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Racial/ethnic disparities in midlife depressive symptoms: The role of cumulative disadvantage across the life course

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ABSTRACT

This study examines the role of cumulative disadvantage mechanisms across the life course in the production of racial and ethnic disparities in depressive symptoms at midlife, including the early life exposure to health risk factors, the persistent exposure to health risk factors, and varying mental health returns to health risk factors across racial and ethnic groups. Using data from the over-40 health module of the National Longitudinal Study of Youth (NLSY) 1979 cohort, this study uses regression decomposition techniques to attend to differences in the *composition* of health risk factors across racial and ethnic groups, differences by race and ethnicity in the *association* between depressive symptoms and health risk factors, and how these differences combine within racial and ethnic groups to produce group-specific levels of – and disparities in – depressive symptoms at midlife. While the results vary depending on the groups being compared across race/ethnicity and gender, the study documents how racial and ethnic mental health disparities at midlife stem from life course processes of cumulative disadvantage through both unequal distribution and unequal associations across racial and ethnic groups.

1. Introduction

A health disparity is by definition a group-level phenomenon, describing differences in health outcomes across important social groups, with a particular focus on differences among socially advantaged and disadvantaged groups. In the United States, racial and ethnic minority groups bear the disproportionate burden of poor health outcomes. There has been increasing interest in examining inequalities in the risk and protective factors that give rise to racial and ethnic disparities in health outcomes, given the persistence and rise of various racial and ethnic health disparities despite efforts to reduce them (National Center for Health Statistics, 2012).

Research documenting racial and ethnic health disparities in the United States demonstrates that at all ages and relative to non-Hispanic whites, blacks are at an increased risk for morbidity, the onset and progression of disease, mortality, and lower life expectancy (see, e.g., Keppel, Pearcy, & Wagener, 2002; Olshansky et al., 2012; Williams & Collins, 1995; Williams, 2012). Hispanics or Latinos have similar or better health and all-cause mortality outcomes compared to non-Hispanic whites on some dimensions of health (often referred to as the Hispanic or Latino health paradox given their comparably lower socioeconomic status), but worse outcomes on other dimensions of health such as rates of infectious diseases and mortality from certain health conditions (Keppel et al., 2002; Palloni & Arias, 2004; Riosmena, Wong, & Palloni, 2013; Sorlie, Backlund, Johnson, & Rogot, 1993; Vega & Amaro, 1994; Williams & Collins, 1995).

Racial and ethnic disparities in mental health, however, do not necessarily follow the patterns of physical health

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disparities. Research on racial and ethnic disparities in mental health shows that some racial and ethnic minority groups are at an increased risk for some mental health outcomes such as depressive symptoms compared to non-Hispanic whites, but not other psychopathological outcomes such as major depressive episodes and anxiety disorders (see, e.g., Breslau et al., 2006; Kessler et al., 2005; Keyes, Barnes, & Bates, 2011; Keyes, 2009; Luo & Waite, 2005; Mezuk et al., 2010, 2013; Turner & Avison, 2003; Walsemann, Gee, & Geronimus, 2009; Williams et al., 2007). While some explanations for the latter pattern (sampling bias, measurement error, differences in positive coping) show limited empirical support (see, e.g., Mezuk et al., 2013), it is plausible that the "reversed" direction of the disparity reflects, in part, differences across groups in who has access to medical treatment, who seeks treatment, and the types of treatment received (Burgard & Chen, 2014; Williams et al., 2007). Using survey-based measures of mental health circumvents this issue in that the questions are asked of everyone regardless of access to medical care, thus putting all respondents on the same plane for making between-group comparisons (to the extent that the meanings of the questions or response options do not differ across groups). This study focuses on depressive symptoms reported as part of the Center for Epidemiologic Studies Depression scale, a measure for which previous research documents increased depressive symptoms for blacks compared to non-Hispanic whites (e.g., Luo & Waite, 2005; Turner & Avison, 2003; Walsemann et al., 2009).

