Trends of Century Mental Disorders of Women in the USA based on Race and Ethnicity

Ericka Vargas

AMH3340: History of Disability in America

Fall 2015

University of Florida

Intro:

This paper focuses on the academic and scholarly journal literature that explores the prevalence of century-specific mental disorders for women depending on race/ethnicity. This has a multi-layer perspective with first the century mental disorder analyzed by prevalence and then with treatment/care modality by race and ethnicity explored. The analyzed disorders for each century are: 1800s and hysteria, 1900s and neurosis, and 2000s and depression and anxiety. In regards to the race/ethnicity of the women studied, the races/ethnicities include: Hispanic or Latina, Black/African American, and White/Caucasian women.

In a deeper level, this review of literature consists on analyzing what the wealth or poverty in the literature in regards to mental health and mental illness for each race/ethnicity suggests in a larger scope of disability. By exploring the presence of literature or the lack of thereof, the differences and similarities on the prevalence of mental disorders among women from different race/ethnicities is aimed to expose other confounding factors such as power, racism, and privilege that make mental illness in women a disability.

1800's:

Hysteria

In order to study hysteria in the United States one must acknowledge what the literature and cultural reality that surrounds this psychological and somatic diagnosis highlights: It is a white women's culture bound disorder. As such, white women must, with much privilege, lead the literature in regards to hysteria. As a matter of fact, Jean Martin Charcot and Sigmund Freud, the fathers of hysteria and its treatment, focused on the white middle and upper-class women with specific sexual, intellectual, and domestic demands and changes in a white and idealistic

society. Those given the label of hysterics were mainly white women who could not or did not want to bear reproduction, their systems were overwhelmed with the intellectual burdens, their weak bodies had no energy for domestic duties, and they could not deal with the sexual demands of their oppressed femininity whilst seeking self-fulfillment (Smith-Rosenberg & Rosenberg, 1973, p. 355). Therefore, Hysteria's scientific literature was meant to proliferate the domestic, fertile, inferior, and middle-class white woman ideal. As a whole, hysteria defines the superior western woman's inability to fulfill sexual and social demands of reproduction, white male's satisfaction, and white society's goals towards a better and fit society. Consequently, when domestic and sexual demands of femininity were not fulfilled or met, then these women fell into a label of insanity and abnormality. As such, if they did not fit at home, admittance into asylums for not complying with social expectations defined by males of female behavior followed (Pouba & Tianen, 2006, p. 95).

Hysteria as a white woman-centered disorder and its diagnosis poses the assumption of the absence of mental health disorders and mental illness in women of other ethnic and racial groups. In fact, the lack of non-white women literature on mental health raises the question of the mental illness manifestations for minority women, and reasons for the lack of thereof. During these years the focus for ethnicities and races other than white in mental health were almost non-existing in the scope of hysteria. Indeed, there are few records of black or Hispanic cases of women with hysteria due to the inapplicability of the hysteria label to their culture and social determinants. During this era, classifications in regards to the mental health of women followed the social segregations in place in regards to racism, slavery, and anti-foreign populations. Hysteria reinforced the dichotomies in place juxtaposing the white woman against the rural, immigrant, non-White, and "savage" women (Briggs, 2000, p. 257). The unfeminine behaviors

or cases that ailed and were reprimanded for white middle class women during this period century, were expected, ignored or non-existent for ethnic minorities, especially Black women. Most importantly, Hysteria was a disorder for “identified white women of the middle and upper classes as endangering the race through their low fertility, while non-white women, immigrants, and poor people had many children” (Briggs, 2000, p. 247). Since Hispanics and African-American/ Blacks had no reproductive value or importance for the direct survival of the white and superior society, they had no scientific value of study in regards to reproductive improvement. Whereas white middle/upper-class women had weaker bodies, soft personalities and lower birth rates and reproductive health, non-white women had no feelings, they were cold, had stronger bodies, and high birth rates and reproductive health (Briggs, 2000). The crux of hysteria consists that "overcivilized" white women avoided sex and were unwilling or incapable of bearing many (or any) children, when "savage" women gave birth easily and often, and were hypersexual (Briggs, 2000, p. 249). Indeed, the society ignored and marginalized non-white women in regards to hysteria, they did not meet the criteria as important women.

