

Psychosocial Mediators of Racial Disparities in Depression Risk Among Black Americans
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Abstract

Black Americans (African Americans and Afro-Caribbeans) have shown to have unexpectedly lower rates of mood disorders, specifically Major Depressive Disorder (MDD) in comparison to Whites. Using data from the National Survey of American Life (NSAL), this study seeks to examine mechanisms that may contribute to the aforementioned racial disparities in MDD.

Results from a series of general linear and mediation models revealed that Black American's low rates of MDD could be the result of five plausible mediating factors: coping mechanisms, social support, hardship, discrimination and internationality. Data indicated that coping mechanisms were not significant for Black Americans generally, but coping did significantly mediate the relationship between race and MDD in African Americans specifically. African Americans had high coping mechanisms, which were shown to be associated with lower rates of MDD. Social support mediation models showed greater levels for Black Americans, significantly mediating their lower rates of MDD compared to Whites. In regard to hardship it held no significance for Black Americans; while in contrast, discrimination showed high scores along with a statistically significant relationship to race. Based on results from regression analyses, high scores in discrimination should influence higher rates in MDD; however, Black American's MDD rates were perplexingly low. This statistical discrepancy supports the existence of racial inconsistencies in the prevalence of MDD. Lastly, internationality was a mediator for Afro-Caribbeans, but not African Americans. Afro-Caribbeans had exceedingly high internationality levels, which in turn influenced lower rates of MDD.

In summary, specific mediators have been shown to provide more of a buffer against MDD for Black Americans as opposed to Whites. This balance of risk for MDD due to higher levels of discrimination, and protection against MDD due to social support, coping, and internationality may indicate for Black Americans that lower rates of MDD are the result of greater protective factors.

Introduction

Correlations between discrimination and mental illness have suggested that minorities, who undergo high levels of discrimination, may be at a greater risk for developing a mental disorder (Williams, Neighbors, & Jackson, 2003). Nevertheless, Black Americans (African Americans and Afro-Caribbeans) have shown to have paradoxically lower rates of mood disorders, specifically Major Depressive Disorder (MDD) in comparison to Whites. This racial disparity in mental health diagnosis is a well-documented concern (Williams, Yu, Jackson, & Anderson, 1997; Williams & Mohammed, 2009; Chow, Jaffee & Snowden, 2003). This disproportionality in MDD rates for underprivileged racial groups is an area of study that requires social awareness and on-going exploration.

Intriguing research findings suggest despite all objective indications of a more difficult life, Black Americans have been shown to have less depression than Whites (Williams et al., 2007). Explanations for less prevalence of depression in Black Americans are vast and unspecified. Indeed, some studies draw attention to cultural bias experienced by Black Americans towards mental health services, habituation to societal difficulties and access to greater levels of community social supports (Williams & Williams-Morris, 2000; Daly, Jennings, Beckett, & Leashore, 1995). Spirituality in particular has been seen as a large social support within the

Black American community and may possibly offset depressive symptoms (Mattis, 2002; Mattis & Jagers, 2001). Furthermore, implications have been made that discrimination and hardships, on-going material or financial stressors, may exacerbate risk of depression, specifically Major Depressive Disorder (MDD).

While many studies have attempted to investigate the reasoning behind usage and non-adherence to mental health service for Black Americans, few studies question intervening variables in the prevalence of diagnosis for this population. Do Black Americans have less depression because they have alternative ways – other than Western psychosocial and psychopharmacological treatments – of addressing mental health concerns? An ideal data set to investigate this question of racial disparity in the prevalence of depression can be found in the National Survey of American Life (NSAL) (Jackson *et al.*, 2004).

Through utilizing data gained from the NSAL, this study seeks to examine social, economic and psychological mechanisms that may contribute to racial disparities in MDD. In this article, five concepts are thought to provide a partial explanation for the racial disparity among Black Americans. These concepts are described as high self-esteem and cognitive coping skills, larger social support networks –religion, family and community-based support, higher levels of societal and financial distress, internal perception and external experiences with discrimination and, lastly, internationality- a person’s ethnic background and country of origin outside of the USA.

High self-esteem and cognitive coping were linked to an adaptation and historical habituation to discrimination and racial hardship (Hughes, & Demo, 1989; Fischer & Shaw, 1999; Coard *et al.*, 2004). While larger social support systems were thought to be associated with

the cultural attitude of “keeping it [problems] in the family,” and a historical mistrust of the medical system (Boulware *et al.*, 2003; Coard *et al.*, 2004). Both internal and external discrimination and hardship are two concepts that have been shown to contribute to additional stressors and possible physical and mental health complications in Black Americans (Williams, Yu, Jackson, & Anderson, 1997). Lastly, a person’s origin of birth and ethnic background was assumed to aid or hinder in his or her level of habituation to hardships. In other words, African Americans were assumed to have a greater level of habituation to discrimination and hardships in the USA, while Afro-Caribbeans were thought to have less; thereby negatively influencing their ability to coping with Westernized stressors. In all the purpose of this study is to generate a working knowledge of partial explanations of the aforementioned racial disparity in prevalence for depression in Black Americans.

