td>
<td>TX group attended mean 2.8 of 8 CBT, 0.6 CD of 4, and 1.8 SSB sessions</td>
<td>No significant differences bw TX and control groups for dep. symptoms, social support or mother–infant interaction at 3-mo F-U</td>
<td>TX vs. UC: 0.07</td>
</tr>
<tr>
<td>Peden, Rayens, and Halli (2005)</td>
<td>136 single L-I mothers (children age 2–6) with dep. risk; 52% W, remainder primarily AA; Mean age: 27.2</td>
<td>6 h group CBT: negative thinking as modifiable risk factor for depression</td>
<td>No treatment control</td>
<td>BDI scores &gt; 10 or CES-D &gt; 16; No dx required</td>
<td>44% attended 50% + of sessions; 67% completed 3 in-home interviews (paid $20 each)</td>
<td>TX group had significantly lower dep. symptoms, negative thinking and chronic stressors at 1 and 6 mo. follow-up</td>
<td>TX vs. control: 0.42</td>
</tr>
<tr>
<td>Ammerman et al. (2005)</td>
<td>26 new mothers in a home-based visitation program for at-risk families; Mean age 22.5; 46% AA, 46% W, 7% Latina/Asian-American</td>
<td>15 weeks in-home CBT delivered by a licensed MSW</td>
<td>None</td>
<td>BDI &gt; 20; PRIME-MD used to dx MDD</td>
<td>100% attended 8+ visits; 77% attended all 15</td>
<td>Significant reduction in dep. sx (69% in full remission; add’l 15% partial remission); Improvements in functioning at home, work, in relationships and views on motherhood</td>
<td>Not Available (No control)</td>
</tr>
<tr>
<td>Rojas et al. (2007)</td>
<td>230 depressed mothers attending postnatal clinics in Santiago, Chile</td>
<td>8-weeks psychoed. group, medication as needed, systematic monitoring, better training for providers or usual care (need to take own initiative to access services)</td>
<td>Usual care</td>
<td>EPDS &gt; 10; MINI used to confirm PPD dx</td>
<td>TX group attended 2.7 of 8 sessions</td>
<td>TX group had greater EPDS reduction, increase in secondary fx, and percentage taking antidepressants at 3 and 6 mo. F-U</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

Table 1
Psychotherapeutic intervention trials for depressed, low-income women.
successfully to specialty mental health care when these other resources are exhausted (Lazear et al., 2008).

Using an engagement or psychoeducation session to teach women about the causes and effects of depression can help her overcome a number of psychological challenges before treatment begins (Abrams & Curran, 2007; Boyd et al., 2006; Grote et al., 2004a,b; Miranda & Green, 1999; Satterfield, 1998). The overarching goal of an engagement session is to help a woman acknowledge depression’s prevalence, causes, effects, and her treatment options. It also provides an opportunity for the therapist to more fully understand each client’s individual experience with depression, and can serve multiple purposes, including information (provision and gathering), empowerment and commitment. Because unrealistic or unmet client expectations are so closely associated with attrition and negative treatment outcomes (Reis & Brown, 1999), the engagement session should allow for an open discussion between the therapist and the client about the therapy process, potential barriers to achieving improvements, the difficult “work” therapy requires, and the type and timing of change that a client can realistically expect. Finally, once a woman makes a decision to enter therapy, providing ongoing encouragement is necessary in order to keep her engaged and reminded that treatment is important, relevant and can be effective (Beeber et al., 2007; Boyd et al., 2006).

Because rates of premature termination of psychotherapy are quite high and are correlated with negative psychological outcomes (Ogrodniczuk, Joyce, & Piper, 2005), several attempts at isolating demographic variables (e.g., gender, age, and ethnicity) that indicate positive treatment prognosis (in the form of both retention in therapy and general treatment success) have been made. While most of these variables do not reliably predict treatment adherence or outcomes, low socioeconomic status and ethnic minority status are the primary demographic variables that have consistently been associated with premature termination of therapy (e.g., Reis & Brown, 1999). Additionally, the chaotic life circumstances of many low-income women lead to their endorsement of a number of psychological characteristics that also have been associated with risk of treatment drop-out; these include social isolation, low motivation, and low psychological mindedness (Walitzer, Dermer, & Connors, 1999). It therefore appears that impoverished women embody many of the personal and demographic characteristics that have historically been associated with difficulties remaining in psychotherapy treatment.

