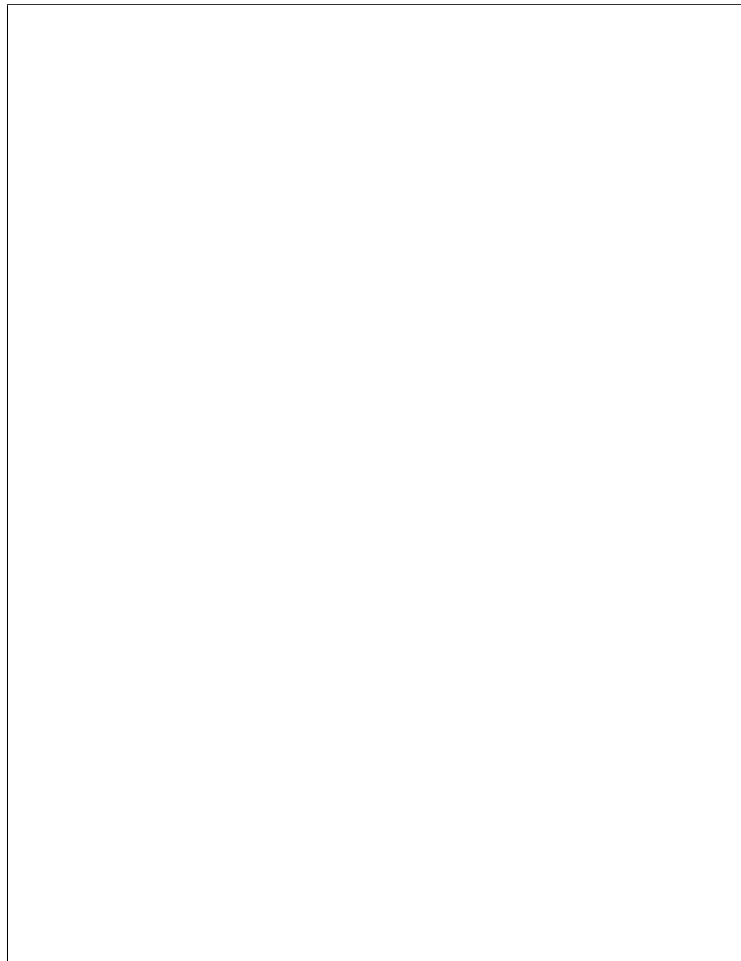


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## Racial and ethnic disparities in depression treatment

Esteban V Cardemil, Tamara Nelson and Kristen Keefe

Over 20 years of research have documented racial and ethnic disparities in depression treatment. To date, however, this research has not led to substantive improvements. In this article, the authors argue for a broader perspective on disparities that encompass individual-level help-seeking processes in addition to the more traditional structural-level analyses. Cultural and contextual factors influence the entire range of help-seeking behaviors, from initial expressions and conceptualizations of distress, to perspectives on depression and depression treatment, to experiences with depression treatment.

Understanding these influences, and their connections to the persistent disparities affecting racial and ethnic minorities, offers clinicians and researchers opportunities for targeted interventions that have potential to improve quality healthcare for all.

### Address

Clark University, United States

Corresponding author: Cardemil, Esteban V ([ECardemil@clarku.edu](mailto:ECardemil@clarku.edu))

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### Introduction

Despite the identification of numerous efficacious psychosocial and pharmacologic treatments for depression [1–4], many individuals in need do not receive adequate treatment [5]. For example, data from the National Comorbidity Survey-Replication (NCS-R) indicate that while 56.7% of individuals who met criteria for past-year depression received some form of treatment, only about half of these received specialty psychiatric care. In a recent analysis of the National Health and Nutrition Examination Survey (NHANES), Wittayanukorn *et al.* [6] found that over 70% of individuals with self-reported depressive symptoms did not receive either pharmacotherapy or psychotherapy, including almost 50% of individuals with severe levels of symptoms. Moreover, among those who received formal mental health services, less than one-quarter will receive an ‘adequate’ dose of treatment [7].

