

Extended Abstract : Discrimination at work and Mental Health: Understanding Depression  
Disparity through the Lens of Race, Migration and Gender

Describing topic:

French migration policies tend to reduce the concept of integration to its economic dimension, emphasizing the “immigrant worker” as a solution to labor market needs (Lochak 2006). Administrative precariousness and insufficient recognition of qualifications often push these workers into low-status jobs. Discrimination is particularly pronounced in employment, affecting primarily people of African origin (Maghreb and Sub-Saharan Africa) (Cognet et al. 2012; van Tubergen and Kros 2025). While second-generation immigrants generally have better labor market outcomes than their parents, they continue to experience discrimination in hiring and in the workplace. The labor market is also gendered: women more frequently occupy positions with high psychological demands and low autonomy (Bonsaksen et al. 2019). The combination of racialization and gendered labor structures may impact mental health through exposure to discrimination and limited socioeconomic resources, penalizing racialized men and women differently (Brown et al. 2023).

In France, research on racial disparities in health remains marginal. The universalist paradigm has historically minimized the consideration of race and ethnicity, limiting the availability of statistical data documenting inequalities (Melchior et al. 2022; Simon 2003). European studies on immigrant health have focused mainly on the Healthy Immigrant Effect (HIE) and physical health, often neglecting the impact of racism on mental health (Ichou and Wallace 2019). While first-generation immigrants may show a relative advantage in mental health, this diminishes among descendants and coexists with the harmful effects of racism, particularly in the labor market (Gosselin and Ichou 2024). Mental health inequalities are also gendered, with women more susceptible to internalizing disorders such as depression and anxiety (Rosenfield and Mouzon 2013). This framework justifies analyzing mental health at the intersection of race, gender, and migration.

Recent French surveys, such as Trajectories and Origins 2 (Beauchemin et al. 2023), allow the study of depression as a central mental health indicator and consider racialization through country of birth. This analysis focuses on African-origin populations, Structural Equation Modeling (SEM) is used to explore the direct and indirect effects of origin on depression, incorporating gender and migration generation, and testing the mediating roles of discrimination and occupational position.

Theoretical focus:

1. Healthy Immigrant Effect and Depression

While there is a well-established consensus on the physical health advantage observed among immigrants and their descendants (Domnich et al. 2012; Moullan and Jusot 2014; Aldridge et al. 2018), the literature is more divided regarding mental health outcomes (Elshahat et al. 2022). Empirical studies suggesting a relative mental health advantage attribute it to a dual

selection process, both individual and institutional (Mood et al. 2016; Vang et al. 2017). First, an individual self-selection occurs prior to migration: those perceiving themselves as healthy are more likely to emigrate, believing they possess the resources necessary to face the challenges of settling in a new country. Second, host-country immigration policies enact institutional selection, favoring profiles considered “desirable” based on education, economic capital, age, or professional skills. Immigrants also often develop resilience strategies to cope with acculturation stress, which can be protective for mental health (Güngör and Perdu 2017; Maene et al. 2022), and maintain cultural practices conducive to well-being. Descendants inherit part of these practices, benefiting from healthier diets, lower tobacco and alcohol consumption, and stronger family cohesion. However, this mental health advantage tends to decline with length of residence (Wu and Schimmele 2005; Bousmah et al. 2019), consistent with the Years Since Immigration Effect (YSIE). This decline reflects reductions in socioeconomic resources in the host country, where recognition of skills and capital acquired abroad is devalued due to systemic racism and discriminatory practices (Joonas et al. 2014; Visintin et al. 2015; Akgüç 2023).

## 2. Racialized and Gendered Labor Organization

Research on racial health disparities recognizes racism as a major determinant, and even a fundamental cause, of social and health inequalities (Williams and Mohammed 2013; Phelan and Link 2015). In France, the immigrant workforce, concentrated in the most demanding, precarious, and low-paid jobs (Desjonquères and Niang 2021), experiences heightened exposure to occupational stress due to challenging working conditions and structural job insecurity. These positions at the bottom of the social hierarchy reflect unequal access to socioeconomic status (SES), shaped by racialized labor market logics, with workers of African origin particularly disadvantaged. Among descendants of immigrants, equivalent educational qualifications do not ensure equal opportunities: their credentials are unequally recognized, access to stable employment remains limited, and wage disparities persist (Meurs et al. 2006; Gueye and Ceci-Renaud 2022). They encounter a glass ceiling, resulting from exclusion from informal networks and the reproduction of social hierarchies (Kanter 1977; Acker 2009). The organization of work is strongly gendered (Acker 1990; 2006): women, and especially racialized women, are concentrated in low-status, physically demanding, and precarious positions. Discriminatory events, occurring intermittently, reinforce the racialized and gendered division of labor, institutionalizing unequal distributions of SES and stress. These intersecting structures perpetuate social hierarchies, making women racialisées disproportionately exposed to both economic vulnerability and occupational stress (Rydström et al. 2023; Motta et al. 2016; Zampoukos et al. 2018). The racialized and gendered organization of work thus consolidates inequalities in both professional opportunities and health outcomes (Ray, 2019).