Several recent review articles present strategies for reducing early termination of psychotherapy services, which may be beneficial for these women. As we have discussed, pre-therapy training or engagement appears critical, especially for clients who are not highly motivated for treatment. Working to increase a client’s treatment motivation, perhaps by addressing ambivalence, is likely to lead to increased retention and greater clinical improvements (Ogrodniczuk et al., 2005; Walitzer et al., 1999).
<table>
<thead>
<tr>
<th>Study</th>
<th>Additions and adaptations to standard care</th>
<th>Critical Features &amp; Major Contributions to Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comas-Díaz (1981)</td>
<td>None</td>
<td>L-I PR women can be engaged into group psychotherapy</td>
</tr>
<tr>
<td>Miranda et al. (2006)</td>
<td>Transportation and childcare; Extensive outreach; Flexible, convenient location and scheduling; TX shortened to 8 wks</td>
<td>Better adherence to meds than therapy but both TX effective for L-I women; therapy and meds—equal over time; community referral not effective for L-I women</td>
</tr>
<tr>
<td>Miranda, Chung, et al. (2003, 2006)</td>
<td>Up to 4 educational meetings; Examples rel. to young women and history of trauma; Goal: improve relationships; Oral administration (many w/ little education)</td>
<td>CM is beneficial for some L-I women; Latina women may use/benefit from addition of CM</td>
</tr>
<tr>
<td>Lara et al. (2003)</td>
<td>TX at community mental health center</td>
<td>Community sample with self-reporting women; MIC lacked TX fidelity; shows L-I women value opp. to speak with clinician, which could be as efficacious as poorly attended group psychotherapy</td>
</tr>
<tr>
<td>Zayas et al. (2004)</td>
<td>TX location choice: CMHC or in-home; Used established prenatal care clinic</td>
<td>Lack of TX fidelity: using CMHC for research is difficult and need to assess true capabilities of institutions: stability in research team is critical to working with L-I pops.</td>
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<td>Peden et al. (2005)</td>
<td>Two format options: 4 x 90 or 6 x 60 min; Reminder calls (night before and day of); Meals (mothers and children); Childcare</td>
<td>Group sessions (normalize and reduce isolation); CBT focus provides specific methodology for reducing sx; Daily thought-stopping HW</td>
<td>None</td>
<td>Pmt. for interviews affects survey completion but does not nec. improve tx adherence; specific aspects of CBT (e.g., reducing neg. thinking) may be especially useful for this population</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<td>(Y) In-home sessions supported by and in conjunction with trusted home visitor program</td>
<td>(Y) Established/trusted home visitor attends first session; “Ladder of Success”—visual depiction of goals and progress; Therapy summary and planning for the future; 1-mo. F-U booster session</td>
<td>(N) Activities developed specifically for low-income young mothers</td>
<td>23% of women on meds; childhood sexual assault survivors had greater improvements in attitudes toward motherhood; control group and methodological rigor critical: results are strong but cannot be attributed directly to TX</td>
<td>N</td>
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<td>Ammerman et al. (2005)</td>
<td>Services in postnatal clinic mother was attending; Childcare</td>
<td>(Y) Psychoed. groups; Reciprocal reinforcement of intervention components</td>
<td>(N) All Chilean patients and providers</td>
<td>Before enrollment, reassessment of EPDS for spontaneous sx reduction; even though free meds provided for both TX and control, more in TX group took meds; aspects of psychotherapy, meds, and CM likely have interaction effect</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Rojas et al. (2007)</td>
<td>TX offered in already accessed community setting</td>
<td>(Y) Designed based on needs/experiences of L-I women</td>
<td>(N) Culturally relevant TX; All Spanish speakers TX separately and in Spanish; Experienced permanent clinic staff</td>
<td>Naturalistic TX center; clients seeking dep. tx; included women with co-morbid conditions; 98% also treated with psychotropic meds, potentially confounding results; women self-seeking depression TX may be qualitatively different than those who are referred</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<td>Perez Foster (2007)</td>
<td>In-home individual maintenance sessions</td>
<td>(Y) Simple language; Combined group and ind. modality; HW used to enhance gains; “Booster” session</td>
<td>(Y) Only AA participants; Built on “Strong Black Woman” framework</td>
<td>L-I women will overcome significant practical barriers to attend TX they are invested in</td>
<td>Y</td>
<td>Y</td>
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<td>Grote et al. (2009)</td>
<td>(N) Engagement session: brainstorm and solve tx barriers immediately upon enrollment; Transportation and childcare; Brief (8-session) model; Care at prenatal clinic (already attending); Case management; Phone sessions, as needed; Intensive outreach</td>
<td>(Y) Psychoeducation about dx (reduce stigma/blame/hopelessness); Behavioral activation tasks; Maintenance IPT sessions; “Stressed” (not “depressed”)</td>
<td>(Y) Ethnographic interview (unbiased curiosity); Culturally sensitive/experienced providers; Culturally-relevant content/illustrations</td>
<td>Y</td>
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Imm. engagement session to identify and address barriers v. effective; L-I women with comorbid anxiety responded equally to TX; even enhanced usual care not sufficient to engage L-I women in TX

Note: Y = Yes, N = No; assesses adequacy of adaptations for practical, psychological, or cultural needs of low-income women or methodological rigor of intervention.

CBT = Cognitive Behavioral Therapy; Sx = symptom; F-U = Follow-up; TX = treatment; Dx = Diagnosis; AA = African American; W = White; L-I = Low-income; PR = Puerto Rican; CM = case management.
addition, shorter-term treatments, reminders, case management, building a strong therapeutic alliance, client participation in treatment decisions, and the facilitation of affect expression (i.e., providing an opportunity to express and explore both positive and negative affect) appear to be highly related to retention in treatment (Ogrodniczuk et al., 2005).

3.1.2.2. Empowerment. Low-income women face significant, chronic life stressors and have little influence over many of their life circumstances, making it prudent for clinicians to empower these women however possible through the psychotherapy process. A recent review of depression treatment for ethnic minority women (most of whom are impoverished) suggests that allowing these women to participate in the treatment decision-making process may lead to better adherence and improved clinical outcomes (Ward, 2007). There is evidence that even when low-income individuals are not seeking or receiving psychological treatment, they have often constructed meaningful narratives of their psychological symptoms (e.g., biosocial, psychosocial, psychological, situational, or somatic; Karasz, Sacajiu, & Garcia, 2003). A patient's conceptual model, based on her understanding of the causes or correlates of her symptoms, determines whether or not she is receptive to various treatment options. Across patients, enormous differences can exist in the acceptability of medication and psychotherapy treatments (Karasz et al., 2003; Ward, 2007), highlighting the importance of assessing and integrating a patient’s attitudes toward her illness into her psychological treatment model. Furthermore, low-income women represent diverse ethnic minority groups and researchers have suggested that the acceptability of various forms of psychological treatment varies across these ethnic minority groups (Cooper et al., 2003). Because patient motivation and commitment to psychotherapy are critical components of its success (Walitzer et al., 1999), assessing patient treatment preferences may increase her investment in the process, and by empowering her, may be directly curative.

