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Symptoms of depression and their management among low-income, African American and White mothers in the rural South

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Abstract

Objective—This study examines experiences of depressive symptoms among a group of 32 low-income African American and White mothers of young children who resided in rural eastern North Carolina, USA.

Design—Women's experiences of depressive symptoms were elicited through a series of longitudinal ethnographic interviews, including an explanatory models interview specifically designed to elicit their beliefs about the causes, symptomatology, and help-seeking behavior and management of depressive symptoms.

Results—A content analysis of interview data indicated that most women (11 African American, 15 White) reported having depressive symptoms currently or in the past. Both African American and White women perceived the main causes of these symptoms as being relationship problems with a spouse, partner, or family member; lack of finances; and parenting stresses. There were no differences in the depressive symptoms African American and White women reported, but there were differences in how they managed these symptoms and where they sought help. Most of the African American women sought no formal treatment (i.e., pharmacotherapy and/or psychotherapy), but instead turned to their religious faith to deal with their feelings. White women were more likely to seek formal treatment.

Conclusion—These findings provide insights into the ways in which women in one non-urban area in the U.S. explained and experienced depressive symptoms, and demonstrate differences in help-seeking behaviors that can be linked to beliefs about depression and perceptions of societal responses to those who have it, as well as to perceptions of and experiences with the health care system. Results have implications for the implementation of education, intervention, and treatment programs in more culturally sensitive ways.

Keywords

depressive symptoms; African American women; low-income; explanatory models

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Introduction

Decades of research indicate that depressive illness is more common among particular groups, including women, new mothers, and those with few economic resources (Chen et al. 2005; Nolen-Hoeksema 2001). Women are more likely than men to experience depressive symptoms—including both major depressive disorder and minor depression or dysthymia—regardless of race or economic status, and women of child-bearing age are particularly at risk for developing depression (CDC 2010; Kessler 2000; Nolen-Hoeksema 2001). Low-income women, especially mothers who are single or have young children, are more likely to have depressive symptoms than women from households that are more economically secure (Chen et al. 2005;Coiro 2001; Gyamfi, Brooks-Gunn, and Jackson 2001). Women who reside in rural areas are also more likely to experience depression than their urban counterparts (Groh 2013;Hauenstein and Peddada 2007) and are less likely to receive treatment (Hauenstein et al. 2006), leading some researchers to state that depression among rural women is a significant public health issue (Groh 2013;Simmons et al. 2008).

Women are found to have elevated rates of depression compared to men both in studies of rates of clinical diagnoses as well as prevalence studies that rely on self-report of current symptoms using validated depression surveys (CDC 2010). A number of theoretical models have been proposed to account for the etiology of depression as well as these gender differences (Hammarström et al. 2009).Biological explanations include genetic, physical or somatic causes, while socio-cultural explanations point to social and cultural forces that increase life stresses. Cognitive theories examine the psychological or behavioral factors associated with depression. Increasingly, however, researchers posit that depression is caused by a combination of multiple biological, social, and psychological factors (Kendler, Gardner, and Prescott 2002).

Help-seeking behavior for depression and other mood disorders has also been found to vary by sociodemographic factors, including ethnicity or race, income, place of residence, and level of education. For example, although African Americans and other ethnic minority groups are more likely to experience depression than Whites (CDC 2010), they are less likely to seek formal mental health treatment (Beauboeuf-Lafontant 2007;Karasz 2005; Wang et al.2005; Williams et al. 2007). Conversely, people with higher family incomes and who live in non-rural areas are more likely to seek mental health services (Wang et al. 2005) as are those with higher levels of education (Karasz 2005).

