Socioeconomic Burden of Subsyndromal Depressive Symptoms and Major Depression in a Sample of the General Population

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Objective: The authors' goal was to evaluate the association between impairment in daily function and subsyndromal depressive symptoms as well as major depression to determine the economic and societal significance of these conditions. Method: Using 12-month prevalence data gathered by the National Institute of Mental Health (NIMH) Epidemiologic Catchment Area Program (ECA), based on responses to the NIMH Diagnostic Interview Schedule, the authors divided the 2,393 subjects from the Los Angeles ECA site into three groups: subjects with subsyndromal depressive symptoms (N=270), major depression (N=102), and no depressive disorder or symptoms (N=2,021). The groups were compared on 10 domains of functional outcome and well-being. Results: Significantly more subjects with depressive symptoms than subjects who had no disorder reported high levels of household strain, social irritability, and financial strain as well as limitations in physical or job functioning, restricted activity days, bed days, and poor health status. Significantly more subjects with major depression than subjects with no disorder reported major financial losses, bed days, high levels of financial strain, limitations in physical or job functioning, and poor health status. Except for lower self-ratings of health status, no significant differences were found between subjects with subsyndromal symptoms and those with major depression. Conclusions: Significantly more people with subsyndromal depressive symptoms or major depression reported impairment in eight of 10 functional domains than did subjects with no disorder. The high 1-year prevalence of subsyndromal depressive symptoms, combined with the associated functional impairment, emphasizes the clinical and public health importance and need for additional investigations into these symptoms.

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Interest in subthreshold depression has increased since the report of Wells et al. (1) that subthreshold depressive symptoms in medical and psychiatric outpatients were associated with significant levels of psychosocial dysfunction. Epidemiologic studies have confirmed that, compared with no depressive symptoms, subthreshold depressions, variously defined, are associated with more disability and work days lost (1-3), greater use of services for mental health problems (3), poor self-ratings of emotional health (1, 3, 4), and more lifetime suicide attempts (5).

To clarify the clinical significance of subthreshold depressive symptoms, we defined a more restrictive condition, subsyndromal depressive symptoms, as at least two or more current depressive symptoms, present for most or all of the time, lasting for at least 2 weeks, in individuals who did not meet criteria for major depression or dysthymia. Using this definition, we found that 11.8% of 9,160 community residents in the National Institute of Mental Health (NIMH) Epidemiologic Catchment Area Program (ECA) met criteria for subsyndromal depressive symptoms during a 1-year period (6). Two-thirds of the subjects with subsyndromal depressive symptoms were women; the most common depressive symptoms were insomnia, fatigue, and recurrent thoughts of death. Significantly more subjects with subsyndromal depressive symptoms than other subjects reported lifetime disability benefits, raising the question of whether subsyndromal depressive symptoms are associated with sufficient disruption in the domains of

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everyday function to have demonstrable public health, societal, and economic impact.

To address this question, we analyzed the database from the Los Angeles site of the ECA, where the investigators systematically probed domains of daily function not obtained at other ECA sites. Results of respondents with subsyndromal depressive symptoms were compared with those of respondents who had no depressive disorder or symptoms. Because the severe impairment associated with major depression has been established unequivocally (1–4, 7), subjects with major depression were included for reference comparison of disability. Two a priori hypotheses were tested: 1) Significantly more subjects with subsyndromal depressive symptoms than subjects with no depressive disorder or symptoms will report functional impairment. 2) Significantly more subjects with major depression than subjects with subsyndromal depressive symptoms or no depressive disorder or symptoms will report functional impairment. Mitigating against hypothesis 2 are empirical reports that subjects with subsyndromal depressive symptoms, even though significantly less impaired, are relatively comparable in impairment to subjects with major depression (1–4).

METHOD

The sampling methodology, human subject consent procedures, study design, survey methods, and demographic characteristics of the ECA sample have been reported elsewhere (8–10). ECA DSM-III diagnoses were developed from responses to the NIMH Diagnostic Interview Schedule (DIS), previously described in the literature (11, 12). A Spanish-language version of the DIS was also used at the Los Angeles site of the ECA (13, 14).

At three ECA sites, including Los Angeles, data were collected for each individual mental symptom probed by the DIS and the time frames when symptoms occurred (i.e., 1 month, 6 months, 1 year, or lifetime). The DIS specifies a standardized threshold to determine if a symptom is clinically significant. For example, depressive symptoms must have been present for at least 2 weeks and substantial enough that the respondent had either talked to a health professional or had taken medications because of it or felt the symptom had interfered substantially with his or her everyday activities. Depressive symptoms identified by the DIS are clinically substantial in severity and duration, extending well beyond normal mood vicissitudes. The DIS requires that depressive or other mental symptoms should not be associated with current medical illnesses and should not be side effects of drug or alcohol consumption or problems; symptoms associated with these conditions are excluded.