3.1.2.3. Addressing stigma. Even if a woman recognizes and accepts that she needs help for her depression, she may have a negative attitude toward mental health care (Miranda & Green, 1999). These attitudes are often perpetuated by family and ethnic group norms that not only increase the level of shame associated with seeking mental health care, but also prevent a woman from obtaining needed social support (on these issues) from those individuals she trusts most (Lazear et al., 2008).

Providers should directly confront common misplaced beliefs that depression is under one's personal control or that seeking treatment indicates weakness or craziness (Miranda & Green, 1999); psychoeducation can be a useful means of accomplishing this goal (e.g., Grote et al., 2004a,b). Additional suggestions to reduce stigma include providing mental health care as one of several services or linking it to better outcomes for children (Beeber et al., 2007). Because shame is ongoing in the lives of many low-income individuals, efforts should be made to normalize the experience of depression (Abrams & Curran, 2007; Grote et al., 2004a; Jesse et al., 2008). Referring to depression symptoms not as "depression", but in each woman's own words (e.g., stressed, blue, sad, and down), may make her more comfortable discussing her experiences or accepting help (Lazear et al., 2008). Because of the greater stigma low-income and minority women place on seeking mental health services, it appears that an increased focus on engaging these women in treatment is indicated (Sue & Sue, 2003; Ward, 2007).

3.1.2.4. Facilitating trust. Many low-income individuals have a general mistrust of "the system" and are accustomed to a lack of responsiveness by medical professionals and other authority figures (Abrams & Curran, 2007; Grote et al., 2004a; Sue & Sue, 2003). Women are particularly wary of showing any sign of "weakness" to social service providers who may have the ability to take custody of their children or impose other restrictions on families (Grote et al., 2007). Additionally, these women have often accumulated many negative experiences with authority figures who are perceived to be disrespectful, not empathic, or simply unable to help (Abrams, Dornig, & Curran, 2009). These counter-therapeutic beliefs need to be discussed and addressed directly (Satterfield, 1998). D’ Angelo et al. (2009) suggest the importance of "transparency of intention," an open conversation between the therapist and the client, that outlines treatment goals and expectations and defines the therapist’s role in the psychotherapy process.

3.1.2.5. Trauma and isolation. Treatment should acknowledge the consistent, traumatic nature of existence for low-income women, including the stress of daily living, as well as the high rates of sexual, interpersonal and community violence typical in this population (Grote et al., 2004a; Miranda & Green, 1999). The "work of therapy" can be difficult for many people, but past trauma may serve as an added barrier to seeking or remaining in treatment if women do not want to be reminded of the painful details of past experiences (Beeber et al., 2007; Miranda & Green, 1999). A woman’s depression may be compounded by the social isolation common among low-income individuals. A specific focus on increasing social networks and adding pleasant social interaction can be helpful and is also why a group modality is often recommended for this population (e.g., Beeber et al., 2007; Boyd et al., 2006; Cunningham & Zayas, 2002; Satterfield, 1998). Additionally, providers should understand that existing social networks are not always entirely positive; they can also cause stress, as they are typically made up of individuals with similarly challenging life histories and daily stressors (Grote et al., 2004a).

3.1.2.6. Managing reality. Although hopelessness and helplessness are hallmarks of depression, these feelings may be legitimate for those who have struggled through a lifetime of poverty and who have little chance of economic mobility (Satterfield, 1998). A study with data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program suggests the importance of actively and openly discussing clients’ concerns about economic stress. Statistically significant clinical improvements were seen in depressed clients whose therapists discussed economic stress during the first two therapy sessions; a stronger therapeutic bond was likely formed by therapists who demonstrated an understanding of the full range of her client's challenges, ultimately leading to greater treatment gains (Falconnier & Elkin, 2008). Another suggestion for approaching mental health care in this population is to use a “healthy management of reality” framework, helping a client understand that her daily challenges are real and difficult, but that she can improve her well-being by learning to control her emotional and behavioral reactions (Muñoz & Mendelson, 2005). Because low-income women are likely to face continuing stressors after therapy ends, teaching them self-care and self-advocacy skills is especially important (Cunningham & Zayas, 2002; Hauenstein, 1997). Check-up appointments or maintenance treatment provides a chance for women to practice new self-care skills under provider supervision and can help reduce the likelihood of a relapse (e.g., Beeber et al., 2007; Grote et al., 2004a; Hauenstein, 1997).

3.1.3. Cultural

3.1.3.1. Provider insensitivity. Low-income women are represented by diverse ethnic and racial groups and the poverty rates for these minority groups are significantly higher than those for Caucasians (Kaiser Family Foundation / statehealthfacts.org, 2008). However, these individuals are quite often treated by Caucasian health care workers who can be insensitive to the cultural manifestations of mental illness (Grames, 2006; Grote et al., 2004a; Sue & Sue, 2003). Regardless of a clinician’s own background, effective treatment of ethnically diverse low-income women requires the development of understanding and appreciation of
these diverse worldviews, including learning about the ways in which cultural differences both contribute to and help a woman overcome her mental health challenges. An ethnographic interview, which encompasses a woman’s perceptions of depression, life stressors, barriers to care, and attitudes toward and goals for mental health treatment, can be a useful means of beginning to understand a woman’s sociocultural experience (Grote et al., 2004a,b).