While sociodemographic variations in rates of depression and its treatment are well documented, we know less about how different groups construct beliefs about depression, its symptoms, and help-seeking behavior. Yet these beliefs are central to understanding people’s experiences and management of depressive symptoms. One method of exploring these beliefs is the explanatory models (EM) interview. The EM interview was developed by Arthur Kleinman (1988) to examine individual beliefs about disease for the purpose of improving medical practice and communications between doctors and patients about disease treatment and management. The EM interview asks respondents to describe their beliefs and experiences related to their illness, including their perceptions of its cause, symptoms, trajectory or prognosis, appropriate treatment and management, and its emotional and social

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impact (e.g., stigma). This type of interview has been adapted and used in numerous anthropological and sociological studies on a wide variety of illnesses (e.g., Bhui and Bhugra 2002;Matthews, Lannin, and Mitchell 1994;Schreiber and Hartrick 2002; Weiss 1997).

Studies that have elicited EMs of depression provide important insights into the ways in which sufferers understand the causes, symptoms and treatment of the condition, and how different models of depression guide whether and where people seek treatment. For example, Waite and Killian (2009) conducted EM interviews with groups of low-income, urban African American women who had been clinically diagnosed with major depressive disorder within the past year. They found that women attributed their depression to traumatic experiences and stressful life events, frequently relied on their faith for emotional support, and often saw medication as a last resort to treat the illness. Schreiber and Hartrick (2002) examined EMs of depression held by a group of highly educated White women in western Canada who had been treated for depression within the previous five years. They found that these women had quickly come to adopt a biomedical understanding of the causes of depression over situational explanations of it. Not surprisingly, adopting this biomedical model affected the kind of treatment they sought, with these White women coming to equate ‘treatment’ with medical intervention (Schreiber and Hartrick 2002).

The present study contributes to this literature by examining EMs among another group of women vulnerable to depression, low-income African American and White mothers who live in the rural South. In eliciting their understandings, experiences, and management of their self-reported depressive symptoms in a series of interviews over a two-year period, our purpose was not to define depression for them or to evaluate if their beliefs about depression adhered to biomedical models or cognitive theories of depression. Our aim was to elicit and examine their own explanatory models—the beliefs and assumptions they held about depression or depressive symptoms, and how these understandings may have guided their help-seeking behaviors. Their accounts indicate that African American and White women shared many of the same experiences and talked about depressive symptoms in similar ways, yet they differed in how they sought to manage and treat these symptoms.

Methods

The data analyzed here come from ethnographic research conducted as one component of the Family Life Project (FLP), a mixed method, longitudinal study examining the effects of rural poverty on child development and family health (e.g., Burchinal et al. 2008; Kainz et al. 2012). For the quantitative component of the FLP, a statistically representative sample (i.e., ‘the cohort study’) was recruited from three counties in North Carolina (NC) and three counties in Pennsylvania (PA). A total of 1611 families representing two major geographical areas of child rural poverty, the Black South and Appalachia, were included in this cohort study (the quantitative component of FLP). The ethnographic component began six months before the cohort study, and was designed to provide in-depth contextual information on communities, family health, and infant and child development that could inform the quantitative assessments used in the cohort study. For the ethnographic study in NC, 36 families were selected to reflect the ethnic and income diversity of the NC cohort sample.

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Both components of the FLP were approved by the University of North Carolina, Chapel Hill IRB.

Sample

This study reports on the families who participated long-term in the NC ethnographic component. We do not report on the families in PA because the PA ethnographic sample included only a few African American families and the EM interview was used only at the NC site. In NC, 36 women who were 5–8 months pregnant were recruited between February 2003 and February 2004 through county health departments, clinics of the federally-funded Women, Infants and Children (WIC) nutrition program, parenting classes, and local maternity clinics and fairs. Four of the women (two African American and two White) withdrew early from the study, resulting in a final sample of 32.These women were the primary respondents except in three cases where grandmothers became the primary caregivers for their daughters' children. For these cases, we interviewed the grandmothers about their own experiences of depression. Table 1 presents demographic characteristics of these 32 women by self-reported ethnicity.

