Ethnic inequalities in psychological distress among urban residents in the Netherlands: A moderating role of neighborhood ethnic diversity?

Özcan Erdem\textsuperscript{a,b,⁎}, Alex Burdorfa, Frank J. Van Lenthea

\textsuperscript{a} Erasmus Medical Center, Department of Public Health, Rotterdam, The Netherlands
\textsuperscript{b} Municipality of Rotterdam, Department Research and Business Intelligence, Rotterdam, The Netherlands

1. Introduction

Health inequalities between ethnic minority groups and natives in Western societies are consistently reported (Kobayashi et al., 2008; Nielsen and Krassnik, 2010). In the Netherlands, more than 20% of the population is of non-Dutch origin, and this is about 50% in the major cities (e.g. Amsterdam and Rotterdam). The three largest ethnic minority groups are from Turkey, Morocco and Surinam and form 7% of the Dutch population. However, in the four major Dutch cities, they represent a substantial part of the population: 23% of the residents in Rotterdam, Amsterdam and The Hague and 16% in Utrecht (CBS, 2013). Whereas the prevalence of poor self-reported health of Dutch natives is 15%, prevalences are substantially higher among Turks (45%), Moroccans (39%) and Surinamese (29%) (Devillé et al., 2006).

Depressive disorders rank fourth in terms of diseases that cause the greatest burden of diseases in the Netherlands (Murray et al., 2012; RIVM, 2007). Depression is more common among ethnic minorities than native Dutch. The 5-year risk of treatment for depression in a major city in the Netherlands was 4–5 times higher for Turks and Moroccans and about 2 times higher for Surinamese compared to native Dutch (Selten et al., 2012). Similarly, the risk of antidepressant and antipsychotic drug prescriptions was higher for Turks and Moroccans in the Netherlands (Wittkampf et al., 2010).

Research has linked depression to features of neighborhood environment (Mair et al., 2008). There are indications that the impact of the neighborhood environment (e.g. neighborhood problems, neighborhood social cohesion) on depression is different across ethnic groups (Echeverria et al., 2008; Gary et al., 2007). Among the neighborhood factors hypothesized to be related to mental health of ethnic minority groups is neighborhood ethnic diversity. It has been suggested that ethnic diversity is associated with higher levels of social cohesion (Bécares et al., 2011). It has also been suggested that social cohesion will be reduced in ethnic diverse neighborhoods (Putnam, 2007), resulting in more mental health problems. In the short run, ethnic diversity may reduce social solidarity and social capital in neighborhoods. In such neighborhoods members of all ethnic minority groups tend to “hunker down”, whereby trust in other ethnic groups and even in own ethnic group is lower, the number of friends is lower and altruism and community cooperation rarer (Putnam, 2007). A recent review on neighborhood ethnic diversity and its effects on social cohesion supports partly this view. Ethnic diversity only weakens intraneighborhood social cohesion: people living in ethnically diverse neighborhood are less likely to trust their neighbors or to have contact with them. Contrary, ethnic diversity is not related to less interethnic social cohesion (Meer and Tolsma, 2014). These mechanisms may have detrimental effects on (mental) health. Adverse changes in neighborhood environments (i.e. reduced social cohesion) may influence changes in depressive symptoms (Mair et al., 2015). In addition, stressful social relations with neighbors and friends are associated with increased mortality risk (Lund et al., 2014).

However, our understanding of the interplay between ethnicity,
The overall response was 49% (n=20,877); 54% in Utrecht, 51% in The Hague, 50% in Amsterdam and 47% in Rotterdam. The response was higher among women than among men and increased with age. The response was highest among native Dutch (57%) and lowest among Moroccans (30%) (Veelen et al., 2009).

2.2. Definition of a neighborhood

In the Netherlands, neighborhoods are areas with a reasonably similar type of buildings of same age, and often delineated by natural boundaries, which makes neighborhoods relatively homogeneous socioculturally (Reijnseveld et al., 2000). Previous research has shown that there is a sense of community within Dutch neighborhoods (Völker et al., 2007). In the Netherlands, neighborhoods may be defined by the four digit postal code, which corresponds to the route of a postman. These four digit postal code areas are quite similar to neighborhoods and often have well-established names to which people identify themselves. We defined neighborhoods based on the four digit postal code. The respondents lived in one of 208 neighborhoods (on average 86 respondents (SD: 63) per neighborhood). In the Netherlands, there are about 4000 neighborhoods. These areas comprise on average of approximately 4000 residents.

Ethical approval was not required as this study relied on secondary anonymized data collected in the context of performing statutory tasks (Public Health Act of the Netherlands), in strict accordance with the national standard (van Bergen et al., 2014). Respondents were informed by letter that by filling out the questionnaire they gave permission for use of anonymous data for research aimed at improving population health in their place of residence. Respondents were contacted through municipal health services and in the dataset available for research all identifying information has been removed. All research activities adhered to the regulations of the Dutch Code of Conduct for Medical Research (FEDERA, 2012).

2.3. Outcome measure: psychological distress

This study used psychological distress as an indicator of depression (Andrews and Slade, 2001; Kessler et al., 2002), measured with the Kessler Psychological Distress Scale (K10). The K10 has been developed as a screening instrument for psychological distress in the general population (Kessler and Mroczek, 1994). The K10 discriminates Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorders from non-cases (Kessler et al., 2002) and is strongly associated with the Composite International Diagnostic Interview (CIDI) diagnosis of anxiety and affective disorders (Andrews and Slade, 2001). In a recent Dutch study, the K10 proved to be reliable (Cronbach’s: 0.94 and valid (area under the curve (AUC: 0.87)) in detecting any depressive disorders. At the cut-off of 20 points, sensitivity (0.80) and specificity (0.81) are sufficiently high to appreciate the K10 as appropriate screening instrument (Donker et al., 2010). The K10 scale consists of 10 questions that measure a person’s level of anxiety and depressive symptoms in the previous four weeks. The items included were: “Did you feel...?” and “nervous?”, “so nervous that nothing could calm you down?”, “hopeless?”, “restless or fidgety?”, “so restless that you could not sit still?”, “depressed?”, “so sad that everything was an effort?”, “so sad that nothing could cheer you up?” and “worthless?”. Each item has five response categories “none of the time”, “a little of the time”, “some of the time”, “most of the time” and “all of the time”. Cronbach’s alpha was 0.92, therefore a sum-score was calculated (range 10–50), with higher scores reflecting more psychological distress.
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