There is some indication that a match between the race or ethnicity of the therapist and client can lead to increased client engagement, disclosure, and continuity in treatment, but the literature on this point remains equivocal. A recent meta-analysis found no differences in client improvement in psychotherapy for individuals with or without an ethnically matched therapist (d = −0.04–0.03; Maramba & Hall, 2002). Alternatively, one large multi-ethnic study exploring this issue found that ethnic matching is an important treatment factor for some clients, but that its utility varies greatly based on a client’s ethnic group, level of ethnic-cultural identity, and acculturation level (Sue, 1998). Importantly, it has been indicated that when working with ethnically and racially diverse clients, cultural awareness and sensitivity are critical, and that cognitive matching (i.e., congruence between how the therapist and the client understand problems and treatment goals) is likely to be more highly associated with treatment adherence and clinical improvement than simple ethnic matching (Reis & Brown, 1999; Sue, 1998). In summary, a therapist’s level of skill and expertise with the treatment population, which does not necessarily come by virtue of similar skin color, appears to be the factor most directly related to positive outcomes (Ward, 2007).

3.1.3.2. Enhancing treatment by incorporating cultural or religious elements. Providers must honor the wide range of cultural and religious beliefs of their clients and can use them to encourage recovery (Abrams & Curran, 2007; Cunningham & Zayas, 2002). Incorporating spirituality or “finding greater life purpose” non-denominationally can be an effective means of empowering women during depression treatment (Muñoz & Mendelson, 2005) and may actually be critical to working with these women. Religious or traditional healers are frequently consulted in diverse ethnic groups and incorporating these beliefs into treatment can demonstrate the therapist’s understanding of cultural beliefs and may serve to amplify the effects of traditional psychotherapy. Guiding minority women to seek a greater understanding of and to feel pride in their culture, as well as allowing them the opportunity to identify with others who have had similar life experiences, may help improve their psychosocial functioning (Jones, 2008). Open discussion regarding minority patients’ encounters with racism, prejudice and discrimination and immigrants’ challenges during the acculturation process is important, as each of these likely contributes to the experience of depression (D’angelo et al., 2009; Muñoz & Mendelson, 2005).

3.1.3.3. Group therapy. Group therapy may be a more effective modality for low-income women, and also may be more cost-effective than individual sessions. Group psychotherapy provides social support, normalization of depressive experiences, and an opportunity for both the leader and other participants to model effective communication and coping strategies (e.g., Boyd et al., 2006; Jones, 2008; Satterfield, 1998). Group therapy can also be used to teach assertiveness and negotiation skills, which can positively impact a woman’s depressive symptoms, self-esteem, and specific life outcomes that require these skills (Jones, 2008).

The literature on group psychotherapy highlights the importance of regular client attendance to the formation of group trust and openness and clinical improvements for the individuals involved in the group process (Yalom & Leszcz, 2005). Because acute and chronic life stressors often interfere with the ability of low-income women to consistently attend therapy sessions, it is critical that group therapy facilitators discuss the importance of regular attendance before treatment initiation. Despite the challenges inherent in maintaining regular attendance with a group of women who each have relatively chaotic lives, several small studies with low-income women show the promise of group therapy. In one, ten of twelve Black women chose group therapy (with all Black women) over a multiethnic CBT group or individual therapy (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002). A strong group alliance, like the therapeutic alliance built in individual therapy, leads to increased retention rates for individual members (Yalom & Leszcz, 2005).

3.1.3.4. Multilingual and multicultural treatment. Demographics in the United States are changing. A large and growing proportion of the US population speaks a language other than English as its primary language (US Census Bureau, 2007b) and mental health treatment must be provided in these native languages for it to be most effective: a recent meta-analysis found that psychotherapy was twice as effective for minority clients when it was provided in their native language (Griner & Smith, 2006). Bilingual and bicultural practitioners can ensure proper communication between a patient and her provider, and can increase the likelihood that treatment will be tailored to a client’s unique cultural needs. Utilizing minority providers to help create and deliver psychoeducation materials and examples, and tailoring these to education and income level in addition to gender, racial and ethnic themes are effective means of increasing the cultural relevancy of psychotherapy (Muñoz & Mendelson, 2005).

Cultural competency must be an integral component of care for low-income women, who represent a variety of cultures and worldviews. Actively exploring, expressing interest in, and accepting the implications of cultural differences on a woman’s experience of depression and options for recovery will increase therapeutic benefits. Providers are also reminded that within a given ethnic group, life experiences vary significantly. Each client’s unique characteristics and circumstances must be considered independently, using a broad understanding of specific cultural groups as a base from which to explore each individual’s experiences.

3.2. Step 2: Type II studies

Since 1980, eleven clinical trials of psychotherapy interventions for low-income women with depression have been published, with a total of 1385 participants. Each trial tailored traditional psychotherapeutic interventions to better meet the practical, psychological and cultural needs of low-income women. We provide an assessment of the degree to which the interventions meaningfully reduced these barriers and then discuss the relationship between these accommodations and engagement and clinical improvements. Tables 1 and 2 contain details regarding these clinical trials.

3.2.1. Practical

The degree to which the various interventions helped women overcome practical treatment barriers appears to be directly related to treatment engagement and retention. Although psychotherapy adherence rates varied dramatically across studies, the intervention programs that had consistently high engagement and retention rates made substantial efforts to ease engagement in the psychotherapy process. For example, offering psychotherapy sessions in the woman’s home in conjunction with an established home visitation program was associated with a high participation rate; all 26 enrolled women completed eight or more psychotherapy sessions and 77% (20 of 26) attended all 15 offered appointments (Ammerman et al., 2005). In a study assessing the impact of adding case management services to standard CBT, attendance was significantly higher in the case management group (76% completed 8+ sessions) than in the CBT-only group; the case management services likely contributed to better management of both general psychosocial stressors and those acute stressors that might otherwise interfere with treatment attendance or commitment (Miranda, Azocar, et al., 2003). In another study
assessing psychotherapy for perinatal depression, treatment was offered at the prenatal health clinic, childcare, transportation and ongoing case management were provided, phone sessions were offered when it was too difficult for a mother to attend an in-person appointment, and intensive outreach was used to keep the participants engaged: 96% of these women attended both an engagement session and an initial therapy session (vs. 36% of the control group), 68% attended 7 or more therapy sessions, and 68% attended an average of 6 additional maintenance sessions (Grote et al., 2009). Perhaps critically, the engagement session in this study was provided in-person immediately upon preliminary enrollment into the study: an interviewer worked with each client to brainstorm potential treatment barriers and then they immediately collaborated to devise methods to overcome them.

