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Unmet Need for Mental Health Services Utilization Among Under-resourced Black and Latinx Adults

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Abstract

Introduction: Substantial unmet need for mental health services (MHS) exists in the U.S., with pronounced disparities among people of color. Research highlights the need to identify facilitators and barriers to MHS utilization among Black and Latinx individuals to better promote overall health. We tested an expanded model of MHS use based on Andersen's (1995) conceptual framework of healthcare utilization. Associations were examined between sociodemographic variables, trauma and adversity burden, living with HIV, and unmet need for MHS in a community sample of under-resourced Black and Latinx individuals. Barriers to MHS utilization are described.

Methods: 500 participants completed the UCLA Life Adversities Screener (LADS), sociodemographic measures, and items assessing need for and barriers to MHS.

Results: 228 (46%) participants reported a need for MHS; of these, 115 (51%) reported receiving MHS. A binomial logistic regression model estimated the relative contribution of the LADS on need for MHS. Severity of LADS, younger age, and living with HIV predicted unmet need for MHS. Barriers to MHS included financial and time constraints and health system-related issues. One-way analysis of variance (ANOVA) tests revealed differences in mental health symptoms by MHS need.

Discussion: The unmet need for MHS in this sample of Black and Latinx individuals highlights the importance of addressing the systemic roots of trauma and adversity burden, and eliminating structural barriers to treatment to reduce existing health and mental health inequities.

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Keywords

Black and Latinx individuals; trauma and adversity burden; mental health service utilization; need for mental health services; under-resourced individuals

There is substantial need for mental health services (MHS) in the U.S. Among adults living with mental illness, fewer than half receive any type of MHS, including inpatient or outpatient treatment or counseling, or prescription medications (SAMHSA, 2020). The unmet need for MHS is especially pronounced among under-resourced people of color who are disproportionately affected by historical inequities in social determinants of health (SDOH) adversities and exposure to trauma that heighten risks for adverse physical (i.e., chronic illnesses) and mental health (i.e., symptoms of depression, post-traumatic stress disorder (PTSD) outcomes (Hamilton et al., 2020; Myers et al., 2015; NAMI, 2019; Shim et al., 2021; Westermair et al., 2018). Particularly concerning is the under-diagnosis and undertreatment of mental health disorders among Black and Latinx individuals in primary care (PC) settings (Liu et al., 2015; Stockdale et al., 2008). As a result of, and compounding these disparities, people of color are less likely to seek out and access MHS, and twice as likely not to utilize MHS, increasing the duration of untreated symptoms (Myers et al., 2015; NAMI, 2021; Pal, 2018; Perzichilli, 2020).

There are shared and distinct explanatory factors for unmet need for MHS among Black and Latinx populations. Shared barriers include racism and discrimination, being underinsured or uninsured, lack of transportation, fear, mistrust, and/or not knowing how to initiate MHS, and societal and culture-specific stigma toward mental health problems and treatment (Alarcon et al., 2020; Fripp & Carlson, 2017; Perzichilli 2020; Shi et al., 2019). Research notes that Black individuals may be less likely to use MHS due to mistrust and fear of being mistreated (Fripp & Carlson, 2017;Shi et al., 2019), whereas Latinx individuals are often deterred by language barriers and fear of deportation (Rios-Ellis, 2005). Given strong linkages between mental and physical health, barriers to MHS utilization must be identified to facilitate the development of intervention strategies that promote health and wellbeing among people of color (Bauer et al., 2020).

Trauma is a significant risk factor for poor health and need for MHS across the lifespan (Bauer et al., 2020). Child and adult trauma are each linked to elevated rates of psychiatric disorders in adulthood, including depression, posttraumatic stress disorder, and substance abuse (Breuer et al., 2020; Bryant-Davis et al., 2010; Green et al., 2010; McLaughlin et al., 2010; Seng et al., 2008; Shahar et al., 2004). Despite research confirming that histories of trauma influence mental health need and utilization, MHS frameworks have yet to test this relationship among under-resourced ethnic minority populations who are also more likely to experience trauma (Myers et al., 2015).

