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POVERTY, INEQUALITY, AND DISCRIMINATION AS SOURCES OF DEPRESSION AMONG U.S. WOMEN

Deborah Belle and Joanne Doucet
Boston University

Poverty, inequality, and discrimination endanger women's well-being. Poverty is one of the most consistent predictors of depression in women, probably because it imposes considerable stress while attacking many potential sources of social support. Economic inequalities within societies are associated with reduced life expectancy and a variety of negative physical health outcomes. Parallel research on economic inequalities and depression has just begun. Discrimination maintains inequalities, condemns women to lives of lessened economic security, and exposes them to unmerited contempt. Although the mental health impact of poverty is documented and largely understood, the implications of inequality and discrimination are less well known. Much important work remains to be done, particularly research that connects individuals' mental health to ecological characteristics of the communities and societies in which they live.

It has long been appreciated that poverty is a major risk factor for depression among women, and the stress processes that account for this risk are increasingly well understood. Economic inequalities within societies are associated with many of the same stress factors and stress processes, and such inequalities have been correlated with many indicators of poor health in women, including their susceptibility to depression. Discrimination contributes to the poverty and economic inequalities women endure and also has direct and demonstrable effects on women's mental health. In this paper, therefore, we review what is known about the depression-risk associated with poverty, inequality, and discrimination, exploring the processes by which economic, political, and social realities can endanger women's well-being. Although poverty, economic inequality, and discrimination are problems around the globe, we focus in this paper on the specific experiences of U.S. women.

ECONOMIC REALITIES

Although U.S. women live in an extremely wealthy nation, the economic circumstances many face are increasingly precarious. In 1996, the U.S. government ended 60 years of guaranteed economic assistance to poor parents (most of them mothers) and their children, leaving few options for economic survival beyond the market economy. About a third of former welfare recipients were not employed in the late 1990s, and those who did find jobs earned, on average, only $6–8 an hour (Boushey, 2002). Legislation mandated health insurance, child care, and job training assistance for women leaving welfare, but many have been denied basic support services (Massing, 2000; Meyers, 2000). More than a million people have lost Medicaid coverage, only 10–15% of families eligible for federal childcare subsidies receive them, and the states have $7 billion in unspent funds that were specifically earmarked to ease the transition from welfare to work (Cohn, 2000; Massing, 2000). Well-documented increases in demand at food banks and homeless shelters have resulted (Burnham, 2002; Green, 2000). Hunger is increasingly a problem for poor women with children, especially poor women of color (Siefert, Heflin, Corcoran, & Williams, 2001).

Over 31 million Americans live below the poverty line, giving the United States a poverty rate of 11.3% (U.S. Census Bureau, 2001). Nearly a fourth of Black and Hispanic women live in poverty, and over a third of women who head their own households are poor (U.S. Bureau of the Census, 2001). In recent years the United States has had the highest poverty rate among the wealthy nations (Mishel, Bernstein, & Schmitt, 1999). The U.S. poor are also poorer now than at any time in the last 20 years, with 41% of those in poverty having incomes below half of the official poverty line (Mishel et al., 1999).

Even these figures do not capture the full extent of material hardship faced by U.S. women because the official poverty line itself is extremely low and does not attempt to measure how much women actually require to support

Deborah Belle, Department of Psychology, Boston University; Joanne Doucet, Jewish Family Services, Montreal, Quebec.
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Address correspondence and reprint requests to: Deborah Belle, Department of Psychology, Boston University, 64 Cummington Street, Boston, MA 02215. E-mail: debbelle@bu.edu

themselves and their children. In 2001, a single mother with two children was considered poor only when her annual income fell below $14,269; a two-parent, two-child family when its annual income fell below $17,960 (U.S. Census Bureau, 2002). Families with incomes even $1.00 higher than these thresholds were not poor, according to the U.S. Census. When social scientists compute the actual cost of living today and when Americans are asked the minimum amount of money necessary to make ends meet, they produce figures that are substantially higher than these poverty thresholds (Boushey, 2002; Edin & Lein, 1997; Opinion Dynamics Corporation, 2001).

The real purchasing power of U.S. wages is lower now than it was in 1973, and the value of the minimum wage has declined precipitously (Folbre & The Center for Popular Economics, 1995). Meanwhile, the costs of housing, health care, and education are much higher than they were a generation ago (Folbre & The Center for Popular Economics, 1995). Responding to these realities, U.S. workers now work more hours per year than workers in any of the other industrialized nations, and with fewer supports, such as subsidized child care, paid vacations, and paid parental leave (Heymann, 2000). Many U.S. workers have lost health insurance, retirement benefits, and paid sick leave in recent years, and more jobs now require work in the evening and weekend hours, when child care is particularly hard to arrange (Folbre & The Center for Popular Economics, 1995; Heymann, 2000).

Recent decades have witnessed striking increases in the concentration of income and wealth in the United States, with corporate profits, the stock market, and chief executive pay at record levels (Mishel et al., 1999). CEOs, almost none of whom are women, earn 475 times as much as the workers at their corporations (Giecek, 2000), and the richest 1% of the population owns more wealth than the bottom 95% (Wolff, 1998). The median U.S. family actually owned less wealth in 1995, in the form of houses, cars, other tangible assets, and financial assets, minus debts, than in 1983. Almost one in five U.S. households has zero or negative wealth. Such economic inequalities are more pronounced in the United States than in any other wealthy country. Economic mobility for those in poverty is also lower in the United States than in most of the other wealthy nations, and U.S. low-wage workers are less likely than those in other wealthy economies to move to high-wage jobs (Mishel et al., 1999).