Engagement rates in these studies are in sharp contrast to other studies that did not focus so critically on reducing practical treatment barriers. In a Randomized Controlled Trial (RCT) comparing medication, psychotherapy and community referral, 83% of the women randomly assigned to the community referral condition did not make or attend a single therapy session (Miranda, Chung, et al., 2003). Disappointing results were even apparent in several other studies that did attempt to ease practical barriers (e.g., McKee et al., 2006; Peden et al. 2005). Furthermore, an “enhanced usual care” control group was used in another study to more directly test whether the provision of accessible mental health care services is sufficient to encourage low-income women to attend psychotherapy appointments. Although substantial attempts to reduce practical treatment barriers were provided to this control group (including educational materials, treatment referral, strong encouragement to obtain psychological care, bus passes to and childcare during appointments, frequent phone monitoring to encourage attendance and to “check in” on the woman’s status, and therapist collaboration with a woman’s existing social worker), only 7% attended a full treatment course of 7–8 sessions (Grote et al., 2009). Together, these data suggest that although providing easy access to mental health care is critical, simple reduction of practical barriers is not sufficient to engage low-income women in psychotherapy treatment.

3.2.2. Psychological

A variety of methods was employed to help low-income women overcome psychological barriers, serving to increase their perception of psychotherapy as salient, relevant, and helpful. Psychoeducation or engagement sessions and extensive outreach were used frequently and appear to be integral to successfully engaging low-income women in treatment. In an RCT comparing medication, psychotherapy, and community referral conditions, women were offered up to four educational meetings that were designed to inform them about depression and treatment, address potential concerns, and increase motivation: 67% and 96% of women in the psychotherapy and medication conditions attended an average of 2.37 and 1.89 education sessions, respectively, before electing to initiate treatment (Miranda, Chung, et al., 2003). These women were also contacted an average of 10.2 (psychotherapy) and 8.8 (medication) times before they agreed to attend an initial clinical appointment. Largely because of these efforts, treatment engagement and clinical outcomes were quite robust for both of the treatment arms in this intervention, and the authors state that “outreach was an essential part of this study” (Miranda, Chung, et al., 2003, p. 62). Engagement rates and clinical outcomes were exceptionally high in another study that provided the engagement session immediately following enrollment into the study; this session served to both address practical barriers and provide psychoeducation that was specifically designed to reduce stigma, blame and hopelessness (Grote et al., 2009). In the study of CBT in conjunction with a home visitation program, the trusted home visitor was present at the first therapy session to ease the client’s initiation of psychotherapy, and 77% of those women completed 15 psychotherapy sessions (Ammerman et al., 2005). Several other studies also used elements of psychoeducation with less conclusive results (Lara et al., 2003a,b; Rojas et al., 2007; Zayas et al., 2004). The most poignant difference between these studies is that in the first set, psychoeducation was embedded within a larger engagement framework that was designed to increase the perceived relevancy of psychological treatment, whereas in the latter studies, the educational information was simply presented to the clients. It therefore appears that psychoeducation alone is not enough to encourage most low-income women to become involved in depression treatment.

3.2.3. Cultural

Cultural adaptations to psychotherapy treatment were sometimes less obvious than their corresponding practical or psychological accommodations, but they nevertheless appear critical to effectively engaging and treating low-income women. For example, poor retention and clinical outcomes were generally characteristic of studies that did not adequately address the cultural needs and differences of the intervention’s participants (Peden et al., 2005; Zayas et al., 2004). Alternatively, impoverished participants from a small rural community without public transportation nevertheless had high retention and almost perfect attendance rates even though the intervention did not address practical treatment barriers in any way (Crockett et al., 2008). Necessity of cultural competence is demonstrated by the fact that these women chose to overcome significant practical barriers in order to attend a group therapy program that was deemed culturally and psychologically relevant to their lives; subjects even requested longer, more frequent therapy sessions (Crockett et al., 2008).

In addition to these overt treatment adaptations, significant efforts were made to infuse cultural competency throughout the interventions reviewed here, typically through a combination of ethnic minority involvement in treatment design, study recruitment, and service provision. Although quantifying these effects is difficult, their cumulative effects led to more culturally-appropriate and acceptable content, modalities and protocols, that seem to have encouraged high participation rates from individuals from a variety of ethnic minority groups. Evidence also suggests that the interventions that were well-integrated into community settings, which typically are familiar with the cultural needs, strengths and challenges of its center’s population, were more effective in engaging participants: several interventions built on the existing infrastructure of social service programs or community health centers and seamlessly integrated their services into the community, yielding high engagement and retention rates (Ammerman et al., 2005; Grote et al., 2009; Miranda, Azocar, et al., 2003; Perez Foster, 2007). Alternatively, studies that had difficulty assimilating recruitment and psychotherapy services into community settings typically had poor outcomes (e.g., Zayas et al., 2004). These latter studies nevertheless serve as important guides for improving the provision of culturally appropriate treatment for low-income women; namely, that conducting a thorough assessment of the needs and capabilities of the potential study population, community, and the treatment center itself is critical.

