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Original article

# Racial/Ethnic Differences in Teen and Parent Perspectives toward Depression Treatment

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**Abstract**

**Purpose:** There are significant racial/ethnic disparities in youth access to and use of appropriate depression treatment. Although there is a growing literature on racial/ethnic differences in treatment preference among adults, we know very little about whether these differences persist for adolescents and whether parents have an influence on their teens' treatment perspectives.

**Methods:** Teens and parents from a sample of primary care settings were interviewed at baseline and 6 months. We used bivarate and regression analyses to describe racial/ethnic differences in teen and parent depression knowledge and treatment preference and to assess the impact of parental views on teen perspectives.

**Results:** Latino and African American teens had lower average scores on antidepressant knowledge ($p < .01$) and counseling knowledge than white teens ($p < .01$). These racial/ethnic differences were greater among parents ($p < .001$). Parent antidepressant knowledge had an impact on teen knowledge when teens reported turning to them for advice ($\beta = 0.20$, $p < .05$). Teen knowledge about medication (odds ratio [OR] = 1.16, $p < .01$) and counseling (OR = 1.26, $p < .001$) were associated with a willingness to seek active treatment.

**Conclusions:** Racial/ethnic differences in depression treatment knowledge persist, but are more pronounced for parents than teens. Talking to parents who have more knowledge about depression treatment is associated with more teen knowledge and that knowledge is associated with greater willingness to seek depression treatment. Research is needed on the content and type of conversations that parents and teens have about depression treatment, and if there are differences by race/ethnicity.


*Keywords:* Adolescent depression; Mental health; Parent–child communication; Treatment preference

Depression is a major adolescent health issue, yet unmet mental health need in this population continues to be a serious problem. Nearly 80% of adolescents who suffer from a mental health disorder do not receive adequate or appropriate care [1–3], with disparities apparent for ethnic minority groups. For instance, despite the fact that Latina teens have the highest rates of depression [4] and the rates of suicide are increasing among African American teens faster than ever before [5], these two groups of teens are less likely to receive necessary mental health services than their Caucasian counterparts [6,7]. Wu [8] found that African American adolescents were less likely to receive care from a mental health professional, and Latino and African American teens were less likely to receive antidepressants compared with white teens.

Traditional access barriers to health care, such as insurance, do not fully account for these differences in mental health service utilization for adults [9,10]. For example, among adult patients with insurance and a usual source of medical care, Latinos are still less likely than whites to receive appropriate, evidence-based treatment consistent with practice guidelines [11]. Researchers have argued that patient factors, including varying perspectives on the mental health system and ideas about treatment modalities, may help to explain these disparities [10,11]. Although adults overall are

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reluctant to use psychopharmacological treatment [12,13], African Americans are more reluctant to seek active treatment and have higher rates of stigma associated with mental health service use [14,15] In a study of depressed primary care adult patients, Dwight-Johnson [16] found that African Americans preferred counseling over medication, although patients with more knowledge about antidepressants were more likely to opt for active treatment (e.g., some type of therapy including counseling and/or medication). Among Latino adults, findings are similar. In studies among Latino immigrants, counseling is often preferred over antidepressants, and counseling is perceived to be more effective than medication in treating depression. In addition, antidepressants are viewed as addictive, causing states of ''druggedness'' [17,18].

Whereas there is an emerging body of adult research on racial/ethnic differences in depression treatment perspectives, comparable studies among adolescents are limited. However, early findings indicate a similar profile. In studies of child mental health service use, ethnic minority parents are less likely than white parents to choose formal mental health providers, opting instead for informal providers, such as members of the clergy, for their children. These families report less confidence in the utility of psychotherapy and fear that contact with a formal mental health provider will result in institutionalization of the child [19–21]. The factors may explain the underlying factors that drive parental treatment preferences.

These few studies are beginning to elucidate factors related to mental health service use, but have focused on younger children, where the parent is deciding on treatment on behalf of the child. This is contrast to the situation involved with older children and adolescents, where the child may play a more active role in decision making about mental health care. There have been very few studies that have addressed ethnic differences in treatment preference when seeking mental health services among adolescents [22,23]. Jaycox and colleagues [22] found that African American teens are less likely to choose medication over counseling than their Caucasian counterparts, and Sen noted that African American and Asian males in particular were less likely to ask for help for a mental health issue [23]. Conceptually, it seems important to study adolescent treatment seeking in its own right, because parent perspectives may affect adolescent willingness to seek active treatment (as for younger children), but teens are also more active in the decision to seek care. In other fields, parent–teen communication about health can have a positive impact on adolescent health behaviors and help seeking. For example, teens who communicate with parents about sex have a greater understanding about sexual risk and a higher likelihood of condom use [24,25]. In addition, interventions that address parent–adolescent communication about diabetes can improve compliance with diabetes regimens among teens [26]. To date, we know very little about the relationship between depression knowledge and mental health treatment preference, and in particular, whether parents and teens have similar perspectives on mental health treatment, and whether these factors differ by racial/ethnic group. Thus, the two aims of this paper are to: (1) describe racial/ethnic differences in teen and parent depression knowledge and treatment preference, and (2) assess whether parent perspectives on treatment are associated with teen knowledge and treatment preference and if this differs by race/ethnicity.

## Methods

### *Study design*

Study enrollment occurred between January 2005 and March 2006. We recruited our sample from seven healthcare organizations in Los Angeles and Washington, DC (three of these sites each had more than one participating clinic, for a total of 11 clinics; two clinics contributed no patients, yielding data from nine clinics). We selected sites purposively to maximize diversity by patient race/ethnicity and whether the clinics were free, public, private managed care, or private insurance. We also selected Los Angeles and Washington, DC, because these locations provided a wide range of public and private settings, and because the study staff are located in these two offices. Youth were approached at the clinic and invited to participate in the study. Youth assent and parent/guardian consent were required. Youth were eligible for the study if they were currently attending school within 2 years of expected grade level, currently living with a parent/guardian who could also speak English or Spanish, not currently pregnant, and did not have a sibling in the study.

Once enrolled, eligible teens were assessed via telephone for participation in the project via the Diagnostic Interview Schedule for Children depression module [27–29]. Teens who were designated as ''depressed'' were invited to participate further in the study. After a depressed teen was enrolled, the next teen who screened as ''nondepressed'' from that same clinic, and of the same gender, was invited to participate as well. Thus, nondepressed teens were matched to depressed teens by clinic and gender. Teens and parents who participated in the study were interviewed at two points in time: shortly after the diagnostic interview, and again approximately 6 months later. One parent, generally the consenting parent, was invited to participate in the study. All measures were administered via Computer Assisted Telephone Interview (CATI). The survey was highly structured. Interviewers were trained to not deviate from the interview questions and script, and interviews were monitored for fidelity to this structure.

During the period between baseline and follow-up interviews, teens, parents, and physicians received feedback on the teen's depression status, and the teen and parent received educational materials about depression. A random half of the depressed teens completed a motivational interview by telephone with study staff. All participants were free to seek care for depression at any time. All teens and parents