Racial/Ethnic Differences in Perceived Reasons for Mental Health Treatment in US Adolescents With Major Depression

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Objective: Racial/ethnic differences in the course of treatment for a major depressive episode (MDE) among adolescents may arise, in part, from variation in the perceived rationale for treatment. We examined racial/ethnic differences in the perceived reasons for receiving mental health (MH) treatment among adolescents with an MDE. **Method:** A total of 2,789 adolescent participants who experienced an MDE and received MH treatment in the past year were drawn from the 2005 to 2008 National Survey on Drug Use and Health. Adolescents reported the settings in which they received care and reasons for their most recent visit to each setting. Distributions of specific depressive symptoms were compared across racial/ethnic groups. Racial/ethnic differences in endorsing each of 11 possible reasons for receiving treatment were examined using weighted probit regressions adjusted for sociodemographic characteristics, health and mental health status, treatment setting, and survey year. **Results:** Despite similar depressive symptom profiles, Hispanic adolescents were more likely than whites to endorse "breaking rules" or getting into physical fights as reasons for MH treatment. Black adolescents were more likely than white adolescents to endorse "problems at school" but less likely to endorse "felt very afraid or tense" or "eating problems" as reasons for treatment. Asian adolescents were more likely to endorse "problems with people other than friends or family" but less likely than whites to endorse "suicidal thoughts/attempt" and "felt depressed" as reasons for treatment. **Conclusion:** Racial/ethnic minority participants were more likely than white participants to endorse externalizing or interpersonal problems and less likely to endorse internalizing problems as reasons for MH treatment. Understanding racial/ethnic differences in the patient's perceived treatment rationale can offer opportunities to enhance outcomes for depression among diverse populations. J. Am. Acad. Child Adolesc. Psychiatry, 2014;53(9):980–990. **Key Words:** race/ethnicity, mental health services, depression, perceived treatment rationale

Although major depressive episodes (MDEs) affect 8% of adolescents between the ages of 12 and 17 in a given year,[1] the majority of adolescents who experience an MDE do not receive any mental health (MH) treatment.[2,3] Not only are treatment rates low for all adolescents, but research has documented significantly lower rates of MH treatment among black, Hispanic, and Asian youth with depression compared to their non-Hispanic white counterparts.[3,4] In addition to differences in the likelihood of receiving any MH treatment, research also suggests that racial/ethnic differences exist in the course of MH treatment for adolescents with depression, including the diagnoses given by clinicians,[5,6] the modality of treatment provided (e.g., antidepressant medication),[3,7] and treatment duration.[7,8]

Racial/ethnic differences in the course of treatment for an MDE among adolescents could arise, in part, from group variation in their perceived understanding of the reasons for treatment. More specifically, research on mediators of treatment response in depression has suggested that patient perception of the treatment rationale as credible (i.e., it identifies relevant problem symptoms and a strategy to improve them) early in treatment is associated with patients' positive expectancies, early treatment response, and improved outcomes posttreatment.[9] Clinician

awareness of racial/ethnic patterns of perceived problems may therefore help clinicians to explore and identify the problems driving the patient to seek treatment, and may help in developing credible treatment rationales. Thus, information on racial/ethnic differences in the perceived reasons for obtaining care could inform clinicians' patient-centered strategies for enhancing quality of care among diverse populations.

Although there are a number of reasons to believe that there may be differences in how adolescents with depression across diverse populations understand the MH treatment process, there is little evidence to date on whether these differences exist. Cultural differences in the conceptualization of depression as an illness, in symptom expression, in the stigma concerning MH treatment, and in the process of engaging the MH care system could all affect the perceived rationale for treatment among adolescents with depression from diverse backgrounds.[10-12] To address this gap in the literature, we use data from a large, nationally representative study to derive a sample of adolescents with MDE who received treatment, and we examine the association between race/ethnicity and the perceived reasons for receiving MH services.

METHOD

Data

We pooled 4 years of data (2005–2008) from the National Survey on Drug Use and Health (NSDUH), an annual, nationally representative, cross-sectional survey.[13] NSDUH samples noninstitutionalized individuals aged 12 years and older in the US civilian population from all 50 states and the District of Columbia; adolescents between the ages of 12 and 17 were oversampled. The survey includes a series of questions to assess whether the adolescent respondent experienced an MDE in the previous year according to *DSM-IV* criteria, as well as information about MH services use, the perceived reasons for MH treatment, sociodemographic characteristics, substance use and other externalizing behaviors, and health status.

Study Sample

Our analytic sample is derived from the subsample of adolescents who experienced an MDE based on *DSM-IV* criteria and received MH treatment during the year. Past-year MDE was assessed with an adolescent depression module adapted from the depression section of the National Comorbidity Survey–Adolescent.[13] This module is based on a modified version of the World Health Organization Composite International Diagnostic Interview–Short Form (CIDI-SF),[14] which has good psychometric concordance with the full CIDI.[14] Furthermore, research has indicated a high concordance between the full CIDI and independent clinical diagnoses in the adolescent population.[15]

Adolescents were also asked if they received treatment or counseling for their behavior and emotions that were not caused by alcohol or drugs (i.e., MH treatment). Racial/ethnic differences in the prevalence of MDE and the receipt of treatment in these data have been documented elsewhere.[3] Of the 71,183 adolescents who participated in NSDUH between 2005 and 2008, 6,031 (8.5%) were identified who had experienced a past-year MDE; of adolescents with an MDE, 2,933 (48.6%) also received MH treatment during that year. Of these, 81 did not indicate any reasons for treatment (dependent variables), and 63 were missing information on at least 1 key explanatory measure (MDE-related impairment [n = 13], externalizing behavior(s) [n = 26], and/or treatment setting [n = 24]) resulting in an analytic sample of 2,789 adolescents for statistical analyses.

Measures

Perceived Reasons for Mental Health Treatment. Adolescents were asked whether they received treatment because of problems with behavior or emotions (not caused by alcohol or drugs) from 1 of 9 settings or providers (hospital, residential treatment program, day treatment program, mental health clinic, private therapist, in-home therapist, doctor's office, foster care/therapeutic foster home, school). For each setting in which they indicated that they received treatment, they were asked about the reason(s) for which they received treatment during their last visit and were offered the following choices: (1) thought about or tried suicide (i.e., suicidal thoughts/attempt); (2) felt depressed; (3) felt very afraid or tense; (4) were breaking rules and "acting out"; (5) had eating problems; or (6) some other reason. Adolescents could endorse multiple reasons, and if a respondent indicated "some other reason," an additional set of choices was offered: (7) had trouble controlling your anger; (8) had been in physical fights; (9) had problems at home or in the family; (10) had problems with friends; (11) had problems with people other than friends or family; (12) had problems at school; (13) some other reason. There were no racial/ethnic differences in the likelihood that an adolescent indicated "other reason" in the first set of choices and was offered the second set of choices. We combined reasons 9 and 10 into a single category of "problems with family/friends" after preliminary multivariate analyses indicated there were no racial/ethnic differences in the patterns of responses, resulting in a total of 11 possible reasons. Each reason was coded with an indicator for endorsed (versus not endorsed) if it was endorsed for any of the settings in which treatment was received.