POVERTY AND DEPRESSION

Poverty is one of the most consistent correlates of depression. High levels of depressive symptoms are common among those with low incomes, especially mothers with young children (Belle, Longfellow, & Makosky, 1982; Bogard, Trillo, Schwartz, & Gerstel, 2001; Brown, Bhrolchain, & Harris, 1975; Chapman, Hobfoll, & Ritter, 1997; Dressler, 1985; Eamon & Zuehl, 2001; Gyamfi, Brooks-Gunn, & Jackson, 2001; Pearlin & Johnson, 1977; Radloff, 1975). One study of current and recent welfare recipients found that more than one-quarter of the mothers met diagnostic criteria for major depression (Siefert, Bowman, Heflin, Danziger, & Williams, 2000). Coiro (2001) found that 40% of the low-income, single, African American mothers she studied reported symptom levels likely to indicate a diagnosis of clinical depression. Rates of major depression in homeless and housed low-income mothers are about twice as high as in the general population of women (Bassuk, Buckner, Perloff, & Bassuk, 1998). In prospective studies, adults in poverty are twice as likely as nonpoor adults to experience a new episode of major depression (Bruce, Takeuchi, & Leaf, 1991), and financial hardship almost doubles women's risk for the onset of depression (Brown & Moran, 1997). However, despite being at great risk for depression, poor women rarely receive mental health services of any kind (Coiro, 2001).

Poor women experience more frequent, more threatening, and more uncontrollable life events than does the general population (Brown et al., 1975; Dohrenwend, 1973; Makosky, 1982), typically in the context of ongoing, chronic deprivation (Ennis, Hobfoll, & Schroder, 2000). Bassuk et al. (1998) found that 83% of the low-income mothers in their sample had been physically or sexually assaulted during their lifetimes. Over a third had experienced posttraumatic stress disorder. The onset of depression has been linked to the experience of humiliating or entrapping severe life events, which are, in turn, more common among women experiencing financial hardship (Brown & Moran, 1997). Loss of material resources, or the threat of their loss, was associated with more depressed mood in both African American and European American low-income single women (Ennis et al., 2000). Inadequate housing, burdensome responsibilities, and other chronic conditions are even more stressful than acute crises and events (Brown et al., 1975; Dressler, 1985; Makosky, 1982; Mathiesen, Tambs, & Dalgard, 1999; Pearlin & Johnson, 1977; Stansfeld, Head, & Marmot, 1998), and typically set the stage for acute, stressful material losses (Ennis et al., 2000). Impoverished women are at very high risk of experiencing just such noxious, long-term conditions (Brown et al., 1975; Makosky, 1982). Recent research also demonstrates that going hungry because one lacks adequate resources for food is a significant predictor of major depression among low-income women, controlling for background characteristics and other social and environmental risk factors (Siefert, Heflin, Corcoran, & Williams, 2001).

Poverty can undermine the ability to fulfill important social roles and to maintain one's own moral standards. As Edin and Lein (1997) point out, the poor mothers they studied generally wished to be employed, both to avoid the stigma of receiving welfare payments and to offer their children positive role models. Yet these mothers also realized that paid employment carried serious risks for their children. "Since neither affordable health insurance nor child care was available to most low-wage workers, mothers who chose work over welfare often had to trust their family's

medical care to county hospital emergency rooms and their children's upbringing to the streets" (p. 5). To supplement wages and welfare payments too low to support their families, mothers sometimes turned to under-the-counter or illegal work (Edin & Lein, 1997). Such breaches of conscience, which were necessitated by poverty, and the sense of being a "bad" mother, wife, or provider were among the most frequent experiences low-income women pointed to as having precipitated their depressions (Wolf, 1987). Financial hardship among single mothers is associated with their perception of success in relatively few domains of life (Brown & Moran, 1997).

Many poor women create mutual aid networks through which they care for each other in times of stress. Such networks are truly "strategies for survival" for many women and their families (Edin & Lein, 1997; Stack, 1974), and support from family, friends, and other network members is associated with a reduced risk of depression among low-income women (Belle, 1982a; Brown et al., 1975; Coiro, 2001; Galaif, Nyamathi, & Stein, 1999).

Yet social networks can serve as conduits of stress, just as they can serve as sources of social support (Belle, 1982b; Belle, 1983; Eckenrode & Gore, 1981; Edin & Lein, 1997; Stack, 1974). Network members are themselves likely to be poor and stressed, so that considerable stress "contagion" (Wilkins, 1974) is likely. Reciprocating the help that is received from network members can be highly time-consuming (Edin & Lein, 1997), and networks can preclude upward mobility or exact emotional penalties (Dressler, 1985; Stack, 1974). Economically secure women can more easily extricate themselves from painful relationships than poor women who rely on others for services they cannot afford to buy, such as child care (Belle, 1982a). Oakley and Rajan (1991) found that British working-class women were more isolated than their middle-class peers, particularly from friends, and that they received less help and support than did women who were more economically secure. Similarly, Brown and Moran (1997) found that British single mothers who experienced marked economic hardship reported fewer confidants who remained close to them over time. In a recent study of poor, middle-aged, Canadian women living in cooperative public housing, Wasylishyn and Johnson (1998) found that many women feared they would become entangled and drained if they involved themselves with the other women of the community, and they preferred, therefore, to isolate themselves.

