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ORIGINAL PAPER

Racial/Ethnic Disparities in Depression and Its Theoretical Perspectives

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Abstract The purpose of this review is to look at racial/ethnic disparities in the diagnosis of depression and its treatment and to explain the dynamics and causes of these racial/ethnic disparities in depression by looking at several theories, such as perceived racism, cultural competency, and other theories. Perceived racism is that the perceptions of an environmental stimulus as being racist affects the coping responses of ethnic/racial minorities, which alters psychological and physiological stress responses, and finally affects health outcomes negatively. A lower level of cultural competence can lead to health disparities. In addition, lower socioeconomic status and health care providers' beliefs and behaviors about patients' race/ethnicity and class can affect depressive symptoms as well as diagnosis and treatment. In order to reduce these racial/ethnic disparities in depression, diverse interventions should be developed to improve depression outcomes for ethnic minority populations based on these theoretical perspectives.

Keywords Health disparity · Racial/ethnic difference · Depression · Theory

Introduction

The prevalence of major depressive disorder (MDD) is 16.2 % in nationwide [1]. Lifetime MDD prevalence estimates were highest for whites (17.9 %), followed by Caribbean blacks (12.9 %) and African Americans (10.4 %); 12-month MDD estimates were similar across groups [2]. However, based only on depressive symptoms, there were no differences in diagnosis of depression between African Americans and whites/others [3]. Other studies have showed that disparities in depression are found for female, racial/ethnic minorities, and those with low socioeconomic status [4]. These inconsistent results may be due to

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methodological issues, such as inconsistency in measuring depression, inconsistency in classifying racial/ethnic groups, and using different controls as confounding factors. It means that further methodologically sound research studies are needed [5].

More interestingly, the chronicity of MDD was higher for both black groups (56.5 % for African Americans and 56.0 % for Caribbean blacks) than for whites (38.6 %) [2]. One systematic review of the literature found lower rates of treatment of depression for African Americans and Hispanics than for Caucasians [5]. For example, white depressive patients were treated with more antidepressants than black patients, controlling for age, gender, insurance coverage, and clinical factors. These statistics mean that rates of depression are underestimated and treatment is inadequate in ethnic minority groups.

There is robust support for higher prevalence rates of depression in ethnic minority groups in the United States. Environmental factors and a level of acculturation are considered in relation to internalizing disorders such as depression or other mental disorders in ethnic minority groups [6]. Of several theoretical perspectives explaining these phenomena, perceived racism and cultural competency are considered to be predominant in addressing dynamics and causes of these racial/ethnic disparities in depression [7, 8].

The purpose of this paper is to (1) look at racial/ethnic disparities in the diagnosis of depression and its treatment; and (2) explain the dynamics and causes of these racial/ethnic disparities in depression by looking at several theories, such as perceived racism, cultural competency, and other theories.

Phenomena of Racial/Ethnic Disparities in Depression

Sclar et al. [9] studied the diagnosis of depression and the use of antidepressant pharmacotherapy using data from the National Ambulatory Medical Care Survey. From 1992–1993 to 2003–2004, the annual rate of visits documenting a diagnosis of depression increased from 10.9 to 15.4 per 100 U.S. population for whites, from 4.2 to 7.6 for blacks, and from 4.8 to 7.0 for Hispanics. A concomitant diagnosis of depression and antidepressant use increased from 6.5 to 11.4 per 100 for whites, from 2.6 to 5.2 for blacks, and from 3.0 to 5.6 for Hispanics. This result suggests that by 2003–2004, diagnostic and treatment rates were similar for blacks and Hispanics, but were less than half the observed rates for whites [9].

In addition to the prevalence and the extent of treatment for depression, Williams et al. [2] estimated the persistence and disability of depression. The results showed that lifetime MDD prevalence estimates showed trends similar to those of the Sclar and colleagues' study [9]. However, 12- month MDD estimates were similar across racial/ethnic groups. The chronicity of MDD was higher for both black groups (56.5 % for African Americans and 56.0 % for Caribbean blacks) than for whites (38.6 %). Both black groups were more likely to rate their MDD as severe or very severe and more disabling. These results demonstrate that when MDD affects minority groups, it is usually untreated and is more severe and disabling compared to non-Hispanic whites. It means the burden of depression may be higher among African Americans than in whites [2].