Method

Participants

The National Survey of American Life (NSAL) study was conducted by the Program for Research on Black Americans at the University of Michigan Institute for Social Research. The study has been defined as one of the most comprehensive investigation of mental disorder and mental health in Black Americans (Americans of African origin). Rationale for the study was to examine the intra- and inter-group racial and ethnic differences concerning mental health diagnoses, psychological stressors, and both formal or informal service usage (Jackson *et al.*, 2004). Survey data collection was completed from February 2001 to March 2003.

The NSAL consisted of a national household probability survey with a total of 6,082 participants over the age of 18 years old. The sample had 3 main ethnic groups: African

Americans (N=3,570), Afro-Caribbeans (N=1,623), and Non-Hispanic Whites (N= 1,006).

Eligibility criteria consisted of: (1) respondents self-identified their race as black (of African descent) and also identified as West Indian or Caribbean, or (2) respondents self-reported their race as black, African descent only, or (3) respondents self-identified as Non- Hispanic White.

Black Americans, both African Americans and Afro-Caribbeans, had to have a households with at least 1 black adult, who was 18 years or older. Criteria for West Indian or Caribbean ancestry were as follows: (1) individual themselves, or (2) their parents or grandparents were born within a Caribbean country (Puerto Rico, Dominican Republic, Cuba, Jamaica Barbados, Trinidad, Tobago, Haiti). Non-Hispanic Whites were a stratified disproportionate sample of white adults living in households located in census districts with a 10% or higher African American population.

Measures

This study examined both sociodemographic and clinical characteristics of all three racial/ ethnic groups. We examined the racial disparities associated with a Major Depressive Disorder diagnosis within the previous 12 months, along with mediating factors that might explain said disparities.

Sociodemographics. Examined sociodemographics consisted of the following: gender, age, level of education, marital status, employment status, incarceration history, household income, and rate of poverty. Education level was based on completion of a higher education, such as college or graduate schooling. Matrimony consisted of individuals who were actively married. Individual's employment level was measured based on current employment status, while incarceration percentage represented individuals who had previously been arrested.

Clinical Characteristics. The main measure used for all participants in assessing clinical characteristics was The World Mental Health Composite International Diagnostic Interview (CIDI) (Wittchen, Robins, Semler, & Cottler, 1993), a structured diagnostic interview used to evaluate psychiatric disorders. An additionally clinical reassessment interview called the Structured Clinical Interview for DSM-IV (SCID) (First, Spitzer, Gibbon, & Williams, 1997), requiring administration by a clinician, was administered to 644 NSAL participants – 303 African Americans, 226 Afro-Caribbeans and 102 Non-Hispanic Whites – to reevaluate the participants' 12-month diagnoses. Both the CIDI and SCID were compared for the 644 participants in the reappraisal assessment and overall there was adequate concordance for a Major Depressive Episode (MDE) (Williams *et al.*, 2007). Thereby providing an elucidated mental diagnosis of MDD used for this study. Depressive Symptomatology was assessed using the Center for Epidemiologic Studies in Depression Scale (CES-D) (Radloff, 1977) mean scores for all three racial groups.

Putative Mediators of Racial Disparity in MDD. Using selected survey questions obtained from the NSAL initial stages of the study involved the formation of five *a priori* mediator composite indexes: Coping Mechanisms, Social Support, Hardship, Discrimination and Internationality. These five mediators are shown to plausibly explain the empirical based racial disparities that exist among the prevalence of MDD diagnoses in America. Coping mechanisms were representative of a person's self-esteem and ability to cognitively cope with life stressors; the index was assessed using Pearlin's Mastery scale (Pearlin and Schooler, 1978) and had an adequate internal consistency (7-items, $\alpha = .717$). Social Support was indicative of a person's access to societal, organizational, and family support networks. This index was evaluated using

The National Survey of Black Americans (NSBA) subsections on Neighbor/Neighborhood interaction and Family/ Organizational Supports (Neighbors and Jackson, 1996); as well as, the Received Emotional Support and Negative Interaction scales (Fetzer Institute/National Institute on Aging Working Group, 1999). Finally, the social support index had an adequate internal consistency (37 items, $\alpha = .791$). The Hardship index was defined as on-going emotional or material strain and was assessed using the NSBA's subsection on Chronic Stress and a modified scale on Experiencing Material Hardships (Bauman, 1999). The internal consistency of the index was also considered adequate (18-items, $\alpha = .742$). The fourth index, discrimination represented an individual's internal perception and external experiences with racism. Discrimination index was measured using the Everyday Discrimination scale (Jackson & Williams, 1995), and had an excellent internal consistency (10-items, $\alpha = .890$). Lastly, Internationality was described as a person's ethnic background and country of origin, the index was evaluated using the NSBA subsection on Early Life and had an adequate internal consistency (3-items, $\alpha = .708$). All indexes were reverse coded prior to assessing internal consistency, and then standardized scores were calculated.

