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Research report

Racial and ethnic differences in depressive subtypes and access to mental health care in the United States

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ABSTRACT

Objectives: Racial and ethnic minorities in the U.S. underutilize mental health service for mood disorders. This study sought to identify depressive subtypes associated with low use of mental health services across racial and ethnic groups based on a large, nationally representative sample of adults in the U.S.
Methods: Based on latent class analysis, we identified the latent profile of depressive symptoms among those who endorsed lifetime depressed mood or anhedonia in the 2001–2002 National Epidemiological Survey on Alcohol and Related Condition (302 Asian Americans; 8602 Whites; 2266 Blacks; 2254 Hispanics). Proportions and types of lifetime mental health service use across depressive symptom subtypes were assessed and compared across the racial and ethnic categories.
Results: A four class model of depressive subtypes was examined across race and ethnicity ("mild," "cognitive," "psychosomatic," and "severe"). Asian Americans, blacks, and Hispanics with "severe" subtype of depression had significantly lower odds of mental health service use compared to whites with "severe" subtype of depression. While Asian Americans did not have higher proportion of "psychosomatic" subtype than other race and ethnic groups, Asian Americans with "cognitive" subtype of depression significantly underused mental health services compared to Asian Americans with "psychosomatic" subtype of depression (Odds ratio:0.34, 95% Confidence interval:0.13,0.91).
Limitation: We were unable to account for heterogeneity of the subethnic group compositions based on country of origin and other socio-demographic factors.
Conclusions: A targeted outreach intervention to raise awareness among Asian Americans, blacks, and Hispanics with "severe" subtype and Asian Americans with "cognitive" subtype of depression may reduce disparity in mental health service utilization across racial and ethnic groups.

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1. Introduction

Lack of regular access to mental health services results in tremendous public health burden in the forms of poor clinical outcomes, including suicide, hospitalization, and loss of productivity (Bijl et al., 2003; Sanderson et al., 2007). Racial and ethnic minorities underuse psychiatric treatment for mood disorders (Alegria et al., 2008). The disparities in mental health care persist between those with similar levels of severity of mental disorders and socio-economic status (Lee et al., 2011). As the number of immigrants and minority populations in the United States and other parts of the world increases (U.S. Census, 2011), there is an increased need for understanding cultural influences on expressions of mental disorders and help seeking behaviors among members of minority groups (Kalibatseva and Leong, 2011; Kung and Lu, 2008; Mallinson and Popay, 2007).

Heterogeneity in the subtypes of mental disorders across racial and ethnic groups adds another layer of complexity on the relationship between culture and mental health (Unick et al., 2009). Particularly, diagnosis of major depression is based on various combinations of symptom profiles and the level of clinical severity (Baumeister and Gordon, 2012; Baumeister and Morar, 2008; Carragher et al., 2009; Chen et al., 2000; Kramer, 2002; Østergaard et al., 2011). Recently, Carragher et al. (2009) assessed subtypes of depression using the 2001–2002 National Epidemiological Survey of Alcohol and Related Conditions (NESARC) data, and identified four classes of depressive symptoms: "non-depressed", "cognitive–emotional", "psychosomatic", and "severely depressed". Other studies also have examined a number of depressive subtypes using latent class analysis (Chen et al., 2000; Kramer, 2002; Sullivan et al., 1998). However, little is known about the heterogeneity of depressive subtypes across racial and ethnic groups and its implications in the access to mental health services.

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Previously, several studies have suggested that racial and ethnic minorities are more likely to report physical symptoms than psychological symptoms compared to U.S.-born whites, and there have been conflicting findings on the association between tendency to somaticize and help seeking patterns (Deisenhammer et al., 2012; Kirmayer and Young, 1998; Lin and Cheung, 1999; Nadeem et al., 2009; Wiesner et al., 2010; Yeung et al., 2004). Racial and ethnic minorities who hold negative attitudes towards psychological illness or take an integrated approach to mind and body may perceive that they need care for physical health, rather than for mental health (Yamashiro and Matsuoka, 1997; Yeung et al., 2004). Nadeem et al. (2009) found, in contrast to their expectation, that black and Hispanic women with a higher level of somatization had greater perceived need for mental health care. Similarly, a community-based study of Chinese Americans found that expression of somatic symptoms was the main impetus for seeking help from mental health professionals (Mak and Zane, 2004). Somatic symptoms, along with other comorbid conditions, may motivate help seeking due to greater perceived need for professional services and may provide more culturally acceptable reasons to seek professional services than emotional distress alone (Kung and Lu, 2008; Nadeem et al., 2009).

