CHAPTER 22

Mental Health of African Americans

COLWICK M. WILSON AND DAVID R. WILLIAMS

Since the mid-1800s, researchers have been interested in the mental health status of African Americans (or Blacks) in the United States (Babcock, 1895; Malzberg, 1944). This search for an understanding of the distribution of mental health problems in the African American population continues to engage the attention of researchers and policymakers, especially in an era of increasing attention to racial disparities in health status. For example, the landmark 1999 report of the Surgeon General of the United States on the scientific evidence on mental health status, in part, highlights the importance of racial and ethnic status in mental health problems or disorders. Two years later, a supplemental report was issued that focused explicitly on the role of racial and ethnic minority status in the development of psychiatric illness and in the utilization of mental health services. These reports and others document that important gaps and paradoxes remain in our understanding of African American mental health status and receipt of psychiatric services (Neighbors & Williams, 2001).

This chapter provides an overview of prior research on African American mental health status and places these data in their sociohistorical context. We consider the evidence on the prevalence of multiple indicators of mental health, such as insanity rates, psychological distress, psychiatric disorders, and psychological well-being. Additionally, we highlight a number of important issues that still remain in our attempts to understand African American mental health status in the United States. In so doing, we identify some of the emerging trends in the literature (and recent national studies) that may explicate our search for clarity on racial differences in mental health status.

A BRIEF HISTORY OF BLACK AMERICAN MENTAL HEALTH

Historically, the mental health of African Americans has been examined within the framework of a Black–White comparative paradigm (Neighbors, 1984). As such, most of the available empirical data on African American mental health use Whites as a standard of comparison. To a large extent, the interpretation of these studies reflects the prevailing social ideology of their time. That is, scientific studies were used not only to classify human diversity but also to support the notion that being Black was associated with inferior social standing in American society (Montagu, 1965). In this section, we present a chronological review of the development of these early studies, which
were mostly based on treatment samples, together with later studies that used community and national samples.

Census Studies: 1840–1930

In 1840, researchers used the U.S. census data to differentiate the number of residents in mental hospitals by race. The initial report indicated that Blacks had higher rates of insanity than Whites in general and that southern Blacks had lower rates of illness than northern Blacks (Jarvis, 1842a). Moreover, rates of insanity were higher in the North than the South, compelling evidence to the authors that freedom made Blacks crazy! However, subsequent investigation of the 1840 census data uncovered grave errors in the computation of rates of mental illness for Blacks as compared to Whites. For example, the highest proportion (1 in 14) of the mentally ill among Blacks was found in the state of Maine. Careful examination of the data from three towns in Maine revealed the following: (1) there were no colored residents in Limerick, yet four insane Blacks were identified; (2) one Black person was found in Lymington, but there were two Black insane residents listed; and (3) although there were no Blacks in Scarboro, the census data reported six insane residents (Jarvis, 1842b). Despite problems with the evidence, many researchers continued to articulate the view that Blacks were biologically inferior (Lind, 1914) and that slavery had served to protect them from insanity (Babcock, 1895; Wittmer, 1891).

In contrast, analysis of census data from 1850 to 1870, which included both the institutionalized and the noninstitutionalized mentally ill, revealed lower rates of mental illness for Blacks compared to Whites (Malzberg, 1944). For the 1880 and 1890 censuses, medical doctors were asked to help in identifying noninstitutionalized mentally ill individuals as a means of securing a more accurate count of this population (Warheit et al., 1975). Nonetheless, the results showed that Whites had higher rates of mental illness than Blacks (Malzberg, 1944; Powell, 1896).

From the next census in 1900 to that of 1920, when first admission rates were used as the measure of the prevalence of mental illness, Blacks again reported lower rates of insanity compared to Whites (Malzberg, 1944). The 1930 census marked a change in the definition of the sample of the mentally ill. Researchers began collecting census data on mental health only from the severely ill in state hospitals. This new definition of mental illness resulted in Blacks reporting higher rates of mental illness than Whites (Warheit et al., 1975; Fischer, 1969). Studies that focus only on the institutionalized mentally ill continue to show higher rates of mental illness for Blacks than Whites (Snowden & Chung, 1990). As was the case in 1930, Blacks are still overrepresented in state mental hospitals, which are the principal source of inpatient care for African Americans (Snowden & Chung, 1990; Mollica et al., 1980). In contrast, Whites are more likely to avoid the stigma associated with state mental hospitals by seeking and obtaining treatment outside these specialized settings, such as general hospitals.