In primary care settings, although the disparities in counseling/referrals for counseling, antidepressant medications, and any care for depression were mostly eliminated over time, continued disparities in diagnosis and care for depression among African Americans and Hispanics remained in the National Ambulatory Medical Care Study from 1995 to 2005 ($N = 96{,}075$) [4]. A study examined racial differences in access to and quality of treatment for depression for persons with past-year depressive disorder. About 69 % of Asians, 64 %

of Latinos, and 59 % of African Americans, compared with 40 % of non-Hispanic whites, did not have access to care for past-year mental health treatment. Disparities in the likelihood of having both access to and receiving adequate care for depression were significantly different for Asians and African Americans compared to non-Hispanic whites [10].

Among ethnic minority adolescents, particularly Filipino/a adolescents, depressive symptom rates were higher than those of non-Hispanic white adolescents in the 2003 and 2005 California Health Interview Surveys (CHIS). The study showed that Filipino/a adolescents had higher scores on the Center for Epidemiologic Studies Depression Scale (CES-D) than non-Hispanic white adolescents (5.43 vs. 3.94 of a total score of 8 points). Moreover, they reported more clinically significant depressive symptoms and lower use of school counseling than non-Hispanic white adolescents. Although this study employed a cross sectional design, it can be inferred that ethnic minority adolescents are more likely to have higher rates of depressive symptoms and underutilization of counseling [11]. A study showed that only 34 % of the total sample received adequate mental health care for past-year major depressive episodes, but Caucasian youths (36 %) received significantly more adequate mental health care than Hispanic youths (27 %). Not surprisingly, having Medicaid or coverage via the State Children's Health Insurance Program significantly increased the odds of receiving adequate mental care for past-year major depressive episodes for both Hispanics and Caucasians [12].

In mental health treatment seeking attitudes, African American older adults with depression showed less positive attitudes about mental health services. These negative attitudes regarding mental health services affected their never having sought mental health treatment [13]. As to adherence to antidepressant medication, white children with depression were significantly more likely to receive an antidepressant prescription and they were significantly more adherent than black children [14]. Thus, in order to address the mechanism of these racial/ethnic disparities in depression, psycho-socio-cultural perspectives such as perceived racism, cultural competency, and other theories along with relevant research studies will be addressed.

Mechanism of Racial/Ethnic Disparities in Depression

Perceived Racism

Perceived racism refers to the "subjective experience of prejudice or discrimination" [7]. Racism is defined as "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" [7]. Racism can be conceptualized into two categories: attitudinal racism and behavioral racism. Attitudinal racism means beliefs and attitudes that denigrate individuals or groups because of ethnic group affiliation. Behavioral racism is any act of an individual or institution that denies treatment. Racism involves intergroup racism (held by a different ethnic group) and intragroup racism (held by the same ethnic group) [7]. Historically, racial discrimination has been a negative experience for ethnic minorities in the U.S. For example, African Americans were more likely to experience racial discrimination than non-Hispanic whites [15].

The biopsychosocial model proposed by Clark et al. [7] explained the effects of perceived racism as a stressor for stress-related health outcomes in African Americans. It was based on the stress and coping model proposed by Lazarus and Folkman. The key tenet of this model is that the perception of environmental stimuli as racist affects coping responses

of ethnic/racial minorities, which alters psychological and physiological stress responses, and finally affects negative health outcomes. The perception of environmental stimuli can be influenced by constitutional factors, sociodemographic factors, and psychological and behavioral factors. When African Americans or other ethnic minorities perceive racism as a chronic stressor, along with more passive coping responses, this can affect the development of depression by "posing transient threats to self-esteem, making the group's failure to receive normative returns more salient, and contributing to a sense of helplessness" [7].