The Los Angeles ECA interviews included questions probing 10 domains of functional outcomes and well-being. Details of the content and methodology of these measures have been reported elsewhere (15–18) but will be summarized here.

Domains of Daily Function

1. High or low social irritability in previous 6 months. Respondents were asked how often over the last 6 months they had felt upset, irritated, or angry in six types of social relationships: with friends, with spouse, with other adults in the household, with family members and relatives not living with the respondent, with boss or supervisor at work, and with co-workers. Response categories were not at all, less than once a month, once a month, a few times a month, and once a week or more. Responses were averaged for each respondent across all applicable categories and then, due to high skewness, were dichotomized into 1) being irritable less than once a month or 2) being irritable more than once a month.

2. High or low household strain. This domain of function is based on the employment strain scale of Pearl and Lieberman (19) but applied to household responsibilities by Golding (20). Respondents were asked to answer yes or no to four items: “I have more home (and family) duties than I am able to do,” “I spend too many hours taking care of my home (and family),” “I do more work around the house than I should have to do,” and “Household and family responsibilities keep me from doing things I would really like to do.” Dichotomous scoring recommended by Golding (20) was used, in which responses were scored as high when any of the four items was endorsed.

3. High or low social contacts in previous month. Number of contacts (visits or telephone calls) during the last month with friends, family members, or other adults (but not including anyone persons living in household) were summed. Skewed response distribution required dichotomized scoring: a rating of high was given to reports of 13 or more contacts in the last month, and a rating of low was given to reports of fewer than 13 in the last month.

4. Major financial loss in previous 6 months. This domain was scored present if one or more of the following five items occurred and reported during the last 6 months: job loss, someone important to the respondent was out of work for 1 month or more, loss of home or anything else important, or the financial situation of someone the respondent depended on got much worse.

5. High or low financial strain. In this functional domain, developed by Pearl and Lieberman (19) and Golding (20), respondents were asked to answer yes or no to the question, “In the last 6 months, is there someone you have talked to about your most personal problems, hopes, or fears?”

7. Any day with restricted activity due to physical illness in previous 2 weeks. Respondents were asked, “During the last 2 weeks, how many days did physical illness or your physical condition make you cut down on things you would like to do, such as getting around or having visitors?” Scores were dichotomized as present or absent.

8. Any day in bed due to physical illness in previous 2 weeks. Respondents were asked, “During the last 2 weeks, how many days did you stay in bed all or most of the day because of feeling physical pain or illness?” Scoring was dichotomized as present or absent.

9. Any chronic limitation in physical or job functioning due to physical illness. Respondents were asked to answer yes or no to seven items, similar to the Hispanic Health and Nutrition Examination Survey (17, 18): “Does your physical health or physical condition make it difficult for you to carry out your daily activities?” “Does your physical health or physical condition keep you from taking the kind of job you would like?” “Does your physical health or physical condition limit the work you can do on your job?” “Does your physical health or physical condition make it difficult for you to get around outside the home, in this place?” “Does your physical health or physical condition prevent you from getting the kind of job you would like?” “Are you able to dress yourself completely, or do you need help?” and “Do you have any problems going to the bathroom, like not being able to get there in time, or need help to get there?” For skewed response distribution, scoring was dichotomized as present if one or more items were endorsed or absent if no items were endorsed.

10. General health status. Respondents were asked one item from the Rand Health Insurance Experiment: “Would you say that your health is excellent, good, fair, or poor?” This item was scored as 1=excellent, 2=good, 3=fair, or 4=poor.
TABLE 1. Demographic Characteristics of 2,393 Subjects in the Los Angeles Site of the NIMH Epidemiologic Catchment Area Survey Divided by Depression Status Into Three Mutually Exclusive Groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Subjects With No Depressive Disorder or Symptoms (N=2,021)</th>
<th>Subjects With Subsyndromal Depressive Symptoms (N=270)</th>
<th>Subjects With Major Depression (N=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1,014</td>
<td>96</td>
<td>35</td>
</tr>
<tr>
<td>Female</td>
<td>1,007</td>
<td>174</td>
<td>67</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married with children</td>
<td>575</td>
<td>52</td>
<td>14</td>
</tr>
<tr>
<td>Married without children</td>
<td>467</td>
<td>51</td>
<td>12</td>
</tr>
<tr>
<td>Single with children</td>
<td>242</td>
<td>43</td>
<td>24</td>
</tr>
<tr>
<td>Single without children</td>
<td>718</td>
<td>122</td>
<td>52</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native Hispanic</td>
<td>433</td>
<td>78</td>
<td>27</td>
</tr>
<tr>
<td>Immigrant Hispanic</td>
<td>643</td>
<td>48</td>
<td>15</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>945</td>
<td>144</td>
<td>60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>41.33</td>
<td>17.06</td>
<td>37.29</td>
<td>14.88</td>
<td>36.18</td>
</tr>
<tr>
<td>Education (total years)</td>
<td>11.34</td>
<td>4.58</td>
<td>12.14</td>
<td>3.83</td>
<td>12.53</td>
</tr>
</tbody>
</table>

