



# The epidemiology of major depression and ethnicity in the United States

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## ABSTRACT

**Objectives:** To determine the prevalence, age of onset, severity, associated disability, and treatment of major depression among United States ethnic groups, national survey data were analyzed.

**Methods:** National probability samples of US household residents aged 18-years and older ( $n = 14,710$ ) participated. The main outcomes were past-year and lifetime major depression (World Mental Health Composite International Diagnostic Interview). Major depression prevalence estimates, age of onset, severity, associated disability, and disaggregated treatment use (pharmacotherapy and psychotherapy) and treatment guideline concordant use were examined by ethnicity.

**Results:** The prevalence of major depression was higher among US-born ethnic groups compared to foreign-born groups, but not among older adults. African Americans and Mexicans had significantly higher depression chronicity and significantly lower depression care use and guideline concordant use than Whites.

**Discussion:** We provide concise and detailed guidance for better understanding the distribution of major depression and related mental healthcare inequalities and related morbidity. Inequalities in depression care primarily affecting Mexican Americans and African Americans may relate to excesses in major depression disease burden.

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## 1. Introduction

In the coming decades, unipolar depression is projected to be the second leading cause of disability worldwide and the leading cause of disability in high-income nations, including the United States (Mathers and Loncar, 2006). Within the US, depression is a leading cause of disability among major ethnic and racial groups and a common problem in medical comorbidity (McKenna et al., 2005). Several technical problems have impeded the ability to identify disparities in depression prevalence and treatment access and quality. The aggregation of ethnic subgroups (i.e., all Latinos or Asians as opposed to specific ethnic subgroups) in national studies creates uncertainty. As a result this practice is discouraged by the Surgeon General and the National Institutes of Health because important differences in major depression are overlooked by

“masking” intra-ethnic differences (IOM, 2003; Jimenez et al., 2010; Alegria et al., 2008b). Furthermore, discrete determinants of seeking and obtaining treatment for depression and related disability and treatment use, such as variable access to insurance, are similarly masked when ethnic groups are lumped together (González et al., 2010).

Several recent studies have reported that differences in depression exist within ethnic groups; however, those studies did not present comprehensive comparisons across groups (e.g., Whites and Filipinos) (Williams et al., 2007; Alegria et al., 2007a,b, 2008a). Our current understanding of the epidemiology of major depression is further complicated because in the United States, mood disorders are combined (e.g., major depression and dysthymia) which makes it difficult if not impossible to specify the prevalence of this leading cause of disability (Jimenez et al., 2010; Williams et al., 2007; Alegria et al., 2008b; Kessler et al., 2003). Extant prevalence estimates are often presented in broad demographic and sociodemographic categories and some are outdated, particularly for older adults. Prevalence estimates for major depression among older adults rely on data from the Epidemiologic Catchment Area (ECA), which are over 30 years old and preceded major changes in current diagnostic criteria and demographic

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composition, especially shifts in the age structure and ethnic composition of the U.S. population in the new millennium (Weissman et al., 1988; Blazer et al., 1987). Later work with original ECA data have yielded interesting ethnic/racial comparisons of depressive symptoms and patterns of psychopathology among older adults; however, these aggregated data do not permit within ethnic/racial groups (e.g., African Americans and Caribbean Blacks) comparison (Rabins et al., 1996; Gallo et al., 1994, 1998). One purpose of this study was to provide a concise and precise report on the epidemiology of major depression among major ethnic and nativity groups across adulthood in the United States. Secondly, we compared the epidemiology of major depression within major ethnic subgroups. To achieve these objectives, nationally representative data were disaggregated by ethnic and nativity groups to provide prevalence estimates of US adults who met criteria for 12-month and lifetime major depression.

## 2. Method

### 2.1. Data collection

The National Institute of Mental Health's Collaborative Psychiatric Epidemiology Surveys (CPES) data were used in this study. The CPES combines three nationally representative studies: the National Survey of American Life (NSAL), the National Comorbidity Survey-Replication (NCS-R) and the National Latino and Asian American Study (NLAAS). Data for the CPES were collected between February 2001 and November 2003. Specially trained non-clinician interviewers administered face-to-face computer-assisted interview technology to collect data. The overall CPES response rate was 72.3%.

