The purpose of this chapter is to present a multicultural analysis of depression using an integrative psychological–sociocultural framework. In devising this framework, we drew on two theories with direct relevance to this topic: multicultural feminist theory (Hurtado, 2010) and the silencing the self theory of depression (Jack, 1991, 1999; Jack & Ali, 2010). As we demonstrate, adopting a multicultural lens in examining the etiological and experiential factors at play in depression requires an acknowledgment of the crucial role played by both the personal–familial dimension of an individual’s lived experience (encompassing such variables as immigrant or refugee status, personal and generational history of trauma, and sources of resilience) and the cultural context in which an individual resides. Our integrative framework therefore aims to capture vulnerability factors and protective factors that can influence onset, course, and recovery in depression.

OUR GUIDING ASSUMPTIONS

In approaching the topic of multicultural factors related to depression, we adhered to certain assumptions that guided both the development of our theoretical framework and our decisions concerning which cultural, psychological, and interpersonal variables we would emphasize. The first of these guiding assumptions is that any viable conceptualization must sufficiently account for certain replicated findings from the empirical literature on depression. In particular, we emphasize the following findings that have consistently been reported: (a) Depression is significantly more common in women than in men across most cultures and across most ages and socioeconomic levels; (b) most episodes of depression are preceded by a precipitating event, usually a severe stressor or chronic life difficulty; and (c) most people who experience severe life stress do not become depressed; aspects of available support—particularly in the form of a close, confiding relationship—can function protectively against the development of depression, even within the context of severe life stress.

Our second guiding assumption is that depression must be conceptualized in a manner that captures the recurring and often chronic nature of this condition. Depressive episodes are usually not isolated events, and most people who struggle with depression do so repeatedly and often in combination with other symptoms of mental disorders. We also consider that the chronic nature of depression reflects social contexts that disempower individuals in unrelenting, spiraling patterns that undermine their ability to respond to the potential onslaught of stressors. These contexts, which include poverty, violence, and discrimination, also themselves generate stressors that can become depressogenic. In particular, because racial discrimination can be a powerful force that shapes the social context in which one resides, it must be central in any multicultural conceptualization of depression.

Our final guiding assumption concerns the socially constructed nature of depression as an illness and as a diagnostic category in psychiatry. As with any condition or syndrome that is deemed
a mental illness, depression cannot be assumed to be real. Rather, *depression* is a term that is invoked when one wants to delineate a constellation of feelings, thoughts, and experiences that together impair an individual’s ability to function. Given the multiculturally focused chapter, we found it particularly helpful to adopt a fluid notion of depression that considers not only the strict criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; DSM–IV–TR; American Psychiatric Association, 2000), but a broader range of experiences that allows for different cultural presentations of depression. Thus, we adopted a continuum lens that includes awareness that culture can affect the experience of, expression of, and response to depression as well as a critical lens that problematizes the White, Western-dominated definition of depression represented in the DSM–IV–TR.

WHY CULTURE MATTERS IN UNDERSTANDING DEPRESSION

Our focus in this chapter is on the cultural construction of depression and on the experience of depression across various cultural groups. We begin with the question, “Why does culture matter in framing and understanding depression?” Ethnocultural research in anthropology, psychology, and psychiatry has uniformly agreed that depressive experience and symptoms vary across cultures (Marsella, 2003; Patel, 2001). Different cultural traditions shape understandings of personal experience, such as personhood, identity, and social worth, thereby promoting or limiting depressive symptom expression. Cultures also protect against depression through factors such as family strengths, religious beliefs, attribution styles, and related coping or support systems. Culturally defined behaviors and values include implicit rules concerning acceptable ways of relating to others and expected ways of functioning within one’s social and practical world. Therefore, culture defines one to oneself and to others.

Depression can be thought of as a disruption—or series of disruptions—in one’s ability to fulfill a meaningful role set forth by one’s culture, whether that role is social, familial, interpersonal, or practical. This disruption is construed as anomalous by other people and by oneself and therefore precipitates a loss of connection with and similarity to others. So culture, by defining the sources of sameness among members of a given group, also defines the differentness that can cast an individual as socially anomalous. At the same time, the unity and shared experience inherent in cultural bonds represents the possibility for (re)connection and can therefore serve a protective function for individuals who may be at risk for depression. So culture is important in framing both the potential causes of and the potential remedies for depression.

Culture also frames the way that depression itself is defined, felt, and described within different groups of people. As we discuss later, the constellation of symptoms and experiences that are labeled *depression* looks different in different cultural groups. These differences matter because (a) they demonstrate the importance of adopting a critical multicultural lens in understanding mental illness and mental health and (b) they tell one something about the notion of culture itself: Culture interacts with the inner, psychological worlds of individuals in ways that are difficult to capture by drawing on mainstream theories of depression but that must be captured if a comprehensive understanding of this increasingly common condition is to be created.

Finally, research that has emerged in the past decade has suggested that culture may matter even in understanding the proposed biological bases of depression. For instance, culture and ethnicity are posited to influence responses and reactions to antidepressant medications (Office of the Surgeon General, 2000; Ruiz, 2000), and the growing field of ethnopsychopharmacology is attempting to integrate various findings that together can help conceptualize drug treatment as occurring within instead of independent of cultural context (Rey, 2006). Clearly, culture cannot be ignored when the aim is to understand the etiology and course of depression.

MULTICULTURAL FEMINIST THEORY

Hurtado (2010) described multicultural feminist theory as a way of understanding cultural variations in definitions of gender relations and differences within cultures related to social class, ethnicity, and...
power. Multicultural feminist theory arose in response to the lack of attention to racial–cultural issues within mainstream feminist thought. Advocates of a multicultural feminism argued that the notion of equality is incomplete without an understanding of the true diversity of women’s experience. Three concepts make up the core of multicultural feminist theory. The first concept, intersectionality, refers to the multiple sources of oppression that can together disempower groups of women in a complex, interacting manner. The second concept, self-reflexivity, refers to the stance that researchers’ own social identities shape what they determine worthy of study and, indeed, shape what they readily see versus what goes unnoticed. Self-reflexivity is important in feminist work because it also considers the role of privilege in the production of knowledge. The third concept, accountability, refers to the need for feminist work to strive for social transformation and equality, including equality across groups and among members of the same cultural group.