There is considerable evidence that for poor women, the costs associated with their social networks often actually outweigh the benefits these networks provide (Belle, 1983). Todd and Worell (2000) found that problematic social ties were associated with lessened resilience among the low-income, employed, urban, African American mothers they studied, while supportive social ties were not associated with enhanced resilience. Similarly, Galaif et al. (1999) found that negative social support, defined as support from drug-users and drinking partners in the social network, predicted more drug use and physical drug dependence among the homeless women they studied, while support from other network members was not protective against such problems. The authors speculate that, "Perhaps because their prosocial support networks are already fragmented, strained, or deficient, homeless women may require more potent tangible remedies, such as financial aid, housing, substance abuse treatment, or medical care, rather than someone who just listens to them, while providing moral and emotional support" (p. 810). In Riley and Eckenrode's (1986) Boston-area study, large social networks exacted higher costs from poor women than they repaid through the provision of supportive resources. Expectations that the social networks of poor women could be an unmitigated blessing or could help poor women extricate themselves from poverty probably reflect the limited experience and limited vision of the economically comfortable researchers who generate such ideas (Belle, 1994; Riley & Eckenrode, 1986).

Undermined social relationships may well be one of the crucial links between poverty and depression (Wolf, 1987). The intimacy of the marital bond is often strained or broken by economic stress, and parent-child relationships are also vulnerable (Brown & Moran, 1997; Eamon & Zuehl, 2001; Longfellow, Zelkowitz, & Saunders, 1982). Economic hardship tends to increase conflict between spouses and diminish their capacity for supportive, attentive, and consistent parenting (Conger, Ge, Elder, Lorenz, & Simons, 1994; Elder, 1974; Longfellow et al., 1982; McLoyd, 1990; Mistry, Vandewater, Huston, & McLoyd, 2002; Zelkowitz, 1982). Parents living below the poverty line are less likely to be happily married than those above the poverty line (Zill, 1978), and low-income women are less likely than middle-class women to turn to their husbands as confidants, particularly during the phase of the life cycle when there are young children at home (Brown et al., 1975). Divorce is more common in low-income families (Sherman, 1994).

With limited resources at their disposal, low-income women engage in many active, thoughtful, and creative strategies to cope with the difficult problems they face (Banyard, 1995; Dill & Feld, 1982). However, many of these coping efforts do not achieve their goals or do so only at great cost. Dill and Feld described one woman whose apartment in public housing was being ruined by leaking water. Public health officials declared the apartment unsafe, but the public housing authority never came to make repairs. The woman appealed to everyone she could find to listen to her case and even called in the local television station for an exposé. Yet at the time, she was interviewed years after these efforts began, water continued to leak into her apartment. Another woman was worried about her son, who was dyslexic and emotionally disturbed. She tried and failed to get him an early learning abilities evaluation through his school and tried and failed to have him placed in a Big Brother program, in after-school day care, and in a special school for the learning disabled. Unable to

obtain the help she needed, through no failure of effort or imagination on her part, she felt guilty and inadequate as a mother and increasingly concerned that her son's problems, left untreated, would only get worse.

Poor women's coping strategies must be understood in relation to their severely limited options and the dangers that threaten their children. Among the mothers Edin and Lein (1997) studied, some occasionally did without necessities in order to pay for luxuries for their children. As Edin and Lein argued, "Although these items are not essential for a child's material well-being, a cable television subscription is a relatively inexpensive way for mothers to keep their children off the streets and away from undesirable peers. Likewise, buying a pair of expensive sneakers is insurance against the possibility that children will be tempted to steal them or sell drugs to get them" (p. 8).

Poor women are often so powerless in their dealings with employers, landlords, and government bureaucracies that their coping strategies are severely constrained and unsuccessful. An unforgettable depiction of the powerlessness of contemporary low-wage women workers can be found in Ehrenreich's (2001) *Nickel and Dimed*: *On* (*Not*) *Getting by in America*. One of Wasylishyn and Johnson's (1998) respondents actually defined poverty as "having no options" (p. 978). Repeated coping failures may then lead to the belief that stress factors cannot be overcome, leading women to palliative coping strategies such as self-medication with drugs or alcohol, overeating, sleeping during the day, and repressing thoughts of the problem (Banyard, 1995; Fine, 1983–1984; Pearlin & Radabaugh, 1976; Wolf, 1983). While many observers would decry the apparent helplessness represented by the choice of such palliative strategies, Fine (1983–1984) argued that such behaviors are also ways of taking control, given the impracticality and even the danger of more "active" problem-solving techniques for low-income and minority women in many situations.

Not surprisingly, long-term economic hardship is associated with a diminished sense of efficacy (Popkin, 1990), while increases in household income, regardless of their source, are associated over time with increases in the sense of personal efficacy expressed by women who head households (Downey & Moen, 1987).

INEQUALITY AND WELL-BEING

While poverty exacts a tremendous toll, the negative effects of economic stress are not limited to those who are impoverished. Rather, mental health, physical health, and life expectancy generally form gradients, in which each increment in income is associated with improved odds of experiencing a healthy and long life (Adler et al., 1994; Wilkinson, 1996). Along with mortality and physical morbidity, depression, psychological distress, and hostility show strong income gradients (Adler et al., 1994; Eaton & Muntaner, 1999; Power & Hertzman, 1999).

Annual income is a useful measure of economic status, yet the ability to plan for the future and to cope with financial emergencies is strongly tied to wealth, that is, the ownership of tangible assets such as a house and car as well as financial assets such as stocks and bonds (Mishel et al., 1999). Very little research has examined the mental health implications of gradients in wealth (Krieger, Rowley, Herman, Avery, & Phillips, 1993), although wealth is far more unequally distributed in society than is annual income. While the average income of White families is two to three times higher than that of Black families, their average net worth is 10 times higher (Krieger et al., 1993). Eaton and Muntaner (1999) reported that individuals who receive income from property, royalties, estates, or trusts experience lower rates of anxiety disorders than individuals without such forms of income. Furthermore, home and car ownership are important independent predictors of health and of social support, above and beyond social class position more traditionally defined (Krieger et al., 1993; Oakley & Rajan, 1991).

