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A critical review of research on the mental health status of older African-Americans

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ABSTRACT
This paper summarises current research on the mental health status of older African-Americans with a specific focus on late-life depression, one of the most common forms of mental disorder among older persons. Social gerontologists have brought to the forefront the need to consider the impact of historical eras, cohort location, and lifecourse development when studying various dimensions of the ageing process. Unfortunately, this type of theorising is still in its infancy, and has not been widely applied to the general population and all dimensions of health, let alone investigations into the mental health status of older African-Americans. Virtually none of the empirical studies we reviewed adequately address the historical, biographical, or structural factors related to the mental health status of older African-Americans. We suggest that to understand contemporary manifestations of racial presumptions, there must be an appreciation of the historical antecedents. African-Americans live with the corrosive effects of a legacy of slavery that presumed black inferiority. The identification of salient factors of risk and resilience among this population is critical to developing effective intervention and mental health maintenance programmes. By emphasising the socio-historical influences on the mental health of older African-Americans, we can develop a greater understanding of this population's mental health needs; thus paving the way for improved mental health services and a reduction in mental health disparities.

KEY WORDS – African-American, older adults, depression, mental health services, culture, lifecourse.

Introduction

According to the World Health Organisation, the prevalence of depression tends to increase with age, resulting in depression being the most common mental disorder among older adults. Late-life depression

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often goes undetected because the symptoms may be mistaken for normal signs of the ageing process (World Health Organisation 2001).[1] The tendency for older African-Americans' mental disorders to go undiagnosed is greater than for non-African-American elders, because of the poor and limited health care traditionally provided to persons of African descent residing in the United States. Although there has been a long documented history of physical health disparities in the United States, more recently emphasis has been placed on the mental health disparities among racial and ethnic minorities (US Department of Health and Human Services 2001). The present study is an analysis of current empirical findings on the mental health status of older African-Americans[2] with a focus on late-life depression. The primary goal of this study was to determine the extent to which empirical research had adequately addressed the mental health needs and treatment of older African-Americans. The unique history and biography of black Americans has been influenced significantly by ideological factors, as well as by past and present social structures and circumstances. By emphasising the socio-historical and contextual influences on the mental health of older African-Americans, we can develop a greater understanding of this population's mental health needs; thus paving the way for improved mental health services and for a reduction in mental health disparities.

The specific aim of this paper is to draw attention to the dearth of research on the psychological wellbeing of older African-Americans. In order to identify the current empirical findings, we have limited the scope of our study to the 1990s.[3] The studies selected for this review allowed us to: (1) evaluate the identified causes and outcomes of psychological disorders among older African-Americans; (2) outline limitations of the most recent research; and (3) identify relevant policy and practical implications of the existing research on the mental health of African-Americans. As the size of the older population increases, the number with mental illness is projected to increase exponentially (Jeste *et al.* 1999). Our effort to document the mental health status of African-Americans is particularly important given the anticipated increase in their number (Administration on Aging 2001).

Analytical framework

As gerontologists and demographers around the world work to develop a better understanding of the mental health issues facing older people, the influence of globalisation becomes locally more and more evident.

Many communities are becoming increasingly multi-ethnic and multi-racial. Consequently, there is an increasing need to develop our understanding of how multiple life-course factors, including history, biography and social structures, influence mental health outcomes among racially and ethnically diverse populations. We contend that current research on the mental health of older African-Americans, and on the differences with non-African-Americans, makes inadequate use of a lifecourse perspective. Our endeavor is to demonstrate how future research on mental health would benefit from using Ferraro's (1997) *gerontological imagination* as an analytical framework.

Definition of terms

As a first step in constructing an appropriate analytical framework for examining mental health research, it is important to define several of the terms that often are used as if they were synonymous: psychological distress and mental illness (disorder); and mental health and psychological wellbeing. We contend that psychological distress is conceptually distinct from mental illness, yet the two concepts are often used interchangeably. *Psychological distress* has been defined as a response to aversive internal and external stimuli that may include anxiety, fear, and psychosomatic responses such as headaches, illness and physical pain (Ambuel *et al*. 1992). *Mental illness* encompasses clinically diagnosable conditions such as personality disorders, dementia, extreme mood swings (bipolar disorders), alcoholism, depression or schizophrenia. These conditions are referred to as mental disorders that can cause distress and impair functioning (US Department of Health and Human Services 2001). In general, *mental health* is defined as a relative state of mind in which a person who is healthy is able to cope with and adjust to the recurrent stresses of everyday living in an acceptable way (Anderson 1998). Persons who are mentally healthy are also referred to as having a positive state of *psychological wellbeing*; therefore, we do not distinguish between psychological wellbeing and mental health. Both terms refer to one's mental or psychological status during the absence of illness or distress.

Ferraro's gerontological imagination

Drawing upon the work of Kenneth Ferraro (1997), a contemporary gerontologist, and C. Wright Mills (1959), the renowned sociologist, social gerontologists tend to attribute the causes of mental illness and

psychological distress to social and ideological factors, such as collective behaviour, the general organisation of society, and individual biography. To understand the link between historical, biographical, and social structural factors that influence mental health among older African-American adults, our focal point incorporates two elements of Ferraro's gerontological imagination paradigm. We use Ferraro's analytical elements as a lens through which to view, and thus to understand, the reported findings on the mental health status of older African-Americans. The first element defines the usefulness of chronological age, and the second considers the multidimensionality of the ageing process and recognises that ageing is a series of transitions from birth to death, with both advantages and disadvantages. Using the gerontological imagination, age is viewed as an index or marker of many life events, and is cautiously used as a causal variable. Therefore, the chronological age of an individual marks a cohort location, which in turn is a reference for the shared experiences of a group of people.

In the case of the current cohorts of older African-Americans (born approximately between 1915 and 1935), their chronological age links them to a childhood and adulthood dominated by war, as well as adolescence marked by the Great Depression. Moreover, this birth cohort came of age during the Jim Crow era that lasted from the end of the 'Reconstruction' following the Civil War (1866–1877), and extended until 1954. This era marked the end of paternalistic relations and the beginning of competitive relations between blacks and whites. At that time, African-Americans were subject to laws, rules and customs that maintained racial segregation and inequality; thus limiting and disallowing African-American participation in political, economic, educational, and social systems (DuBois 1965). For these reasons, the cohort of African-Americans who survived this period have been collectively influenced by a social context that has come to define the lifecourse transitions experienced by today's older African-Americans.