Many studies have been conducted examining the relationship between perceived racism as a stressor and depression or other health problems. One study recruited 215 Mexican Americans to examine whether perceived discrimination directly affected health outcomes. The results showed that perceived discrimination predicted depression and poorer general health. The influence of perceived discrimination on general health was greater for men than women. This result means that discrimination can be a source of chronic stress and the accumulation of stress is detrimental to both mental and physical health [16]. These results are consistent with those from another study in which racial discrimination was associated with lower levels of psychological functioning as measured by perceived stress, depressive symptomatology, and psychological well-being [17]. Moderating factors between perceived stress and depression have also been measured. Lower utilization of reactive coping strategies and higher family support significantly reduced the strength of the association between racial discrimination stress and depressive symptoms [18, 19].

Several studies have been conducted using the longitudinal link between perceived racial discrimination and depressive symptoms and its moderating effects in adolescents with depression. Increases in perceived discrimination were associated with increased conduct problems and depressive symptoms. For conduct problems, the association was stronger for boys than for girls. For depressive symptoms, no gender differences were found. This association was weaker when youths received nurturing-involved parenting, were affiliated with friends, and performed well academically. These can be moderating factors of perceived discrimination in the adjustment of African American youths [20]. Among 199 South Asian international students in the U.S., higher levels of depressive symptoms were predicted by higher perceived prejudice and lower self-reported competence in work, personal/social efficacy, and intracultural behaviors. There was a gender difference in the relationships among the predictors and depressive symptoms [21].

Like the results from the above studies, there is a growing evidence to support the relationship between perceived racial discrimination and depression. Perceived racism has been regarded as an appropriate theory to use to illuminate its negative effects on mental health status. Through longitudinal analysis, this relationship has become more robust [20]. Several conceptual frameworks were developed to look at the relationship between perceived racism, moderating factors, and mental health status in ethnic minorities [7]. However, perceived racism does explain how the perceived racism of a subject can affect health outcome. This theory does not consider issues with interpersonal relationships between health care providers and patients in health care settings, cultural issues, and issues about barriers of access to health care.

Cultural Competency

Culture is a dynamic process that is shaped by social, historical, and political context. Through the culture, people form and develop definitions of health and illness and perceive

and assimilate health messages. Thus, culture can affect decisions about choosing healthcare providers, describing symptoms, and considering treatment options, furthermore, treatment adherence [8]. Being culturally competent stresses the importance of an interactional perspective between the client and the provider. In the larger meaning, cultural competency includes not only the ability of the provider but also that of the client. In terms of provider's perspectives, cultural competency refers to "having cultural self-awareness, knowledge, and skills that facilitate the delivery of effective services to ethnically and culturally diverse clients" [22]. As to client's perspectives, bicultural competence refers to "the perceived ability to function in both the heritage culture and in the new host society" [23]. A lack of bicultural competence for immigrants or ethnic minorities may lead to inconsistent diagnosis and treatment recommendations, and non-adherence to the recommended treatments [23].

Language and communication skills are important factors in cultural competency. A study of cultural-linguistic factors and depression or psychotic symptoms was conducted with 259 monolingual English-speaking Latino, bilingual Latino, and European American patients. Compared with European Americans, bilingual Latinos had significantly higher rates of depression and lower levels of mania. No significant differences were found between monolingual English-speaking Latinos and European Americans. The results suggest that the diagnostic process is affected by an apparent association with cultural-linguistic influences, notably speaking English as a second language [24]. Another study examined the direct effect of perceived bicultural competence (PBC) on depressive symptoms in 167 Asian American, African American, and Latino American students. The results suggested that minority stress was positively associated with depressive symptoms, controlling for perceived general stress and the interaction between minority stress and PBC was significant in predicting depressive symptoms. A higher level of PBC moderated the association between minority stress and depressive symptoms. Social groundedness and cultural knowledge can be important coping resources for minorities [25].

