THE ACCEPTABILITY OF A CULTURALLY-TAILORED DEPRESSION EDUCATION VIDEOTAPE TO AFRICAN AMERICANS

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The aim of this project was to determine the acceptability and usefulness of an educational videotape for African Americans with depression. Four focus groups were held in two community settings and at a historically black university. Subjects included 24 African Americans, aged 18–76 years, who screened positive for depression. Focus group questions addressed the usefulness of the videotape to understand depression and its treatment, the most and least effective parts of the videotape, and the cultural appropriateness of the information presented.

Participants took pre- and post-tests on attitudes about depression. Discussions were audiotaped, transcribed, and reviewed independently by two investigators to identify and group comments into specific themes. Two other investigators reviewed the themes and comments for consistency and relevance. The videotape was generally well received and was rated effective in improving knowledge about depression and its treatment. After watching the videotape, attitudes improved in several areas, including depression as a medical illness, effectiveness of treatment, negative perceptions of antidepressant medication and reliance upon spirituality to heal depression.

This culturally tailored videotape about depression is deemed acceptable and effective for most African Americans with depression participating in focus groups. It also improved knowledge and several attitudes about depression. (*J Natl Med Assoc.* 2002;94:1007–1016.)

Key words: depression ◆ health education ◆ videotape ◆ African Americans ◆ cultural tailoring

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INTRODUCTION

Racial differences in mental health care have been well documented.[1-5] The National Survey of Black Americans and other studies have shown that compared to whites, African Americans with emotional problems and grief are more likely to use informal help or no professional help at all.[6,7] Even when African Americans do seek help from health professionals, they are less likely than whites to receive care in specialty mental health settings. Racial differences in mental health care are partially explained by differences in access (financial,

structural, and personal barriers).[8] Personal barriers to treatment of depression of potential importance identified in recent work include patients' fears of the addictiveness of antidepressant medications and mental illness-associated stigma, reliance upon spiritual beliefs to cope with depression, and concerns about trust and other aspects of relationships with health care providers.[9]

One way to stimulate change in beliefs and practices with respect to mental health care and depression in particular is through health education tools. In the past, there have been community education programs such as the Depression Awareness Recognition and Treatment campaign (D/ART) and National Depression Screening Day, which have been helpful in encouraging people to get treatment for depression.[10,11] However, given the high prevalence of functional illiteracy in the United States, the use of written information in patient education programs may be ineffectual.[12]

Several studies have focused on the effectiveness of videotapes to provide patient education for many health problems, including depression.[13-19] The benefits of educational videotapes include their effectiveness in increasing knowledge; providing role-modeling to decrease anxiety related to specific health issues; simplifying complex medical information provided by health professionals; reaching individuals with low literacy skills; and involving less staff time.[12,14,20] In addition, culturally tailored educational videotapes have been found to be effective with African Americans.[21]

The National Mental Health Association Campaign on Clinical Depression and the pharmaceutical corporation Pfizer Inc. have recently developed educational materials on depression that target African Americans. However, the majority of educational materials from other sources, such as the National Institute of Mental Health and other pharmaceutical companies, do not address the specific cultural beliefs or concerns of African Americans.

We have developed a culturally tailored, educational videotape to address the unique concerns of African Americans. We have also evaluated its effectiveness as a teaching tool by showing the videotape, administering a brief questionnaire to measure participants' attitudes before and after viewing, and conducting focus groups to record reactions to the videotape.

METHODS

Development of Videotape

Black and Blue: Depression in the African-American Community is an educational videotape that features African Americans who have experienced depression, African-American health professionals, and an African-American member of the clergy. The specific aims of the videotape are: 1) to present depression as a medical illness with symptoms using individuals who have experience with the illness; 2) to emphasize the importance of early recognition and treatment; 3) to discuss standard treatments, including antidepressant medication and psychotherapy; 4) to increase awareness of the negative consequences of untreated depression; 5) to provide information on how and where to get treatment; and, 6) to encourage relatives and friends of depressed individuals to try to understand the illness and be supportive. Additionally, the videotape includes three salient messages that address cultural beliefs and barriers to depression care identified by African Americans.[9] These messages are: 1) spirituality is an important component of healing for depression, but should not be used as a replacement for professional treatment; 2) antidepressant medications are not addictive; and 3) depression is a medical illness, not a character weakness or something to be ashamed of.

