Chapter 3 Mental Health Care for African Americans

Introduction

African Americans occupy a unique niche in the history of America and in contemporary national life. The legacy of slavery and discrimination continues to influence their social and economic standing. The mental health of African Americans can be appreciated only within this wider historical context. Resilience and forging of social ties have enabled many African Americans to overcome adversity and to maintain a high degree of mental health.

Approximately 12 percent of people in the United States, or 34 million people, identify themselves as African American (U.S. Census Bureau, 2001a). However, this figure may be lower than the actual number, because African Americans are overrepresented among people who are hard to reach through the census, such as those who are homeless or incarcerated (O'Hare et al., 1991). Census takers especially miss younger and middle-aged African American males because they are overrepresented in these vulnerable populations and because they often decline to participate in the census (Williams & Jackson, 2000).

The African American population is increasing in diversity as greater numbers of immigrants arrive from Africa and the Caribbean. Indeed, 6 percent of all blacks in the United States today are foreign-born. Most of them come from the Caribbean, especially the Dominican Republic, Haiti, and Jamaica; in 1998, nearly 1.5 million blacks residing in the United States were born in the Caribbean (U.S. Census, 1998). In addition, since 1983, over 100,000 refugees have come to the United States from African nations.

Historical Context

The overwhelming majority of today’s African American population traces its ancestry to the slave trade from Africa. Over a period of about 200 years, millions of Africans are estimated to have been kidnapped or purchased and then brought to the Western Hemisphere.

Ships delivered them to the Colonies and later to the United States (Curtin, 1969). Legally, they were considered chattel-personal property of their owners. By the early 1800s, most Northern States had taken steps to end slavery, where it played only a limited economic role, but slavery continued in the South until the Emancipation Proclamation in 1863 and passage of the 13th Amendment to the U.S. Constitution in 1865 (Healey, 1995).

The 14th Amendment (1868) extended citizenship to African Americans and forbade the States from taking away civil rights; the 15th Amendment (1870) prohibited disfranchisement on the basis of race. However, these advances did not eliminate the subjugation of African Americans. The right to vote, supposedly assured by the 15th Amendment, was systematically denied through poll taxes, literacy tests, grandfather clauses, and other exclusionary practices. Racial segregation prevailed. Many Southern State governments passed laws that became known as Jim Crow laws or "black codes," which reinforced informal customs that separated the races in public places, and perpetuated an inferior status for African Americans.

The economy of the South remained heavily agricultural, and most people were poor. Exploited and consigned to the bottom of the economic ladder, most African Americans toiled as sharecroppers. They rented land and paid for it by forfeiting most, if not all, of their harvested crops. Some worked as agricultural laborers and were paid rock-bottom wages. With very low,
irregular incomes and little opportunity for betterment, African Americans continued to live in poverty. They were kept dependent and uneducated, with limited horizons (Thernstrom & Thernstrom, 1997).

As late as 1910, 89 percent of all blacks lived in legalized subservience and deep poverty in the rural South. When World War I interrupted the supply of cheap labor provided by European immigrants, African Americans began to migrate to the industrialized cities of the North in the Great Migration. As Southern agriculture became mechanized, and as the need for industrial workers in Midwestern and Northeastern States increased, African Americans moved north in even greater numbers. Following World War II, blacks began to migrate to selected urban centers in the West, mostly in California.

Segregation continued until the early 1950s. Then in 1954, in *Brown v. Board of Education*, the Supreme Court declared racially segregated education unconstitutional. In the 1960s, a protest movement arose. Led by the 1964 Nobel laureate, the Rev. Dr. Martin Luther King, Jr., activists confronted and sought to overturn segregationist practices, often at considerable peril. New legislation followed. The Civil Rights Act of 1964 prohibited both segregation in public accommodations and discrimination in education and employment. The Voting Rights Act, passed in 1965, suspended the use of voter qualification tests.

While the African American experience in the United States is rife with episodes of subjugation and displacement, it is also characterized by extraordinary individual and collective strengths that have enabled many African Americans to survive and do well, often against enormous odds. Through mutual affiliation, loyalty, and resourcefulness, African Americans have developed adaptive beliefs, traditions, and practices. Today, their levels of religious commitment are striking: Almost 85 percent of African Americans have described themselves as "fairly religious" or "very religious" (Taylor & Chatters, 1991), and prayer is among their most common coping responses. Another preferred coping strategy is not to shrink from problems, but to confront them (Broman, 1996). Yet another successful coping strategy is the tradition of turning for aid to significant others in the community, especially family, friends, neighbors, voluntary associations, and religious figures. This strategy has evolved from the historical African American experience of having to rely on each other, often for their very survival (Milburn & Bowman, 1991; Hatchett & Jackson, 1993).

African Americans have also developed a capacity to downplay stereotypical negative judgments about their behavior and to rely on the beliefs and behavior of other African Americans as a frame of reference (Crocker & Major, 1989). For this reason, at least in part, most African Americans do not suffer from low self-esteem (Gray-Little & Hafdahl, 2000). African Americans have a collective identity and perceive themselves as having a significant sphere of collectively defined interests. Such psychological and social frame-works have enabled many African Americans to overcome adversity and sustain a high degree of mental health.

What it means to be African American, belonging to a certain race, can no longer be taken for granted. As noted in Chapter 1, racial classification based on genetic origins is of questionable scientific legitimacy and of limited utility as a basis for understanding complex social phenomena (Yee et al., 1993). Still, the category "African American" provides a basis for social classification. African Americans are recognized by their physical features and are treated accordingly. Many African Americans identify as African American; they share a social identity and outlook (Frable, 1997; Cooper & Denner, 1998. Scholars have defined and measured aspects of this sense of racial identity: its salience, its centrality to the sense of self, the regard others
hold for African Americans, what African Americans believe about the regard others hold for them, and beliefs about the role and status of African Americans (Sellers et al., 1998).

Current Status

Geographic Distribution

In spite of the Great Migration to the North, a large African American population remained in the South, and in recent years, a significant return migration has taken place. Today, 53 percent of all blacks live in the South. Another 37 percent live in the Northeast and Midwest, mostly in metropolitan areas. About 10 percent of all blacks live in the West (U.S. Census Bureau, 2001). Nationally, 15 percent live in rural areas, compared to 23 percent of whites and 25 percent of Americans overall (Rural Policy Research Institute, 1997).

Figure

Figure 3-1. African American Population by Region: 2000.

Many African Americans still live in segregated neighborhoods (Massey & Denton, 1993), and poor African Americans tend to live among other African Americans who are poor. Poor neighborhoods have few resources, a disadvantage reflected in high unemployment rates, homelessness, crime, and substance abuse (Wilson, 1987). Children and youth in these environments are often exposed to violence, and they are more likely to suffer the loss of a loved one, to be victimized, to attend substandard schools, to suffer from abuse and neglect, and to encounter too few opportunities for safe, organized recreation and other constructive outlets (National Research Council, 1993). Personal vulnerabilities are exacerbated by problems at the community level, beyond the sphere of individual control.