Andersen's behavioral model of health care access and utilization was the first to move beyond an individual focus to examine health care use (Andersen, 1968; Andersen, 1995; Andersen & Newman, 1973). Andersen's (1995) conceptual framework incorporates predisposing (e.g., *sociodemographic factors*), need (*perceptions of need*), and enabling (*logistical aspects of receiving care*) factors. This framework has been infrequently used to

predict MHS use among under-resourced community individuals with histories of trauma (Babitsch et al., 2012). The current study addressed this gap, testing an expanded model of MHS use to better understand facilitators of and barriers to MHS use among under-resourced Black and Latinx individuals. Consistent with Andersen's model, we examined predisposing factors (sociodemographic factors, trauma and adversity burden, and chronic illness), need factors (perceived need for MHS and mental health symptoms), and enabling factors (barriers to MHS). We (a) tested the role of trauma and adversity burden in MHS use; (b) identified barriers to MHS among those with unmet need for MHS; and (c) examined whether mental health symptoms differed between those with no need for MHS, unmet need for MHS, and those who accessed MHS to better understand barriers to MHS among marginalized populations.

Methods

Participants

A multi-ethnic sample of 500 participants, including 230 (46%) African-American (n = 167 males; 63 females) and 270 (54%) Latinx participants (n = 50 males; 220 females), was recruited to participate in four studies supported by the NIMH-funded Center for Culture, Trauma and Mental Health Disparities with overlapping and unique eligibility criteria (see Myers et al., 2015). Study participants were male or female, English or Spanish speaking, had a history of interpersonal violence or sexual abuse, and were recruited from community clinics and community-based organizations, some of which served people living with HIV, through flyers and word-of-mouth referrals (see Glover et al., 2010; Myers et al., 2015). Given recruitment at HIV service organizations, coupled with research that documents high rates of trauma, psychological distress, and SDOH adversities among people living with HIV that impact engagement in care, HIV (a chronic, manageable illness) was conceptualized as a predisposing factor for MHS (Brezing et al., 2015; Leddy et al., 2021; Machtinger et al., 2012; Taylor, 2021; Tsuyuki et al., 2019).

A standard core battery of psychosocial measures was administered to all participants, in English or Spanish. Child sexual abuse and adult trauma questions were completed via face-to-face interviews due to their sensitivity. All other measures were administered utilizing the Audio Computer-Assisted Self-Interview system. Participants were provided with transportation, childcare, and refreshments, if needed. They were compensated for their time and received information on mental health and other services. The research was approved by the Institutional Review Board at the University of California, Los Angeles (UCLA) and all study participants provided written informed consent (Liu et al., 2015).

Measures

Predisposing Factors—Predisposing factors included sociodemographic variables, trauma and adversity burden, and HIV-serostatus.

Sociodemographic Factors.: Sociodemographic factors included self-reported (i.e., age, *Black or Latinx ethnicity*), gender (i.e., *male or female*), and monthly household income (≤ $1,249 vs > $1,249).

Trauma and Adversity Burden.: Trauma and adversity burden was assessed by the UCLA Lifetime Adversities Screener (LADS). The LADS is a brief 5-item screening tool used to assess 4 lifetime variables (sexual abuse, interpersonal violence (IPV), community violence, and family adversity) and recent experiences of discrimination (see Liu et al., 2015). The LADS is a validated, multi-dimensional measure that results in a weighted lifetime exposure score. Responses to the five items were summed and rescaled to create a score between 0 (*no to any experiences*) and 1 (*yes to all 5 experiences*). A cut score of 0.33 identifies patients at high risk for mental health problems (see Liu et al., 2015).

Chronic Illness.: HIV-serostatus (positive or negative) was confirmed through recent HIV, CD4 or viral load tests or medical records (Williams et al., 2013).

Need Factors

Perceived Need for MHS.: Participants' perceived need for MHS was assessed with one item asking them whether, in the previous six months, they felt they had needed professional treatment or counseling for emotional or mental health problems, such as feeling sad, depressed, anxious, or nervous (*Yes/No*). Those who did not perceive a need for MHS were labeled, "No need for MHS." Participants who responded in the affirmative were asked whether they had received treatment or counseling (*Yes/No*). Respondents who reported need for MHS and obtained treatment or counseling were categorized as, "MHS use"; those who did not as, "Unmet need for MHS".

