

# RACE in AMERICA

*Restructuring Inequality*

# MENTAL HEALTH

The Fifth of Seven Reports on the Race in America Conference

June 3–6, 2010

CENTER ON RACE AND SOCIAL PROBLEMS  
SCHOOL OF SOCIAL WORK  
UNIVERSITY OF PITTSBURGH

Editors: Larry E. Davis and Ralph Bangs

# RACE IN AMERICA: RESTRUCTURING INEQUALITY

## MENTAL HEALTH REPORT

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Despite significant progress in America's stride toward racial equality, there remains much to be done. Some problems are worse today than they were during the turbulent times of the 1960s. Indeed, racial disparities across a number of areas are blatant—family formation, employment levels, community violence, incarceration rates, educational attainment, and health and mental health outcomes.

As part of an attempt to redress these race-related problems, the University of Pittsburgh School of Social Work and Center on Race and Social Problems organized the conference *Race in America: Restructuring Inequality*, which was held at the University of Pittsburgh June 3–6, 2010. The goal of the conference was to promote greater racial equality for all Americans. As our entire society has struggled to recover from a major economic crisis, we believed it was an ideal time to restructure existing systems rather than merely rebuilding them as they once were. Our present crisis afforded us the opportunity to start anew to produce a society that promotes greater equality of life outcomes for all of its citizens.

The conference had two parts: 20 daytime sessions for registered attendees and three free public evening events. The daytime conference sessions had seven foci: economics, education, criminal justice, race relations, health, mental health, and families/youth/elderly. Each session consisted of a 45-minute presentation by two national experts followed by one hour of questions and comments by the audience. The evening events consisted of an opening lecture by Julian Bond, a lecture on economics by Julianne Malveaux, and a panel discussion on postracial America hosted by Alex Castellanos of CNN.

This report summarizes information provided by those speakers who focused on race and mental health. The value of this report is that it provides access to the extensive and detailed information disseminated at the conference. This information will be particularly helpful to community and policy leaders interested in gaining a better understanding of racial disparities in mental health conditions and finding effective strategies for improving these conditions.

*Disclaimer:*

*This post-conference Race in America report includes detailed summaries of the presentations and subsequent discussions that took place. Any opinions, findings, conclusions, or recommendations expressed in this report do not necessarily reflect the views of the University of Pittsburgh School of Social Work or Center on Race and Social Problems.*

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## **Improving the Mental Health of Asian Americans, Native Hawaiians, and Pacific Islanders**

Presenter: D.J. Ida, Executive Director of the National Asian American Pacific Islander Mental Health Association

Moderator: Ralph Bangs, Associate Director, Center on Race and Social Problems, University of Pittsburgh

Communities of color bear a disproportionately high burden of disability from behavioral health disorders. The burden cannot be attributable only to greater frequency or increased severity in these populations. Rather, it is a lack of care and, in many instances; people of color are the recipients of poor quality care. Even when communities of color receive mental health services, they are usually of substandard quality, and not equal to those of the White population. Failure to provide quality health care has far-reaching psychological and economic side effects. The U.S. health care system continually fails to provide mental health care that is culturally competent to communities of color. Also, the system doesn't recognize the correlation between health and mental health, and the two issues tend to be serviced separately.

### ***The Problem***

#### *Minority Youth and Mental Health Care*

One in five Latino girls has attempted suicide. Black and Latino youth are referred for help with mental health issues at the same rate as the general population. However, they are less likely to receive mental health care due to the lack of quality care that is available to them in their schools and community. Also, African American and Latino children have a higher number of unmet needs when it comes to receiving proper medications.

#### *Cost of Mental Health Disorders*

Mental health disorders are the leading cause of disability in the United States based on the "burden of disease," which is the impact of a health problem in terms of financial cost, mortality, morbidity, or other indicators. Severe mental illness costs the United States \$192 billion in lost wages. This exceeds the gross revenue of 499 of the Fortune 500 companies. People with serious mental health issues die 25 years earlier than the general population. This is due primarily to health conditions that have a mental health component for which the individual did not receive proper medical care.