Procedures

Primary caregivers were interviewed approximately once every six weeks over an 18 month period. Follow-up interviews were then conducted every six months through the spring of 2007 for an average of 15 interviews per respondent. Interview questions covered the full range of family and community life, but some questions asked specifically about the mother's mental and physical health and access to health care. We also designed a more targeted set of questions about depression based on Kleinman's (1988) explanatory models interview (see Appendix), which we conducted one time with every participant. The EM interview inquired about 1) past and present depressive episodes, 2) how they talked about these episodes and the context around them, 3) what they perceived as symptoms, 4) their experience and management of symptoms, 5) how depression affected their lives, 6) whether counseling or medical interventions were sought, and 7) feelings of stigma or discrimination. We did not ask specific probes across all participants, for example, asking them if they had experienced symptoms like loss of appetite or insomnia. Rather we asked these more general questions to elicit their experiences in their words and what was most salient to them. The authors, who have extensive experience in EM and other semi-structured interview methods, extensively trained the two community ethnographers to carry out the interviews. An African American woman conducted the interviews with African American participants and a White woman conducted interviews with White participants. All interviews were digitally recorded and transcribed verbatim.

The EM interview transcripts were entered into a software program (QSR N6) to facilitate systematic coding and analysis. The two authors, who have conducted qualitative analysis for numerous projects, conducted a content analysis guided by the questions asked as part of the EM interview. The vast majority of women's accounts about depression resulted from the EM interview, but we also examined the full set of ethnographic interviews for any other data relevant to experiences of depression. To do so, we used the software program to search for keywords that women used to talk about depressive symptoms (e.g., 'feeling down,'

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'feeling bad,' 'tired,' 'blue', 'sad'). We then collated all segments of text where these and other depression-related words occurred, being careful to analyze these segments in their original contexts (i.e., the complete transcribed interview) and combined this information with data from the EM interview on each participant to describe and compare women's understandings of and experiences with depression. To do this in a systematic manner, we employed a data display matrix (Miles, Huberman, and Saldaña 2013) to summarize and record information on the different dimensions of the EMs held by each woman. We were interested in women's entire experiences with depressive symptoms, whether the symptoms were current or occurred in the past. Although we analyzed talk related to depression whenever it occurred in the course of the study, we did not explicitly elicit information about depression except in the EM interview, nor did we focus on changes related to experiences or understandings over time, but rather on the dimensions and content of women's explanatory models. We also did not explicitly ask whether women linked their symptoms to being post-partum.

In all phases of the research, we followed established practices for qualitative studies to enhance the trustworthiness of data collection and analysis (Guba 1981; Lincoln and Guba 1985; Miles, Huberman, and Saldaña 2013). We designed a study with clear research questions and protocols, trained ethnographers to be consistent using comparable data collection protocols, and engaged with families in their homes and community sites to gain a depth of knowledge about the ways in which they viewed and talked about their lives and communities. We established multiple audit trails for data collection and analysis. The co-authors were primarily responsible for systematic analysis of data using within and cross-site comparisons. We tested our emerging interpretations against each interview/observation for negative evidence and alternative explanations; and discussed and revised these interpretations with input from community ethnographers as well as the families themselves (i.e., member checks). The community ethnographers and co-authors met frequently to review all aspects of the study and reflect on and address possible biases that may have affected data collection and analysis. Transferability of data is addressed in the discussion section.

Findings

Twenty-six (11 African American and 15 White) of the 32 participants reported experiencing depressive symptoms at some point in their lives. Because these women self-identified as being or having been depressed, this group likely included women who suffered from depressive mood rather than from clinical depression. Our aim was not to formally assess their depression status, but to examine how women in this rural community talked about 'being depressed' in line with the dimensions of the EM interview: disease causation and symptoms, help-seeking and management, and social and emotional associations.

