African-American women's mental health is affected by their double minority status of being black and female within American society (Dressler, 1985a). As minority members, African-American women encounter barriers against full participation within American society and are affected by the dynamics of that society (Carrington, 1980). African-American women generally find themselves situated at the lower end of the American economic-political system and are involved in contradictory ethnic, cultural, family, and work roles (Carrington, 1980; Oakley, 1986).

African-American women are at risk for depression because of the occurrence and linkage of their minority status and role contradiction (Carrington, 1980). Psychiatric mental health nurses must be aware of these dynamics in the assessment and intervention of African-American women who are at risk for depression (McGrath, 1990).

An understanding of the literature regarding depression in African-American women can provide psychiatric nurses with knowledge to use in providing care. This article presents a critique of the literature about depression in African-American women and delineates clinical implications for psychiatric mental health nursing practice.

It is estimated that one out of four women will experience a major depressive occurrence (McGrath, 1990). The reported incidence in African-American women is unclear due to controversy regarding misdiagnosis and the lack of clinical research (Brown, 1990). African-American women, however, report more depression than African-American men (Brown, 1990; Jones-Webb, 1993).

Available statistics combine the incidence of depression for both sexes in the African-American population. It is estimated that 20% to 30% of African-Americans experience depressive symptoms and that 4% to 6% of African-Americans are diagnosed with clinical depression (Brown, 1990). These statistics are an underrepresentation, as many African-American women do not seek help (Neighbors, 1990).

**Definition of Depression**

Depression is an umbrella term that describes one of the most prevalent mental health problems in the United States (McGrath, 1990). In regard to this article, the essential feature of depression is a disturbance of a person's mood that produces a variety of human, emotional, and clinical responses that influence an African-American woman's daily functioning (Brown, 1990). Depressed African-American women exhibit negative feelings toward themselves and their environment, have difficulty thinking, and experience lowered energy levels (Carrington, 1980).

The *DSM-III-R* (American Psychiatric Association [APA], 1987) categorizes depression as a mood disorder that is subdivided into depressive and bipolar disorders. There is no current research on the appropriate use of *DSM-III-R* criteria for depressed African-American women. Controversy exists in the literature over whether *DSM-III-R* diagnostic criteria are appropriate for use with diverse minority populations and whether additional categories must be developed (Barbee, 1992; McGrath, 1990; Olmedo, 1981).

The *DSM-III-R* categories were developed without consideration of the
context in which depression occurs. Gender, societal, and ethnic cultural issues were not incorporated into development of the manual. Consequently, African-American women may not be diagnosed or may be misdiagnosed into other categories because of the inadequacies of the diagnostic manual. Psychiatric mental health nurses must consider this point when assessing and counseling African-American women who might be depressed.

Contextual and diagnostic inadequacies are being reviewed and assessed for DSM-IV, due out this summer. The APA has established the DSM-IV Task Force in order to update DSM-III-R into a more relevant diagnostic manual that will facilitate communication between divergent clients, clinicians, and cross-cultural environments (APA, 1993).

The Task Force has assessed empirical information from a broad spectrum of educational, clinical, and research sources (APA, 1993). Thirteen work groups were developed in conjunction with the task force in order to systematically evaluate DSM-III-R and make recommendations for changes. The DSM-IV Task Force and the work groups’ empirical process involved examination of literature, available data sets, and field trials conducted by The National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism (APA, 1993).

Theories of Depression

Little research testing the theories of depression in African-American women has been conducted. Theories of depression consist of cognitive, interpersonal, biological, and integrated perspectives (Beck, 1979; Calarco, 1991; Johnson, 1993; Klerman, 1984). There has been research conducted on depressed African-American women using the cognitive and interpersonal perspectives; however, no nursing research has been published that incorporates the biological or integrated perspectives in relationship to African-American women.

Cognitive theories of depression include Beck’s Cognitive Model of Depression and Seligman’s Learned Helplessness Theory of Depression. In Beck’s (1979) model, a depressed person perceives stressful situations from a viewpoint that is grounded in negative perceptions about himself or herself, the world, and the future. Because the individual expects negative outcomes in interactions with others, he or she avoids developing or sustaining relationships, experiences low self-esteem and self-concept, and develops depressive symptoms (Beck, 1979). According to Seligman’s (1975) theory, a depressed person perceives that he or she has no control over life outcomes. Consequently, the person has no desire to deal with life events; perceptions become rigid, global, and fixed. Passivity develops and depressive symptoms occur.

According to the interpersonal theory, a depressed person has difficulty in sustaining relationships because of developmental experiences.

According to the interpersonal theory, a depressed person has difficulty in sustaining relationships because of developmental experiences (Klerman, 1984). Depressed persons have difficulty managing losses, role changes, and social interactions (Klerman, 1984); depressive symptoms occur as a result of the person’s inability to manage these life events. These symptoms may escalate into clinical depression without treatment.