On the other hand, not all African American communities are distressed. Like other well functioning communities, stronger African American communities (both rich and poor) possess cohesion and informal mechanisms of social control, sometimes called collective efficacy. Evidence indicates that collective efficacy can counteract the effects of disabling social and economic conditions (Sampson et al., 1997). It also forms the foundation for community-building efforts (Bell & Fink, 2000).

Family Structure

In 2000, there were approximately 9 million African American families in the United States. On average, African American families are larger than white families; (65% versus 54% of families had three or more members), but smaller than families from other racial and ethnic minority groups (76% had three or more members). On the other hand, many African American children grow up in homes with only one parent. Only 38 percent were living in 2-parent families compared to 69% of all children in the United States. For children who lived with one parent,
African Americans were more likely to live with their mothers than were U.S. children overall (92% versus 69%) (U.S. Census Bureau, 2001c).

Those who study African American life have argued that these trends are offset by an extended family orientation that calls for mutual material and emotional support (Hatchett & Jackson, 1993). This perspective has found wide acceptance and is reflected in policies such as family foster care, where children and youth removed from their homes are placed with relatives. African Americans participate extensively in family foster care in numbers proportional to their representation in foster care in general Berrick et al., 1994; Landsverk et al., 1996; Altshuler, 1998.

Increasingly, however, researchers have discovered gaps and limitations in extended family support. Analyzing data from the National Survey of Families and Households, a large, community survey, Roschelle (1997) demonstrated that African American women were more likely than other women to provide assistance with child care and household tasks, but were less likely to receive such assistance in return. Respondents reported during in-depth interviews that levels of intergenerational support provided to teen mothers had waned (McDonald & Armstrong, 2001). They further indicated that several factors, including the youth of many grandmothers and the burden of problems brought on by urban poverty, had undermined supportive traditions.

Education

African Americans have shown an upward trend in educational attainment throughout the latter half of the 20th century. By 1997, there was no longer a gap in high school graduation rates between African Americans and whites. The number of African Americans enrolled in college in 1998 was 50 percent higher than the number enrolled a decade earlier. By 2000, 79 percent of African Americans age 25 and over had earned at least a high school diploma and 17 percent had attained a bachelor's or graduate degree. These rates are in comparison to 84% and 26%, respectively, for Americans overall (U.S. Census Bureau, 2001c).

Income

When considered in aggregate, African Americans are relatively poor. In 1999, about 22 percent of African American families had incomes below the poverty line ($17,029 for a family of 4 in 1999) but only 10 percent of all U.S. families did (U.S. Census Bureau, 2001c). The difference in poverty rates has shrunk over the past decade, however, and the socioeconomic distribution of African Americans has become increasingly complex.

At one end of the income spectrum, the official poverty rate may understate the true extent of African American poverty. African Americans are more likely than whites to live in severe poverty, with incomes at or below 50 percent of the poverty threshold; the African American rate of severe poverty is more than three times the white rate. Children and youth are especially affected; while the national poverty rate for U.S. children is nearly 20 percent, almost 37 percent of African Americans 18 and younger live in poor families (U.S. Census Bureau, 1999b). There is considerable turnover in the poverty population. Most of the poor move out of poverty over time but are replaced by others. African Americans move in and out of poverty, but their periods of poverty tend to last longer, making African Americans more likely than whites to suffer from long-term poverty (O'Hare, 1996).
African American families fall well below white families on an important measure of aggregate financial resources: total wealth. Net worth, the value of assets minus liabilities, is a useful indicator. The median net worth of whites is about 10 times that of blacks (U.S. Census Bureau, 1999a). This wide disparity reflects limited African American family assets, lower rates of home ownership, limited savings, and few investments (O'Hare et al., 1991). Because most are descendants of deeply impoverished rural agricultural workers, many contemporary African Americans can expect to borrow only modest sums from relatives and can expect only small inheritances. Most African Americans have little financial cushion to absorb the impact of the social, legal, or health-related adversity that often accompanies mental illness.

African American poverty is associated with family structure. Despite historical patterns to the contrary and a slight reduction in recent years, African American children in particular, are especially likely to live in single-parent, mother-only families. This pattern reflects relatively low and declining marriage rates; the number of never-married African American adults almost equals the number of those who are married. Taking cohabitation into account reduces, but does not eliminate differences in the domestic partnership rates of African Americans versus other groups (Statistical Abstract of the United States, 1999).

The disparity in poverty rates affects older adults as well. Older African Americans are almost three times as likely as whites to be poor. The poverty rate among single African American women living alone or with non-relatives is very high (Ruiz, 1995). Older African American women are far more numerous than older African American men because of different mortality rates.

While many African Americans live in poverty, many others have joined the middle class. Between 1967 and 1997, African Americans benefited from a 31 percent boost in their real median household income, a raise that contrasts with an 18 percent increase for whites (U.S. Census Bureau, 1998). Nearly a quarter of all African Americans had incomes greater than $50,000 in 1997, and the median income of African Americans living in married-couple households was 87 percent that of comparable whites. Almost 32 percent of African Americans lived in the suburbs (Thernstrom & Thernstrom, 1997).

Thus, in socioeconomic terms, the African American population has become polarized. Many African Americans are very poor and sometimes suffer an added burden from living in impoverished communities. African Americans, poor and nonpoor alike, possess relatively few financial assets. However, a large and increasing number of African Americans-more than once expected-have taken up well-earned positions in the middle class.

Physical Health Status

As a group, African Americans bear a disproportionate burden of health problems (DHHS, 2000a). Mortality rates until age 85 are higher for blacks than for whites (National Center for Health Statistics, 1996). Disparities in morbidity, too, are pronounced. The African American rate of:

- diabetes is more than three times that of whites;
- heart disease is more than 40 percent higher than that of whites;
- prostate cancer is more than double that of whites;
- HIV/AIDS is more than seven times that of whites (In the past decade, deaths due to HIV/AIDS have increased dramatically in the African American population, and this disease is now one of the top five causes of death for this group);
• breast cancer is higher than it is for whites, even though African American women are more likely to receive mammography screening than are white women (DHHS, 2000a);
• infant mortality is twice that of whites.

The disparity in infant mortality rates, which are considered sensitive indicators of a population’s health status, is particularly stark. It is not entirely accounted for by socioeconomic factors. Although infant mortality tends to decrease with maternal education, the most educated black women have infant mortality rates that exceed those of the least educated white women (DHHS, 1998).

