

# **African American Mental Health: Persisting Questions and Paradoxal Findings**

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The study of African American mental health has had a long and, at times, disturbing history in the United States. Studies of racial differences in health during the 19th century were used to obscure the social origins of illness, demonstrate black inferiority, and provide a "scientific" rationale for policies of inequality, subjugation, and exploitation of blacks (Krieger 1987). For example, one scientific report deliberately falsified the black insanity rates from the 1840 U.S. census to show that the further North blacks lived, the higher their rates of lunacy — strong evidence, of course, that freedom drove blacks crazy! Current research on black mental health is no longer characterized by such blatant racism, and today we have better and more reliable estimates of the distribution of psychopathology within the African American population. However, 150 years after the 1840 census, there are still important gaps and paradoxes in our knowledge of the mental health status of the African American population.

## **Early Studies of Mental Illness**

Most of our knowledge of the mental health of the African American population in the first half of the twentieth century came from several large studies that focused only on the severely mentally ill (hospitalized patients). These early studies consistently found that blacks had higher rates of mental illness than whites (Fischer, 1969). These studies had a serious methodological flaw. Only patients in certain treatment sites, predominantly state hospitals, were included in the samples. Treated rates are not accurate estimates of the prevalence of psychiatric illness. A client's economic status, the number of available beds, health care financing options, distance, available transportation, racial discrimination, and other structural and cultural barriers affect the likelihood of both seeking and receiving medical care.

State hospitals have been and continue to be the principal inpatient care source for African-Americans (Mollica et al., 1980; Snowden & Cheung, 1990), and are not representative of all treatment facilities. In contrast to their black peers, white patients could frequently avoid the stigma of a mental hospital admission by obtaining treatment outside the psychiatric specialty sector, such as admission to a general hospital ward. As later studies expanded their study population by the inclusion of outpatients, private patients, and/or community residents, the bias inherent in the earliest studies was reduced, and the findings of racial differences in mental health status became more inconsistent (Jaco, 1960; Pasamanick, 1963), but some studies of expanded treatment populations continued to find higher rates of mental illness in blacks (U.S. Bureau of Census, 1960).

## **Studies of Psychological Distress**

After World War II, a new generation of studies emerged. Community surveys using statistical methods to select a sample of residents representative of the total community were increasingly used to provide information on the social distribution of disease. However, the field of psychiatry had not reached consensus on a standardized diagnostic system for psychiatric disorders. Therefore, indicators of nonspecific emotional malaise such as psychological distress were utilized. These new studies avoided selection biases

associated with treatment samples but they provided information only on psychological well-being, and not on mental illness.

Although various instruments were used to measure psychological distress, higher rates of symptomatology and depressive symptoms among blacks were fairly consistently found. These racial differences in distress tend to disappear when controlled for socioeconomic status (SES) (Williams, 1986; Neighbors, 1984; Vega and Rumbaut, 1991). The higher rates of distress in blacks compared to whites have been attributed to characteristics of their social situation, such as a greater number of life stressors (Kessler, 1979), and higher levels of alienation and powerlessness (Mirowsky and Ross, 1989). Researchers have also given attention to exploring interactions between race and SES. Kessler and Neighbors (1986) reanalyzed data from eight epidemiologic surveys and demonstrated that although controlling for SES reduced the association between race and psychological distress, low SES blacks had higher rates of distress than low SES whites. Similarly, Ulbrich et al. (1989) found higher levels of psychological distress in blacks with low income and occupational levels compared to similarly situated whites.

### **Population-based Studies of Psychiatric Disorders**

By the late 1970s developments in mental health research allowed for the use of both standard psychiatric diagnostic criteria and a structured interview in community-based studies. The National Institute of Mental Health's Epidemiologic Catchment Area (ECA) Study, the largest study of mental illness ever conducted in the United States, used this approach (Robins & Regier, 1991). It provided estimates of the prevalence and incidence of specific psychiatric disorders (both current and lifetime) in representative samples of institutionalized and non-institutionalized persons. Between 1980 and 1983, almost 20,000 adults were interviewed in five mental health catchment areas in the United States. Table 1 shows rates of disorders for blacks and whites. Overall, the ECA study found little variation in rates of disorder by race (Robins & Regier, 1991). Rates of depressive disorders, alcohol and drug abuse, are very similar for blacks and whites, with a tendency for some white rates to be higher. Rates of schizophrenia are slightly higher for blacks, but the difference is not significant when differences in socioeconomic status (SES) is controlled for. The findings for schizophrenia and depression are interesting in the light of previously conflicting findings in the literature.