Community and National Studies: 1940 to Present

During World War II, the Selective Service System rejected a significant number of men because they failed the screening test for psychiatric disorders. However, many soldiers who passed the test displayed acute psychiatric reaction to combat. As a result, the military invested enormous resources in the development and use of neuropsychiatric screening and impairment scales (Weissman et al., 1986).

Psychological Distress. After World War II, researchers modified these measures and began using community-based studies to evaluate the distribution of mental health. The emphasis here was in assessing true prevalence rates in communities rather than in treatment settings by using sophis-
mented sampling procedures, highly trained lay interviewers, and structured questionnaire design (Gurn et al., 1960; Leighton et al., 1963; Srole et al., 1962). However, the absence of a consensus about a standardized diagnostic instrument for evaluating psychiatric disorders resulted in researchers using measures of psychological distress or depressive symptoms that assess nonspecific emotional symptoms (Crandell & Dohrenwend, 1967; Robins & Regier, 1991; Weissman & Myers, 1978b). Within this framework, mental health status is often conceptualized as a continuum that can be assessed by symptom checklists that typically capture depressed mood, psychological distress, and levels of dysfunction (Link & Dohrenwend, 1980; Vega & Rumbaut, 1991).

Dohrenwend and Dohrenwend's (1969) review of eight of the early community-based studies reveals an inconsistent pattern of findings by race. Four of these studies report higher rates of distress for Blacks (Cohen, Fairbank, & Green, 1939; Hyde & Chisholm, 1944; Leighton et al., 1963; Rosanoff, 1917), while the remaining four reveal higher rates for Whites (Lemkau et al., 1942; Rowntree et al., 1945; Roth & Luton, 1943; Pasamanick et al., 1959). Subsequent community studies conducted during the 1970s and 1980s report higher rates of distress for Whites than Blacks (Antunes et al., 1974; Gaitz & Scott, 1972) or no racial differences at all after adjustments are made for socioeconomic status (Comstock & Helsing, 1976; Mirowsky & Ross, 1980; Schwab et al., 1973; Warheit et al., 1975).

Reviews of the literature on minority mental health find that while some studies report higher levels of distress for Blacks, others reveal lower levels for Blacks as compared to Whites (Vega & Rumbaut, 1991; Williams & Harris Reed, 1999). Some recent studies have also found equivalent rates of distress in Blacks and Whites. For example, a probability sample of the Detroit metropolitan area reported no Black-White difference in psychological distress (Williams et al., 1997). Similarly, a nonsignificant racial difference in psychological distress also emerged in a recent study of a nationally representative sample of adults in the United States (Williams, 2000). Overall, the pattern of findings for racial differences in psychological distress remains unclear. Some studies report higher levels of nonspecific symptoms for Blacks than Whites, while others show lower rates for Blacks or no difference between the two racial groups.

**Psychiatric Disorders.** The post-World War II search for diagnostic categories of psychiatric disorder persisted in the face of the increased use of nonspecific measures of distress. This quest for standardization was buttressed by the results of a study of U.S. (New York) and U.K. (London) residents, which documented that relatively similar diagnostic rates are possible when common diagnostic and standardized assessment tools are employed (Cooper et al., 1972). This study, together with a confluence of other factors, set the stage for new approaches to addressing the limitations of nonstandardized measures of mental illness.

During the 1970s, significant progress was made in the development of specific diagnostic criteria to obtain standardized information of mental disorder from structured interviews (Endicott & Spitzer, 1978; Spitzer et al., 1978). Among the many instruments that emerged, the Schedule for Affective Disorders and Schizophrenia-Research Diagnostic Criteria (SADS-RDC) received much attention in the research community. This categorical approach of assessing psychiatric symptoms included information on the criterion, subject, occasion, and information variance of 25 discrete psychiatric disorders by employing a structured questionnaire design and operational definitions (Spitzer et al., 1978). It was arguably one of the most developed diagnostic tools available in the United States at the time and was developed in conjunction with the DSM-III (Diagnostic and Statistical Manual of Mental Disorders).