The multi-dimensionality of the ageing experience is associated here with how lifecourse events will result in varying health outcomes for ageing populations based on their individual and collective experiences. For instance, by most measures, compared to their white counterparts, the health of older black Americans is worse, which is often a continuation of poorer health from middle age, and an outcome of the cumulative effects of poverty, racism, and genetics. The socio-economic disadvantage experienced by African-Americans explains much of the variance in lower utilisation of health services, reduced access to health care, poorer health status, and higher rates of mortality (Hooyman and

Kiyak 2002). Further, there are a myriad of social and political barriers to health care for older African-Americans that can be attributed to the history of discrimination within health care systems, especially in the American South, where oftentimes health care providers are perceived as unwelcoming (Poussaint and Alexander 2000). Additionally, indirect communication styles, used to function in a racist society, may interfere with the open information-sharing needed for diagnosis, and make it difficult for health providers to understand health concerns, which then may lead to misdiagnosis of conditions (Hooyman and Kiyak 2002). According to Ferraro (1997), ageing involves a series of lifecourse transitions that result in positive and negative outcomes that vary, for example, by race, social class, and gender.

Using a gerontological imagination as the guiding framework, we emphasise the effects of a legacy of presumed black inferiority that is so ingrained in American culture that it is often not recognised, yet has far-reaching health implications that are reflected in persistent physical and mental health disparities, despite advances in medicine and technology. We concur with research that concludes older African-American's psychological *vulnerability* or *resilience* has been affected by their exposure to social institutions and policies that have maintained the unjust, inequitable, and inhumane treatment of persons from African descent by European Americans. In this paper, we analyse the research findings from studies that focus on: (1) the racial disparities in referral, diagnosis and treatment; (2) the reasons for variability in prevalence rates; (3) the relationship between physical health and mental health; (4) the risk and protective factors associated with mental illness and mental health; and (5) the barriers to receiving mental health treatment. These discussions are preceded by an historical account of the mental health research on older African-Americans. We conclude with several policy and practical implications stemming from this critical review of the literature.

A historiography of mental health research on African-Americans

There are very few historical data available on the mental health of African-Americans, despite the long history of research on the status of black mental health in pre- and post-slavery years. For example, during the 19th century, dubious research reports on racial variances in mental health helped to obscure the social etymology of illness and disease. Southern journals of the antebellum era were full of advice for

slaveholders. *De Bow's Review*, for example, offered various articles setting down methods for dealing with slave discipline, nutrition, work strategies, and other topics. In his article, 'Diseases and peculiarities of the Negro race', Dr Samuel Cartwright (1851), a highly respected and widely published doctor from the University of Louisiana, discussed two mental disorders that he claimed were unique to African-Americans. One was his newly-discovered 'Drapetomania', a mental illness which caused slaves to run away and seek freedom; the other, 'Dysaethesia Aethiopica', a mental condition that supposedly caused black people free and enslaved to waste, destroy and disregard property, and raise disturbances with their overseers. In his scholarly journal article, Dr Cartwright offers advice on the prevention and treatment of these diseases. He suggests that if the proper medical advice is strictly adhered to, the practice that many Negroes had of running away could be almost entirely prevented. Dr Cartwright contended that this mental problem could be cured, regardless of whether the slaves were located on the borders of a free state, or within a stone's throw of the abolitionists (Cartwright 1851; Thomas and Sillen 1979; Gallagher 1995).

From the 1840s to the 1890s, several reports argued that the black population in the United States was relatively free of mental illness because of the 'special treatment' they had received from their slave masters. Of particular note was a study based upon the 1840 US Census indicating there were higher rates of mental illness among northern black people, compared with their counterparts in the American south. Edward Jarvis (see Gallagher 1995), a Massachusetts physician, to gain favour with southern slave states declared:

> Slavery must be a wonderful influence upon the moral faculties and intellectual powers of the individual, for in refusing many of the hopes and responsibilities which the free, self-thinking and self-acting enjoy and sustain, of course it saves him from some of the liabilities and dangers of active self direction. The false position of the Negro in the North had a disturbing effect on his character (Gallagher 1995: 312–13).

The notion that the institution of slavery had a positive influence on the mental health of American blacks was used to argue that the farther north blacks lived, the greater the incidence of mental illness. The conclusion was that … freedom drove blacks insane! (Williams 1995; Warheit *et al.* 1975). Ultimately, it was demonstrated that the census report was falsified (see *The National Era* 1854), and Jarvis later issued a complete repudiation of his statement. Regrettably, the harm had already been done and those with pro-slavery interests had been served (Gallagher 1995).

The 1860 US Census also reported some questionable findings. For example, out of a total population of more than 4.4 million black persons, only 766 'coloured insane' were reported. By 1890, the number of 'coloured insane' increased to 6,776 representing a change from 17.5 per 100,000 in 1860 to 88.6 per 100,000 in 1890. The racist spirit of the time related this increase to the abolition of slavery, arguing that abolition had altered the 'peaceful' conditions black people had enjoyed as slaves, introducing them to the stress of the competitive life of free men. It was common for many 19th century researchers either not to recognise mental illness among black people, or to attribute it to their 'natural inferiority' (Gallagher 1995).[4] Sadly, these misrepresentations helped to propagate 'evidence' of black inferiority, and to trumpet scholarly justification for policies of inequality, exploitation, and oppression of the American black population.

After 1900, information on the 'insane' was available only on persons who came to the attention of a physician, or who were remanded for treatment in an institution. It is no surprise that more white than black people were identified as insane since most of the latter were still residing in southern states where they had limited or no access to health care due to segregation and the enforcement of Jim Crow laws which mandated substandard treatment of black people. Prior to the mass increase in state mental health facilities in northern states, most blacks simply did not receive treatment for mental disorders even when it was needed. It was not until the 1930 census when counts of the mentally ill were restricted to those in state hospitals, that black people had higher rates of reported insanity than white. At this time, the poor, especially the black poor, were more likely than whites to receive treatment in public settings where they were counted and included in reports by researchers who conducted mental health research (Warheit *et al.* 1975).