Biological theories of depression have been developed based upon physiological changes within systems that affect brain functioning. These theories have suggested that depressive symptoms develop in certain persons, because of left prefrontal cortex changes; maladaptive amines functioning; changes in neurotransmitter systems’ interaction of norepinephrine, serotonin, and corticotrophic hormone; and cortical secretion disturbance (Bower, 1992; Calarco, 1991; Johnson, 1993; McGrath, 1990).

An integrated theory of depression has been proposed by Calarco and Krone (1991). According to these nurses, “depression and depressive behavior” must be “conceptualized from a broader perspective.” Their integrated nursing model of depressive behavior includes cognitive, biological, and interpersonal disruption components and relates development of these components to a depressed person’s reaction to acute and chronic stressors. This model has not been tested with depressed African-American women, but might provide meaningful contextual information on the biopsychosocial factors that predispose this population to develop depressive symptoms and clinical depression.

Research on Depression in African-American Women

Research concerning depression in African-American women has been limited. The research has focused on examination of the risk factors, independent symptoms, and occurrences of depression in primarily lower socioeconomic populations (Barbee, 1992). Investigators have generally ignored the context under which depression has occurred (McGrath, 1990).

Research regarding depression has primarily been conducted on European-American male populations; this research has sometimes been generalized to female ethnic minority populations (McGrath, 1990). Counseling protocols and interventions have been developed to meet the needs of European-American males and then generalized to females and ethnic minority populations (Copeland, 1982). When health care programs are not culturally and gender-role specific, African-American female clients may perceive themselves as being misunderstood, neglected, and unwanted in the mental health care system (Copeland, 1982). Consequently, African-American women may not enter the mental health system or will withdraw from the system during treatment (Copeland, 1982).

The American Psychological Association’s National Task Force on Women and Depression has recommended that researchers examine both the context in which depression occurs and the
biopsychosocial factors that may form linkages in predisposing female ethnic minority populations to develop depressive symptoms and clinical depression (McGrath, 1990). Depression in African-American women may be related to the development of other health hazards, such as hypertension, alcohol and other substance abuse, and suicide attempts (McGrath, 1990; Taylor, 1992).

Four studies have examined contextual factors in African-American women. Carrington (1980) incorporated the cognitive and interpersonal perspectives in her clinical study of depressed middle-class African-American women. She found that all these women had incurred psychological or physical separations from their parents during their childhood years. The women developed negative (ie, prolonged) patterns of grief, lowered self-concept, and depressive symptoms. According to Carrington (1980), the women's negative internal thinking was reversed through the use of "structured mental exercises" that facilitated development of positive self-esteem and self-concept.

Green (1982) analyzed the African-American community using the learned helplessness model. He theorized that problems for women, men, and children in the African-American community might be attributed to "racial discriminatory practices and resultant life conditions" that produced feelings of passivity, helplessness, powerlessness, and depression. Tomes and associates (1990), however, did not find support for the learned helplessness theory of depression in their study of depressed African-American women. They instead found that mildly depressed women persisted in efforts to achieve goals even though they perceived racism as affecting their lives. In addition, the women perceived themselves as being capable of dealing with negative life events.

Barbee (1992) conducted a qualitative anthropologic study of 15 depressed African-American women from various socioeconomic levels. Themes identified were "feeling down and low, feeling blue and depressed, losing control, feeling lonely, feeling suicidal, friends help, couldn't eat, and professionals don't understand" (Barbee, 1992).

Epidemiologic studies of depression in African-American women have examined the sociodemographic variables of race, class, sex, income, education, and geography. There is confusion, however, regarding the prevalence of depression in African-American women and the use of statistical adjustment procedures when conducting research on these populations (Brown, 1990).

Socioeconomic status, the most frequently adjusted variable, is the chief factor that often creates the greatest disparity between ethnic/cultural and gender groups (Brown, 1990; Taylor, 1992). Initial epidemiologic studies, after controlling for socioeconomic status, found no differences in depression prevalence rates between African-American and European-American female and male populations, but did find higher depression rates in African-American male populations versus African-American female populations (Comstock, 1976; Roberts, 1981).

Recent research, however, has produced different results. Findings indicate that there is a negative correlation between depression and socioeconomic status, and that African-American women have more intense depressive symptoms and higher depression rates than African-American men and European-American women and men (Brown, 1990; Dressler, 1985b; Eaton, 1981; Jones-Webb, 1993; Neighbors, 1990; Taylor, 1992). African-American women are often overrepresented in lower socioeconomic groups and are, therefore, at increased risk to develop depressive symptoms and clinical depression (Brown, 1990; Taylor, 1992; Tomes, 1990).

