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CHAPTER SIX

THE EPIDEMIOLOGY OF MENTAL DISORDER

1985 to 2000

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In 1985, the landmark report of the Task Force on Black and Minority Health (the Heckler Report) was instrumental in stimulating a tremendous amount of research and writing on racial health disparities (U.S. Department of Health and Human Services [DHHS], Task Force on Black and Minority Health, 1985). Due to its heavy emphasis on mortality, however, the report was conspicuous in how little it had to say about racial differences in mental health. As a result, it did not stimulate much public health research on serious mental disorders. Although the period between 1985 and 2000 has yielded much information on physical health problems, it has not drawn enough attention to the mental health challenges that African Americans face. Thus the picture of African American mental health that has been drawn on the basis of epidemiological studies conducted over the last fifteen years is interesting but incomplete.

The issue of black-white differences in the epidemiology of mental illness has a long and varied history (Cannon & Locke, 1977; Dohrenwend & Dohrenwend, 1969; Fischer, 1969; Kramer, Rosen, & Willis, 1973; Pasamanick, 1963; Thomas & Sillen, 1972). For much of that history, the epidemiological research focused on methodologically limited anecdotal accounts and nonrepresentative treatment rate studies (Fischer, 1969; Jaco, 1960; Kramer et al., 1973; Schermerhorn, 1956). During the 1980s, more rigorous community surveys of psychological distress often found significantly higher symptom rates among blacks compared to whites, although these differences were eliminated when socioeconomic status was controlled (Neighbors, 1984; Vega & Rumbaut, 1991). By the late 1980s, publications from the Epidemiologic Catchment Area (ECA) program of the National Institute of Mental Health (NIMH) provided, for the first time, information

on discrete mental disorders, free from much of the clinical ambiguity associated with symptom checklists and unencumbered by the selection bias of treatment rate studies. Although epidemiologists continue to study racial differences in psychological distress, a large part of what we now know about the prevalence of mental disorder among African Americans comes from community surveys of specific diagnostic categories (Brown, Ahmed, Gary, & Milburn, 1995; Robins & Regier, 1991; Somervell, Leaf, Weissman, Blazer, & Bruce, 1989; Williams, Takeuchi, & Adair, 1992a, 1992b).

The purpose of this chapter is to review the empirical findings on black-white differences from community epidemiological surveys of well-being, psychological distress, and serious mental disorder. Within-race demographic comparisons (gender, age, socioeconomic status, and marital status) are summarized for particular disorders (for example, mood and anxiety disorders) in order to illustrate some of the more interesting descriptive statistics in need of further investigation. Clinical issues related to treatment are not addressed—with the exception of diagnosis, which we argue is directly relevant to improving epidemiological case finding.

The Public Mental Health Perspective

Perhaps more than any other health construct, the concept of mental health encompasses a tremendously wide variety of topics, issues, and meanings (Fellin, 1996; Mechanic, 1999; Taylor, 1992). As a result, no chapter on mental health can cover all factors that have been placed in this broad area. Therefore the emphasis here is on public health approaches resting on a sound psychiatric epidemiological foundation. The goal of this nation's public mental health efforts should be to direct resources toward developing tools for clearly identifying African Americans who are experiencing disability due to psychological pain and toward developing interventions designed to raise these individuals to a relatively symptom-free level of functioning. This is not to imply that there is no benefit in encouraging African Americans to strive for self-development and self-actualization (Franklin & Jackson, 1990, p. 300; Jahoda, 1958; Peterson, 1999, p. 116). In fact it is clear that the vast majority of African Americans are seriously engaged in the process of self-betterment and the struggle for upward social mobility. Rather, this chapter will address the mental health implications of such striving efforts, and what can be done to reduce the psychiatric morbidity that results from race-based blocked opportunities. We must focus our energies on increasing the overall mental health of African American communities by reducing stress and increasing resiliency among those blacks suffering the incapacitating effects of life in the United States.

Effective public health interventions are based on accurate, comprehensive epidemiology. The conceptualization of epidemiology presented here includes more than the counting of mental disorder. It addresses the full spectrum of the

epidemiological paradigm, including the development of theories concerning risk and protective factors, the utilization of services, and preventive intervention. When it comes to research on African Americans, however, the psychiatric epidemiological picture remains largely descriptive. Although theory-based risk factor research is accumulating, this review shows that we still do not have enough information on how various biological, psychological, and social factors increase or decrease vulnerability to mental disorder among African Americans.

Important Research Questions

This chapter draws attention to a set of interesting and important research questions. The goal is to stimulate a new generation of research investigators to accept the challenge of clarifying the results presented here. Many argue that the stress associated with racial status and exposure to discrimination should increase the vulnerability of African Americans to mental disorder (Cannon & Locke, 1977; Fischer, 1969; Kramer et al., 1973). As a result, the *minority status* hypothesis predicts higher rates of mental disorders for blacks than for whites at *all* levels of socioeconomic status (Halpern, 1993; Kessler & Neighbors, 1986; Mirowsky & Ross, 1980; Parker & Jones, 1999). Yet the epidemiological data are not consistent with this hypothesis. Blacks have comparable or lower rates of mental disorder than whites do (Kessler, McGonagle, et al., 1994; Robins & Regier, 1991). Despite this general trend, there are significant racial differences for a few mental disorders. For example, rates of anxiety disorders, particularly phobias, are significantly higher for blacks than for whites; whereas rates of depression are lower for blacks. Some have speculated that cultural factors explain the findings for both depression and phobia (Brown, Eaton, & Sussman, 1990; Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Warheit, Holzer, & Arey, 1975). Yet the empirical evidence demonstrating that protective processes operate differently for blacks than for whites remains unsatisfactory.

Cultural factors also come into play in the assessment of psychopathology. Because so much of what we now know about race and mental disorder is based on findings from the ECA program (Robins & Regier, 1991; data collected from July 1980 to August 1984) and the National Comorbidity Survey (NCS) (Kessler, McGonagle, et al., 1994), the data on race are largely a function of a methodological approach characterized by highly structured questionnaires that employ the same diagnostic criteria used by clinicians, that is, the criteria of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Yet it is frequently argued that racial groups often differ in their presentation and expression of mental disorder. This presents a particularly important challenge for psychiatric epidemiology because the rigid implementation of *DSM* criteria via highly structured survey instruments does not allow assessments of psychopathology to be adjusted on the basis of such cultural differences (Neighbors, Trierweiler, et al., 1999; Rogler, 1999; Vega & Rumbaut, 1991, p. 359; Wakefield, 1999, pp. 30–39, 50–54).