Since the literature for Hysteria juxtaposes white women and non-white women, one assumes the inclusion of Hispanic or Latina women under the cases of Hysteria in White or Black women. Due to the racial diversity in the Hispanic population, studying Hispanic women’s mental health consists of a gray or empty area in the literature. Hispanic women’s study in the domain of hysteria is not even directly or indirectly accounted for or mentioned in the literature. Nonetheless, Hispanics’ cases for hysteria can also follow Blacks’ trend in the absence of literature despite the presence of the Hispanic population in the country. Yet, history does include, with minor focus, the presence of Hispanic settlers during the 1800s and the Mexican war, and the Spanish speakers since colonial and imperialistic times in Florida, California, and

Texas (Office of the Surgeon General, Center for Mental Health Services [CMHS], & National Institute of Mental Health [NIMH], 2001, p. 130). Thus, their absence from mental health literature suggests their isolation, and marginalization similarly to Black women.

As a result of racial and cultural differences between women, treatment and cures enveloped different conditions. Civilized women were generally observed in their homes during illness and childbirth episodes and received hypnotic sessions, and "savage" women were more often rendered legible to medical science in hospital dispensaries and museums than at home (Briggs, 2000, p. 265). Black women were still under slavery terms, civil war issues, and post-war agendas. Other races and/or ethnicities did not have the literature representation in regards to hysteria due to their existence deemed as unimportant for white affairs related to mental health, therein resulting in their marginalization and stigmatization. As such, the little existent literature of non-white mental health consisted of anecdotal accounts, such as diaries, social reports, and excerpts of personal writings (Vega & Rumbaut, 1991, p. 364). For Black women, *We Are Your Sisters: Black Women in the Nineteenth Century*, by Dorothy Sterling (1984), is one of the epistolary and autobiographical accounts of black women's lives from the eighteenth century and slavery times, until the nineteenth hundreds during the reformation and reconstruction period. This book gives a wealth of information in regards to the social factors that affected black women's mental health, such as sexual trauma, abuse, rigorous work, and how their sexuality was not valued for social definitions of femininity (i.e. white femininity). This book exemplifies the use of anecdotes, oral history, and hidden excerpts for the accounts of mental health, and also general life of black women during the nineteenth century. The absence of research in regards to nineteenth century black women's mental health suggests the marginalization of a group deemed not important to study outside of scientific and physical

experiments for the medical discoveries meant for the white population. Black women did not pertain to the white society's definitions of psychological or physical health, therein their mental health did not pertain in the literature at the time.

The literature of Hysteria suggests the label of disability as a historical and situational label, as well as rich in diversity. Nineteenth century mental illness for women exposed the racial and social intersection of disability as abnormality from the prescribed roles in society. Hysterics were disabled white middle class women that did not meet white feminine ideals of submissiveness, domesticity, and reproduction; non-hysterics consisted of non-white women, such as Black and Hispanic women, who did not meet white ideals of humanity and civilization, and ideals of citizenship in American culture. The label of hysteria suggests a need to fix the ideal women for hope of improvement, and the lack of diagnosis and absence in the literature suggests the need to isolate and suppress the non-ideal women from thinking they can aim for that ideal. The white race's superiority in regards to access and study of mental health did not apply or include the "other" races or groups in society. Whereas this offers the assumption that non-Whites did not manifest symptoms of mental illness, this phenomenon of "absence" of mental illness suggests the lack of importance given to non-white women, the oppression of mediums to be able to report and manifest mental illness, and the idea that anyone other than white middle or upper-class Americans do not matter. This gap in the literature suggests disability in women as a tool to maintain white male hegemony and ableist supremacy in place to prevent sharing civil treatment and rights with other groups. This reinforces the lack of inclusion and interest in groups that do not envelop the same traits as the superior group in society.