Multicultural feminist theory has not been applied extensively to the study of mental health problems. Because mental illness is most often viewed from a medical standpoint, both multiculturalism and feminism are usually viewed as incompatible with dominant approaches to understanding and treating depression. However, the need to consider multiple viewpoints and the need to create social change must be central in the efforts to more fully conceptualize depression. Authors in the realms of psychology of liberation (Aron & Corne, 1994; Blanco, 1998) and pedagogy of the oppressed (Freire, 1970; Freire & Macedo, 2000) have argued convincingly for the requisite emphasis on social equality as an aim for practitioners and scholars alike. Thus, we have adopted the central concepts of intersectionality, self-reflexivity of the researcher, and accountability to strive for social transformation and equality as central to our framework.

Cultures create differing sources of vulnerabilities that sometimes have meaning only to individuals within a given cultural group. Therefore, cultural context can be viewed as a source of specificity of experience in terms of the onset and maintenance of depressive symptoms. At the same time, we argue that there is a core of universality that transcends cultural bounds in the experience of depression. That core is the universal human need for relational connection. Therefore, the other theory that we have drawn on in building our theoretical framework of depression is the relational theory of silencing the self.

SILENCING THE SELF THEORY

Silencing the self theory emphasizes the interplay between social and psychological factors in precipitating and prolonging depression. As with multicultural feminist theory, silencing the self theory differs on important dimensions from dominant psychological and psychiatric approaches to understanding mental health. Specifically, silencing the self theory calls attention to the social, interpersonal context of depression, particularly how social inequality and gender live in one’s mind to affect everyday interactions and the experience of self.

The social categories of thought that people bring to actively interpret their worlds, guide their behavior, and assess the self are socially constructed and are reflexive with social institutions and contexts. Gender specific aspects of socialization practices and material social power are reflected in self-silencing thoughts and behaviors. (Jack & Dill, 1992, p. 99)

The theory also is based on assumptions about the centrality of relationships in people’s lives and on the depressogenic effect of social–relational disconnection (Jack, 1991, 1999; Jack & Ali, 2010). Because oppression creates and demands silence, self-silencing works as a strategy of survival in situations that hold threat and is used to create an outer appearance of conformity to social–relational expectations, to offset the stigma that may attend exposing one’s culturally discrepant feelings, or both (see Beauboeuf-Lafontant, 2007; Jack, 1991; Kennedy, Beck, & Driscoll, 2002; Woods, 2010). Thus, self-silencing may serve as a marker of accommodation to inequality or oppression.

The theory was derived from longitudinal research involving clinically depressed women who described their understanding of factors that led to
their depression and that fostered their movement out of depression (Jack, 1991, 1999, 2003). Establishing positive, close connections was evident as a primary motivation; their cognitive–relational schemas about how to make and keep relationships reflected a set of attachment behaviors that were based on social inequality. These relational schemas, which were based on prevailing standards of feminine “goodness,” led women to put others’ needs first and to silence certain feelings, thoughts, and actions to avoid interpersonal conflict in their intimate relationships. This silencing was at the core of their self-devaluation and led to a fall in self-esteem and feelings of a loss of self, inner division, and disconnection. This dynamic, deeply tied to social context, is understood to foster depression.

Although the construct of silencing the self was initially developed from the narratives of clinically depressed White women, this social–relational paradigm of depression has proven to be relevant to a diversity of experiences. Scores on the Silencing the Self Scale (Jack & Dill, 1992), a measure developed to capture the dynamic of silencing the self, have been found to correlate with level of depressive symptoms across a wide range of cultures and groups (Beauboeuf-Lafontant, 2007; Grant, Jack, Fitzpatrick, & Ernst, 2011; Jack & Ali, 2010). Higher levels of oppression are associated with more self-reports of self-silencing and depression across specific contexts. For example, self-silencing has been found to be significantly higher among women who experience intimate partner violence (IPV; Jack & Dill, 1992; Woods, 2010); among women who are stigmatized, such as low-income, ethnically diverse women with HIV/AIDS (Brody et al., in press; DeMarco, 2010; Jacobs & Thomlison, 2009); and among lesbians (Kirk, 2002). Finally, ideologies of masculinity affect men’s self-silencing, although their motivations for self-concealment appear to differ from women’s (Smolak, 2010); self-silencing has been found to predict men’s depression (Gratch, Bassatt, & Attra, 1995; Jack, Pokharel, & Subba, 2010; Smolak, 2010). Thus, silencing the self theory has relevance to understanding how specific contexts such as discrimination and stigma foster silence and how they may be linked to gender, disconnection, and depression.

OVERVIEW OF DEPRESSION IN MULTICULTURAL GROUPS

Research on depression in multicultural populations is filled with inconsistent findings and complexities. For example, some investigators have found African Americans to have higher rates of depressive symptoms than White Americans (Mizell, 1999; Neff, 1984; Plant & Sachs-Ericsson, 2004), whereas the majority of epidemiological studies have reported lower or equivalent rates of major depressive disorder in African Americans compared with Whites (Blazer, Kessler, McGonagle, & Swartz, 1994; Breau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; Hasin, Goodwin, Stinson, & Grant, 2005; Kessler et al., 1994, 2003; Riolo, Nguyen, Greden, & King, 2005). Findings from a large study have suggested that depression in African Americans is of greater severity, more disabling, and more often untreated than in Whites (Williams et al., 2007), and a review of the literature has suggested that underdiagnosis of depression may be a cause of its lower prevalence in African Americans (Simpson, Krishman, Kunik, & Ruiz, 2007). Meyer (1995) suggested that findings regarding depression among Blacks are affected by selection bias because of the disproportionately greater institutionalization of Blacks in the United States, who are likely to have higher rates of depression.

Findings regarding Native Americans are also contradictory: A study of two American Indian tribes—a Northern Plains and a Southwest tribe—found that after differences in demographic variables were accounted for, both groups were at lower risk for major depressive episode (Beals, Novins, et al., 2005) compared with rates in the general U.S. population in the National Comorbidity Study (Kessler et al., 1994). Yet Native Americans also had a higher risk of major depression than other ethnic groups, including Whites, in other large studies (Chester, Mahalish, & Davis, 1999; Hasin et al., 2005).

These contradictory findings likely result from a number of factors:

- **Bias in diagnostic instruments.** Given that (non-Latino) Whites have been the focus of the vast majority of psychiatric research in the United States, depression among the White majority...
population is well identified and has largely shaped its conceptualization, diagnostic instruments, and treatments (Mendelson, Rehkopf, & Kubzansky, 2008). Thus, there may be cultural differences between groups in the experience of depression and bias in the diagnostic instruments that account for contradictory findings (Breslau et al., 2005). For example, evidence exists of differential item functioning across ethnic groups on mental health rating scales (Turner & Lloyd, 2002), which may reflect phenomenological differences in the experience of depression and which could lead to under- or overestimation of depression.