In the present study, we aimed to examine the relationship between subtypes of depressive symptoms and mental health service use patterns across racial and ethnic groups based on a large epidemiological survey. Following Carragher et al. (2009) assessment of latent subtypes of depressive symptoms, this current study examined the variations in the latent subtypes of depression across race and ethnicity in NESARC wave 1 (2001–2002). The primary purpose of our analysis was to compare the prevalence and odds of mental health services across racial and ethnic minorities with different depressive subtypes. The secondary aim of this study was to examine the prevalence of depressive subtypes and forms of mental health services used (inpatient, outpatient, emergency room, and prescribed medication) across racial and ethnic groups.

2. Methods

2.1. Sample

Fig. 1 illustrates the source of the study sample for this analysis. Participants were drawn from the NESARC wave one, which was conducted in 2001–2002 and had a total sample size of 43,093. NESARC is a community-based, epidemiological survey of adults over 18 years of age and it is sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The Office of Management and Budget approved the research protocol and informed consent. Detailed NESARC study methods can be found elsewhere (Grant et al., 2005, 2003b). In order to capture the full spectrum of depressed individuals with varying degree of depression severity, we included all participants ($n=13{,}753$) who endorsed lifetime 'criterion A' symptoms (i.e., depressed mood or anhedonia) of DSM-IV diagnostic criteria for major depressive disorder (American Psychiatric Association, 1994). Native Americans were excluded due to a small sample size and inability to assess more than five conditional probabilities of depressive symptoms ($n=294$). Participants who endorsed the 'criterion A' symptoms but were missing all other depressive symptom responses were excluded ($n=35$). This resulted in an analytic sample of $n=13{,}424$.

2.2. Measures

2.2.1. Ascertainment of DSM-IV depressive symptoms

Trained lay interviewers assessed DSM-IV depressive symptoms using a structured psychiatric interview, the NIAAA Alcohol Use

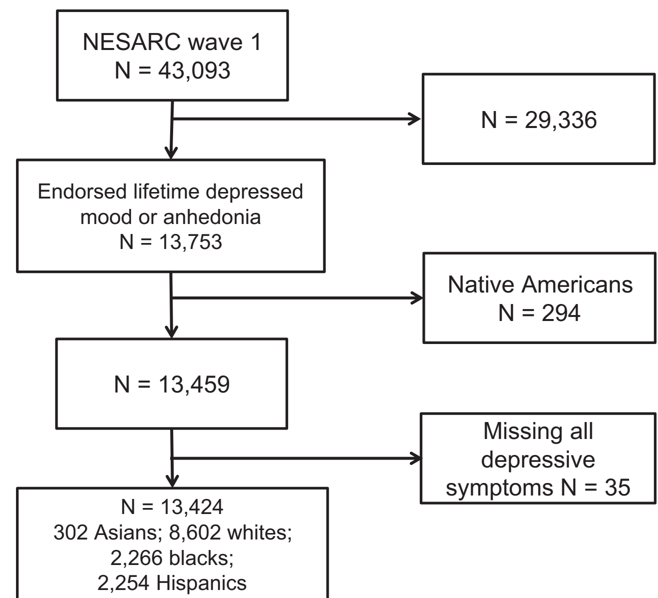

Fig. 1. Flow chart of the study population used for analysis.

Disorder and Associated Disabilities Interview Schedule-DSM-IV (AUDADIS-IV) (American Psychiatric Association, 1994). Test–retest reliability of lifetime major depression was fair (kappa=0.65) (Grant et al., 2003a). Those participants who endorsed 'criteria A' symptoms of depression, depressed mood or anhedonia, for at least two weeks in the lifetime were subsequently asked about seven other depressive symptoms experienced during the time "when their mood was the lowest or they cared the least about things": increasing/decreasing of weight, difficulty falling asleep/oversleeping, tiredness, psychomotor difficulty, having concentration difficulty or difficulty making decisions, having excessive feelings of worthlessness or guilt, or having thoughts of death or suicide. All lifetime depressive symptom responses were coded as binary variables (yes/no).

2.2.2. Mental health service use

Lifetime mental health service use was assessed among participants with one or more depressive symptoms in the AUDADIS-IV. Mental health services included: "ever receiving help to improve mood from (1) any kind of counselor, therapist, doctor, or psychologist; (2) staying at a hospital for at least one night; (3) visiting an emergency room; (4) prescribed medications or drugs from a doctor." Lifetime mental health service use was coded as a binary variable (yes/no) if a participant used one or more professional mental health services. The current analysis did not include mental health service use responses for the treatment of anxiety or substance use disorders.

2.2.3. Ascertainment of race or ethnicity

Race and ethnicity were identified based on the question, "What is your origin or descent?" and respondents chose from a list of 58 categories.

2.3. Statistical analysis

A latent variable is an unobservable variable that induces the association between measurable, observed variables (Lazarsfeld and Henry, 1968). Latent class analysis characterizes a latent variable that consists of different subtypes or categories. While factor analysis aggregates observed variables to continuous and latent subdomains, latent class analysis classifies people into latent

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