The Theoretical Relationship Between Materialistic Depression and Depression: Preliminary Data and Implications for the Azibo Nosology

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Materialistic depression is a culture-specific disorder of the African (Black) personality construct. Housed in the Azibo nosology, it is defined as a condition in which material goods or the lack of them serve as one's criteria for judging oneself and/or others. It is felt to be a major way that depression in contemporary Africans is expressed. A positive correlation between materialistic depression and general depression was hypothesized. Results supported the hypothesis as the correlation between materialistic depression measured by Black, Braithwaite, and Taylor's (1980) Materialistic Depression Quiz (MD Quiz) and general depression measured by Zung's Self-Rating Depression Scale was statistically significant and positive, albeit small. The pattern of correlations was consistent with materialistic depression theory. Gender differences in the pattern of correlations may also be suggested. Topics covered include the construct validity of materialistic depression, the measurement and conceptualization of depression in African people, and implications for the Azibo nosology.

Depression is a very serious disorder.

Major depressive illness can be severe, persistent and disabling of everyday bodily and social functioning. It is the most common psychiatric disorder and

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> can lead to suicide. . . . [It] is the most common cause for psychiatric hospitalization and the mainstay of outpatient psychiatric practice. (Harrold, 1989, pp. 10-11)

Depression as a disorder involves dysphoric feelings beyond the normal range of human emotions such as blueness, sadness, discouragement, and frustration to include worthlessness, self-reproach, guilt, wishing that one were dead, loss of energy and fatigue, indecisiveness, decreased ability to concentrate, oversleeping (or inability to sleep), and marked retardation of activity (or restlessness), among others. The depressive behavior including sadness and sleep and appetite disturbances associated with uncomplicated bereavement, the normal grieving process that shows improvement over time, is exceeded in depression. In addition, depression can occur as an emotional reaction to a medical condition (Harrold, 1989).

Depression can also involve a self-defeating cycle of progressive social isolation, which only serves to make the depression worse. Harrold (1989) explained,

> The complex symptoms [place] . . . the depressed individual . . . in a vicious cycle that complicates the illness. These complications often result from inability to function sexually, loss of job due to nervousness and concentration difficulties, and social isolation due to loss of interest in pleasurable things. (p. 13)

This is one prominent way in which the exacerbation of the depression of an individual removed from or in retrenchment from her or his normal social loop can be realized.

DEPRESSION AND AFRICANS IN THE UNITED STATES

Clearly, depression is not a lightweight topic for mental health in general. Regarding Africans, the topic of depression is overdue for serious African-centered theoretical and empirical attention. The trend in Euro-American mental health practice has been to outright misdiagnose Africans (Atwell & Azibo, 1991; Bell, 1988) and to overdiagnose Africans as having more severe prognosis (Myers & King, 1981). For example, "Black patients run a higher risk of being misdiagnosed as schizophrenics, whereas White patients showing identical behaviors are more likely to receive diagnoses as depressed"

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(White & Parham, 1990). This trend has prevented the topic of depression in Africans from receiving its deserved attention.

Fortunately, there have been some studies looking at depression and Africans. In summarization of her literature review, Brown (1990) reported that "between 20 and 30 percent of black Americans experience high levels of depressive symptoms. From 4 to 6 percent . . . can be clinically diagnosed as having a major depressive disorder" (p. 87). Duane Schultz (1992) cites Gibbs's (1989) report of "rates of severe depression as high as 15 percent, with the highest incidence found among male and low-income Black teenagers" (pp. 22-23). Gary and Berry's (1985) study of 142 African men in the United States found that 31% had depression scores indicating serious depressive symptoms and that income showed a statistically significant negative relationship with depression. Munford (1994) did not find social class to be related to depression in a study of students at a historically Black college. Her results did show that "Preencounter and encounter attitudes were positively related to levels of depression" (p. 157). According to Duane Schultz (1992),

> A study of urban 6th-grade African-American children found that more than one third could be classified as at least mildly depressed . . . at a school in a poorer neighborhood, the incidence of depression was twice that found in the first school. (p. 17)

Depression as a phenomenon among African children and youth should not be surprising; some regard depression as the most common psychological disturbance among adolescents (Steinberg, 1993). Also, as the 20th century closes, White world supremacy has wreaked such havoc on African life and development through the inferiorization process (Welsing, 1991, chap. 20, 21) as to place us at the precipice of genocide (Olomenji, 1996). As Dr. LaFrances Rodgers-Rose (1993) said in a powerful keynote lecture, "our children cannot help but be depressed."

