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Skin Colour, Perception of Racism and Depression among Adolescents in Urban Brazil

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Background: The relation between race, ethnicity and health has been recognised as having an important role in the understanding of social inequalities in health. In Brazil, miscegenation (the mixing of different ethnicities or races, especially in marriage) is recognised as a sign of racial tolerance, but individuals with black skin colour have poorer social and health indicators than whites. The hypothesis that perceived racial discrimination is associated with depression and depressive symptoms among adolescents living in a Brazilian urban area is analysed, taking into consideration sociodemographic variables, socioeconomic status and skin colour. **Method:** This paper presents results from a cross-sectional study carried out with a random one-stage cluster sampling of households in the city of Salvador, Bahia, Brazil. The study population comprises 973 individuals from 10 to 21 years of age who answered questionnaires about racial discrimination, sociodemographic and health-related variables. Major depression according to DSM-IV criteria was assessed using a validated Portuguese version of the Patient Health Questionnaire (PHQ). The overall prevalence of major depression was estimated as 10.4%. **Results:** No statistically significant differences were found for prevalence of major depression or any depressive symptom according to skin colour (Black versus non-Black). However, adolescents who reported racial discrimination were more likely to have major depression, even after adjustment for age, sex, socioeconomic status, skin colour and self-esteem (Adjusted Prevalence ratio = 2.00, 95% Confidence Interval: 1.37–2.97). Low self-esteem was not associated with racial discrimination. **Conclusion:** Depression among adolescents is a common disorder. Skin colour, a biological component of ethnic differences, was not a factor associated with depression or depressive symptoms. Instead, the perception of racial discrimination was a strong potential risk factor for major depression in this population group, which needs to be addressed in further studies and considered in preventive and mental health care programs.

Keywords: Depression; depressive symptoms; skin colour; racial discrimination; adolescents.

Introduction

The relation between race, ethnicity and health has been recognised as having an important role to the understanding of social inequalities in health. A review of population-based studies shows that, in developed countries minority ethnic groups identifiable by darker skin colour have increased mortality and prevalence of poor self-perceived health, physical diseases and mental health problems (Nazroo, 2003). Although other factors also contribute to racial disparities in health, more recent studies clearly indicate that racism plays a key role to the understanding of the relations between race, ethnicity and health outcomes, particularly mental health problems (Nazroo, 2003; Williams, Neighbors, & Jackson, 2003). Several studies described a consistent increased frequency of depression or depressive symptoms among adults who perceived racial discrimination (Kessler, Michelson, & Williams, 1999; Noh et al., 1999; Finch, Kolody, & Vega, 2000; Karlsen & Nazroo, 2002; Karslen et al., 2005) or among adolescent populations (Johnson, 1994; Whitbeck et al., 2001; Szalacha et al., 2003; Wong, Eccles, & Sameroff, 2003).

Explanations for these findings are still under discussion: one hypothesis is that racism is a risk factor for depression because of the stress from unfavourable life conditions or social exclusion prevailing among most ethnic minorities, while the other assumes that racism is a psychological pathogen by itself, a consequence of living under stigma, segregation and discrimination (Nazroo, 2003). Low socioeconomic status is the most consistent predictor of common mental disorders such as anxiety, minor depressive states and stress (Dohrenwend et al., 1992) and since racial discrimination is strongly related to poverty, socioeconomic status needs to be taken into account when this hypothesis is examined. Interestingly, the association between racial discrimination and depression

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remains after adjustment by socioeconomic status (Noh et al., 1999; Karlsen & Nazroo, 2002; Wong et al., 2003), although some critiques have been made about the way this variable is defined, conceptualised or measured (Nazroo, 2003). In support of the second hypothesis, observational (Kessler et al., 1999) or experimental (Jones et al., 1996) studies suggested that discrimination comprises a specific and important origin of stress that is responsible for mental health problems (Meyer, 2003).

Results from recent research also reveal that effects of racial discrimination on health may be mediated by low self-esteem (Mossakowski, 2003), social support networks and coping strategies (Noh & Kaspar, 2003). Individuals who reported perceived racial discrimination are more likely to have symptoms of internalised conflicts, a more common response among girls and young individuals, that may lead to an enhanced acceptance of dominant norms and rules of a given group, which may result in hate against oneself or cause depressive feelings (Whitbeck et al., 2001).