Study Design

We held four focus group discussions during September and October of 1999. Three of the groups were comprised of African-American adults who screened positive for depression at health fairs or other community settings and

one group was composed of African-American students at a local historically black university, who were screened for depression during National Depression Screening Day. Participants were recruited face-to-face by screeners or by flyers posted on campus. Focus groups have been found to be effective in allowing in-depth examination of the views people have about a given issue or problem. A focus group is defined as a carefully planned discussion with the goal of identifying perceptions in a specific area of concern in an open, nonthreatening setting.[22] We held separate groups for the different age groups because attitudes toward a depression videotape might vary by age.

Focus Group Population

To be eligible for the focus groups, subjects had to be at least 18 years of age, English-speaking, able to give informed consent, and to identify their race as African American. They had to have screened positive on the depression section of the MINI International Neuropsychiatric Interview (M.I.N.I.), comprised of 10 questions corresponding to DSM IV and ICD-10 criteria for major depression with good validity and reliability.[23,24] A positive screen was indicated by endorsement of one or both of the following questions: In the past two weeks, 1) have you been consistently depressed or down most of the day, nearly every day? and 2) have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?[23] The remaining eight questions addressed other depressive symptoms occurring almost daily in the preceding two weeks: weight gain or loss, appetite changes, sleep disturbances, psychomotor retardation or agitation, fatigue, concentration problems, feelings of guilt or worthlessness, and suicidal thoughts or death wishes.[23] A total score was derived by summing positive responses to all 10 items.

Focus group participants were recruited with the help of community mental health workers who conducted depression screenings at a health fair and at a neighborhood center. Individuals who screened positive were contacted by telephone and invited to participate using a standardized script. The counseling center at a local historically black university held a National Depression Screening Day event, and students who screened positive were invited to participate in the focus groups. We asked individuals doing recruitment to keep records of refusals and the reasons for refusals. Only one individual who was approached refused to participate.

Conduct of Focus Group Sessions

A trained focus group facilitator led the sessions after discussing the goals of the study with investigators and reviewing the literature regarding health education and attitudes of African Americans. Neither of the study physicians were present during the focus group sessions. The sessions were entirely audiotaped and each lasted approximately 90 minutes. Participants were offered a small honorarium to cover child-care expenses and transportation, and refreshments were provided.

Before and after watching the videotape, the participants were asked to answer 20 questions to measure their attitudes about depression. Following completion of the post-test, the focus group facilitator asked the participants a series of open ended questions to elicit comments about the videotape. The questions were: (1) Did this videotape help you understand what depression is? Why or why not? (2) Did this videotape help you understand how depression is treated? Why or why not? (3) In your opinion, which were the best or most effective parts of the videotape? (4) In your opinion, which were the worst or least effective parts of the videotape? (5) How could this videotape be improved? (6) Is there anything about depression that you think African Americans should know that was not included in the videotape?

Data Analysis and Development of Key Themes

Audiotaped recording of the focus group discussions were transcribed verbatim with the participants' identities masked. Two

study investigators (a psychiatrist and a primary care physician/health services researcher) independently read each of the four focus group transcripts, identified separate thoughts or comments, and grouped related comments into themes. The themes address the range of issues voiced by participants and were named according to words and concepts used by them. Repetitive or rephrased comments by the same participant were considered to be one comment. The two reviewers then discussed their individual observations and came to a consensus regarding categories and comments.

The themes and comments for each of the groups were then reviewed independently by two additional study investigators (a psychiatric nurse and a psychiatric social worker) for relevance and consistency. Consensus was achieved after reviewing input from study clinician-investigators.