Recently, depression in Africans has not gone without notice by some African clinicians. Gilbert Parks (1993) pointed out that, for African American male youth, depression manifests itself in "acting out" behavior. Therefore, diagnoses such as conduct disorder, socialized aggressive disorder, and the like may often be incorrect. Misdiagnosing depression as conduct disorder in African American youth leads to improper treatment psychologically and penologically and inappropriate removal from home to foster care and "receiving" home (incarceration).

According to Parks (1993), many depressive symptoms are not compatible with African American culture. Some depressive symptoms may look like

fear, social withdrawal, and weakness from the vantage point of African American culture. Such appearances set up the individual to be perceived as a target or as a "punk" or "chump," especially to certain segments of the population such as male youth. Thus, there may be a generative force within the culture for Africans not to display many depressive symptoms directly. Consider that "in response [to the Maafa] we have developed a facility called 'cool'. Don't let anybody know how you're feeling. Hide your sadness, your fears'" (Tucker, 1980, p. 41). The stigma placed on having a mental disorder within the culture might also contribute to a generative force militating against the direct manifestation of depressive symptoms.

Frances Welsing's (1988) observations are consistent with Parks's regarding the expression of depression through acting out behaviors, especially where children and youth are concerned. Within the process of inferiorizing Africans, she sees "sex obsession" and other "dependency deprivation" behaviors as surface manifestations of underlying depression.

MASKED DEPRESSION AND AFRICANS

Apparently, there is a strong case for masked depression in Africans. Masked depression as used here means depression that is conveyed in some form or activity other than the symptoms said to characterize depression in the prevailing Eurocentric nosologies, the *International Classification of Diseases* and *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994). In addition to the incongruence between the display of depressive symptoms and African-American culture and the stigmatization of having a mental disorder, two factors underlying the culture-based generative forces that may impede the direct expression of depression, there are at least two other factors that contribute to masked depression. One is the sheer cultural distinctness of Africans vis-à-vis Europeans, as against the idea of a cultural monism (Baldwin, Brown, & Hopkins, 1991). Rejecting the latter concept in favor of the former compels the admission that depression in Africans might not be isomorphic to depression in Europeans. It follows, then, that because the prevailing view of depression is Eurocentric in its conceptualization and assessments, whenever an African might suffer what in the Eurocentric context is regarded as depression, its expression might be conveyed differently or masked. It has been reported, for example, that "depression among Black males may be masked by alcohol use, cigarette smoking, and substance abuse" (Brown, 1990, p. 87).

The other contributing factor is the continuing reality of what Professor Marimba Ani has termed the Maafa, which means "great disaster . . . unbelievable misfortune of death and destruction . . . beyond human comprehension and convention . . . a total systematic and organized process of spiritual and physical destruction of African people" (Nobles, 1994, p. 10; Richards, 1989). As mentioned earlier, the devastation brought on by the Maafa is so great and cataclysmic as to be omnipresent. And, for the psychologically defeated African, it may be proof of omnipotence in Africans' ubiquitous and perpetual Eurasian enemy (ben-Jochannon, 1971; Williams, 1976). Depression, therefore, should be expected in response to the reality of the Maafa. However, straightforward manifestation of depressive symptoms under conditions that chronically induce depression (i.e., African life in the context of the Maafa) would itself militate against personality integrity. The personality would simply have to break down and disorganize substantially when the environment perpetually, chronically engenders depression. These conditions most likely warrant masked depression if for no other reason than the maintenance of personality integrity. It is even more certain that the fact of the perpetual depression brought on by the Maafa is contributory to the development of varied ways that Africans might exhibit depression.