Studies of help-seeking show that like members of other population groups, many African Americans who could be helped by specialty mental health services do not access the professional help they need. On the one hand we need interventions designed to overcome both the psychological and structural barriers African Americans face in seeking professional help. This means effective mental health education programs designed to facilitate the recognition of mental disorders and to overcome the stigma associated with admitting to emotional difficulty. On the other hand it is not at all clear that increasing access to mental health services for African Americans will result in quality care (Neighbors et al., 1992). Some literature indicates that African Americans are at increased risk for being misunderstood, misdiagnosed, and mistreated (Adebimpe, 1981; Bell & Mehta, 1980, 1981; Neighbors, Jackson, Campbell, & Williams, 1989; Strakowski, McElroy, Keck, & West, 1996; Whaley, 1997). For example, rates of treated mental disorder have consistently shown that blacks have a higher rate of schizophrenia and a lower rate of mood disorder than whites. However, although these data have been interpreted as evidence of widespread misdiagnosis among African Americans, they are consistent with black-white differences in the community prevalence of these two disorders. It is possible that the treatment rates for depression and schizophrenia are a function of racial differences in the true prevalence of mental illness and of the fact that depressed African Americans are less likely to enter treatment than depressed whites.

Finally, public health researchers are increasingly being called on to clarify exactly what they mean by the concept of race and whether it differs from the related construct of ethnicity. Issues related to conceptualizations of race and ethnicity have important implications for sampling, recruiting study participants, classifying respondents for data analysis, and devising explanatory frameworks for the nature of racial differences in mental disorder. Clearly, race matters for mental health, although there are differing opinions as to how and why. Although for some this means doing a better job of measuring the impact of discrimination, for others it is a matter of understanding the relative importance of biology, genetics, and the environment (Farone & Tsaung, 1995; Lawson, 1990, 1996; Lin, Poland, & Silver, 1993; Lin, Poland, & Wallaski, 1993).

A Closer Look at the Epidemiological Evidence

The epidemiological data in five areas of concern—well-being and distress, depression, anxiety disorder, phobia, and suicide—will provide an initial picture of the mental health status of African Americans.

Well-Being and Distress

African Americans are disadvantaged compared to whites on most subjective indicators of the quality of life. Blacks report lower levels of life satisfaction, happiness, and marital happiness, and higher levels of anomia and mistrust than

whites. There has been no change in the black disadvantage on these quality-of-life indicators between 1972 and 1996 (Hughes & Thomas, 1998). In addition, these racial disparities in the quality of life cannot be explained by socioeconomic status. However, blacks have comparable or better mental health than whites on other indicators. For example, there are no black-white differences in self-esteem (Jackson & Lassiter, in press; Porter & Washington, 1979, 1993). Similarly, elevated rates of psychological distress among African Americans as compared to whites are not consistently found. Although some studies find that blacks have higher rates of distress compared to whites, other studies find the opposite, and some studies find no racial differences at all (Dohrenwend & Dohrenwend, 1969; Neighbors, 1984; Vega & Rumbaut, 1991; Williams & Harris-Reid, 1999). Moreover, blacks have comparable or lower rates of mental disorder than whites. The ECA study found very few differences between blacks and whites in the rates of both current and lifetime psychiatric disorders. The absence of a racial difference in drug use history and the prevalence of alcohol and drug dependence is especially noteworthy given popular perceptions of elevated rates of drug use in the black community. The more recent National Comorbidity Survey found that blacks do not have higher rates of mental disorder than whites for any of the major classes of disorders. Instead, lower rates of disorders for blacks when compared to whites are especially pronounced for mood disorders and the substance abuse disorders (alcohol and drug abuse). Anxiety disorders, especially phobias, however, stand out as one area where blacks had considerably higher rates than whites.

Taken together, national epidemiological estimates from both the ECA and the NCS show that the prevalence of serious mental illness in African Americans is equivalent or below that of whites. Focusing on overall rates of any disorder is not, however, particularly useful because it obscures important subgroup differences for specific disorders. The manner in which rates of disorder vary once demographic categories such as age, sex, marital status, and socioeconomic status are taken into account has not been inspected adequately. Unfortunately, the NCS remains a relatively untapped data resource. A comprehensive investigation of NCS data for black-white differences in *DSM* disorders has yet to be published. Therefore some of the best information in this area still comes from the ECA study.

Depression

The ECA found that overall, blacks and whites did not differ in the lifetime prevalence of major depression (Robins & Regier, 1991; Robins, Helzer, Croughan, & Ratcliff, 1981; Somervell et al., 1989), but factoring in the effect of age, gender, and socioeconomic status reveals some interesting patterns (see Table 6.1, columns 1 to 4). The most dramatic racial difference in depression occurred among men aged thirty to forty-four, where white men display a higher lifetime prevalence rate than black men (7.2 percent compared to 2.6 percent). A similar but much less dramatic racial difference was found for the one-year and

TABLE 6.1. THE RELATIONSHIP OF AGE AND RACE TO MOOD, GENERALIZED ANXIETY, AND PHOBIA (ONE-YEAR AND LIFETIME PREVALENCE) FOR MEN AND WOMEN.

	Men											
	Any Mood Disorder				*Generalized Anxiety Disorder*				*Any Phobic Disorder*			
	One-Year		*Lifetime*		*One-Year*[a]		*One-Year*[b]		*One-Year*		*Lifetime*	
	Black	White	Black	White	Black	White	Black	White	Black	White	Black	White
18–29	2.9	2.8	5.3	6.3	8.80	3.10	7.38	2.88	11.46	5.84	16.18	10.65
30–44	1.4	2.9	2.6	7.2	2.28	2.06	1.68	1.11	10.48	5.82	14.29	10.27
45–64	1.1	1.8	1.9	3.7	6.76	1.35	6.71	0.91	12.71	6.23	20.26	9.93
65+	0.2	0.6	1.9	1.5	0.90	1.50	1.02	0.83	12.04	4.20	15.30	7.18
	Women											
	Any Mood Disorder				*Generalized Anxiety Disorder*				*Any Phobic Disorder*			
	One-Year		*Lifetime*		*One-Year*[a]		*One-Year*[b]		*One-Year*		*Lifetime*	
	Black	White	Black	White	Black	White	Black	White	Black	White	Black	White
18–29	7.6	5.8	11.1	10.9	10.55	5.42	8.24	3.14	22.99	12.24	27.23	14.84
30–44	5.1	8.3	10.5	16.1	6.89	4.69	3.97	3.03	18.04	16.35	24.60	22.33
45–64	2.8	3.6	6.0	9.5	3.44	5.35	1.68	4.24	21.03	10.49	30.63	15.56
65+	1.8	1.4	3.4	3.4	2.76	2.82	2.71	2.28	14.80	8.45	24.17	13.01

Note: "One year" means that there was some sign of the disorder within one year before the interview.

[a]GAD with no exclusions for other *DSM* disorder.

[b]GAD excluding people with panic or major depression.