3.2.4. Analysis of outcomes

Studies reviewed in this article employed a wide range of methodologies and depression inclusion and outcome criteria, making it quite difficult to compare them. In addition, a number of reports did not adequately document the intervention’s impact on engagement, attrition, or improvements in clinical functioning, which limit their contribution to the development of more effective interventions for this population. Given these limitations, we were able to calculate effect sizes for only five of the eleven Type II studies. The effect sizes characterizing depression treatment for low-income women are quite variable, ranging from $d = 0.07$ to $d = 2.17$. Variability across the five treatments was observed not only in...
methodological differences or subjects’ adherence to treatment, but also in the control groups, which ranged from wait-list controls to treatment referral to the “enhanced usual care” control described earlier. The wide range of effect sizes observed is therefore not surprising, but by reviewing the effect sizes reported in other intervention studies, these results can be better contextualized. Meta-analyses for a variety of psychotherapy modalities report moderate to large ($d = 0.40–0.82$) treatment to no-treatment control effect sizes (e.g., Bell & D’Zurilla, 2009; Driessen et al., 2010; Mazzucchelli, Kane, & Rees, 2009) and a recent meta-analysis of FDA-approved antidepressant pharmacotherapy treatments found $d = 0.31$ (Shedler, 2010; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). These meta-analyses combine data from many subjects across multiple intervention trials, thereby reducing effect size variability and arriving at the best estimate of a true effect size; the small number of studies on depression treatment for low-income women limits our ability to similarly synthesize data. We provide effect sizes from these large meta-analyses as a point of reference; however, the nature of these studies is quite distinct from the depression treatments for low-income women reviewed here and care should therefore be taken when comparing these results.

In recent years, psychotherapy researchers have debated the relative importance of efficacy versus effectiveness studies. Efficacy studies are highly controlled assessments of a specific intervention under optimal conditions, whereas effectiveness studies are less methodologically rigorous, but place more emphasis on the potential effects of an intervention under more naturalistic circumstances (Nathan, Stuart, & Dolan, 2000). The meta-analyses reported above typically represent efficacy studies of “gold standard” empirically-validated treatments, with large sample sizes, stringent exclusionary criteria, researchers experienced in implementing large-scale studies, and clinicians experienced in the provision of manualized treatments. Alternatively, the interventions we reviewed for depressed, low-income women measured the effectiveness of interventions that can actually be implemented with low-income women in community settings. In our review, study design and implementation were challenges that clearly affected outcomes, and depression was often complicated by co-morbid conditions and life stressors; however, this is the reality of life for low-income women, and if depression treatment is to be useful for them, treatment models must account for these variables and cannot simply exclude difficult cases or participants who cannot readily adhere to treatment. The studies represented above, therefore, sacrificed internal validity (i.e., methodological rigor) in order to ascertain the true effectiveness of depression interventions with stressed, impoverished women.

4. Discussion

Research devoted to depression treatment for low-income women has increased dramatically in recent years. This is the first review that summarizes the state of the literature on psychotherapy treatment for low-income women with depression, and it provides both a guide for understanding extant research and a basis for identifying treatments and adaptations that show the most promise for low-income women. This review indicates that adapting standard psychotherapy methods for low-income women can increase their engagement in treatment, reduce depressive symptoms, and improve psychosocial functioning. However, it also refutes the notion that simply providing free, accessible depression treatment will ensure that low-income women will consistently take advantage of it. Despite some significant success engaging depressed low-income women in a variety of forms and modalities of psychotherapy, much work remains to make a meaningful reduction in depression rates and its negative psychosocial sequelae for these women. This conclusion is challenging because low-income women are twice as likely to be depressed as the general population, and both the APA and the Surgeon General have declared improving mental health treatment for ethnic minority and low-income groups to be a priority (APA, 2001; Department of Health & Human Services, 2001).

The overarching message of our analysis is that empirically-validated psychotherapy interventions can be effective for low-income women with numerous life stressors. However, overwhelming evidence indicates that a combination of practical, psychological, and cultural barriers must be removed or reduced in order to engage these women in psychotherapy treatment. Furthermore, while each of these accommodations is necessary, none of them is sufficient: the interventions that were most effective in engaging and treating this population simultaneously met the multiple, diverse needs of low-income women. Isolating the “active” ingredients of treatment that lead to strong engagement and outcomes is difficult because of heterogeneous study design and overall lack of methodological rigor. However, the large majority of the interventions attempted to reduce treatment barriers in at least two areas (See Table 2), and the most effective studies overall made significant, sustained efforts to simultaneously reduce the negative effects practical, psychological, and cultural barriers have on low-income women who seek mental healthcare (i.e., Grote et al., 2009; Miranda, Chung, et al., 2003). This demonstrates that as the literature base on psychotherapy treatment for low-income women grows, researchers are in fact gaining and implementing knowledge about the unique challenges of treating this population.

Mixed results observed in these studies illustrate the importance of truly engaging low-income women in their psychological treatment. Across a variety of treatment protocols, modalities, and ethnic