### ***Causes***

#### *Barriers to Quality Health Care*

- **Poor Communication and Lack of Access:** Language barriers exist in many ethnic and immigrant communities. In addition, medical professionals often use medical terminology and jargon that are perplexing to patients. The inability of those needing care to speak the language and the failure of the medical system to provide proper accommodations to those who don't speak English perpetuate the lack of access to healthcare that many in these communities face.
- **Economics:** The Mental Health Parity Act, which mandated that financial or treatment limits for mental health services can be no more restrictive than financial or treatment limits for medical or surgical benefits offered in the same plan, was passed in October of 2008. This law neglected to guarantee the quality of services. Parity in relation to the poor healthcare that communities of color receive is of little or no benefit.
- **Lack of Identification or Acknowledgement of Mental Health Issues:** People in communities of color are much less likely than others to seek help for mental health issues out of feelings of shame or fear of being stigmatized.
- **Fear of Deportation:** Illegal immigrants may not seek health care because they fear that health care workers will alert authorities about their unlawful residence in the United States.
- **Lack of Effective Providers:** There are not enough people of color or culturally competent individuals working within the health care system
- **Lack of Quality Evidence-based Research:** People of color often receive poorer health care because there is a lack of research showing how mental health issues affect their communities specifically. A majority of mental health research is conducted focusing primarily on whites; and all other minorities are typically grouped together as non-Whites.
- **A Fragmented Healthcare Delivery System:** Mental and physical health often are treated as separate issues within the health care system. Many people suffering from physical health issues have undiagnosed mental health issues they may be contributing to their condition, or vice versa.

### *The Need to Improve Workforce Diversity*

Poor communication and lack of access are due in part to lack of diversity in the mental health workforce. While ethnic minorities comprise 30 percent of the population, they make up 7 percent of psychologists, 8 percent of social workers, 5 percent of psychiatric nurses, 17.4 percent of counselors, 4.5 percent of family and marriage counselors, and 5 percent of school psychologists. It is not known what percentage of the minorities in these professions has bilingual capabilities.

### *Asian Americans and Mental Health Issues*

Asian Americans often experience a lack of help and resources in dealing with mental health issues because there is a deficiency of data to prove that there are problems in their communities.

Asian American and Pacific Islander females have the highest suicide rate of any ethnic group ages 15–24 as well as over the age of 65. Native Hawaiian youth have significantly higher rates of suicide. Seventeen percent of Asian American boys ages 5–12 suffer physical abuse compared to 8 percent of White boys. Thirty percent of Asian American girls ages 5–12 report depressive symptoms. Additionally, more than 40 percent of Vietnamese and Cambodian women experience domestic violence.

### *Evidence-based Practice*

Evidence-based research has become one of the critical factors in determining which programs receive funding. Unfortunately, research on the negative effects and determinates of mental health issues in communities of color is extremely lacking. Data affect resources, but it takes resources to get the data. Many communities of color lack the resources to do rigorous data collection and research. Of the 7,670 individuals included in clinical trials for major depression, bipolar disorder, and schizophrenia, only 1 percent of the participants were identified as non-White. For example, of the 1,675 children included in the studies on attention deficit hyperactivity disorder (ADHD) in children, only 1 percent were identified as Black, Latino, or Asian American. Less than half of the 378 National Institute of Mental Health (NIMH)-funded clinical trials from 1995 to 2004 provided any information on specific ethnic composition.

### *Solutions*

- Remove the five-year ban to receive benefits for immigrants that are in the United States legally.
- Pass the Development, Relief and Education for Alien Minors (DREAM) Act, which provides provisional permanent residency to undocumented students of good moral character who graduate from U.S. schools.
- Recruit and retain people of color as health care professionals.
- Require cultural competency training as part of the licensing and recertification process for health care professionals.
- Mandate mental health and cultural competency training for teachers.
- Develop certification and reimbursement rates for mental health interpreters.
- Improve data collection when researching mental health issues.
- Improve conditions in housing, education, gainful employment, safe communities, and access to quality health care in communities of color.