Explanations of causes and symptoms of depression

African American and White women shared similar views of what caused them to feel depressed. In large part, they named situational factors (see Table 2) such as financial issues

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or relationship problems with a spouse, partner, or family member. For example, one African American woman talked about her marriage as being a key factor:

> I know when I was married and I stayed depressed all the time, and that's the reason I'm tired of marriage 'cause I seen my kids weren't happy at all, the three oldest ones. They were shutting down just as much as I was and that's the main reason I did pack up and leave 'cause I couldn't see my kids being that way, even if I have to raise 'em on my own.

Women also talked about feeling depressed when they could not pay their bills or provide for their children. One woman elaborated, 'Late bills, bill collectors calling, sometimes having to beg for money….the water got cut off, phone got cut off. Phone is still cut off. Not having money.'Others noted that death or illness in the family and parenting stresses and feelings of overwhelming responsibility for raising children brought on feelings of being depressed. Four women said that 'feeling trapped,' having no transportation or employment made them feel lonely and isolated. Only one woman mentioned a biological cause, in this case a chemical imbalance, but not as the primary cause, which she attributed to her poor marital relationship. Ethnographers were prepared to refer any woman who expressed current suicidal thoughts or behaviors to services, but this did not become necessary, although three women talked about having these thoughts in the past.

Over the series of interviews, and sometimes within the course of one interview, women cited multiple factors simultaneously interacting or accumulating to cause their feelings of depression. One woman noted that lack of finances, unemployment, and problems with her family were all significant stressors, but it was not until after her baby was born and her feeling of being 'cornered' that she reported becoming 'really depressed.'

For the most part, African American and White mothers described symptoms in similar ways (see Table 3). By far the most commonly noted symptom was uncontrollable crying. One woman recounted, 'At one point I would just stay in my room, lock myself in my room and just cry day and night.'Women talked about crying in response to little things, even something as seemingly benign as a television commercial. Other symptoms included not wanting to have any contact with people, feeling angry or irritable, marked changes in appetite, and a lack of energy or desire to do anything. One commented:

> I didn't want to leave out the house. I didn't want to be around people. Half the time I didn't even want to eat, I just laid in bed. There were days when I would flip on the TV, but I did not want no outside contact. That was my thing. I stayed in the house. I didn't even want to talk to nobody.

Another woman recounted that her depression caused her to have low self-esteem and to feel so angry and irritable that she would start fights with her husband: 'I would take something he said and just turn it totally around. It was like I hated myself so I wanted everybody else to hate me too to feel a little better about hating myself.'

Although both African American and White women shared a similar discourse about their feelings of depression, there were two differences. Fewer African Americans reported feeling angry or irritable, and no African American woman reported physical symptoms,

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while four White women did. Differences were more apparent in help-seeking and management strategies.

Help seeking and management of depression

Table 4 depicts how African American and White women sought help for management of depression. Only three African American women reported seeking mental health counseling. One of these women, who worked in health services, also sought medication upon her therapist's advice. Among the 15 White women who reported depressive symptoms, three tried medication and counseling, and six used medication only.

The eight African American women who did not seek formal treatment said they dealt with their depression by turning to their religious faith. They prayed, read the Bible, or talked to their minister or other members of their church congregation. One of the African American women who had received counseling through the county mental health clinic explained that she left after a few sessions and began relying entirely on her faith to cope with her depression. She expressed the opinion that to manage or prevent depression, people should 'get in tune with God 'cause depression I don't think comes from God…from now on that's what I'm really doing is praying my way out of it. Every bad situation I come into I'm praying about it.' Another woman who said she relied totally on her faith for relief from depression described how prayer helped her:

> I pray and it works for me….I can deal with another day. It alleviates the pressures, it takes it right off my shoulders and clears my mind and I see nothing but positive things…. Before there was counseling or medication, there was God.

In contrast, no White woman talked about relying on religion or faith to alleviate depressive symptoms despite the fact that the majority expressed a belief in God and attended church. One White woman who sought medication for her depression commented that, while it was all well and good to pray to God for relief from depression, God 'may be answering you by sending you to the doctor.' White women, however, were more likely than African American women to seek social support through talking with family and friends.

