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Editorial

Black-White Differences in Social, Psychological, and Medical Correlates of Depression in the United States

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Unfortunately, limited knowledge exists about the causes and consequences of depression and depressive symptoms among minorities and subpopulations. In this editorial, I summarize a growing literature suggesting that presentations, epidemiology, risk factors, and consequences of major depressive disorder (MDD) and depressive symptoms depend upon race, gender, and their intersections.

While American Blacks have lower risk for MDD than White Americans,[1] they report higher levels of depressive symptoms.[2,3] Blacks have lower access and trust to the health care system, compared to Whites.[4,5] As a result, their MDD is commonly left as untreated.[6] In line with the above note, the cross-sectional association between MDD and depressive symptoms is stronger for Blacks than Whites.[7] This, however, is not the case for the longitudinal association between depressive symptoms and MDD[8] which is stronger for Whites than Blacks.[8]

The cognitive elements that are core to depression may also be specific to race.[9-11] Depression is more strongly linked to low mastery[10] and self-esteem[9] for Whites than Blacks.[10] The same finding can be seen in elderly[10] and youth,[11] indicating that these results are robust. Blacks with depressive symptoms maintain high levels of hope[12] and positive emotions.[13] Higher concordance of positive emotions and depressive symptoms[12,13] may explain why depressive symptoms, depression,[14-19] and other negative emotions[20-22] increase risk of chronic diseases[20-22] or obesity in Whites but not in Blacks. The same may explain why depression is linked to inflammation in Whites but not in Blacks,[23-25] as positive emotions undo the harmful effects of negative emotions.

The story is even more complex. Some of the above links are different for Black men, suggesting that it is not race but the intersection of race and gender that impacts these links. This view is in line with the intersectionality approach.[28-30] Some examples are the reverse link between depression and obesity,[27] failure of the link between sustained depression and obesity,[31] and lack of protective effects of education and income on depressive symptoms among elderly.[32] High education credentials are positively associated with increased depressive symptoms over time[33] and MDD is positively associated with income among male Black youth.[34] These unexpected findings are at least in part due to racism and discrimination.[35]

These findings also depend on design, as results are different in longitudinal and cross-sectional studies.[36] At each cross-section, there is more risk of comorbid depression – chronic disease for Blacks than for Whites.[36] The bidirectional links between depressive symptoms and chronic disease over time are weaker for Blacks.[14-22] That is, depressive symptoms that have a good predictive role in chronic disease for Whites do not have the same role for Blacks.[14-22] Depression also does not similarly reflect risk of obesity for race and gender groups at each time point[27] and over time.[26,31] Sustained depressive symptoms only co-occur with sustained obesity among White women.[31]

To conclude, the intersection of race and gender alters the social, psychological, medical, and biological correlates of depression. These factors include education, income, stress, mastery, self-esteem, chronic disease, obesity, and mortality. Future research should explore the role of cultural, behavioral, contextual, and political factors in causing such heterogeneities.

Ethical Approval
Not applicable.

Conflict of Interest Disclosures
None.

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