Additional Data Collection

The participants were asked to complete a brief questionnaire prior to seeing the videotape, which included demographic data and 20 attitudinal statements about depression and its treatment with 5-point Likert response scales (from 1, strongly disagree, to 5, strongly agree). Many of these statements were derived from focus groups with depressed black and white primary care patients and have been previously described.[9,25] Chi-square procedures, Fisher's exact tests, and *t*-tests were used for bivariate analyses comparing demographics, health status, and depression treatment of college students to other participants. We used the binomial test to test the probability that the proportion of those in agreement or strong agreement with positively worded statements and disagreement or strong disagreement with negatively worded statements would be higher after viewing the videotape than beforehand. Given our hypothesis that changes would be in one direction, we used a one-tailed test of significance for analysis of attitudinal changes.

RESULTS

Characteristics of Focus Group Participants

The characteristics of subjects are presented in Table 1. The sample (N=24) was composed of 13 college students between the ages of 18 and 25 years and 11 other adults between 32 and 76 years of age. Somewhat more women (58.3%) than men were represented. Fifty-eight percent of the total sample had a high school or less education. With regards to marital status, 58.3% were never married (92.3% of college students vs. 18.2% of other adults). Less than half of the sample had previously been treated for depression (63.6% of community adults vs. 15.4% of college students). Of those who had received treatment, most participants had used medication but were currently not being treated. Seven individuals reported having seen a mental health specialist. Mean scores on the MINI depression scale did not significantly differ between groups; 5.38 for college students and 6.72 for other participants.

Development of Themes

Themes and examples of corresponding comments from focus group participants are presented in Table 2. They include: 1) most effective parts of the videotape; 2) suggestions for improvement of the videotape; 3) identification with depressed people featured in the videotape; 4) concerns about antidepressant medication; 5) stigma and stereotypes; 6) race, ethnicity, and cultural issues; 7) validation and support from being in a focus group; and 8) spirituality. Several participants found that the videotape gave them a better understanding of depression in the following respects: realizing it is a medical illness that runs in families; seeing it as a recognizable cluster of symptoms; appreciating the importance of early treatment to prevent negative consequences; and understanding the importance of convincing loved ones to get help.

Table 1. Characteristics of Focus Group Participants

	Total n = 24 (%)	College Students n = 13 (%)	Other Persons n = 11 (%)	p-value*
Demographics				
Age:				0.001
18–25	13 (54.2)	13 (100)		
25 +	11 (45.8)		11 (100)	
Gender:				0.729
male	10 (41.7)	5 (38.5)	5 (45.5)	
female	14 (58.3)	8 (61.5)	6 (54.5)	
Marital Status:				0.001
never	14 (58.3)	12 (92.3)	2 (18.2)	
d/s/w	7 (29.2)	1 (7.2)	6 (54.5)	
married	3 (12.5)	0 (00.9)	3 (27.3)	
Education:				0.408
HS or<	14 (58.3)	9 (69.2)	5 (45.5)	
HS+	10 (41.7)	4 (30.8)	6 (54.5)	
Treatment History				
Ever treated:				0.033
yes	9 (37.5)	2 (15.4)	7 (63.6)	
no	15 (62.5)	11 (84.6)	4 (36.4)	
Medication:				0.016
yes	7 (33.3)	1 (8.3)	6 (66.7)	
no	14 (66.7)	11 (91.7)	3 (33.3)	
Current Treatment:				0.155
yes	5 (21.7)	1 (8.3)	4 (36.4)	
no	18 (78.3)	11 (91.7)	7 (63.6)	
Depression Status:				
MINI Score, mean (SD)	6.00 (+/−2.41)	5.38 (+/−3.04)	6.72 (+/−1.10)	0.180

*p-values are from Fisher's exact and Chi-square tests for categorical variables and *t*-test for MINI score comparing college students and other persons.

