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Underserved Women in a Women's Health Clinic Describe Their Experiences of Depressive Symptoms and Why They Have Low Uptake of Psychotherapy

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Introduction

Most people with depression never engage in psychotherapy (Grembowski, et al., 2002; Jaycox, et al., 2003; Rost, et al., 1998; J. Wang, Langille, & Patten, 2003), despite the fact that psychotherapy is an effective treatment for depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008), and preferred by many people with depression (Alvidrez & Azocar, 1999; Arean, Alvidrez, Barrera, Robinson, & Hicks, 2002; Brody, Khaliq, & Thompson, 1997; Cooper, et al., 2003; Dwight-Johnson, Unutzer, Sherbourne, Tang, & Wells, 2001). The majority of individuals with depression delay seeking treatment until their symptoms or level of impairment become intolerable (Thompson, Hunt, & Issakidis, 2004), leading to greater suffering caused by more severe and treatment resistant depression. Furthermore, non-adherence and drop-out rates are high, particularly among individuals of color and low-income individuals (Arnow, et al., 2007; Simon & Ludman, 2010), leading to frequent under-treatment of symptoms even among individuals who attempt to engage in care. As a result, few individuals with depression receive adequate treatment to achieve and maintain remission (Andrews, 2000; Lin, et al., 1998; Stecker & Alvidrez, 2007; Stockdale, Klap, Belin, Zhang, & Wells, 2006).

Poverty is associated with increased rates of depression (Bruce, Takeuchi, & Leaf, 1991; Kessler, et al., 2003; Roberts & Lee, 1993; Weich & Lewis, 1998; Wilson, Chen, Taylor, McCracken, & Copeland, 1999) and reduced likelihood of obtaining treatment for depression (Cooper-Patrick, et al., 1997; P. S. Wang, Berglund, & Kessler, 2000). Similarly, African American women as compared to White women are more likely to experience depression (Green, Baker, Sato, Washington, & Smith, 2003; Riley, Robinson, Wade, Myers, & Price, 2001) and less likely to utilize mental health treatment (Cooper, et al., 2003; Neighbors, 1988; P. S. Wang, et al., 2000). Low-income and African American women are particularly likely to seek treatment for depressive symptoms from women's health (Obstetrics/Gynecology) clinics (Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003; USDHHS, 2001), providing a valuable opportunity to engage them in depression treatment.

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Both African American and low-income individuals are more likely than White middle-class individuals to conceptualize depression as a social or life problem and report a preference for psychotherapy over pharmacotherapy as a treatment for depression (Cooper, et al., 2003; Karasz, Sacajiu, & Garcia, 2003; Mukherjee, et al., 2006a). While women's health patients report interest in individual psychotherapy, most are not receiving any form of mental health treatment (Alvidrez & Azocar, 1999). In order to reduce rates of depression among low-income and African American women's health patients, it is critical to understand what factors are contributing to their underutilization of psychotherapy as a treatment for depression.

Previous studies have identified a range of practical, cultural, symptom, systems, and professional barriers to increased delivery of mental health treatment to low-income and African American individuals, although none has been with women's health patients specifically. Common barriers identified include lack of knowledge of where to go, inability to pay, lack of awareness that symptoms require care, and social stigma (Alvidrez & Azocar, 1999; Van Voorhees, et al., 2006). African Americans in particular were likely to report concerns about stigma, practical barriers (insurance, scheduling, location, etc.), a lack of knowledge about signs and symptoms of mental illness, and poor access to care (Cruz, Pincus, Harman, Reynolds, & Post, 2008; Sanders Thompson, 2004). The decision to seek help for mental health problems has been found to be linked not only to whether the treatment is believed to be efficacious, but also if the symptoms are considered to be a treatable problem and the problem is considered unlikely to improve without professional intervention (Neighbors, 1988). Because women's health clinics provide a unique opportunity to interact with women at high risk for depression and under-treatment of their symptoms, we were interested in determining what factors regarding their experiences of symptoms associated with depression and uptake of psychotherapy were most relevant for women's health clinic patients specifically. We selected a qualitative approach as the best way to ascertain women's feelings, ideas, and opinions about depression and psychotherapy because it provides an opportunity for them to share their unique perspectives and individual stories beyond what can be captured with quantitative measures. Our eventual aim is to facilitate development of novel approaches to improve psychotherapy uptake for this patient population.