Our objective in presenting this historical account was to draw attention to the need to consider the ways in which the boundaries of a hierarchical social structure have influenced the development of mental health care practices for African-Americans. Dating back to Robert Burton's *Anatomy of Melancholy* (1621), or William Battie's *Treatise on Madness* (1758), or Charles Darwin's *Origin of Species* (1859), the contextual experience of African-Americans has been ignored, distorted, or incongruously integrated into the training of mental health providers. What is striking in the history of mental health care, is that at various periods through the centuries there have been accepted ways of dealing with people with mental health problems,

conventional and accepted for the time but which have often been inhumane. Through the lens of the gerontological imagination, we are able to focus on the historical context of the African-American experience, and begin to make culturally relevant associations that will lead to transformed thinking about mental health services delivery for older African-Americans. The history of slavery in the United States is the starting point for understanding the health crisis in modern day America (Hollar 2001).

Missing historical dimensions on black mental health

Three key themes are missing from the historical account of black mental health research in the United States: (1) the association between traumatic life experiences and the mental health of blacks; (2) the relationship between ageing and mental health; and (3) linkages between mental health and mortality among blacks as these relate to the effect of inadequate health care. Clearly, the present cohort of older black Americans experienced very stressful life events and warlike trauma. Yet little has been reported about the outcomes of these traumatic period effects on black Americans' mental health status. To clarify the point, Bender (1997) investigated the presumptions of continuing war-related stress among World War II British male ex-combatants *and* civilians to determine the effects of war on the participant's development. He speaks of the 'distorting effects of lost opportunities; lost adolescence and young adulthood' (1997: 339). Accordingly, a traumatised person is never the same, since their assumptive world has been shattered. Seemingly, large numbers of older African-Americans in the US today would fall into Bender's two trauma categories: those whose traumatic experiences deleteriously affected their lives for evermore, and those who became distressed later in their lives as a result of their traumatic experiences. Other researchers have also studied Post-traumatic Stress Disorder (PTSD) among older, white male former prisoners of war, finding support that PTSD severity may increase in older trauma survivors; and that PTSD is neither stable, nor does it uniformly decrease in severity over time (Port *et al.* 2001).

Poussaint and Alexander (2000) make a strong case for a type of post-traumatic slavery symptom stressor, resulting in the dehumanisation of the human spirit, the emasculation of black males, and a distrust of white society and its judgmental health care delivery. They argue that social factors have indeed played a significant role in the mental and physical health of African-Americans. For example, the docu-

mented high rates and disproportionate distribution of heart disease, hypertension and other stress-related illnesses found in African-Americans are traceable in part to social factors. Poussaint and Alexander propose that the most prominent of these factors is the long history of blacks being required to endure racism, poverty, discrimination and the lack of adequate health care services, including mental health care in America. It is not difficult to envisage that black children born into the present cohort of older adults in the US were brought up by mothers and fathers who themselves had been actively grieving and at risk of stress related to Jim Crow laws, World War I and the Great Depression. Thus, one generation could not take succour from the other.

As stated earlier, the brief account of the history of research on black mental health did not uncover reports on the relationship between mortality and mental disorders. Recent census data show that life expectancy at age 65 years is shorter for black people (men 14.6 years; women 18.7 years), compared with white people (men 16.9 years; women 20.5 years) (Barresi 1997). This shorter life expectancy for blacks may in part be due to the stressful living conditions that began during slavery, and persist in many ways today (for excellent background see Cade 1935). Byrd and Clayton (2000) reported on the sanitary and nutritional deprivation that was associated with the Atlantic slave trade as early as 1518, where substandard health care and diminished expectations of black health status originated (also see Mannix and Cowley 1962; Bennett Jr 1966). The general health care of enslaved people was barely adequate to meet the demands of their heavy workload. Most lived in crude quarters leaving left them exposed to bad weather and at risk for disease. The heat and humidity of the South created health problems for everyone living there, but the health of plantation slaves was far worse than that of whites. Insanitary conditions, inadequate nutrition and unrelenting hard labour made slaves highly susceptible to disease. Illnesses were generally not treated adequately, and slaves were often forced to work even when sick. The rice plantations were notoriously deadly. Black people had to stand in water for hours at a time in the sweltering sun, and malaria was rampant (see Public Broadcasting System no date).

It was the Jim Crow years that systematically established black health deficts through the exclusion of African-Americans from the mainstream of the medical profession. This exclusion included restricted access to training, limited hospital admitting privileges for black physicians, and other elements of medical authority – including denial of membership in the *American Medical Association* for most black

physicians until the 1960s (Byrd and Clayton 2000). It is not entirely clear how the absence of routine medical care affected the mental health of black Americans in the late 19th century; or how the attitudes and health behaviours concomitant with consistently inadequate health care have developed and been transmitted down the generations.

This brief historical account of mental health research on black Americans has admittedly broad-brushed nearly 200 years of American history. Still, from the partly ignoble beginnings in the 19th century, the review helps us understand the socio-historical and social structural factors that influenced the perceptions of the mental wellbeing of African-Americans. As we move into a new millennium, it becomes even more important to review history, previous empirical studies *and* the presumptions about the mental health status of African-Americans, with an eye toward the future mental health care needs of this population.

Racial disparities in mental health referrals, diagnosis and treatment

The United States thrives on the unique contributions made by its racially and ethnically diverse population. African-Americans, in particular, have made significant contributions to the economic and cultural development of the United States, despite their historically underprivileged status in the social structure. Notwithstanding the great strides made toward a more equitable social system, racial disparities persist, including mental and physical health disparities. According to the US Surgeon General, poor mental health outcomes for African-Americans and other racial and ethnic minorities living in the United States are linked to disparities in referrals, diagnosis and treatment (US Department of Health and Human Services 2001).