Most comments regarding the effectiveness theme referred to the videotape as being informative. However, members of one group, who had read extensively, or experienced depression in the past, found the videotape not to be helpful at all. Criticisms included the need for more detail about: manic depression; specific symptoms such as overeating or weight loss and physical symptoms associated with depression; the non-debilitating subtleties of depression; how stressful life events trigger depression; biological aspects of the illness; specific types of medications and counseling; and alternative ways of coping with depression, such as humor.

Concerns about antidepressant medication was a theme in which participants commented on antidepressant side effects, apprehension about dependency, and problems associated with discontinuation. Many individuals who had experience with antidepressants felt strongly that they were addictive, despite the salient message in the videotape that antidepressants are not addictive. Participants likened using antidepressant medications to taking methadone for the treatment of opiate dependence, in that it creates a problem in addition to depression. Subjects felt that if a medication is given for the treatment of depression, it should ameliorate depressive symptoms and not add to them.

For the stigma and stereotypes theme, focus group members gave accounts of their experi-

Table 2. Focus Group Themes and Sample Comments

Themes	Sample comments
Most effective parts of the videotape:	"I think having real people with real problems was effective."
	"[Before watching the videotape], I just did not know [depression] was a bonafide medical problem. I thought it was strictly a mind thing."
	" [the video] helped me to appreciate that I did the right thing to get out there and get that help."
Ways to improve the videotape:	"It would have been more effective if maybe we had more specifics on what caused their depression, and how they got through it, and what treatment worked for them."
Concerns about antidepressant medication:	" they give you something to keep you high so you won't be depressed, that's why, as far as I'm concerned, I would rather be treated for my depression through therapy and counseling rather than drugs because I just think it is something that your body will get used to every time you get down."
	"Now [the antidepressant medication is] causing the problem, she's got to take another kind of medicine to relieve *that* problem."
Identification with people in the videotape:	"Depression, in the younger fellow who talked, yes, everything he said hit home to me."
	"[Depression] forces you to do things like go to drugs and alcohol, which I've been on too. And like that girl [in the video] said, the more you do it, the shorter the high gets, the less the thrill gets and you're still depressed."
Validation and support from the group:	"For me, like I said, this [focus group] is the first time I've ever talked about it to anyone."
	"I can't talk to my family and friends about [depression], but I can talk with strangers about it."
Race, ethnicity and cultural issues:	"I've never really paid much attention to videos in the past because they mainly had Caucasians that I couldn't really relate to and to sit here and watch something with people who look like me, talk like me, and went through what I went through, seeing is believing that black people have gone through this."
	"I think, as black people, we tend to use defense mechanisms, like we deal with depression in other ways, we hide our feelings rather than verbalize them."
	"A lot of the reasons we [blacks] don't seek out this help that we so desperately need, is because as African-American children, we're taught to be strong-don't let them see you cry. Then when you show up you don't want to say, "I need help, can somebody help me?"
Stigma and stereotypes:	"I wouldn't talk about depression with other people, you know, that I've been depressed, because I don't want that stigma. I don't want people looking at me and saying, "My goodness, she's depressed, whatever."
	"I don't really think black people consider depression as a black person's problem, maybe sickle cell, diabetes, or sugar, most black people consider depression to be a white person's problem."
	"I was surprised to see so many men [in the video] because a lot of times [depression] is called the woman's disease because men don't really get upset 'cause they have a strong backbone, so it was cool to see men going through it."
Stigma and stereotypes:	"When I told my father I was going to National Depression Screening Day, he said, "You're too young, you don't have no real problems."
Spirituality:	"The other thing [that was effective about the video] was the faith piece, other people who are of your faith that tell you, you don't pray, you need to pray harder, that's all you need to do. That's not true.
	"My mother said, 'Let go and let God, and you better not go to no doctor.'"

ences with stigma related to having depression, seeking treatment from psychiatrists, being regarded differently by family and church members, and feeling a double stigma associated with being a black person and having a mental health problem. A related theme, race, ethnic-

ity, and cultural issues, included comments about the all African-American cast in the videotape. Participants who appreciated having all African Americans (professionals and patients) in the videotape reported having bad experiences with white therapists and doctors who were insensitive to their issues as African Americans. Other opinions included race of the cast being irrelevant to the universal message of the videotape and concern that it gave the impression that only blacks have depression or have it more seriously than others. There were several comments about the extraordinary life stresses African Americans face as a racial minority group.