Two studies examined racial/ethnic differences in communication about depression. One study found that whites and Hispanics were significantly more likely to communicate about depressive symptoms with a physician or other practitioner than African Americans, controlling for personal characteristics [26]. The other study found that the average number of depression-related statements was much lower in African-American patients than whites (11 vs. 38 statements). African-American patients also experienced visits with less rapport building than white patients (21 vs. 30 statements) [27]. As to antidepressant treatment, African Americans were less likely to find antidepressants acceptable than whites. Non-preference of antidepressant medication was found for treatment of depression in blacks. Moreover, they had misbeliefs about the efficacy of antipsychotics and side effects [14]. These differences can influence the diagnosis and treatment of depression, which may lead to racial/ethnic health disparities.

Cultural competency can be effective in explaining the cause of racial/ethnic differences in the diagnosis of and choice of treatment for depression and adherence to treatment in healthcare settings. Cultural competency theory explores diverse cultural factors in social, historical, and political context. Especially, in the U.S., cultural competency has strong power of explanation. In contrast to perceived racism, it can explain issues about interpersonal relationships between health care providers and patients in health care settings, and cultural barriers of access to health care. Moreover, efforts such as training courses about learning about different cultures have been offered to reduce health disparities. Thus, culturally sensitive and effective interventions or treatments need to be studied and developed for ethnic minorities [22].

Other Theories

Viewing socioeconomic status as a fundamental cause of diseases is one theory explaining health disparities in depression. There was an inverse relationship between socioeconomic status and depression in women. Lower status jobs with low decision power and high job demands, can decrease the sense of personal control, which is related to depression [28]. A study of 164 homeless women examined depression and its treatment. The study found that 56 % of the homeless were currently depressed at the time. The prevalence of depression in the homeless was higher than that of general population. There were also racial differences in use of health care. Fourteen depressed women reported needing mental health services but not receiving them during the past 3 months and all of these women were black. About 60 % of non-black depressed women and only 16 % of black depressed women were currently taking antidepressants [29]. Socioeconomic status can be regarded as an influencing factor regardless of the type of disease. This means that it can be a generally accepted theory but not a specific theory to explain racial/ethnic disparities in mental health. However, racial/ethnic differences in health status are reduced after controlling for socioeconomic status, which means race/ethnicity was related to socioeconomic status.

According to social cognition theory, when health care providers encounter patients, health care providers' beliefs and behaviors are affected by patients' race/ethnicity and class. In turn, these providers' behaviors affect patients' behaviors and health outcomes [30]. Providers' beliefs are important factors in interpreting information from or symptoms of patients, and in making decisions such as diagnosis or treatment. Under identical clinical situations of depression, health care providers can perceive black patients' symptoms as less significant than white patients' through their own frameworks about race/ethnicity. As a result, they tend to treat more white patients with antidepressants. Social cognition theory focuses more on interpersonal relationships between the provider and the client in health care settings. However, it cannot explain issues such as non-adherence to treatment which occurs outside of health care settings.

Conclusions

There are significant disparities in the treatment process and in symptomatic and functional outcomes of depressive disorders in racial/ethnic minority patients [31]. Several theoretical perspectives can explain these health disparities. Perceived racism is that the perceptions of an environmental stimulus as being racist affects the coping responses of ethnic/racial minorities, which alters psychological and physiological stress responses, and finally affects health outcomes negatively. A lower level of cultural competence can lead to health disparities. In addition, lower socioeconomic status and health care providers' beliefs and behaviors about patients' race/ethnicity and class can affect diagnosis and treatment of depression.

In order to reduce these racial/ethnic disparities in depression, diverse interventions should be developed to improve depression outcomes for ethnic minority populations based on these theoretical perspectives. For example, multicomponent chronic disease management interventions can be effective in improving depression outcomes for ethnic minority populations. Case management appears to be a key component of effective interventions. Socioculturally tailored treatment and prevention interventions may be more efficacious than standard treatment programs [31].

Conflict of interest The author declares that she has no conflict of interest.

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