Considering that childhood and adolescence are both crucial phases in the life course, when sexual, cultural and social identities are formed, it is plausible that social exclusion and experienced or perceived racial discrimination at that age may cause even more intense damages to mental health (Wong et al., 1993). The sense of group belonging (alikeness), adjustment and peer acceptance (Williams-Morris, 1996) are also developed in these life stages. Several studies on race or ethnicity and depression among children and adolescents have been reported (Roberts, Roberts, & Chen, 1997; Rickert, Wiemann, & Berenson, 2000), but they have not addressed the racism experience and perception as a relevant variable on the association between race and mental health in young age groups. An exception is Johnson's (1994) finding of a strong association between racial discrimination and depressive symptoms among Native American children.

Brazil, the country that holds the largest number of Afrodescendents in the world, has been for a long time described as a racial democracy (Heringer, 2002). Nevertheless, the growth and strengthening of black movements in the last decades led to a renewed interest in the social impact of racial discrimination, not always open or visible, even to the victims themselves. Epidemiologic studies on race, ethnicity and depression in Brazilian populations are scarce and do not focus on children or adolescents. Census data have shown that individuals considered to be black, mulattoes or mestizo hold unfavourable social and health indicators across different regions of the country (Heringer, 2002; Chor & Araujo-Lima, 2005). With the purpose of contributing to a better understanding of this issue, in a setting where the majority of the population is black, in this paper the hypothesis that having black skin colour and perceived experience of racial discrimination are positively associated with major depression and depressive symptoms among adolescents is tested, taking into consideration age, sex, and socioeconomic status.

Method

Data analysed in this study come from the baseline of a cohort study about work conditions and health carried out with a sample of individuals living in Salvador, capital city of Bahia State, Brazil in the year 2000. In this historical urban area, there were approximately 2.7 million inhabitants, mostly poor, black or mulatto. The study population comprises children and adolescents 10 to 21 years of age. Households were selected by a random single-stage area sampling design, based on predefined sub-areas of the city official urban plan. Sample size was defined based on parameters related to the main hypotheses of the cohort study. From 32 selected sub-areas needed to obtain the required number of individuals, three had no households and were excluded. In the remaining 29 areas, all households were visited and one family member provided general sociodemographic information about each family member. Further visits were scheduled to complete individual interviews for data collection on other sociodemographic characteristics, ethnicity, work conditions, and several health outcomes, including depression, suicidal ideas and low self-esteem. Interviewers were trained and answers checked for internal consistency by supervisors. A sub-sample of families was visited for double checking. When applicable, missing information was obtained by phone interviews. Research instruments were based on a conceptual map developed in accordance with the existing literature, theoretical models and personal experiences of the epidemiology and the ethnographic staff members, social movement leaderships, labour unions and health professionals. The language and operational feasibility of instruments were appropriately tested in a pilot study, and the study protocol approved by Internal Review Boards from the University of Texas, Health Science Center at Houston and the Federal University of Bahia.

Skin colour assessment was made by the interviewer using a 7-categories classification: black, white, mulatto, brown (moreno), yellow, indigenous, other. Because of small numbers, black and mulattoes were analysed as black, and all remaining groups considered non-black. The experience of racial prejudice was assessed by means of answers given to the following questions: 1) 'Have you ever been impeded access to social clubs, shopping malls, carnival groups (a very popular aggregate of people who dress in similar costumes to outdoor carnival parties) or hotels?', and when the answer was positive, 'Did you consider that it happened to you because of your skin colour?'; 2) 'Do you think your skin colour makes it difficult to have access to loans or other bank services?' 3) 'Have you ever noticed that you have been targeted by racial prejudice? 4) 'Have you ever had difficulties getting a job because of your skin colour?' Positive answers were coded as 1 and negative as 0. An individual score was calculated by summing up corresponding values, which was analysed dichotomously: at least a positive answer = 1 and no positive answers = 0.