### *How to Create a Culturally Competent Workforce*

Cultural competency is a key component to improving the quality of health and mental health care for racial and ethnic minorities. A culturally competent workforce requires training and ongoing support. It encompasses more than just speaking the language of the group of people that you are serving.

There are five categories of cultural competency:

- The ability to self-assess: learning to take account of the beliefs and biases we may have toward the groups we work with
- The ability to effectively connect with others: gaining the ability to listen, understand, and respect your patients. Taking the time to learn and understand the body language and nuances of someone else's culture
- The ability to perform culturally appropriate and sensitive diagnosis
- The ability to develop a culturally responsive intervention
- The ability to understand systems

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## Current Race-related Mental Health Problems and Their Solutions

Presenter: King Davis, Robert Lee Sutherland Endowed Chair in Mental Health and Social Policy at the University of Texas at Austin School of Social Work

Moderator: Ralph Bangs, Associate Director, Center on Race and Social Problems, University of Pittsburgh

There is a central policy dilemma in mental health that is based on long-term differences in access to and use of services by race, ethnicity, language, class, religion, gender, insured status, region, and diagnosis. The scientific cause of mental illness continues to be elusive for all groups and has remained so from the year 1760 to the present. In addition, the current trend in dealing with many of those that suffer from mental illness has been to deinstitutionalize them from asylums and mental hospitals and trans-institutionalize them into the criminal justice system. In addition, many people suffering from mental health conditions die several decades before those without a mental health problem because they have underlying physical health conditions that never receive care. Numerous poor communities and communities of color face so many intense social problems, ranging from housing issues to discrimination, that dealing with matters of mental health often become impertinent issues that receive little to no attention. When the people of these communities make the decision to seek care, they often lack access to medical attention or are forced to deal with substandard care with a poorly trained workforce and poorly equipped facilities. In order for mental health conditions within communities of color to change, new mental health facilities need to be built, linkages between independently operated facilities need to be made with general hospitals to monitor both physical and mental health, and a policy that provides federal insurance support to the mentally ill should be enacted.

### *The Problem*

In 1955, there were 600,000 people in mental institutions around the United States. At that time there were 559,000 beds in mental hospitals to accommodate the mentally ill. Since then the number of available beds to accommodate the mentally ill in hospitals across the nation has decreased by 500,000. There are currently only 22 beds per 100,000 people available to service the mentally ill. Sixteen percent or 310,000 of the prison population in the United States have been diagnosed as having a mental illness.

In 1955, there were practically no homeless people with a diagnosis of mental illness in the United States. Today, it is estimated that more than 200,000 homeless individuals are suffering from mental illness or severe mental illness.

In 2004, there were 1.4 million people admitted to psychiatric hospitals in the United States with mental illness as the primary diagnosis, and 7.1 million were admitted with mental health issues as a secondary diagnosis. Of those primary diagnoses, 730,000 were for depression, 300,000 for

schizophrenia, 131,000 for cognitive disorder, 76,000 for anxiety, and 4,000 for issues with personality.

### *Mortality and Mental Illness*

People with diagnosed mental health issues tend to die 25 to 32 years sooner than those without mental health issues. Thirty-four percent of excess or premature deaths from those suffering from mental illness come from suicide. There also is increased morbidity and mortality from metabolic disorders, cardiovascular diseases, diabetes, hypertension, chronic obstructive pulmonary disease (COPD), obesity, infectious diseases, psychiatric medications, low mental health literacy, diagnostic errors, and the absence of primary care. Adults receiving treatment in behavioral health care settings tend to have major health issues, and these problems are rarely diagnosed.

### *The Economic Burden of Mental Illness*

The direct cost of mental illness in 2002 is \$317 billion in direct and indirect costs. This figure does not include the additional costs of incarceration, homelessness, morbidity, and early mortality.

## ***Causes***

The United States has had three prevailing hypothesis regarding mental health.