Description of Sample

Demographic characteristics of the Los Angeles ECA site sample have been described in greater detail elsewhere (15, 16). Using the 12-month DIS data, we divided the 2,393 subjects into three mutually exclusive subgroups: those with subsyndromal symptomatic depression, defined by the presence of at least two or more depressive symptoms in respondents not meeting criteria for major depression or dysthymia; those with major depression as defined by DSM-III; and those with no depressive disorder or symptoms.

During a 12-month period, 270 subjects met criteria for subsyndromal depressive symptoms, 102 met DSM-III criteria for major depression, and 2,021 were assigned to the subgroup subjects with no depressive disorder or symptoms. The demographic characteristics of the three groups are given in Table 1. The groups with subsyndromal depressive symptoms and major depression had approximately a two-to-one preponderance of women to men, and the group with no depressive disorder or symptoms had a balanced sex distribution. Compared with the group with no depressive disorder or symptoms, the group with subsyndromal depressive symptoms had fewer married people and the group with major depression even fewer. The groups with subsyndromal depressive symptoms and major depression were, on the average, younger and better educated. There was a slightly higher prevalence of non-Hispanic whites and native Hispanics and fewer immigrant Hispanics in the groups with subsyndromal depressive symptoms and major depression than in the group with no depressive disorder or symptoms.

Statistical Methods

Due to the complex sampling design and the multiple comparisons involved, two distinct statistical approaches were used to determine the effects of depression on functional status. First, a multiple analysis of variance (MANOVA) (SAS) was carried out that included all variables characterizing functional status as dependent measures and depression status (i.e., no depressive disorder or symptoms, subsyndromal depressive symptoms, or major depression) as the independent measure to determine whether depression status had a significant effect on functional status. This analysis included one-way ANOVAs and Tukey’s Studentized Range post hoc comparisons to determine the effect of depression status on the individual variables characterizing functional status. Second, a multinomial logistic regression analysis adapted for the multistate sampling design was used to obtain predictions for the prevalence of disturbances in functional status due to the effect of depression status (21, 22). The STATA statistical package, which enables the adjustment of standard error calculations by means of Taylor linearization, was used for this regression analysis. For each dependent variable, a separate Huber regression analysis was calculated (22). Candidate variables included education, age, marital status, ethnicity, gender, current chronic medical condition, comorbid mental disorder, comorbid alcohol use disorder (12-month and lifetime), and the three diagnostic groups (no depressive disorder or symptoms, subsyndromal depressive symptoms, and major depression). The comorbid mental disorder variable included manic episode, dysthymia (lifetime only), bipolar disorder (lifetime only), atypical bipolar disorder (lifetime only), cannabis abuse or dependence, schizophrenia,
TABLE 3. Adjusted Percentagesa of Subjects in the Los Angeles Site of the NIMH Epidemiologic Catchment Area Survey, Divided by Depression Status, Who Reported Impairment in Social, Financial, and Physical or Role Function

<table>
<thead>
<tr>
<th>Category of Function</th>
<th>Subjects With No Depressive Disorder or Symptoms (N=2,021)</th>
<th>Subjects With Subsyndromal Depressive Symptoms (N=270)</th>
<th>Subjects With Major Depression (N=102)</th>
<th>Significant Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>SE</td>
<td>%</td>
<td>SE</td>
</tr>
<tr>
<td><strong>Social function</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High social contact (≥13 contacts per month)</td>
<td>50</td>
<td>1</td>
<td>41</td>
<td>3</td>
</tr>
<tr>
<td>Talked to someone about your most personal problems, fears, and hopes in last 6 months</td>
<td>64</td>
<td>1</td>
<td>69</td>
<td>3</td>
</tr>
<tr>
<td><strong>Financial status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major financial loss in last 6 months</td>
<td>14</td>
<td>1</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>High financial strain</td>
<td>53</td>
<td>1</td>
<td>61</td>
<td>3</td>
</tr>
<tr>
<td><strong>Physical or role limitations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any chronic limitations in physical or job functioning due to physical illness</td>
<td>9</td>
<td>1</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Any restricted activity day due to physical illness in last 2 weeks</td>
<td>10</td>
<td>1</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>Any bed day due to physical illness in previous 2 weeks</td>
<td>5</td>
<td>1</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>