Both African American and White women talked about combatting their depression by adopting a philosophy of 'keeping going,' 'not giving up,'or 'just dealing with it.' One woman explained, 'You just have to keep going. You take the good with the bad and you keep going.'

Barriers to seeking pharmacotherapy and/or psychotherapy were evident in women's accounts. In general, the African American women regarded medication negatively, seeing it as a crutch or circumventing what people really needed to do, that is, work to change their situation or rely on religion before taking pills. One woman commented: 'The first thing people do is go to mental health and say they are depressed and start taking pills…. I mean, it's routine. It's [name of town], North Carolina. That's how they do it here.' Counseling was also viewed as problematic because medication was a primary means of treatment through the county health department's mental health service. Two of the three African American women who tried counseling reported quitting after a few sessions because their therapists had recommended medication.

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White women, in contrast, for the most part believed that medication was an effective way of treating depression. Those who took anti-depressant drugs obtained prescriptions from their family physician or obstetrician/gynecologist. In most cases the women themselves, not the physician, suggested a specific medication they had heard about on television or from a relative or friend. They thought the medication was beneficial, but limited financial resources and lack of insurance coverage were barriers to consistent use. Of the 10 women (9 White, 1 African American) who took prescription anti-depressants, four went on and off the medication depending on their finances. When they had insurance, they took the medication, but when they did not have coverage, they stopped because they could not afford the out-of-pocket payment of about $75 a month. Three women were able to get free samples from their physicians, which prolonged the time they took the medication. One uninsured woman who had been taking antidepressants before she got pregnant (paying for them out of pocket) became eligible for Medicaid with her pregnancy. Rather than take the medication while pregnant, which she did not feel comfortable doing, she continued to have the prescription filled while insured, but saved the antidepressants for use after the baby was born when she would not have the insurance to pay for them.

Limited economic resources also affected use of counseling services. Several women assumed they could not afford counseling. One remarked that she never considered counseling ‘because you have to pay for it and I have no insurance and counseling is not cheap.’ There was also fear of being stigmatized. This same woman said she was ashamed of going to counseling and fearful of the possibility that ‘they gonna say I’m crazy and take my kids away.’The African American woman who both went to a therapist and tried medication said she felt stereotyped because she did not have a lot of money, was African American, and went to the county mental health clinic for treatment. She explained:

> I just felt kind of grouped…. Well maybe it’s a question they ask everybody, like, “Do you use a lot of drugs?” or “Do you drink a lot?” or “Were you beaten as a child?” Well I don’t think [those questions] would be posed to somebody in a private mental health setting…. I felt like they felt like anybody who doesn’t have insurance is probably in a situation where they’re around drugs and alcohol and I don’t know. I don’t even know how to say it. I felt like it was a social class--probably more a social class thing than it was a race thing. But like I just felt like, “Okay, everybody who comes here this is probably the main problems that they have,” you know.

Despite these negative experiences, she continued to see her therapist because she felt she needed the benefits of counseling.

Social and Emotional Associations with Depression

Social judgments, moral values and emotions come to be attached to specific diseases and illnesses (Kleinman, Eisenberg, and Good 1978, Zigon 2008). In the case of depression, both African American and White women felt stigmatized for showing signs of depression or seeking help for it. One woman who had taken medication and been through therapy tried to keep her depression hidden from others: ‘I guess it’s smiling depression. That’s what I call it…I don’t think a lot of people know that I am (depressed).’Another woman said that

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she had to overcome her own sense of shame to seek treatment at the county mental health clinic: ‘I was scared, it being my first time ‘cause that’s where all the nuts go. That’s where all the nuts go around here.’One woman commented on the social censure of those who admitted to depression, ‘I think there’s a lot of shame. I think people who are really depressed are too ashamed to ask for help ‘cause they think they’re gonna be laughed at.’