MATERIALISTIC DEPRESSION

Ptah-Hotep's ancient proscription of material orientation (Azibo, 1989, p. 188; Karenga, 1984, p. 44) reveals it to be discordant with African-centered culture and psychological functioning. It is also very destructive socioculturally, as the Kemetic sage's observations attest:

> There . . . can be no confidence among those infected with it. It turns a kind friend into a bitter enemy. It causes conflict with fathers, mothers . . . and it separates the wife from her husband. It is a bundle of all kinds of evil and a bag containing vices of every kind. (Azibo, 1989, p. 188)

In contemporary times, it was Harun Black, Harold Braithwaite, and Kevin Taylor (1980) who articulated the concept of materialistic depression as a genuine mental affliction engulfing Africans. Referring to the condition in which the possession of material goods or the lack of them is the criteria of an individual's self-worth or his or her evaluation of others (the more material possessions the greater the perceived worth and more favorable the judgment of another), materialistic depression incorporates a system of values and behaviors antithetical to the African-centered cultural orientation

(see Baldwin, 1985; Baldwin & Hopkins, 1990; Richards, 1989) and its attendant statement of the African personality (see Azibo, 1990a, in press; Kambon, 1992; Khoapa, 1980; Williams, 1981), especially its dictates on spirituality versus materiality and religiosity/moral calling and collectivism versus orientation to personal and self-centered gain. For example, sufferers of materialistic depression seek the accumulation of money and status symbols, often regarding them as having some inherent value above and beyond their economic value. In some cases, money and items of conspicuous consumption are practically revered. People possessing the material get the benefit of a halo effect, as materialistic depression sufferers ascribe all manner of positivity to them and/or their possessions. The key for distinguishing materialistic depression is that in the final analysis, the symptomatology (see Azibo, 1989; Black et al., 1980) is driven by or otherwise pertains to issues of self-valuation (worth, esteem, regard, image).

As just shown, materialistic depression is disordered functioning in its own right in the framework of African personality theory (Azibo, 1989, in press). It may also be a vehicle for masked depression. It is plainly evident that within the contemporary African American popular culture, rank and vulgar materialism is a serious community mental health problem. Pushed by mass media organs, which are notorious for depleting African consciousness (Azibo, 1988), as well as informal networks, concepts such as the following permeate the community:

living large
I want to be rich
I want to get paid
I want to get mine

People are motivated to buy expensive and designer clothing and jewelry and status-indicative accessories for their homes and cars. Many people who desire a lifestyle that they cannot afford are "shamming" and "fronting" to maintain the image of having these things. Some even commit crimes to obtain these things. News reports (to say nothing of police reports) are replete with incidents of earrings and nose rings ripped right off of the victim's person, strong-armed robberies of designer coats and shoes, ad nauseam. The loss of life is an all too frequent occurrence in these materialism-based incidents. For those motivated for material things but who will neither engage in destructive acts nor fronting (or who may have ceased fronting), dysphoria is probably common. It would appear that Ptah-Hotep's observations millennia ago remain on the mark today.

Although our description of this negative aspect of African community functioning has been casual, it is believed that the reader will find it to ring true. It would seem safe to say, then, that depression is probably significantly involved in the situation described, much of it masked. It seems even more certain that materialistic depression is involved. In addition, materialistic depression may be etiologically involved with depression by creating strain intrapersonally and in African familial relationships over the urge for material things. The strain in turn might result in depression.

RESEARCH HYPOTHESES

Therefore, because materialistic depression and depression are apparently intricately commingled in contemporary African American life, a positive correlation between depression and materialistic depression is the primary hypothesis. The second hypothesis is that the depression-materialistic depression relationship should be the same for both genders because neither materialism nor the Maafa is a respecter of gender. Our orientation to the data is mainly of the exploratory mode of analysis as opposed to confirmatory (Hartwig & Dearing, 1979).