1900's:

Neurosis

In regards to neurosis, this disorder follows a similar path as hysteria as far as the literature dedicated to its study in women. The majority of the literature of neurosis in women explores white middle and upper class women's mental illness. Despite this trend, neurosis also follows some of the social changes and inclusion of the twentieth century. Due to century phenomena of War, Civil rights, Women's rights, immigration waves, and the high demands of modernization and industrialization the landscape of mental disorders for neurosis includes a more encompassing label for effects of mental illness in women. As such, other non-white and non-middle or upper class groups gained more access into mainstream culture's attention due to the acknowledgement of their labor, and the improvement of modern measures and modalities to track and record mental illness. In a work and role-fixated society, nerve exhaustion or nervousness became the fashionable label for those that could not perform their societal duties—duties ascribed by white hegemonic and capitalistic society.

Despite the new growing racial and ethnic diversity in the United States, the reported neurosis cases consisted mainly of white men or women. White women neurotics belonged to the middle or upper classes, and did not fulfill the demands in the feminine sphere. Plenty of the literature towards neurosis, whether epistemological, empirical, scientific, fictional, or historical focuses on white women. This trend is shown in psychoanalysis and women's literature (such as Betty Friedan's *Feminine Mystique*). Despite labor demand for women in the workplace, white male society demanded the middle class and upper class woman to be at home, and embrace her

womanly duties as a housewife. This became an issue due to the counter demands placed on women during and after war. The burden of the fit American culture rested on her shoulders.

In regards to neurosis and other ethnicities and races, Hispanic and Black/African-American women were also affected as they gained more access into mainstream white male hegemonic society. African Americans and Hispanic or Latina populations did also have high rates neurasthenia or neurosis, yet not as defined as for the white population. Unlike white women with symptoms due to pressure to fulfill domestic roles, other ethnicities had struggles with neurosis as they assimilated into mainstream white society, the labor demands and danger placed on them, and the rising pressures of a new role in society with civil rights. Indeed, the busy agenda of ethnic and racial minorities in civil rights issues, the previous lack of knowledge and inclusion of non-white women might also correlate to their minimal inclusion in the literature. In Hispanic women, one of the few neurological clinical disorders explored consists of psychosomatic disorders. For example, *Ataque de nervios,* a response to acute stress with brief and sometimes recurrent episodes of seizure-like responses, suicidal fits, and panic-like responses became a milestone for Latina and Hispanic women's mental health culture-bound syndromes (Oquendo, 1995, p.138). But regardless of the ubiquity of this disorder in the female Hispanic population, the mental health of Hispanic women included narrow populations within Hispanics, such as Mexican-Americans and Puerto Ricans (Trevino, 1977; Stoker, Zurcher, & Fox, 1968).This corresponds with the immigration waves and predominant populations of these nationalities in the country that exerted their presence. The studies focused on Hispanic populations in the twentieth century document a high rate of psychoneurosis in Hispanic Americans than for non-Hispanic whites (Vega, Kolody, & Warheit, 1985, p.523). Moreover, Mexican-Americans had higher cases and prevalence of psychoneurosis, yet this trend was more

pronounced for Spanish-speaking Mexican-Americans who had recently migrated to the country (Vega, Kolody, & Warheit, 1985, p. 526). This suggests the use of acculturation to marginalize Hispanics from society, and their inability to fit into American culture as a contributing factor to their neurosis. Furthermore, as Hispanics became a driving labor force in the country, their inability to perform their work roles posed a problem for their day to day wellbeing and mental health. Hispanics were seen as foreigners, and still not part of the American society; as such, only their symptomatology was studied due to the lack of priority given to develop modalities for unknown interlopers (Office of the Surgeon General, CMHS, & NIMH, 2001, p. 130). As a result, little is known about Hispanic women and neurosis in the academic literature that is representative.