Source: Robins & Regier, 1991 (data abstracted from the NIMH Epidemiologic Catchment Area study, p. 60, p. 165, and pp. 187–188).

lifetime prevalence of depression for women in the same age group (16.1 percent for white women over a lifetime compared to 10.5 percent for black women). Blacks also had lower one-year and lifetime rates for both men and women aged forty-five to sixty-four. The most dramatic difference for this age group was seen in lifetime rates for black women (9.5 percent compared to 6 percent for white women). There were no appreciable racial differences in depression among elderly (sixty-five-plus) men or women.

Black women show higher rates of depression than black men at all age groups for both one-year and lifetime prevalence. For both black men and women, the highest rates of depression occur in the eighteen to twenty-nine age range, and both one-year and lifetime rates decline with age (Weissman, Bruce, Leaf, Florio, & Holzer, 1991, p. 60). In a detailed analysis of race and depression, Somervell et al. (1989) found no black-white differences in the six-month prevalence of depression. Taking age into account, however, a high rate of depression was revealed among black women aged eighteen to twenty-four. This is consistent

with ECA findings. Black women aged eighteen to twenty-four in both the New Haven and Baltimore ECA sites had a higher lifetime prevalence of depression than white women; a higher six-month prevalence of depression for black women was seen at all five ECA sites. Williams, Takeuchi, and Adair (1992b) focused more closely on socioeconomic status, race, and psychiatric disorder. They found that, unlike the pattern for whites, the six-month prevalence of depression among blacks was not related to socioeconomic status. Neither was there a relationship between socioeconomic status and lifetime depression among black men, although there was a significant positive relationship between lifetime depression and education. Black men with some college were more likely to be depressed than less educated black men. Lifetime depression was not related to socioeconomic status among black women. Brown, Ahmed, Gary, and Milburn (1995) conducted a regional study of major depression in a community sample of African Americans. The one-year prevalence of depression was higher for men than for women but the difference was not significant. The highest rates of depression were among those aged eighteen to twenty-nine (the youngest examined). Depression was not related to income or to education.

Williams, Takeuchi, and Adair (1992a) used the ECA data to examine racial differences in mental disorder when marital status was also considered. Married blacks and whites had lower rates of psychiatric disorders than the previously married (separated, divorced, and widowed) did. Widowed black women, for example, had levels of major depression that were three times higher than those of their married counterparts. Never-married black men and women and white men had rates of depression comparable to married respondents' rates. The absence of an elevated risk of psychiatric illness for never-married black women is especially instructive because of concerns about the psychological consequences of being a female head of household, given the rise of such households in the black community. An examination of which sex benefits more in mental health terms from marriage found that among the separated and divorced, black men had a higher rate of depression than black women. Gender differences were also evident among the never married and widowed. For never-married blacks, men had higher rates of depression than women; whereas among the widowed, as mentioned, black women were at higher risk of major depression.

Generalized Anxiety Disorder

Warheit, Bell, Schwab, and Buhl's study (1986) of northern Florida, using a twelve-item symptom checklist, found significantly higher anxiety scores for blacks than for whites. Blazer, Hughes, George, Swartz, and Boyer (1991) concluded that despite wide variation in the definitions used in epidemiological studies conducted between 1970 and 1986, generalized anxiety disorder (GAD) was more common in blacks than in whites. In general, these early findings were confirmed by the ECA (see Table 6.1, columns 5 to 8). Blacks had higher one-year prevalence rates of generalized anxiety than whites. The ECA used three different definitions of

GAD. Blacks who had GAD without depression or panic had significantly higher rates than whites. Among blacks and whites with GAD with or without other *DSM* diagnoses (that is, with no exclusions for other diagnoses), the overall difference was quite noticeable (6.09 percent for blacks versus 3.47 percent for whites). Among men less than thirty years of age and men forty-five to sixty-four, blacks had higher rates than whites for all three measures of GAD; there were no racial differences among the elderly or among the thirty to forty-four age group. Black women aged eighteen to twenty-nine and thirty to forty-four exceeded white women for all three GAD measures. The differences were most pronounced for GAD with no exclusions for other disorders. Interestingly, white women aged forty-five to sixty-four had slightly *higher* rates of GAD than black women of that age did. No racial differences in GAD were found among the elderly. For black men, GAD was highest in the youngest age group across all three measures. Among black men, the GAD rates drop for those aged thirty to forty-four and then rise again among those aged forty-five to sixty-four, to rates almost comparable to those less than thirty years of age. The lowest rates of GAD among black men were for those aged sixty-five and above. For black women the GAD rates were also highest among those less than thirty years of age. Unlike black men, however, black women consistently exhibited less GAD with age. Similar to black men, black women incurred the lowest rates of GAD at age sixty-five and older.

Phobia

Black-white comparisons for phobia, also an anxiety disorder, are even more interesting than those for GAD. Historically, blacks have consistently exhibited higher rates of phobia than whites. As far back as the mid-1970s, Warheit et al. (1975) reported significantly higher rates of phobic symptomatology for African Americans than for whites, even with controls for socioeconomic status. Similarly, the ECA study reported that blacks had higher rates of phobia for one-month, one-year, and lifetime prevalence (Table 6.1, columns 9 to 12). In fact, 23.4 percent of blacks in the ECA study met lifetime criteria for phobic disorder. Controlling for sex did not change this pattern. In terms of phobia subtypes, blacks exceeded whites for agoraphobia and simple phobia but not for social phobia. Controlling for sex yields this same pattern for men, but black women exceeded white women for social phobia as well as for agoraphobia and simple phobia. Twenty-four percent of black women met lifetime prevalence criteria for simple phobia. Controlling for both sex and age, black men exceeded white men in both the one-year and lifetime prevalence of phobia at all age groups. There was no relationship of phobia to age for black men; the rates were high for all ages, but highest in the forty-five to sixty-four age group. For one-year and lifetime phobia. black women exceeded white women at all ages, although black and white women aged thirty to forty-four were very similar. There were no noticeable trends for phobia by age for black women. Finally, blacks also had higher rates of any phobic disorder (one-year prevalence) than whites when data were controlled for education (Robins & Regier, 1991).

Brown et al. (1990) performed a multivariate analysis of racial differences in phobia using data from the ECA study. This analysis showed that African Americans were 1.52 times more likely than whites to report recent phobia. In a very comprehensive analysis of respondents in wave 2 of the Durham ECA site, Hybels et al. (1997) found significantly higher phobia rates for blacks when controlling for social network structure, social interaction, social support, religiosity, self-confidence, physical health, and comorbidity as well as for the typical list of demographic characteristics (age, gender, socioeconomic status, marital status, urbanicity). Even with all of these controls, a multivariate logistical analysis showed that Durham blacks were 1.97 times more likely than whites to meet criteria for phobia. The initial findings from the NCS also revealed that the prevalence of phobias was significantly higher among African Americans and that blacks were twice as likely as whites to meet criteria for one-month agoraphobia (Magee et al., 1996). Blacks were also 33 percent more likely than whites to meet criteria for simple phobia. Closer inspection of the NCS data revealed that black women had a higher current rate of agoraphobia and simple phobia than white women did. White males, however, had rates of simple and social phobia that were two and three times higher than the rates for black men (Magee, 1993).