Methods

Subjects

A community sample of women attending appointments for routine gynecological care at a university hospital-based women's health clinic targeting publicly insured patients were randomly selected and screened with the PHQ-2 (Kroenke, Spitzer, & Williams, 2001; Spitzer, Kroenke, & Williams, 2000). The PHQ-2 was selected to identify women currently reporting depressive symptoms and to facilitate a conversation about their current experiences associated with those symptoms and their perspectives about psychotherapy. These inclusion criteria were selected to balance sample homogeneity (low-income women's health patients bothered by depressive symptoms) and generalizability of the findings (women with and without therapy experience; not requiring a DSM-IV diagnosis of depression). Women were eligible to participate if they were 18 or older and demonstrated the ability to communicate in English. The PHQ-2 questions are: "Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?" and "Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?" Response options were: 0 = not at all; 1 = several days; 2 = more than half the days; 3 = nearly every day. If a woman scored a total of 3 or greater it was considered a positive screen. The PHQ-2 has 87% sensitivity and 78% specificity for detecting major depressive disorder (Lowe, Kroenke, & Grafe, 2005) but does not provide a diagnosis of

major depression. Those who were eligible were invited to complete an interview immediately following their appointment. If women were unable to stay following their appointment, they were invited to return for the interview at a time more convenient for them. Informed consent procedures were completed, and women were interviewed individually for 45–60 minutes. Interviews took place privately in consultation rooms and were audiotaped. Mental health referrals were offered as needed after completion of the interview. All procedures were approved by the institutional review board.

Demographics

A total of 23 women participated, with a mean age of 32.87 years (SD = 10.32, range = 18–49) (Table 1). The majority of women described themselves as African American or Black (n = 14, 60.9%); 7 (30.4%) were Caucasian or White; 1 (4.3%) Latina or Hispanic; and 1 (4.3%) Other. Twenty (87.0%) women were single, and 3 (13.0%) women were married or living with a partner. The women were generally poor, with 15 (65.2%) reporting an annual income <$10,000, 5 (21.7%) reporting an annual income between $10,000 and $19,999, 2 (8.6%) reporting annual income > $19,999, and 1 (4.3%) did not know.

Measures

A brief demographic form was completed by all participants. A semi-structured interview guide was developed by the investigators based on their clinical experience and review of the literature, with the goal of eliciting perceptions of depression and psychotherapy, as well as possible facilitators and barriers to engaging in psychotherapy. The interview guide was modified iteratively by the research team, as the interviews and concurrent data analysis proceeded, to incorporate new information and to focus progressively on emerging themes.

Three of the authors conducted the interviews: two clinical psychologists (BC, ELP), and a clinical research coordinator with extensive experience conducting clinical assessments (NL). All three interviewers were women, ages 28–41, with experience working with depressed women in women's health settings. Two are Caucasian (BC, ELP) and one is African American (NL). All interviews were audiotaped and professionally transcribed. The final iteration of the questions analyzed for the current paper is outlined below:

1. You were invited to participate in this study because of the way you responded to these questions (show patient PHQ-2). Can you please tell us what is happening for you that you responded this way? How else would you describe how you are feeling? How do these feelings affect your life?
2. I would like to hear your thoughts about counseling or therapy. Have you ever tried counseling or psychotherapy? If yes, what has it been like for you? If no, what do you imagine counseling would be like for you?
3. Some people consider counseling as an option for themselves personally and others do not. What are your thoughts about it? What do you see as the possible benefits of counseling, if any? What bad things might you feel come as a result of counseling or psychotherapy, if any?

Analytic Strategy

A thematic content analytic approach was employed using a group consensus process, based primarily on the Consensual Qualitative Research (CQR) approach (Hill & Williams, 1997; Hill et al., 2005). CQR was selected because of its rigorous and replicable yet accessible approach and its fit for mental health-related issues specifically (Hill & Williams, 1997; Hill et al., 2005). The essential components of CQR are: 1. the use of open-ended, semi-structured interviews for data collection; 2. involvement of several raters with diverse

perspectives analyzing the interviews; 3. judgments are arrived at by consensus; 4. an auditor checks the work of the primary team; and 5. data analysis involves determining domains, core ideas, and cross-analyses (Hill et al., 2005). Given the demographic distribution and sample size, we conducted sub-group analyses for race/ethnicity and household income, and report frequencies only on those that revealed differences. Descriptive statistics are not provided due to the lack of reliability and validity of statistics given that participants were not given structured, identical questions and the small sample size. We identified several potential biases held by the team members prior to beginning data analysis: the PHQ-2 would do a reasonable job of identifying women who are troubled by depressive symptoms; psychotherapy is a useful treatment option for women with depressive symptoms; the women interviewed would be able to articulate their views; and it is reasonable to accept the women's reports as truthful.