High rates of African American HIV/AIDS pose special challenges related to mental health. HIV infection can lead to mental impairment, from minor cognitive disorder to full-blown dementia, as well as precipitate the onset of mood disorders or psychosis. Opportunistic infections, use of psychoactive substances associated with HIV infection, and adverse effects from treatment can gravely compromise mental functioning (McDaniel et al., 1997).

Disparities in access to appropriate health care partially explain the differences in health status. In 1996, about 76 percent of whites had an office-based usual point of care, which facilitates preventive and primary care treatment. This compared to only 64 percent of African Americans (Kass et al., 1999). Only 10 percent of African Americans, versus 12 percent of other Americans, made a visit to an outpatient physician in 1997; African Americans made 26 percent fewer annual visits than whites. African Americans are especially likely to obtain health care from hospital outpatient and emergency departments. In 1997, African Americans made about 22 percent of emergency department visits (U.S. Census Bureau, 1999b). As will be shown in the next section, the pattern of mental health treatment for African Americans is characterized by low rates of out-patient care and high rates of emergency care.

The Need for Mental Health Care

Historical and Sociocultural Factors that Relate to Mental Health

Historical adversity, which included slavery, sharecropping, and race-based exclusion from health, educational, social, and economic resources, translates into the socioeconomic disparities experienced by African Americans today. Socioeconomic status, in turn, is linked to mental health: Poor mental health is more common among those who are impoverished than among those who are more affluent (Chapter 2). Also related to socioeconomic status is the increased likelihood of African Americans becoming members of high-need populations, such as people who are homeless, incarcerated, or have substance abuse problems, and children who come to the attention of child welfare authorities and are placed in foster care. Members of these groups face special circumstances not fully explained by socioeconomic differences, however.

Racism is another aspect of the historical legacy of African Americans. Negative stereotypes and rejecting attitudes have decreased, but continue to occur with measurable, adverse consequences for the mental health of African Americans (Clark et al., 1999). Historical and contemporary negative treatment have led to mistrust of authorities, many of whom are not seen as having the best interests of African Americans in mind.

The overrepresentation of African Americans in the South, especially in impoverished rural areas, is another result of history. Hardship in these communities is notable, and a limited safety
net provides relatively few services to address high levels of mental health need (Fox et al., 1995).

**Key Issues for Understanding the Research**

When seeking to explain differences between African Americans and whites, it is important that researchers first consider the impact of black-white demographic and socioeconomic differences. This is because disparities found in research sometimes are attributable to differences in poverty and marriage rates, regional distribution, and other population characteristics. However, investigators often continue to observe black-white differences after controlling for differences in social status and demographics and must look elsewhere to explain their findings. One of many possible explanations is racial bias: African Americans might, under the circumstances being investigated, be victims of adverse treatment because they are black.

Researchers must conceive and evaluate other explanations also. Differences in access to insurance and other mechanisms to defray costs, in levels of illness or patterns of symptom expression, in health-risk behaviors, and in beliefs, preferences, and help-seeking traditions can also explain disparities. Citing a large-scale study of Medicare beneficiaries (McBean & Gornick, 1994), Williams (1998) reported numerous black-white disparities in health care and mortality. The findings were consistent with the presence of race-based discrimination, but other possibilities were also noted: "A greater percentage of black Medicare beneficiaries made out-of-pocket payments;" "There may be higher levels of severity of illness among black patients;" "Blacks may be more likely than whites to refuse procedures recommended by their physicians;" and "Whites may be more aggressive in pursuing medical care" (p. 312).

Survey researchers face challenges when they attempt to generalize findings from household samples to the larger African American population. Because of African American overrepresentation in high-need populations, community surveys that do not include persons living in jails, shelters, foster care, or other institutional settings are likely to undercount the number of African Americans with mental illness. Furthermore, mistrust causes large segments of the African American population not to participate in the U.S. Census, making accurate accounting difficult and having what are estimated to be dramatic effects on population-based rates of health and social problems (Williams & Jackson, 2000).

The legitimacy accorded assessment procedures widely used to measure mental illness and mental health, when they are applied to African American and other minority groups, is sometimes questioned (Snowden, 1996). If African Americans do not disclose symptoms as readily as other groups, for example, or if they present their symptoms in a distinctive manner, then attempts to accurately assess African American mental illness will suffer. For many procedures, neither validity nor lack of validity among African Americans has been demonstrated; the issue has not yet been addressed. Variation in reliability and validity can be and should be assessed (Chow et al., in press).

**Mental Disorders**

**Adults**

The Epidemiologic Catchment Area study (ECA) of the 1980s sampled residents of Baltimore, St. Louis, Durham-Piedmont, Los Angeles, and New Haven and assessed samples from both the community at large and institutions such as mental hospitals, jails, residential drug or alcohol
treatment facilities, and nursing homes (Robins & Regier, 1991). In total, it included 4,638 African Americans, 12,944 whites, and 1,600 Hispanics. A more recent study, the National Comorbidity Survey (NCS), included a representative sample of persons living in the community that included 666 African Americans, 4,498 whites, and 713 additional U.S. residents (Kessler et al., 1994). Participants of both studies reported whether or not they had experienced symptoms of frequently diagnosed mental disorders in the past month, the past year, or at any time during their lives.

Results for certain disorders are presented in Table 3-1. After taking into account demographic differences between African Americans and whites, the ECA found that African Americans were less likely to be depressed and more likely to suffer from phobia than were whites (Zhang & Snowden, 1999). The NCS findings also indicate that African Americans were less likely than whites to suffer from major depression.

### Table 3-1. Results of the ECA and NCS Studies of Mental Health Care for African Americans.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>ECA Total</th>
<th>Black</th>
<th>White</th>
<th>NCS Total</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>2.0%</td>
<td>2.7%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Phobia Disorder</td>
<td>10.0%</td>
<td>8.0%</td>
<td>11.0%</td>
<td>10.0%</td>
<td>8.0%</td>
<td>11.0%</td>
</tr>
<tr>
<td>All Others</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
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</table>

The studies revealed gender differences in rates of mental illness. Prevalence rates of depression, anxiety disorder, and phobia were higher among African American women than African American men. These differentials paralleled those found for white women and men.

In light of the findings, whether African Americans differ from whites in rate of mental illness cannot be answered simply. On the ECA, African Americans had higher levels of any lifetime or current disorder than whites. This was true both over the respondent’s lifetime (Robins & Regier, 1991) and over the past month (Regier et al., 1993). Taking into account differences in age, gender, marital status, and socioeconomic status, however, the black-white difference was eliminated. From the ECA then, it appears that African Americans in the community suffer from higher rates of mental illness than whites, but that the difference is explained by differences in demographic composition of the groups and in their social positions.