<table>
<thead>
<tr>
<th>Data required</th>
<th>Research question</th>
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<tr>
<td>How, when, and where were women approached to solicit their participation?</td>
<td>Which methods lead to better engagement?</td>
</tr>
<tr>
<td>Were women seeking depression treatment at study entrance?</td>
<td>Are there differences in depression severity, retention rates, or symptom improvements in women who are and are not seeking treatment?</td>
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<td>Compensation: were women paid? If so, how much? When were payments distributed, for attending appointments or filling out follow-up data forms?</td>
<td>How does compensation affect retention? Are there differences in clinical improvements between those who are intrinsically and extrinsically motivated?</td>
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<td>Any and all other accommodations researchers made to encourage appointment attendance (e.g., transportation, childcare, meals). Engagement and retention rates (percentage of women who would not enroll and those who dropped out of treatment, before attending a single appointment and after beginning therapy). Average number of appointments attended, frequency of rescheduled and cancelled appointments. Amount of time and effort researchers spent encouraging attendance and treatment adherence (e.g., phone calls, letters, cooperation with medical professional/social worker, psychoeducation sessions) Quantifiable treatment outcomes, including pre- and post-test means, standard deviations, and resulting effect sizes for both treatment and control conditions; percentage of women no longer depressed upon treatment termination</td>
<td>Which logistical accommodations are necessary?</td>
</tr>
<tr>
<td>What are realistic financial and human resource requirements to engage women in treatment?</td>
<td>How clinically meaningful is the intervention?</td>
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groups, high treatment engagement was consistently associated with clinician attempts to assess, acknowledge, and accommodate the unique treatment needs of study participants. Furthermore, high engagement and retention rates were nearly always associated with strong clinical improvements, demonstrating the necessity of truly engaging low-income women in their psychotherapy treatment. Effective engagement may best be accomplished by taking the time to explore and overcome treatment ambivalence, ideally by combining psychoeducation, demonstration of empathy and support, and cultural assessment through an ethnographic interview (Grote et al., 2009). Instead of asserting that a specific type of psychotherapy, or depression treatment at all, is ideal for a given patient, engaging women in a serious discussion about their symptoms, understanding of them, and desire for treatment appears imperative. While some low-income women claimed to be “stressed, not depressed” and therefore did not need depression treatment (Zayas et al., 2004, p. 506), extremely disadvantaged Black women in another study voluntarily overcame substantial obstacles to regularly attend treatment, and they even demanded longer, more frequent sessions (Crockett et al., 2008). This seemingly contradictory evidence demonstrates the clinical necessity and utility of assessing treatment preferences, both within and across ethnic groups.

Although the focus of this review is on psychotherapy, an assessment of treatment options would not be complete without considering antidepressant medication, which is often the first line of treatment, especially in general medicine (Lennon et al., 2001). Given our knowledge of the hectic lives and substantial barriers that prevent many low-income women from consistently engaging in psychotherapy, medication may be a viable treatment option. Despite claims that psychotherapy is the treatment of choice for a variety of ethnic groups and young women in particular (Miranda, Azocar, et al., 2003), low-income women demonstrated significantly greater adherence to medication than to psychotherapy (Miranda, Chung, et al., 2003). Furthermore, limited evidence indicates that in addition to pharmacological effects that can directly reduce depressive symptoms, medication may increase a woman’s ability to engage in (and therefore benefit from) other aspects of treatment, such as psychotherapy, case management, or psychoeducation (Perez Foster, 2007; Rojas et al., 2007). However, despite the possibility that low-income women can most easily adhere to a full course of medication treatment, further exploration of its utility as the treatment of choice may be warranted. A recently published meta-analysis found that antidepressant medications are only more effective than placebo for very severe episodes of depression, cautioning against relying too heavily on pharmacotherapy (Fournier et al., 2010). Moreover, because the likelihood of a future depressive episode increases with each successive episode, investigating and implementing depression treatments with lasting effects becomes increasingly important. Whereas the literature base and several of the studies we reviewed concur that treatment gains can attenuate when antidepressant medication is terminated (e.g., Rojas et al., 2007), the effects of psychotherapy may actually increase over time, even for women who attend relatively few appointments (Grote et al., 2009; Miranda, Chung, et al., 2003). Because the core objective of many psychotherapy treatments is to improve a client’s ability to adapt to challenging life circumstances by permanently changing her attitudes, behaviors, or cognitions, psychotherapy may be the preferred treatment for low-income women, despite significant difficulties in implementing it (DeRubeis et al., 2005).

We identified offering treatment in community locations as a method to reduce practical barriers to treatment, and we propose that more fully integrating research for low-income women into the settings where they are most likely to encounter and utilize it is necessary. In this way, an evaluation of treatment utility will be based on a realistic assessment of a community center’s ability to implement and sustain it. Community-based clinics often have extensive experience working with low-income populations and are likely to clearly understand the specific needs and resources of its clients. We found that an intervention that was fully embedded within existing social service or community health systems was highly related to both researchers’ ability to collect data and positive clinical outcomes for research subjects.

4.1. Recommendations

4.1.1. Reporting empirical data

Because clinicians face significant difficulty engaging and appropriately treating low-income women with depression, there are a number of critical details that should be included in publications regarding research with this population. See Table 3 for recommendations.

Several of these research design specifics are not typically reported in empirical journals, but this review makes it clear that clinics and practitioners will be required to spend a significant amount of time engaging impoverished women in psychotherapy treatment, and identifying, understanding, and incorporating the aforementioned treatment specifics into future treatment protocols and payment schemes will be critical to treating depression in this population.

4.1.2. Improving treatment

Treatment must be easily accessible to patients. Our analysis indicates that any attempts to reduce the logistical or financial burden low-income women face when seeking psychotherapy treatment is likely to increase their ability and motivation to engage in treatment. Suggestions to increase engagement include providing low-cost or no-cost care, transportation, childcare, accessible community treatment locations, convenient and flexible appointment times and rescheduling, and the use of telephone or in-home sessions, as needed. Clearly, the costs of addressing these practical barriers will be high, but the societal costs of both poverty and mental illness suggest that these up-front expenses may prove to be cost-effective over time (Simon et al., 2001; Stewart et al., 2003).

Simply addressing practical barriers is not sufficient to fully engage low-income women. Practitioners must understand that low-income women may not deem psychological care as relevant to their problems or lives. Offering potential patients an opportunity to explore their participation in therapy, perhaps in the form of an engagement session (including psychoeducation, normalization, and an opportunity to ask questions and voice concerns) appears useful. Providing this session as soon as possible after study enrollment may allow it to be most effective (Grote et al., 2009). Clinicians should work with each client to define her challenges and goals in her own words, keeping her unique life experiences, difficulties, and strengths in mind.