For Black women the trend in literature suggests a growing inclusion into the mainstream mental health as Psychotherapeutic modalities for black women were developed following the first surveys on health for blacks included during 1970s (Jones & Gray, 1984 , pp. 24 & 26). As a result, new psychotherapeutic methods striving to adapt to the black female patient were created (Cohen, 1974). Such methods and services suggested the prevalence of depression and anxiety in black women related to work and family issues (Jones & Gray, 1984, p.24). As a matter of fact, this research conveys a similarity to white women's condition of neurosis, but it also suggests the existing interracial disparities of the time. White middle and upper class women had neurosis due to the lack of involvement in the labor force, whereas black women had to deal with discrimination and low paying jobs. But aside from the cases explored, this period reflects a significant lag of research focusing on Black women. Their absence in research suggests the continuation of neglect given to the mental health of black women. Indeed, an explanation of lack of mental health literature for black women consists as the continuation of medical

experiments on them. An example of this consisted of the Tuskegee syphilis experiments as well as sterilization of black women (Okeke, 2013, p. 4). The trauma caused by the perpetuation of medical exploitation caused mistrust of health services in American society, also including mental health. Therefore, regardless the progress of mental health treatments for the African American and Black community, the systematic marginalization persisted in the attitudes of mainstream society. As such, the African American and/or Black culture had to resort to community services and support for spiritual and mental health as in prior times (Houle, 2003, p.102).

During the twentieth century in the United States disability took various faces, one of them the mental illness of women in a high demanding society. Women, like other marginalized groups, were faced with the struggle of acculturation. In this case, each culture had to adapt to superior demands of entrance into mainstream society. Meeting or failing to meet those expectations of white hegemonic and capitalistic society attributed normality or abnormality to people. As a mark of abnormality, mental illness signaled the failure to enter mainstream society as minorities had weaker bodies and minds that could not take the load of these requirements of fitness of Americans. Therefore, nervousness was the term coined for a disease of over civilization (Briggs, 2000, p. 246). This term suggests the development of a mental illness due to the inability of sub-groups and minorities in society to stand equal to superior groups in society. So, whether unfit to be the perfect domestic white upper-middle class woman, or the adapted immigrant worker, or the perfect submissive and supportive black woman, the women with a neurotic disorder stand as proof of how rebelling against an oppressive powerful system can further marginalize them.

2000's (Current society):

Depression and Anxiety

Contemporary society has a mental disorder phenomenon of a ubiquitous presence… Anxiety and depression. It has become the face of women's mental health struggles as it affects many women more than men (National Institute of Mental Health [NIMH], 2010), with medication and psychotherapy as the best treatment modalities (NIMH, n.d.). Thanks to more inclusive research and culturally sensitive methods developed due to civil rights and multicultural awareness, the study of depression and anxiety in women includes a wider range of cultures. As a consequence, these measures allow for accessibility to a more diverse multi-cultural population, as well as a more inclusive definition for minority populations. However, depression and anxiety affect women from different ethnic and racial backgrounds differently, and these differences suggest a racial and ethnic factor that predisposes certain women to be diagnosed with these disorders more than other women.

In the case of White/Caucasian women, one of the major sub-diagnosis of anxiety disorder, panic disorder, is higher in non-Hispanic whites (Levine et al., 2013, pp. 711-712). Also, white Caucasian women use more pharmacological treatments when compared to black women for depression and anxiety disorders (Brown, Bromberger, Schott, Crawford, & Matthews, 2014, p. 551). This phenomenon suggests the utilization, and if not, the over utilization of mental health services by white women. It appears as if the mental illness label still haunts white women and places them in a less favorable state of inferiority. Prior to the twenty-first century, their disability revolved around their physical inability to compare to the white

man, yet today white women have equal rights and access as the white man. Their main obstacle today to equality consists of the psychologically rooted tradition of their feminine roles to prevent their achievement of equality. White women are seen as weaker because their thought processes, and how their brains function.