Mental Health Symptoms.: Participants completed measures of depression, post-traumatic stress symptoms (PTSS), somatic symptoms, and suicidal ideation. *Symptoms of Depression* were assessed with the 21-item Center for Epidemiological Studies-Depression Scale (CES-D), (Radloff, 1977). The alpha for this measure was 0.91. *Post-traumatic stress symptoms* were assessed using the Posttraumatic Diagnostic Scale (PDS), (Ehring et al., 2007; Foa et al., 1997). The PDS consists of 17 post-traumatic stress symptoms; participants rate how frequently each is experienced, with response options ranging from 0 (*not at all or only one time*) to 3 (*five or more times a week or almost always*). Participants responded to these items with the traumatic experience that has been the most bothersome to them in mind. Summed responses were used to calculate a total continuous score to assess PTSS. The Cronbach's alpha for this measure was 0.92. *Somatic symptoms* were measured using the somatic symptom module of the PHQ-13 (Kroenke & Spitzer, 2002). Participants were asked to rate the severity, over the last 4 weeks, of 13 symptoms as 0 (*not bothered at all*), 1 (*bothered a little*), or 2 (*bothered a lot*). Two additional somatic symptoms (i.e., *feeling tired or having little energy; trouble sleeping*) were added to this measure. The Cronbach's alpha for the 15 item measure in this sample was 0.83. *Suicidal ideation* was assessed with one of two items: participants either completed the Beck Depression Inventory (BDI); (Beck et al., 1996) or the PHQ-9, depending on the particular study they were enrolled in. The following item was used from the BDI: "For the past week, including today…suicidal thoughts or wishes was administered, using the Likert-scale from 0 (*I don't have thoughts of killing myself*) to 3 (*I would kill myself if I had the chance*). For the PHQ-9, participants endorsed an item, "thoughts that you would be better off dead or of hurting yourself in some way"

using the scale: 0 (*not at all*) to 3 (*nearly every day*). Responses of 1 or higher were coded as indicating suicidal ideation.

Enabling Factors

Barriers to MHS.: Barriers to MHS were reported by participants with a perceived need for MHS but who did not receive treatment. Participants were asked to select all the reasons they did not receive treatment. Participants could also select "other" and provide a response. Responses included characteristics related to mental health settings ("*It was hard for you to get an appointment," ; "Having a long wait time at the clinic*"), finances ("*You didn't have enough money or insurance to pay for your visits*"), transportation ("*You had no way to get to the clinic or doctor's office*"), childcare ("*You had no one to take care of your children*"), time constraints ("*You had too many other things going on*"), and fear of negative consequences *("You were afraid to go because of your partner"*). Responses to the, "other" option were coded into two further categories, MH literacy (e.g., "*needed more information*") and stigma (e.g., "*ashamed*").

Statistical Analyses—Data analyses were conducted in four phases: (a) Spearman correlation coefficients were obtained to determine bivariate associations between unmet need for MHS, sociodemographic variables, LADS, and HIV-serostatus; (b) a binomial logistic regression model was fit to estimate the relative contribution of the LADS on unmet need for MHS with relevant sociodemographic variables and HIV-serostatus; (c) barriers to MHS use were summed and reported as descriptive statistics; (d) a series of one-way analysis of variance (ANOVA) tests were run to examine differences in PTSS, symptoms of depression, somatic symptoms and suicidal ideation by MHS need.

Results

Descriptive Data for Study Variables

Predisposing Factors—The combined sample had a mean age of 37 years (range = 18–67; $SD = 10$), and consisted of 46% Black ($N = 230$) and 54% Latinx ($N = 270$) participants. There were 57% females ($N = 283$) and 43% males ($N = 217$). More participants completed study materials in English (72%, $N = 362$) than in Spanish (28%, $N = 138$). The majority reported household incomes of less than $1,249 dollars per month in the past year ($N = 271$, 65%); with significantly more males reporting incomes in the lower range ($N = 167$, 79%) than females ($N = 104$, 50%). Most participants were unemployed ($N = 335$, 68%). Thirty one percent of the sample ($N = 153$) had less than a HS education. The mean LADS score for the sample was 0.34 ($SD = 0.27$); males had a significantly higher mean LADS score ($M = 0.39$, $SD = 0.26$) than females ($M = 0.30$, $SD = 0.27$), $t = -3.84$, $p = .0001$. Males ($N = 199$, 92%) reported experiencing more penetrative sexual abuse than females ($N = 116$, 41%). Thirty-eight percent of participants ($N = 148$) were living with HIV; all but three were male ($N = 145$, 68%). See Table 1 for descriptive data for all study variables.