METHOD

PARTICIPANTS

Participants were 84 African American undergraduates at a mostly White college in New Jersey. They were volunteers solicited through Educational Opportunity Program counselors; flyers handed out at the library, cafeteria, and student union; and word of mouth. They were paid $3. There were 37 females, 21 males, and 26 who did not report their gender.

MATERIALS

Self-Rating Depression Scale. Depression was measured using Zung's (n.d., 1973) Self-Rating Depression Scale (SDS). The SDS measures quantitatively the intensity of depression. It consists of 20 items, each relating to a specific characteristic of depression and comprehensively delineating the depressive disorders. The SDS items cover symptoms that signify the pres-

ence of pathological disturbances in four areas: pervasive affective disturbance, physiological disturbances, psychomotor disturbances, and psychological disturbances (Zung, n.d.). Total raw scores were used. Each item's score could range from 0 to 3. A total score was calculated by summing item scores. Higher scores indicate higher depression. A Cronbach's alpha of .7229 was obtained for this sample.

Materialistic Depression Quiz (MD Quiz). Materialistic depression was measured using the 10-item MD Quiz (Black et al., 1980). Each item is answered yes (a response indicating materialistic depression) or no, and the number of yes responses is tallied. The MD Quiz was used by Black et al. in their clinical and counseling settings as an adjunct to practice. It has not been subject to psychometric analysis but appears to have face validity and enough content validity for an adjunctive therapeutic tool. A Cronbach's alpha coefficient of .6274 was obtained for the present sample. This is encouraging, because the MD Quiz was developed for usage as a convenient therapeutic tool, not an instrument that plumbs the materialistic depression concept. Our results, therefore, are rightly regarded as preliminary and suggestive. In this study, materialistic depression is operationalized by summing the yes responses to the 10 items contained in the appendix.

PROCEDURE

The materials were administered to the participants as part of a Survey of Black Students. Participants were informed that they would complete a battery of tests covering psychological and mental health issues, opinions on race and race relations, college student behaviors, and demographic information. The survey packet consisted of several instruments randomly ordered. A large, comfortable auditorium was used for the group administration. There was no time limit, and participants were enjoined to take the research seriously and not to talk while completing the survey. When they turned in the survey, participants received their pay.

RESULTS

Pearson product moment correlations were computed using SPSS/PC+. All significance tests were two-tailed. Correlation coefficients for depression and materialistic depression for the total sample and the genders were as follows: As hypothesized, depression and materialistic depression correlated

significantly, $r(82) = .2391$, $p < .05$. For women, the correlation between depression and materialistic depression was almost significant: $r(35) = .3243$, $p = .05$. Given the exploratory versus confirmatory (Hartwig & Dearing, 1979) mode of this research, however, we recommend this correlation be regarded as statistically significant because the mere increase in alpha level that results is riskable relative to the importance of minimizing Type II error here. This is consistent with the logic of hypothesis testing (e.g., Blalock, 1972, p. 162; Hays, 1973, p. 385; Winer, 1971, pp. 13-14), which does not always justify the arbitrary p value, $< .05$. For men, depression did not correlate with materialistic depression: $r(19) = .1383$, $p > .05$. Gender identification was not available for 26 participants.

This pattern of the correlations could be suggestive that the materialistic depression-depression relationship exists only for the female gender. These apparent gender differences, which are contrary to our second hypothesis, can be further explored by tests of the significance of the difference between correlation coefficients for independent samples (Cohen & Cohen, 1975, pp. 50-54). The depression-materialistic depression correlation for women (.3243) is not significantly different from the depression-materialistic depression correlation for men (.1383): $Z = .66$, $p > .05$.