Evidence from the NCS, on the other hand, indicated that even without controlling for demographic and socioeconomic differences, African Americans living in the community had lower lifetime prevalence of mental illness than did white Americans living in the community (Kessler et al., 1996). This difference existed for all of the disorders assessed.

The results from these major epidemiological surveys appear to converge on at least one point: The rates of mental illness among African Americans are similar to those of whites. Yet this judgment, too, is open to challenge because of African American overrepresentation in high-need populations. Persons who live, for example, in psychiatric hospitals, prisons, the inner city, and poor rural areas are not readily accessible to researchers who conduct household surveys. By counting members of these high-need groups, higher rates of mental illness among African Americans might be detected.
**Children and Youth**

Mental health epidemiological research on children and youth provides little basis for conclusions about differences between African Americans and whites. Certain studies suggest higher rates of symptoms or of certain types of full-blown mental illness among African American children and youth than among whites: functional enuresis (Costello et al., 1996), obsessive-compulsive disorder (Vallenini-Basile et al., 1996), symptoms of conduct disorder (Costello et al., 1988), and symptoms of depression (Roberts et al., 1997). Other studies have reported no differences between rates for blacks and whites (Siegel et al., 1998). Underlying patterns are masked by differences in the regions from which the samples were drawn, in the age of respondents, in assessment methods, and in other methodological considerations.

A study discussed in the Surgeon General's report on mental health (DHHS, 1999b) included an assessment of how much mental health care children in four geographic regions received. Children were identified as having unmet need if they were impaired because of mental illness and had had no mental health care in the preceding six months; African American children and youth were more likely to have unmet need than were white children and youth (Shaffer et al., 1996).

**Box 3-1: A Child's Grief**

**John (age 10)**

A 10-year-old African American male, "John," suffered from declining grades. Formerly a B and C student, he now received Ds. His mother could not explain his drop in academic achievement. John was unable to concentrate on homework and was sick to his stomach when studying. When questioned, John said that his father, now deceased, had formerly helped him carry out his assignments.

John told this story of his father's death: He and his father had been entering an elevator. They came upon two men arguing; one drew a gun and began to shoot. John's father, an innocent bystander, was shot in the stomach. He died on the moving elevator. The shooting and death produced a nauseating smell; John became sick and threw up.

Studying reminded John of his father's death and triggered nausea. This recognition helped to guide treatment. The focus was on providing a supportive relationship in which John could grieve his father's death. Overwhelmed, his mother had been unable to tolerate John's grief. Over time, John was able to transform his remorse into academic effort as a memorial to his father. His grades gradually improved. (Bell, 1997).

**Older Adults**

Little is known about rates of mental disorders among older African Americans. Older African American ECA respondents exhibited higher rates of cognitive impairment than did their counterparts from other groups. The rate of severe cognitive impairment continued to be higher for African Americans even after the researchers controlled for differences in demographic factors and socioeconomic status. Cognitive impairment is strongly related to education; simple measures may fail to assess fully the long-term impact of excluding African Americans from good schools.
Even less is known about the mental health of older African Americans whose physical health is poor. It appears that many living in nursing homes need psychiatric care (Class et al., 1996). In addition, 27 percent of older African Americans living in public housing needed mental health treatment (Black et al., 1997).

Several studies have examined rates of depressive symptoms in older African Americans living in the community. Three of the more rigorous research efforts reported few differences in depressive symptoms between African Americans and whites Husaini, 1997; Blazer et al., 1998; Gallo et al., 1998. As with older whites, elevated symptoms of depression in African Americans have been related to health problems Okwumabua et al., 1997; Mui & Burnette, 1994.

**Mental Health Problems**

**Symptoms**

Sometimes symptoms are considered not as markers of an underlying mental disorder but as mental health problems in their own right. Although much remains to be learned about symptom distress, it can pose significant problems. Symptoms of depression have been associated with considerable impairment in the performance of day-to-day tasks of living, comparable to that associated with common medical conditions (Wells et al., 1989). Among African Americans especially, symptoms of depression are associated with increased risk of hypertension (Pickering, 2000).

Before the advent of the epidemiological studies discussed above, parallel studies addressed symptoms of depression. Vega and Rumbaut (1991) conducted a comprehensive review of the research focusing on African American-white comparisons. Sometimes African Americans reported more distress than did whites, but investigators were often able to attribute the differences to socioeconomic and demographic differences (Neighbors, 1984).

**Somatization**

Somatization is an idiom of distress in which troubled persons report symptoms of physical illness that cannot be explained in medical terms. In some people, somatization is thought to mask psychiatric symptom distress or full-blown mental illness; somatic symptoms may be a more acceptable way of expressing suffering than psychiatric symptoms. Severe forms of somatization, which qualify as a disorder, are relatively rare; less severe forms are more common.

Somatization is not confined to African Americans, but somatic symptoms are more common among African Americans (15%) than among white Americans (9%) (Robins & Regier, 1991). Milder somatic symptoms, too, are expressed more often in African American communities (Heurtin-Roberts et al., 1997).

**Culture-Bound Syndromes**

Some distress idioms are more confined to particular racial and ethnic groups. Several are characterized in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV; American Psychiatric Association, 1994), in an Appendix devoted to culture-bound syndromes. One is *isolated sleep paralysis*, a state experienced while awaking or falling asleep and characterized by an inability to move (Bell et al., 1984, 1986). Another such syndrome, a
sudden collapse sometimes preceded by dizziness, is known as *falling out*. (See DSM-IV, 1994, Appendix I, "Outline for Cultural Formulation" and "Glossary of Culture-Bound Syndromes," p. 846.) How widely these syndromes occur among African Americans is unknown.

These syndromes are examples of what anthropologists describe as a rich indigenous tradition of ways for African Americans to express psychiatric distress and other forms of emotion (Snow, 1993). Researchers have demonstrated that the symptoms reported in anthropological literature resemble those of certain established mental disorders, and that they are linked among African Americans to a tendency to seek assistance (Snowden, 1999a).

**Suicide**

Because most people who commit suicide have a mental disorder (DHHS, 1999b), suicide rates indicate potential need for mental health care. Official statistics indicate that whites are nearly twice as likely as African Americans to commit suicide (National Center for Health Statistics, 1996).

Suicide among African Americans has attracted significant scholarly interest Baker, 1990; Gibbs & Hines, 1989; Griffith & Bell, 1989. Attempts to explain the disparity between African Americans and whites have brought to light several qualifying considerations. It has been noted that much of the difference is attributable to very high rates of suicide among older white males. When looking at other age groups, "the risk of suicide among young African American men is comparable to that of young white men" (Joe & Kaplan, 2001). Moreover, the disparity has shrunk appreciably over time Griffith & Bell, 1989; Baker, 1990. The increasing convergence is associated with striking increases in suicide rates among African American youth. Between 1980 and 1995, for example, the suicide rate among African Americans ages 10 to 14 increased 233 percent; the suicide rate for comparable whites increased 120 percent (Centers for Disease Control and Prevention [CDC], 1998).

