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Gender, Ethnicity and Depression: Intersectionality in Mental Health Research with African American Women

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Introduction

Currently, a remarkable amount of information has emerged regarding gender and mental health and, to a lesser degree, ethnicity and mental health. However, a number of gaps in the literature remain. Further, empirical investigations that examine the effects of both gender and ethnicity are rare. Why is this important? After nearly a full decade of mental health services research, major conclusions regarding ethnic disparities in mental health have been drawn with regard to ethnic minorities and mental health (see: DHHS, Mental Health: A Report of the Surgeon General, 1999). Most disturbingly it was found that large racial disparities in mental health treatment exist. Understanding and improving discrepant rates of treatment requires close examination of the unique factors related to mechanisms underlying distress and suffering in ethnic minority groups, including a better understanding of the epidemiology, etiology, and symptomatology of mental illness across gender and race. However, investigation of these variables must take into account the unique ways in which race and gender interact to affect psychological processes.

This review synthesizes the current knowledge regarding African American women and depression. After highlighting major findings related to the epidemiology, etiology, symptomatology and treatment, we will discuss the gaps in our understanding of these factors specific to African American women. We will argue that filling in these gaps will require a theoretical framework that takes into account the intersection of race and gender. We will present an empirically defined heuristic for studying mental illness among African American women, in terms of both experiences and outcomes.

Epidemiology

First, what do we know about the epidemiology of depression and African American women? Prevalence rates of depressive disorders among African American women are not clear. Being a woman increases your risk for depression but being African American does not. Many studies have reported that the lifetime prevalence rate of depression among women is twice the rate of men in both community and clinical

settings (Culbertson, 1997; Frerichs, Aneshensel & Clark, 1981; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994; Klerman & Weissman, 1989; McGrath, Keita, Strickland & Russo, 1990; Nolen-Hoeksema, 1990; Wetzel, 1994).

The prevalence of major depressive disorder appears to be lower among African Americans in comparison to White Americans and Latinos in the United States (Jones & Gray, 1986; Kessler et al., 1994). In contrast, there have been reports of increased unadjusted rates of depression in some ethnic groups. However, when socioeconomic status is controlled, differences in rates are not evident in either community samples (Brown, Ahmed, Gary & Milburn, 1995; Frerichs et al., 1981; Roberts, 1987; Somervell, Leaf, Weissman, Blazer & Bruce, 1989) or among general medical patients (Jackson-Triche, Sullivan, Wells, Rogers, Camp & Mazel, 1997; Schulberg, Block, Madonia, Scott, Rodriguez, Imber, Perel, Lave, Houck & Coulehan, 1996). These data suggest that African American women do not experience depression at higher rates than White American women do, but do experience depression more often than African American men.

Etiology

Currently both biological and psychological theories have been proposed to account for depression. Biological explanations include genetic factors, structural abnormalities in the brain, and neurotransmitter and/or neuroendocrine dysfunction. Psychological and sociocultural explanations include psychodynamic theories of attachment and loss, behavioral theories based on lack of reinforcement, cognitive theories based on negative attributions and helplessness, and reactions to stress. Hypothesized factors explaining the observed gender differences in depression include limitations related to gender roles and ruminative response styles to depressed mood (Nolen-Hoeksema, 1990). In addition, in comparison to men, women may be more likely to report symptoms and seek treatment and more likely to exhibit depression in ways that are consistent with diagnostic criteria. Unfortunately, the majority of studies of both biological and psychological theories of etiology have not included ethnically diverse samples. For example, Kendler and colleagues' (1994) attempt to develop an integrated etiologic model for predicting depression in women did not include ethnicity. Their analysis only included the following risk factors: recent stressful life events, genetic predisposition and a previous history of depression. From these data and similar analyses, one can either assume universal causality or take the position that we know very little with regard to the etiology of depressive disorder among African Americans in general and African American women in particular.

Risk Factors

In the general population, having a depressed parent has been identified as the single largest risk factor for becoming depressed (Mrazek & Haggerty, 1994). In addition, having a depressed parent is associated with a host of other deleterious outcomes for offspring. In comparison to other children, children with a depressed parent experience increased psychiatric problems (Breslau, Davis & Prabucki, 1988; Hammen, 1988; Hammen, Burge, Burney & Adrian, 1990), increased physical health problems (Billing & Moos, 1983; Mortimer, Kay, Jaron & Good, 1992) and more maladaptive social functioning (Anderson & Hammen, 1993). However, these investigations have not included low-income or ethnic minority families, and it is unclear if having a depressed parent is a robust risk factor among African Americans. There is some evidence that maternal transmission of depression is more powerful for daughters than sons, possibly related to shared social disadvantage related to gender (Fergusson, Horwood & Lynskey, 1994).