aPercentages are adjusted for education, age, marital status, ethnicity, gender, current chronic medical conditions, comorbid mental disorders, comorbid alcohol use disorder (12-month and lifetime), and anorexia nervosa (lifetime only).

bConfirmed by Tukey’s Studentized Range test (p<0.05). In all cases, the scores of subjects with subsyndromal depressive symptoms and subjects with major depression were higher (indicating greater impairment) than those of subjects with no depressive disorder or symptoms.

schizophreniform disorder, obsessive-compulsive disorder, phobias, somatization disorder, panic disorder, antisocial personality disorder (lifetime only), and anorexia nervosa (lifetime only).

Based on the calculated logistic regression model, predicted prevalences for the following dependent variables were obtained: social irritability (high versus low), household strain (high versus low), social contacts (high [≥13] versus low [≤12]), talking to someone about personal problems, financial loss, financial strain, restricted activity days due to physical illness, bed days due to physical illness, chronic limitations in physical or job functioning, and general health status (excellent, good, fair, poor). Three different statistical analyses were used to address the two hypotheses.

The hypotheses advanced here were tested by using the two statistical approaches already described here. Specifically, the hypothesis that depression status significantly affects domains of function was tested by a MANOVA followed by post hoc comparisons using Tukey’s Studentized Range tests for alpha <0.05. Moreover, specific predictions of prevalence rates of disturbances in domains of function were obtained for the groups with no depressive disorder or symptoms, subsyndromal depressive symptoms, and major depression. The average predictions and the standard errors were subjected to a t score comparison. Only those comparisons which were found to be significant by using Tukey’s test and the t score differences obtained from the regression analysis are reported as significant in this investigation.

RESULTS

The MANOVA for effects of depression status on domains of function revealed that significant effects were present for nine of the 10 domains of everyday function (Table 2).

Table 3 includes results of regression analyses for seven of the 10 functional domains. Subjects with major depression differed significantly from those with no depressive disorder or symptoms on two financial status domains and from the group with subsyndromal depressive symptoms on one financial status domain. Significantly more of the subjects with subsyndromal depressive symptoms than of those with no depressive
disorder or symptoms reported impairment in three physical or role limitation domains; significantly more of the subjects with major depression than of those with no depressive disorder or symptoms reported disability in two of these domains. There were no significant differences between the subjects with major depression and those with subsyndromal depressive symptoms in these domains of function.

Figure 1 compares the results of the regression analyses on the domains of household strain and social irritability. Compared with the subjects who had no depressive disorder or symptoms, significantly more of the subjects with subsyndromal depressive symptoms reported high levels of household strain and social irritability. No significant differences were found between the subjects with major depression and those with no depressive disorder or those with subsyndromal depressive symptoms.

Estimates of general health status. On the 4-point health scale (1 = poor to 4 = excellent), the subjects with subsyndromal depressive symptoms gave themselves a significantly poorer mean health rating (mean = 2.91, SE = 0.05) than did the subjects with no depressive disorder or symptoms (mean = 3.13, SE = 0.02) (t = 4.5, df = 2289, p < 0.001). Respondents with major depression also gave themselves a significantly poorer mean health rating (mean = 2.67, SE = 0.09) than did those with no depressive disorder or symptoms (t = 5.03, df = 2289, p < 0.0001). The respondents with major depression gave themselves a significantly poorer mean health rating than did the subjects with subsyndromal depressive symptoms (t = 4.6, df = 2305, p = 0.05).

DISCUSSION

The full Los Angeles ECA sample included approximately equal numbers of Hispanic and non-Hispanic whites, which differs from the general U.S. population (15, 16). Our conclusions here, therefore, should be tested in more representative samples; however, the reported findings apply for both Hispanic and non-Hispanic groups, and ethnicity was controlled for in the analysis.

Significantly more subjects with subsyndromal depressive symptoms than subjects with no depressive disorder or symptoms reported disability on seven of 10 domains of function: high social irritability (62%), high household strain (45%), high financial strain (63%), restricted activity days due to physical illness (18%), bed days due to physical illness (11%), chronic limitation in physical or job functioning (18%), and self-rating of health as poor.