Experimental research with nonhuman primates illuminates some of the psychological and physiological consequences of low social status. Shively, Laber-Laird, and Anton (1997) manipulated social status among captive female cynomolgus monkeys and discovered that those monkeys who were placed in a low status situation received more aggression from other monkeys, engaged in less affiliation with other monkeys, spent more time alone and more time fearfully scanning the social environment, and spent more time in a slumped or collapsed body posture, a behavioral indicator of depression. In addition, social subordination was associated with suppressed reproductive function and the hypersecretion of cortisol. Because diet and other aspects of the environment were controlled experimentally, these findings can confidently be attributed to low social status.

While ethical constraints forbid manipulations of social status among humans, nonexperimental research with humans suggests that we, too, endure health-damaging emotional and physiological consequences of low social status. In their study of healthy, nonsmoking, White women between 30 and 45 years of age, Adler, Epel, Castallazzo, and Ickovics, (2000) found that those who reported lower subjective social status experienced higher levels of chronic stress, more negative affect, more pessimism, more passive coping, and less perceived control over life. While objective indicators of social status (education and income) were associated with some of these psychological variables, subjective social status was a far stronger predictor. Subjective social standing was also significantly associated with self-rated health, sleep latency, body fat distribution, resting physiological arousal, and cortisol habituation. Neither education nor income was related to any of these physical health indicators.

Status hierarchies appear to be most harmful to health when they are most extreme. Among the industrialized

nations it is the most egalitarian societies, not the wealthiest societies, that have the longest-lived citizens (Wilkinson, 1996). The United States, which leads the industrialized world in income inequality, ranks behind 19 other nations in life expectancy, including Costa Rica, Greece, and Spain (Kawachi & Kennedy, 1999). Within the U.S., those who live in states or cities with greater income inequality experience poorer health and die younger than those who live where income is more equally distributed (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998; Kennedy, Kawachi, & Prothrow-Stith, 1996; Lynch et al., 1998). Furthermore, the effect of income inequality on mortality is found at every income level (Lynch et al., 1998). In highly egalitarian societies, mortality shows a weaker association with social class, and individuals of all social classes live longer than do individuals of comparable social class in more unequal societies (Wilkinson, 1996).

The deadly effects of income inequality appear to be mediated by the stresses of life in a winner-take-all economy, losses in social cohesion and trust, and the skewing of social policies in favor of the wealthy at the expense of the poor and the middle class (Kawachi & Kennedy, 1999; Wilkinson, 1996). Public spending for education is lower and economic assistance to poor parents is more meager in U.S. states with higher levels of income inequality, controlling for the wealth of the state (Kaplan et al., 1996). Not surprisingly, children in more unequal states show lower levels of educational achievement and high school completion than their peers from more egalitarian states. Unequal states then spend more of their state budgets on police, prisons, and health care (Kaplan et al., 1996).

Very little research directly examines the mental health consequences of economic inequalities, although several observers point to its emotional costs. Schor (1998) argued that the vast discretionary incomes of the wealthiest Americans, their lavish lifestyles, and the advertising messages meant for them but viewed by many others have fueled overspending, overextended credit, economic anxiety, and a wave of bankruptcies among Americans. The wealth of the advantaged also creates a housing market that displaces those who cannot keep up with rapidly rising housing costs, fracturing communities and producing homelessness and the fear of becoming homeless.

Drawing on his own ethnographic and historical research, Nightingale (1993) points to the damage done to poor, Black children and their mothers by the consumerist, materialist mass culture that has engulfed the children, even as these children face overwhelming racial and economic exclusion from much that the larger society values. The experience of exclusion has made poor, Black children's "participation in mass culture particularly urgent and enthusiastic, for the culture of consumption has given them a seductive means to compensate for their feelings of failure" (p. 135). Nightingale found that when poor mothers could not satisfy their children's inflated demands for consumer goods, children sometimes questioned their mothers' love and resisted their control.

In national surveys, the extent to which Americans express trust in each other has declined by approximately a third during the past 25 years, a period in which income inequality in this country has also grown alarmingly (Kawachi, 1999). Cross-sectional analyses reinforce this picture, showing that in U.S. states with high levels of income inequality, trust in others is far lower than in states with lower levels of income inequality (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997). Studying the regions of Italy, Putnam (1993) found a very high negative correlation between the extent of income inequality within each region and its indicators of social cohesion.

The experience of poverty, homelessness, and hunger in a vastly wealthy society must also "damage the sense of connection between individual and community" (Herman, 1992, p. 55) by conveying the community's lack of concern, despite its evident capacity to help. Herman recounted the experiences in therapy of a Navy enlisted man who was rescued at sea after his ship was sunk during wartime. The officers had been rescued first, even though they were already relatively safe in lifeboats, while the enlisted men hanging onto the raft had to wait, some of them drowning before help came. The rescued man "was horrified at the realization that he was expendable to his own people. The rescuers' disregard for this man's life was more traumatic to him than were the enemy attack, the physical pain of submersion in the cold water, the terror of death, and the loss of the other men who shared his ordeal. The indifference of the rescuers destroyed his faith in his community" (p. 55). It would be important to understand how impoverished women experience their communities and how they cope with the realization that they, too, are expendable.