Validation and support from being in a focus group was a theme echoed by many participants. Some likened the focus group to a group therapy session and appreciated having the opportunity to come together to talk about depression. Additionally, many focused on the difficulty of getting family members to understand depression.

Participants said they found the videotape to be particularly helpful in addressing issues of spirituality. They felt the videotape was effective in presenting depression as an illness and not something that God put on them, that they did to themselves, or that they needed to pray harder about. Others focused on how hard it is to get family and church members to understand that lack of prayer or faith is not a cause of depression. Some said they felt that spirituality could serve as a barrier to talking about depression with other African Americans and getting medical treatment.

Pre- and Post-Test Questions

The results of pre- and post-test attitudinal analyses reveal several significant changes (Table 3). Percentages of those in agreement with the following three out of six items pertaining to the *medical* aspects of depression were found to increase significantly after the focus groups watched the videotape: "Depression is a medical condition"; "Depression runs in families"; and "Some physical illnesses such as stroke or cancer can cause depression." In the area of *effectiveness of treatment*, the videotape appeared to have had a significant impact on changing attitudes. The percentage of participants who agreed with the items stating that "Antidepressant medications are effective" and "Most people who are treated for depression begin to feel better in a few weeks" increased from 68% to 95%, and from 17% to 65%, respectively. One item related to *problems with treatment*, "Antidepressants are usually addictive", was also associated with a significant improvement in post-test over pre-test responses (65% vs.17% disagreement). In the area of *spirituality*, the statement, "Prayer alone can heal depression", elicited significantly improved responses after videotape viewing, with a change from 43% to 91% disagreement. In addition, the percentage of those who disagreed with the statement that having depression was indicative of not having faith in God increased from 82.6% to 95.6%. The percentage of focus group participants who disagreed with a statement designed to measure *stigma*, "If you are depressed, the best thing to do is to keep it a secret," increased significantly after seeing the videotape. Attitudes regarding availability of health providers and negative coping (i.e., alcohol and drug use) showed ceiling effects and had no room for improvement.

DISCUSSION

We developed a videotape that was deemed acceptable and effective to most African Americans with depression participating in focus groups. The participants were largely those with some higher education and a prior history of treatment for depression. There were improvements in attitudes about depression as a medical illness with hereditary features. Several attitudes regarding the effectiveness of treatment improved after videotape viewing. Before watching the videotape, several individuals who believed antidepressants were addictive expressed a preference for counseling, similar to a previous study.[25] After watching the videotape, the proportion of those who believed that antidepressants were addictive decreased significantly.

The videotape appeared to change some atti-

Table 3. Comparison of Attitudes Pre- and Post-Videotape Viewing

Attitudinal Item	Pre-test	Post-test	p-value*
Positive Attitudes (% who strongly agree or agree):			
Biological changes in the brain cause depression.	82.6%	82.6%	0.629
If my doctor told me I had Depression, I could accept that.	73.9%	82.6%	0.244
Antidepressant medicines are effective in treating depression.	68.2%	95.4%	0.002
There are professionals available to help if I had depression.	100%	100%	---
Counseling can be just as effective as medicines in treating depression.	30.4%	43.5%	0.146
Depression is a medical condition like other illnesses.	78.3%	95.6%	0.027
Depression runs in families.	56.5%	82.6%	0.008
Most people who are treated for depression begin to feel better in a few weeks.	17.4%	65.2%	0.001
Depression affects both your body and your mind.	95.7%	100.0%	0.364
Depression can cause physical changes like pain or headaches.	87.0%	91.3%	0.410
Some physical illnesses such as stroke or cancer can cause depression.	65.2%	91.3%	0.005
If you have depressive symptoms (loss of energy, trouble sleeping, pains, feeling sad) you should tell your health care provider.	87.0%	91.3%	0.410
Negative Attitudes (% who strongly disagree or disagree):			
Antidepressant medicines are usually addictive.	17.4%	65.2%	0.001
Prayer alone can help to heal depression.	43.5%	91.3%	0.001
People who suffer from depression do not have faith in God.	82.6%	95.6%	0.072
I would be embarrassed if my friends knew I was getting professional help for an emotional problem.	30.4%	39.1%	0.242
People who are of weak character are likely to suffer from depression.	22.7%	21.7%	0.573
If you are depressed, the best thing to do is to keep it a secret.	82.6%	100.0%	0.012
People who are depressed should use tranquilizers, alcohol, drugs to feel better.	100.0%	100.0%	---
Life is hard for black people, so it's natural to be depressed if you are black.	34.8%	21.7%	0.135