Preliminary thematic categories and core ideas were identified in the initial 8 interviews by BC, GFK, NL, & ELP. The primary research team reviewed all transcripts independently (BC, NL, and ELP), and quotes representing the codes were extracted in order to test or explore the initial themes. Consensus meetings allowed for each of the transcripts to be discussed by the primary research team. The team iteratively modified and refined the codes until consensus ratings were obtained. The team looked for shared aspects across the codes, discarded the preliminary themes that no longer fit, and synthesized the codes into three primary themes. The themes and associated codes were then given to a researcher (GFK) who was not involved with coding the original transcripts. She provided auditing and feedback, and determined if important themes were missed. The auditor's feedback was reviewed, discussed, and incorporated by the primary research team to finalize the themes. Finally, the team met to understand and discuss the themes for what they can offer to medical providers and psychotherapists working with low-income women in medical settings with depressive symptoms.

Results

The three major themes from this study are: (1) the psychotherapy relationship itself is the primary barrier to engagement in psychotherapy for depression, with physical and mental health symptoms and doubt about the efficacy of psychotherapy serving as secondary barriers; (2) the symptoms described as problematic by the women are unique from the diagnostic symptoms generally assessed in a psychotherapy intake; and (3) even with their concerns, the women felt that psychotherapy might assist with gaining safety, insight, and ability to change. Each theme is described and then illustrated with examples selected from the transcripts. As recommended by Hill and colleagues (2005), frequencies are referred to in the following way: *general* includes all or all but one case, *typical* includes more than half of the cases, *variant* refers to at least two cases but less than half the cases, and *rare* includes only two to three cases.

1. Perceived Threat of the Therapeutic Relationship, Current Symptoms, and Doubt Were Barriers to Psychotherapy

A. Perceived Threat of the Therapeutic Relationship—It was typical for women interviewed to identify substantial risks that actively deterred them from engaging in psychotherapy. General responses included feelings of vulnerability to therapists who have the power to betray them and cause harm, and typical responses included feelings that therapists do not understand or accept their needs and wants, and of the belief that therapy is challenging yet does not create concrete change.

Therapists can be controlling and dismiss patient preferences: The women reported a clear conceptualization of their difficulties and what they felt they needed from therapy. Typically, their own beliefs of what would be helpful clashed with what they had experienced therapists focusing on in treatment. These experiences left patients feeling disrespected and misunderstood. Furthermore, when they did not feel a shared agenda with their therapist, they often lost motivation to continue in therapy. This difficulty was expressed by the women in two primary ways. First, sometimes it was perceived that therapists were unwanted authority figures who desired patients to take steps they did not feel ready for: "I didn't like nobody like telling me what . . . I need to do and what's wrong for me and what's right for me. That was my problem. So that's why I never kept going." Another woman remarked, "I don't do people very well. And to be forced into a situation is really not gonna make a person open up or talk about it." Second, many women described a mismatch between what they felt they wanted or needed and what they believed the therapist wanted for them to do in therapy:

- When I first started getting counseling I had a therapist . . . who would not let me talk about what I needed to get off my chest. She dictated everything we were gonna talk about and I didn't like that.

Therapists' recommended actions or treatments were not always acceptable:

- One of the main reasons she shut me down is [be]cause she feels like I should leave John and I'm not gonna leave John. That's not an option.
- I won't take this pill because . . . it might make me gain weight. If the person won't listen to me, I don't wanta hear 'em. If they're not gonna listen to what I know about me then…
- I can't afford to be pulled out of school to go to an inpatient right now so I've been lying to them because if I tell them that how much I've been drinking they'll pull me from school and put me in inpatient."

Therapists abandon you: Many therapists who work with low-income women are employed in under-funded settings. They have very stressful positions, high caseloads, patients with overwhelming need, limited access to supervision, and low salaries. As a result, the turnover at agencies is often high. Also common in these settings are therapists-in-training who graduate and move on to different positions. Women reported it was devastating to get close to their therapist only to learn that the therapist was leaving. This experience often led to a decision to stop psychotherapy. "Honestly I stopped because my original counselor ended up leaving."

- That's what made me stop . . .. You gotta get close to your therapist, you know [be]cause you're letting them know some really deep stuff you know that you really can't tell a lot of people . . . I've got abandonment issues too. . . . you feel like a guinea pig, test monkey or whatever you know? They got what they wanted off you. . . . passed around so like I said abandonment issues [be]cause you kinda get close to your therapist [be]cause like I said, you can't help it because you know they're there.

Therapy is invasive: Therapy traditionally involves eliciting private information from patients that can invoke prior traumatic experiences or feelings of shame. Women may have never shared their experiences or feelings before. Sharing such intimate information can leave patients feeling very vulnerable and exposed. A variant response by women was expressing a lack of understanding why the intimate questions were necessary, and found the experience needlessly invasive and violating. Another variant response was that women

felt they would be violating the privacy of others by sharing their experiences with a therapist.