Kahn, Wise, Kennedy, and Kawachi (2000) have demonstrated that income inequality, measured at the state level, is strongly associated with women's risk of depression. In their study of a nationally representative stratified random sample of 8,060 women who gave birth in 1988 and were successfully re-contacted three years later, they replicated the familiar finding that low income is a significant risk factor for both depressive symptoms and poor physical health. In addition, they found that living in a state with high income inequality significantly and substantially increased the chances that women would report high levels of depressive symptoms and only fair or poor health. The effects were strongest for the poorest women, with high income inequality associated with a 60% greater risk of depressive symptoms and an 80% greater risk of fair or poor health among women already at risk because of their low household incomes. Kahn et al. (2000) concluded that household income and income inequality operate together to influence maternal mental and physical health, and suggest that a more integrated approach is needed to explore the combined effects of income inequality and individual income.

Economic inequalities between rich and poor are not the only inequalities to predict negative health outcomes. Status differentials between men and women are also correlated with mortality rates, morbidity rates, and the frequency of severe marital violence against women (Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999; Yllo, 1983). Kawachi et al. (1999) correlated indices of women's political participation, economic autonomy, employment and earnings, and reproductive rights in each of the 50 U.S. states with female mortality and morbidity rates in those states. Higher political participation by women and a smaller wage gap between women and men were associated with lower female mortality rates and fewer limitations in daily functioning among women brought about by poor physical or mental health. These findings persisted after adjusting for income inequality, poverty rates, and median household incomes in the states. Furthermore, male mortality rates were also lower when the status of women was higher. Kawachi et al. (1999) noted that women's employment and earnings directly influence the economic well-being and the health of all family members, including males. "Considered as a whole, a society that tolerates gender inequalities is also likely to be a more unhealthy place to live for both men and women, compared to a more egalitarian one" (p. 31).

DISCRIMINATION AND WELL-BEING

Discrimination is often understood to be irrational, the product of poor upbringing or lack of education, and the province of a small number of conspicuously bigoted individuals (Feagin & Feagin, 1978). Yet, discrimination can also be understood as a process in which the dominant group's privileges are maintained, at the expense of a subordinate group or groups (Feagin & Feagin, 1978). Discrimination can occur without intent, when unconscious stereotypes distort our impressions of individuals (Reskin, 2002). Discrimination can even take place without an individual perpetrator when, for instance, certain groups are impeded by job requirements that are irrelevant to job performance. From this perspective, discrimination is dynamic, its effects generally tending to maintain and accentuate existing inequalities within society. Discrimination exposes individuals to the undeserved contempt of others and to repeated negative experiences over which they have little or no control. Discrimination can lead to lowered economic and social status and losses (of jobs, promotions, housing, etc.) which are particularly frustrating and anger-producing "in a culture which promotes the expectation of achievement in proportion to merit" (Fernando, 1984, p. 45). Such experiences of loss and lack of control can lead to diminished self-esteem and feelings of helplessness, inducing depression. While individuals cope with discrimination in different ways, many of these coping strategies are themselves dangerous or problematic. Women experience discrimination based on many characteristics, including sexual orientation, disability, and age. In this paper we focus on the discrimination women experience because of gender, race, and socioeconomic status, as these forms of discrimination are most central to the maintenance of women's poverty and economic inequality.

Laboratory experiments have demonstrated that even brief episodes of discrimination have a measurable short-term impact on victims, leading experimental participants to perform more poorly on cognitive tasks, to behave less altruistically to peers, and to report elevated levels of stress, aggression, sadness, egotism, and anxiety (Dion & Earn, 1975; Glass & Singer, 1972). Black college students who experienced racism vicariously, by viewing brief film clips depicting racist incidents, demonstrated elevations in blood pressure, which did not occur after their viewing of anger-producing but nonracist film clips (Armstead, Lawler, Gorden, Cross, & Gibbons, 1989). Recent research on "stereotype threat" (Steele, 1997) documents the insidious effects of widespread cultural beliefs about the inferiority of Blacks and women, particularly when individuals from these groups are reminded of these negative stereotypes shortly before attempting a difficult task. Fear that one will prove the negative stereotype true acts as a major disruptor of performance, leading to exactly the feared consequences.

Sexist discrimination has usefully been conceptualized and operationalized as a form of stress (Klonoff & Landrine, 1995). Landrine, Klonoff, Gibbs, Manning, and Lund (1995) found that sexist discrimination accounted for more of the variance in depressive and somatic symptoms among women than did standard measures of life events and daily hassles. Women's reporting of recent and lifetime sex discrimination entirely accounted for the observed differences between men and women in depressive, anxious, and somatic symptoms (Klonoff, Landrine, & Campbell, 2000).

Discrimination based on race continues to be pervasive in the lives of African Americans and to constitute a significant source of stress (Landrine & Klonoff, 1996). Of Landrine and Klonoff's African American sample, 98.1% reported experiencing racial discrimination within the past year, with 64.2% reporting instances of discrimination by institutions such as banks and universities, 54.8% reporting discrimination by social workers, doctors, dentists, or therapists, and nearly half of the sample (49.7%) reporting having been called a racist name. Racist discrimination was associated with low self-esteem, depression, anxiety, and stress-related somatic symptoms such as headaches and backaches.