*from one-sided binomial test comparing % of participants who agreed with the statement pre- and post-viewing the videotape
---, not applicable

tudes towards stigma. However, attitudes such as perceiving social embarrassment associated with treatment did not change. Surprisingly, the percentage of those equating depression with a weak character increased slightly after watching the videotape. This increase could be an artifact of statistical methods or a result of the videotape not specifically addressing stereotypes of depression as a reflection of weak moral character. Despite the lack of positive change in these areas, there was a significant reduction in the percentage of those who felt that keeping their depression a secret was appropriate. Several racial and cultural issues were raised, such as, extraordinary life stresses of African Americans, feeling misunderstood by non-minority health professionals, interpersonal and institutional mistrust of the larger society, the value given to stoicism among African Americans, and the belief by many African Americans that they are not as susceptible to depression as whites. Videotape viewing seemed to have little or no impact on responses to the question about depression being a natural experience for blacks; the majority of participants held this belief before and after watching the videotape.

Our study participants raised many concerns related to spirituality and depression similar to that identified in previous work.[9] Many focus group participants felt that church members interpreted depressive symptoms as a lack of faith and a need for more fervent prayer. At least one previous study suggests that help-seeking from clergy may serve as a barrier to mental health care for African Americans.[26] However, none of the participants in this study made specific references to clergy discouraging mental health treatment. In this study, a large percentage of focus group members changed their minds on the post-tests and disagreed with the statement, "Prayer alone can help depression." Because of the high reliance of African Americans on religion and religious activity for coping with illness and other serious problems, attitudinal changes in this area might impact favorably upon help-seeking behavior from health professionals.

There are some limitations of this study that should be addressed. The study is limited by a small sample size and lack of random selection of study subjects. Second, there was no comparison group or control condition in which participants watched a non-culturally tailored videotape about depression. Additionally, the cross-sectional design of the study does not allow us to study the relationship of watching the videotape to patients' health service utilization or outcomes. In addition, there may be less honesty in focus group formats than on a survey. However, responses to attitudinal items did not indicate that participants gave only socially acceptable responses. Because of these limitations, additional evaluation of the videotape in a larger sample, using an experimental study design, would provide stronger evidence of its effectiveness.

Nonetheless, this study breaks new ground in that it is the first investigation to date conducted to evaluate the use of culturally-tailored educational materials for depression. The videotape, *Black and Blue*, also makes an important contribution to health education as a strategy to address cultural diversity and cultural sensitivity.[27,28] For example, the videotape could be used to educate patients in community or clinical settings and to provide insight for providers interested in improving care for African Americans with depression. Results of this study will be used to refine this videotape further and to develop brochures and other educational materials about depression for African Americans. Such materials should focus on providing more detailed information regarding bipolar illness, the biological and psychosocial aspects of depression, and different treatments for depression. Future studies should evaluate the impact of culturally-tailored videotapes on help-seeking behavior, receipt of depression care, and health outcomes for African Americans and other ethnic minority individuals with depression. If this educational strategy is shown to be effective, it could be replicated across different ethnic groups to improve access to mental health care.

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