This sense of stigmatization affected women’s willingness to seek treatment, but conversely, media had a more positive influence on how women viewed depression. Several women discussed seeing advertisements on television that promoted selective serotonin reuptake inhibitors (SSRIs) (such as Prozac) and advocated for individuals to talk with their doctors about depression. These advertisements helped to normalize and medicalize the experience of depression. One woman related how she was influenced by such a commercial:

> I’ve always had a problem with [depression]. I just know it got worse over the past few years….It just got to the point that I knew I had to go do something about it….I mean I never realized this whole time that is what it was. I thought I was like my mother, crazy, it just ran in the family. I didn’t realize it was really something wrong, and I was ashamed to go and say anything to the doctor and ask him about it until [my husband] saw that bipolar [commercial] and I thought wow, a lot of the symptoms apply and [the doctor] told me that I was just suffering from severe depression. He told me, “You wouldn’t believe the people that actually do. It’s nothing to be ashamed of.”

When asked what advice she would give to others who might be suffering from depression, she responded, ‘This is here. It’s real. It’s not a weakness or anything else. It’s chemistry and you just need to recognize it and make sure you stop it before it goes too far for you.’

Discussion

This examination of explanatory models of depression provides insights into the beliefs and experiences of low-income, African American and White women living in one region of the rural South. Four-fifths of the 32 women in this ethnographic study reported experiencing depressive symptoms at some point in their lives, a figure in line with findings from another study of rural North Carolina residents (Kemppainen et al.2009). Comparing African American and White women’s discourse about the cause and symptomatology of depression, we found few differences. Both groups primarily believed their depression was due to situational stressors such as financial hardship or difficult relationships with a spouse or partner, stressors also found by Brown and colleagues (2000) to be correlates of depressive symptomology in their study of African American women in the rural South. In line with other studies of explanatory models of depression (Karasz 2005; Williams and Healy 2001), most women listed multiple causes for their depression, fitting the multi-causal model of depression posited by some researchers (Kendler et al. 2002), although with a notable lack of attribution to biomedical causes.

Similar to other studies (de Groot et al. 2006; Egede 2002; Probst et al. 2006), we found that African American women were far less likely than White women to seek counseling or medication for their depressive symptoms. This was partly due to their aversion to taking

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medication, but also because of their fear of being stereotyped and stigmatized in the local health clinics. Both White and African American women, however, believed that depression was a stigmatized disorder in their community—a sign of personal failure--and should be kept hidden.

Similar to other studies that highlight African Americans' use of spirituality in managing depression (Clarke 2010;Ellison and Flannelly 2009; Kemppainen et al. 2009;Waite and Killian (2009), we found that the African American women most commonly turned to religious faith to help them cope whereas no White woman talked about religion as a means of managing depression.

These findings have implications for the delivery of mental health education, intervention, and treatment programs for low-income women in non-urban areas. There is a need for community-wide health education about the causes, prevalence, symptoms, and options for treatment related to depression that could lessen the stigma surrounding the illness. Educational materials could be made available at venues frequented by these women, such as health care centers, primary care and pediatrician offices, daycare centers, schools, and churches. Other studies have reported on utilizing the influence of African American churches in providing health education and promoting healthy behaviors among their members (Markens et al. 2002;Resnicow et al. 2001). There is also a need for mental health specialists and physicians in the communities to be aware of women's explanatory models of depression and have open discussions with them about its possible causes and treatment options, as well as working to establish trust and revising any practices or language that could be viewed as stigmatizing (see Nelson 2002).

This study is limited by the relatively small number of women interviewed and the regional restriction to three counties in North Carolina, but the findings are similar to other studies of depression conducted with African American and White respondents, and suggests the need for further examinations of explanatory models of depression and responses by communities and mental health services to decrease stigmatization and inequities of care.

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Appendix

Explanatory Models Interview for Depression

- ☐ Tell me what it's like for you to have depression.
- ☐ What symptoms have you had? How severe is this condition?
- ☐ When did you first start having symptoms?
- ☐ What do you think caused the depression?
  - ○ Have your ideas about what caused the depression changed at all over time? If yes, how so?