- **Variation in measures of depression.** Many studies rely on symptom counts (e.g., Center for Epidemiological Studies Depression Scale, Beck Depression Inventory), and others, especially the nationally representative epidemiological surveys, use DSM–IV–TR diagnostic criteria. Moreover, all such measurement instruments focus on the individual, which allows interpretation of scores independent of context.

- **Inconsistent designation of cultural/ethnic groups.** For example, in some studies Latino or Hispanic is considered an undifferentiated group even though its members represent different varying cultures, nationalities, and migration experiences (Comas-Díaz, 2006). In research, what matters regarding an ethnic identity is the extent to which a person endorses and practices the cultural traditions and lifestyles of that group (Marsella, 2003). Adding to the complexity of findings is inconsistency in designation of foreign born or length of time within the United States within ethnic minority groups.

- **Inadequate consideration of social class and other demographic variables within ethnic groups.** Many of the previous community-based studies have not analyzed the confounding of socioeconomic class with chronic stress and their effect on depression (Beals, Manson, et al., 2005; Neff, 1984; U.S. Department of Health & Human Services, 2001; Vega, Warheit, Buhl-Auth, & Meinhardt, 1984).

- **Inadequate measurement of the psychological effects of racism as a chronic stressor** (Clark, Anderson, Clark, & Williams, 1999). Inadequate measurement includes the interaction of minority status with socioeconomic status on the basis of the incorrect assumption that the effects of socioeconomic status are similar for minority and nonminority groups (Breslau et al., 2005).

### AN INTEGRATIVE MULTICULTURAL FRAMEWORK OF DEPRESSION

Given these confounding issues related to research on depression in multicultural groups and our guiding assumptions, we devised the following framework to examine factors that most powerfully affect depressive vulnerability within and across these populations. The structure of our integrative framework draws on essential features of both multicultural feminist theory and silencing the self theory. We view these two theories as complementary and compatible, largely because they share a deep consideration of sociocultural factors in shaping lived experience. The framework consists of the following elements that together reflect an integration of social, cultural, relational, and psychological factors in depression.

Our first element, *oppression as pathogen*, is derived directly from the work of Smith, Chambers, and Bratini (2009) and focuses on the illness-producing effects of various forms of oppression. It integrates the multicultural feminist concept of intersectionality among various sources of oppression affecting disadvantaged groups and the emphasis of silencing the self theory on the interaction of oppressive environments with psychological factors.

In our framework, depression begins in the social environment; that is, depression is best understood as the psychological manifestation of oppressive events, circumstances, and forces functioning at levels of interpersonal or family relationships, structural or systemic forms of discrimination, and overt attacks on an individual’s sense of self through physical and nonphysical violence. Looking first at exogenous causes for depression achieves two key goals. First, this approach is less likely than mainstream medical approaches to blame the depressed individual for his or her own suffering. Unlike these dominant approaches, our framework looks at
dismaying events and the sociocultural
context to understand the etiology and expression of
depression rather than assuming that psychological
distress arises from the depressed person’s defective
ways of thinking about his or her circumstances.
Second, this approach enables a fuller consideration
of the cultural contexts that can give rise to emo-
tional suffering.

This fuller consideration leads us to the second
element in our framework, which is self as culture.
In this element, we draw on silencing the self theory’s
notion that freedom of self-expression and action
reflect one’s sociocultural standing. For
example, a subscale of the Silencing the Self Scale—Externalized Self-Perception—emphasizes
the powerful role played by culturally derived
messages that constrain an individual along dimensions that are defined by one’s perceived
social status. The idea of a connection between
low social status and a diminished sense of self
helps to explain higher rates of depression in
women than in men: Women are almost universally relegated to lower social status than men.
This notion is also crucial in our consideration of
depression among immigrant groups and ethnic
minority groups in the United States. Research has
documented a downward trajectory of mental
health in which the likelihood of mental health
problems increases for immigrants as length of residency in the United States increases (Gee,
Ryan, Laflamme, & Holt, 2006; Williams et al., 2007). One interpretation of these findings is that
immigrant men and women arrive with a “cultural
buffer” in which experiences, beliefs, and traditions from their country of origin may protect
them against mental health problems. They have
been socialized in a culture that is not directly
White dominated and have alternatives to the
deviling gaze of dominant U.S. culture. The ero-
sion of this buffer over years of contact with U.S.
culture—and years of encountering direct and
indirect racism—can lead to a diminished sense of self and compromised emotional wellness.

Clearly, a devaluing culture can affect one’s self-
regard and foster self-silencing, which have been
found to correlate with depression (Ali, 2010;

The final element in our framework is depression
as disconnection. This element draws on the multi-
cultural feminist principle of accountability by
assuming that our primary accountability in theoriz-
ing depression is to individuals who experience
depression. Various accounts have documented that
depressed individuals report feeling out of step with
the world and a sense of isolation. Our notion of
depression as disconnection emphasizes intersecting
forms of disconnection: relational disconnection
from others in which depression is experienced as a
lack of closeness with any person or group of peo-
ple; disconnection from self, as reflected in silencing
the self theory’s notion of the divided self, in which
the outer, conforming self-presentation hides an
inner, angry self that is not allowed self-expression;
and cultural disconnection, in which an individual
feels that his or her surrounding social world is for-

gin to him or her. This final form of disconnection
is highly relevant to a multicultural conceptualiza-
tion of depression because perceived minorities and
members of immigrant groups may be at particular
risk for feeling disconnected from the dominant
culture through discrimination and racism (Nazroo,
2003). However, we should note that cultural dis-
connection is not simply a feeling of being different;
rather, it is a feeling of being at odds with or excluded
from the most salient values and attitudes of the
culture by which one is dominated (whether one
lives in that dominant culture or resides elsewhere
but is dominated by an outside culture through
colonization).

As we apply our integrative multicultural frame-
work of depression using these three elements—
oppression as pathogen, self as culture, and
depression as disconnection—we call attention to
the fact that these elements themselves are overlap-
ning and interlocking. For example, the depression-
inducing nature of poverty (oppression as pathogen)
overlaps with the chronic disconnection that groups
marginalized by discrimination and social stratifica-
tion experience in their sense of disempowerment
(depression as disconnection). The resulting experi-
ence and presentation of depressive symptoms may
vary among ethnic groups and be misunderstood by
dominant, Western definitions of depression (self
as culture). Thus, even though we use separate
headings to organize our review of depression from an integrative multicultural perspective, each of the three elements contains aspects of the other two.