Mental health was assessed using the Patient Health Questionnaire, PHQ, developed by Spitzer et al. (1999), which was translated to Portuguese, after evaluation of adequacy with back translation and tested for reliability as compared to psychiatric diagnosis. An overall agreement of 70.6% and a Kappa Index of 0.25 were estimated. Major depression diagnosis was based on the criteria recommended by DSM-III-R and DSM-IV

(Spitzer et al., 1999). Suicidal ideas, suicide planning and feeling unhappy or unhealthy were registered from answers given to specific questions with answers yes/no. To assess self-esteem a list of assertions was read to each study participant: 'I feel a worthless person'; 'I feel that I have nothing that makes me proud of'; 'I feel that I am useful'; 'I feel that I'm not capable to do anything right'; 'I feel that my life is not very useful'; to which they were asked to choose one of the following alternative answers: 0) never; 1) rarely; 2) sometimes; 3) frequently, and 4) almost always. This check list was developed by Roberts et al., (1997).

Age was analysed in three categories (10–14, 15–17 and 18–21 years of age) and as a continuous variable for modelling. Other covariates were sex, socio-economic status (based on the total number of a list of goods and assets of the family categorised as low: less than two items; medium - three to five items; and high - over five items); having paid jobs, and type of family categorised as nuclear (both parents), single parent, and other type. Lack of social support was defined from answers given to questions corresponding to two questions about availability of people to help in emergency situations or to take care of children, elders or ill individuals in the family, which answers were classified as always, several times, a few times and never. Because of sparse data answers lack of social support were analysed as yes (at least one positive answer to a few times or never) and no for the remaining.

Prevalences were estimated and compared using the Pearson Chi Square using a .05 significance level. Prevalence ratios were used to estimate associations, calculated from unconditional logistic regression parameters. Potential effect modifiers were skin colour and self-esteem, analysed by means of maximum likelihood ratio tests for modelling fitting for corresponding product terms. Adjustment variables were selected based on empirical or theoretical evidence of the relevant role for the hypotheses under study, such as age, sex, and socioeconomic status left in the final models. The Delta Method was used to calculate confidence intervals for prevalence ratios (Oliveira et al., 1997). Data entry was conducted by two distinct individuals using EPIINFO-6.0 (CDC, 1995) which allows for double checking and correction of mistakes. The statistical analysis was performed with SAS 8.11 (SAS, 1999/2000). Adjustment for the sampling design was performed to the final estimates but did not change considerably non-adjusted estimates.

Results

From a total of 2361 individuals from 10 to 21 years of age, 1049 reported having a paid job, or were responsible for unpaid domestic family chores for at least eight hours a week, which made them eligible for individual interviews. Approximately 76 refused to participate (7.2%) so reducing the study population to 973 subjects. The study population was mostly composed of females (68.9%), individuals 18 to 21 years (54.1%), from low socioeconomic status (58.1%), nuclear families (56.6%), and who reported having social support (92.4%). The majority was identified as having black skin colour (64.9%). The overall proportion of subjects that recall a racist experience was estimated as 19.4%, higher among individuals of black skin colour (25.4%)

Table 1. Characteristics of the study population according to the perceived racial discrimination

	Perceived racial discrimination				Total	
	Yes		No			
Variables	$n = 189$	%	$n = 784$	%	$n = 973$ (19.4)[1]	%
Sex						
Female	136	72.0	534	68.1	670 (14.0)	68.9
Male	53	28.0	250	31.9	303 (17.5)	31.1
Age range						
10–14	31	16.4	148	18.9	179 (17.3)	18.4
15–17	52	27.5	216	27.6	268 (19.4)	27.5
18–21	106	56.1	420	53.6	526 (20.2)	54.1
Socioeconomic status						
Low	119	63.0	446	56.9	565 (21.1)	58.1
Medium	52	27.5	241	30.7	293 (17.8)	30.1
High	18	9.5	97	12.4	115 (15.7)	11.8
Family type						
Nuclear	109	57.7	442	56.4	551 (19.8)	56.6
Single parent	59	31.2	259	33.0	318 (18.6)	32.7
Others	21	11.1	83	10.6	104 (20.2)	10.7
Lack social support						
No	177	94.7	696	91.8	873 (20.3)	92.4
Yes	10	5.4	62	8.2	72 (13.9)	7.6
Paid job						
Yes	78	41.4	345	44.1	423 (20.2)	43.5
No	111	58.7	439	55.9	550 (18.4)	56.5
Skin colour						
Non-Black	29	15.3	313	39.9	342 (8.5)[2]	35.1
Black	160	84.7	471	60.1	631 (25.4)	64.9