A coroner judges whether someone has died by suicide. The accuracy of suicide determinations, especially in the case of African Americans, has also been called into question (Phillips & Ruth, 1993). Mohler and Earls (2001) notably reduced the gap in suicide rates between African American and white youths and young adults after correcting for attribution to other causes.

**High-Need Populations**

Owing to a long history of oppression and the cumulative impact of economic hardship, African Americans are significantly overrepresented in the most vulnerable segments of the population. More African Americans than whites or members of other racial and ethnic minority groups are homeless, incarcerated, or are children in foster care or otherwise supervised by the child welfare system. African Americans are especially likely to be exposed to violence-related trauma, as were the large number of African American soldiers assigned to war zones in Vietnam. Exposure to trauma leads to increased vulnerability to mental disorders (Kessler et al., 1994).

**Individuals Who Are Homeless**

African Americans make up a large part of the homeless population. One attempt to consolidate the best scientific estimates reported that 44 percent of the people who are homeless were African American (Jencks, 1994). Other estimates concur, concluding that the African American proportion is no lower than 40 percent Barrett et al., 1992; U.S. Conference of Mayors, 1996.
Proportionally, 3.5 times as many African Americans as whites are homeless. This overrepresentation includes many African American women, children, and youth Cauce et al., 1994; McCaskill et al., 1998.

People who are homeless suffer from mental illnesses at disturbingly high rates. The most serious disorders are the most common: schizophrenia (11 to 13% of the homeless versus 1% of the general population) and mood disorders (22 to 30% of homeless versus 8% of the general population) Koegel et al., 1988; Vernez et al., 1988; Breakey et al., 1989. Homeless and runaway youth also suffer from mental disorders at high rates Feitel et al., 1992; Mundy et al., 1989; McCaskill et al., 1998.

Individuals Who Are Incarcerated

Nearly half of all prisoners in State and Federal jurisdictions are African American (Bureau of Justice Statistics, 1999), as are nearly 40 percent of juveniles in legal custody (Bureau of Justice Statistics, 1998; Bureau of Justice Statistics, 1999). African Americans are also overrepresented in local jails (Bureau of Justice Statistics, 1999).

African American jail inmates and prisoners have somewhat lower rates of mental illness than comparable white American populations, but African American and white differences are overshadowed by the high rates of mental illness for incapacitated persons in general (Teplin, 1999; Teplin et al., 1996). A study conducted on women entering prison in North Carolina (Jordan et al., 1996) is illustrative. Investigators found that while lifetime rates of mental disorders among African American were slightly lower than those for whites, rates for both incarcerated groups typically were eight times greater than rates observed among African American and white American community residents. Incarcerated African Americans with mental illnesses are less likely than whites to receive mental health care (Bureau of Justice Statistics, 1998).

Children in Foster Care and the Child Welfare System

African American children make up about 45 percent of the children in public foster care and more than half of all children waiting to be adopted (DHHS, 1999a). Children come to the attention of child welfare authorities because they are suspected victims of abuse or neglect. Often they are removed from their homes and placed elsewhere-and then again placed elsewhere if an initial placement cannot be continued. These conditions carry a high risk of mental illness, as confirmed in epidemiological research. After investigating a large representative sample, Garland, and colleagues (1998) reported that around 42 percent of children and youth in child welfare programs met DSM-IV criteria for a mental disorder.

Individuals Exposed to Violence

Blacks of all ages are more likely to be the victims of serious violent crime than are whites Griffith & Bell, 1989; Jenkins et al., 1989; Gladstein et al., 1992; Bureau of Justice Statistics, 1997; Jenkins & Bell, 1997. In one area, a community survey revealed that "nonwhites," many of whom were African American, were not only at greater risk of being victims of physical violence, but also at greater risk of knowing someone who had suffered violence (Breslau et al., 1998). The greater risk could not be attributed to socioeconomic differences or differences in area of residence.
The link between violence and psychiatric symptoms and illness is clear. Fitzpatrick & Boldizar, 1993; Breslau et. al, 1998; Schwab-Stone et al., 1999. One investigator reported that over one-fourth of African American youth who had been exposed to violence had symptoms severe enough to warrant a diagnosis of PTSD (Fitzpatrick & Boldizar, 1993).

**Box 3-2: Fragmentation in the Foster Care System**

**Michael (age 17)**

A 17-year-old African American male in foster care, "Michael," was referred for mental health care. He was described as "hostile"; he had recently dropped out of school.

Michael was surly and irritable initially, but ultimately began to cry. Eventually he spoke about his past.

His father lost his job when Michael was 9 and was unable to support Michael, his mother, and his three siblings. In desperation, Michael's father began to sell drugs. Michael's mother came to use the drugs being sold by his father. She became unable to care for her four children, resulting in their placement in foster care.

Michael reported living in five foster homes; lack of continuity undermined his educational success. He had seen none of his siblings for some time and knew nothing of their whereabouts or of his parents' well-being. He revealed that he had suffered crying spells for over a year (Bell, 1997).

**Vietnam War Veterans**

Although 10 percent of U.S. soldiers in Vietnam were black and 85 percent were white, more black (21%) than white (14%) veterans suffer from PTSD (Kulka et al., 1990). Investigators attribute this difference to the greater exposure of blacks to war-zone trauma, which increases risk not only for PTSD but also for many health-related and psychosocial adversities (Fairbank et al., 2001). African American and white veterans used Veterans' Administration (VA) mental health care equally, but African Americans proved less likely to use supplemental care outside the VA system (Rosenheck & Fontana, 1994).

**Availability, Accessibility, and Utilization of Mental Health Services**

**Availability of Mental Health Services**

The overrepresentation of African Americans in high-need populations implies great reliance on the programs and providers-public hospitals, community health centers, and local health departments-comprising the health care and mental health safety net (Lewin & Altman, 2000). State and local mental health authorities figure most prominently in the treatment of mental illness among African Americans. They may provide care either directly through the administration of mental health pro-grms, or by contracting with not-for-profit providers or for-profit firms. The number, type, and distribution of safety net providers, as well as arrangements made for the provision of care, greatly influence the treatment options available to the most vulnerable populations of African Americans and others. Fortunately, the safety net includes programs and practitioners that specialize in treating African Americans. Several
studies suggest that these care providers are especially adept at recruiting and retaining African Americans in outpatient treatment \cite{Yeh1994, Snowden1995, Takeuchi1995}.