Suicide

In general, suicide rates have been and remain much lower for blacks than whites, a pattern that is remarkably consistent with the general finding of no black-white differences in mental disorder. Racial differences in suicide have been termed a "cultural paradox," given that African Americans have experienced discrimination, decreased economic opportunity, and low social status (Gibbs, 1997). A closer inspection of the suicide data, however, reveals some troubling trends. In fact, suicide is now the third leading cause of death for African American youths fifteen to twenty-four years old. Suicide among elderly African Americans, over seventy-five years old, increased more than 50 percent from 1980 to 1992 (Davis, 1979; Kachur, Potter, James, & Powell, 1995). Interestingly, suicide among black girls ten to nineteen years old decreased over this period. Paradoxically, although more black men than women complete suicide, African American females are more likely to attempt suicide, and their rate of attempts is virtually equal to that of white women (Cannetto & Lester, 1995; Kachur et al., 1995; Lester, 1998; Molock, Kimbrough, Lacy, & McClure, 1994; Summerville, Kaslow, & Doepke, 1996).

Within the black population, women are much more protected from completing suicide than are black men (Cose, 1995). Little is known, however, about why these protective factors do not prevent women from *attempting* suicide and why these factors protect women but not men (Baker, 1988; Early, 1992; Gibbs, 1997; Singh, Kochanek, & MacDorman, 1996; Smith & Carter, 1986). It could be, on the one hand, that there are no gender differences in the underlying processes, and that the outcome difference may be due entirely to the differential

lethality of the methods chosen. Certainly, men tend to use more effective suicide strategies than women. The difference may, on the other hand, have something to do with the concept of black male masculinity. Majors and Billson (1993) discuss the mental health implications of the construct *cool pose,* a cluster of behaviors designed to deliver a message of strength and control. Majors and Billson speculate that the cool pose may in fact mask feelings of self-doubt and insecurity. It may then increase the risk of suicide because its use as a coping strategy results in losing touch with one's feelings. Although interesting explanations for the observed patterns abound, few have been tested empirically. For example, some have speculated that because blacks report being more religious than whites, religiosity operates to protect African Americans from suicide (Neeleman, Wessely, & Lewis, 1998). Some research suggests that social support from family and friends protects African American women against suicide and that low social status (particularly for single mothers) may actually *increase* involvement in suicide-protective support systems (Nisbet, 1996). The protective effects of religiosity or family support have not been linked empirically to suicidal ideation, nor has the *differential* impact of such factors been tested across races.

One of the more popular explanations for the black male suicide increase has to do with the stress of upward social mobility and the provocative hypothesis that academic and economic achievement and success are detrimental to black mental health (Centers for Disease Control and Prevention, 1998). It has been argued that upwardly mobile African Americans are exposed to stressful events (for example, racial slurs, social isolation) associated with moving into new, more racially integrated social environments. Assimilation into the middle class might also draw African Americans away from the traditional social institutions that have operated as protective factors. As blacks move up economically and into more racially integrated settings, they may lose access to some culturally based protective factors such as family and religious support. This line of thinking is provocative because conventional wisdom would suggest that economic success leads to improvements in mental health. But as the depression and anxiety data show, middle and upper socioeconomic status blacks are just as depressed and anxious as low socioeconomic status blacks. It is possible that the impact of upward social mobility varies as a function of differences in the ways black men and women are socialized. We do not know enough to determine whether successful upward mobility is the culprit that explains the increasing rates of suicide among young African American males or whether it is the persistently poor who have lost hope who are committing suicide in ever higher numbers. Furthermore, we do not understand why such stresses do not affect black women in a similar manner. These mobility-related hypotheses about the mental health effects of assimilation remain largely untested. In summary, despite some very troubling trends and suicide's importance as an "ultimate outcome" of risk for depression, epidemiological research on race and suicide remains much too descriptive. More studies are needed before we can better understand the impact of specific risk and protective factors on race and suicide.

The African American Experience: Risk and Protection

African Americans must continually confront issues of acculturation and identity, discrimination, goal-striving stress, and the stress of imposed and sometimes internalized inferiority. Learning how they do so and with what results is important to improving black mental health.

Acculturation and Identity

The concept of acculturation offers a promising direction for broadening psychiatric epidemiological research on race beyond its preoccupation with describing demographic differences. The relationship between acculturation and mental health has been applied much more to Hispanics and Asians than to American Indians and African Americans (Banks, 1996; Landrine & Klonoff, 1996a; Snowden & Hines, 1999; Williams-Flournoy & Anderson, 1996). There is, however, some overlap between research on African American identity and acculturation models. Black identity and acculturation research overlap most with respect to the concept of psychological acculturation (Marger, 1997), where the focus is on the individual's changes in self-concept and the extent to which individuals feel that they belong to a mainstream, largely white society as opposed to their own particular racial group. Models of black identity development and acculturation are concerned both with the mental health implications of separation (segregation), assimilation, and feelings of marginalization and with the ability to successfully integrate aspects of multiple cultures (to be multicultural) (Berry, Poortinga, Segall, & Dasen, 1992). Some African Americans are able to become multicultural with relatively little cost to mental health and self-concept; others find it much more difficult and stressful.

Black racial group identity and other forms of psychological acculturation are partly a function of how members of other racial groups (for example, whites) respond to the acculturation strategies adopted by African Americans. The manner in which highly visible phenotypic characteristics (for example, skin color) are used to facilitate or limit access to societal resources has important implications for factors such as social status, social mobility, power, control, and social support. The African American identity literature is dominated by social and clinical psychology and, as such, is certainly relevant to mental health. The issues of identity and acculturation have not, however, been adequately explored with respect to the epidemiology of mental disorders. Psychiatric epidemiology has much to learn by linking more directly with the body of knowledge about these matters. Rogler, Cortes, and Malgady's review (1991) demonstrates that the acculturation and mental health literature is still fraught with conceptual ambiguities, measurement problems, and conflicting results. Nevertheless, acculturation remains an increasingly promising but underexplored explanatory framework for racial differences in mental disorder.

Discrimination

A growing body of research is examining the mental health consequences of exposure to discrimination. In a national probability sample of blacks, whites, Hispanics, and Asians, Williams (2000) found that reports of discrimination due to race or cultural background were positively related to psychological distress. In the first wave of the National Survey of Black Americans (NSBA), Williams and Chung (in press) documented that perceptions of racial discrimination were related to higher levels of psychological distress and lower levels of life satisfaction and happiness as well as to poorer physical health. Prospective analyses of the NSBA data revealed that discrimination was inversely associated with life satisfaction but unrelated to happiness and psychological distress (Jackson et al., 1996). Several recent studies have provided more comprehensive assessments of discrimination than the single-item global measures used in most early studies of discrimination and mental health. Landrine and Klonoff (1996b) developed an eighteen-item scale of racist events, and found that this measure of discrimination was positively related to psychological distress. Thompson (1996) found that a multiple-item measure of exposure to discrimination was predictive of higher levels of psychological distress in a probability sample of African Americans in St. Louis, Missouri. Ren, Amick, and Williams (1999) found that experiences of discrimination were positively related to self-report measures of physical and mental health in a nationally representative sample.