Complex multi-stage area probability sampling methods were used for data collection and sampling weights accounting for unequal probability of selection into the CPES samples and non-response rates were created by CPES staff to enable nationally representative analyses using the integrated data set. These weights were incorporated in all analyses presented in this study, allowing for the generation of population estimates by analyzing data specific to populations of interest (Pennell et al., 2004).

### 2.2. Analysis of subpopulations

Ethnic and racial categorization in the CPES was based on respondent self-identification. Since we were unable to adequately specify the Race or Ethnicity of respondents classified as "other" ethnic groups, we restricted our study subpopulation to nine groups including: Chinese ( $n = 600$ ); Filipinos ( $n = 508$ ); Vietnamese ( $n = 520$ ); Cubans ( $n = 577$ ); Mexican Americans ( $n = 1422$ ); Puerto Ricans ( $n = 495$ ); Caribbean Blacks ( $n = 1476$ ); African Americans ( $n = 4249$ ); and Whites who are not Latinos ( $n = 5071$ ). The overall sample size for the study was  $n = 14,710$ . Appropriate methods for subpopulation analyses of complex sample survey data were used for all analyses in this study.

Our primary interest was in the subpopulation meeting World Mental Health Composite International Diagnostic Interview (WMH-CIDI) criteria for Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria 12-month and lifetime major depression (Haro et al., 2006; APA, 1994).

### 2.3. Measures

The WMH-CIDI was administered by well-trained, non-clinical interviewers. Five sets of major depression epidemiological outcomes were examined: prevalence, age of onset, severity, associated disability, and treatment use.

### 2.4. Prevalence and age of onset

Prevalence estimates were based on the sample proportion that met WMH-CIDI criteria for 12-month and lifetime major depression, and the first episode age was used for calculating the mean age of onset.

### 2.5. Severity

The Quick Inventory of Depressive Symptomatology Self-Report (QIDS-SR) was used to measure symptom severity during the worst two-week period of the past-year (Rush et al., 2003). The QIDS-SR is a brief and reliable test that has been validated using other established measures of depression severity (e.g., 24-item Hamilton Depression Rating Scale). Following depression care guidelines and to facilitate the interpretability of our results, severity was dichotomized with individuals scoring 10 or less being classified as "Mild" and those scoring more than 10 grouped in a second category containing "Moderate, Severe, and Very Severe" cases.

### 2.6. Impairment

The World Health Organization Disability Assessment Scale (WHODAS-II) was used to measure depression-related impairment (i.e., past-30 days out of role) in five domains from the International Classification of Function, Disease and Health: (1) overall role impairment; (2) cognition; (3) mobility; (4) self-care; and (5) social impairment (WHO, 2001a,b). The WHO-DAS II has been used in previous psychiatric epidemiologic studies (Williams et al., 2007; Kessler et al., 2003). Individuals reporting no such problems in a specific domain the past 30-days were assigned a zero-value for that domain. All other respondents were assigned values based on their self-reported number of out-of-role days in specific domains.

### 2.7. Treatment

For past-year treatment, two depression care modalities were examined: pharmacotherapy and psychotherapy. Pharmacotherapy was determined by self-report and pill bottle inventories. Generic and trade names were reviewed by two board certified psychiatrists and a psychiatric nurse specialist to verify that the drugs were antidepressants prior to drug coding for the analyses. For psychotherapy, treatment codes were based on self-reports of visits to mental health professionals, including psychologists, counselors, social workers and other health professionals (lay counselors were excluded), and the mean time (minutes) spent during those visits. Three past-year depression care use outcomes were computed for analyses: (1) any pharmacotherapy; (2) any psychotherapy; and (3) either therapy. To determine the depression care adequacy, we applied the American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Major Depressive Disorder (APA, 2000). We considered Guideline concordant pharmacotherapy as the use of antidepressant agents for at least 60-days with supervision by a psychiatrist, or other prescribing clinician, for at least four visits in the past year. For psychotherapy, Guideline concordance was operationalized as having at least four visits to a mental health professional in the past-year lasting on average for at least 30 min each.

### 2.8. Analytic approach

Procedures designed for the analysis of complex sample survey data in the Stata (10.1) software package were used for analyses on all subpopulations (Anon, 2008). All statistical estimates were weighted, utilizing the CPES sampling weights to account for

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