These numbers are even worse for individuals from racial and ethnic minority groups, for whom research

has consistently documented lower rates of depression treatment [8–11,12], despite evidence of effectiveness [13]. Even when racial and ethnic minorities seek out treatment for depression, they are less likely to receive an adequate dosage of treatment [14,15], and more likely to prematurely drop out [16–18].

The consistent findings over the past 20 years that racial and ethnic minorities are less likely than Whites to receive adequate treatment for depression has unfortunately not yet produced substantive changes in these disparities. Indeed, recent analyses of data from the National Ambulatory Medical Care Survey (NAMCS) suggest that the disparities between minorities and Whites are not improving, and in some cases may be worsening [19,20,21].

There are numerous reasons for the field’s difficulty in reducing the disparities in mental healthcare. Given that many of the explanations for these disparities are structural in nature and therefore located at the level of society (e.g., funding for community health centers), communities (e.g., limited number of bilingual providers), and systems (e.g., insurance limitations), many of the changes needed to address these disparities take time to implement. However, there is also reason to believe that limitations in disparities research have prevented the field from fully exploring and understanding the complexity of the relevant underlying issues. In particular, very little disparities research has conceptualized the help-seeking process in its entirety from individuals’ initial experiences of distress, through the range of perspectives and attitudes toward treatment that individuals display, to individuals’ use of and experiences with mental health services. An expanded focus on the entire help-seeking process would allow for a comprehensive analysis that includes factors at both individual and systems levels. Moreover, it would better accommodate the complexities of a process that is most likely non-linear and iterative, with experiences of services recursively feeding back to inform experiences and attitudes.

In this article, we briefly review the literature on the help-seeking process for depression as it pertains to racial and ethnic disparities in mental healthcare. Importantly, although our focus is on help-seeking at the individual level, we are not arguing against the very real structural factors that make important contributions to racial and ethnic disparities (e.g., insurance limitations, insufficient funding for community mental health centers). However, less attention has been given to individual-level help-seeking behaviors in the literature, and these behaviors

may be most amenable to intervention and change. Therefore, we focus on the contextual and cultural factors that have been identified as playing important roles in shaping help-seeking processes in three interrelated areas: (1) experiences and conceptualizations of depression, (2) perspectives on formal mental health services, and (3) experiences with formal mental health services.

### Definitions of disparities in mental healthcare

In discussing this literature, it is important to define a few key terms, given that research on disparities is replete with inconsistencies and incomplete definitions [22]. Even the most commonly used definition of disparities, which was published by the Institute of Medicine (IOM), is limited. In particular, the IOM definition describes disparities as 'differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention' [23]. By distinguishing between differences in the use of healthcare from disparities in the quality of healthcare received [22,24], this definition recognizes the existence of group differences in need, which would lead to group differences in need for services and subsequent differences in utilization rates. In addition, this definition acknowledges that important cultural beliefs and preferences might lead some individuals to seek mental healthcare outside of the formal system — behavior that would in turn also contribute to group differences in utilization of services.

However, this definition has important limitations; the most salient being that it works from a conceptualization of disparities that begins only when individuals make contact with the mental healthcare system. That is, the definition does not adequately account for the ways in which negative experiences with healthcare can shape perspectives and subsequent utilization of healthcare. These negative experiences can be personal, but they can also be historical and shared among members from the same racial or ethnic groups (e.g., distrust of medical community by African Americans due in part to historical legacy of racism) [25], which could then contribute to the disparities reported in the literature. This reciprocal relationship between utilization of healthcare and experiences with healthcare may be especially important in the area of depression treatment, where decisions to seek formal mental healthcare are often influenced by prior treatment experiences [26].

Relatedly, the disparities literature interchangeably uses a number of overlapping, yet distinct, terms, including *access*, *utilization*, and *engagement*. Access can be understood as the availability of services for individuals who want them, and so barriers to access are primarily structural factors (e.g., insurance limitations, availability of community health centers). Utilization of services, in contrast, refers to behavior of individuals with respect to services. Barriers to utilization can include structural

factors, but they also include individual-level logistical (e.g., lack of transportation, financial constraints, inability to take time off work) and psychological (e.g., attitudes toward mental health services, stigma, cultural values) factors. Engagement refers to the initial contact and continued interaction with mental health services; barriers include structural and individual barriers, as well as problems with patient–provider interactions (e.g., cultural competence and working alliance). Thus, although these constructs overlap, they emphasize different aspects of patient contact with the mental healthcare system.