When compared to White women and the rates of depression and anxiety, Hispanic and Black women are less likely to be diagnosed with an anxiety disorder or to have a major depression disorder (NIMH, 2010; Substance Abuse and Mental Health Services Administration [SAMHSA]& Center for Behavioral Health Statistics and Quality [CBHSQ], 2015a; 2015b). For Hispanic women, as a growing and predominant ethnic group of the United States, Mexican American women make up most of the mental health population studied (Gonzalez, Haan, & Hilton, 2001, p. 948). As such, this group still envelops a significant part of the Hispanic image in the United States, and their mental health is used as a blueprint for other Hispanic nationalities. According to the research, Latinas experience more depression and are less likely to receive mental health support than White women or African American women (Shattell, Smith, Quinlan-Colwell, & Villalba, 2008). Nevertheless, despite this high incidence and prevalence of depression they seldom seek treatment and adhere to the treatment modality given and available (Kanter, Santiago-Riviera, Rusch, Busch & West, 2010; SAMHSA & CBHSQ, 2015c). A correlated factor may be that Hispanic women are less likely to have a social dysfunction due to depression, therein see no need to get help (Lanza et al., 2012, 486). Similarly to Hispanic women, African American women when compared to Caucasian women tend to get less treatment or seek treatment at all for depression and anxiety (Brown et al., 2014, p. 551; SAMHSA & CBHSQ, 2015c). A contributing factor to this is how African women are less likely

to report high depressive symptoms compared to Caucasian/white women (Lanza et al., 2012, p. 486).

The depression and anxiety trends in racially and ethnically diverse women clearly show the role of culture and the emphasis on inter-cultural differences as inhibiting factors to equal mental health care. Although history and the mental disorders for women have changed, even in today's society their unchanged stereotypes are still present; society still has the afflicted cocktail drinking white middle class woman overworked with psychotherapy, the hard working Latina or Hispanic woman bearing through her own symptoms, and the tough black woman not reporting her symptoms due to her doubting the white system. New technology, more inclusive studies, and more culturally sensitive measures still reinforce the negative outlook on women with mental health issues and the racial and ethnic barriers between them. The data does show a progress in the inclusivity of racially and ethnically diverse women in mental health, but the negative stigmas due to mental health and anti-nonwhite attitudes continue to show in the mental health of women. Difference is not seen as a positive diversifying factor, yet as a disability present in a perfectionistic society. Indeed, this is shown as today there is the knowledge of existing diverse outward manifestations of affective and cognitive states according to ethnic, racial, and cultural factors, yet these factors are often subject to fault, attributions by those who do not share the characteristics (Lindsey, Paul, & Mariotto, 1989). The literature today boasts about cultural inclusivity and sensitivity, yet it focuses in the surface of the intercultural disparities and differences without targeting the basic causes (Williams, Lavizzo-Mourey, & Warren, 1994, p.36). For example, common knowledge today shows that the Hispanic and Latina population are diverse, but despite this studies still do not include a representative measure that envelops its diversity. This poses a problem due to the ambiguous and ambivalent definition of a

minority (Williams, Lavizzo-Mourey, & Warren, 1994, p.37); therefore, today's society still lags behind equality and acknowledgement of others culture.

An all-encompassing Conclusion:

The marginalization and oppression of a group of individuals is proven by their absence in the literature of society. History is written by the winners, and if the winners do not see the need or benefit on including others into reality marginalization and other social problems occur. As a matter of fact, the sense of superiority of one group to not include others' reality in history, and imposing superior terms of definition is a tradition. The "othered" groups, such as women and racial and ethnic minorities are excluded from rights and resources in life, and research reflects this. Research consists of a human tool, and social attitudes permeate in research. For example, the study of white women for hysteria shows a sense of putting the white woman on a feminine pedestal; the limited study of diverse Hispanic Americans reflects a sense of neglect to foreigners, and the pure physical study of African Americans reflect their objectification. The mental health of women and racially and ethnic minorities further shows the intersection of disabilities related to mental illness, sex, race, and ethnicity. Today, although things have changed and these populations have been included in the "normal" system, the micro attitudes of unwanted disabilities against them still dominate the literature. As long as people are seen as lacking, they shall be shunned upon. In order to prevent this, a group of individuals willing to include mental health of different women and their ethnicities into the literature are needed (Williams, Lavizzo-Mourey, & Warren, 1994, p.37). Personally, this lays in the hands of those sex and ethnic minorities to voice their opinion. Yet changes will not reproduce and come about until the "superior" sex and race also acknowledges the lack of inclusion and equality of the

"other." This is a work of multiple people; those seen as disabled need to be heard, and everyone should collaborate for their cause.

References

Beard, G. M. (1881). *American nervousness: Its causes and consequences*. New York, NY, US: G P Putnam's Sons. doi:10.1037/10585-000

Briggs, L. (2000). The race of Hysteria: "Overcivilization" and the "savage" woman in late nineteenth-century obstetrics and gynecology. *American Quarterly*, *52*(2), 246–273. Retrieved from http://www.jstor.org/stable/30041838

Brown, C., Bromberger, J. T., Schott, L. L., Crawford, S., & Matthews, K. A. (2014). Persistence of depression in African American and Caucasian women at midlife: Findings from the Study of Women Across the Nation (SWAN). *Archives of Women's Mental Health*, *17*(6), 549-557. doi:10.1007/s00737-014-0444-5

Cohen, A. I. (1974). Treating the Black patient: Transference questions. *American Journal of Psychotherapy*, *28*(1), 137-143. Retrieved from http://www.ajp.org/

Gary, F.A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26(10), 979-999.* doi: http://dx.doi.org/10.1080/01612840500280638

González, H. M., Haan, M. N., & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results of the Sacramento Area Latino Study on Aging. *Journal of The American Geriatrics Society*, *49*(7), 948-953. doi:10.1046/j.1532-5415.2001.49186.x

Houle, A. L. (2003). *Psychoanalysis, western culture, and African-Americans: A conflicted past--a hopeful future* (Order No. 3098524). Available from ProQuest Dissertations & Theses Global. (305227732). Retrieved from http://search.proquest.com/docview/305227732?accountid=10920

Jones, B. E., & Gray, B. A. (1984). Similarities and differences in Black men and women in psychotherapy. *Journal of the National Medical Association*, *76*(1), 21–27. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/journals/655/

Kanter, J. W., Santiago-Rivera, A. L., Rusch, L. C., Busch, A. M., & West, P. (2010). Initial outcomes of a culturally adapted behavioral activation for Latinas diagnosed with depression at a community clinic [Abstract]. *Behavior Modification, 34(2), 120-144.* doi: 10.1177/0145445509359682

Lanza di Scalea, T. T., Matthews, K. A., Avis, N. E., Thurston, R. C., Brown, C., Harlow, S., & Bromberger, J. T. (2012). Role stress, role reward, and mental health in a multiethnic sample of midlife women: Results from the Study of Women's Health Across the Nation (SWAN). *Journal of Women's Health (15409996), 21*(5), 481-489. doi: 10.1089/jwh.2011.3180

Levine, D. S., Himle, J. A., Taylor, R. J., Abelson, J. M., Matusko, N., Muroff, J., & Jackson, J. (2013). Panic disorder among African Americans, Caribbean blacks and non-Hispanic whites. *Social Psychiatry and Psychiatric Epidemiology*, *48*(5), 711-723. doi:10.1007/s00127-012-0582-x

Lindsey, K. P., Paul, G. L., & Mariotto, M. J. (1989). Urban psychiatric commitments: Disability and dangerous behavior of Black and White recent admissions. *Hospital & Community Psychiatry*, *40*(3), 286-294.