These recent studies of racist and sexist events almost certainly underestimate the overall impact of discrimination, because much discrimination is actually continual and routinized (Feagin & Feagin, 1978), and stress research has shown that such chronic stress is more damaging to individuals than episodic stressful events, as discussed earlier. Furthermore, much discrimination is not even evident to those who suffer from it. Reskin (2002) has described how easily nonconscious cognitive processes such as categorization,

ingroup preference, stereotyping, and attribution error can lead employers and other decision-makers to "micro acts of discrimination" (p. 221) such as overlooking qualified female or minority candidates, giving a White male a tip on a job opening, or failing to recognize the contribution of an individual from a minority group. Just as the beneficiaries of such practices often fail to recognize that they receive advantages because of their ingroup status, the victims of such practices are often unaware of the specific ways in which they have been harmed. Although workers do react negatively over time to blocked opportunity, they may not label their experience discrimination (Reskin, 2002).

Sexism in the valuing of workers and occupations contributes to the disparities in salaries between males and females (Barko, 2000). American women who work full time earn an average of 74 cents for each dollar earned by men, and the gender discrepancy is most pronounced among low-income workers. If women were paid as much as men, more than half of all the poor households in the country would rise above the poverty line (Barko, 2000).

Racial discrimination often confines Blacks to neighborhoods with higher crime rates and more environmental contaminants such as lead and toxic waste dumps, to occupations involving severe health and safety hazards, and to medical care that is less aggressive and effective (Krieger et al., 1993; Yinger, 2000). Racial profiling and police violence lead to elevated rates of Black imprisonment, terror, and death. Black people represent only 13% of those who use drugs, but almost 75% of those who are imprisoned for drug crimes (Butler, 1997). Black women, although imprisoned in much smaller numbers than Black men, are incarcerated at seven times the rate of White women (Cose, 1997), and they are the fastest-growing segment of the prison population (Gillespie, 1997). Racism can also lead people of color to "adopt the oppressor culture's denigrating views" of themselves and others of their racial/ethnic group, with great costs for both self-validation and social support (Krieger et al., 1993, p. 88).

The experience of racism may lead to many different stress responses, including "anger, paranoia, anxiety, helplessness-hopelessness, frustration, resentment, and fear" (Clark, Anderson, Clark, & Williams, 1999, p. 811). In turn, these responses may influence subsequent coping strategies. Anger, for instance, may be suppressed, channeled into chronic hostility, or expressed verbally or nonverbally, and individuals may turn to alcohol or other substances to blunt their own anger (Clark et al., 1999). Blacks who have experienced racist episodes report troubling, intrusive thoughts and dreams about the events, as well as attempts to avoid such thoughts and reminders of the incidents (Sanders Thompson, 1996). Krieger (1990) found that Black women who usually accepted and kept quiet about unfair treatment were at elevated risk for high blood pressure, in contrast to Black women who talked to others and took action. Yet the expression of anger at racist treatment may be dangerous. Not surprisingly, therapists report that depression, tension, and rage about racism is the single most common cluster of problems presented by African Americans in therapy (Landrine & Klonoff, 1996).

Complementing research on the subjective experience of discrimination is recent research examining discrimination as an ecological variable, one that can characterize entire communities or regions in which people live, and that can be reported on, not by the victims of discrimination, but by those who engage in racist thinking. Kennedy, Kawachi, Lochner, Jones, and Prothrow-Stith (1999) have examined the association between racial prejudice, measured at a collective level, and Black and White mortality in the United States. Anti-Black prejudice was measured through a survey question which asked why, on average, Blacks have worse jobs, income, and housing than White people. Those who responded that the differences were mainly due to discrimination or lack of educational opportunities were considered unprejudiced, while those who answered that most Blacks have less in-born ability to learn or lack the motivation or will power to pull themselves up out of poverty were considered racist thinkers. Individual answers were then aggregated on a statewide basis, so that states could be rated on the prevalence of racist thought. These measures of racist thinking were positively correlated with Black mortality as well as with White mortality. No research to date has analyzed in this way the association of racist thinking with rates of depression or has extended this line of research to examine the physical and mental health correlates of sexist thinking.

The association between collective levels of anti-Black racist thinking and increased mortality among Whites suggests that there may be "deleterious health consequences of racism for those who hold such views, as well as for those who are the targets of prejudice" (Kennedy et al., 1999, p. 471). As Pratkanis and Turner (1999) point out, prejudice blocks the development of a self-aware, autonomous, integrated self by requiring distortions of reality in the projection of stereotypes onto outgroups, conformity to groups supporting such distortions, and rigid dichotomized thinking.

Poverty is deeply discrediting within U.S. society, and the language used by social scientists often serves to deepen this discredit. According to O'Connor (2001), the ways in which poverty experts have written about welfare "dependency" "made receiving welfare a personal pathology, something that became harder to 'escape' the longer it went on, while such descriptors as 'long-termer' and 'recidivism' virtually equated using welfare with a criminal offense" (p. 254). "To fight dependency was, in essence, to fight a kind of substance abuse that led to unrestrained sexuality, drug problems, violent crime, civic irresponsibility, and even poverty itself" (Schram & Soss, 2000, p. 64). Edin and Lein (1997) model the avoidance of such language, using the phrase "welfare reliant" to describe women who receive welfare benefits, and "wage reliant" to describe women who work for wages. They do not use the word "dependent" because, as they point out, neither welfare payments nor work

provides enough income to support a family. Nor does "dependency" make sense if its opposite is "independence." The experience of women who have been forced off the welfare rolls is, instead, dependence on low-wage jobs that do not provide economic security (Edin & Lein, 1997; Gordon, 2001). Adopting the language of welfare "dependency" accepts the fundamental assumption that moving mothers into the labor force in ever-increasing numbers is inherently a positive goal, ignoring the difficulties and dangers women and their children often experience with such a move (Steinitz & Mishler, 2001).