1760–1860     **The Immunity Hypothesis (no services for people of color)** In the 1700s, persons that suffered from mental illness often are described as violent individuals or criminals. They often were homeless, and, subsequently, very costly to the local parishes. Because local citizens were growing more angry with and wary of the mentally ill, the decision was made to establish institutions for those with any kind of mental disorder. They also decided to create a policy to segregate the mentally ill by diagnosis and race. This policy was based on the notion that Blacks, other groups of color, women, and poor Whites were immune to mental illness because it was thought to derive from the stress of owning and operating property. The implications of this hypothesis were that these groups of people were not in need of any services. This immunity hypothesis was the school of thought from 1760 to 1860. In 1840, if you were a freed Black person who developed a mental illness you could be admitted to the first institution for the mentally ill in the New World as long as it did not displace a White person. The first asylums for the mentally ill were basically established for wealthy White men. Their goal was to remove them from their stressful environments and provide treatment so they could recover.

- 1860–1968 **Segregated Services by Race** One of the prevailing hypotheses was that Blacks were considered to be at extreme risk of developing mental illness because of freedom. It was assumed that their inability to deal with freedom, living in Northern states, and concentration in urban locales would cause African Americans to have extraordinarily high rates of mental illness. Between 1860 and 1968, the proportions of persons in the African American community diagnosed with severe mental illness was significantly greater than any other population in the United States. In the 1860s, it was believed that the numbers of mentally ill would sky rocket after emancipation. In 1868, The Central Lunatic Asylum for the Colored Insane in Virginia was created so that Blacks could be treated separately from Whites. It was the first institution created specifically for Blacks in the world. Native Americans also were allowed to be treated at this facility.
- 1968–present **The Null Hypothesis (Deinstitutionalization)** One of the current hypotheses about mental health is that no significant difference by race exists in either the risk or the frequency of most mental illnesses. More and more asylums have been closed across the nation, and the movement to integrate the mentally ill back into society was initiated. One outcome has been a transinstitutionalization of those with mental health issues into the criminal justice system. Many of the people occupying prisons in the United States are people who are diagnosed with mental illness or severe mental illness.

The problem of mental illness often is viewed as miniscule in terms of the other kinds of issues and social problems that occur in poor communities. Many low-income communities and communities of color face issues involving asset accumulation, housing/homelessness, voting patterns, political office, jail and prison reentry, being uninsured, literacy, HIV/AIDS, and domestic violence. Problems with mental health issues often are so invisible or secondary within the community, that the community delays seeking help. This is probably due to low levels of mental health literacy or mental health issues not being the most prevailing issues in their lives. In the African American community, there can be a delay of up to 30 years after the onset of symptoms before seeking services. During these 30 years, churches and ministers tend to be the primary source of care for mental health issues.

## *Solutions*

All state mental health hospitals, particularly those built prior to 1995, need to be closed. Only the more recent hospitals should be allowed to operate. Also, there needs to be a linkage created between these facilities and general hospitals.

Free standing psychiatric hospitals and institutions for mental disease (IMDs) are excluded from reimbursement for psychiatric care. This exclusion should be eliminated with the condition that IMDs create linkages to general hospitals.

All general hospitals in a community, or some consortium of those, should be required to provide in-patient mental health care. Psychiatric care cannot be reimbursed by Medicaid in state hospitals, but it can be reimbursed if the person was in psychiatric treatment in a general hospital.

All community mental health centers should be eliminated. The centers should be merged with federally qualified health centers.

There should be federal insurance support for anyone with a diagnosis of schizophrenia. Furthermore, there needs to be a national long-term care policy for the mentally ill.

Integrated care should be provided through strategies such as co-location, collaborative care, or enhanced training for people in primary care. Medical care should be provided to all people with mental illness. Integrated care should include health, mental health, and social problem issues. Mental health professionals should work with clergy to encourage referrals to mental health professionals.