Procedure

NSAL researchers administered mostly face-to-face interviews (86%) using an electronic instrument for assistance, while the remaining interviews were administered by telephone. On average interviews lasted for 2 hours and 20 minutes and were all conducted in English (Williams *et al.*, 2007). The final overall response rate was 72.3%. African Americans had a

response rate of 70.7%, Afro-Caribbeans response rate was 77.7% and Non-Hispanic Whites response rate was 69.7%.

The African American sample was selected from geographic areas in proportion to African American populations, while the Afro-Caribbean sample was selected from African American segments and additionally metropolitan sections in which Black Americans of Caribbean descent made up approximately more than 10% of the population. (Neighbors *et al.*, 2007). All three ethnic/racial groups were nationally representative of households located in the 48 coterminous states, with African Americans and Afro-Caribbeans being more likely to reside in urban and major cities (Woodward *et al.*, 2013). All participants provided written informed consent prior to participation and the NSAL study was reviewed and approved by the University of Michigan's Institutional Review Board (IRB).

Data Analysis

Analyses began with evaluating and replicating the previous racial disparities in MDD using general linear regression models. After replication of these racial disparities, mediator analyses were used to partially explain the existing racial disproportionality in the prevalence of MDD. Indexes used to explore racial disparities in MDD prevalence were analyzed using general linear models based on the mediator-analytic framework of Baron and Kenny (1986). This statistical approach, a series of general linear and mediation models, consisted of testing the association between racial group statuses in the study to mediator indexes using a linear regression (Path A). These analyses were followed by a logistic regression to assess the

association between the mediator index and MDD (Path B). Finally, mediating effects were calculated using the asymptotic approach to indirect effects outlined by MacKinnon et al. (2002). Mediation effect sizes were quantified using a ratio of indirect effect to direct effect proposed by Sobel (1982). All mediation models were adjusted for covariates; sociodemographics: gender, age, education status, matrimony, employment status, history of arrest, income status and poverty index.

Results

Sample Characteristics

We began our investigation of racial disparities in risk for depression by first examining the demographic and clinical characteristics of the sample. The mean age for Afro-Caribbeans and African American's was statistically different than Whites. Average age for African Americans and Afro- Caribbeans was early 40s; while, Whites had an average age in the late 40s. Statistically significant differences in educational status showed more than 50% of Whites and Afro-Caribbeans were college educated, while less than 40% of African Americans had obtained a college education. Matrimony among Whites was significantly higher than both groups of Black Americans. Afro-Caribbeans had exceedingly high employment rates that were statistically different from African Americans and Whites. Incarceration history for African Americans was statistically double the rate of Afro-Caribbeans and Whites, whose rates were fairly equivalent. Household income presented the greatest difference for African Americans. Whites had the highest household income mean followed closely by Afro-Caribbeans, and African American had roughly \$10,000 less in income. Poverty rates were the highest for African Americans, followed by Afro-Caribbeans.

When examining the clinical characteristics of the sample, CES-D mean scores were statistically higher in Whites than Afro-Caribbeans and African Americans. As has been reported previously (Williams, Yu, Jackson, & Anderson, 1997), Whites (17.2%) were significantly more likely to be diagnosed with Major Depressive Disorder when compared to African Americans (10.6%). Afro-Caribbeans (8.9%) were the least likely to be diagnosed with Major Depression in comparison to Whites and African Americans. Thereby reinforcing racial disparities in MDD diagnosis that exist among ethnic groups.

Mediators of Depression Risk Among African Americans

Turning our attention to potential mediators of racial disparities in MDD between Black and White Americans, we examined the degree to which coping, social support, hardship, discrimination and internalization served as mechanisms of these well-documented disparities (Williams, Neighbors, & Jackson, 2003). Regression analyses indicated that African Americans had higher levels of coping, and that greater coping was related to less MDD. Subsequent mediator analyses demonstrated that coping significantly mediated the relationship between race and MDD. African American had increased levels of coping partially explaining the disparity in MDD diagnosis between African American and Whites. Therefore, coping had a protective mediating effect against risk of depression among African Americans (Table 1). Social support in African Americans was higher than Whites; high social support was related to significantly less MDD. This inverse relationship indicated social support had a protective mediating effect for African Americans, thereby reducing their risk for MDD. In regard to hardship, African Americans were shown to experience more hardship; however hardship had no significant

association to race for African Americans; indicating hardship had no mediating effect for African Americans. Discrimination levels were higher for African Americans, and high levels of discrimination were statistically related to increased MDD. Mediator results for discrimination narrowed the racial disparity in MDD for African Americans. Lastly, internationality was linked to a decrease in risk for MDD. African Americans did show slightly higher internationality, yet mediator analyses were not statistically significant. In summary, it is plausible that coping and social support help to offset the effects of discrimination on racial disparities in MDD among African Americans.