One of the first studies to use the SADS-RDC in a community survey was a New Haven study in the late 1970s. In that study, Weissman and Myers (1978a, 1978b) found no significant racial difference for anxiety disorders but higher rates of major depression, minor depression, and depressive personalities for non-Whites (mainly Blacks) than for Whites. Not unlike most studies during this period, a major limitation of this study was the small overall sample size (511) with only 51
non-Whites. Vernon and Roberts (1982) also used SADS-RDC in a study of two southeastern cities (N = 528) and found that Blacks, compared to Whites, had higher prevalence of current rates of major and minor depression and lower lifetime rates of these disorders. While this study has a larger number of Blacks (187) than the Weissman and Myers study, Vernon and Roberts (1982) caution that the small overall sample size should be considered when interpreting their results. Weissman and Myers' New Haven study was the precursor for the more expansive and comprehensive National Institute of Mental Health Epidemiologic Catchment Area Study (ECA). Weissman and Myers served as the principal investigators in New Haven, the first (of five) site(s) for the ECA.

The ECA remains the largest mental health study ever conducted in the United States, with 20,000 adults interviewed in five communities from 1980 to 1983 (Robins & Regier, 1991). With an emphasis on the use of highly structured interviews that were administered by lay interviewers and survey sampling techniques that allowed for generalizing the findings to a defined population, the ECA sought to estimate the prevalence of specific psychiatric disorders in community samples of noninstitutionalized persons as well as of institutionalized persons in the defined catchment area (Leaf et al., 1991). These interviews had two standard sections in all of the five sites, a diagnostic section that used the Diagnostic Interview Schedule (DIS) to evaluate the presence or absence of specific diagnostic categories and a Health Services Questionnaire that assessed the utilization of medical and mental health services. The DIS is based on operational criteria and algorithms from the DSM-III and is a fully structured, lay-administered instrument that assesses the presence, severity and duration of symptoms (Boyd et al., 1985; Robins et al., 1981).

Overall, the ECA reports little difference between Blacks and Whites in the prevalence of psychiatric disorders in general (Robins & Reiger, 1991). Specifically, these data reveal that Blacks and Whites were not different in lifetime rates or six-month prevalence of major depression (Robins & Reiger 1991; Somervell et al., 1989). Although not statistically significant, Blacks consistently reported lower rates of major depression than Whites in these data (Weissman et al., 1991). There was also no statistical difference between African Americans and Whites in the overall prevalence of alcohol and drug use or dependence. Further, analysis reveals that these findings may be importantly patterned by age differences. Whites between the ages of 18 and 29 have a rate of alcohol abuse that is twice that of their Black peers, but the lifetime rates of Blacks exceeds that of Whites in all other age groups, with the difference being especially pronounced in the 45–64 category. Additionally, Blacks report higher rates of schizophrenia than Whites, but after adjusting for age, gender, marital status, and socioeconomic (SES) status, this difference disappeared.

Consistent with earlier studies (e.g., Warheit et al., 1986), the ECA data indicate that Blacks had higher one-year prevalence of generalized anxiety compared to Whites (Robins & Regier, 1991). However, African Americans reported higher rates of one-month, one-year, and lifetime prevalence of phobia. In particular, Blacks scored higher than Whites on measures of agoraphobia and simple phobia but not for social phobia. While this pattern of findings persisted for men after controlling for sex, Black women did report higher rates of agoraphobia and simple and social phobia than White women. In addition, Black men and women exceeded their White peers in rates of one-year and lifetime phobia. One exception was that Black and White women aged 30 to 44 reported very similar rates of lifetime phobias (Robins & Regier, 1991).

The first national probability survey to assess psychiatric disorder in the United States was the National Comorbidity Study (NCS), in which over 8,000 adults were interviewed in the early 1990s. Table 22.1 shows the results of the Black–White comparison across four major categories of psychiatric disorders. The first column presents the overall rate for each class of psychiatric disorders. The Black–White ratio is shown in second column where a relative risk greater than 1.0 indicates that Blacks have a higher rate of that particular disorder than Whites. Overall, Blacks do not have higher rates of psychiatric disorders in any of the four major classes of disorders than Whites (Kessler...
Table 22.1
Overall prevalence and Black-White ratios of psychiatric disorders in a national sample