- She would really try to get personal with me like stuff that I really felt wasn't her business. . . . Yeah she would ask like what's going on in the house. Why does what's going on in my household have to do with you figuring out why I'm so angry, like because my mother is none of her business [be]cause she's not the angry one. Neither does my father because he doesn't live here.
- They start getting into your business too much. Goin' places they don't need to go. . . .I shut down. I ain't gonna talk about it. You ask me another question I'm gonna go crazy. You better leave me alone.

"I rather just leave it where it's at.": One variant response identified was that of women coping with their distress by using distracting activities such as socializing, music, or drugs. In contrast, therapists typically encourage their patients to talk about their difficult experiences and feelings. The women reported this can be very uncomfortable and threatening, particularly if they do not understand how it is supposed to be helpful to them. "I feel as though if you constantly bring it up there's a piece that always gonna make you cry so I rather just leave it where it's at."

- I got some deep rooted ugly childhood stuff. I don't think that counseling will do anything for me but stir that crap up and make me feel even worse. I'd rather just leave it alone and go on with my life.

Fear of vulnerability and exposure: Nearly half of women described finding it difficult to trust the therapist to safeguard their stories or information. Several of the women interviewed spontaneously disclosed experiences of abuse and betrayal by family members, partners and friends who they thought were trustworthy. Life experiences taught them to be distrustful of others and avoid vulnerability, making interpersonal relationships risky and a safe and trusting therapeutic relationship challenging. Concerns regarding breaches in confidentiality were described: "If they feel like you tell them something that they think somebody should know, they will". Other women were concerned about the difficult process of self-disclosing to someone who they later feel will not be a good match: "It's just a dreadful thing to have to think about going through the whole thing and seeing if you're gonna like 'em and if they, if it feels right." Women with annual household incomes under $10,000 (n = 12) were more likely to describe these risks than other women (n = 4).

B. Physical and Mental Health Symptoms were Significant Obstacles—

Symptoms of physical and mental disorders (e.g. lack of motivation, fear of using public transportation, difficulties with trust, chronic diarrhea related to irritable bowel syndrome, substance abuse) were identified typically as barriers to treatment. Some of the women who were interviewed reported feeling literally unable to get out of bed or off the couch. The intensity of their vegetative symptoms suggests their depressive symptoms served as a direct barrier to attending appointments and engaging in depression treatment. "I was constantly in the basement alone, isolated, depressed and laid in bed for four years."

- I mean basically what I do when I wake up I just lay there on the couch. That's what I do all day, I lay there. I don't even do the dishes. I don't get up and take a shower unless I'm going somewhere. . . when I'm gonna leave the house, which is not very often, you know I'll still get up and take a shower in the middle of the week or something but you know I don't even do that. I don't do the dishes, I just lay there. I don't do anything. I don't want to do anything.

- Catching the bus . . . that's a hard thing to you know be out in the public and just like I'm so nervous.

African American and Black women (n = 6) and women with annual household incomes under $10,000 (n = 6) reported these themes more often than other women (n = 2 for both groups). In contrast, concerns such as transportation, childcare, cost, stigma and lack of therapists of the same race and ethnicity were rarely raised by the participants, even when queried directly.

C. Doubt: Therapy won't change anything—The last barrier women typically described was the risk of finding psychotherapy will not be helpful. They were skeptical that therapy could actually create any changes in their lives. "That's all I did when I was in counseling. I went there and vented for a half hour and went home with nothing's fixed."

- I'm still upset over stuff that happened twenty years ago and I've talked to people about it before you know. Usually they say if you talk about it you're gonna feel better. Well I just don't.
- They can't make my husband get a job or help my back . . . what's the point? I mean I'm gonna go in there and say well this is the same stuff I'm telling you and doing the same stupid crying and they're gonna say, "Well, gee what do you want me to do about it?"

2. Women Reported a Diverse Array of Symptoms Causing Life Interference

A simple depression screening tool was used and we do not know if participants met diagnostic criteria for depression, but we were able to learn how participants with symptoms often associated with depression described their emotional distress. While women used language such as feeling depressed or down to describe their experiences, they generally reported being bothered particularly by symptoms that can interfere directly with engaging in psychotherapy, such as withdrawing from relationships, anger and irritability, feeling overwhelmed, and significant physical symptoms. There was rarely a focus on interior mood states; in fact, several women were explicit in reporting they were not feeling depressed despite their elevated PHQ-2 scores.

A. "Everybody is ticking me off."—Feelings of anger, irritability and interpersonal sensitivity were typical and especially prominent and bothersome to women. For example, one woman stated, "I don't know why it's just everything aggravates me. Everything aggravates me." Another woman remarked, "I snap. I get up and I just I just snap . . . Somebody could park in front of my house in my walkway and I'll have a fit. You know stuff like that just ticks me." Many reported these feelings significantly disrupted their ability to engage in health care appointments, function in their roles, and maintain relationships. African American and Black women (n = 8) typically reported these feelings more often than other women (n = 4).