Mental health referrals

Despite the limited number of research studies of older African-Americans, there is some evidence that they are less likely to be referred for mental health treatment than white Americans who present similar symptoms. Leo *et al.*'s (1997) two-year study of patients aged 65 years and older found that whites were referred for psychiatric consultations 6.2 per cent of the time compared with a rate of 3.8 per cent for black patients. Leo *et al.* (1998) also found that whites were more likely to

receive a referral for a psychological evaluation, resulting in a higher rate of diagnosis of depression.

Mental health diagnosis

Strakowski and colleagues found racial differences in the types of diagnosis that black and white patients received. In a clinical review of 176 medical records of discharged psychiatric patients, the researchers identified 56 black and 117 white patients. There was a significant difference in the use of psychiatric diagnosis. The black patients were diagnosed with schizophrenia, bipolar disorder, schizoaffective disorder, major depression and atypical psychosis at a higher rate than whites. On the other hand, whites were more likely to be diagnosed with an affective disorder such as alcoholism or drug abuse (Strakowski *et al*. 1993).

Since the 1970s, studies have reported over-diagnosis of schizophrenia and under-diagnosis of affective disorders among African-Americans, compared with overall prevalence of these disorders in the psychiatric inpatient population (Simon *et al*. 1973; Bell and Mehta 1980, 1981; Strakowski *et al*. 1995; Baker and Bell 1999). But it was not until the 1980s that empirical research raised the issue of the higher rate of misdiagnosis of mental illness among African-Americans compared with whites. There has been much debate about the causes of misdiagnosis of African-Americans. The debate has centered on the attribution of causes for the disproportionate distribution of serious mental illness. Researchers have argued whether differences in diagnoses were attributable to clinician bias or screening instruments (*e.g*. Bell and Metha 1980). Additionally, some have suggested that differential diagnoses were the consequence of clinician prejudice or the misinterpretation of symptoms (Jones *et al*. 1981; Adebimpe 1981; Coleman and Baker 1994). Other arguments have focused on the cultural insensitivity that traditional mental health services have shown regarding ethnic differences in the ways that patients recognise, define, and express symptoms of emotional distress (Neighbors 1997; Strakowski *et al*. 1996).

Whaley (1997) suggests that as a result of clinician bias, although blacks and whites in the United States exhibit similar symptoms, diagnosticians judge them differently. Further, Whaley contends that, based upon a cultural relativity hypothesis, blacks and whites present psychopathology in different ways, but that diagnosticians are either insensitive to or unaware of these cultural differences. Retrospective studies of the diagnoses of African-American patients at a Veterans'

Affairs medical centre and a community mental health meeting place have shown that misdiagnosis remained a problem throughout the 1990s (Kales *et al.* 2000; Baker and Bell 1999; Neighbors 1997; Finn 1994; Baker 1995; Strakowski *et al.* 1996).

Mental health treatment

The use of anti-psychotic medication is disproportionately applied to black and white psychiatric patients in a manner similar to the differences in diagnosis (Strakowski *et al.* 1993; Leo *et al.* 1998). Strakowski and associates (1993) found that antipsychotic drugs were prescribed in higher doses to black patients than white patients. Additionally, in a larger retrospective study of emergency psychiatric services, Strakowski *et al.* (1995) found that hospitalisation was more likely to be the prescribed treatment for blacks regardless of insurance coverage or measures of suicidal and homicidal tendencies. Although these studies did not specifically target African-American elders, they revealed a pattern of racial disparity in the referral, diagnosis, and treatment of psychiatric patients.

In a prospective study of psychiatric patients, Friedman *et al.* (1994) reported that African-Americans were more likely than whites to experience unnecessary psychiatric hospitalisations. Further, African-Americans had a higher rate of medical emergency room visits, a higher incidence of isolated sleep paralysis, greater likelihood of childhood trauma, and a greater number of life stressors. The patients in this well-controlled study were interviewed, assessed, and treated using standardised scales and procedures that resulted in non-differential diagnosis and treatment and a lack of evidence for differences in the presentation of psychiatric symptoms. This finding suggests that some racial disparities are a consequence of cultural variation in the *assessment* of mental illness and psychological wellbeing rather than innate racial differences. In support of this position, Grier and Cobbs (1992) concluded with reference to the mental health of African-Americans:

> There is nothing reported in the literature or in the experience of any clinician known to [us] that suggests that Black people *function* differently psychologically from anyone else. Black men's mental functioning is governed by the same *rules* as that of any other group of men. Psychological principles understood first in the study of White men are true no matter what the man's color. (p. 154)

Sources of variation in prevalence rates

Diagnostic measurement tools

Prevalence rates are based on symptoms and assessments, and are measured variously through screening, referral, and diagnosis. Cultural variation can be demonstrated in the varying rates of effectiveness of standardised instruments for assessment (Williams 1995), the differential attitudes that black and white communities have toward diagnosis and treatment of mental disorders, and the differing lifestyles and backgrounds of both races (Schwabe and Kodras 2000). Researchers have examined the effectiveness of screening instruments used to diagnose mental illness and/or psychological distress, as a means of explaining the racial disparities found by mental health researchers. For example, Williams (1995) argues that the use of standardised diagnostic instruments is problematic for assessing African-Americans since the criteria are based on studies of predominantly white participants. Research by Neighbors *et al*. (1999) also demonstrates the ambiguous diagnoses that occur between whites and blacks when different forms of assessment are used. They found that, depending on the type of assessment, black people were more likely to be diagnosed with schizophrenia than white, while the latter had a higher rate of mood disorder diagnosis.

The use of screening instruments to standardise the identification of symptoms and to characterise their intensity can simplify the assessment process. But the selected instruments must be chosen with the characteristics of the population being evaluated in mind (Baker and Bell 1999). Baker *et al*. (1995) conducted a study of the effectiveness of two popular screening tools for depression: The Center for Epidemiological Studies-Depression Scale (CES-D) and the Geriatric Depression Scale (GDS). The sensitivity of the CES-D to blacks was 71 per cent and to whites it was 85 per cent. The sensitivity of the GDS was 53 per cent in black patients and 65 per cent in white patients. These findings suggest that the CES-D and GDS may not be equally effective in identifying depression among older African-American and white patients.