National Institute of Mental Health. (2005). *Any anxiety disorder among adults.* Retrieved from http://www.nimh.nih.gov/health/statistics/prevalence/any-anxiety-disorder-among-adults.shtml

National Institute of Mental Health. (2010).Who is at risk? In *Generalized anxiety disorder*. Retrieved from http://www.nimh.nih.gov/health/topics/generalized-anxiety-disorder-gad/index.shtml

National Institute of Mental Health. (n.d.). *Depression.* Retrieved from http://www.nimh.nih.gov/health/topics/depression/index.shtml#part_145396

Office of the Surgeon General, Center for Mental Health Services, & National Institute of Mental Health. (2001). Mental health care for Hispanic Americans. In *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General* (chapter 6). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44247/

Okeke, A. (2013). A Culture of stigma: Black women and mental health. *Undergraduate Research Awards* (Paper 13). http://scholarworks.gsu.edu/univ_lib_ura/13

Oquendo, M. A. (1995). Differential diagnosis of ataque de nervios. *American Journal of Orthopsychiatry, 65*(1), 60-65. doi:10.1037/h0079589

Pouba, K., & Tianen, A. (2006). Lunacy in the 19th century: Women's admission to asylums in United States of America. *Oshkosh Scholar, 1*, 95-103. Retrieved from http://digital.library.wisc.edu/1793/6687

Shattell, M. M., Smith, K. M., Quinlan-Colwell, A., & Villalba, J. A. (2008). Factors contributing to depression in Latinas of Mexican origin residing in the United States: Implications for nurses [Abstract]. *Journal of the American Psychiatric Nurses Association, 14*(3), 193-204. doi:10.1177/1078390308319034

Smith-Rosenberg, C., & Rosenberg, C. (1973). The female animal: Medical and biological views of woman and her role in nineteenth-century America. *The Journal of American History, 60*(2), 332–356. http://doi.org/10.2307/2936779

Sterling, D. (Eds.). (1984). *We are your sisters: Black women in nineteenth century*. New York, NY: W. W. Norton & Company.

Stoker, D. H., Zurcher, L., & Fox, W. (1968). Women in psychotherapy: A cross-cultural comparison. *International Journal of Social Psychiatry*, *15*(1), 5-22. doi:10.1177/002076406901500101

Substance Abuse and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality. (2015a). [Table 1.106A Major Depressive Episode (MDE) in the Past Year among Persons Aged 18 or Older, by Demographic Characteristics: Numbers in Thousands, 2005- 2014]. *Results from the 2014 National Survey on Drug Use and Health: Mental health detailed tables*. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.pdf

Substance Abuse and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality. (2015b). [Table 1.106B Major Depressive Episode (MDE) in the Past Year among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2005-2014]. *Results from the 2014 National Survey on Drug Use and Health: Mental health detailed tables*. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.pdf

Substance Abuse and Mental Health Services Administration & Center for Behavioral Health Statistics and Quality. (2015c). [Table 1.108B Received Treatment for Depression in the Past Year among Persons Aged 18 or Older with Past Year Major Depressive Episode (MDE), by Demographic Characteristics: Percentages, 2009-2014]. *Results from the 2014 National Survey on Drug Use and Health: Mental health detailed tables*. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.pdf

Trevino, F. M., & Bruhn, J. G. (1977). Incidence of mental illness in a Mexican-American community [Abstract]. *Psychiatric Annals, 7*(12), 33-51.

Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17, 351-383.* Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1881264

Vega, W. A., Kolody, B., & Warheit, G. (1985). Psychoneuroses among Mexican Americans and other whites: prevalence and caseness. *American Journal of Public Health, 75*(5), 523–527. Retrieved from http://www.ajph.org/

Williams, D. R., Lavizzo-Mourey, R., & Warren, R. C. (1994). The concept of race and health status in America. *Public Health Reports, 109*(1), 26–41. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1402239/?page=11