B. "I just go into a shell and withdraw."—Rather than reporting feelings of isolation, loneliness, or disconnection, these women typically reported a desire to be left alone, actively cutting off contact with others. They suggested that their depression left them depleted of the resources to interact with others. "I got this wall put up. And I won't let nobody, like if somebody come in they be like girl come on let's talk, I don't want to talk. . . . I just shut down." Similarly, "I just go to a room by myself. Like I need to be alone when stuff like that is going on so I need to distance myself from everything."

C. "My body hurts."—Physical pain reported as an integral part of the women's depression was a variant theme. The women described pain and other physical symptoms as intrinsically connected to their emotional distress.

- I bottled everything up. And now when I get like depressed and I think about one thing that depresses me, the thousands come running behind it and I don't know why that happens but it does. And that's why it's more hurting now then like it's more stressful and I don't know my back is going hunch like. It's a lot of weight like just all over.

  Pain was also viewed as contributing to feelings of depression. "I have a lot of back problems and it's just hard to deal with. It's not that I'm making excuses for myself, it's just hard to deal with when you can't do the certain things that you want to do that normal people can do."

D. "I feel buried."—Another variant theme was feeling overwhelmed and burdened by the responsibilities and difficulties of daily life. The immediacy of life demands, often related to poverty, created a sense of defeat and a lack of future orientation. "Everything just seems insurmountable to me." Common challenges included being inundated by multiple pressures and responsibilities:

- Just the responsibility of being a parent sometimes, not being able to find employment that's gonna help me better my situation. . . . Just the fathers really not understanding their roles in the kids' lives. It is basically being more than one person basically is becoming overwhelming
- We've been short at work. Not enough help then by the time the morning comes, I do my running around, take my mother-in-law to work, drop my son off, come back home, feed my baby, take my shower, lay down for about an hour and a half, maybe two hours, time to get right back up, pick my niece up from school and pick my son up from school and go take them home. Then I go pick up my mother-in-law so I don't have no time during the day to myself.

This dynamic was different from the symptom of hopelessness because of the women's focus on the present moment, rather than anticipating negative outcomes for the future.

3. Psychotherapy Might Provide Safety, Insight, and Ability to Change

Despite the theme of risk viewed as inherent in the therapeutic relationship, every woman interviewed identified potential benefits for psychotherapy. More specifically, women viewed psychotherapy as an opportunity to feel safe and accepted, gain insight, and create tangible change in their lives.

A. Feeling safe and accepted—Viewing psychotherapy as an opportunity to discuss feelings and experiences in a way that felt safe and supportive was a general finding. The most common idea described was of psychotherapy as an opportunity to "vent", "get it off my chest", and release intense affect. Many women reported feeling they had few people in their lives who they experienced as empathic and accepting. "If I get a lot of stuff off my chest to someone who is actually listening to me . . . it will make me feel way better." Similarly, "I have a lot of things built up, I mean golly just a lot of things built up, and I just I need to vent. And my bones is too fragile to be hitting walls so just I need to talk."

Women reported relief at the idea of having "someone non-judgmental to talk to" who still accepted and respected them regardless of what they might have to say.

- It is lovely to talk to somebody who doesn't look at you differently or you know that doesn't take for granted what you're saying, yeah so it feels good to talk to somebody that actually had and not judge me.
- I guess you get somebody to talk to and they, you ain't gotta worry about them. They not gonna pass judgment on you or think whatever you say is stupid.

Women also expressed relief about the normalizing experience psychotherapy can provide. Women expressed the belief that "I don't feel so crazy" after speaking with a therapist and that it "helps you know that you're not alone". Last, women talked about the value of having someone to talk to who would respect and cherish the privacy of what is shared. For example, "you don't have to worry about them going and telling people what you have told them so it's that's the most comfortable part." African American and Black women (n = 10) and women with annual household incomes under $10,000 (n = 11) were more likely than other women (White/Caucasian/Latina/Other: n = 6; household income > $10,000: n = 5) to identify feeling safe and accepted as an important benefit of psychotherapy.

B. Gaining insight and understanding—Gaining insight was a variant response regarding the benefits of psychotherapy. Despite the difficulty discussing past experiences, many recognized that these experiences continued to impact their current feelings and struggles. Psychotherapy was described as an opportunity to explore the impact of their life experiences on their current functioning: "I know I must deal with it. I can't hang onto this. Then maybe I can go on with my life and do some things in my life. . . even if I have to live through them . . . maybe that won't hold me back to the point where it's holding me back now." And, "I mean you get you end up getting insight into why you're feeling what you're feeling or how you might deal with it better." African American and Black women (n = 7) were more likely to identify insight as a psychotherapy benefit than other women (n = 3) interviewed.