Knowledge and attitudes about mental illness

In terms of differential attitudes and knowledge of mental illness, Zylsrta and Steitz (1999) found that black Americans knew less about depression than whites, which suggests differences in the social construction of depression in the black and white communities.

TABLE 1. *Rates of psychiatric disorder among black and white people*

Disorders	Black (Current)	White (Current)	Black (Lifetime)	White (Lifetime)
Affective	3.5	3.7	6.3	8.0
Drug use history	–	–	29.9	30.7
Drug abuse	2.7	2.7	5.4	6.4
Alcohol abuse	6.6	6.7	13.8	13.6
Schizophrenia	1.5	0.9	2.1	1.4
Panic disorder	1.0	0.9	1.3	1.6
Phobic disorder	16.2	9.1	23.4	9.7
Somatisation	0.4	0.1	0.5	0.1

Source: Robins and Regier (1991).

According to a National Mental Health Association Survey (1996) on attitudes and beliefs about depression in the African-American community, fewer African-Americans are aware of the 'active' symptoms associated with clinical depression such as anxiety, agitation, and reduction in sleep and eating habits. Only one in four recognises change in eating habits and sleeping patterns as a sign of depression, and only 16 per cent recognise irritability as a sign. About 63 per cent of African-Americans believed that depression was a personal weakness, compared with the overall survey average of 54 per cent. Further, although 31 per cent of African-Americans said they believed depression was a health problem, almost 66 per cent reported they believed prayer and faith alone would successfully treat depression 'almost all of the time' or 'some of the time'. About 19 per cent of African-Americans said they would seek help for depression from family or friends. Yet, 27 per cent said they would 'handle it' (clinical depression) by themselves. Only about 33 per cent of this population said they would take medication if prescribed by a doctor, compared to 69 per cent of the general population (National Mental Health Association Survey 1996).

Socio-economic status and mental health

The Epidemiologic Catchment Area Study (ECA), the most comprehensive survey of mental illness and psychological wellbeing ever conducted in the United States (Robins and Regier 1991), also provides evidence of racial disparities in the diagnosis of African-American and white elders (see Table 1). However, in this study of over 20,000 institutionalised and community-dwelling adults, the racial variations disappeared

when the independent effect of socio-economic status (SES) was considered. The racial differences in schizophrenia and depression became non-significant when controlling for socio-economic status (Williams 1995). Nonetheless, the prevalence of phobia was significantly greater for blacks than whites regardless of socio-economic and demographic factors. This finding provides evidence for the importance of cultural relativity, as described by Whaley (1997) and discussed in a later section of this article.

Although racial variance in mental health status seems to disappear when controlling for SES, we do not have a good understanding of how age and ageing influence the relationship between SES and mental health. There are a number of competing substantive and methodological explanations for diminished SES differentials in mental health status at older ages (Robert and House 1994). One explanation is that the observed pattern may result from poor conceptualisation and measurement of SES at older ages. Generally, income, education and, to a lesser extent, occupation are the standard measures of SES in the United States: these may actually be poor measures for older adults, since they focus on the individual (Berkman and Gurland 1998; Robert and Li 2001). Yet, community SES (*e.g.*, percentage of unemployment in one's community, percentage of families earning $30,000 or more) may be a significant factor in the mental health status of older persons. Lack of attention to community SES measures is particularly striking in health-related research, given that community SES may be more important to the lives of older persons who may be ageing in place, compared to younger persons who are likely to be more mobile (Robert and Li 2001).

Importance of the historical legacy

As we have argued, it is imperative that researchers assess the impact of historical eras, cohort location, and lifecourse development on the differences between blacks and whites in mental health referrals, diagnosis, and treatment. The historical era in which one was diagnosed can profoundly affect one's treatment later in life. Hollar (2001) reports on the role of racism in mental health services delivery. He relates the story of Dr Alan Stone, who in 1980 presented the Presidential Address at the 133rd annual meeting of the *American Psychiatric Association*. Dr Stone gave a personal account of racism that was compounded by the blindness of a system and the failure of the examining professional to be aware of both his own and the system's faults. In his story, Dr Stone relates how a black US Army sergeant was caught stealing a deodorant

stick, and upon assessment by Dr Stone was declared not to be suffering from kleptomania or any other mental disorder that might help explain his behaviour. Ultimately, the black man was court-martialed and received five years of hard labour, a dishonorable discharge, and loss of all benefits. At his presidential address, Dr Stone reconsidered his conclusions pointing out that he should have taken into account the cultural factors of the sergeant's life. Initially, Dr Stone concluded that psychiatry should not consider cultural factors in making a diagnostic determination. However, in his capitulation he argued that psychiatry needs a historical and cultural perspective to fully understand psychiatric disorders (see Hollar 2001). Another study demonstrates how the existence of cross-cultural differences may have caused many African-Americans to be mistakenly labelled as paranoid, when this condition may well be associated with a distrust of whites (Whaley 1998). Presumably, this distrust can vary from one cohort to the next, depending on the timing and context of experiences with whites, *e.g.* during the Jim Crow era and after the American Civil Rights Movement (1954–1968). In general, distrust of the scientific and medical communities has persisted because of the legacy left by the collective effect of maltreatment during slavery (*e.g.* 1518–1865), the Jim Crow era (1877–1954), the Tuskegee Alabama Syphilis Study (1932–1972), and the recent inequitable treatment of communities victimised by HIV/AIDS.

The *gerontological imagination* allows us better to understand the milieu of life experiences of black Americans, and thus, the contextual relationship to poor health outcomes. Clearly, the findings reported so far demonstrate the ways in which historical, biographical and structural factors have played a significant role in the misreporting, misdiagnosis and inequitable treatment of mental health among African-Americans. Using a gerontological imagination, we argue that variability in lifecourse development and in everyday lived experience creates cultural differences that can confound clinical assessments as well as research findings on the disparities in blacks' and whites' psychological wellbeing.