<table>
<thead>
<tr>
<th>Psychiatric Disorders</th>
<th>Prevalence in general population (%)</th>
<th>Black/White ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any affective disorder</td>
<td>11.3</td>
<td>0.78</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>17.1</td>
<td>0.90</td>
</tr>
<tr>
<td>Any substance abuse or dependence</td>
<td>11.3</td>
<td>0.47</td>
</tr>
<tr>
<td>Any disorder</td>
<td>29.5</td>
<td>0.70</td>
</tr>
</tbody>
</table>

*Source: Adapted from Kessler et al. (1994).*

et al., 1994). Lower rates for Blacks than Whites are pronounced for affective disorder (depression) and substance abuse. However, the patterns of findings for some anxiety disorders are different in the NCS than in the ECA. Kessler et al. (1994) report no racial differences in panic disorder, simple phobia, or agoraphobia. Moreover, Magee's (1993) analysis of NCS data suggests that there are complex interactions between race and gender in predicting the levels of phobia. That is, White males tend to report higher current and lifetime rates of agoraphobia, simple phobia, and social phobia than Black men. In contrast, Black women have higher rates of agoraphobia and simple phobia than their White counterparts.

**Psychological Well-Being.** Researchers have also examined the extent to which membership in socially defined racial groups predicts levels of psychological well-being. This measure is typically viewed as a subjective assessment of positive and negative affect, satisfaction, and the lack of strain that characterizes the quality of life in multiple domains (Andrews & Withey, 1976; Campbell, 1981; Clemente & Williams, 1976). In this regard, Bracy's (1976) review of the literature between 1957 and 1972 revealed that African Americans report significantly lower levels of happiness and life satisfaction than Whites. In addition, Bracy (1976) examined Black-White differences in well-being by using a scale with 11 different domains of life and concluded that Blacks were significantly less satisfied than Whites controlling for family income, education, occupation, northern versus southern residence, household size, and age. Also, low-socioeconomic-status Whites reported higher levels of life satisfaction than Blacks of low socioeconomic status. Moreover, the results of Clemente and Williams' (1976) analysis of the 1973 General Social Survey supported Bracy's findings. They reported that Blacks were less satisfied than Whites with their place of residence, family, friendships, and activities after controlling for demographic and SES characteristics. One recent study using a nationally representative telephone sample of adults noted a marginally significant tendency for Blacks to report higher levels of life satisfaction based on a single-item measure than Whites (Williams, 2000).

Other data suggest that the pattern of lower well-being of Blacks compared to Whites has remained remarkably stable over time. Thomas and Hughes (1986) analyzed General Social Survey (GSS) data for 1972 to 1985 and reported that after controlling for socioeconomic status, age, and marital status, the subjective well-being of Whites was significantly and consistently higher than that of African Americans. Recently, Hughes and Thomas (1998) revisited GSS data from 1972 to 1996 in
an effort to examine the extent to which race continues to be significant in levels of subjective well-being. Consistent with their earlier research, Blacks continue to report lower levels than Whites for multiple measures of subjective well-being (Hughes & Thomas, 1998).

In sum, the review of the empirical evidence of Black–White difference across multiple measures of mental health suggests the following. First, Blacks have similar or lower depression rates compared to Whites. For most measures of anxiety disorders (except for social phobias) Blacks report either higher or similar rates to those of Whites. Second, the association between race and depressive symptoms is unclear. Some studies report higher rates for Blacks, others report higher rates for Whites, while still others show no racial differences. Finally, the weight of the evidence over time and from multiple national studies point to lower levels of psychological well-being for Blacks compared to Whites.

PERSISTENT AND EMERGING ISSUES

Despite over 100 years of research evidence documenting mental health status for Blacks in the United States, a number of important issues still remain to be addressed. These unresolved issues may provide additional information that may enhance our understanding of African American mental health over time.

Diversity among African Americans

The focus on a majority/minority comparative paradigm in epidemiological research on racial differences in mental health obscures the heterogeneity of the Black population (Williams & Fenton, 1994). There are variations within racial categories in the United States, and as such it is necessary to consider ethnic and or cultural differences among Blacks when assessing mental health status. Thus, while evaluating differences in mental health status between Blacks and Whites is an important and necessary first step in understanding the psychological and psychiatric status of Blacks in the United States, identification of within-group variations may reveal useful information about the various subgroups that form the African American population. For example, Blacks in the United States include immigrants from the Caribbean region and from the continent of Africa. In 1997, it was estimated that 6 percent of the Black population in the United States was foreign-born and an additional 4 percent of the Black population was of foreign parentage (Schmidley & Gibson, 1999). These 3.5 million Blacks of foreign stock are geographically concentrated in certain regions of the United States and are a substantial proportion of the Black population in some areas such as New York City, Washington, D.C., and South Florida.