Mediators of Depression Risk Among Afro-Caribbeans

Now focusing in on Afro-Caribbeans, a similar examination of the five mediators of racial disparities in MDD diagnoses was also conducted. Afro-Caribbeans had high levels of social support. Increased levels of social support were shown to be associated with a statistically significant decrease in risk for MDD. Thus, high levels of social support partially explain the racial disparity associated with MDD diagnosis for Afro-Caribbeans compared to Non-Hispanic Whites. Internationality was exceedingly high for Afro-Caribbeans as expected. High internationality was linked to a significant decrease in risk for MDD. Signifying internationality had a protective mediating effect against depression for Afro-Caribbeans, explaining part of the racial disparity in MDD diagnosis compared to Whites. As for hardship, Afro-Caribbeans had more hardship than Whites; however, hardship was not a significant indicator of increased potential for MDD, indicating hardship had no mediating effect for Afro-Caribbeans when compared to Whites. Comparatively, discrimination was also high in Afro-Caribbeans. High

discrimination contributed to an increase in vulnerability to MDD, indicating that the mediating effect for Afro-Caribbean lessens the racial disparity associated with MDD diagnosis. In final, mediation analyses for coping showed Afro-Caribbeans had less coping. While less coping was related to decrease in MDD, coping was not a significant mediator of racial disparities in MDD.

Discussion

Racial disparities among Black Americans in the prevalence of mental health diagnoses, specifically Major Depressive Disorder (MDD), are well-documented concerns in the field of social research. Indeed, Black Americans have been shown to have lower rates of depression diagnoses, despite experiencing more discrimination and societal difficulties when compared to Non-Hispanic Whites. This study utilizes data from the National Survey of American Life (NSAL) to examine the social, economic and psychological mechanisms that possibly explain the racial disparities in MDD. Five *a priori* mediator composite indexes were composed using survey questions from the NSAL to examine contributing factors to the racial disproportionality. These five mediators were coping mechanisms, social support, hardship, discrimination and internationality. Results indicate that African American's high coping mechanisms and social support levels partially explain the racial disparities in MDD, while increased levels of discrimination narrowed the racial disparity for African Americans compared to Whites in MDD diagnoses. As for Afro-Caribbeans high social support and internationality helped to slightly explain the racial disparity, while high levels of discrimination also narrowed the racial disparity in MDD, similar to African Americans.

The implication found in this study provides partial explanations for the current racial disparity in MDD among Black American. We found in Black Americans- African Americans have higher levels of coping, social support, while Afro-Caribbeans have higher levels of social support and internationality than Non-Hispanic Whites. These indexes are associated with a decrease in risk of MDD among African Americans and Afro-Caribbeans, thus partially accounting for the reduced prevalence of MDD among Black Americans. Nevertheless, higher levels of discrimination were shown to increase the risk of MDD in both groups of Black Americans, and thus narrow the MDD disparity between Blacks and Whites. These study results gives researchers in the world a slightly better understanding of some of the contributing factors to this mental health disproportionality for Black Americans. The study provides a fundamental framework for more research in the future to be conducted.

Limitations of the study include differential concordance between the CIDI and SCID by race; African Americans had a fair concordance of 0.43, while Non-Hispanic Whites has a lower concordance level of 0.27 and Afro-Caribbean has the lowest concordance of 0.10. This discrepancy between the two diagnostic interview assessments influence the validity and consistency of MDD diagnoses in this study. Moreover, the mediators used in this study only offer partial explanations for the racial disparities that exist in MDD rates, signifying there are additional plausible mediators and rationales that may be associated with these disparities in race.

In summary this study's main implication is coping mechanism, social support and internationality offer possible explanations for the existence of racial disparities in MDD among Black American, and its main limitation is the inconsistency between the CIDI and SCID. In

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conclusion more research is required to completely assess the reason for the racial disparity in
MDD among Black Americans.