The relationship between physical health and psychological wellbeing

In this section, we discuss the relationship between physical health and mental health because it is important to our understanding of how somatic disorders contribute to the psychological distress of older

adults. As people age, the propensity for health problems increases and this increase is correlated with reduced functioning and mental distress. Many studies have examined the relationship between psychological distress and chronic illnesses such as: cardiac disease and heart conditions (Carney *et al.* 1999; Murrell *et al.* 1983); respiratory problems (Dealberto *et al.* 1996); diabetes (Von Dras and Lichty 1990); cancer (DeLeeuw *et al.* 2000; Walker *et al.* 1999; Wilkinson and Kitzinger 2000); Alzheimer's disease (Devanand 1999; Harwood *et al.* 2000; Wagle *et al.* 2000), and arthritis (Hussani and Moore 1990; Mills 2000*a*, 2001). Unfortunately, African-Americans are at greater risk of experiencing each of these chronic medical conditions than their non African-American counterparts. For example, on self-assessments of physical health, older African-Americans are less likely to report good or excellent health than non African-Americans. Additionally, among those persons aged 70 and over, African-Americans have a disproportionate percentage of chronic medical conditions. Among this age group, more blacks (67.2 per cent) suffer from arthritis than whites (57.9 per cent). Diabetes is another chronic condition experienced more by older blacks (20.4 per cent) than older whites (10.9 per cent). Moreover, victims of stroke are more prevalent among older blacks (12.2 per cent) than older whites (8.6 per cent). Finally, more blacks suffer from hypertension (58.7 per cent) than whites (44.0 per cent) (Federal Interagency Forum on Aging-Related Statistics 2000).

The demonstrated relationship between psychological and physical wellbeing is particularly disconcerting given the evidence that African-American older adults tend to suffer more chronic medical conditions and debilitating diseases than whites. Research suggests that older African-Americans with multiple medical problems and decreased activities of daily living (ADLs) are at an increased risk of depression and psychological distress (Baker *et al.* 1996; Ormel *et al.* 1997). In a study of 96 community-dwelling African-Americans aged 60 years and older, Baker and colleagues (1996) found that, as chronic illnesses such as hypertension, arteriosclerosis and circulatory problems increased, depressive symptomology as measured by the CES-D increased. A longitudinal investigation of the prevalence of ADL dependence and mobility impairment among a sample of 508 persons aged 65 years old and older, found that black respondents had poorer baseline functioning and more ADL dependence and mobility impairment than non-black (Strawbridge *et al.* 1992).

Older African-Americans who report kidney, vision or circulation problems are at greater risk for depression (Barzargan and Hamm-Baugh 1995). Okwaumabua *et al.* (1997) found that arteriosclerosis,

hypertension and circulatory problems were significant predictors of depression among older blacks, and that difficulty adapting to a chronic illness was significantly related to depression, anxiety and decreased wellbeing and high levels of depression (Ragonesi *et al.* 1998; Hussaini and Moore 1990). Moreover, black older adults with six or more chronic illnesses or who reported using four or more prescription medications in the past month were at greater risk of depression.

Although various diagnostic measurement tools clearly indicate that African-Americans are at a greater risk of depression as a result of their greater susceptibility to somatic disorders, it is important for researchers to evaluate the way in which depression is measured and defined. For instance, in the studies where depression is measured using the CES-D, the items correlate highly with somatic complaints (Collins 1995) and the instrument is not as effective in identifying depression among older African-Americans as for older whites (Baker *et al.* 1995*b*). Future researchers should evaluate the relationship between physical health and mental health by employing the multi-dimensional perspectives of the gerontological imagination. They might ask, how has the history of segregation and prejudice in the United States influenced the measures of depression and psychological wellbeing? What are the cumulative effects of racial discrimination and social and economic hardship on the physical and mental wellbeing of African-Americans? These are important questions to ask when collecting and analysing data, and when interpreting the measures of the mental and physical wellbeing of older African-Americans, particularly when comparing their outcomes to those of white people (see Table 2).

Risk and protective factors

Differences have been reported between African-American and non African-American older adults in access to quality health care, physical health status and lifecourse trajectories that influence perceptions and attitudes about mental health care. Researchers have also explored the differences in the factors that contribute to risk and resilience among older adults. These factors include gender, socio-economic status, social support, and marriage. The results of several studies in these areas are discussed below.

The racial differences in the prevalence of mental disorders persist across gender lines. Table 3 shows that the percentage of older black women who ever experienced a mental disorder is greater than for their white counterparts (Robins and Regier 1991). Thirty per cent of

TABLE 2. *Summary of current empirical findings of correlates with depression among African-Americans*

Correlates with depression	Sources
Multiple medical problems	Baker *et al.* 1996; Ormel *et al.* 1997
Six or more chronic medical conditions	Okwaumabua *et al.* 1997
Decreased ADL functionality	Baker *et al.* 1996; Ormel *et al.* 1997
Increases in hypertension, arteriosclerosis, and circulatory problems	Baker *et al.* 1996; Okwaumabua *et al.* 1997
ADL dependence and mobility impairment	Baker *et al.* 1996; Ormel *et al.* 1997; Strawbridge *et al.* 1992
Kidney, vision, and/or circulation problems	Barzargan and Hamm-Baugh 1995
Lower body disability	Stump *et al.* 1997
Difficulty adapting to chronic illness	Ragonesi *et al.* 1998; Hussaini and Moore 1990

TABLE 3. *Age, sex, ethnicity and lifetime mental disorder*

	Ever experienced a mental disorder (percentages)			
Age group	Black men	Black women	White men	White women
Under 45	41	37	41	35
45–64	47***	33*	28	24
65 or more	*39**	*30*	*21*	*19*

Source: *The Epidemiologic Catchment Area Study*. Adapted from Robins and Regier *et al.* 1991: 335.
Note: *p < .05; ***p < .001.

African-American women aged 65 years or older have experienced a mental disorder compared with 19 per cent of white women. Comparatively, 39 per cent of African-American males aged 65 years or older reported a mental disorder in the Epidemiologic Catchment Area Study.

African-American women have been identified as at high risk for depression (Barbee 1992), yet they are not very likely to seek treatment when experiencing psychological distress. Warren (1994) suggests that these women may see themselves as devalued within American society, and have fewer support systems to buffer stressful conditions. Nonetheless, Mui and Burnett (1996) found that older African-American women reported fewer depressive symptoms than their white counterparts even though they had more predictors of depression, including physical illness, perceptions of unmet need and low sense of control. This finding may of course be a reflection of the use of standardised measures, clinician bias or differences in the presentation of mental disorders.