Moreover, immigrant Blacks represent very diverse groups. For example, Blacks from the Caribbean region are characterized by different colonial heritages, such as Spanish, French, Dutch, and English. While sharing common cultural norms, these groups are anything but monolithic. Even greater diversity exists among various national origins Black groups from sub-Saharan Africa. Awareness of ethnic differences among Blacks is crucial to understanding both the distribution of mental health problems and the effective targeting of the delivery of mental health services. Future research must assess interactions between mental health and social and psychological resources and stressors across different racial groups, as well as within race, taking ethnicity into account. One national study with a small sample of persons of Caribbean ancestry found that Afro-Caribbeans reported higher levels of stress (especially financial stress), higher levels of psychological distress, and lower levels of life satisfaction than native-born Blacks (Williams, 2000). Future research needs to identify how stressors, migration status, and acculturation combine to affect the mental health of immigrant Blacks. Another neglected dimension of heterogeneity of the Black population is the extent of regional variation in sociodemographic characteristics and health for the native-born Black population.
Some evidence suggests that there are distinctive cultural-ecological regions of residence for the African American population (Williams et al., 1994). However, the associated health consequences linked to residence in these regions have not been clearly identified.

Place and Mental Health

Relatedly, research suggests that the quality of the social environment can affect the mental health status of African Americans. That is, resources and stressors, such as crime rates, quality of educational and health services, neighborhood quality, social cohesion, levels of poverty, and exposure to environmental risks have consequences for mental health status (Dalgard & Tambs, 1997). Consideration of the role of the environment in predicting levels of mental health is heightened when placed within the context of racial and ethnic minorities. The racial residential segregation of American society is a central determinant of racial differences in SES and results in unequal distribution of social and economic resources by race (Williams & Collins, 2001). African Americans live in distinctively different residential environments than Whites, and residence in highly segregated areas is known to adversely affect health (LaVeist, 1993; Williams & Collins, 2001). For example, an initially observed higher rate of cocaine use by Blacks as compared to Whites was reduced to nonsignificance when respondents were grouped into neighborhood clusters as determined by the U.S. census track characteristics (Lille-Blanton et al., 1993).

Comprehensive Measurement of Mental Health Status

Enhancing our understanding of racial differences in mental health requires studies that consider a broad range of endpoints. Most prior research has used one measure of mental health to assess for racial differences. Mental health is a multifaceted phenomenon with multiple indicators, each of which may capture varying aspects of people's lives (Aneshensel & Phelan, 1999). This may be especially salient for comparisons across racial groups. Social groups experience the world in different ways largely due to social inequities that are associated with the relative location and position of minority and majority populations in society. As such, the experiences and interpretations of the circumstances of life may vary across racial groups. This may have important implications for specific measures of mental health outcomes (Coyne & Downey, 1991; Schulberg et al., 1985). Most of the studies of racial differences in mental health are based on single-outcome measures, making it unclear whether the complex pattern of findings reflects differences in study design (Kramer et al., 1973). The use of multiple measures of mental health status within the framework of a specific study will allow for a more complete evaluation of the complexities of mental health for African Americans.

Misdiagnosis

Another important aspect of measurement that is often implicated in differential rates of mental health for Blacks and Whites is misdiagnosis (Neighbors et al., 1989). This is especially pronounced when assessing racial differences in mental health status, especially within the context of psychiatric disorders. For example, Blacks are more likely to be overdiagnosed as schizophrenics and less likely to be diagnosed with mood disorders than Whites (Neighbors et al., 1989; Adebirinpe, 1981). The free expression of emotions associated with depression, which is one of the most frequent mood disorders, may be discouraged among Blacks because of existing cultural norms that render such disclosure inappropriate. Indeed, somatization is found to be about twice as prevalent among Blacks than Whites (Heurtin-Roberts et al., 1997; Robins & Regier, 1991).