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Reference

- Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of personality and social psychology*, 51(6), 1173.
- Bauman, K. (1999). Extended measures of well-being: Meeting basic needs: 1995 (No. 67). US Dept. of Commerce, Economics and Statistics Administration, Bureau of the Census.
- Boulware, L. E., Cooper, L. A., Ratner, L. E., LaVeist, T. A., & Powe, N. R. (2003). Race and trust in the health care system. *Public health reports*, 118(4), 358.
- Chow, J. C. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93(5), 792-797.
- Coard, S. I., Wallace, S. A., Stevenson Jr, H. C., & Brotman, L. M. (2004). Towards culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child and Family Studies*, 13(3), 277-293.
- Daly, A., Jennings, J., Beckett, J. O., & Leashore, B. R. (1995). Effective coping strategies of African Americans. *Social Work*, 40(2), 240-248.
- Fetzer Institute/National Institute on Aging Working Group. (1999). Multidimensional measurement of religiousness/spirituality for use in health research: A report of the Fetzer Institute/National Institute on Aging Working Group. Kalamazoo, MI: Fetzer Institute.
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1997). User's guide for the Structured clinical interview for DSM-IV axis I disorders SCID-I: clinician version. American Psychiatric Pub.
- Fischer, A. R., & Shaw, C. M. (1999). African Americans' mental health and perceptions of racist discrimination: The moderating effects of racial socialization experiences and self-esteem. *Journal of Counseling psychology*, 46(3), 395.
- Hughes, M., & Demo, D. H. (1989). Self-perceptions of Black Americans: Self-esteem and personal efficacy. *American Journal of Sociology*, 132-159.
- Jackson, J. S., Torres, M., Caldwell, C. H., Neighbors, H. W., Nesse, R. M., Taylor, R. J., & Williams, D. R. (2004). The National Survey of American Life: a study of racial, ethnic and cultural influences on mental disorders and mental health. *International journal of methods in psychiatric research*, 13(4), 196-207.

- Jackson, J., & Williams, D. (1995). *Detroit Area Study, 1995: Social influence on health: Stress, racism, and health protective resources*. Ann Arbor, MI: University of Michigan.
- MacKinnon, D. P., Lockwood, C. M., Hoffman, J. M., West, S. G., & Sheets, V. (2002). A comparison of methods to test mediation and other intervening variable effects. *Psychological methods*, 7(1), 83.
- Mattis, J. S. (2002). Religion and spirituality in the meaning-making and coping experiences of African American women: A qualitative analysis. *Psychology of Women Quarterly*, 26(4), 309-321.
- Mattis, J. S., & Jagers, R. J. (2001). A relational framework for the study of religiosity and spirituality in the lives of African Americans. *Journal of Community Psychology*, 29(5), 519-539.
- Neighbors, H. W., Caldwell, C., Williams, D. R., Nesse, R., Taylor, R. J., Bullard, K. M., & Jackson, J. S. (2007). Race, ethnicity, and the use of services for mental disorders: results from the National Survey of American Life. *Archives of general psychiatry*, 64(4), 485-494.
- Neighbors, H. W., & Jackson, J. S. E. (1996). *Mental health in Black America*. Sage Publications, Inc.
- Pearlin, L. I., & Schooler, C. (1978). The structure of coping. *Journal of health and social behavior*, 2-21.
- Preacher, K. J., & Kelley, K. (2011). Effect size measures for mediation models: quantitative strategies for communicating indirect effects. *Psychological methods*, 16(2), 93.
- Radloff, L. S. (1977). The CES-D scale a self-report depression scale for research in the general population. *Applied psychological measurement*, 1(3), 385-401.
- Sobel, M. E. (1982). Asymptotic confidence intervals for indirect effects in structural equation models. *Sociological methodology*, 13(1982), 290-312.
- Williams, D. R., Gonzalez, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. *Archives of General Psychiatry*, 64(3), 305-315.
- Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of behavioral medicine*, 32(1), 20-47.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American journal of public health, 93*(2), 200-208.

Williams, D.R., & Williams-Morris, R. (2000). Racism and mental health: the African American experience. *Ethnicity and health, 5*(3-4), 243-268.

Williams, D. R., Yu, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health socio-economic status, stress and discrimination. *Journal of health psychology, 2*(3), 335-351.

Wittchen, H. U., Robins, L. N., Semler, W. J., & Cottler, L. (1993). Composite International Diagnostic Interview (CIDI): Interviewer's Manual. World Health Organization.

Woodward, A. T., Taylor, R. J., Abelson, J. M., & Matusko, N. (2013). Major depressive disorder among older African Americans, Caribbean blacks, and non-Hispanic whites: secondary analysis of the national survey of American life. *Depression and anxiety, 30*(6), 589-597.

Table 1

Sociodemographic and Clinical Characteristics of African Americans, Afro-Caribbeans, and Whites in the National Survey of American Life (N = 5363).