## **The White House or the Jail House: The Mental Health Trajectories of African American Boys**

**Presenter:** Oscar A. Barbarin III, the L. Richardson and Emily Preyer Bicentennial Distinguished Professor for Strengthening Families in the School of Social Work and senior investigator at the Frank Porter Graham Child Development Center at the University of North Carolina at Chapel Hill

**Moderator:** Marcia Sturdivant, Deputy Director of the Allegheny County Department of Human Services and Administrator of the Office of Children, Youth, and Families

African American boys tend to have a cross-section of the kinds of dilemmas, strains, and vulnerabilities that result from race and gender. By the time African American boys reach adolescence, they are disproportionately represented among children in special education, particularly in classrooms of behaviorally and emotionally disturbed children. The rate of suicide among African American males is increasing rapidly. There is a disproportionately high rate of incarceration for African American males beginning at age 14. Many African American men are marred by the social consequences of incarceration. In addition, African American men with mental health issues often are funneled through prisons. There continues to be a close link between the African American males that are associated with the criminal justice system and mental health issues, learning disabilities, and limited education. There currently are more than 800,000 Black males between the ages of 20 and 50 in the prison system. African American youth between the ages of 14 and 18 make up more than 60 percent of the population of incarcerated youth, despite being only being 10 percent of the nation's population. The incarceration rate for Black males is 48.3 per 1,000, compared to only 8.5 per 1,000 for White males.

African American males also tend to have higher rates of morbidity, mortality, and premature death, greater rates of unemployment, and higher proportions of marginalization from society. Some measures that can be taken to ensure brighter futures for African American boys and students from all other backgrounds would be to promote the health and well being of the parents that raise them, encourage mental health through academic and social competence, and incorporate more African American males as teachers in schools, especially at the early childhood level.

### ***The Problem***

*Conduct Issues in African American Men*

A majority of the mental health issues that African American males are diagnosed with are associated with conduct. Although there are many mental health disorders that are biological, genetic, or neurological in nature, conduct disorders largely are socially determined. Conduct issues are less likely to be caused by underlying neurological issues and more likely to be caused by a combination of experience and social issues. Mental health diagnosis for conduct issues usually derive from a social construct that defines people as problematic once they fall out of line with some social norm.

## *Causes*

### *Vulnerability of Boys Entering School*

Young boys are more vulnerable in some areas of development than girls. Boys under the age of 6 tend to have delayed language abilities, are more socially immature, have more difficulty with self regulation, and have a lower propensity for action than girls. With a lower level of vocabulary, boys often come to school less ready to read than girls.

<i>Schools prefer and reward</i>	<i>Predispositions of boys</i>
Verbal mastery and fluency	Communicate and interact through movement
Inductive indirect communication	Direct communication
Quiet desk work using fine motor skills	Hands-on activities that rely on gross motor skills

Boys on average have fewer fine motor skills than girls under the age of 6. In addition, boys under the age of 6 have more difficulty regulating their attention and behavior.

### *Responses by Educators to Boy Behavior*

The above issues tend to be magnified in the eyes of educators in reference to African American boys, making them subject to punishment, negative labeling as poorly adjusted, special education placement, and grade retention more frequently and routinely. The social processes carried out by educators that punish boys for these vulnerabilities diminish the excitement that young boys have for school and can also be the cause for low-grade depression in boys because of the amount of failure that they experience.

White boys are typically characterized as being high-strung in school. African American boys are usually thought to be less able to concentrate and more disobedient. Although most boys come into schools with the same vulnerabilities, it is often misconstrued that Black boys are less well-behaved and less apt to learn than White boys.

African American boys are often viewed as men rather than children in school. The loud active play that most boys exhibit are misconstrued as aggression. Their assertive responses get

miscommunicated as challenges to authority, and their fear-induced posturing often is misinterpreted as being menacing or dangerous. Educators consequently tend to lower academic expectations and have more harsh and punitive responses to African American boys.

### *Disadvantaged Schools*

The schools that poor and ethnic minority children attend tend to be disadvantaged in the following ways, which contribute to behavior, education, and mental health problems:

- High concentrations of ethnic minority poor children
- Peers who have below-average skills
- Teachers who are less experienced
- Teachers who have low performance expectations
- More danger
- Poorer facilities, including fewer books and science labs
- Fewer music, art, and drama rooms

Often, there also is a gap between the skills boys require and the ability of their learning institution to accommodate their needs.

### *Social Development of Incarcerated Adolescents*

Most incarcerated adolescents had a typical early development, but at some point they may have experienced some type of trauma in early childhood (e.g., disruption in family life). They also often have unremediated learning difficulties. A majority of incarcerated adolescents grew up in poorer communities that were in transition, especially with an influx of poorer people with fewer resources. These boys also tended to have families that were unable to transmit a legacy of spirituality, and these boys often became disconnected from extended families.