Table 1  
Rates of Psychiatric Disorder for Blacks and Whites

	Current		Lifetime	
	Black	White	Black	White
1. Affective disorders	3.5	3.7	6.3	8.0
2. Alcohol abuse	6.6	6.7	13.8	13.6
3. Drug use history	-	-	29.9	30.7
4. Drug abuse	2.7	2.7	5.4	6.4
5. Schizophrenia	1.5	0.9	2.1	1.4
6. Panic disorder	1.0	0.9	1.3	1.6
7. Phobic disorder	16.2	9.1	23.4	9.7
8. Somatization	0.4	0.1	0.5	0.1
9. Any disorder	1.4	0.4	1.6	0.5

Source: Epidemiologic Catchment Area Study

The anxiety disorders category stands out as the one area where striking racial differences were found. African-Americans had higher lifetime rates of simple phobia, social phobia, and agoraphobia, than whites. The one-month prevalence of phobia was one and a half times higher for blacks than whites even after adjustment for demographic and socioeconomic factors (Brown et al., 1990). When reviewing the ECA findings regarding phobia, it should be recognized that it was relatively easy to be diagnosed as phobic. A respondent needed only to have responded "yes" to both having an "unreasonable fear" and reporting it to a physician or other health care provider.

Recent data from the National Comorbidity Study (NCS) are even more striking (Kessler et al. 1994). The NCS interviewed over 8,000 adults and is the first study to use a national probability survey to assess psychiatric disorders in the U.S. Table 2 presents findings from this study. It presents the overall rate for each major class of disorders and the black/white ratio. A ratio greater than 1.0 means that blacks have a higher rate of disorder than whites. Blacks did not have higher rates than whites of any of the 14 psychiatric disorders studied. Lower rates for blacks than whites were particularly pronounced for the affective disorders (depression) and the substance use disorders (alcohol and drug abuse). Phobias were measured differently and probably more appropriately in the NCS than the ECA study. Table 3 presents the rates of phobias for blacks and whites (McGee, 1993). Surprisingly, in contrast to the ECA study, the current and lifetime rates of simple phobia, social phobia, and agoraphobia are higher for white males than for black males. Black women tend to have higher phobia rates than their white peers, but the differences are much smaller than in the ECA data.

Another unexpected finding came from recent analyses of the ECA data. This study explored the extent to which low SES blacks had higher rates of psychiatric disorders than their white peers. Surprisingly, it documented that low SES white males have higher rates of psychiatric disorder than their black counterparts (Williams et al., 1992). Among women, low SES black females had higher levels of the substance abuse disorders than their white peers. These findings suggest the importance of distinguishing distress from disorder, as well as the need to understand the interactions among race, gender and class. The overall evidence on black mental health is somewhat surprising. African Americans are disproportionately exposed to social conditions considered to be important risk factors for physical and mental illness. Consistent with their social location they have higher rates than whites on most indicators of death, disease and disability. For example, with the exception of pulmonary disease and suicide, blacks have higher death rates than Whites for the 15 leading causes of death in the United States (NCHS, 1991). At the same time, blacks do not have higher rates of suicide or higher rates of mental illness than whites. And among the poor, white males have higher rates of mental illness than black males. These findings emphasize the need for renewed attention to identify the cultural strengths and health-enhancing resources that provide protection from pathogenic risk factors. In this respect, two social institutions—the family and the church—stand out as crucial in the African American community (Williams & Fenton, 1994). They also rekindle old questions about data quality.

### **Data Quality Questions**

It is likely that, despite the recent large studies like the NCS and ECA, we still lack a complete picture of the mental health status of the black population (Williams & Fenton, 1994). There are several important problems that must be resolved before we can obtain

an accurate picture of the distribution of mental illness in the black population. First there is a problem of sampling. The noncoverage of black males in most epidemiologic surveys is a serious problem. African American males tend to have low response rates in survey research studies. In addition, they are overrepresented in marginal and institutional populations that are likely to be characterized by poor levels of health. And the widespread use of post-stratification weights to make samples correspond to that of the U.S. Census's estimates of the population does not solve these problems. Weighting would adequately address these problems only if we assume that nonrespondents are similar to respondents and that the Census has an accurate count of black males. Second, concerns persist about the validity of standardized diagnostic instruments for African Americans because their criteria are based on studies of predominantly white patients (Neighbors et al., 1989). Diagnostic instruments created from these observations cannot be blindly transferred to minority mental health assessment without validation for the specific minority population. Third is the issue of misdiagnosis. Differential rates of misdiagnosis by ethnicity have been proposed as an explanation for the higher treated rates of psychiatric disorder among minorities (Neighbors et al., 1989; Adebimpe, 1981). The overdiagnosis of schizophrenia and underdiagnosis of affective disorders are the most frequently specified types of misdiagnosis for African-Americans (Adebimpe, 1981). The differential interpretation of similar symptoms that may arise from sociocultural distance, and/or stereotyping, may also contribute to misdiagnosis (Neighbors et al., 1989; Adebimpe, 1981). If races belong to different cultures, they may have distinct belief systems, values and standards for acceptable behavior. Therefore, the domain of symptoms for any specific psychiatric disorder would be unlikely to remain identical across cultural groups. For example, depression may have a strong somatic component for individuals raised in cultures which frown at the free expression of emotion. Research currently underway at the AAMHRC will shed important new light on some of these issues.

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