Variables	AA N (%)	AC N (%)	Whites N (%)	<i>p</i> ^a
Sociodemographics				
Female	2187 (64.6%)	848 (60.9%)	365 (62.6%)	.050
College	1234 (36.4%)	728 (52.3%)	309 (53.0%)	< .001
Married	1168 (34.5%)	600 (43.1%)	283 (48.5%)	< .001
Employed	2226 (65.7%)	1033 (74.2%)	371 (63.6%)	< .001
History of Arrest	1108 (32.7%)	223 (16.0%)	98 (16.8%)	< .001
Clinical Characteristics				
MDD	360 (10.6%)	124 (8.9%)	100 (17.2%)	< .001
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>p</i> ^a
Sociodemographics				
Age	43 (16.2)	41 (15.5)	49 (17)	< .001
Income	31666.84 (28802.2)	41782.86 (33964.2)	43783.24 (35642.1)	< .001
Poverty Index ^b	2.5 (2.3)	3.17 (2.7)	3.69 (2.9)	< .001
Clinical Characteristics				
CESD	1.22 (.35)	1.14 (.32)	1.28 (.36)	< .001
Mediators				
Coping	.035 (.6)	-.063 (.61)	-.030 (.61)	< .001
Support	-.012 (.36)	.014 (.33)	-.037 (.37)	.007
Hardship	.026 (.44)	-.010 (.41)	-.088 (.39)	< .001
Discrimination	.041 (.71)	-.002 (.7)	-.234 (.57)	< .001
Internationality	.312 (.42)	-.963 (.89)	.331 (.37)	< .001

Note. MDD = Major Depressive Disorder; CESD = Center for Epidemiologic Studies Depression Scale

^a χ^2 test or analysis of variance, two-tailed, for significant differences between racial groups

^bCensus 2001 income two needs ratio, higher scores indicate lower poverty levels

Table 2

Direct and Indirect Effects of Psychosocial Mediators on Racial Disparities in Depression Risk Among African Americans Versus Whites.

Mediator	Models Tested	Direct Effect			Indirect Effect			
		<i>B</i>	<i>SE</i>	<i>p</i>	<i>z'</i>	<i>p</i>	<i>ES^a</i>	Type _b
Coping								
	a: AA → Coping	.11	.03	.000				
	b: Coping → MDD	-.76	.07	.000	-3.68	.031	.12	P
Support								
	a: AA → Support	.07	.02	.000				
	b: Support → MDD	-.41	.12	.001	-2.45	.011	.04	P
Hardship								
	a: AA → Hardship	.02	.020	.200				
	b: Hardship → MDD	1.06	.09	.000	1.25	.209	-.03	NS
Discrimination								
	a: AA → Discrimination	.18	.03	.000				
	b: Discrimination → MDD	.40	.06	.000	4.24	p>.001	-.09	R
Internationality								
	a: AA → Internationality	.02	.02	.270				
	b: Internationality → MDD	-.19	.06	.004	-1	.302	.01	NS

Note. AA = African American, MDD = Major Depressive Disorder

^aEffect size of the mediation effect is represented by k^2 , the proportion of the maximum possible indirect effect accounted for by the mediator

^bType of mediated effect, P = protective, R = risk, NS = not significant

Table 3

Direct and Indirect Effects of Psychosocial Mediators on Racial Disparities in Depression Risk Among Afro-Caribbean Versus Whites.

Mediator	Models Tested	Direct Effect			Indirect Effect			
		<i>B</i>	<i>SE</i>	<i>p</i>	<i>z'</i>	<i>p</i>	<i>ES^a</i>	Type _b
Coping								
	a: AC → Coping	-.06	.03	.04				
	b: Coping → MDD	-.76	.07	.467	2.13	.037	-.05	NS
Support								
	a: AC → Support	.07	.02	.000				
	b: Support → MDD	-.41	.12	.001	-2.63	.009	.04	P
Hardship								
	a: AC → Hardship	.04	.02	.054				
	b: Hardship → MDD	1.06	.09	.000	1.95	.055	-.04	NS
Discrimination								
	a: AC → Discrimination	.15	.03	.000				
	b: Discrimination → MDD	.40	.06	.000	3.81	p>.001	-.06	R
Internationality								
	a: AC → Internationality	1.33	.04	.000				
	b: Internationality → MDD	-.19	.06	.004	-2.91	.004	.57	P

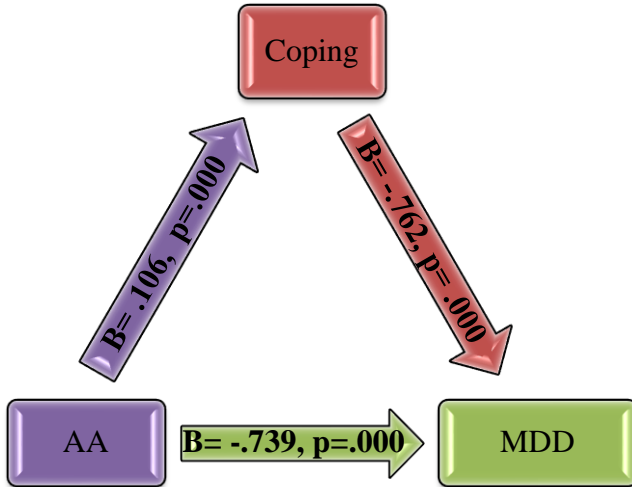
Note. AC = Afro- Caribbean, MDD = Major Depressive Disorder