### *Depression in the Home*

More than 40 percent of African American mothers suffer from depression. More than 70 percent of African American children are being raised in single-parent, female-headed households. On average, African American children have little contact with men in their daily life.

## ***Solutions***

The mental health of African American boys can be promoted through academic and social development. This requires:

- Warm demanding parenting
- Nurturing school environments

- Safe, health-promoting communities
- Character/moral/spiritual development

We should begin by doing things to promote the health and well being of parents. It is imperative to focus on or develop goals for parents that will help them be nurturing. The goals can include health goals and career goals.

Parents should promote the development of language and higher-order thinking skills for young children. This should include:

- Talk, read to, and have fun with the child
- Use thoughtful rather than reactive discipline
- Address problems directly but in affirming ways
- Raise the child to take pride in family and ethnic identity and cultural heritage
- Guide the child to be caring and responsible

Parents should also be teachers to their children by:

- Giving children ways of interpreting things that occur in their lives
- Answering their questions
- Expanding the knowledge that they already have (in early childhood education, this technique is called scaffolding)
- Supporting
- Directing
- Minimizing criticism while providing explicit direction

Schools can promote the development of African American boys by:

- Employing more African American males as teachers in schools, especially at the early childhood level
- Acknowledging the challenge and promise of African American boys
- Because a large percentage of the teaching force is White women, developing innovative methods of training them how to teach and raise Black boys
- Supporting positive development
- Developing a strong connection to each child's family
- Affirming boys' identities as young men of African descent by selecting literature that displays positive images of Black men and having Black men mentor Black boys in the schools
- Changing schools and classrooms to create a better fit with boys' abilities, needs, and interests
- Improving instructional quality for all students
- Using instructional approaches that motivate and engage Black boys

- Teaching boys to be caring, responsible, and ethical

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## **Race, Place, and Depression**

**Presenter:** David T. Takeuchi, Professor in the School of Social Work and Department of Sociology at the University of Washington

**Moderator:** Marcia Sturdivant, Deputy Director of the Allegheny County Department of Human Services and Administrator of the Office of Children, Youth, and Families

Notions about correlations between race and mental health issues have been constantly evolving since the birth of the United States as a nation. America currently has the highest rates of depression of any country in the world. Where it was once believed that Blacks and immigrants to this country could not have issues with mental health, it is now assumed that Blacks and immigrants are some of the most susceptible due to the conditions under which they tend to live. In addition, it is now believed that an individual's environment can have tremendous social, psychological, and physical effects on their health. At this time, research on mental health as it specifically relates to immigrants and people of color is extremely lacking. Greater effort by groups like the National Institute of Mental Health to expand its interest regarding the social determinates of mental health issues for people of color would be very beneficial to establishing services that are geared specifically toward them.

### ***The Problem***

There continues to be a strong biological and genetic component to looking at issues of race, especially around issues of health and mental health. In addition, the cultural aptitude of racial and ethnic minorities to assimilate into society continues to be questioned. Additionally, the United States has a higher rate of people suffering from depression than any other country: 16.9 to 21 percent of the American population experiences an episode of major depression in their lifetime.

### ***Causes***

*Varying Perspectives about How Race and Ethnicity Correlate with Mental Health and the Ability to Assimilate into American Society*

#### **1900s (Biological/Genetic Perspective)**

In the early part of the twentieth century, most immigrants in mental facilities were placed there because they exhibited innate character flaws that led Whites to believe that they were too inept to adjust to American society. During this same period, it was believed that African Americans

were genetically and biologically unable to become depressed because they were stereotypically defined as happy with their social circumstances.

### **1920s (Cultural Perspective)**

American society began to move away from notions of biology explaining the social circumstances of groups of people. At this point, social situations were viewed to be the result of culture. The cultural perspective was a reaction to the biological and genetic argument regarding mental health and race. Proponents of the cultural perspective questioned whether or not racial and ethnic minorities were too different culturally to actually assimilate into American society. It was thought at the time that racial and ethnic minorities did not have the cultural capacity to successfully integrate into American society.