[1]Numbers within parentheses correspond to the proportion of perceived racial discrimination.[2]$p < .0001$

Table 2. Prevalence of major depression, depressive symptoms and corresponding prevalence ratios and 95% Confidence Intervals for the association with perceived racial discrimination ($n = 973$)

	Prevalence (%)				
		Perceived racial discrimination			
Depression and depressive symptoms	Total ($n = 973$)	Yes ($n = 189$)	No ($n = 784$)	Crude Prevalence ratio	95% Confidence Interval
Major depression (DSM-IV, (Patient Health Questionnaire)	10.4	17.5	8.7	2.01	1.37–2.96
Depressive symptoms					
Little interest or pleasure in doing things	32.4	40.7	30.4	1.34	1.10–1.64
Feeling down, depressed or hopeless	19.3	30.2	16.7	1.80	1.38–2.36
Trouble falling or staying asleep or sleeping too much	26.8	33.9	25.0	1.35	1.07–1.71
Feeling tired or having little energy	30.3	33.9	29.4	1.15	0.92–1.45
Poor appetite or overeating	39.3	38.6	39.5	0.98	0.80–1.19
Feeling bad about yourself or that you are a failure	13.4	22.2	11.2	1.98	1.42–2.75
Trouble concentrating on things	23.2	27.7	22.2	1.25	0.96–1.63
Moving or speaking slowly or restless more than usual	20.4	27.0	18.8	1.44	1.09–1.90
Thoughts that you would be better off dead	7.8	14.3	6.3	2.29	1.45–3.56
Other depressive symptoms					
Suicidal ideas	10.4	14.8	9.4	1.57	1.05–2.35
Had planned suicide	6.5	10.5	5.6	1.87	1.07–3.00
Feeling unhappy	10.5	16.4	9.1	1.81	1.23–2.68
Feeling unhealthy	12.9	20.6	11.0	1.88	1.33–2.65
Low self-esteem (Robert et al., 2000)	8.2	10.0	7.8	1.29	0.79–2.11

than non-black (8.5%) (X^2, $p < .0001$). No other statistically significant differences were found (Table 1). As expected, a higher proportion of individuals rated as black (84.7%) were aware of situations of racial prejudice as compared to the non-black group (15.3%) (Table 1).

The prevalence of major depression was 10.4%, higher among those who reported racial discrimination (17.5%) than in the referent group (8.7%), a statistically significant difference (Prevalence Ratio, $PR_{crude} = 2.01$; 95% CI: 1.37–2.96) (Table 2). Eating (39.3%) and anhedonia symptoms (32.4%) were the most prevalent symptoms, in contrast with low frequency estimates of suicidal plans (6.5%) and low self-esteem (8.2%). Consistently, the majority of depressive symptoms used to assess clinical diagnosis of major depression (PHQ) was more common in the group aware of racial discrimination ($p < .05$), except for 'feeling tired or having little energy', 'poor appetite or overeating' and 'trouble concentrating on things'. In the group of other depressive symptoms, it is worth noticing the high prevalence of suicidal behaviour was more likely to be reported by adolescents who recall a racial prejudice situation ($PR_{crude} = 1.57$ 95%CI: 1.05–2.35 for suicidal ideas, and $PR_{crude} = 1.87$, 95%CI: 1.07–3.00 for suicide planning. Feelings of unhappiness or being unhealthy also were more common in the group who report experience of racism, as compared to those who did not report. Interestingly, low self-esteem was not statistically significantly associated with racial discrimination.