The supply of African American clinicians is important. Studies of medical care reveal that African American physicians are five times more likely than white physicians to treat African American patients \cite{Komaromy1996, Moy1995} and that African American patients rate their physicians’ styles of interaction as more participatory when they see African American physicians \cite{Cooper-Patrick1999}. Mental Health United States reported that, among clinically trained mental health professionals, only 2 percent of psychiatrists, 2 percent of psychologists, and 4 percent of social workers said they were African American \cite{Holzer1998}. African Americans seeking help—who would prefer an African American provider will have difficulty finding such a provider in these prominent mental health specialties.

The availability of mental health services also depends on where one lives. As discussed earlier, a relatively high proportion of African Americans live in the rural South. Evidence indicates that mental health professionals are concentrated in urban areas and are less likely to be found in the most rural counties of the United States \cite{Holzer1998}. Furthermore, African Americans living in urban areas are often concentrated in poor communities; urban practitioners who do not accept Medicaid or offer services to high-need clientele are not available to them.

**Accessibility of Mental Health Services**

Lack of health insurance is a barrier to seeking mental health care. Nearly one-fourth of African Americans are uninsured \cite{Brown2000}, a percentage 1.5 times greater than the white rate. In the United States, health insurance is typically provided as an employment benefit. Because African Americans are more often employed in marginal jobs, the rate of employer-based coverage among employed African Americans is substantially lower than the rate among employed whites (53% versus 73%; \cite{Hall1999}).

Although insurance coverage is one of the most important determinants for deciding to seek treatment among both African Americans and whites, it is clear that insurance alone, at least when provided by private sector plans, fails to eliminate disparities in access between African Americans and whites \cite{Scheffler1989, Snowden2000}. Provision of insurance benefits with more generous mental health coverage does not increase treatment seeking as much among African Americans as among whites \cite{Padgett1995}. Overcoming financial barriers is an important step in eliminating disparities in care; however, according to evidence currently available, it is not in itself sufficient.

Medicaid, a major public health insurance program subsidizing treatment for the poor, covers nearly 21 percent of African Americans. Medicaid payments are among the principal sources of financing for the services of safety net providers on which many African Americans depend. Medicaid-funded providers have been more successful than others in reducing disparities in access to mental health treatment \cite{Snowden2000}.

African American attitudes toward mental illness are another barrier to seeking mental health care. Mental illness retains considerable stigma, and seeking treatment is not always encouraged. One study found that the proportion of African Americans who feared mental health treatment was 2.5 times greater than the proportion of whites \cite{Sussman1987}. Another study of parents of children meeting criteria for AD/HD discovered that African American parents were less likely than white parents to describe their child's difficulties using specific medical labels and more likely to expect a shorter term course \cite{Bussing1998}. Yet
another study indicated that older African Americans were less knowledgeable about depression than elderly whites (Zylstra & Steitz, 1999).

Practitioners and administrators have sometimes failed to take into account African American preferences in formats and styles of receiving assistance. African Americans are affected especially by the amount of time spent with their providers, by a sense of trust, and by whether the provider is an African American (Keith, 2000). Among focus group participants, African Americans were more likely than whites to describe stigma and spirituality as affecting their willingness to seek help (Cooper-Patrick et al., 1997).

Utilization of Mental Health Services

Community Studies

Adults

Both the ECA and NCS investigated the use of mental health services by African Americans. Although only about 1 person in 3 of all respondents needing care received it, African Americans were distinguished by even lower levels of use (Robins & Regier, 1991). After eliminating the impact of sociodemographic differences and differences in need, the percentage of African Americans receiving treatment from any source was only about half that of whites (Swartz et al., 1998). Most African Americans who received care relied on the safety net public sector programs.

The more recent NCS also examined how many persons used mental health services. Results indicated that only 16 percent of African Americans with a diagnosable mood disorder saw a mental health specialist, and fewer than one-third consulted a health care provider of any kind. Table 3-2 shows that most African Americans suffering from mood and anxiety disorders did not receive care. The NCS also compared the use of mental health services by various ethnic groups and concluded that African Americans received less care than did white Americans.

![Table 3-2. Use of Mental Health Services by African Americans.](image)

Disparities between African Americans and whites also exist after initial barriers have been overcome. After entering care, African Americans are more likely than whites to terminate prematurely (Sue et al., 1994). They are also more likely to receive emergency care (Hu et al., 1991). These differences may come about because African Americans are relatively often coerced or otherwise legally obligated to have treatment (Akutsu et al., 1996; Takeuchi & Cheung, 1998).

Besides using fewer mental health services than do white Americans, African Americans appear to choose different care providers. The National Ambulatory Medical Care Survey, which asked U.S. physicians about their patients, found that African Americans with mental health concerns
were appreciably more likely to see their primary care physician than to see a psychiatrist (Pingitore et al., in press). Whites with mental health concerns, on the other hand, were only slightly more likely to see their primary care physician than to see a psychiatrist. Another study that included only private sector providers reported similar findings (Cooper-Patrick et al., 1994).

Research cited above documents a pervasive under-representation of African Americans in outpatient treatment. At the same time, it may be that African Americans have become willing to seek mental health care as much as, if not more than, other Americans. In a follow-up study at the Baltimore site of the ECA, Cooper-Patrick and colleagues (1999) discovered that all groups studied had increased their rates of mental health help-seeking. The increase among African Americans was such that the disparity between blacks and whites had been eliminated.

Notable differences between African Americans and white Americans have been documented in the use of inpatient psychiatric care. African Americans are significantly more likely than whites to be hospitalized in specialized psychiatric hospitals and beds (Snowden & Cheung, 1990; Breaux & Ryujin, 1999, Snowden, 1999b). Underlying the difference are a number of factors, such as delays in treatment seeking and a high African American rate of repeat admission. One study of clients discharged from State mental hospitals found that African Americans were substantially more likely than others to be hospitalized again during the ensuing year (Leginski et al., 1990). Researchers have not yet evaluated the impact of managed care rationing on hospitalization rates.

**Children and Youth**

African American and white American children receive outpatient mental health treatment at differing rates. Using the National Medical Expenditure Survey, a large, community survey, Cunningham and Freiman (1996) discovered that African American children were less likely than white children to have made a mental health outpatient visit. The difference could not be attributed to underlying socioeconomic, family-related, or regional differences between the groups. Among children who received outpatient mental health treatment, African Americans and whites had similar rates of receiving care from a mental health specialist.

A handful of smaller studies support this finding. One of them considered mental health care provided by specialists, by physicians and nurses, and in the schools (Zahn & Daskalakis, 1997). African American children and youth were less likely than whites to receive treatment, and their underrepresentation varied little, no matter which source of treatment was used. Other school-based studies have reported similar findings (Cuffe et al., 1995; Costello et al., 1997).