**Oppression as Pathogen: Framing Discrimination, Poverty, and Violence**

Discrimination, poverty, and violence are powerful predictors of depression that disproportionately affect ethnic minority groups, particularly women. Traditional gender roles and the chronic burden that confronts women in various sociocultural settings are associated with a number of psychosocial stressors (e.g., gender-based violence across the life course, forced child marriage, IPV, forced labor, trafficking for economic and commercial sexual exploitation, poverty, lower economic and social stability; Astbury, 2010). These stressors, as well as ethnic/racial discrimination, play a significant role in “initiation and maintenance of” (women’s) depression (Astbury, 2010, p. 19).

**Discrimination.** According to a growing body of evidence from population-based studies, racial discrimination negatively affects the physical and mental health of members of minority groups in the United States (Schultz, 2006). Self-reported discrimination, that is, experiences of being unfairly treated because of one’s race/ethnicity, is associated with depression or depressive symptoms among African Americans (Fischer & Shaw, 1999; Schulz, Israel, Williams, Parker, & James, 2000; Williams & Williams-Morris, 2000). Latinos (Finch, Kolody, & Vega, 2000; Gee, Ryan, Callambe, & Holt, 2006), Southeast Asian refugees (Noh, Beiser, Kaspar, Hou, & Rummens, 1999), and American Indians in the upper Midwest (Whitbeck, McMorris, Hoyt, Stubben, & Lafortune, 2002). Ethnic minority women in poverty appear to experience more discrimination than men in poverty because of the intersections of race, poverty, and gender (Banks, Rohn-Wood, & Spencer, 2006; Belle & Doucet, 2003). Specifically, a 5-year longitudinal study of African American women in Detroit found that increasing self-reports of discrimination are related to increasing depressive symptoms over time and to declining self-rated general health status (Schulz et al., 2006). Finally, evidence of discrimination associated with gender appears in the finding that across racial/ethnic groups, women’s rates of major depressive disorder are approximately 2 times higher than men’s (Riolo, Nguyen, Greden & King, 2005).

Because of stigmatized sexual identities, lesbian, gay, and bisexual (LGB) individuals experience discrimination through a range of factors, such as health care barriers, legal inequalities, and physical threats (Meyer, 1995). Individuals who have dual or triple minority statuses arising from ethnicity, sexual orientation, and female gender have been found to be at elevated risk for psychological and substance use morbidity, especially lifetime histories of suicide attempts (Cochran, Mays, Alegría, Ortega, & Takeuchi, 2007). However, findings are mixed regarding the rates of depression among such individuals. For example, the Urban Men’s Health Study (Mills et al., 2004) of men who have sex with men found the following rates of depression: African American, 21%; Hispanic, 20%; Asian or Pacific Islander, 21%; and Native American or other, 26%, compared with White men (16%). Yet a national household probability psychiatric survey of Latino/a and Asian Americans found individuals of minority sexual orientation to be at somewhat lower risk for psychiatric disorders than LGB individuals in general (Cochran et al., 2007), a finding attributed to protective cultural factors such as community and family support. Few studies have focused on depression among Black lesbian or bisexual women who face triple jeopardy—the intersection of sex, ethnicity, and sexual identity (Greene, 1994)—and such studies are critical for guiding mental health interventions (Bowleg, Craig, & Burkholder, 2004).

Although most studies of LGB ethnic minority groups focus on individual-level factors, Hatzenbuehler et al. (2010) examined the impact of living in states that instituted bans on same-sex marriage during the 2004 and 2005 elections and the prevalence of psychiatric morbidity among LGB populations. This 3-year longitudinal, nationally representative study found the following changes among LGB respondents: any mood disorder, 36.6% increase; generalized anxiety disorder, 248.2% increase; any alcohol use disorder, 41.9% increase; and psychiatric comorbidity, 36.3% increase. These psychiatric disorders did not increase significantly among LGB
respondents living in states without constitutional amendments, and no increases of the same magnitude were found among heterosexual respondents living in states with constitutional amendments. Such findings emphasize the impact of a discriminatory sociocultural context on the mental health of LGB individuals and the importance of overturning oppressive social policies.

Poverty. According to the U.S. Census Bureau (2010), 14.3% of the total U.S. population lived in poverty in 2009. This population of 43.6 million makes up the largest number of people living in poverty in the 51 years for which the poverty estimates have been published. Minority groups are overrepresented among those in poverty: In 2009, Blacks or African Americans had significantly higher rates at 25.8%, followed by Hispanics at 25.3%, and Asians at 12.5%, with non-Hispanic Whites having the lowest rate at 9.4%. Of all family groups, poverty is highest among those headed by single women. In 2009, African American women were the highest group heading single-family households (67%), followed by Native Americans (53%) and Hispanics (40%). Of the total population, 29.9% were female-headed families (4.4 million families) and poor, compared with 5% of married-couple families (3.4 million families). Immigrant women were also overrepresented among the poor (Nadeem, Lange, & Miranda, 2009). These figures tell a significant story: Ethnic minority identity and gender play a significant role in poverty demographics.

Poverty causes depression. Research has shown a higher lifetime and higher 12-month incidence of major depressive disorder, anxiety, and substance use disorders among low-income individuals and those living in or near poverty (Kessler et al., 1994, 2003; Wang et al., 2005). Analysis of depression symptoms in a large random sample including Hispanic, African American, non-Hispanic Whites, and Native American individuals found that ethnic minority group members experienced more depressive symptoms than White individuals and that this effect was mediated both by chronic problems meeting basic needs (e.g., food, shelter, clothing) and household income (Plant & Sachs-Ericsson, 2004).

Research has shown that society consistently stigmatizes those who are poor—either by blaming them for their situation or through stereotypes; thus, living in a disadvantaged neighborhood often leads to perceived stigma. Stigma leads to greater fear of seeking support, and not seeking support or treatment for depression is higher in “traditionally underserved groups, including elderly persons, racial-ethnic minorities, those with low incomes, those without insurance, and residents of rural areas” (Wang et al., 2005, p. 639). The reasons for not seeking support or treatment are complex and include perceiving that none is forthcoming, that it will not be helpful, and that seeking help is stigmatizing and encountering practical issues such as no transportation, childcare, or insurance (Bullock, 2004).

Depression rates among women in the United States living in poverty range from 42% to 60% (Ali, Hawkins, & Chambers, 2010). Poor women experience more frequent, more threatening, and more uncontrollable life events than does the general population, and they typically experience multiple chronic stressors (Belle & Doucet, 2003). Moreover, poor African American women experience the chronic stress of racial discrimination, are overrepresented among the poor, and thus are at increased risk for depression, particularly when they are parenting young children (Belle & Doucet, 2003; see also Siefert, Williams, Finlayson, & Delva, 2007).

Nancy Grote et al. (2007) also found that that African American women living in poverty experience a greater number of depressive symptoms than White women in similar circumstances as a result of a greater number of chronic stressors, including racial discrimination, housing in disrepair, dangerous neighborhoods, and lack of transportation.