C. Getting help to change—A third potential benefit of psychotherapy noted to be typical was to obtain help in creating tangible, meaningful changes in their lives. Women reported psychotherapy could assist with reducing the frequency and intensity of negative emotions (e.g. "I probably wouldn't be as angry"), gaining coping skills, improving their level of functioning, and achieving meaningful goals:

- It would probably make me stop doing half of the stuff that I've been doing like running back and forth in the room screaming and yelling and stuff like that. You know, getting out and being with people and being around family and doing different things and not just staying stuck in the house and depressed and stuff like that.
- You can you know feel better, go back to school, get a job, become a productive member of society, maybe you take care of your kids better if you've got them, you know or you know you're not snapping as easily at them or whatever if you have kids.

Discussion

Barriers to the Therapeutic Relationship are Salient and Lead to Difficulty Engaging in Psychotherapy

Participants' concerns about the patient-therapist relationship were identified as a primary barrier to engagement in psychotherapy. Lifelong experiences of prejudice, trauma, and abandonment likely exacerbate feelings of vulnerability, distrust and caution about psychotherapy and psychotherapists. If a patient does not feel safe, understood and

supported by the therapist, psychotherapy cannot succeed. Therapists often embrace personal and discipline–specific values (e.g. substance abuse is not healthy coping), processes (e.g. expression of feelings associated with a difficult experience is beneficial), goals (e.g. decrease anger outburst; complete educational degree), and administrative needs (e.g. assess DSM-IV diagnosis; if primary diagnosis is substance abuse, transfer to different program) without recognizing they may conflict with those of the patient. Yet our findings suggest that some women may not be receptive to what are considered to be common therapist recommendations. This is supported by a study of 201 community-based African Americans which found that psychologists were described as older white males who were unsympathetic, uncaring, impersonal, elitist, and removed from their community (Sanders Thompson, 2004) . Furthermore, participants believed therapists could not accept or understand the life and struggles of African Americans, and viewed psychotherapy as invasive, with concerns about confidentiality and lack of trust, despite its potential for benefit.

Low-income and African American women who are not seeking out treatment from specialty mental health settings may benefit from a slow, gentle introduction to the psychotherapy experience in order to establish a sense of safety, understand the process of therapy, and view it as a potentially beneficial process. Often women have longstanding, trusting relationships with their women's health provider; close collaboration between the women's health provider and the therapist will increase the patient's follow through with psychotherapy. Psychoeducation may be helpful to explain the purpose of personal questions, and give permission to decline sharing until ready. Explicitly addressing concerns about feeling understood, rejection of priorities and goals, abandonment, and disappointment may be a valuable part of the joining process. A careful discussion about confidentiality and its limits, rather than the usual perfunctory mention at the initial appointment, also may be useful. Women may require an extended period of time to build safety and identify mutually acceptable goals and approaches for psychotherapy. Therapists may find it helpful to be open to the patient's own agenda and goals for treatment, even if they are not goals typically addressed in psychotherapy. Recognizing the positive intention of their choices and respecting their existing coping strategies and strengths may also allow the women to feel understood and validated. Then together the therapist and the woman can identify alternative options to making progress toward their identified goals. Last, discussion about the therapist's role in supporting the woman in her goals may facilitate development of realistic expectations for the course and outcomes of therapy.

High turnover of therapists is a systems problem unlikely to be changed easily. There are approaches that may help to reduce the feelings of abandonment this can cause, however. First, short-term structured psychotherapies begin therapy with a known timeline and focus on current difficulties. This may be less threatening to those who fear their therapist may leave or those who feel too vulnerable discussing their past experiences. Many women's health patients such as those interviewed in this study, however, may be looking for an opportunity to "vent" and have symptoms requiring longer-term therapy. Another alternative is to structure clinical settings so that supervisors and administrators can provide the continuity as therapists come and go. If women in therapy are aware that a supervisor is involved in their care, and perhaps even meet with the supervisor in conjunction with the therapist on occasion, it may help to establish a sense of connection and support from the larger agency even when therapists change.