The chief instrument used in epidemiologic studies, the Center for Epidemiologic Studies Depression (CES-D) Scale, has never been developed or normed for African-American women (Radloff, 1977). This raises the question of reliability and validity of the instrument for use with African-American women. Available data on reliability and validity issues have been lacking in research conducted on African-American women (Brown, 1990). The norming of instrumentation must be considered in future research of depressed African-American women.

African-American Cultural Influences

Research on depression in African-American women has not examined linkages between the African-American value system and development of depression. This value system is the cornerstone of the Afrocentric epistemology and consciousness that is predominant for African-American women (Collins, 1991; Jones, 1986). Consequently, the role of African-American women has centered around family and group survival, as well as development of strategies that counteract oppressive conditions within American society (Collins, 1991; Giddings, 1984). This traditional value system is grounded in the Afrocentric world view of community: each person has a unique spiritual contribution and value to offer to other members within the community (Collins, 1991).

Research has suggested that African-American women may internalize their role designation and the media's portrayal of African-American women into an unobtainable "superwoman" or matriarch image (Carrington, 1980; Collins, 1991). This internalization, combined with nurturing responsibilities, may be in direct opposition to African-American women's need to participate in "self-enhancing activities, either professionally or personally, that do not directly or indirectly include their families" (Carrington, 1980).

Failure of the African-American woman to achieve this superwoman/matriarch image may produce a sense of failure and frustration for the woman—as well as precipitate the development of guilt, hostility, depression.
Depression in African-American Women

sive symptoms, and conflicts in interpersonal relationships (Carrington, 1980; Oakley, 1986; Tomes, 1991).

The sense of guilt is especially apparent in upwardly mobile middle-class African-American women who have been diagnosed as clinically depressed (Carrington, 1980). Carrington (1980), in her examination of depressive symptoms in African-American women, delineated five characteristics that these women exhibit:
- Poor self-esteem;
- Preoccupation with failure;
- Dependence on others' good opinions;
- Sensitivity to criticism or rejection by others; and
- Decreased drive in pursuing sources of gratification.

These findings were supported in the studies on African-Americans by Dressler (1985a) and Dressler and Badger (1985b). Women, in these studies, were found to have higher mean depression scores than men. In addition, the women reported they felt restricted in their traditional maternal roles, and were bored and frustrated.

Implications for Psychiatric Nursing Practice

Psychiatric mental health nurses can be instrumental in developing mental health protocols and interventions for depressed African-American women. These psychiatric nurses need to be aware of the variables that influence the development of depression in African-American women, as well as nurses' attitudes and orientation toward these women. The literature reviewed within this manuscript provides an initial knowledge base on depression in African-American women.

Counseling protocols and interventions also must be developed to meet the contextual needs of each client.

Counseling protocols and interventions also must be developed to meet the contextual needs of each client. African-American women might facilitate discussion of individual problems and provide a sense of community support for women. The atmosphere during counseling sessions must be open and conducive to discussion of clients' feelings regarding perceptions of self-concept, self-esteem, and racial identity. Psychiatric nurses can conduct stress management and relaxation sessions for depressed African-American women so they can learn to change negative thinking and increase energy levels.

In addition, psychiatric nurses need to be aware of feelings and attitudes possessed by clients, other nurses, and themselves regarding the ethnic cultural heritage of African-American women. These feelings and attitudes can influence transference and countertransference between nurses and their depressed clients.

Psychiatric nurses can participate in cultural sensitivity training in order to sensitize themselves to minority cultures and assist other health professionals in developing culturally relevant care for African-American women. Psychiatric mental health needs to culturally expand themselves in order to assist their depressed African-American female clients toward development of positive self-esteem, self-concept, racial identity, and social interactions.

Summary

Depression is an increasing problem for African-American women. These women are experiencing role changes and additional stressors. Depressed African-American women may perceive themselves as being devalued within American society and may have fewer support systems to buffer stressful conditions (Carrington, 1980). Depressive symptoms may escalate into clinical depression, which can erode quality of life for African-American women. Psychiatric mental health nurses can be instrumental in developing protocols and individualized interventions that respond to the psychological and physical needs of their depressed clients and promote an improved quality of life.

References

Comstock, G.W., Helsing, K.J. Symptoms of

1. Depression is an increasing problem for African-American women. Depressed African-American women may perceive themselves as being devalued within American society and may have fewer support systems to buffer stressful conditions.

2. Depressive symptoms (eg, poor self-esteem, preoccupation with failure, dependence on others' good opinions, sensitivity to criticism or rejection by others, and decreased drive in pursuing sources of gratification) may escalate into clinical depression.

3. Psychiatric mental health nurses can be instrumental in developing protocols and individualized interventions that respond to the psychological and physical needs of their depressed clients and promote an improved quality of life.