The interaction of practical, psychological, and cultural accommodations appears critical to engaging low-income women in psychotherapy treatment, and it is essential for a potential therapy client to feel that her worldview, life circumstances and needs are understood by her clinician and that they can be met through psychological treatment. Importantly, despite their lack of representation in the mental healthcare system, many low-income women do perceive psychotherapy as needed and beneficial and it appears that with appropriate motivation, these women may make significant attempts to engage in treatment.

4.2. Limitations

First, although we discuss and analyze the entire universe of published studies that investigate psychotherapy treatments for low-income women with depression, these studies vary greatly in their scientific rigor and exhibit considerable heterogeneity in virtually all study variables. It is therefore inappropriate to directly compare results across interventions and difficult to identify with certainty which specific adaptations were responsible for affecting treatment outcomes. Second, many studies excluded women with additional...
diagnoses beyond major depression (e.g., substance abuse or current interpersonal violence). Although this practice is typical in academic research, co-morbidity of psychiatric conditions appears to be the norm for low-income populations (Lennon et al., 2001; Ward, 2007). If we hope to treat depression in low-income women, it may be necessary to simultaneously treat their additional (and often more complicated) diagnoses. Notably, the studies reviewed here that did include women with co-morbid psychiatric diagnoses reported that those women responded equally as well to treatment as those with unipolar depression (Grote et al., 2009; Perez Foster, 2007). Third, large numbers of potential participants could not be contacted, chose not to participate, or dropped out of treatment prematurely in these studies. Although this is a typical challenge of work with low-income individuals, women who choose to participate in a research study and to adhere to psychotherapy treatment may be qualitatively different from the entire population of depressed, low-income women. Furthermore, these women were typically compensated for their participation in treatment, which likely inflated attendance rates. Fourth, because ethnic minorities represent such a large proportion of low-income women in the US, disentangling the properties of treatment that are curative or salient due to low-income status, as opposed to ethnic minority status, is difficult. It appears that extant literature at times confuses these elements. Previous researchers have argued that psychotherapy treatment must be adapted for specific minority groups in order to maximize its efficacy; however, we believe there are common barriers to depression treatment for low-income women of all ethnicities, and have therefore proposed a set of adaptations that are likely to improve depression treatment for all low-income women. Fifth, few studies measured clinical improvements over any significant period of time, with only one study following participants more than six months after ending treatment. Longer follow-up periods would allow researchers to determine whether clinical improvements increase or attenuate over time.

4.3. Conclusions and future directions

Despite the fact that they have elevated rates of mental illness compared to the general population, low-income women continue to under-utilize mental health services. While our review of the literature demonstrates that psychotherapy treatment can be effective for low-income women, especially if their unique life circumstances are understood and accommodated, the fact remains that low-income women are exceedingly difficult to engage in psychotherapy treatment, and those who most need help are often the least likely to seek or utilize it. We must therefore continue to learn about the needs of the most difficult patients in addition to providing services to more readily accessible and motivated patients. Healthcare providers, especially OB/GYN and primary care physicians who are most likely to encounter depressed low-income women (Lennon et al., 2002), must understand that a psychotherapy referral is unlikely to be sufficient for this population. Importantly, if guidance to seek depression treatment is perceived as simply another dictate from service providers who do not understand the extent of a low-income woman’s needs or stressors, it is unlikely to be well-received or acted upon. Physicians, who may have a critical opportunity to engage low-income women in mental health treatment, must receive training in the multiple, complex reasons that often prevent even motivated low-income women from following through on a psychotherapy treatment referral. Further integration of psychological care into community health settings where low-income women routinely access physical health care, encouraging a woman to speak to a psychologist immediately upon referral, and providing time for a clinician to specifically address a patient’s concerns, treatment barriers and ambivalence to mental health care are several methods that show promise for increasing service utilization.

Because initially engaging low-income women appears to be critical to achieving long-term clinical improvements, additional research that focuses more specifically on personal and contextual factors that allow or prevent low-income women from engaging in treatment is needed. This may include approaching women in the informal settings where they are most likely to seek help for depression and other psychosocial problems (e.g., churches or other community social settings), and finding unique ways to increase the understanding and acceptability of psychotherapy in this population, perhaps by engaging them in creative brainstorming and participatory action research.

Finally, as the empirical literature grows and treatment methodologies and clinical outcomes begin to improve for low-income women with depression, attention must turn to the sustainability of treatment methods. It appears that without consistent, significant outreach and compensation for logistical challenges, few low-income women will engage in psychotherapy treatment. It is essential to determine the level of treatment commitment that clinicians can reasonably expect from this population and to work with policymakers and insurance companies to allocate provisions for both direct psychological care and reducing practical treatment barriers.

Although psychotherapy appears to be an acceptable and effective way to reduce psychological suffering for poor women, these individuals exist within social and political systems that continue to limit their economic opportunity and societal worth. It is therefore important to realize that the provision of psychotherapy treatment (even if financially or logistically feasible) will not resolve the serious psychological and economic struggles that dominate the lives of low-income women. However, hope resides in the fact that a number of researchers have begun to focus on the needs of depressed, low-income women, and considerable progress has been made in identifying, understanding and overcoming barriers to depression treatment for this population. Embedding psychological care within existing social service systems will allow the benefits of these services to be multiplicative. Continually refining these systems is critical to reducing the mental health disparities between low and upper-income individuals, which will ultimately remove an important barrier that low-income families face to achieving economic stability and upward mobility.

References