Additional studies have pointed to specific aspects of living in poverty that increase depression among ethnic minority women who are parenting. In their study of 824 African American mothers living in the poorest census tracts in Detroit, Siefert et al. (2007) found that household food insufficiency and deteriorated housing significantly predicted depression. In fact, household food insufficiency more than doubled the odds of depression among these mothers, and food shortages are known to be associated with a number of additional adverse
effects on mental and physical health. Not having enough food for one’s family in a society of plenty not only adds severe acute stress to the chronic stress of poverty but is also stigmatizing. Hunger has increasingly become a problem for poor women with children, especially ethnic minority women (Plant & Sachs-Ericsson, 2004; Siefert et al., 2007).

Maternal depression carries well-known risks for mother–infant bonding and adverse effects for children’s health and development (Civic & Holt, 2000), and depression during pregnancy serves as a strong predictor of postpartum depression (Canady, Bullen, Holzman, Broman, & Tian, 2008). A study of discrimination and symptoms of depression among pregnant African American and White low-income women ($N = 2,731$) found that African American women reported higher levels of depressive symptoms than White women (Canady et al., 2008). Gender, race, and socioeconomic discrimination were each positively associated with depressive symptoms; the study pointed to potential links between lifetime discrimination and depressive symptoms in pregnancy.

However, important specific factors have been found to offset the risk of depression for ethnic minority mothers living in poverty. Siefert et al. (2007) found that women’s access to supports—a loan in a financial crisis, available help with childcare, and access to help with transportation—significantly reduced the odds of maternal depression. This finding carries an ethical imperative: Wider society can easily affect depression and its consequences for women and children in poverty through simple, direct programs. Similar findings were reported by Ali, Hawkins, and Chambers (2010), who found that 40.5% of poor, depressed participants in an empowerment-based poverty-transition program were no longer depressed after participating in the program for 6 months. This evidence demonstrates the importance of fostering a sense of control over one’s circumstances as a means of escaping the psychological entrapment in poverty.

Violence against women. Another obvious indicator of the depression-producing effect of oppression comes from research on the effects of violence.

Violence against women, whether by their intimate partners or men not known to them, is the most prevalent and most emblematic gender based cause of depression in women. . . . Such violence encapsulates humiliation, subordination, grossly unfair treatment and blocked escape or entrapment. (Astbury, 2010, p. 27)

Epidemiological surveys have revealed that one in three women in the United States will have experienced physical, emotional, or sexual abuse in a close relationship at some point in her life and that IPV has acute and long-term effects on women’s physical and mental health, including depression and post-traumatic stress disorder (Woods, 2010). People in disadvantaged positions such as poverty and minority status, encounter multiple forms of discrimination and institutionalized violence that may exacerbate abusive relationships (Richie, 2005); that is, domestic violence is likely not the only form of abuse that ethnic minority individuals experience (Sokoloff & Dupont, 2005).

IPV among African American women. Although African American women experience more frequent and severe IPV than White women in low-income groups and are in general viewed as being “multiply victimized by having to endure a combination of racism, sexism, and poverty” (Wright, Perez, & Johnson, 2010, p. 1), research has found that African American women report less psychological distress related to their abuse and endorse higher levels of empowerment than their White counterparts (Wright et al., 2010). The racial stereotype of the strong Black woman has come to describe an individual capable of enduring struggles and distressing experiences responsibly and carries both positive and negative connotations. The need to show strength has been used to explain the self-silencing of emotional distress among this population with negative consequences (Beauboeuf-Lafontant, 2007). The positive is that empowerment among African American women may explain decreased psychological distress, including lower levels of depression, with empowerment defined as the ability to “construct meaning from these experiences through the development of creative essence or internal methods of coping with
trauma” (Wright et al., 2010, p. 5). These findings suggest that understanding empowerment and other resiliency factors, not only in this population but in other ethnic minority groups, may be important when developing interventions for domestic violence and also for psychological distress such as depression. At present, psychologists’ knowledge of depression as an independent risk factor for IPV across racial/ethnic groups is circumscribed by the limited number of studies that have addressed race/ethnicity in ways that avoid “ethnic lumping” and are methodologically sound (see Malley-Morrison & Hines, 2007).

**IPV among immigrant women.** Immigrant women face specific stressors that may exacerbate their risk of IPV because many arrive in the new host country with disadvantages in social status and economic resources in comparison to immigrant men (Menjívar & Salcido, 2002). Their susceptibility to IPV may also increase because many immigrant women live within two conflicting cultures and within a framework in which language barriers, social isolation, and restriction resulting from immigration or legal or undocumented status may exist (Raj & Silverman, 2002). For example, language barriers may impede immigrant women from calling emergency hotlines as well as from effectively navigating legal, health, and social services (Yick, 2001), and can inhibit them from breaking away from the cycle of IPV. A study conducted by Yick (2001) on IPV with Chinese immigrant families found that as a result of the many Chinese languages and dialects, domestic violence shelters and other services cannot accommodate groups’ individual needs.

**IPV among Hispanic immigrant women.** In a study conducted by González-Guarda et al. (2009), self-esteem and income were the two highest predictors of exposure to IPV for Hispanic immigrant women. Hispanic immigrant women with higher incomes reported slightly higher rates of IPV. Changes toward less traditional gender role beliefs may increase the risk of IPV, particularly in traditional Hispanic households where men are viewed as the providers and women as financially dependent (González-Guarda et al., 2009; Raj & Silverman, 2002).

A study conducted by Harris, Firestone, and Vega (2005) with Mexican-born immigrants and U.S.-born Mexicans (N = 997) on the impact of acculturation, acculturated stress, depression, and gender role ideology on wife abuse reported similar results. Both Mexican-born immigrants and U.S.-born Mexican abused women who espoused traditional gender role attitudes reported a lower level of abuse, presumably because the man’s traditional gender role was not being challenged. Women who had a higher level of education and wanted a more egalitarian decision-making process reported higher levels of acculturative stress, depression, and abuse.

The Sexual Assault Among Latinas study, which was conducted between May and September 2008 and interviewed 2,000 Hispanic women living in the United States (foreign born and U.S. born), found that more than 40% of their sample had experienced at least one form of victimization, with 22% stating they were victims of IPV (Cuevas et al., 2010). Furthermore, about 42% of their sample had clinically significant levels of anxiety and around 30% had clinically significant levels of depressive symptoms. These results are congruent with other studies that have explored the relationship between IPV and depression and have reported that Hispanic female victims of IPV have higher rates of depression than both their White and African American counterparts (González-Guarda, Peragallo, Vasquez, Urrutia, & Mitrani, 2009).