The logistic regression analysis showed that being coded by the interviewer as black was not associated with major depression or depressive symptoms for either crude or adjusted estimates (Table 3). However, perceived racial discrimination was positively associated with major depression with crude estimate ($PR_{crude} = 1.96$ 95%CI: 1.33–2.89) or after adjustment for potential confounding effects of age, sex or socio-

Table 3. Prevalence ratios (PR) and confidence intervals (CI) for the association between Black skin and major depression or depressive symptoms based on logistic regression models

Models	Major depression PR (95%CI)	Suicidal ideas PR (95%CI)	Had planned suicide PR (95%CI)	Feeling unhappy PR (95%CI)	Feeling unhealthy PR (95%CI)	Low self-esteem PR (95%CI)
Crude	1.12 (0.75–1.66)	0.99 (0.68–1.46)	1.26 (0.75–2.12)	0.95 (0.65–1.39)	1.07 (0.76–1.52)	1.26 (0.80–2.00)
Adjusted by age and sex	1.13 (0.76–1.67)	0.99 (0.68–1.45)	1.26 (0.75–2.10)	0.98 (0.67–1.44)	1.10 (0.78–1.55)	1.24 (0.79–1.97)
Adjusted by age, sex and SES	1.10 (0.74–1.62)	0.98 (0.68–1.43)	1.23 (0.74–2.06)	0.95 (0.65–1.39)	1.08 (0.76–1.53)	1.23 (0.78–1.94)
Adjusted by age, sex, SES and low self-esteem	1.06 (0.71–1.59)	0.94 (0.64–1.39)	1.20 (0.70–2.05)	0.88 (0.60–1.28)	1.05 (0.74–1.49)	—
Adjusted by age, sex, SES, low self-esteem and racial discrimination	0.92 (0.61–1.38)	0.84 (0.55–1.28)	1.09 (0.61–1.93)	0.75 (0.50–1.13)	0.86 (0.59–1.26)	—
Adjusted by age, sex, SES, and racial discrimination	0.94 (0.63–1.41)	0.88 (0.59–1.32)	1.14 (0.67–1.94)	0.81 (0.54–1.21)	0.91 (0.63–1.33)	1.22 (0.77–1.94)

Confidence Intervals based on Delta Method. No effect modifiers were found.

Table 4. Prevalence ratios (PR) and confidence intervals (CI) for the association between perceived racial discrimination and major depression or depressive symptoms based on logistic regression models

Models	Major depression PR (95%CI)	Suicidal ideas PR (95%CI)	Had planned suicide PR (95%CI)	Feeling unhappy PR (95%CI)	Feeling unhealthy PR (95%CI)	Low self-esteem PR (95%CI)
Crude	1.96 (1.33–2.89)	1.57 (1.05–2.35)	1.79 (1.07–2.99)	1.81 (1.23–2.68)	1.88 (1.33–2.65)	1.29 (0.79–2.10)
Adjusted by age and sex	1.99 (1.35–2.92)	1.55 (1.04–2.30)	1.77 (1.07–2.95)	1.74 (1.18–2.56)	1.81 (1.29–2.54)	1.29 (0.79–2.10)
Adjusted by age, sex and SES	1.97 (1.33–2.91)	1.55 (1.04–2.30)	1.75 (1.05–2.92)	1.69 (1.15–2.50)	1.80 (1.28–2.55)	1.31 (0.79–2.16)
Adjusted by age, sex, SES and skin colour	1.88 (1.25–2.81)	1.58 (1.03–2.43)	1.75 (1.03–2.98)	1.74 (1.16–2.62)	1.86 (1.28–2.70)	1.21 (0.73–2.03)
Adjusted by age, sex, SES, skin colour and low self-esteem	1.76 (1.18–2.62)	1.47 (0.96–2.24)	1.67 (0.98–2.83)	1.69 (1.11–2.58)	1.92 (1.31–2.82)	—-

Confidence Intervals based on Delta Method. No effect modifiers were found.

economic status ($PR_{adjusted} = 1.97$ 95%CI: 1.33–2.91. The introduction of skin colour and self-esteem in the model did not change substantially the association ($PR_{adjusted} = 1.76$ 95%CI: 1.18–2.62) (Table 4). Similar results were found for each depressive symptom even after adjustment for all covariates, except for suicidal ideas and planned suicide whose correspondent prevalences did not differ according to racial discrimination after adjustment for self-esteem (Table 4). Self-esteem was not associated with reported experience of racism, nor changed the direction or magnitude of the association with major depression based on maximum likelihood ratio tests. No relevant changes were observed between crude and adjusted estimates of the association between skin colour or perceived racial discrimination with major depression or any depressive symptom considered.