Need Factors—About half (54%, $N = 269$) of participants did not perceive a need for MHS, while ($N = 228$, 46%) reported needing help. More males ($N = 114$, 53%) than

females (N = 269, 55.16%) perceived a need for MHS. Of the 228 (46%) reporting need for MHS, 115 (51%) received MHS; 112 (49%) did not.

Enabling Factors—Participants with Unmet need for MHS reported barriers to MHS access. The most prevalent barriers included not having enough money or insurance (56%, N = 63) and competing needs (50%, N = 56). Others included difficulty obtaining appointments (29%, N = 32), long wait times (24%, N = 27), transportation obstacles, (16%, N =18), lack of childcare (13%, N = 14), low mental health literacy (13%, N = 14), fear of negative consequences (6%, N = 7), and stigma (2%, N = 2). Participants who completed the study materials in Spanish (37%, N = 11) reported low mental health literacy as a barrier significantly more often than those who completed study materials in English (3%, N = 3); no other language differences were noted for other barriers. Barriers to MHS access did not differ by HIV serostatus.

Correlations Between Study Variables

Spearman correlation coefficients were run to determine the relationships between predisposing factors and MHS use. Factors associated with unmet need for MHS included being younger (r = 0.168, p = .0002), HIV-seropositive (r = 0.154, p = .0025) and greater trauma and adversity burden (r = −0.236, p < .0001). Gender (p = .204), race/ethnicity (p = .269), and household income (p = .625) were not correlated with unmet need for MHS (see Table 2).

Logistic Regression Model

A binomial logistic regression model estimated the relative contribution of the LADS on need for MHS, with significant variables from step one (age and HIV-serostatus) included as covariates (see Table 3). The unstandardized Beta weight for the LADS was significant (B = 1.91, SE = .471, $Wald$ = 16.4, p = < .0001) as well as the unstandardized Beta weight for age (B = −.031,SE = .015, $Wald$ = 4.5, p = .033) and HIV-serostatus (B = .682, SE = .318, $Wald$ = 4.6, p = .032). For every unit increase in LADS, the estimated odds of having unmet needs for MHS increased (see Table 3).

ANOVAs: Differences in Mental Health Symptoms by MHS Need

Mental health symptoms across MHS groups (No need for MHS, MHS use, and Unmet need for MHS) were examined using a series ANOVAs. Compared to MHS use and Unmet need for MHS, No need for MHS had a significantly lower mean for post-traumatic stress symptoms [F(1,405) = 99.86, p = <.0001, R^2 = .198], depression [F(1,493) = 131.71, p = <.0001, R^2 = .211], and somatic symptoms [F(1,493) = 76.63, p = <.0001, R^2 = .135]. There were no significant differences in mental health symptoms between MHS use and Unmet need for MHS groups. There was a statistically significant positive association between MHS group and suicidal ideation [X^2(2) = 14.05, p = .0009] (see Table 4).

Discussion

This study examined predictors of and barriers to MHS utilization among an under-resourced sample of Black and Latinx individuals. The findings suggest that despite high

rates of trauma and adversity and MHS need, approximately half of those who perceived a need for MHS did not receive it. Males in this sample reported lower income, higher trauma and adversity burden, were more likely to be living with HIV, and were more likely to use MHS than females. Higher trauma and adversity burden predicted the need for MHS, taking age and presence of chronic illness into account.

There were no significant differences in mental health symptoms between those who engaged in MHS and those with unmet need for services. This finding may reflect our inability to determine the extent of MHS utilization among those who received HMS, or whether those who accessed MHS had more significant mental health symptomatology prior to engaging in treatment. Both groups reported MH symptoms significantly higher than those without a perceived need for MHS.

Care-seeking in our sample was compromised by known systemic barriers such as financial burdens, competing life demands, difficulty maneuvering the health care system, childcare needs, stigmatization and little knowledge about mental health care. The primary perceived barrier was related to economic status or lack of insurance, despite the lack of association between monthly income and MHS use. The second most reported barrier was, “too many things going on,” which could reflect the interplay of burdens associated with low income, unemployment, and mental health symptoms. Stigma was infrequently reported and may reflect the salience of SDOH-related barriers over stigma concerns in this sample. Participants in the sample living with HIV were already engaged in treatment for health management and may have been more likely to utilize services offered through their HIV provider, and/or government funded services for integrated behavioral health care (Novacek et al., 2020; Weiser et al., 2015).