DISCUSSION

The primary hypothesis of a positive relationship between materialistic depression and depression received confirmation. Although the magnitude of the correlations are for the most part small by conventional standards, the detection of this relationship has theoretical, clinical, and paradigmatic importance as discussion below will reveal. A surprising result was the apparent gender difference in the depression-materialistic depression relationship. However, the failure of the difference between correlation coefficients to achieve statistical significance between genders (men's vs. women's correlations of materialistic depression with depression) suggests that no sex difference in these relationships exists in the population. The gender difference that appears in the pattern of the correlations may be more apparent than real, in keeping with the second hypothesis.

CLARIFICATION OF SOME TECHNICAL CONCERNS

Small correlations. Under the prevailing confirmatory mode of research, small correlations usually are regarded as negative results suggestive of

abandoning or revamping the line of research. This is not necessarily the case in the exploratory mode of research, which employs openness to patterns in the data that might reveal something about the relationship between the variables. It is especially useful, according to Hartwig and Dearing (1979), when the model only specifies that the variables are related. In the present study, for example, the detection of small correlations between the variables is theoretically encouraging and confirming, as discussed above. In addition, the nonsignificant correlation obtained for men was based on a small $n = 20$ and could be a function of insufficient statistical power.

Operationalization of materialistic depression. The MD Quiz consists of a set of 10 face valid items used adjunctively in therapy. Black et al. (1980) report no psychometric data for this measure; therefore, the results must be regarded with caution. The evidence for construct validity of the MD Quiz provided by the present study is best viewed as tentative or preliminary. Obviously, a materialistic depression scale developed according to psychometric standards, rather than as an adjunct to therapy, is needed and warranted by the present results. Such a scale, with demonstrable internal consistency, could be used in a replication and extension of this study. A Cronbach's alpha at or above .80 is regarded as desirable for widely used scales (Carmines & Zeller, 1979). (People interested in such psychometric work should see the "Guest Editor's Remarks" in this issue for a solicitation.)

Operationalization of depression in Africans. In a personal communication (September 1994), professor Jules Harrell pointed out that the low correlation between depression and materialistic depression found in this study could indicate that measures of depression developed within a Eurocentric conceptual framework incompletely or insufficiently capture essential features of the disorder in Africans. The extent of truth in Harrell's observation is the extent of need for culture-specific assessment of depression in Africans. But first, depression needs to be defined and clarified Africentrically. This may require deconstruction and reconstruction of the concept of depression as it exists now or an Africentric construction. (See Azibo, 1992, p. 21, footnote 4, and 1996a for definitions of these terms.)

Because the practical problem of hegemony is still very much with us (Azibo, 1992), Zung's SDS, as well as the numerous other Eurocentric-based depression scales, will be used with Africans. Therefore, they should be scrutinized psychometrically vis-à-vis Africans. Still, regardless of how the Eurocentric tests of depression perform with Africans, the primary issue is the concept of depression itself. This ultimately should be the determinant of the operationalization of depression in Africans.

College student population. There are strengths and weaknesses in using college students as participants. Investigating the materialistic depression-depression relationship does not require a clinically depressed sample. This relationship is a community mental health issue pervasive to all segments of the African community. Thus, a college student population is likely superior to a clinical one at this stage of the research. Of course, the generalizability of findings based on college students to the larger African population is always a concern.

IMPLICATIONS FOR THE AZIBO NOSOLOGY

Construct validity. This is the first investigation of any facet of the Azibo nosology from the empiricist or quantitative paradigm. The results, rightfully regarded cautiously as tentative and preliminary, are supportive of the construct validity of materialistic depression and, by extension, the Azibo nosology in which it is housed. In that regard, it is hard to overstate the noteworthiness of this study. It is an obvious milestone in the solidification of the Azibo nosology, which heretofore relied solely on theoretical and case study arguments (Atwell & Azibo, 1991; Azibo, 1989). Paradigmatically speaking, this research represents one more piece of evidence that shows the appropriateness and viability of theorization and research about authentic African psychology formulations such as the Azibo nosology and its constituents. Of course, future research should improve on and extend the present study.