For both physical and mental health outcomes, the overall direction and size of racial and ethnic health disparities is modified when certain social and psychological *health risk factors* are controlled. However, race and ethnicity often have statistical associations with health beyond the adjustment for health risk factors, or what Williams (2012: 283) calls "the added burden of race." One potential added burden of race that has not been systematically examined with respect to racial and ethnic health disparities is the *accumulation* of health risk factors across the life course. Previous research has shown that certain health risk factors accumulate across the life course in various ways to influence physical and mental health outcomes, yet much of this research has not systematically accounted for racial and ethnic differences in these life course processes of accumulation, and the studies that do often focus on racial and ethnic disparities in physical health as opposed to mental health. Scholars studying mental health "have only scratched the surface of the temporal dynamics upon which mental health and illness rest" (George, 2014: 251); this is particularly true with respect to the temporal dynamics of health risk factors that give rise to racial and ethnic disparities in mental health.

This study links various operationalizations of cumulative disadvantage to the study of racial and ethnic disparities in depressive symptoms, focusing on the accumulation of certain health risk factors over the life course and examining how these cumulative disadvantage factors combine within racial and ethnic groups to produce group-level racial and ethnic disparities in depressive symptoms at a particular point in the life course, midlife. In particular, this study attends to three different cumulative disadvantage mechanisms and how they underlie racial and ethnic disparities in depressive symptoms at midlife: through differences across racial and ethnic groups in the composition of *early life* and *persistent* exposure to health risk factors, as well as *status–resource interactions* in which there are varying mental health returns to health risk factors across racial and ethnic groups.

2. Review of the literature

Health at any one point in time is the product of a series of decisions, contexts, and experiences across the life course. While concurrent health risk factors may contribute in part to racial and ethnic disparities in depressive symptoms at midlife, the composition of health risk factors from across the life course is likely to contribute to these disparities as well (see, e.g., Pearlin, Schieman, Fazio, & Meersman, 2005). Cumulative (dis)advantage is broadly defined as "a general mechanism for inequality across any temporal process (e.g., life course, family generations) in which a favorable relative position becomes a resource that produces further relative gains," or an unfavorable relative position becomes a resource for further relative losses (DiPrete & Eirich, 2006: 271; see also Dannefer, 2003 and O'Rand, 1996). Focusing in particular on the accumulation of potential health risks, this study uses the cumulative disadvantage perspective to identify the various temporal mechanisms through which health risk factors accumulate across the life course given the myriad operationalizations of these temporal cumulative processes within the perspective (DiPrete & Eirich, 2006).[1]

Previous research documents that the *early life* exposure to certain health risk factors leads to racial and ethnic disparities in adult health outcomes through what is often referred to as a path-dependent cumulative disadvantage mechanism (DiPrete & Eirich, 2006; Willson, Shuey, & Elder, 2007) in which early life health and socioeconomic conditions have direct effects on later physical and mental health, as well as indirect effects through the intervening health and socioeconomic conditions they engender (Blackwell, Hayward, & Crimmins, 2001; Goosby, 2013; Haas, 2008; Hayward & Gorman, 2004; Kuh, Hardy, Langenberg, Richards, & Wadsworth, 2002; Miech & Shanahan, 2000; Pais, 2014; Pudrovska & Anikputa, 2014; Walsemann, Geronimus, & Gee, 2008; Willson et al., 2007). Thus, racial and ethnic disparities in midlife depressive symptoms may be attributable to differences between groups in the composition or level of early life health risk factors, such as socioeconomic background. Consistent with this mechanism, previous research has found evidence that early life socioeconomic factors account in part for racial and ethnic disparities in

[1] Other perspectives integral to – and often overlapping with – the study of such temporal mechanisms include the life course perspective more broadly as well as the stress process, cumulative adversity, and cumulative inequality perspectives (see, e.g., Ferraro, Shippee, & Schaefer 2009; Kuh, Ben-Shlomo, Lynch, Hallqvist, & Powe, 2003; Turner, Wheaton, & Lloyd 1995).