Williams and colleagues (Forman, Williams, & Jackson, 1997; Williams, Yu, Jackson, & Anderson, 1997) developed a scale to capture minor but recurrent experiences of discrimination. This measure of chronic, everyday discrimination assesses the frequency of experiences such as being treated with less courtesy, being shown less respect, and receiving poorer service than others in restaurants or stores. Two recent studies found that blacks report markedly higher levels of both minor and major experiences of discrimination (Kessler, Mickelson, & Williams, 1999; Williams et al., 1997). Such discriminatory events adversely affected self-rated health, chronic physical conditions, psychological distress, and life satisfaction in the metropolitan Detroit study (Williams et al., 1997). Importantly, these associations between discrimination and health were independent of other measures of stress. Perceptions of discrimination were related to psychological distress, major depression, and generalized anxiety in the national study (Kessler et al., 1999).

Goal-Striving Stress

Climbing the ladder of success is a central feature of the American dream. As integral members of U.S. society, black Americans fully endorse the core value of achievement and the idea that hard work and persistence can ensure socioeconomic success (Clark, 1965; Gurin, Gurin, Lao, & Beattie, 1969; Hyman, 1953; James, 1994). As the findings on discrimination show, the mental health of

African Americans has a lot to do with how blacks deal with expectations for success and aspirations for achievement in the face of race-based obstacles. This is the delicate psychological balancing act faced by African Americans living in the United States. The manner in which each black person resolves the counteracting forces of the upward pull of his or her dream and the downward pressure of discrimination is the key to whether or not he or she will make a successful adaptation to life in the United States (Edwards & Polite, 1992). The desire for a better life coupled with the fact of blocked opportunities can be frustrating, disappointing, and worse, psychologically damaging (Dressler, 1988; Neighbors, Jackson, Broman, & Thompson, 1996). Yet few psychiatric epidemiological investigations have empirically examined the relationship between aspirations, achievements, and the stress of blocked opportunities.

The concept of goal-striving stress is a useful but underutilized way to capture the social psychological effects of race-based discrimination. Parker and Kleiner (1966) were the first to apply the concept of goal-striving to a psychiatric epidemiological investigation of black Americans. Goal-striving stress is the psychological discrepancy between aspiration and achievement, weighted by the subjective probability of success and the disappointment experienced if those aspirations are not achieved. Parker and Kleiner found that low socioeconomic status blacks displayed *low* goal-striving stress and high psychological distress; the opposite was true for high socioeconomic status blacks. Further analyses of the data showed that social mobility modified the relationships among socioeconomic status, goal-striving, and mental health. Upwardly mobile, high socioeconomic status blacks had high goal-striving stress and high rates of distress, which Parker and Kleiner interpreted as failure to reduce striving even after achieving success. Downwardly mobile, poor African Americans had high goal-striving stress scores and high symptoms, which Parker and Kleiner saw as a failure to reduce aspirations associated with past status. Stable, persistently poor blacks had low goal-striving stress and low symptoms. For this group, Parker and Kleiner speculated that the reduction of active goal-striving was psychologically adaptive. It is time we linked such concepts as goal-striving (and related constructs like John Henryism) to the epidemiology of mental disorder (Neighbors & Lumpkin, 1990, pp. 63–64). Recently, analyses from the National Survey of Black Americans found that high goal-striving stress lowers happiness, life satisfaction, and self-esteem and increases psychological distress as well as clinical depression for African Americans regardless of age, sex, income, or education (Neighbors & Sellers, 2000; Sellers, 2000).

The Stress of Inferiority

Another significant psychological effect of racism and discrimination is its attack on the ego identity of its victims. By this we do not mean self-hatred. Rather, we refer to the erosion of self-confidence that can result when others voice skepticism about the cognitive and behavioral abilities of African Americans (Wilson, 1999).

Negative images of blacks are pervasive in American culture. Although focusing on academic achievement (a stereotype threat), the research of Claude Steele (Steele, 1992, 1999) clearly shows the pervasive impact of negative stereotypes on self-concept and test performance. These beliefs about biological or cultural black inferiority can attack the self-worth of some African Americans. The term *internalized racism* describes their acceptance of the negative societal beliefs and stereotypes about their group. It has been suggested that in a color-conscious, racially stratified society, one adaptive response of populations defined as inferior is to accept the dominant society's ideology of their inferiority (McCarthy & Yancey, 1971; Pettigrew, 1964). For some African Americans the normative cultural characterization of the superiority of whiteness and the devaluation of blackness, combined with the economic marginality of blacks, can lead to self-perceptions of worthlessness and powerlessness.

Several lines of evidence suggest that the internalization of cultural stereotypes by stigmatized groups can create expectations, anxieties, and reactions that can adversely affect social and psychological functioning. Fischer et al.'s review of research from several countries (1996) indicates that groups that are socially regarded as inferior have poorer academic performance than their more highly regarded peers (this has been found for Koreans versus Japanese in Japan, Scots versus the English in the United Kingdom, and Eastern European–origin Jews versus Western European–origin Jews in Israel). Research in the United States revealed that under experimental conditions, when a stigma of inferiority is activated, performance on an examination is adversely affected. African Americans who were told in advance that blacks perform more poorly on exams than whites, women who were told that women perform more poorly than men, and white men who were told that whites usually do worse than Asians, all had lower scores on an examination than control groups who were not confronted with a stigma of inferiority (Fischer et al., 1996; Steele, 1992, 1999). Similarly, studies of mental patients revealed that the expectation of negative stigmatization adversely affected social networks, job performance, and self-esteem (Link, 1987; Link, Streuning, Cullen, Shrout, & Dohrenwend, 1989).

Jerome Taylor and his colleagues at the University of Pittsburgh have empirically examined the mental health consequences of internalized racism. In a study of 289 African American women, Taylor and Jackson (1990) found a positive association between internalized racism (believing in the innate inferiority of blacks and feeling uncomfortable around other blacks) and psychological distress (see also Taylor, Henderson, & Jackson, 1991; Taylor & Jackson, 1991). These associations remained significant after adjustment for stress, social support, religious orientation, socioeconomic status, marital status, and physical health. Other studies with Taylor's instrument (the nationalization scale) have produced similar results (Tomes, Brown, Semenya, & Simpson, 1990). Support for the adverse health consequences of internalized racism also comes from analyses of the NSBA (Williams & Chung, in press). In this study, blacks were asked the extent to which

they regarded seven negative stereotypes and seven positive stereotypes as true of most black people. The endorsement of negative stereotypes was positively related to psychological distress. The rejection of positive stereotypes as true was inversely related to happiness and life satisfaction. These associations were significant after controlling for sociodemographic factors (age, education, and gender) and discrimination.