### **1950s–1960s (Institutional Racism Perspective)**

During this time period, the social and structural components that led to different inequities in society were examined. The federal government was a key catalyst in investigating these components. The National Institute of Mental Health was established during this time. The government also sponsored several centers focused on institutional racism. During this time, research was conducted on poverty as one of the factors for the social standing of Blacks in American society and why there were different outcomes at the end of mental health programs for people along racial lines.

### **1970s to Present (Social Class Perspective)**

Social class was believed to be a major factor causing differences or disparities among racial groups. The debate continues today on whether social class explains all of the variance in racial effects. The question continues to be whether race still matters when you control for social class.

### **1980s–1990s (Perspective of Race as just a Social Construct)**

In this period, many people believed that race is a series of fluid categories with meaning that changes over time rather than precise classifications that are fixed and unchangeable.

### **Present Day (Super Diversity)**

The current dominant view is that:

- Disparity exists along racial lines due to intersections between race and one or more of the other perspectives above.
- The notion of Super Diversity is more appropriate to reflect the complexity of the current time, i.e., simple notions of race may not help to understand the causes and effects that are most concerning.

Today, there also are two prevailing hypotheses about race, ethnicity, and depression:

- Blacks should have higher rates of depression due to the social circumstances within which they live.
- Immigrants should have higher rates of depression than American Whites due to the social stressors they encounter during their adjustment into American culture.

In addition, research on place now focuses on the social and psychological effects it has on individuals rather than just on the effects of the built environment. Someone's *place* is defined by a geographical location that includes a nexus where social life is initiated and engaged. It is a place where social activity occurs. Also, someone's place is a holder of different symbols, values, and traditions. Someone's place has a sense of meaning, identity, and belonging. A person's place or environment can have negative effects on health and mental health because there may be fewer resources, fewer employment opportunities, less social control, weaker social support, fewer educational opportunities, greater contact with air pollutants and industrial contaminants, less access to healthy food, less access to quality health care, and a greater concentration of various social problems and stressors.

### **Geographic Segregation (Ethnic Density)**

When you have a concentration of a racial group in an area, there can be detrimental health and mental health effects because of the conditions of the environment. There also are some positive effects of ethnic density. It can be associated with reducing exposure to discrimination and providing added protection from discriminatory practices. Additionally, there can be a concentration of economic capital that can be used among the group (especially if they are denied access to more mainstream means of resources). Geographic segregation can be a facilitator of ethnic identity, which can have a positive influence on reducing the effects of discrimination. There is greater access to resources that are specifically tailored to that particular group and greater opportunity to build positive social networks.

Mood disorder and depression decreases in Asian and Latino immigrants as ethnic density increases. For Latinos, there tends to be less drug and alcohol abuse where ethnic density was more prevalent. However, anxiety disorder increases in both Latinos and Asians as ethnic density increases.

### **Treatment Effects**

People who develop a mental illness often lose their place in society. When they seek treatment, the treatment actually creates a greater distance for the individual's place in society. Whites are more likely to receive adequate treatment for depression than people of color. Over 50 percent of Whites receive adequate treatment for depression and other mental health issues, while an overwhelming number of people of color receive inadequate treatment or no treatment at all.

## *Solutions*

The National Institute of Mental Health should expand its interest regarding the social determinants of mental health issues. In recent years, it has become less focused on the social determinants of mental health and more focused on the individual, clinical, biological, and genetic aspects of mental health.

There also need to be programs that take preventive measures for immigrants before social conditions adversely cause mental health issues. This includes:

- Developing community partnerships that focus on preventing mental health problems and promoting health in general
- Conducting research on health and mental health in a more holistic fashion and focusing on the role race plays

A three-pronged strategy to combat institutional factors causing mental health problems should be adopted:

- Community groups can change the structure of their programs to make them more compatible with their clients (especially racial and ethnic minority groups).
- Culturally tailored programs can be developed to meet the specific needs of each racial and ethnic group.
- Better individual therapist results should be encouraged when working with people from varying backgrounds.

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