Many of the women's health patients described physical and mental health symptoms as direct obstacles to engaging in psychotherapy. Symptoms of depression such as fatigue, lack of motivation, and poor self-care have been found to interfere with obtaining care in other studies as well (Cooper-Patrick, et al., 1997). Similarly, patients with comorbid conditions

reported that their symptoms, such as agoraphobia, arthritis, seizures, and interaction effects from multiple medications, interfered with treatment attendance (Mukherjee, et al., 2006a). Recognizing the direct interference that symptoms can cause with treatment engagement and adherence and proactively addressing these barriers with their medical providers may increase perceived empathy and ability to demonstrate adherence. Perhaps alternative approaches to transportation can be identified, or patients may find they are better able to attend appointments if they are scheduled at a particular time of day when they are feeling better.

Several previous studies have identified stigma as a significant barrier to treatment. Concerns about stigma were identified as causing social isolation and a desire to hide depressive symptoms from family and friends among African Americans with depression (Waite, 2007). Stigma and shame were described as primary barriers to care seeking among low-income depressed African Americans seeking treatment in a community mental health center in a low-income, urban, African American neighborhood (Cruz, et al., 2008) and among 201 community-dwelling African Americans interviewed in focus groups (Sanders Thompson, 2004). In other studies of African Americans with depression, treatment for mental health problems was seen as unacceptable to friends and family members (Cooper-Patrick, et al., 1997), and the need to seek therapy was associated with weakness and diminished pride (Thompson, et al., 2004).

Participants in this study reported that they did not view stigma as a significant barrier to treatment. While many of the women in our study reported others might not approve of psychotherapy, they consistently stated that others' beliefs would not stop them from seeking psychotherapy if they felt they needed it. There are several possible ways to interpret these discrepant results. First, participants in this study sample had already chosen to obtain care from a university-affiliated women's health clinic with predominantly white clinicians. Perhaps the group was self-selected to be less concerned with stigma than other study samples. Supporting this possibility are two studies of low-income Hispanic patients in health care settings that also found stigma was not considered to be a barrier to care. (Alvidrez & Azocar, 1999; Karasz & Watkins, 2006) A second possible interpretation is that the women in the study did experience concerns about stigma, similar to other studies, but felt that the potential for relief offered by psychotherapy minimized the importance of this concern; this perspective was described by several of the women. Third, two of the study interviewers are therapists (BC, EP). Women may not have wanted to acknowledge stigma as a barrier directly to them. Lastly, it is possible societal norms have evolved to the point that psychotherapy is associated with less of a stigma than in the past.

Additional barriers commonly reported in other studies included practical issues such as financial problems or lack of insurance coverage (Alvidrez & Azocar, 1999; Karasz & Watkins, 2006; Sanders Thompson, 2004), transportation (Alvidrez & Azocar, 1999; Mukherjee, et al., 2006b), and lack of time for scheduling (Karasz & Watkins, 2006; Mukherjee, et al., 2006b). These issues were not seen as significant barriers to our study participants, even when directly queried. In order to qualify for our study, however, participants had already successfully attended a medical appointment at a women's health clinic. This suggests they have adequate insurance coverage, transportation, and the time to attend an appointment already in place, so perhaps these issues are less of a challenge for women identified in women's health clinics.

An Expanded Array of Symptoms

In standard approaches to psychological assessment, the emphasis is on DSM-IV symptoms. While we have no way of knowing if participants would meet DSM criteria for major depressive disorder, the women's health patients interviewed for this study identified

irritability, social withdrawal, pain, and feeling overwhelmed as particularly problematic symptoms that interfered with functioning and associated with depressed mood or anhedonia. Life stressors such as poverty, violence, conflictual relationships, and multiple life demands directly impacted the symptom presentation of many of the women in this study. Of note, when queried about their current symptoms, participants made no reference to being bothered by the majority of DSM-IV major depression disorder criteria, such as weight change, sleep disturbance, feelings of worthlessness or guilt, poor concentration, or thoughts of death. While the symptoms reported may not indicate a DSM diagnosis of depression, they are reflective of experiences interfering with the lives of our participants. It may be useful for clinicians working with women's health patients to evaluate the identified domains of symptoms during clinical assessments, and consider targeting these symptoms as relevant in treatment.

Our findings extend results from studies with different samples demonstrating that cultural identity, culturally-bound traditions around expression of distress, and perceptions of depression shape the presentation of depressive symptoms (Waite, 2007) and require taking women's unique life contexts into consideration. For example, a focus group study of low-income African American women in an urban setting with depression found women described their depression using language such as "tired", "irritable", "pain", "stressed", and "drowning," and felt these symptoms were associated with histories of trauma and loss, socioeconomic challenges, and relational stressors (Waite, 2007). Similarly, 20 African American community dwelling women ages 80 and older who were not necessarily depressed described depression as being tied to experiences with poverty, loss, and suffering (Black, White, & Hannum, 2007).