Discussion

In this study, approximately one-fifth of the study population reported at least one situation in their life-time when they were targeted by racial-related prejudice. Low self-esteem, a well-known depressive symptom, was not more common in the black population nor among those reporting racial discrimination. Also, low self-esteem was not found to be a mediator variable for the association between racial discrimination and major depression or any depressive symptom analysed (data not presented). The main finding, however, of this study is that major depression was more common among those who reported racial discrimination. This result did not change when other potential confounding variables such as age, sex, socioeconomic status, and skin colour were used to obtain adjusted estimates. Consistently, most depressive symptoms were more likely reported by those who described experience of racial discrimination than those who did not, except for lack of energy and eating problems.

However, discrimination is usually an everyday life experience, and probably occurs throughout the entire life, even before it is possible to be perceived or reported. It is also plausible that discrimination may affect health, depending on the frequency and intensity, or at individual (interpersonal) or institutional level, it may represent barriers to opportunities or access to resources (Karlsen & Nazroo, 2002). In addition to its subjective nature, there are questions about the validity of perceptions as an adequate expression of objective racial discrimination (Finch et al., 2000), in the way people interpret and feel more or less comfortable to speak about these events. It has been suggested that under-reporting of this type of prejudice can be beneficial for the respondent in the way that this conforms to social behaviour expected by dominant groups (Ruggiero & Taylor, 1997), a situation that can vary according to sex and social position (Karlsen & Nazroo, 2002). Also, healthy individuals may be more apt to deny stressful life events such as racial discrimination, thus avoiding negative affects (Meyer, 2003). However, experimental and longitudinal studies have not shown evidence in support of this statement (Wong et al., 2003; Brown et al., 2000). Another methodological caveat is the use of the Patient Health Questionnaire to identify major depression, not yet evaluated in adolescent population, but results are consistent with other community-based morbidity data.

Conclusions from these findings need to be made with caution because of methodological drawbacks. First, difficulties in the assessment of race and racial discrimination have been widely recognised (Bhopal, 2004), leaving room for measurement bias. Second, the cross-sectional study design and the lack of data regarding the time and frequency of situations of racial discrimination do not allow conclusion as to whether racial prejudice precedes or its perception follows the outcome in consideration. Third, questions about depressive symptoms cover four weeks, but their onset was not defined. It is possible that depressive mood facilitates the perception or reporting of negative experiences such as racial discrimination. Therefore, the association found may not reflect a causal relation but rather can be interpreted as a reverse causal pathway.

Despite these limitations, our results are comparable to those reported in similar studies. Several authors observed a positive association but most published research was conducted with adults, and only more recently a few studies examined this hypothesis among adolescents. In the previous studies, a positive association between racial discrimination and depression among adolescents was observed (Wong et al., 2003; Szalacha et al., 2003), but depressive symptoms were not yet addressed. Racial discrimination was positively correlated with depression among Black students when perceived to be caused by their classmates (Pearson coefficient, $r = -0.17$, $p < .001$) or teachers ($r = -0.23$, $p < .001$) (Wong et al., 2003). In the investigation

conducted by Szalacha et al. (2003), results are similar to those found in this study, a positive association between racial discrimination and depression, but not with self-esteem. Prevalence of major depression and depressive symptoms were close to estimates of other studies reviewed by Roberts et al. (1997). Based on DSM-III criteria, major depression estimates for 1-year prevalence was 9% in a middle school population (Garrison et al., 1992), and among adolescents from 15–24 years of age the 12-month prevalence of DSM-III-R major depression was 12.8% (Kessler et al., 1993). However, several authors have reported differences in depression and scores of depressive symptoms across ethnic groups (Roberts et al., 1997), even though some results are inconsistent. Comparison findings are limited because of distinctions in several methodological aspects, most often case definition and age range.