Efforts to address or understand IPV in immigrant communities and its relationship with depression must consider the powerful influence of sociocultural factors from the culture of origin (e.g., cultural values, traditional gender roles, laws or other institutional arrangements or lack thereof) and those being experienced in the new host country (e.g., immigrant and minority status, acculturated stress, language barriers, discrimination) can have on immigrant women and men (Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005). It is also important to understand that acculturative stress and the acculturation gap within individuals in a family contributes immensely to family conflicts, IPV, and depression (Farver et al., 2002).

As this overview has demonstrated, oppression—discrimination, poverty, and IPV—is a pathogen for
depression among ethnic minority populations who disproportionately experience its effects. Feelings of humiliation can be seen as an almost inevitable response to the experience of being treated unfairly through discrimination and from chronic exposure to insults that create and reflect social marginalization. Such insults are uncontrollable and unable to be anticipated or prevented and can thus be characterized by entrapment, humiliation, and defeat, identified as central characteristics of situations that precipitate depression in women (Brown, 2002). Certainly, these characteristics affect depression in men as well.

Self as Culture: Framing Cultural Bias in the Context of Depression

Culture shapes the development of emotional expression, morality, self-concept, and behaviors, all key concepts in how psychiatry and psychology conceptualize mental illness. Culture also shapes how patients from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment (U.S. Department of Health & Human Services [DHHS], 2001). As Choi (2002, p. 74) stated, “Culture governs all types of illness experiences among all individuals,” including diagnosis, treatment, and utilization of treatment. Yet, more important, concepts that determine conceptualization, research, and treatment of depression have been formulated by White psychologists and psychiatrists whose ideas are steeped in Western historical understandings of the meanings and origins of this illness (Marsella, 2003). Despite documented differences in diagnosis of African American and other minority groups, dominant biomedical concepts have been universalized and applied to ethnic minority groups assuming that (a) experts are unbiased and use “value-free assessment of an individual’s mental state” (Ali, 2004, p. 71), (b) “diagnosis occurs in a decontextualized space free from prejudice and discrimination” (Ali, 2004, p. 71), and (c) the origins and manifestations of depression are generally homogeneous across individuals and across groups.

It is increasingly evident, however, that systematic differences exist in how various ethnic groups experience and report symptoms of depression (Uebelacker, Strong, Weinstock, & Miller, 2009). For example, explanatory factors such as language, cultural variance in somatization of depressive symptoms, and clinician cultural biases have been suggested as sources of inappropriate diagnoses in the Hispanic population (Foster, 2007).

Investigating symptoms of depression among ethnic minority groups, Uebelacker, Strong, Weinstock, and Miller (2009) conducted a secondary analysis of the National Epidemiological Survey on Alcohol and Related Conditions dataset (N = 13,733) and compared women and men from the following groups: Hispanics and non-Hispanic Whites, African Americans and Whites, Asian Americans and Whites, and American Indians and Whites. Their results failed to support the idea that one group, in particular one racial or ethnic group, is more likely to “somatize” than another group. The group comparison that yielded the most differences in the likelihood of endorsing somatic symptoms was the gender comparison, in that women are more likely than men to endorse appetite or weight disturbance and fatigue.

Exploring depressive symptom patterns, Saint-Arnault, Sakamoto, and Moriwaki (2006) conducted a meta-analysis that looked at patients with depression and the percentage who reported unexplained physical symptoms in primary care clinics in the United States, comparing it with international studies. The analysis revealed that in the United States, only 10% to 20% of depressed patients reported unexplained physical symptoms, whereas international studies showed that a majority of patients with depression report “only physical symptoms (45 to 95%, average 69%), with 11% denying depressive emotions upon direct questioning” (p. 276). Studies of symptom patterns have supported the argument that instead of believing that non-Western cultures tend to somaticize distress, perhaps specific Western cultures are anomalous in being prone to psychologize or express distress in cognitive or affective terms. In the following sections, we review cultural bias as it has affected research and understanding of depression among ethnic minority groups, including immigrants.
African Americans and cultural bias

Limited culturally relevant research has been conducted with African Americans in the area of depression and other mental illnesses. African Americans continue to have less access to mental health services than do Whites (DHHS, 2001), in part because of lack of health insurance; almost one quarter of African Americans are poor, and their per capita income is much lower than that of Whites. African Americans are also overrepresented in vulnerable, high-need populations because of homelessness, incarceration and, for children, placement in foster care. Low access to mental health services is also due in part to African Americans' collective distrust of and frustration with institutions that have always discriminated against and oppressed them. As a result, African Americans frequently receive mental health care in emergency rooms or in psychiatric hospitals or seek help in primary care (DHHS, 2001).

As a group, African Americans are more likely to present with somatic symptoms and co-occurring disorders than their White counterparts (Bailey, Blackmon, & Stevens, 2009). African Americans also choose “relatively strong words to express their anguish and emotions . . . ; increased anger, aggression, and irritability, rather than hopelessness, sadness, and depressed mood, are common ways of exhibiting depression” (Choi, 2002, p. 77). Diagnostic biases, as well as misunderstandings of African American culture and expression of emotion, cause not only overdiagnosis of psychotic disorders and schizophrenia but also underdiagnosis of depression (Bailey et al., 2009; DHHS, 2001). These errors occur more often for African Americans and other ethnic minorities than for Whites (Choi, 2002; DHHS, 2001). A variety of reasons exist for such discrepancy in diagnostic patterns: (a) Limited resources may impair African Americans' ability to receive quality and culturally relevant diagnostic evaluation and assessment; (b) clinician bias may play a role in altering the correctness of the diagnosis; and (c) somatic symptoms and complaining of physical discomfort may account for some of the difficulty in detecting depression and misdiagnosis in the African American population (Bailey et al., 2009; Choi, 2002; DHHS, 2001).

Latinos and cultural bias. Depression rates among Hispanics vary depending on level of acculturation, gender, and generational status in the United States. Recent epidemiological data have suggested that the overall lifetime prevalence of psychiatric disorders in the Latino population is 28.14% among men and 30.23% among women. Foreign-born Latinos were shown to have a lower lifetime and past-year prevalence of psychiatric disorders (24% lifetime and 13% past-year prevalence) than their Latino U.S.-born counterparts (37% lifetime and 19% past-year prevalence; Kaltman, Green, Mete, & Shara, 2010) as well as non-Hispanic Whites (Alegria et al., 2007). Furthermore, studies have also shown that rates of depression are lowest for immigrants born in Mexico or in Puerto Rico, compared with second-generation Hispanic Americans (i.e., those born in the United States). This is important because nearly two thirds of U.S. Hispanics self-identify as being of Mexican origin, and about 27% of Mexicans Americans live in poverty compared with other Hispanic groups (Pew Hispanic Center, 2010). However, first-generation Mexican immigrants show lower rates of depression than other Hispanic groups. Furthermore, second-generation Hispanic youths are at significantly higher risk for poor mental health than their White or African American counterparts by virtue of higher depressive and anxiety symptoms as well as higher rates of suicidal ideation and attempts (DHHS, 2001). High poverty rates among Latinos, along with the fact that out of all ethnic groups, Latino Americans are the least likely to have health insurance, might correspond with increased poor mental health in adulthood.