Poverty is a statistically powerful risk factor for the development of depressive disorders (Culbertson, 1997; Frerichs et al., 1981). Furthermore, experiencing poverty as a woman has been labeled a "pathway to depression" (McGrath et al., 1990). African Americans, as an overrepresented group among the poor, are at increased risk for depression. Both gender and poverty risk factors suggest that low-income African American women, in particular, are at high risk for experiencing depression at some point in their lives (Barbee, 1992; Taylor, Henderson & Jackson, 1991; Warren, 1997).

However, Taylor and colleagues' (1991) model for predicting depressive symptoms in African American women reveals that the effects of socioeconomic status are mediated through other factors including physical health problems, marital status, religious orientation and internalized racism. In addition, life events, physical health and internalized racism were directly related to symptoms. These findings with a community sample have been corroborated by investigations of correlates of depression in medical patients across ethnic groups (Azocar, Miranda & Dwyer, 1996; Jackson-Triche et al., 1997; Perez-Stable, Miranda, Muñoz & Ying, 1990).

Correlates and Clinical Profiles

In general, investigations of ethnic differences in correlates of depression and symptomatology have not included analyses by gender. However, interesting differences in the clinical picture of depression and mental illness have been reported. Many of these differences are relevant for understanding African American women's experiences.

In comparison to White Americans, African American men and women report greater

psychiatric comorbidity (Blazer, Kessler, McGonagle & Swartz, 1994; Brown, Schulberg & Madonia, 1996), increased severity of somatic symptoms, greater life stress, and differences in perceived physical functioning and health beliefs (Brown et al., 1996). African Americans are less likely to report suicide ideation in comparison to Whites, Latinos and Asian Americans, less likely to report melancholia than Whites and Latinos, but more likely to report poorer health-related quality of life and more stressful life events, most of which are related to economic disadvantage (Jackson-Triche et al., 1997).

Symptomatology may differ by ethnicity and gender. In comparison to White American women, African American women may experience increased mood irritability (as opposed to melancholia), increased appetite (as opposed to decreased) and hypersomnia (as opposed to insomnia) (Kohn, Oden, Muñoz, Robinson & Leavitt, 2001). Overall, however, systematic investigations of symptom differences in depression by ethnicity and gender are rare.

Race-related stress appears to be an important correlate of mental health among African Americans (Franklin, 1998; Outlaw, 1993; Utsey, 1998). Survey data suggests that self-reported perceived discrimination including both lifetime and day-to-day events is common among African Americans (Kessler, Mickelson & Williams, 1999). Further, racism is related to poor psychological health including depression (Brown, Sellers, Brown & Jackson, 1999; Fernando, 1984; Kessler et al., 1999; Klonoff, Landrine & Ullman, 1999; Landrine & Klonoff, 1996). However, the relationship between perceived racism and mental health may be mediated by racial identity (Anderson, 1991). Specific characteristics of racial identity appear to be related to low levels of depression among African American male and female college students (Munford, 1994). Racial identity appears to buffer the effects of discrimination on mental health among African Americans (Jackson, Brown, Torres, Sellers & Brown, 1996) and may mediate the relationship between racial socialization and symptoms of stress (Thompson, Anderson & Bakeman, 2000). However, little is known about gender differences in perceptions of race-related stress or the effect of racial identity on the relationship between perceived discrimination and racism (Munford, 1994).

Intersectional Framework

This review highlights the lack of specific knowledge regarding our understanding of differences related to ethnicity and gender and the epidemiology, etiology and risk factors for depression. These gaps point to the need for a coherent theoretical framework for studying the intersection of race and sex and mental health. Why is it important to understand the interaction of these variables? Improving racial disparities in treatment may not be solved by targeting groups, but rather specific beliefs

among empirically identified members of particular groups. For example, variation in treatment utilization among African American women may be more closely related to the strength of adherence to culturally defined beliefs about disclosing personal problems to mental health professionals rather than directly related to ethnicity. In order to address the limits of our understanding of depression among African American women, we propose a multidimensional and multiplicative framework based on the intersection of dimensions of gender and ethnicity. In addition, prior to collecting and analyzing mental health data it is important to consider particular constructs relevant to the diverse experiences of African American women.