Much is yet to be learned about the determinants and consequences of internalized racism. Hughes and Demo (1989) found an inverse association between internalized racism (measured in terms of the endorsement of stereotypes) and self-esteem among blacks, but we do not currently understand the causal dynamics underlying this association. Research is needed to explicate the ways in which racial group self-esteem and personal self-esteem relate to each other and combine to affect health. The research so far provides intriguing leads but as yet has not been subjected to rigorous examination within the context of black mental health.

The Classification of Psychopathology

The ability and means to make accurate diagnoses within the context of African American culture, a recognition of racial influences on epidemiological case-finding, and an understanding of the meaning of race and ethnicity all affect the provision of effective mental health care for African Americans.

Diagnosis

Psychiatric diagnosis is centrally important to quality mental health care because it predicts and informs treatment. However, psychiatric diagnosis is especially difficult because the diagnosis of mental disorder depends disproportionately on symptoms and behaviors observed and reported by the patient and on complicated inferences made by clinicians. Diagnosis within the context of race is fraught with difficulties and serious problems that we are only beginning to address in depth.

Historically, there have been two perspectives on the manner in which race influences diagnosis (Neighbors, Jackson, Campbell, & Williams, 1989). The first perspective assumes that blacks and whites exhibit symptomatology in essentially the same manner and that diagnostic criteria are equally applicable to both blacks and whites. Diagnostic errors then are the result of stereotypes that clinicians have about black people. The second perspective assumes that blacks and whites display psychopathology in different ways but that diagnosticians incorrectly assume racial similarity in symptom presentation. Diagnostic errors then result from the fact that clinicians are unaware of or insensitive to cultural differences in the way the same disorder can be manifested in blacks and whites.

These conflicting perspectives raise critical questions that need to be answered before we can determine the appropriateness of applying diagnostic models and instruments developed on whites to blacks.

Numerous studies of patient samples have shown that whites are more likely than blacks to be diagnosed with a mood disorder and that African Americans are more likely than whites to be diagnosed with schizophrenia (Neighbors, Jackson, Campbell, & Williams, 1989; Snowden & Cheung, 1990). There has been much discussion, however, about how to interpret the meaning of these relationships. Many scholars argue that these statistics are indicative of widespread misdiagnosis among African Americans. Although the misdiagnosis hypothesis is varied and complex, the fundamental premise is that clinicians have not been sensitive enough to black-white differences in the expression of symptoms of emotional distress. Specifically, researchers suggest that unfamiliarity with the cultural aspects of African American behavior and language leads to misinterpretation and misdiagnosis of African American patients (Jones & Gray, 1986; Lawson, 1986). Although much has been written about the misdiagnosis of African American psychiatric inpatients, a careful review of the empirical literature reveals that the data are neither clear nor definitive (Adebimpe, 1981; Good, 1993; Neighbors, Trierweiler, 1999; Whaley, 1997). Thus, although treatment statistics suggest that schizophrenia is overdiagnosed in African Americans, more in-depth explorations are needed of black-white differences in presenting symptoms and their impact of these differences on the diagnostic process.

Studies comparing two diagnoses for each patient, one clinical and the other arrived at by researchers using semistructured instruments and adhering strictly to *DSM* criteria, often find that black patients with a clinical diagnosis of schizophrenia are more often than white patients given a research diagnosis of depression. This finding raises two important issues. First, it underlines the importance of exploring diagnostic divergence under varying interview conditions as a useful technique for exploring racial influences on diagnosis. If two reasonable diagnostic processes disagree, we must be willing to assume that one of those diagnostic techniques is *more* accurate or valid. More important, pinpointing the precise location of the diagnostic divergence—for example, more disagreement when distinguishing bipolar disorder from schizoaffective disorder among blacks than among whites—should document more precisely where race poses a particularly difficult diagnostic challenge for clinicians. Second, it highlights the importance of arriving at a set of clinical procedures that skillfully implement diagnostic taxonomies like *DSM-IV,* procedures that can interpret responses to carefully crafted questions in the context of racial culture.

Interestingly, despite the indictment of clinical judgment as the culprit in racial bias in diagnosis, the mental health field has taken the position that for clinicians to become competent diagnosticians, they must acknowledge differences among patients that are due explicitly to racial group membership. The challenge is for clinicians to learn how to take cultural context into account in an appropriate manner. As a result the importance of using *clinical judgment* in the application

of *DSM* criteria must not be underemphasized. Indeed, it is absolutely crucial that sociocultural contextual information be taken into account in making diagnostic judgments of psychologically painful symptoms, troubling thoughts, and disturbing behaviors. In essence the field is searching for a reasonable and effective way to *control* the manner in which cultural context is brought into play in clinically important processes such as diagnosis (Grier & Cobbs, 1968, pp. 177–179). The best solution is to rely on procedures that inquire about the entire range of diagnostic categories, using criteria in conjunction with interviewing techniques that allow enough *flexibility* to effectively incorporate knowledge and understanding of the patient's culture. These diagnostic issues have important implications for psychiatric epidemiology.

Racial Influences on Epidemiological Case-Finding

There are many ways that culture may affect the epidemiology of mental disorder, but the one most relevant to this review is the assumption that symptom expression varies as a function of racial group membership (Kleinman, 1996). The notion of racial differences in the patterning of symptomatology creates important challenges for psychiatric epidemiological case-finding, which relies heavily on mimicking the clinical diagnostic process. The *DSM,* by making criteria explicit and specific, has implied that it can reduce diagnostic bias (for example, misdiagnosis) by guiding clinicians to treat *all* patients in the same manner, regardless of race. The *DSM* also set the stage for the large psychiatric epidemiological community studies on which the present review is based (Rogler, 1999, p. 426). The problem with the approach is that it contradicts a fundamental assumption underlying cultural psychiatry. Persons of different racial groups often differ from one another and, as a result, should *not* be treated the same (Aponte, Rivers, & Wohl, 1995; Dana, 1993; Gaw, 1982; Kleinman & Good, 1985; Lefley & Pedersen, 1986; Marsella & Pedersen, 1981; Mezzich, Kleinman, Fabrega, & Parron, 1996; Rogler, 1999). To make an "accurate" diagnosis, case-finding procedures *must* have the ability to distinguish symptoms of pathology from normative cultural experiences that are not indicative of mental disorder (American Psychiatric Association, 1994; Frances, 1998). This raises an interesting dilemma for psychiatric epidemiology as it is currently practiced, using questionnaire instruments like the Diagnostic Interview Schedule (DIS) and the Composite International Diagnostic Interview (CIDI) administered by nonclinical survey interviewers. Because diagnostic instruments like these are highly structured, it is difficult to take cultural context into account.