^aEffect size of the mediation effect is represented by k^2 , the proportion of the maximum possible indirect effect accounted for by the mediator

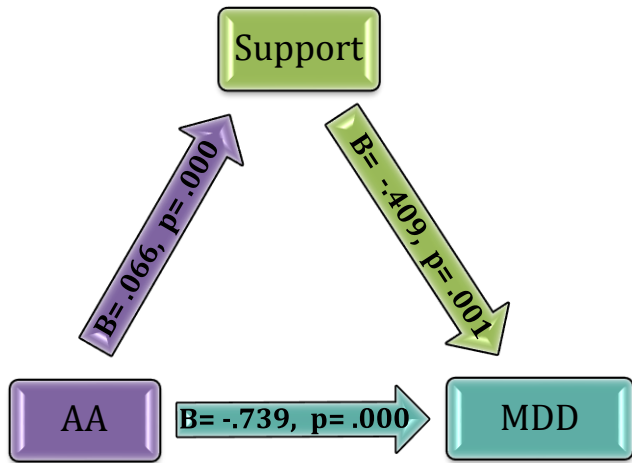
^bType of mediated effect, P = protective, R = risk, NS = not significant

General Linear Regression Models

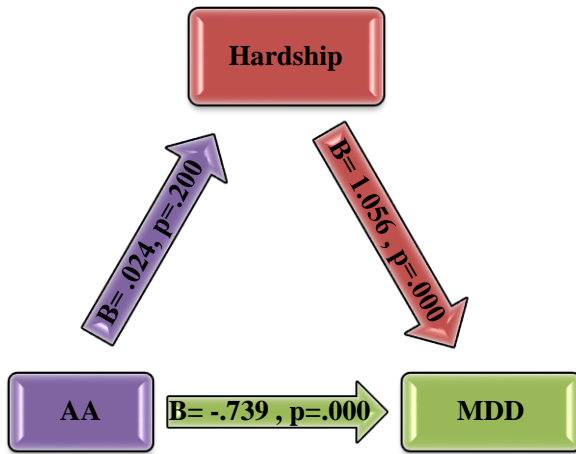
African Americans



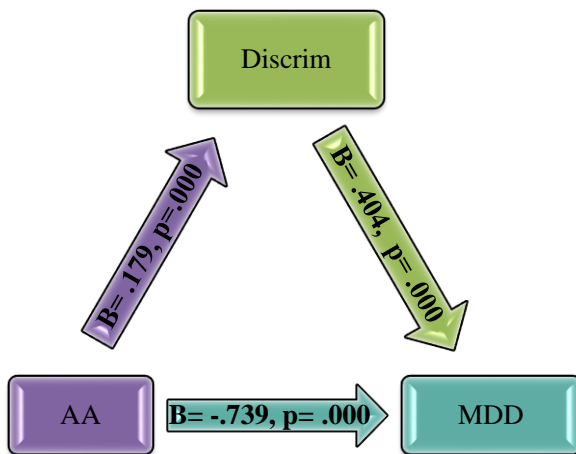
1. Ind= .081, SE= .022, CI= .039 - .126



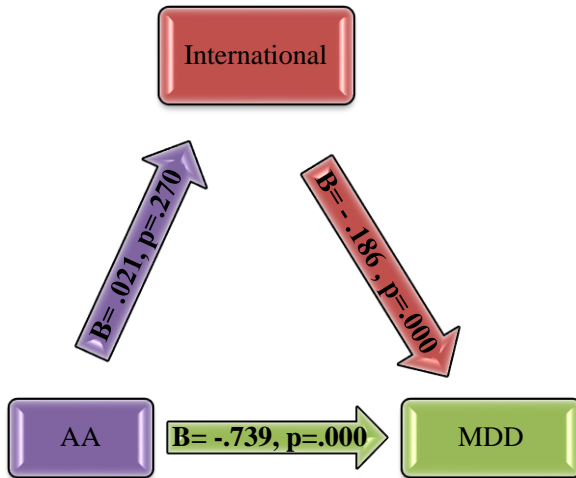
2. Ind= .027, SE= .011, CI= .009 - .051



3. Ind= 0.025, SE= .022, CI= - .014 – .074