Future research. This study should have a heuristic influence on future research. Now that it has been demonstrated that the Azibo nosology lends itself to empirical research, the present study (as well as the Dixon & Azibo article published in this special section) could be the impetus of a zeitgeist of investigations into the disorders constituting the Azibo nosology. Researchers are urged to give attention to the research framework to be employed (Azibo, 1996b). Regarding future materialistic depression research, we mention again the necessity for developing a materialistic depression scale in accord with psychometric principles as the first task. Comparisons of clinical versus nonclinical, college versus noncollege, the well-off versus the not well-off, the strong versus the weak African personality (e.g., Azibo, 1991, 1996b) variables are in order.

In addition to studying the materialistic depression-depression relationship with measures of levels of depressive symptoms, major depressive disorders must also be investigated for relationship with materialistic depression. Epidemiologic studies collecting data on community samples of non-

institutionalized Africans addressing incidence and prevalence rates with attention to subgroups within African populations should be pursued for materialistic depression (and every disorder found in the Azibo nosology for that matter). Future studies might also investigate affective, cognitive, and behavioral correlates of materialistic depression. There are few limitations for the direction of future research as the area is fresh and wide open. Any study, however, must examine the role of gender.

The recommendations for future research just presented neither derive from nor are dependent on the preliminary data presented here. The main value of the data is as a demonstration that the empiricist tradition can be applied to the Azibo nosology. This could be heuristic for research into both the materialistic depression construct and the Azibo nosology in general. The facts of the articulation of the Azibo nosology in 1989 and its development into the forthcoming 2nd edition entitled *The Azibo Nosology II* (see Guest Editor's Comments) warrant, nay cry out for research by African psychological workers.

Clinical practice. Mental health workers must be aware of the theoretical depression-materialistic depression relationship. For African people, it would seem that neither construct can be addressed without considering the other. Because of the pervasiveness of depressive symptomatology, materialistic depression and the Azibo nosology in which it is housed are injected into clinical practice by virtue of theoretical relationship. The empirical results of this study, albeit preliminary, are encouraging of the theoretical contention that clinical practice should incorporate usage of the Azibo nosology (Azibo, 1989, 1990b, in press). Case studies show that it *can* (Atwell & Azibo, 1991; Dennard, 1998 [this issue]).

Community mental health. What was said under the clinical practice heading can be repeated for community mental health. In addition, the theoretical depression-materialistic depression relationship justifies programming designed to ameliorate these conditions.

In concluding, we believe our study has built African-centered theory, posed culturally relevant intelligent questions, and yielded implications for clinical-applied activities that would be enhancing of African psychological functioning in keeping with Baldwin's (1992) reproof of African-U.S. psychologists' performance in these areas. We hope that authentic African psychology will continue to revitalize itself with efforts in the same vein as and improving on the likes of this one.

APPENDIX

The MD Quiz

- Do you find yourself admiring richer people or looking up to them? (e.g., wishing you could be rich like them, feeling kind of good when you are around them, etc.)
- Do you or have you ever bought some clothing, furniture, a car, and so forth. because you felt other people would think it was nice or admire you for having it?
- Have you ever felt a little down or depressed because you were not as well-off as other people you know or other people around you?
- Do you ever buy things because they are made by a famous designer or because they cost a lot?
- Have you ever bought a car that cost more than one half of your annual income or a house that cost more than 2 1/2 times your annual income from one job? (or would you support/agree with such spending?)
- Have you ever chosen a friend or a mate because he or she dressed well or had a nice car?
- Have you ever lost a friendship with someone over a money-related matter?
- Have you ever felt that you would be happy if you had enough money?
- Do you have difficulty making it from pay day to pay day in spite of the fact that you make a "good salary"?
- Can you sometimes get out of a bad mood by going on a spending spree?

NOTE: The authors wish to point out that this instrument is fine as an adjunct to therapy, the purpose for which it was developed. However, the utmost caution is in order for usage in empirical research: In the absence of psychometric information about it, except the Cronbach alpha of .6274 reported in this article, the MD Quiz at best only yields preliminary and suggestive data. A full-fledged psychometric undertaking to develop a materialistic depression instrument is warranted.

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