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- What things make the symptoms better?
- What things make them worse?
- What things do you do to manage the depression?
  - What treatments have you tried?
  - Have you ever tried anything other than what the doctor recommended? [probe: home remedy, alternative medicine, vitamins/herbs, prayer, etc.]
- Have you seen doctor about these symptoms?
  - Was it diagnosed?
  - When was this and where?
  - How satisfied were you with the medical care?
- How do you get information about depression?
- Are there things about depression that you don't understand or you want to know more about?
- What are the main problems you or your family has faced related to this condition?
- What effects, if any, does the depression have on your life?
  - (Probe for work, social life, relationship with partner, ability to care for self, ability to care for children, etc.).
- What do you fear most about experiencing depression? What concerns you most about it?
- Some people think about an illness and treatment of it in religious terms. Do you think about depression in this way sometimes? How so? Do others in your family think about depression in a religious way? What do they say?
- How much control do you feel you have over this condition?
- Do you think that there are things people can do to prevent depression? If so, what?
- How do you think people in your community/this country view people with depression?

Now I would like to follow up with a few specific questions about how you handle your depression.

[If respondent tried medication]: You mentioned that you tried medication.

- What was the medication?
- Which doctor prescribed it? [probe: family practitioner, psychiatrist]
- Did you ask for it or did the doctor suggest it?

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- How long did you take it? Why did you stop taking it?
- What difference has/did taking the medication made for you?

[If respondent *did not* try medication]:

- Would you ever consider taking anti-depression medication? Why or why not?
- IF YES: How would you know when it's time to try anti-depressants?
  - Are there any barriers to you taking anti-depressants (probe for social, financial, personal)?

[If respondent tried counseling]: You mentioned that you tried counseling.

- How did you make the decision to try counseling for your symptoms?
- Who did you talk to?
- How long did you go to counseling?
- What were the effects or benefits of the counseling? What difference did it make for you with your depression?

[If respondent did not try counseling]:

- Would you ever consider counseling? Why or why not?
- IF YES: How would you know when it's time to try counseling?
  - Who would you go to?
  - Are there any barriers to you going to counseling (probe for social, financial, personal, lack of access)?

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Key Messages

Several findings emerge as key in this study:

1. The majority of White and African American women in our study report having experienced depression at some point in their lives.
2. African American and White women describe the causes and symptoms of their depression similarly, but they manage it in different ways.
3. Both African American and White women viewed counseling to manage their depression as expensive and potentially stigmatizing. The majority of White women chose medication to manage their depressive symptoms while African American women turned to their religious faith.

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Table 1

Demographics by ethnicity

Demographics	African American n=15	White n=17	Total&(%) n=32
Age			
16 – 20	4	5	9 (28%)
21 – 25	3	5	8 (25%)
26 – 30	6	6	12 (38%)
31 – 40	2	1	3(9%)
Marital status			
Never married	11	7	18(56%)
Married	3	6	9 (28%)
Divorced	1	2	3 (9%)
Separated	0	2	2 (6%)
Education			
< 12 years (high school)	3	3	6 (19%)
High school graduate	4	4	8 (25%)
Some college	7	9	16 (50%)
Associate's degree	0	1	1 (3%)
Bachelor's degree	1	0	1 (3%)
Household monthly income			
< $500	8	4	12 (38%)
$501 – $1,000	2	4	6 (19%)
$1,001 – $1,500	3	4	7 (22%)
$1,501 – $2,000	0	1	1 (3%)
$2,001 – $2,500	2	2	4 12%)
> $2,500	0	2	2 (6%)
Number of children in household			
1	6	9	15 (47%)
2	1	4	5 (15%)
3	4	3	7 (22%)
4	2	0	2 (6%)
5 or more	2	1	3 (9%)