Evaluating the patient's current and past life circumstances is necessary to recognizing and understanding women's depressive symptoms and communicating with her about them in a way that fit with her own conceptualizations of her experiences. Assessing patients for the symptoms that are most relevant and problematic to them and using language that fits with their concerns, rather than encouraging women to accept a diagnosis of depression, may facilitate building rapport and improve engagement into treatment. For example, we learned that women presenting to a women's health clinic were likely to describe pain and other physical symptoms as closely related to their mood; targeting their concerns regarding physical concerns may prove essential to helping women's health patients to feel cared about and understood. Connecting symptoms to life circumstances and using language that is consistent with patients' experiences may also facilitate women's self-recognition that their symptoms are causing significant difficulties in their lives. The women in this study tended to be present-focused, suggesting the importance of focusing on obtainable goals that can feel relevant to the patient (e.g. sign up for GED classes) may be more important than longer-term, more intangible goals (e.g. be financially secure).

The Chief Benefit of Treatment is Having a Good Listener

Despite the significant theme of women feeling unsafe in therapy, each and every woman interviewed also felt therapy could be beneficial. This apparent contradiction likely reflects a common feeling of ambivalence toward psychotherapy, with women recognizing there are both potential risks and potential benefits. An explicit discussion about the patient's feelings toward psychotherapy, including an assessment of the perceived risks and benefits, will allow the clinician to normalize any ambivalence, build upon how she hopes psychotherapy might be helpful, and acknowledge and address identified concerns. Study participants consistently identified the opportunity to express their feelings to a safe person outside of their situation as a valuable opportunity. Similarly, two of the three most common benefits associated with psychotherapy among 121 depressed Hispanic patients attending medical appointments were catharsis and support (Karasz & Watkins, 2006). While therapists are

routinely trained to be empathic and supportive, today's culture and billing structures tend to encourage therapists to focus on short-term treatments with an emphasis on diagnosis and outcomes such as symptom improvement, behavioral change, and improved function. Yet for women who tend to be overwhelmed, isolated, and have few safe people to turn to with their private feelings and experiences, the opportunity to feel heard and understood can be powerfully therapeutic. These findings are a good reminder of the importance of using common factors in psychotherapy (e.g., joining; building rapport; reflection) and providing a safe place for women who rarely have it. They also support the use of relationally-focused therapies, such as interpersonal psychotherapy, or relatively non-invasive present-focused therapies, such as problem solving therapy, as good matches for women with experiences similar to those in this study.

Subgroup differences highlight the importance of clinician sensitivity to symptoms, fears, and hopes that may be particularly relevant for Black, African American, and lower income women. These results must be considered more tentative, however, due to the smaller sample size of the subgroups.

Study Limitations

While study participants endorsed depressive symptoms, it is unknown if they would meet criteria for major depressive disorder or if psychotherapy would have been recommended by their provider for their particular treatment needs. We felt it was important to include women with and without psychotherapy experience to represent all women presenting in women's health clinics with depressive symptoms; this did lead to some heterogeneity in the sample, however, as some of the women had experience with psychotherapy or were currently receiving psychotherapy, while others had no exposure. Moreover, a significant proportion of the women spontaneously reported substance abuse which would impact their treatment needs. We did not assess medical conditions and are unable to consider how pain and physical disease may have been associated with women's responses. The team's pre-existing biases may have interfered with our ability to be open to all possibilities offered by participants. Perspectives are limited to young women in a women's health clinic, and therefore the findings are limited in their generalizability. Findings might be different with men, older women, other settings, or with different racial, ethnic, and socioeconomic representation.

Conclusions

These findings add to our understanding about women's health patients' experiences and perspectives about depression and psychotherapy. Women's health clinics may benefit from on-site psychotherapists who can collaborate closely with women's health providers and their patients. Moreover, additional efforts may be required to support patients moving from women's health clinics to specialty settings that offer psychotherapy. Tentative recommendations for both women's health providers and psychotherapists wanting to improve uptake of psychotherapy among their patients include: using language that resonates with patients' experiences of depression; an emphasis on rapport, safety, and developing mutual goals in psychotherapy; targeting physical and mental health symptoms as direct barriers to treatment engagement; and recognizing the power of using psychotherapy as a forum for emotional expression and support. Future studies assessing these proposed strategies are indicated.

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Table 1

Participant Characteristics

	N (%)
Age, mean (SD)	32.87 (10.32)
Self-reported Race/Ethnicity	
African American/Black	14 (60.9)
Caucasian/White	7 (30.4)
Latina/Hispanic/Other	2 (8.6)
Relationship Status	
Single/Divorced/Widowed	20 (87.0)
Married/Living with a partner	3 (13.0)
Annual household income	
<$10,000	15 (65.2)
$10,000–19,999	5 (21.7)
>$19,000	2 (8.6)
Unknown	1 (4.3)