In an epidemiologic field survey, Biafora (1995) found that when controlling for socio-economic status, racial differences in depression were eliminated. He argues that race is a proxy for low socio-economic status or occupational status, educational attainment, or income, and that when it is controlled the racial disparity in the rate of depression disappears. Poverty, therefore, is a huge risk factor in depression and poor psychological wellbeing. For example, a study of older African-American residents in public housing (Black *et al*. 1998) found that 35 per cent have high rates of psychiatric disorders. Yet contrary to older African-Americans overall, those in public housing rely more on formal than informal resources for mental health problems. Among public housing residents who needed mental health care, more were likely to use formal (39 per cent) than informal (19 per cent) sources for care. The strongest correlates of *using formal care* were substance use disorder, *Medicare* insurance, and psychological distress. The strongest correlates of *using informal sources* were perception of having little or no support from religious/spiritual beliefs, cognitive disorder, and having a confidant (Olfson and Klerman 1992).

Blazer *et al*. (1998) found a significant relationship between education, income and psychological and physical wellbeing. Bivariate analyses of specific somatic and psychological complaints by race, suggest that African-Americans are more likely to report less hope for the future, poorer appetites, difficulty concentrating, requiring more effort for usual activities, less talking, feeling people were unfriendly, feeling disliked by others, and being more bothered than usual. Yet when controlling for education, income, cognitive impairment and physical health, racial differences in somatic complaints and life satisfaction disappeared. These findings confirm earlier studies that have shown small overall differences in symptom frequency between African-American and non African-American community-dwelling older adults when controlling for socio-economic status.

Although residents of all ages in lower-status communities might have equal exposure to some negative risk factors, such as weak social and medical services, the impact of environmental, behavioural, and psychological risk factors may actually increase with age. This increased risk may in part be due to increases in biological and potential psychological vulnerability with age (Robert and Li 2001; House and Robbins 1983; House *et al*. 1994; Rodin 1986). The potential impact of these risk factors raises an important question, how does community socio-economic status influence pathways to mental health care, treatment options and patient/client satisfaction, even when controlling for other factors?

Marital status as a risk and protective factor

Studies have shown that being in a good or quality marital relationship is related to mental wellbeing (Gove *et al.* 1983; Engram and Lockery 1993), and that marriage is negatively associated with depression, anxiety and poor health (Williams *et al.* 1992; Cockerham 2000). Although the psychological wellbeing of African-Americans is also enhanced by a satisfactory marriage, and threatened by an unsatisfactory one, research by Broman (1993) suggests that African-Americans experience greater strains and more unhappiness in marriage than whites. Lower levels of spousal support and financial satisfaction make a significant contribution to these racial differences. Among African-Americans who were legally married or in long-term common-law marriages, marital strain is associated with higher levels of depression (Keith and Norwood 1997). However, older African-Americans are two times less likely than whites to be married and living with a spouse or partner (Engram and Lockery 1993; Mills 2000*b*). Reports on the living arrangements of older Americans reveal that, in general, whites are more likely to live with a spouse (men 74.3 per cent; women 42.4 per cent), compared to African-Americans (men 53.5 per cent; women 24.3 per cent). Additionally, older African-Americans are more likely to live alone (men 24.9 per cent; women 40.8 per cent), compared to their white counterparts (men 17.0 per cent; women 41.3 per cent) (Older Americans 2000: *Key Indicators of Health*). People with a previous history of depression have been found to be significantly less likely to be married and more likely to be divorced or separated (Kessler and Magee 1994).

Although empirical evidence has consistently reported the positive benefits of a marital relationship, there are still several unresolved issues. First, are there gendered differences by marital status in the rates of psychological distress and mental illness among older black women and men? Second, is marital status truly a relevant variable? For example, if mentally disturbed people are less likely to be married, then marital status might not be particularly important to understanding mental illness or psychological distress (Cockerham 2000). While there is scientific support for the benefits of a close, confiding and equitable relationship that many happily married couples experience; there remains the unresolved issue of whether unmarried persons with similar partners and high levels of social support have comparable mental health levels as happily married couples? (Tausig *et al.* 1999).

Barriers to treatment and mental health services utilisation

Many of the studies that report higher rates of mental illness among blacks than among whites are based on records of admission to public institutions. It is more likely that poor people would utilise such services, while more affluent whites can better afford private care (Gallagher 1995). Older African-Americans face various treatment barriers, such as: knowledge deficits, losses and social isolation, multiple medical problems and lack of financial resources (Unutzer *et al.* 1999). In addition, a paucity of research exists on depression, anxiety disorders and psychological wellbeing among African-Americans. This dearth of studies may reflect a negative perception of research among African-Americans, the small number of African-American researchers and clinicians, a fear of being treated as a 'guinea pig', or a community reliance on the support of family and the religious community during periods of emotional distress (Neal and Turner 1991; Biegal *et al.* 1997; Shavers-Hornaday *et al.* 1997; Bonner and Miles 1997; *National Mental Health Association Survey* 1996).

The low participation of African-American older adults in mental health research may also be attributed to other factors: (1) African-American older adults may recognise depressive symptoms, but do not seek or cannot obtain medical treatment; (2) older African-Americans may attribute depressive symptoms to a crisis of the spirit, so they seek help through prayer and the church; and (3) they may perceive the 'slowing down' process of ageing as part of life's burden to be endured (Steffens *et al.* 1997). However, predictors of treatment seeking include a history of prior treatment, higher education and greater episode duration. Non-seekers generally feel that they can handle the episode, do not consider it serious, or do not recognise it as an illness. Seekers, on the other hand, feel the episode is too painful and lasts too long, and causes significant disruption in their interpersonal relationships and role functioning (Blumenthal and Endicott 1996; Brown *et al.* 1995).