Recently, increased scholarship has focused on the multidimensional aspects of the psychology of individuals and the importance of applying multiple contextual factors in understanding psychological phenomena. While this research has been introduced across several disciplines it has particular relevance for the study of psychopathology. Intersectionality refers to the interaction of fixed variables such as gender and race in analyses of relationships between important constructs. This interaction represents a shift from focusing on direct effects, unidimensional variables, and acontextual empiricism. In addition, intersectionality requires a move toward alternative methodologies in order to incorporate measures that take into account multiple facets of individuals, dynamic contextual influences, and multiplicative effects on outcomes. Psychopathology could be characterized as a field of interactions rather than direct linear relationships. It is unlikely that we will be able to understand the epidemiology, etiology, risk and protective factors of mental disorders until we move beyond standard models and methods of inquiry.

We propose that several dimensions need to be included in empirical investigations of depression among African American women. First, it is necessary to question assumptions of homogeneity among ethnic and gender groups. In order to understand variation across and within ethnicity and gender, these dimensions should be measured to determine the degree to which individuals endorse aspects of African American-ness and Woman-ness. Well-developed measures of gender and racial identity can identify the salience of these constructs across situations and in relationship to specific outcomes. Does it make sense to identify ethnic differences in rates of depression if members of the "ethnic" sample do not endorse affiliation, values, behavioral norm congruence or identification with other members of the group? Without clarifying the nature of this dimension, race differences may be meaningless and important effects of culture may be undetectable. A similar argument could be made with regard to gender. Many experiences of African American women are different from other women. Further, African American women do not identify with or attend to issues of gender in a monolithic fashion. Elucidating dimensions of gender identity would help with the interpretation of recent research related to gender differences in depression and provide a context for mental health research that addresses

the interaction of gender and race.

In addition to the inclusion of race and gender as interactive and dynamic dimensions, several other variables are important aspects of psychopathology in African American women. Specifically, understanding dimensions of gender and ethnicity would be helpful in determining variation in the sources of coping and reactions to stress among African American women. The lack of information about coping in the context of African American women's experiences has been identified as a major shortcoming in coping research (Riley-Eddins, Hobfoll & Jackson, 2000).

For illustrative purposes, our review of the literature on the epidemiology and etiology of depression suggests that African American women face increased risk for depression based on gender, poverty, perceived discrimination and other factors. However, the prevalence rate of major depressive disorder among African American women appears to be equivalent or lower than rates among White American women. Also, rates of suicide completion, an indicator of severe distress, is lower for African American women than White women and men of almost all races (Burr, Hartman & Matteson, 1999; NIMH, 1997). The explanation of this paradox is likely related to factors that could be loosely defined as culturally-based methods of coping. Religious orientation, spirituality, social support, the role of family and other interpersonal relationships have all been implicated as important protective factors for African American women. In addition, it is likely that many African American women have developed a posture for coping with the inferiorized status of being Black and female in this country. This posture may be a result of direct or indirect socialization experiences in family, school, social and occupational realms. Similar to previously identified multidimensional characteristics of racial identity (e.g. Sellers, Rowley, Chavous, Shelton & Smith, 1997), this posture may involve psychological processes that allow one to deflect the effects of negative external estimations of worth. These processes could include an expectation of race-related hostility or inferiority and an adaptive sense of distrust. As a method of coping, deflective strategies may protect against stigmatization and the subordinate status of African American women. However, deflective coping may have implications for the expression and manifestation of mental health. In order to understand the role of deflection and experiences of depression, a multidimensional framework assessing the aspects and salience of gender and racial identity must be utilized.

In summary, mental health research on African American women has suffered from a paucity of analyses that include both race and gender. In order to address racial disparities in treatment for psychological disorders it is crucially important to develop greater specificity in our understanding of contextual factors. We propose an intersectional framework that accounts for dimensional variation in ethnicity and gender identity and incorporates the interaction of gender and ethnicity in examin-

ing psychopathology. Further, intersectionality may require alternative methodological approaches including ethnographic data collection, empirically established within-group profiles and analysis strategies that will account for the primacy of interaction effects. However, these challenges should not dissuade mental health researchers from attempting to represent the phenomenological complexity of African American women in their work.

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