Taken together, we therefore conceptualize disparities in mental healthcare as any group-based inequity in treatment access, utilization, or engagement that is not accounted for by group-based differences in underlying need. This definition builds on the IOM definition by conceptualizing disparities across the range of ways that individuals make contact with the mental healthcare system, allowing for a fuller analysis of the help-seeking process. We now turn our focus to how this conceptualization of disparities may be applied to mental healthcare for depression, emphasizing utilization and engagement with services, as these are areas that incorporate individual-level factors.

### Experiences and conceptualizations of depression

Before seeking out mental health services, individuals must first recognize that they are experiencing distress in ways that could be ameliorated through formal services. Since Kleinman's [27] seminal work examining the relationship between neurasthenia in China and depression in the West, there has been increasing recognition that cultural and contextual factors can influence the experience and expression of distress [28,29], which can make the connection between distress and formal treatment less obvious.

With regards to depression, research has documented different prevalence rates of depression among racial and ethnic groups in the U.S. [5,30,31]. Numerous theories have been developed to explain this group-based variability in risk for depression, including the possibility that for some groups, cultural influences may produce an experience of depression that does not fit the standard DSM model. For example, subsequent to Kleinman's [27] study, other researchers have found evidence that the experience of depression among individuals from China may be characterized predominantly by somatic symptoms [32,33]. There has also been some emerging support for the possibility that anger, rather than sadness, might be a central component of depression for some groups, like Latinos [34].

Insofar as cultural and contextual factors might influence the expression of depressive symptoms, they might also

affect how individuals understand and conceptualize depression. In support of this notion, several researchers have found that racial and ethnic minorities are less likely to conceptualize depression as resulting from biological factors. Instead, the data suggest greater endorsement of psychosocial causes (e.g., trauma, death of loved one, immigration factors), as well as religious and spiritual ones (e.g., lack of faith) [35–40].

This nascent research body suggests that individuals whose experiences and conceptualizations of distress differ from traditional, Western conceptions of depression may be less likely to seek out formal depression treatment, as well as follow through on recommendations from providers. Future research would do well to more rigorously investigate the ideas of alternative expressions of depression, as well as investigate other cultural groups and their normative expressions of distress.

### Perspectives on depression and depression treatment

Another body of research has examined the extent to which disparities in depression treatment may result from different perspectives on treatment itself. Most of this work has explored group differences in individual-level psychological factors, including stigma, attitudes toward mental health services, and coping behavior. With regards to stigma, a robust literature has documented greater stigma about mental illness among racial and ethnic minorities than among European Americans [41–43]. However, a recent review of the literature examining stigma and depression treatment yielded mixed findings for African Americans and Latinos [44]. The limited research among Asian Americans, however, has generally found greater stigma among Asian Americans than European Americans [45,46].

Relatedly, researchers have tended to find few racial and ethnic differences in attitudes toward mental health services, and some have found more positive attitudes among African Americans [44,47]. However, a consistent finding has been that racial/ethnic minorities are more likely to indicate preferences for counseling and psychotherapy over antidepressant medications [48,49]. This distinction in preferences may be due to differences in attitudes and ideas about antidepressant medications, including the extent to which depression is caused by biological factors, the effectiveness and addiction potential of antidepressants, stigma associated with taking antidepressants, and the effectiveness of alternative forms of coping like counseling and prayer [49–52].

There is also some evidence that group differences in stigma and attitudes may be connected to cultural values and expectations regarding gender roles, family relationships, and interpersonal interactions [53,54]. For example, some research has found that the cultural value of

*familism* is associated with some Latinos' reluctance to discuss mental health issues outside of the family [35,55]. Recent work has also noted the important role of religiosity and spirituality in shaping attitudes toward mental health services, with many racial and ethnic minorities reporting a preference for religious and spiritual approaches to treat depression [37,48,56–58].