These findings support those reported in both cross-sectional or longitudinal studies (Brown et al., 2000), and they are also consistent with widely accepted theoretical models addressing life events as risk factors for mental symptoms (Dohrenwend, 2000). There is also biological evidence that supports the occurrence of physiological stressful reactions when individuals are exposed to situations of racism and discrimination (Harrel, Hall, & Taliaferro, 2003). Adolescence is a critical step in the life course because it is the time when sexual, cultural and social identities are formed and it is plausible that racial discrimination experienced and perceived at that age may affect mental health. In this life stage, there is also development of the sense of (alikeness) group belonging, adjustment and peer acceptance, which confers the feeling of being part of microsocial group arrangements (Williams-Morris, 1996).

It is commonly believed in Brazil that a high level of tolerance concerning racial differences is the norm. Indeed, the city of Salvador was the government centre of the colony until 1750 and, between the 16th and 19th centuries, it was a major port of entry for the slave trade from Africa. This has deeply influenced its current ethnic and demographic profile–over 70% of the population is of African origin, mainly from *gege* (Yoruba) nations. These distinctive historical and cultural features are manifested in the arts, cuisine, the use of *nago* (Yoruba language), and particularly in the elaborate rituals of the Afro-Brazilian religions (Bastide, 1974). However, associations between ethnic discrimination and health outcomes were similar to those reported in studies conducted in UK (Nazroo, 2003) and in the US (Williams et al., 2003), where the history of racial discrimination, the struggles for advances of racial minorities and the racial ethnic categorisation are totally different. Therefore, the most intriguing finding from this study was that racial discrimination may be as common in a Brazilian urban environment, which holds a majority of Black inhabitants and maintains a rich, well-preserved African culture, as it is in the US, where Black Americans comprise a minority.

Theoretical explanations for these findings can be based on psychopathological processes, in which the biological bases of the construct 'race' raised from a phenotype perspective have little meaning when taken separately from the cultural and political dimensions of the ethnicity concept. Race is not the determinant of racism, rather, racial segregation or ethnic discrimination and other forms of oppression are rooted on structural inequity and symbolic stigma processes. The validity of this interpretation may be reinforced by the fact that no direct or isolated effect of race or ethnicity on mental health, as evaluated by depression and depressive symptoms, was found. Micro and macro social racist behaviour would directly determine chronic daily stress, as a consequence of segregation, oppression and humiliation. Acute stress may also be raised as a consequence of life events related to racial discrimination, as a barrier for school acceptance, for example. To affect the adolescent or young adult's mental health, such stressors may be mediated by the experience or perception of racism and ethnic discrimination. In addition, coping strategies and other mechanisms of psychological compensation, as increased self-esteem and reduction of social vulnerability, as exemplified by social support networks, may play the role of buffers in the aetiology of mental dysfunctions (Kawachi & Berkman, 2001).

This study adds to the knowledge that racial prejudice is associated with depression, and that there is individual resilience against ethnic determinants of psychological symptoms. Interestingly, socioeconomic status was not an important covariate for the hypothesis under consideration, and no evidence that self-esteem was affected by racial discrimination was found. It is possible that efficient coping mechanisms, culturally rooted, are bringing benefits concerning self-esteem in this population. A key point, to be addressed by further social psychological research, is how the individual perceives a particular experience as stressful or threatening beyond whatever in fact the experience is. A positive, robust self-identity, which includes cultural components of ethnic origins, may negate some of the noxious effects of racism, whereas someone with low self-esteem may even perceive racism where none was intended. This is particularly relevant to draw culturally sensitive strategies for prevention. It is of special importance for adolescents who face an intense cycle of emotional development and construction of social and cultural identity.

Our results, however, may be interpreted taking a broader perspective concerning mental health consequences of ideological and social forces, such as racism or other forms of discrimination (Krieger, 2000). There is a growing literature that attempts to refine and enlarge the Marxist concept of class by articulating it into theoretical frameworks to consider race/ethnicity (Anthias, 2001). In line with it, we should overcome the idea that youngsters and racial/ethnic minorities constitute the reserve army of labour of our times. Although being a promising hypothesis, this could be true for Western industrialised countries but it might not hold for poorer contexts such as urban Bahia. In such a framework, class needs to be redefined not only in terms of organisation and production of economic resources but also as differential consumption of material and non-material goods. In this connection, race/ethnicity must be considered not only in terms of production and reproduction of collective bonds related to biological or cultural background but also in terms of its prospects for concerted political action towards

eradicating racism and related oppression as roots of inequality and social injustice.

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