Discussion

This paper has highlighted the beginnings of the scientific reporting of mental illness among African-Americans, and has found that race as a social status influenced both the interpretations of the mid-19th century census data and the patterns of diagnosis, treatment, access

and use of mental health care by African-Americans. We argue that the legacy of the slavery experience and the history of racism in the United States is integral to understanding the mental health of older African-Americans. Additionally, we argue that to appreciate the significance of historical, structural and individual forces, the use of a gerontological imagination is critical. We suggest that racial classifications affect mental health in several ways. For instance, although there have been legislative and cultural inroads over the past four decades, in the United States, the races still remain unequally distributed across health, educational, income, occupational and community profiles. Specifically, African-Americans are disproportionately represented in the low socio-economic status category, and disproportionately reside in low status communities. This positioning is partly due to historical patterns of institutional and individual racism, discrimination, and limited opportunity structures.

Many poor African-Americans report high levels of mental distress, in part because of their relatively poor socio-economic status. Yet as this report has shown, individual socio-economic status cannot alone account for the differences in the prevalence of mental illness or psychological distress. Individual SES must be assessed in conjunction with community-level SES. Hence, we propose that old age may be a proxy for exposure to the community. In other words, compared to younger adults, exposure to the physical community may lead to older adults suffering worse health consequences. If lower SES communities are unable to provide adequate and quality services, or if there are significant barriers to access, the mental health of African-American older adults may be compromised (Robert and Li 2001).

We are interested in the ways in which social position, social context, and access to resources at early ages affect social position, social context, and access to resources in later life. This relationship can be viewed from either of two perspectives, cumulative advantage or adversity. The 'cumulative advantage' perspective suggests that initial disadvantages in access to resources and opportunities operate over the lifecourse to preserve or even widen status-related differences in psychological wellbeing (Ross and Woo 1996). Conversely, the 'cumulative adversity' perspective considers how the relationship between age and psychological wellbeing reflects the fact that stressful life events and traumas occurring early in life may affect adult psychological status (Tausig *et al*. 1999). Childhood adversity has been associated with difficulties in making successful adjustments to adult roles, and such difficulties affect adult wellbeing (Kessler and Magee 1994). Accordingly, we would expect that the greater the extent of

childhood traumatic experience, the greater the likelihood that adults would report current distress and psychological disorders (Turner and Lloyd 1995). Viewing the entire lifecourse of older African-Americans through the gerontological imagination allows us to recognise that the consequences of exposure to stressors may persist for a considerable time, perhaps for life.

Viewing chronological age as a marker of events has facilitated the examination of how life events, chronic strains, and resource availability affect an individual's life over time. When we consider the present cohorts of older African-Americans, events that have shaped their lives include being raised in the southern regions of the United States where they faced persistent institutional racism, prejudice, segregation, and a limited opportunity structure. The consequences of these structural barriers include mental and physical health disparities, less adequate health care, and a general mistrust of the health profession and of scientific research.

Conclusion

Major gaps exist in the empirical literature on the mental health of older African-Americans, and few studies adequately address the antecedents and consequences of psychological disorders among this older population. Virtually none of the studies that we have reviewed have sufficiently addressed the historical, biographical and structural factors; or the context of being black in America. Considering the projected growth of the older black American population and the increasing public health concern about late-life mental disorders, more systematic identification of salient risk and resilience factors for mental illness and psychological distress is critical in making effective intervention programmes. It is important to understand how socio-historical factors and individual biography influence African-American's mental health and psychological distress, since health policy and service delivery planning are based on reported rates of disorders.

According to research conducted by the US Department of Health and Human Services and the World Health Organisation, the US spends more per capita on health care than any other affluent nation, yet its quality of care is the poorest. Comparatively low spending hinders African-Americans, older Americans, and the poor from accessing and receiving quality mental health care. Researchers must continue to identify the barriers to treatment, and to determine the

most effective combinations of treatment strategies. Finally, the research and mental health services communities should approach African-American elders as peers, and attempt to explore and better understand their ideologies and the power imbalances that they experience. The projected growth of the older African-American population has long-term implications for mental health care in America, and a more sophisticated understanding of African-Americans' cultural and ethnic identity in the context of their social environment is required. Moreover, the projected growth of the older African-American population underlines the importance of understanding the cultural elements of the relationship between the clinician and patient. Thus, attention to the growth of the older African-American population is a demographic and social imperative.

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NOTES

1 Around the world, mental distress among older adults has been recognised as a major public health concern. Worldwide interest in depression among older adults is reflected in research being conducted in countries such as Taiwan (Compton *et al*. 1991), Finland (Ahto *et al*. 1997), Germany (Herschbach *et al*. 1999), Saudi Arabia (Al-Shammari and Al-Subaie 1999), Canada (Newman *et al*. 1998), England (Goldberg *et al*. 1995), and Norway (Malt *et al*. 1999).

2 In most of the literature produced in the United States, the terms Black, black, Afro-American, and African-American are used interchangeably. The terms White, white, Caucasian, and European American are used synonymously as well. In our paper, however, we have chosen to use lower-case black and white primarily as adjectives, but also occasionally as nouns (*e.g*. black American, or older blacks). Moreover, we also use African-American, European American or Caucasian Americans to describe the two predominant racial groups in the United States. We realise, however, that none of these terms are universally acceptable, and may be exclusionary or offensive to some.

3 The literature reviewed was compiled from electronic and library searches of scholarly journal articles on depression, mental health, and psychological wellbeing. Fifty-eight studies were found in the Sociological Abstracts, ISI Citation Index, PubMed, and PsychINFO. The authors also searched additional electronic and library indexes (PsychFirst, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Social Science Abstracts, and MedLine) for anxiety, alcohol and substance abuse, dementia, and other keywords that are associated with mental health status. This supplemental search yielded no relevant empirical studies meeting the selection criteria. We pinpointed 23 studies that addressed differences in the mental health status of African-Americans and Caucasian Americans. Additionally, 12 studies focused on the relationship

between physical health and mental health. Also, 13 studies reported on risk and protective factors; while 10 investigated barriers to treatment and mental health services utilisation.

4 Readers familiar with the history of African-American health may be unaware of efforts by the Union Army during the US Civil War that involved pseudo-scientific anthropometric tests to 'prove' the mental inferiority of its 180,000 Negro soldiers, who were then systematically positioned on hazardous front lines, and ordered to pass over wounded blacks to evacuate white casualties (see Byrd and Clayton 2000).

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