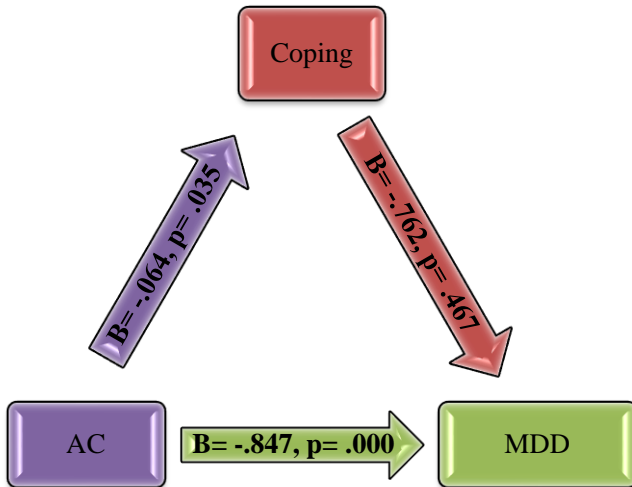


4. Ind= .072, SE= .017, CI= .042 – .108

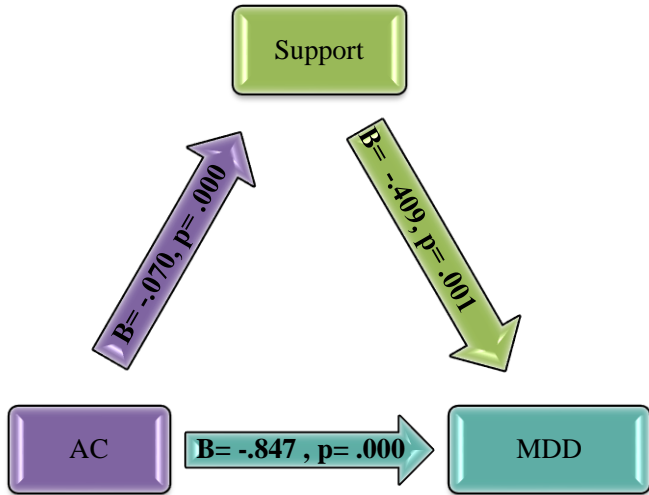


5. Ind= $-.004$, SE= $.009$, CI= $-.026 - .012$

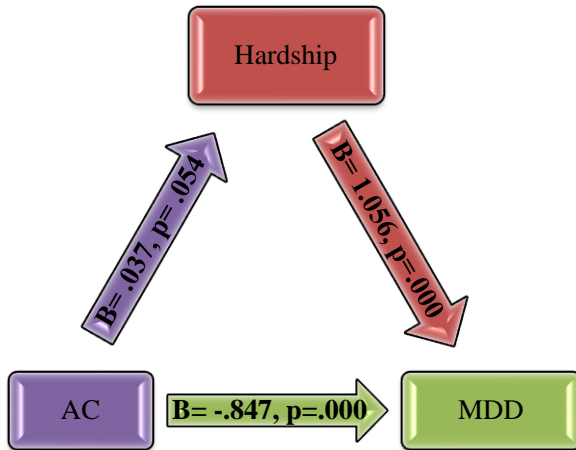
Afro-Caribbeans



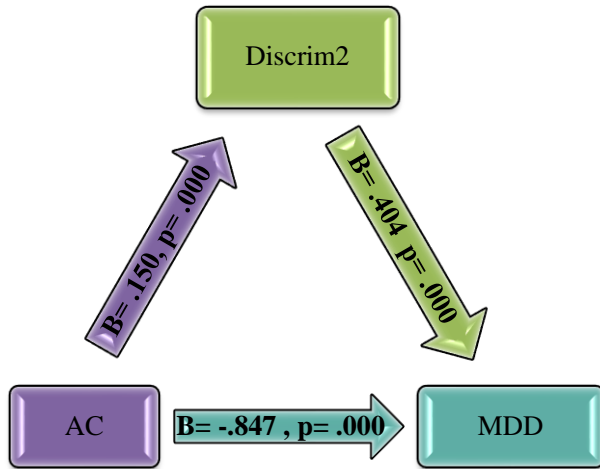
1. Ind= $.049$, SE= $.023$, CI= $.004 - .096$



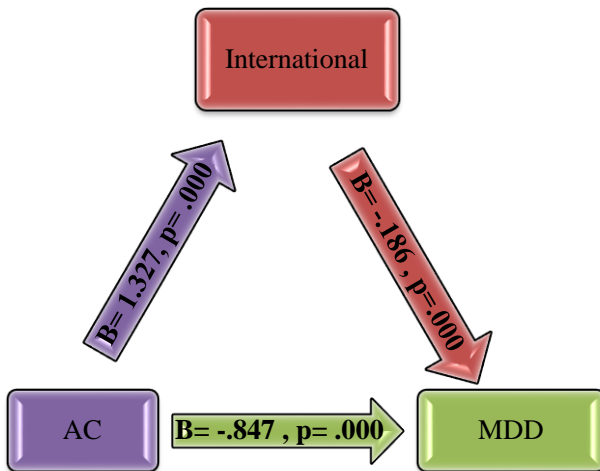
2. Ind= .029, SE= .011, CI= .01 – .053



3. Ind= .039, SE= .02, CI= 0 – .08



4. Ind= .061, SE= .016, CI= .032 – .095



5. Ind= -.247, SE= .085, CI= -.415 – -.008