Perhaps because of lack of health insurance, few African American children are in psychiatric inpatient care (Chabra et al., 1999), but there are many black children in residential treatment centers (RTCs) for emotionally disturbed youth (Firestone, 1990). RTCs provide residential psychiatric treatment similar to that available in hospitals, but they are more likely to be funded from public sources.

In many cases, it is not parents, but child welfare authorities who initiate treatment for African American children. The child welfare system is a principal gate-keeper for African American mental health care (Halfon et al., 1992; Takavama et al., 1994). For this reason, several studies focusing on metropolitan areas have found an overrepresentation of African American children and youth in public mental health services (Bui & Takeuchi, 1992; McCabe et al., 1999). However, access via the child welfare system often does not result in beneficial treatment.
Older Adults

Little evidence is available documenting the use of mental health services by older black adults. However, one study found that these adults, like their younger counterparts, often do not obtain care (Black et al., 1997). In fact, this study reported that 58 percent of older African American adults with mental disorders were not receiving care. Another study indicated that older blacks in long-term care were less likely to use available community services than were older whites in long-term care (Mui & Burnette, 1994).

Complementary Therapies

African Americans are thought to make extensive use of alternative treatments for health and mental health problems. This preference is deemed to reflect African American cultural traditions developed partly when African Americans were systematically excluded from mainstream health care institutions (Smith Fahie, 1998).

Box 3-3: Complementary treatments are not always beneficial

Joan (age 50)

50-year-old African American woman, "Joan," was hospitalized following a suicide attempt. She cried and was nearly mute, reporting only her inability to sleep and having heard voices commanding her to kill herself. Her medical records indicated a previous admission for psychotic depression. Joan recovered after she took antidepressant medication.

In response to questioning, Joan indicated that she had been successfully treated before, but that she had discontinued psychiatric medication after responding to a letter from an itinerant minister. He had administered holy oil in exchange for payment and informed her to stop taking medication because she had been cured.

After relating this story, Joan was supported in her religious belief and in seeking spiritual uplift from one of many legitimate religious institutions in her community. She was warned, however, against opportunists and charlatans (Bell, 1997).

However, there is scant empirical data on the use of complementary therapies among African Americans suffering from mental health or other health problems (Koss-Chioino, 2000). Preliminary community- and clinic-based studies have found that complementary therapies are used to treat anxiety and depression Elder et al., 1997; Davidson et al., 1998 and to treat health problems that occur in conjunction with mental health problems (Druss & Rosenheck, 2000). One nationally representative survey indicated that African Americans held more favorable views toward use of home remedies than did whites (Snowden et al., 1997).

It is important to realize that alternative therapies are popular in general: As many as 40 percent of Americans use them to complement standard medical care (Eisenberg et al., 1998). Nevertheless, research from rural Mississippi and from public housing in Los Angeles suggests that African Americans may turn to alternative therapies more than do whites Becerra & Inlehart, 1995; Frate et al., 1995; Smith Fahie, 1998.
Appropriateness and Outcomes of Mental Health Services

Upon entering treatment, do African Americans receive effective care? That effective treatments do exist was documented in the Surgeon General’s Report on Mental Health (DHHS, 1999b). The questions that remain are whether novel, standardized treatments and treatment-as-usual are equally effective when administered to African Americans, and whether in settings where African Americans receive care, clinicians diagnose their problems correctly and assign effective forms of treatment.

Studies on Treatment Outcomes

Clearly, an effective treatment is better than no treatment at all. However, for psychosocial interventions that might be sensitive to social and cultural circumstances, there is the question of whether interventions are as effective for African Americans as they are for whites. Few researchers have addressed this question when considering either novel, standardized treatments or treatment-as-usual. Among the handful of studies available for review, many included small samples of participants and lacked adequate controls.

One preliminary effort found that African Americans and white Americans responded similarly to treatment for PTSD (Rosenheck & Fontana, 1994; Zöllner et al., 1999). Cognitive-behavioral therapy, which focuses on altering demoralizing patterns of thought, has been shown to be equally effective in reducing anxiety among African American and white children and adults Friedman et al., 1994; Treadwell et al., 1995. Similarly, behavioral treatment for older medical patients has been shown effective for African Americans (Lichtenberg et al., 1996). A study of persons suffering from severe and persistent mental illness found that a heavily African American sample, drawn from an intensive psychosocial rehabilitation program located in an urban, predominantly African American area, demonstrated increased levels of adaptive functioning in the community (Baker et al., 1999).

On the other hand, African Americans were found less responsive than white Americans in a pilot study of behavioral treatment for agoraphobia (Chambless & Williams, 1995). In another study of treatment for depression, African Americans proved similar to whites in response to psychotherapy and medication, except that African Americans had less improvement in their ability to function in the community (Brown et al., 1999). In a study of treatment as usually provided in the Los Angeles County mental health system, African Americans improved less than whites and members of other racial and ethnic minority groups (Sue et al., 1991). Exposure therapy, which involves overcoming fears in graduated steps, proved ineffective as a treatment for panic attacks among African Americans (Williams & Chambless, 1994).

Studies of children and youth have largely shown positive effects from treatment. African American and white juvenile offenders were assisted comparably by multisystemic therapy, which engages a network of supportive figures in a helping effort (Borduin et al., 1995). In addition, African Americans showed positive outcomes for medication for attention-deficit/hyperactivity disorder (Brown & Sexson, 1988).

Diagnostic Issues

Appropriate care depends on accurate diagnosis. Carefully gathered evidence indicates that African Americans are diagnosed accurately less often than white Americans when they are
suffering from depression and seen in primary care (Borowsky et al., 2000), or when they are seen for psychiatric evaluation in an emergency room (Strakowski et al., 1997).

For many years, clinicians and researchers observed a pattern whereby African Americans in treatment presented higher than expected rates of diagnosed schizophrenia and lower rates of diagnosed affective disorders (Neighbors et al., 1989). When structured procedures were used for assessment, or when retrospective assessments were made via chart review, the disparities between African Americans and whites failed to emerge (Baker & Bell, 1999).

One explanation for the findings is clinician bias: Clinicians are predisposed to judge African Americans as schizophrenic, but not as suffering from an affective disorder. One careful study of psychiatric inpatients found that African Americans had higher rates of both clinical and research-based diagnoses of schizophrenia (Trierweiler et al., 2000). The clinicians in the study were well trained and included both African Americans and white Americans. However, it was found that they applied different decision rules to African American and white patients in judging the presence of schizophrenia. The role of clinician bias in accounting for this complex problem has not yet been ascertained.