These findings are consistent with research documenting that Black and Latinx populations with trauma histories, living with HIV and/or residual, chronic mental health symptoms often perceive the need for MHS and fail to obtain needed services (Davis et al., 2016; Shim et al., 2021). To address these inequities, primary care settings are increasingly integrating mental health services. Primary care-mental health integration (PC-MHI) allows patients to receive MHS without having to obtain a consult with outside providers. PC-MHI decreases barriers to MHS access and facilitates screening, engagement with care, and clinical outcomes, while decreasing the impact of systemic biases faced by individuals with multiple marginalized statuses (i.e., mental illness and race/ethnicity), (Alang, 2019; U.S. Department of Veteran’s Affairs, 2016; WHO, 2007). Successful PC-MHI is aided by the utilization of brief screeners like the LADS, that include types of trauma experienced by under-resourced populations (Hamilton et al., 2020).

Communities can also play an important role in raising awareness of the prevalence of mental health problems and addressing unmet MHS need. Resources designed to facilitate conversations about mental health problems and facilitate strategies to improve the mental health of individuals, families, and schools are available in English and Spanish (U.S. Department of Health and Human Services, 2021). Prioritizing the expansion of the community-based mental health workforce can also help to eliminate barriers and increase access to MHS (O’Donnell et al., 2019). Community-based mental health professionals can

be trained to provide a wide range of services to help navigate systemic and SDOH-related barriers (O'Donnell et al., 2019).

Implications

The results of this study have important implications for MHS provision for Black and Latinx adults with unmet need. Nearly half (46%) of the current study's total sample reported having a need for MHS; of these, approximately half received MHS (51%). Those who did not receive care identified numerous barriers that interfered with their receiving MHS services. Results indicated that for every unit increase in trauma and adversity burden, the odds of having unmet need for MHS increased. Given interrelationships between mental and physical health, accessing MHS is important to prevent escalating morbidity and mortality; for instance, among people living with HIV, histories of trauma are associated with poorer health outcomes (Machtinger et al., 2012; NAMI, 2019).

Our study represents a novel extension of Andersen (1995)'s model by considering the impact of trauma and adversity burden on need for MHS. Despite its strengths, limitations include use of convenience samples recruited through community clinics and community-based organizations with differing eligibility requirements, and the inability to control for all study effects, particularly those pertaining to males' lower income, higher trauma and adversity burden and likelihood of living with HIV. We did not assess whether participants sought out support, counseling, or treatment, or the type of treatment, only whether they perceived a need for and received professional services. We did not asses for health care coverage or retention in care.

Future Directions

To better understand facilitators and barriers to MHS seeking, access, utilization, and retention, research that includes a more comprehensive assessment of predisposing, enabling, and need factors is required. Methodologies that clarify how disproportionate exposure to SDOH-related adversities, chronic illness, and trauma intersect to heighten risks for mental health symptoms are needed to reduce mental health disparities among people of color. Policies that expand MHS coverage for low income and uninsured individuals disproportionately impacted by SDOH are critically needed to address widespread unmet need for MHS in the U.S. (Roll et al., 2013).

Conclusion

This study extended a conceptual model of health care use, testing the role of trauma and adversity burden in predicting need for MHS among under-resourced Black and Latinx individuals. Despite perceiving a need for MHS and experiencing elevated mental health symptoms, the majority of individuals in this sample did not access MHS. Given strong associations between mental and physical health, unmet need for MHS must be addressed to better promote overall health. National policies and programs that target systemic inequities and structural barriers to MHS for populations impacted by disparities are needed to eliminate health and mental health inequities.