In sum, it is critical to examine the extent to which perspectives on depression and depression treatment may affect utilization of services. Stigma, attitudes toward treatment, and cultural values can play key roles in shaping the help-seeking process, thereby influencing the likelihood that individuals will seek out formal or alternative treatments for depression. It would be valuable for future research to investigate how interventions targeted at both providers and patients might be able to influence these constructs.

### Experiences with mental healthcare

Racial and ethnic disparities still exist even for those individuals who eventually make contact with the mental health care system. Disparities in engagement with the system can occur at the initial contact, where minorities are less likely to get appropriate referrals [21], and over the course of treatment, where minorities are less likely to receive an adequate dosage of treatment [14,15] and are more likely to drop out prematurely [16–18].

Much of the research on racial and ethnic disparities in engagement has focused on provider–patient interactions. Studies have shown that some providers view patients from racial and ethnic minority groups as less effective communicators, less compliant, and more likely to abuse alcohol and drugs [59,60]. Relatedly, a considerable literature has argued that deficits in cultural competence — most commonly defined as provider self-awareness, knowledge about diversity issues, and skill in working with individuals from different backgrounds — can lead to worse provider–patient interactions and subsequently worse treatment engagement [61,62].

Empirical support for the importance of cultural competence has been found across the spectrum of mental health services, with the majority of research focused on the psychotherapy process. This work has documented evidence for associations among level of cultural competence, quality of provider–patient relationships, and level of treatment engagement [61,63–65]. More recently, the concept of cultural competence has been extended to primary care settings, where Ishikawa and colleagues [66] found that patient perception of their primary care physician's (PCP) cultural competence was associated with both a more positive PCP–patient relationship and with greater intention to follow up on PCP referrals to formal depression treatment.

Cultural competence has also been investigated at the level of the intervention, whereby standard interventions are adapted for particular cultural groups [67]. Several meta-analyses have found evidence for the effectiveness of cultural adaptations of interventions, although the data are mixed regarding the extent to which adapted interventions outperform standard ones in alleviating symptoms [68\*,69,70]. With regards to depression treatment specifically, there is strong evidence for the efficacy of adaptations of cognitive-behavioral therapy and interpersonal therapy among Latinos and African Americans, though the evidence base is more limited among Asian Americans and American Indians [13,71,72\*\*]. In addition, research has not yet empirically evaluated the extent to which cultural adaptations might directly improve treatment engagement [73].

Taken as a whole, understanding patient experiences with mental healthcare, including the central factor of patient–provider interaction, can provide essential insight into understanding disparities in engagement. Cultural competence, whether at point of contact or during the course of treatment, seems to play an important role in improving engagement with treatment. Future research in this area should explicitly evaluate the connections between cultural competence and engagement, as well as explore cultural competence among non-providers (i.e., staff, case managers).

## Conclusion

The mental healthcare disparities that affect racial and ethnic minorities in the U.S. have persisted despite 20 years of research investigating their causes. Research across the entire help-seeking process highlights the many different ways in which cultural and contextual factors can contribute to racial and ethnic disparities, above and beyond structural barriers. Focusing on help-seeking affords opportunities for researchers, clinicians, and organizations to develop targeted interventions that can respond to the cultural and contextual processes that contribute to disparities. Notably, this process is likely recursive and iterative, whereby experiences with mental health services will shape conceptions of depression, as well as perspectives on treatment (either positively or negatively).

A challenge of this approach relates to the complexity of integrating research literatures that work with differing assumptions, definitions, and methodologies. Moreover, important gaps remain in the knowledge base with different disorders and different racial and ethnic minority populations. Still, this approach has potential to advance our understanding of the multiplicity of factors that impact racial and ethnic disparities, due to the focus on modifiable individual-level factors. Ultimately, because of the persistent and often daunting nature of disparities that continue to affect many communities, it is critical

that providers and researchers find novel approaches to engage fully with culture and context across the help-seeking spectrum in order to increase equitable access for all.

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