Psychiatric epidemiology has been relying on instruments like the DIS and the CIDI for so long that the innovative case-finding technology they represent is often taken for granted. But we cannot afford to forget just how radical it is that our best prevalence estimates are arrived at by nonclinical survey interviewers and computer algorithms based on *DSM-III, DSM-III-R,* and *DSM-IV* criteria. We cannot ignore the fact that the methodological foundation on which all of our

mental health statistics is based is an ambitious, pragmatic approximation of the clinical interview. The original ECA studies included a clinical reappraisal as an evaluation of how well the DIS operated. Those studies showed that for some disorders there was low agreement between the DIS and clinical diagnoses (Anthony et al., 1985; Eaton, 2000; Helzer et al., 1985; Hendricks & Bayton, 1983; Kessler & Zhao, 1999). This should not be surprising given that epidemiological investigations and clinical reappraisals are such different diagnostic procedures. Clearly these differences in diagnostic outcomes are due to the role that clinical judgment plays in determining the presence or absence of psychopathological symptoms. On one hand, nonclinical survey interviewers employed in large epidemiological studies like the ECA and the NCS have to accept all responses *at face value.* They are not allowed to cross-examine respondents to probe beyond the standard questions that make up the DIS and CIDI questionnaires. Nor are they allowed to make a sociocultural interpretation of the meaning of the responses provided. On the other hand, as a function of their clinical expertise, clinicians have the flexibility to decide whether there is something about a response that needs clarification. Thus clinicians, unlike survey interviewers, can continue probing until they are satisfied that the response is or is not indicative of the presence of psychopathology.

Perhaps the inability of highly structured instruments to compensate for cultural influences when assessing psychopathology is a key to understanding some of the paradoxical findings presented here. For example, earlier we suggested that the lack of black-white differences in depression could be explained on the basis of the counterbalancing effects of risk and protective factors. Yet it is equally plausible that the case-finding methods employed in psychiatric epidemiology are underdiagnosing depression among African Americans. A number of writers have noted the curious finding that many black respondents with very high depressive symptom checklist scores *do not* meet diagnostic criteria for major depression (Sue, Chun, & Gee, 1995; Vega & Rumbaut, 1991; Williams & Harris-Reid, 1999). Similarly, many authors suggest that African Americans with mood disorders present in such varied and different ways that the identification of major depression is especially difficult (Adebimpe, Hedlund, Cho, & Wood, 1982; Brown, Schulberg, & Madonia, 1996; Fabrega, Mezzich, & Ulrich, 1988; Fabrega, Mulsant, Rifai, & Al, 1994; Jones & Gray, 1986; Lawson, 1986; Leo, Narayan, Sherry, Micchalek, & Pollock, 1997; Strakowski et al., 1996). Another possibility is that depressive symptoms and a major depressive episode are not the same phenomenon. Checklists likely capture a mental state more akin to demoralization, which is qualitatively different from clinical disorder (Dohrenwend, Shrout, Egri, & Mendelsohn, 1980; Seiler, 1973). Although more research is needed to substantiate this possibility, the implications for psychiatric epidemiology are immensely important because the screening item that qualifies respondents for detailed follow-up questions in the depression module of the DIS requires a positive response to "feeling sad" (dysphoria) for two weeks or more. If clinical judgment continues to be eliminated from psychiatric epidemiological case-finding, the

only alternative for obtaining more accurate diagnoses is to make culturally based modifications to the diagnostic instruments. It is currently difficult to find concrete examples of ways investigators have modified diagnostic instruments for use with African Americans in community epidemiological surveys.

The Meaning of Race and Ethnicity

This chapter has reviewed empirical studies, most of which did not make much distinction among ethnic groups from different countries of origin. We have employed the term *race* to refer to a socially constructed category of limited biological and genetic significance. As such, the term race overlaps with the concept of ethnicity (Landrine & Klonoff, 1996b). We opted in this chapter to employ the term race as a convenient descriptor to refer to a research variable most often operationally defined by self-identification by the respondent. Such self-definitions of race have been shown to be associated with important mental health outcomes. Certainly, there is considerable ethnic variation in both the so-called black and white groups, but the vast majority of psychiatric epidemiological investigations do not attend to this within-group ethnic variation. Most of the studies reviewed here asked respondents to self-identify within the traditional U.S. racial categories (African American, Caucasian, Hispanic, and so forth) and not to differentiate themselves in terms of their specific ethnic group memberships (Haitian, Nigerian, Jamaican, Irish, Italian, and so forth). Thus the two groups described as black and white should be viewed as aggregations of various ethnic groups. Although there are important commonalities among blacks in the United States, there is also considerable heterogeneity in the black population. Green (1978), for example, has argued that there are nine distinctive "cultural-ecological areas" for the black population that vary in history, economics, and a broad range of social characteristics. These cultural-ecological areas are (1) Tidewater-Piedmont (eastern Maryland, Virginia, and North Carolina); (2) coastal Southeast (South Carolina and eastern Georgia); (3) black belt (central and western Georgia, Alabama, Mississippi, parts of Tennessee, Kentucky, Arkansas, Missouri, Louisiana, and Texas); (4) French tradition (Louisiana, eastern coastal Texas, and southwestern Mississippi); (5) areas of Indian influence (Oklahoma and parts of Arkansas and Kansas); (6) Southwestern areas (west Texas, New Mexico, Arizona, and California); (7) old Eastern colonial areas (New Jersey, Pennsylvania, New York, Massachusetts); (8) Midwestern and far Western areas (Illinois west to Washington State); and (9) post-1920 metropolitan North and West ghetto areas (major inner cities in such cities as New York, Detroit, Chicago, and San Francisco). Health researchers have not explored the usefulness of this typology for predicting variations in African American health.

Immigrants from the Caribbean area and the African mainland are important ethnic subgroups in the black population. These immigrant groups are also characterized by considerable heterogeneity. For example, the black population from the Caribbean basin countries is a diverse group including

Spanish-speaking persons from Cuba, the Dominican Republic, and Panama; French-speaking persons from Haiti and the other French-speaking Caribbean territories; Dutch-speaking individuals from Aruba and the Netherlands Antilles; and English-speaking persons from the former British colonies in the Caribbean Sea and the mainland territories of Belize and Guyana. The 1990 census estimated that there were almost one million Americans of English-speaking West Indian ancestry and an additional three hundred thousand of Haitian ancestry. However, some research suggests that persons of West Indian or other Caribbean descent are at least 10 percent of the black population in the United States (Hill, 1983). In addition, the 1990 census indicated that there were almost half a million persons of sub-Saharan African ancestry in the United States. Although these ethnic subpopulations are relatively small within the entire black population, they constitute a substantial proportion of that population in some areas. For example, it is estimated that at least 25 percent of New York City's black population consists of foreign-born West Indians (Vickerman, 1999). Variations in the mental health status of blacks by ethnicity have not been systematically addressed in the literature. One recent national study found that blacks of Caribbean descent had higher levels of both stress and psychological distress than native-born blacks (Williams, 2000). However, the sample size of Caribbean-origin blacks was relatively small, and these findings await further replication.