Some have argued that African Americans are more appropriately characterized as a cultural group (Landrine & Klonoff, 1996). It is therefore possible that given distinctiveness in beliefs and values,
minority status may influence both the experience and interpretation of symptoms of mental illness. Misdiagnosis then, gets at the issue of differential rates of disorders across racial groups by suggesting two possible explanations (Neighbors et al., 1989). First, Blacks and Whites express psychiatric symptoms in about the same manner, rendering diagnostic criteria equally applicable to both racial groups. Second, mental illness is experienced and displayed in different ways for Blacks and Whites. Measures of mental health status for Blacks should therefore be approached from the perspective of a careful examination of the items used to assess mental illness. There is growing research attention to the extent to which racial influences can lead to both overdiagnosis and underdiagnosis of mental illness in African Americans (Neighbors & Williams, 2001). However, definitive conclusions to these issues are not currently available. It has also been suggested that researchers should consider unique categories of mental health problems that may reflect the distinctiveness of the Black experience in the United States (Brown, 2003).

Culture and Mental Health

Over the past decade much attention has been given to the ways in which culture impacts the expression, assessment, and interpretation of mental illness (Lopez & Guarnaccia, 2000). Culture has been defined as the values, beliefs, and practices that characterize a particular ethnic group (Betancourt & Lopez, 1993). However, more recent conceptualizations of culture emphasize the importance of exploring and understanding how the larger social context interacts with the individual in a dynamic process that gives meaning to cultural experiences (Lopez & Guarnaccia, 2000). For example, there is a need for mental health professions and related organizations to be aware of the environmental factors that may facilitate the development and legitimacy of stereotypical and prejudicial views of the mental health of ethnocultural groups. In addition, researchers and clinicians may be trained to become aware of their biases and prejudices that may influence the development and interpretation of assessment instruments, data collection methods, analysis, or therapy for specific racial and ethnic groups (Rogler, 1989). A recent Institute of Medicine report documented that Blacks and other racial minorities receive poorer-quality care across a broader range of therapeutic proceedings, including mental health treatment (Smedley et al., 2003). The report suggested that provider bias based on negative stereotypes of clients is a likely contributor to this pattern. Increased awareness of both large social structures and organizations and individuals of cultural biases in the process of defining and treating mental health problems can only serve to clarify some of the present ambiguities around the evidence on racial differences in mental health status in the United States.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, of the American Psychiatric Association (1994), reveals that some distress idioms or ethnomedical symptoms are more common in specified racial and/or ethnic groups. For example, African Americans are associated with the culturally orientated syndrome referred to as "falling out." This identified "disorder" is characterized by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or "swimming in the head" (p. 846). There is some evidence that ethnomedical symptoms among African Americans overlap with symptoms of DSM III anxiety and other somatization-related psychiatric disorders (Snowden, 1999). Moreover, findings from the ECA indicate that Blacks report significantly higher rates of somatization disorder and syndrome than Whites (Robins & Regier, 1991).

Racism and Mental Health

There is growing research interest in the ways in which racism can affect the health of stigmatized racial and ethnic populations (Krieger, 1999; Harrell et al., 1998; Clark et al., 1999; Rollock & Gordon, 2000). This research suggests that racism operates at multiple levels to affect mental healh
status (Jones, 2000; Williams & Williams-Morris, 2000). First, institutional mechanisms of racism produce racial differences in socioeconomic mobility and attainment, and SES in turn is a powerful predictor of elevated risk of mental illness. Second, the internalization of the societal stigma of inferiority by at least some African Americans can lead to elevated rates of mental health problems and substance use (e.g., Taylor & Jackson, 1990, 1991).

Third, experiences of racial discrimination are an important type of stressor that has been neglected in the conventional assessment of psychosocial stress. A recent review documented that mental health status has been the most studied health indicator in the burgeoning research on perceived discrimination and health (Williams et al., Neighbors & Jackson 2003). Perceptions of discrimination have been adversely related to psychological distress, psychiatric disorders, and psychological well-being among children and adults for diverse racial/ethnic stigmatized populations in multiple societies. The review concluded that this is a high-priority area for research on racial/ethnic minorities and that the larger literature on stress points to promising new directions for future research.