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Table 2

Causes of depression

Cause and *related quotes*	African American n=11	White n=15	Total n=26
Relationship problems *I was a little depressed when me and [my child's] father broke up…. I knew I was gonna get over it, but it just seemed like it was taking so long.*	6 (55%)	5 (31%)	11 (42%)
Finances/unemployment *[I feel depressed] 'cause I don't have a job. I don't have money and I don't have things to do*	4 (36%)	6 (38%)	10 (38%)
Death/illness in family *I remember when my mom died I was really depressed*	3 (27%)	3 (19%)	6 (23%)
Parenting stresses *My baby, sometimes she got on my nerves and… she just still had to be here, you know what I'm saying? I couldn't get a break or anything.*	3 (27%)	3 (19%)	6 (23%)
Stuck in house/inability to get around *There have been times that I have felt depressed [when] things happen as far as my transportation.*	1 (9%)	3 (19%)	4 (15%)
'Let stuff bother you' *Just every once in a while if someone says something, I might take it the wrong way and there I go!*	1 (9%)	1 (6%)	2 (7%)
Weight gain *When I quit smoking I put on all this weight. This depresses me as well.*	1 (9%)	1 (6%)	2 (7%)
Other *I firmly believe that my depression…stemmed from untreated PMS.*	0 (0%)	1 (6%)	1 (4%)

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Table 3

Symptoms of depression

Symptom and*related quotes*	**African American n=11**	**White n=15**	**Total n=26**
Uncontrollable crying *I can be riding down the road and the tears start coming.*	9 (82%)	9 (60%)	18 (69%)
Angry/irritable *[E]very little thing wants to send me over the edge, everything.*	3 (27%)	8 (53%)	11 (42%)
Desire to be alone *I just didn't want to deal with anybody … see anybody, that kind of thing.*	5 (45%)	6 (40%)	11 (42%)
Change in appetite/weight *My appetite has been out the window I went like 4 days…didn't eat nothing.*	4 (36%)	4 (27%)	8 (31%)
Low self-worth *When I'm depressed, I feel like nobody.*	4 (36%)	2 (13%)	6 (23%)
Change in sleep patterns *I didn't really sleep that much. I would stay up.*	3 (27%)	2 (13%)	5 (19%)
Sadness *[It was] just me getting really, really upset, really sad and down and dreary*	3 (27%)	1 (7%)	4 (15%)
Physical symptoms *I was throwing up constantly, stomach hurting real bad, couldn't hardly move*	0 (0%)	4 (27%)	4 (15%)
Inability to care for child *I didn't even want to be around [my son]. … I was afraid if [he] cried or did something I would take it out on him and I just didn't want to do that.*	0 (0%)	3 (20%)	3 (12%)
Lack of enjoyment in life *In the last Harry Potter when the Dementors are there and it says it takes all of the good away, that's depression…You don't see any good Even when it's there you don't recognize it.*	1 (9%)	1 (7%)	2 (8%)

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Table 4

Help seeking and management strategies

Type of help/management sought and *related quotes*	African American n=11	White n=15	Total n=26
Medication *After I went on the antidepressant… I felt so much better. It was like, "Yes Ma'am, here it is, the miracle cure!"*	1 (9%)	9 (60%)	10 (38%)
Mental health counseling *It's good to be able to talk to somebody who is an outsider to everything 'cause there's stuff you don't want [your family] to know.*	3 (27%)	3 (20%)	6 (23%)
Religious faith *I have my good days and my bad days but with the help of the Lord, I will make it.*	8 (72%)	0 (0%)	8 (31%)
"Keep going" philosophy *I didn't give up. I think that's what really did it, I didn't give up. I kept myself going.*	3 (27%)	5 (33%)	8 (31%)
Talk to family/friends *I called one of my friends and he told me he was coming over here last night and after he left I felt a little better [We] just sat here talking.*	1 (9%)	5 (33%)	6 (23%)
Get out of house *Mostly I'm…trying to get out of the house so I won't be depressed. Just [go] riding just to ride.*	3 (27%)	2 (13%)	5 (19%)