Conclusion

Numerous questions are raised by this review, and there is much opportunity offered by the many research directions that have been suggested. Clearly the epidemiology of mental disorder between and within racial and ethnic groups is a field ripe for investigation. There is especially a need to link theories and findings from the social sciences with epidemiology and public health. Although psychology and sociology have been concerned with the study of race and ethnicity for quite some time, they have not focused as much on risk for serious mental disorder. Similarly, the psychiatric epidemiology of race has focused too much on the demographic correlates of disorders and not enough on the psychological and sociological processes that influence racial differences in the prevalence of illness.

The relationship between socioeconomic status and depression among African Americans deserves more attention. The typical inverse relationship between these two variables was not uniformly observed in the ECA, and the patterns that emerged suggest that education for blacks does not translate into mental health protection in the same way that it does for whites (Robins & Regier, 1991; Williams et al., 1992b). Another area in need of further investigation emerged from the fact that younger African Americans appear to be particularly vulnerable to mental health problems. Depression is much higher among young adults, particularly young black women (Somervell et al., 1989). The same is true for generalized anxiety and phobia. Furthermore, suicide is increasing at an alarm-

ing rate among young black men. How do we explain this increased risk among younger blacks? Could it be that the desire to "make it" in this country coupled with the uncertainty about exactly how to guarantee a positive return on the personal investment is in itself an anxiety-provoking proposition (Bowman, 1992; Dressler, 1991)?

This speculation underlines the importance of understanding the meaning of anxiety in the lives of African Americans. We have presented evidence that phobia and generalized anxiety may be more prevalent among blacks than whites. Although depression reflects disappointment about the past, anxiety is characterized by feelings of apprehension and worry about the future, precisely the kind of uncertainty that we suspect most African Americans must cope with in the course of their day-to-day struggles for upward social mobility. The majority of African Americans must confront these issues in integrated settings such as work and school, where race is consistently salient. The inevitability that differences in skin color will be highlighted places a pervasive racialized context around attempts to understand both successes and failures. The attributional uncertainty that many blacks feel as they weigh the relative importance of personal capabilities and institutional racism can weigh heavily on their "nerves." Although this heightened vigilance concerning race can be seen as an added stress that all African Americans must carry, it can also be viewed as a psychological protection that keeps the negative effects of prejudice and discrimination from damaging the psyche. Because so many African Americans feel that they cannot afford to let their guard down, they keep their racial defenses up. This degree of caution practically guarantees a certain level of social distrust, particularly of whites. Such feelings of distrust are experienced on a continuum (Whaley, 1998). Maintaining a healthy level of distrust (Grier & Cobbs, 1968) without allowing it to develop into a more painful, maladaptive sense of paranoia is a complicated and delicate balancing act. It is no coincidence that the vocabulary of mental health in the black community is dominated by the language of "nerves" and "worry" (Neighbors, 1996). Realistically, African Americans should be worried and somewhat nervous about what the future may bring. Even when blacks have been successful, racial problems remain that must be dealt with (Cose, 1995). It is possible that the necessity of maintaining a perspective of cultural mistrust that derives from the potential for racial victimization and exploitation may increase risk for anxiety disorders among African Americans. More research is necessary before we can state definitively that these processes are operative.

In general, the epidemiological findings reported here fail to show a higher prevalence of morbidity for blacks as compared to whites. This seems paradoxical; we easily assume that blacks should routinely evidence higher levels of mental disorder as a result of greater stress exposure (Halpern, 1993; Mirowsky & Ross, 1980; Somervell et al., 1989). Supporting this easy assumption are at least two underlying assumptions. First, viewing African Americans within the *minority* construct fosters a notion of inferiority and powerlessness (Aponte et al., 1995). Second, the idea of being in a racial minority remains closely linked to ideas of

being *disadvantaged* and a *victim* (Clark, 1965). As a result, there is a tendency to downplay the idea that African Americans have developed successful coping responses to stress exposure. But many of the issues this chapter presents are fundamentally concerned with the human capital that individuals draw upon to defend against the personally damaging insults of discrimination (Neighbors, Braithwaite, & Thompson, 1995). Thus a better driving question for psychiatric epidemiology is, Given that African Americans are exposed to greater stress than whites, why do they *not* experience higher levels of mental disorder?

The field of African American mental health currently faces an interesting dilemma. We know that among African Americans, symptoms of disorder often go unrecognized, and as a result, disorders like depression and anxiety are undertreated (Sussman, Robins, & Earls, 1987). This underutilization of professional services results in a large amount of unrelieved pain and suffering among African Americans. This raises the important question of how to redirect African American perspectives on mental illness. There is a strong need for mental health education programs targeted specifically toward African Americans. The means of reaching African Americans and the specific content of these messages remain unclear, but certainly the reduction of the stigma attached to mental health should be one of the first issues tackled by mental health educators (DHHS, 1999).

Understanding black-white differences in mental heath is important because analyses that compare race are part of the foundation upon which the existence of racial inequality is made evident. It will be even more useful to address racial differences in mental disorder through more comprehensive studies that incorporate factors that can account for both exposure and response to stress. We must be careful, however, not to focus exclusively on population group comparisons. The variability in rates of disorders that is revealed when such factors as age and sex are inspected within race is impressive and speaks to the limitations inherent in treating blacks and whites as monolithic groups.

Finally, much of the evidence presented here is based on analyses of data from the Epidemiologic Catchment Area program (a study that although still relevant is now more than fifteen years old). The authors of this chapter were surprised to find that no papers focusing explicitly on issues of race and ethnicity and based on data from the more recent National Comorbidity Survey have been published. It seems likely that the underutilization of this epidemiological resource stems from the relatively low numbers of researchers interested in African American issues who are actively engaged in psychiatric epidemiological investigations. We need more investigators to address the research questions raised by this review. Over twenty years ago, Mildred Cannon and Ben Locke called upon the National Institute of Mental Health to increase its efforts toward training investigators of color so that they might address research questions from a different cultural perspective (Cannon & Locke, 1977). Soon after Cannon and Locke's article was published, the NIMH funded the National Survey of Black Americans (Jackson, 1991), a study that has produced numerous books, articles, and research investigators committed to working on issues of black mental health. The

next generation of large epidemiological investigations is beginning, and at least one, the National Survey of American Life, will include a nationally representative sample of African Americans (Jackson, 2000). We cannot afford to neglect these new data resources. It is hoped that the questions raised in this review will stimulate a new wave of psychiatric epidemiological research. Only in this way will we generate the volume of quality work necessary to advance our knowledge and understanding of African American mental health.

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