Evidence has shown that Latino subgroups may differ in idioms of distress and “represent determined behavioral patterns by which dysphoria and dysfunction are experienced and expressed” (Opler, Ramirez, Dominguez, Fox, & Johnson, 2004, p. 136). For example, among Puerto Ricans and other Latino Caribbean cultures, somatization, in particular ataques de nervios (“attacks of nerves”), is more prevalent than for Mexican or Mexican Americans (Canino, 2004). Ataques de nervios occur across various cultures with subtle differences, such as in the Dominican Republic under the name of nerviosismo, in Portuguese culture with the name problemas de...
nervos, and Greek culture with the name of nevra (James et al., 2009). Ataques de nervios tend to be expressed mainly by women and can also be viewed as a “voice of resistance.” For many women, “their ataques become a powerful, albeit encoded, way to express their resistance to the various forms of domination imposed by a patriarchal, discriminatory, society and their lack of power” (Guarnaccia, Rivera, Franco, & Neighbors, 1996, p. 361). The Sexual Assault Among Latinas results (Cuevas et al., 2010) confirmed, for example, that victimization may have a differential psychological impact on Hispanic women that leads to unique expression of emotional and somatic symptoms of depression. Ataques de nervios, described by women in the study, include fearfulness, anxiety, and dissociative qualities (Cuevas et al., 2010). These findings suggest that this phenomenon constitutes a culturally patterned response to stressful or traumatic experiences and is viewed as an expected and appropriate way for women to express their distress (James et al., 2009).

As noted, ataques de nervios are not unique to just the Hispanic population. A study conducted by James et al. (2009) with Portuguese immigrant women in the United States and in Canada found that these women suffered from a phenomenon called problemas de nervos, literally translated as “problems with nerves.” Physiological symptoms reported, such as mal da cabeça or “having problems in the head,” which included loss of control and visions, and aflição or “affliction,” which included nervous attacks, gastrointestinal problems, and heart problems, were seen by the Portuguese immigrant women as causes and as being at the root of somatic symptoms. These cultural differences in the expression of symptoms, not only across cultures but also within cultures, are important clinical observations that have an impact on diagnosis and clinician biases.

Asians and cultural bias. Asian Americans are often stereotyped as the “model minority” and labeled as “mentally healthier” than other groups (DHHS, 2001). Much as have other minority groups, Asians have lower rates of mental health utilization than Whites and tend to emphasize somatic symptoms of depression. Many of the Asian cultures, such as the Japanese culture, are collectivist, and “individual psychological well-being is subordinate to the well-being of the group; i.e. maintenance of social harmony is one of the most important values” (Iwata & Buka, 2002, p. 2249). The collectivist ideals are characterized by compliance with family values and interdependence and may lead to specific symptoms, such as weakness, tiredness, or imbalance, rather than complaints of personal meaninglessness, worthlessness, helplessness, guilt, and suicidal thoughts as in individualistic societies. Collectivist ideals conflict with the individualistic views of Western culture and could lead to diagnostic biases as well as noncompliance with treatment if the treatment fails to take these cultural differences into account.

Native Americans and cultural bias. There is an immense diversity in tribes, languages, and cultures among the approximately 2.9 million Native Americans in the United States, and thus it is difficult accurately to discuss mental health issues, including bias. More than one quarter of Native Americans live in or below the poverty line, compared with 8% of Whites. Although research is limited, evidence has suggested that 21% of Native Americans suffer from “mental illness, mental dysfunction, or self-destructive behaviors” (Duran et al., 2004, p. 71) and that 48% have recorded at least one lifetime disorder according to the DSM–IV–TR (Gone, 2004).

Native Americans are also at higher risk for comorbidity than any other group in the United States (Gone, 2004). The percentage of certain diseases, compared with Americans in general, are as follows: “death from alcoholism 770% greater, tuberculosis 750% greater, diabetes 420% greater, accidents 280% greater, and suicide 190% greater” (Gone, 2004, p. 11). Because Native Americans make up less than 1% of the total U.S. population, when their rates of illnesses are compared with those of non–Native Americans, the percentages are highly inflated to more than 100%.

Research by Duran et al. (2004) found that Native American women who held on to traditional gender roles had significantly higher depression scores than those who adhered to less traditional
gender roles. The same study screened 489 women in outpatient care in one of the Indian Health Service hospitals in New Mexico and found that somatoform disorder was the most common at 84.2%, followed by any substance disorder at 65.4%, any anxiety disorders at 62.8%, and any mood disorders at 48.3%. Of the anxiety disorders, posttraumatic stress disorder was the highest diagnosis at 33.3%; of the mood disorders, major depression was the highest at 41.5%; and of the substance disorders, alcohol abuse or dependence was the highest at 60.7%. These percentages shed light on the needs of this population and how any mental health prevention and treatment for women or for Native Americans in general must take into account comorbid conditions. Prevention and treatment also need to take into account both the “external and internalized attitudes and behaviors—racism, sexism” (Duran et al., 2004, p. 75) along with other forms of colonial stratification and historical trauma that continue to affect Native Americans and their communities.

Depression as Disconnection: Framing Immigrant Experience and Social Isolation

The convergence of factors we have presented thus far—discrimination, poverty, and IPV—can foster disconnection between individuals and between individuals and the dominant society. Such disconnection is particularly problematic given the convergence of findings from neuroscience, evolutionary theory, biology, and psychology that affirm the importance of positive relationships to human functioning. Numerous studies have found that positive social connection fosters mental health and that positive intimate and community relationships offset depression (see Mair et al., 2010).