## 3. Stress, Socioeconomic Status, and Depression

Position within organizations structures individual agency (Ray 2019): those at the bottom of the hierarchy have limited control over their trajectories and access to resources, whereas those at the top—mainly white men—exercise greater autonomy. These organizational

asymmetries translate into extra-organizational inequalities, including mental health. Depression, affecting more than one in ten adults in France, is a leading cause of work incapacity and is strongly patterned by social hierarchies (Remes et al. 2021; Kirkbride et al. 2024). Socioeconomic status (SES) is consistently linked to health and depression (Krieger et al. 1997; Williams et al. 1997; Muntaner et al. 2004; P et al. 2009; Kiely et al. 2015; Silva et al. 2016) and is considered a fundamental cause of health inequalities (Link and Phelan 1995). Higher SES provides access to material and social resources, reduces stress exposure, and facilitates health-promoting behaviors (Marmot 2002). Gendered dynamics persist: men in low-skilled jobs do not exhibit lower depression prevalence than their counterparts in higher-status positions (Halonen et al. 2018). Accordingly, we hypothesize:

- H1a: Differences in depression between African-origin men and majority men are not associated with lower-tier occupational positions.
- H1b: Differences in depression between African-origin women and majority women are associated with lower-tier occupational positions.

Membership in a minoritized group exposes individuals to institutional and interpersonal discrimination, which is embodied and linked to health inequalities (Krieger 2014). Empirical evidence shows a negative association between discrimination and mental health (Safi 2010; Paradies et al. 2015; Wallace et al. 2016; Williams et al. 2019). Discriminatory events act as social stressors, triggering biopsychosocial and behavioral responses that increase depressive symptoms (Pearlin et al. 1981; Williams 2018; Hammen 2005; Williams and Mohammed 2009), and may generate secondary stressors that amplify effects across life domains (Pearlin et al. 2005). Anticipation of discrimination further sustains vigilance and stress (Williams 2018). Workplace discrimination, during hiring or on-the-job, is consistently linked to depressive and anxiety symptoms (Rospenda et al. 2009; Di Napoli et al. 2021; Clausen et al. 2022; Han et al. 2023), particularly when it hinders career aspirations, reduces control, or increases workload without adequate recognition or compensation (Bhui et al. 2005). Given systemic racism and sexism interacting with multiple social structures (Bonilla-Silva 1997; Risman 2004), examining a single context is theoretically reductive. Women and racialized individuals face higher exposure and may perceive multiple, intersecting forms of discrimination across contexts (Triana et al. 2015; Lê et al. 2022; Lavest et al. 2025). Among descendants of immigrants, discrimination is reported more frequently than among parents, reflecting both increased sensitivity and lower tolerance for unjust behaviors (Brinbaum et al. 2016). Hypotheses:

- H2a: Depression differences between African-origin men and majority men are associated with exposure to workplace discrimination.
- H2b: Depression differences between African-origin women and majority women are associated with exposure to workplace discrimination.

Cumulative discrimination across life domains can exacerbate mental health impacts (Denise 2012; Seng et al. 2012). Chronic workplace exposure contrasts with more episodic

experiences elsewhere. Prolonged stress is more strongly associated with depression than brief events (Malykhin et al. 2025), leading to:

- H3: Workplace discrimination mediates depression more strongly than discrimination in other contexts.

Data and analytical strategy:

This research is based on the TeO2 survey (INED, INSEE), a cross-sectional study representative of the French mainland population. The survey includes sociodemographic variables, measures of discrimination experiences, and data on major depressive episodes (MDE). Mediation analyses is used to explore the direct and indirect effects of origin on depression, incorporating gender and migration generation, and testing the mediating roles of discrimination and occupational position.

A total of four models are developed :

	Model 1	Model 2	Model 3	Model 4
Exposure	Immigrant Women from Africa vs. Majoritary Population Female (0/1)*	Immigrant Men from Africa vs. Majoritary Population Male (0/1)	Second Generation Women from Africa vs. Majoritary Population Female (0/1)	Second Generation Men from Africa vs. Majoritary Population Male (0/1)
Mediators :				
Stressors			Discrimination at work (0/1) Discrimination in other context (0/1) Discrimination at work and in other context (0/1)	
Occupational Status			Unskilled Workers (0/1) Unskilled Employees (0/1) Skilled Workers (0/1) Skilled Employees (0/1)	
Outcome			Executives and Higher Intellectual Profession (0/1) Major Depressive Outcome (0/1)	

Results :

For first-generation immigrant women of African origin, they are overexposed to low-skilled jobs compared to majority women, and these jobs are positively associated with MDE; thus, belonging to low-skilled occupations constitutes a significant indirect association. For second-generation African women, although overrepresented in low-skilled jobs compared to their white counterparts, working in these positions is not associated with an increased risk of depression, so membership in low-skilled occupations is not a significant indirect association.

Regarding discrimination, workplace discrimination is positively associated with depression, but African-origin women (both G1 and G2) are not overexposed compared to majority women. However, racialized women are overexposed to cumulative discrimination including the workplace, which is strongly associated with MDE, constituting a significant indirect association.

For African-origin men (G1 and G2), although overexposed to low-skilled jobs, there is no difference in MDE exposure across job types, so this is not a significant indirect association. First-generation men are overexposed to workplace discrimination, strongly associated with depression, while second-generation men report more frequent discrimination at work combined with other contexts. Cumulative exposure across contexts, including workplace, is a significant indirect association.

Finally, across all models, the direct association between workplace discrimination and MDE was highly significant, whereas discrimination in other contexts alone was not. Not all discrimination contexts are equally relevant for depression.

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