Access to Mental Health Services

One striking area in which racial disparities exist between Blacks and Whites is that of access to, and use of, mental health services (Freiman et al., 1994). A recent supplement to the first-ever Surgeon General’s Report on Mental Health focused on mental health issues related to culture, race, and ethnicity (USDHHS, 2001). This report documents the striking racial/ethnic disparities in mental health care in the United States. Compared to Whites, African Americans and other minorities have less access to, and availability of, mental health services. As noted earlier, when Blacks enter the mental health system, they are also less likely to receive needed services and more likely to receive poorer-quality mental health care. In addition, African Americans are underrepresented as mental health providers and researchers.

The Surgeon General’s Report (USDHHS 2001) indicates that these disparities in mental health care impose a greater disability burden on African Americans and other minorities compared to Whites. Accordingly, it calls for improved geographic availability of mental health services, greater integration of mental health care into primary care, greater coordination of care to vulnerable high-need groups, and renewed efforts to reduce barriers to mental health care and to improve the quality of mental health services.

The National Survey of American Life

The National Survey of American Life (NSAL) is a unique new mental health study that offers important new vistas for understanding the mental health of the Black population. Funded by the National Institute of Mental Health and directed by James S. Jackson at the University of Michigan, the study has gathered data from a nationally representative adult sample of about 4,000 native-born Blacks, 2,000 Blacks of non-Hispanic Caribbean ancestry, and 1,000 Whites. Data collection was completed early in 2003.

The study administered a structured diagnostic instrument that uses DSM IV criteria to assess the presence of psychiatric illness. In addition, it included multiple indicators of psychological symptoms, psychological well-being, and impairment linked to mental health problems. The main goals of the study are to examine (1) the nature and distribution of multiple types of stressors among Blacks and other racial groups, (2) the contribution of stressors to psychiatric illness and psychological distress, and (3) how social and psychological resources can shield individuals from the negative effects of stress on mental health and help-seeking.

Two unique features of the study are an adolescent sample and a clinical reinterview. Additional interviews were completed with adolescents aged 13 to 17 in all Black households where an adult
was interviewed to yield a national adolescent sample of about 1,500. The adolescent supplement to
the NSAL will permit an assessment of a broad range of sociocultural hypotheses about the nature
and correlates of mental disorders among African American and Caribbean Black adolescents. A
trained clinician also reinterviewed about 10 percent of the adult and adolescent respondents with a
semistructured diagnostic instrument and a variety of other assessment scales to allow for a systematic
evaluation of the reliability and validity of the broad range of mental disorders assessed with the
lay-administered diagnostic interview. No prior study has concurrently assessed rates of psychiatric
disorders, nonspecific psychological distress, and psychological well-being along with a broad range
of social, psychological, political, and economic contextual risk factors and resources in a large,
ethnically diverse national sample of Black Americans.

CONCLUSION

The available evidence of the mental health status of African Americans remains paradoxical and
somewhat surprising. The finding of poorer mental health status on some measures of mental health
compared to Whites, but similar or even lower rates on other measures, points to the complexities
of assessing and delineating existing patterns of mental health status for Blacks. African Americans
are disproportionately exposed to adverse social conditions that are often implicated as risk factors
for mental illness. Yet, Blacks do not report higher rates of mental illness. Future research on African
American mental health needs to better understand the ways in which social and psychological
resources, such as social ties, religious participation, and coping can sustain the mental health of
African Americans and provide some protection from exposure to a broad range of pathogenic
characteristics.

REFERENCES

(Eds.), Handbook of the sociology of mental health (pp. 3–17). New York: Kluwer Academic Plenum.
Antunes, G., C. Gordon, C.M. Garz, & S.I. Scott. 1974. Ethnicity, socioeconomic status and etiology of
psychological distress. Sociology and Social Research, 58, 361–368.
Psychologists, 48, 629–637.
Rodgers (Eds.), The quality of American life: Perceptions, evaluations, and satisfactions (pp. 443–469).
New York: Russell Sage.
by racial stratification. Journal of Health and Social Behavior, 44(3), 292–301.
Clark, Rodney. Norman B. Anderson, Verneesa R. Clark, and David R. Williams, 1999. Racism as a stressor
Cohen, B.M., R. Fairbank, & E. Green. 1939. Statistical contributions from the Eastern Health District of