Americans tend to view the poor more negatively than they view the middle class (Cozzarelli, Wilkinson, & Tagler, 2001), and they are more likely than most other national groups to blame poverty on the poor themselves (Feather, 1974; Stern & Searing, 1976), with older individuals, Whites, males, and the economically advantaged particularly likely to endorse this point of view (Carr & MacLachlan, 1998; Feagin, 1975; Hunt, 1996; Kluegel & Smith, 1986; Nilson, 1981). Those with higher incomes generally believe that the economic system is fundamentally just, that there is plentiful economic opportunity for all, and that the causes of both poverty and wealth are internal to the persons who experience them (Kluegel & Smith, 1986; Rytina, Form, & Pease, 1970). Such classist beliefs, as well as classist behaviors and practices, serve to "maintain and legitimatize class-based power differences" (Bullock & Lott, 2001, p. 154).

As Goodban (1985) has noted, those "who experience economic failure are doubly branded. Not only are they unable to enter the mainstream of consumer society, but they are often judged to be personally responsible for their failure" (p. 403). Low-income women who can retain self-esteem and reject the denigrating vision of others may in that way protect their mental health. As a coping strategy, many low-income women do not identify with one another, and emphasize their differences in order to retain a sense of individuality and separateness from this undesirable image (Wasylishyn & Johnson, 1998). As one of Wasylishyn and Johnson's respondents said, "To identify with other low-income women is equivalent to admitting failure" (p. 977). Todd and Worell (2000) found that, among low-income, employed, urban African American mothers, those who more frequently made downward social comparisons experienced more resilience.

The most stigmatized form of poverty involves reliance on government economic support, and welfare recipients often describe experiences of humiliation, dehumanization, denigration, depression, and shame (Davis & Hagen, 1996; Goodban, 1985; Jarrett, 1996; Marshall, 1982; Popkin, 1990; Seccombe, James, & Walters, 1998). Most of the welfare recipients interviewed in one recent study claimed that negative comments about people on welfare had been directed to them personally (Seccombe et al., 1998). Even women who receive welfare payments themselves are not immune from endorsing the pervasive societal contempt for the "welfare mother." Seccombe et al. (1998) found that women who received welfare payments typically blamed societal factors or fate for their own economic situations, but subscribed to popular notions of *other* welfare mothers as lazy and unmotivated. At the societal level, a focus on welfare, driven by "myths and stereotypes about the poor" provides "a scapegoat for larger, complex social problems" and deflects our attention from the real problem, which is poverty, not welfare (Rice, 2001, p. 356).

Contempt for welfare mothers can also carry racist overtones. One woman interviewed by Seccombe et al. (1998) reported hearing welfare recipients referred to as "White and Black niggers sucking off the system." As Seccombe et al. noted, "One of the many reasons that welfare is stigmatized is because it is incorrectly associated with primarily African Americans. Whites tend to deny that our social structure limits the opportunities for African Americans. They sometimes feel that they, themselves, are victimized by policies of 'reverse discrimination' and that African Americans reap employment and social welfare benefits" (p. 854).

Nor are policymakers immune from the racism of the larger society. A recent analysis of state-level welfare policies found that by far the strongest predictor of restrictive and punitive policies was the racial composition of the state: states with larger Black and Hispanic populations had stricter time limits, family caps, and sanction policies than states with fewer minorities (Soss, Schram, Vartanian, & O'Brien, 2001).

Although individuals generally protect self-esteem by attributing successes to themselves and failures to outside forces (Lau & Russell, 1980), the dominant American achievement ideology demands that individuals take responsibility for their own economic fortunes in life (MacLeod, 1995). Goodban (1985) found that women who accepted the ideology of equal opportunity were more likely to blame themselves for their own welfare status, less likely to be assertive about their rights as welfare clients, less likely to take part in welfare activism, and more likely to experience low self-esteem.

PREVENTION EFFORTS

Public policies that can diminish economic hardship, inequality, and discrimination would promote the well-being of women. Enacting such policies is a daunting task, and yet one which holds out great promise for reducing the incidence of depression among U.S. women. Anti-poverty efforts should include actions to ensure that women actually receive the government benefits to which they are already legally entitled, particularly health care, child care subsidies, food stamps, subsidized housing, and job training.

Ironically, recent welfare "reform" has foreclosed for many women the only plausible route to real economic security (Edin & Lein, 1997; Scarbrough, 2001). Women have been forced to leave colleges and serious vocational

training programs to take dead-end minimum wage jobs that will never enable them to support their families at a decent level (Edin & Lein, 1997; Human Rights Monitoring Project in Massachusetts, 1998; Scarbrough, 2001; Schmidt, 1998). A single year of college cuts minority women's poverty rate in half, and welfare recipients who have attended college report significant improvements in self-esteem and agency (Rice, 2001; Scarbrough, 2001). Some states have begun to redefine work requirements to include the possibility of higher education (Scarbrough, 2001). Other states should follow these examples.

Enhancements in the minimum wage and in the Earned Income Tax Credit are needed to raise low incomes. Communities can also enact Living Wage laws mandating that employers pay workers enough to ensure a decent standard of living. Reviving union strength is also crucial if workers are to reclaim power in their negotiations with powerful corporations. Grassroots community organizing to achieve such goals is a way to assert control, while building a supportive community. Religious organizations have unique moral credibility and can be powerful voices for affordable housing, fair lending practices, living wages, and other forms of economic justice.