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Table 1

Characteristics of Study Sample

Variables	Females		Males		Total	
	N	**%**	***N***	**%**	***N***	**%**
Race/ethnicity ***						
Black	63 (22.26%)		167 (76.96%)		230 (46.00%)	
Latinx	220 (77.74%)		50 (23.04%)		270 (54.00%)	
Monthly household income ***						
≤ *$1249*	104 (50.24%)		167 (78.77%)		271 (64.68%)	
> $1249	103 (49.76%)		45 (21.23%)		148 (35.32%)	
Employment						
Unemployed	179 (65.33%)		156 (72.22%)		335 (68.37%)	
Full/part time	95 (34.67%)		60 (27.78%)		155 (31.63%)	
Education **						
Less than high school	102 (36.43%)		51 (23.5%)		153 (30.78%)	
High school or more	178 (63.57%)		166 (76.5%)		344 (69.22%)	
LADS Domains						
Penetrative Sexual Abuse ***	116 (40.99%)		199 (91.71%)		315 (63%)	
Perceived Discrimination	32 (11.64%)		36 (16.59%)		68 (13.82%)	
Community Violence *	73 (25.98%)		75 (34.88%)		148 (29.84%)	
Family Violence *	118 (41.99%)		113 (52.07%)		231 (46.39%)	
Interpersonal Violence **	129 (45.91%)		69 (31.94%)		198 (39.84%)	
Perceived Need for MHS						
No	155 (55.16%)		114 (52.78%)		269 (54.12%)	
Yes	126 (44.84%)		102 (47.22%)		228 (45.88%)	
MHS Use						
Did not Receive	69 (55.2%)		43 (42.16%)		112 (49.34%)	
Received	56 (44.8%)		59 (57.84%)		115 (50.66%)	
HIV Serostatus ***						
Negative	176 (98.32%)		68 (31.92%)		244 (62.24%)	
Positive	3 (1.68%)		145 (68.08%)		148 (37.76%)	
Suicidal Ideation						
No	261 (92.55%)		191 (88.02%)		452 (90.58%)	
Yes	21 (7.45%)		26 (11.98%)		47 (9.42%)	
	M	***SD***	***M***	***SD***	***M***	***SD***
Age ***	34.01 (7.570)		40.65 (11.04)		36.89 (9.80)	
LADS ***[a]	0.30 (.27)		0.39 (.26)		0.34 (0.27)	
LADS Domains Endorsed ***	1.65 (1.42)		2.27 (1.24)		1.92 (1.37)	
Depressive Symptoms[b]	15.69 (12.42)		16.97 (12.25)		16.24 (12.35)	
PDS[c]	12.56 (10.78)		11.02 (10.79)		11.75 (10.8)	

Somatic Symptoms **d	6.38 (4.65)	5.23 (4.90)	5.89 (4.79)

Note.

[a]UCLA Lifetime Adversities Screener

[b]CESD

[c]Posttraumatic Diagnostic Scale

[d]PHQ-13

*p<.05.

**p<.01.

***p<.0001.

Table 2

Bivariate correlations between sociodemographic characteristics, HIV serostatus, the LADS, and need for MHS

Variable	1	2	3	4	5	6	7
1. Need for MHS	1	0.16**	0.06	0.05	0.15*	−0.02	−0.24***
2. Age		1	0.32***	0.46***	0.49***	−0.16*	0.05
3. Gender - male			1	0.54***	0.68***	−0.24***	0.17**
4. Race-ethnicity - Black				1	0.61***	−0.33***	0.24***
5. HIV Serostatus					1	−0.31***	0.06
6. Monthly household income						1	−0.18**
7. LADS[a]							1

[a] UCLA Lifetime Adversities Screener

* p<0.05.

** p<0.001

*** p<0.0001

Table 3

Final Logistic Regression - Effects of LADS on Need for MHS

	DF	*Estimate*	*SE*	*Pr>Chi-Square*
Age	1	−0.0312	0.0147	0.0333 *
HIV Serostatus	1	0.6821	0.3179	0.0319 *
LADS[a]	1	1.9052	0.4706	<.0001 ***

[a] UCLA Lifetime Adversities Screener

* p<0.05.

*** p<0.0001.

Table 4

Mental Health Symptoms across MHS groups.

	No need for MHS (*n* = 269)	MHS Use (*n* =114)	Unmet need for MHS (*n* =112)	p-value
PDS[a]	6 (7.1)	16.8 (11.6)	16.5 (10)	<.0001***
Depressive Symptoms[b]	10.7 (9.5)	22 (12.3)	23.5 (12.2)	<.0001***
Somatic Symptoms[c]	4.1 (4.1)	7.8 (4.9)	8 (4.6)	<.0001***
Suicidal Ideation[d]	13 (4.83%)	17 (14.91%)	16 (14.41%)	0.0009**

** p<0.001.

*** p<0.0001.

[a] Posttraumatic Diagnostic Scale

[b] CESD

[c] PHQ-13

[d] BDI or PHQ-9 item