**Evidence-Based Treatments**

In a nationally representative telephone and mail survey conducted in 1996, African Americans were found to be less likely than white Americans to receive appropriate care for depression or anxiety. Appropriate care was defined as care that adheres to official guidelines based on evidence from clinical trials. (Wang et al., 2000). Similar findings emerged in another large study that examined a representative national sample (Young et al., 2001). One large study of antidepressant medication use included all Medicaid recipients who had a diagnosis of depression at some time between 1989 and 1994 (Melfi et al., 2000). This study found that African Americans were less likely than whites to receive an antidepressant when their depression was first diagnosed (27% versus 44%). Of those who did receive antidepressant medications, African Americans were less likely to receive the newer selective serotonin reuptake inhibitor (SSRI) medications than were the white clients. This is important because the SSRIs have fewer troubling side effects than the older antidepressants; therefore, they tend to be more easily tolerated, and patients are less likely to discontinue taking them. Failure to treat with SSRI medications may be widespread and might help to explain African American overrepresentation in inpatient facilities and emergency rooms. Also, in a large study of older community residents followed from 1986 through 1996, whites in 1986 were nearly twice as likely, and in 1996, almost 4 times more likely, to use an antidepressant than were African Americans (Blazer et al., 2000).

**Best Practices**

Biological similarities between African Americans and whites are such that effective medications are suitable for treating mental illness in both groups. At the same time, recent evidence suggests that African Americans and white Americans sometimes have different dosage needs. For example, a greater percentage of African Americans than whites metabolize some antidepressants and antipsychotic medications slowly and might be more sensitive than whites (Ziegler & Biggs, 1977; Rudorfer & Robins, 1982; Bradford et al., 1998. This higher sensitivity is manifested in a faster and higher rate of response (Overall et al., 1969; Henry et al., 1971; Raskin & Crook, 1975; Ziegler & Biggs, 1977 and more severe side effects, including delirium (Livingston et al., 1983), when treated with doses commonly used for whites. However, clinicians in psychiatric emergency services prescribe both more and higher doses of oral and injectable
antipsychotic medications to African Americans than to whites (Segel et al., 1996), as do other clinicians working in inpatient services (Chung et al., 1995). Other studies suggest that African Americans are also likely to receive higher overall doses of neuroleptics than are whites Marcolin, 1991; Segel et al., 1996; Walkup et al., 2000.

The combination of slow metabolism and overmedication of antipsychotic drugs in African Americans can yield extra-pyramidal side effects, including stiffness, jitteriness, and muscle cramps (Lin et al., 1997), as well as increased risk of long-term severe side effects such as tardive dyskinesia, marked by abnormal muscular movements and gestures. Tardive dyskinesia has been shown in several studies to be significantly more prevalent among African Americans than among whites Morgenstern & Glazer, 1993; Glazer et al., 1994; Eastham & Jeste, 1996; Jeste et al., 1996.

Conclusions

African Americans have made great strides in education, income, and other indicators of social well-being. Their improvement in social standing is marked, attesting to the resilience and adaptive traditions of African American communities in the face of slavery, racism, and discrimination. Contributions have come from diverse African American communities, including immigrants from Africa, the Caribbean, and elsewhere. Nevertheless, significant problems remain:

1. African Americans living in the community appear to have overall rates of distress symptoms and mental illness similar to those of whites, although some exceptions may exist. One major epidemiological study found that the rates of disorder for whites and blacks were similar after controlling for differences in income, education, and marital status. A later, population-based study found similar rates before accounting for such socioeconomic variables. Furthermore, the distribution of disorders may be different between groups, with African Americans having higher rates of some disorders and lower rates of others.

2. The mental health of African Americans cannot be evaluated without considering the many African Americans found in high-need populations whose members have high levels of mental illness and are significantly in need of treatment. Proportionally, 3.5 times as many African Americans as white Americans are homeless. None of them are included in community surveys. Other inaccessible populations also compound the problem of making accurate measurements and providing effective services.

The mental health problems of persons in high-need populations are especially likely to occur jointly with substance abuse problems, as well as with HIV infection or AIDS (Lewin & Altman, 2000). Detection, treatment, and rehabilitation become particularly challenging in the presence of multiple and significant impediments to well-being.

3. African Americans who are distressed or have a mental illness may present their symptoms according to certain idioms of distress. African American symptom presentation can differ from what most clinicians are trained to expect and may lead to diagnostic and treatment planning problems. The impact of culture on idioms of distress deserves more attention from researchers.

4. African Americans may be more likely than white Americans to use alternative therapies, although differences have not yet been firmly established. When complementary therapies are used, their use may not be communicated to clinicians. A lack of provider knowledge of their use may interfere with delivery of appropriate treatment.
5. Disparities in access to mental health services are partly attributable to financial barriers. Many of the working poor, among whom African Americans are overrepresented, do not qualify for public coverage and work in jobs that do not provide private coverage. Better access to private insurance is an important step, but is not in itself sufficient. African American reliance on public financing suggests that provisions of the Medicaid program are also important. Publicly financed safety net providers are a critical resource in the provision of care to African American communities.

6. Disparities in access also come about for reasons other than financial ones. Few mental health specialists are available for those African Americans who prefer an African American provider. Furthermore, African Americans are overrepresented in areas where few providers choose to practice. They may not trust or feel welcomed by the providers who are available. Feelings of mistrust and stigma or perceptions of racism or discrimination may keep them away.

7. African Americans with mental health needs are unlikely to receive treatment—even less likely than the undertreated mainstream population. If treated, they are likely to have sought help from primary care providers. African Americans frequently lack a usual source of health care as a focal point for treatment. African Americans receiving specialty care tend to leave treatment prematurely. Mental health care occurs relatively frequently in emergency rooms and psychiatric hospitals. These settings and patterns of treatment undermine delivery of high-quality mental health care.

8. African Americans are more likely to be incorrectly diagnosed than white Americans. They are more likely to be diagnosed as suffering from schizophrenia and less likely to be diagnosed as suffering from an affective disorder. The pattern is longstanding but cannot yet be fully explained.

9. Whether African Americans and whites benefit from mental health treatment in equal measure is still under investigation. The limited information available suggests African Americans respond favorably for the most part, but few clinical trials have evaluated the response of African Americans to evidence-based treatments. Little research has examined the impact on African Americans of care delivered under usual conditions of community practice. More remains to be learned about when and how treatment must be modified to take into account African American needs and preferences.

Adaptive traditions have sustained African Americans through long periods of hardship imposed by the larger society. Their resilience is an important resource from which much can be learned. African American communities must be engaged, their traditions supported and built upon, and their trust gained in attempts to reduce mental illness and increase mental health. Mutual benefit will accrue to African Americans and to the society at large from a concerted effort to address the mental health needs of African Americans.

References


**Footnotes**

1

This figure includes individuals reporting Black or African American race alone. It does not include individuals who also identify as Hispanic or who indicate two or more races.