Yet relieving the material hardship of poor people is not sufficient. Living in a highly unequal society, even those at higher income levels experience economic insecurities and negative social comparisons that damage their emotional and physical well-being. Reducing the distance between the wealthy and the poor, through redistributive tax policies and shareholder rejection of immense corporate salaries, is also needed. Public policies that further advantage the rich, such as the repeal of inheritance taxes, should be strenuously opposed. Unfortunately, economic power tends to engender political power, making such battles difficult. United for a Fair Economy (www.FairEconomy.org) is one group which has developed creative strategies to publicize the growing economic divide in this country and to rally grassroots support for efforts to achieve greater economic equality. Through its publications, curricula for young people, speakers, rallies, workshops, and street theater, it has built coalitions to fight against corporate abuses such as predatory lending practices and excessive corporate salaries, and against legislation such as repeal of the estate tax.

Sexist and racist discrimination must be fought through the enforcement of equal opportunity laws and through public education. In combatting discrimination, new avenues toward economic security are opened up to women, particularly those from ethnic/racial minority backgrounds. Lessening the contempt to which many women are exposed, by virtue of their sex and/or ethnicity, will also have a positive effect on mental health. Beliefs about the supposed inferiority of women, particularly poor women and ethnic minority women, are prevalent in our society. Continuing efforts are needed to overturn centuries of socially condoned prejudice and discrimination.

TREATMENT AND SERVICE DELIVERY RECOMMENDATIONS

Poor women are at high risk for depression yet can rarely afford to pay market rates for mental health treatment. They are also unlikely to have medical benefits with their jobs that will provide for mental health care. Cutbacks in publicly funded mental health services must be restored if poor women are to obtain the treatment they need. In addition, low-income women may need help in paying for transportation and child care before they can successfully undertake treatment. Because the jobs poor women hold rarely offer paid or even unpaid leave for health care, many women have to choose between treatment and continued employment. Resolution of such dilemmas may require legislation mandating and supporting job security for women who require mental health care.

Treatment for depression should build on our knowledge of the depressogenic nature of poverty, inequality, and discrimination. Training on this topic would help clinicians understand the mental health impact of these stress factors and appreciate the variety of coping strategies women adopt. Because social and economic stress is often the root cause of emotional problems, alleviating such stresses can often alleviate the mental health problems as well. Active mastery of a particular problem (such as inadequate housing), even with the assistance of a professional helper, can be a gratifying, esteem-building experience. For once, the system did respond and acknowledge one's legitimate needs. Such experiences offer a respite from overwhelming life stresses and can begin a benign cycle of new hope, new efforts, and new successes. Thus, advocacy efforts to help women resolve legal problems, gain the benefits to which they are entitled, or secure education can be therapeutic in themselves. Clinicians who cannot undertake such work might ally themselves with other service providers in a close working relationship so that all of a client's pressing and interlocking problems can receive attention as part of an overall treatment plan. Mutual help groups can also be powerful antidotes to guilt and depression, revealing through group discussions the systemic factors responsible for many of the difficulties women face.

RESEARCH DIRECTIONS

Contemporary U.S. society provides a unique laboratory in which to examine the mental health consequences of poverty and economic inequality. Nowhere else in the industrialized world does one find such high poverty rates, such stunning income and wealth inequality, and such ideological assurance that both rich and poor deserve their fates.

While the association between income and depression has been thoroughly documented, less attention has been paid to the role of wealth in protecting mental health. Because income can fluctuate with the vicissitudes of the labor

market, but wealth is more static and secure, it could be hypothesized that wealth is even more strongly associated with mental health than is income.

Very little is known about the significance of economic inequalities for mental health. The findings of Kahn et al. (2000) certainly point to the power of income inequality in explaining women's risk for depressive symptoms. The impressive body of research correlating income inequalities with mortality and physical morbidity also suggests that this would be a productive topic for future research. Similarly, research is needed on the mental health consequences of living in a racist or sexist community. Research that brings together ecological data on the prejudiced thinking characteristic of certain regions and individual data on the experience of discrimination and of depression would be particularly powerful.

Most research on the impact of racial discrimination has focused on discrimination against African Americans. Such research should be complemented with studies of the mental health consequences of discrimination directed against Hispanics, Asians, and other groups. In addition, studies should further explore the origins of class prejudice and prejudice against the poor.

Research is also needed to uncover the origins of Americans' faith in the justice of the current distribution of wealth. What social psychological processes, such as the just world illusion and the fundamental attribution error, help to account for Americans' tendency to attribute wealth and poverty to the characteristics of individuals, ignoring structural causes? How do our educational system and our media contribute to the belief that economic inequalities are just? How are children socialized to think about the wealthy and the poor? What interventions are useful in alerting adults and children to the systemic sources of poverty and inequality? Do such interventions promote greater compassion and respect for poor people? Do they lead to changes in behavior (charitable giving, voting, political action, etc.)?

It will be particularly important to understand how poor women cope with the contempt they experience for their economic status and with the pervasive achievement ideology that promises economic security if one simply works hard enough. If women reject this ideology, how do they maintain self-efficacy and the hope that they will someday escape their current poverty? If women accept the achievement ideology, how do they maintain self-esteem?

Research on the consequences of recent changes in the welfare system should focus on the well-being of the women and children who are affected, not merely on whether or not they have moved off the welfare rolls. Indicators of material hardship, such as deficiencies in food, winter clothing, and medical care, should be routinely gathered. Researchers must also continue to focus attention on an issue that is more fundamental than the welfare system: "the unequal distribution of resources and the economic, political, and psychological processes that maintain it" (Bullock & Lott, 2001, p. 148).

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