Although one primary study goal was to evaluate associations between “pure” subsyndromal depression and major depression and functional impairment, some identified impairment could be associated with other conditions. The logistic regression analysis was designed to control for the comorbid effects of lifetime and current (12-month) alcohol and drug use disorders, mental disorders, and current chronic medical conditions. An additional control in reducing the influence of comorbid conditions was provided by the DIS itself, which requires that when a depressive symptom is recorded it not be associated with a medical illness or be a side effect from alcohol or drug use or disorders. These data support and extend findings from six previous studies reporting significant associations between subthreshold depressive symptoms and greater impairment in everyday function (1–6). There is now strong evidence that subsyndromal depressive symptoms are associated with substantial disability in many spheres of human activity, placing notable burdens on individuals and the society.

Compared with respondents who had no depressive disorder or symptoms, individuals with major depression reported impairment in five of 10 functional domains. Significantly more subjects with major depression reported major financial loss in the last 6 months (25%), more suffered from high financial strain (69%), more reported physical or job limitations due to illness (24%), more reported bed days (11%), and their self-ratings of health were poorest. These data strengthen the confluence of scientific evidence that major depression is associated unquestionably with severe pervasive disability in many aspects of daily functioning, which has a palpable impact on society and the economy (1, 2, 4, 7, 23). For example, 24% of the subjects with major depression reported limitations in physical or job performance.

![FIGURE 1. Adjusted Percentages of Subjects With No Depressive Disorder or Symptoms, Subsyndromal Depressive Symptoms, or Major Depression Reporting High Levels of Household Strain or Social Irritability*](image-url)
functioning, and this is consistent with annual cost estimates for mood disorders, which found that the two largest cost categories were increased absenteeism and reduced worker productivity (23).

No large consistent differences in impairment in the domains of function emerged between the subjects with subsyndromal depressive symptoms and those with major depression, apart from their self-ratings of their health status, which could have occurred by chance alone. This does not support one of our a priori hypotheses—that more subjects with major depression than those with subsyndromal depressive symptoms will report impairment. However, every other study using different outcome measures than those reported here, such as absenteeism, use of health services, use of public assistance, and suicide attempts, have found significantly more adverse outcome associated with major depression than subsyndromal depressive symptoms (1-6). We did find that higher absolute percentages of subjects with major depression than of subjects with subsyndromal depressive symptoms reported impairment in five of 10 functional domains, but the differences were not sufficiently robust to survive formal testing. Further, the functional measurements used in this study were primarily dichotomous; it is apparent that there are differences between subsyndromal depressive symptoms and major depression that we did not have the power to detect. It should be noted that our findings are also consistent with those of previous investigations (1-4), which found that the impairments in subjects with subsyndromal depressive symptoms and those with major depression are qualitatively comparable and more similar to each other than they are to any impairment found in subjects without subsyndromal depressive symptoms or major depression.

It is not fully clear what subsyndromatic symptomatic depression represents clinically, but we do know from the studies of Broadhead et al. (2) and Howarth et al. (5) that subthreshold depressive symptoms are associated with greater risk for future major depressive episodes. In a large sample of medical and psychiatric outpatients (24), we found that the demographic and clinical characteristics of subjects with subsyndromal depressive symptoms significantly more closely resembled those of subjects with major depression than those of nondepressed medical outpatients. For example, we found that 41% of outpatients with subsyndromal depressive symptoms had family histories of depression, a rate nearly as high as that for subjects with major depression (59%). We have proposed that subsyndromal depressive symptoms represent, respectively, either prodromal manifestations or residual depressive symptoms from impending or incompletely resolved major depression or dysthymia (25). Subsyndromal depressive symptoms may also be a low-grade chronic condition, placing patients at higher risk for future major depressive episodes (25). This has led us to conclude that subsyndromal depressive symptoms are a clinically meaningful, subthreshold variant of unipolar major depression.

The fact that approximately one in 10 people in this community sample met criteria for subsyndromal depressive symptoms during 1 year, when combined with the associated functional impairment reported by us and others (1-6), supports the conclusion that subsyndromal depressive symptoms are a clinical condition of public health significance. Prospective, controlled studies of subsyndromal depressive symptoms in unipolar major depression are needed, especially treatment investigations, because no data are available indicating that subsyndromal depressive symptoms respond to treatment or if they should be treated at all. It is possible that effective treatment of subsyndromal depressive symptoms may not only reduce the associated functional disability identified but also prevent more severely disabling future episodes of major depression or dysthymia.

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