The mind exists in dynamic interactions with the biological systems of the body and brain and with the social world in which it is embedded. Even the brain is a social organ; its very structure and biology are shaped by social contexts and interpersonal interactions throughout life (Cozolino, 2006). Social events affect neural processes; thus, focusing attention on depression as primarily a biological (e.g., genetic, neurotransmitter deficit) or psychological (e.g., poor self-esteem, faulty cognitions, personality styles) disorder often fails to ignore the interaction and interdependencies of cultural roles, institutions, and social structures with neurochemistry, cognitions, or both. Even though depression has specific biological components, such as genetic moderation of stressful life events by a functional variant of the serotonin transporter gene (5-HTT; Kendler, Kuhn, Vittum, Prescott, & Riley, 2005), and though depression is accompanied by physiological changes such as the smaller volume of the hippocampus (Videbech & Ravnkilde, 2004), such biological factors strongly reinforce the importance of a holistic, mind–body understanding of this illness. For example, neurochemistry responds to both internal (genetic) and social variables: The anticipation of social exclusion leads to a firing in the anterior cingulate, the area of the brain that registers both physical and social pain. Being left out, being marginalized personally or as part of a social group, is experienced as real pain (Eisenberger & Lieberman, 2004). In addition to clarifying the pain of individual isolation, findings from neuroscience have confirmed the suffering that occurs with social marginalization and oppression and offered alternative ways to understand how the social affects the body and the mind.

Social isolation through marginalization, shaming, and nonresponsiveness is a powerful form of social control in both intimate relationships and larger social groups. The psychological results of social isolation are evident from a study that focused on Mexican immigrants in a nontraditional receiving site, in this case rural North Carolina, that found that 67.9% of their sample reported poor levels of adjustment, meeting the study’s threshold for anxiety, depression, or comorbidity. The links between normative stress and depression were particularly strong for Hispanic women (Kiang, Grzywacz, Marin, Arcury, & Quandt, 2010). Nontraditional immigrant receiving sites are characterized by rural areas and small towns in the U.S. Midwest and South. These sites tend to lack infrastructure and social resources to support immigrants, increasing their isolation and creating intense competition over jobs, limited housing stocks, xenophobia, and narrowing cross-cultural experiences, with the majority creating substantial...
opportunity for social conflict and discrimination (Kiang et al., 2010).

Social isolation makes it easier for men to control women’s lives, both emotionally and physically. The isolation of immigrant women allows men to control not only the family resources, such as finances, but also to limit or prohibit where a woman is allowed to work (Menjívar, & Salcido, 2002). All of these factors can contribute to feelings of depression and can have fatal results, such as in the case of Tamil women living in Canada. Isolation combined with a feeling of powerlessness, and lack of social support, led many (no actual number was provided) of these women to jump to their death from their apartment buildings. These immigrant women felt they had nowhere to go to escape, and death was easier than living in isolation and fear and with abuse (Menjívar, & Salcido, 2002). Disconnection or isolation engages a range of processes known to precipitate depression, such as a negative experience of self, a threat of separation that in turn engages the attachment system, and an activation of neurobiological systems and higher order self-regulatory cognition (Cozolino, 2006). Conversely, positive intimate and social relationships protect individuals from depression, and cultural values specific to certain ethnic groups may promote such relationships. For example, describing results of a meta-analytic study of Latinos in the United States, Mendelson, Rehkopf, and Kubansky (2008) noted that “the Latino cultural value of *familismo*, which implies an emphasis on strong family relationships, may foster positive social support that protects individuals against depression, even in the face of substantial environmental risk” (p. 355). The phenomenon of Latino resilience to a range of negative health outcomes, including infant mortality and low birth weight, compared with other ethnic minority groups and non-Latino Whites, has been termed the *Hispanic paradox* (Paloni & Morenoff, 2001). This resilience appears to decrease as Hispanics spend more time in the United States (Gee et al., 2006). Plant and Sachs-Ericsson (2004) found that minority group members reported a higher quality of interpersonal functioning than did White participants, which appeared to protect them against depression and demoralization. This difference in interpersonal functioning may be cultural: Minority group members tend to come from cultures that are collectivistic or interdependent, whereas the dominant U.S. culture fosters independence and autonomy. Moreover, episodes of major depression were more likely among individuals with poor interpersonal functioning over the past month (Plant & Sachs-Ericsson, 2004), a finding consistent with numerous other studies that confirmed the importance of positive relationships for mental health.

**CONCLUDING THOUGHTS**

Our consideration of depression using an integrative, multicultural framework points to the intersecting nature of factors frequently associated with depression: oppression (poverty, discrimination, violence), culture (as a source of vulnerability and resilience), and disconnection (the dangers of social isolation, the protection of close relationships). It also identifies social conditions as sources of depressive vulnerability and directs attention to the public policy implications of research findings regarding the mental health of ethnic minorities. One message that emerges from this analysis of depression is that psychology must promote and support social change as a means of reducing the potency of depressogenic forces operating at the societal level. Accordingly, we argue for viable approaches that are not incompatible with mainstream psychological interventions but that do move beyond the traditional aim of symptom reduction to additionally encompass broader aims of advocacy and social action.

One example of such an approach is that described by Grant, Ernst, and Streissguth (1996). These authors reported on the effects of an advocacy-based intervention that has helped drug- and alcohol-abusing, low-income mothers overcome addiction by building connections with advocates who support their development as parents and as individuals (Grant, Ernst, Streissguth, & Stark, 2005). An important part of this advocacy is encouraging the women’s integration into their communities as a means of connecting them with sustainable support. Similarly, Ali, McFarlane, Hawkins, and Udo-Inyang (2012) proposed a model of anti-oppression advocacy that is suited to meeting the mental health
needs of immigrant and ethnic minority populations. The anti-oppression advocacy approach is guided by principles that weave together the provision of basic supportive services (e.g., providing information on housing initiatives, food stamps, and childcare arrangements) with psychological support and grassroots activism, all of which are tied closely to university partnerships that evaluate, promote, and improve the services provided. As with the Grant et al.’s (1996) model, anti-oppression advocacy recognizes existing strengths even in very low-income, under-resourced communities. Although these are only two specific approaches to using advocacy to address mental health problems, they meet a need that exists in many immigrant and minority communities: the need to become socially and relationally self-sustaining in a way that promotes emotional and material growth for individuals and collectively for communities.

Near the beginning of this chapter, we stated that culture protects against depression. The key to protective sources may indeed lie within individuals’ own cultural communities. However, when cultures themselves are pathologized because they do not conform to mainstream notions of normalcy or adaptiveness, traditional psychological interventions are not enough. Psychology and other disciplines must encourage depressed individuals to transform negative emotions from an experience of personal failing into an experience of awareness of social injustice and a need for social change (Kaufman, 2003). Advocacy and activism may therefore be the most promising future for psychology as it struggles to adapt to the needs of immigrant and ethnic minority populations across Latino subgroups in the United States. American Journal of Public Health, 97, 68–75. doi:10.2105/AJPH.2006.087205


Depression in Multicultural Populations


