

# COMMENTARY: DISPARITIES AND SOCIAL INEQUITIES: IS THE HEALTH OF AFRICAN AMERICAN WOMEN STILL IN PERIL?

An amalgam of health concerns differentially affects the behavioral, psychological, and physical well-being of African American women. These disparities are both the result of, and contributors to, marked differences in the perception, interpretation and treatment of various psychological disorders and chronic medical conditions. Data show that African American women are diagnosed with more chronic and debilitating illnesses than found in the general population, and are often misdiagnosed with a myriad of psychiatric and medical disorders. Despite these findings, ambiguity remains about the contextual factors that affect the physical and mental well-being of African American women. The focus of this review was not to describe all psychological or medical conditions with deleterious outcomes among African American women, but rather collectively address identified mental and physical health issues prevailing among African American women. This approach addresses the urgent need to better understand the health needs of African American women in the United States, and demonstrates how advancing our knowledge of this marginalized group may lead to sustaining mental and physical health-related dialogue, while advancing policy. (*Ethn Dis.* 2010;20:304–309)

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## INTRODUCTION

Although persons from diverse races and ethnic groups account for an increasingly large proportion of the US population, information regarding their health status and behaviors is insufficient. Designed to increase the quality of healthy life years and to eliminate health disparities among different segments of the population, *Healthy People 2010* and the (former) President's Freedom Commission on Mental Health are national initiatives inviting researchers, scientists, politicians, and the public health sector to address this lack of information by examining and servicing the needs of persons of color.<sup>1,2</sup>

Assessing the collective mental and physical health needs of those from diverse groups is a complex task that requires methodical and systematic approaches. This critical assessment step is important given that minority populations, particularly African Americans, are more likely to: 1) be diagnosed with severe and debilitating illnesses; 2) be diagnosed at a younger age with a medical condition; and 3) be more incapacitated from similar diseases than Whites.<sup>3,4</sup> These disparities are further captured as scientific efforts begin to direct more attention to the physical and mental health needs of women from diverse racial populations. It is only recently, with the National Institutes of Health's (NIH) Revitalization Act of 1993, that guidelines were set requiring the inclusion of women and ethnic minorities in research. Prior to this, research predominantly focused on convenience samples of younger White (often male) adults.<sup>5</sup> As a result, both women and people of color were vastly underrepresented – rendering much of

the extant literature on the physical health and psychological well-being inconclusive for women, particularly women of color.

## MENTAL HEALTH CONCERNS OF AFRICAN AMERICAN WOMEN

At present, questions remain regarding the relative prevalence of psychological disorders across racial groups and reasons why those differences exist. Although studies have reported a disproportionately high rate of psychological disorders among African Americans compared to Whites others have found no racial differences in their incidence.<sup>6–12</sup>

The disparities and ambiguities presented among African Americans are similarly perpetuated among African American women. In 1999 and 2001, the first Surgeon General's report on mental health (and its supplement) asserted that “culture counts” in every aspect of mental health, including etiology, prevalence, risk factors, treatment, illness course and trajectory.<sup>13,14</sup> Most notably, the reports document a variety of racial and ethnic disparities in each of these domains, such as bias in the interpretation of symptoms and diagnoses, the availability and utilization of mental health services, and the quality and nature of treatment provided to racial and ethnic minorities. Despite these findings, these reports suffered from one notable limitation: little focus was given to gender differences in the race-based perspectives on mental health disparities, thereby reflecting the absence of an integrated race and gender analysis on mental health disparities. As such, the prevalence,

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etiology, and treatment of mental disorders among African Americans, particularly African American women, remains unclear.

A contributing source that may explain why there is some vagueness in understanding the health of African American women is practitioner biases. This important factor may result in an increased risk of African American women being inaccurately diagnosed with a mental health condition, such as post-traumatic stress disorder (PTSD).<sup>14</sup> Despite having similar violence-related hospitalizations, African American women, for example, are less likely than White women to be diagnosed with PTSD or related conditions (eg, dissociative disorder) and, are more likely to be diagnosed with behavioral and psychotic disorders such as conduct disorder, schizophrenia, or substance abuse/dependence, all of which carry considerable stigma.<sup>15</sup>

Important differences may also be masked or attenuated when gender and race are not concomitantly examined. For example, comparisons across Whites and African Americans indicate that African Americans have lower rates of depression; however, when examining across both gender and race, depression emerges as a significant concern for African American women.<sup>14,16,17</sup> Similarly, in a recent investigation examining the impact of race across race and gender, African American women reported higher levels of depression than African American men and White women, with even larger differences between African American women and White men.<sup>18</sup> Other studies addressing the intersection of race and gender have also determined that African American women have elevated rates of depression and are more likely to have comorbid disorders such as PTSD, which complicates treatment.<sup>9,19–21</sup> Without addressing both race and gender, the combined race and gender effects are overlooked and leave African American women at risk for being under treated for psychiatric disorders such as depression and misdiagnosed as presenting with psychosis or distur-

bances in conduct. This may then affect diagnostic decision making and the way clinicians observe, perceive, and interpret clients' symptoms.<sup>22</sup>

Related concerns surround the measures and nomenclature used to assess and categorize symptoms, which may also reflect systematic biases across cultural groups. On measures of paranoia and distrust, African Americans frequently have elevated scores, regardless of their psychological health.<sup>23,24</sup> Rather than psychopathology, theorists assert that these scores may reflect a healthy level of cultural mistrust that is normative and even adaptive for marginalized groups.<sup>24,25</sup> To the extent that assessment measures are not sensitive to these elevated levels in psychologically healthy African American adults, they have the potential to over-pathologize these individuals. Specifically, African American women report higher rates of somatization than Whites and, although these symptoms may be indicative of a somatoform disorder, they frequently reflect symptoms of depression.<sup>26</sup> Clinicians who are unaware of these clinical nuances in the presentation of paranoia, somatization, and depression may incorrectly diagnose African American women and contribute such behaviors to disparities in psychological health and mental health care.

In addition to diagnostic factors, other sociocultural factors including SES, discrimination, and cultural beliefs about strength and help-seeking behaviors may also contribute to psychological health disparities. This is particularly relevant as poverty, which is more prevalent among African American women, is related to more severe pathology, less access to mental health services, and increased rates of involuntary psychiatric hospitalizations.<sup>10,27–30</sup> Research literature shows a robust relationship between socioeconomic status (SES) and mental health status, where members of low SES groups are three times more likely to have a psychiatric disorder than higher SES group members.<sup>27,31,32</sup> More important-

ly, when SES is combined with other marginalized social identities (eg, race, gender), distress increases, thereby placing the individual at a higher risk for developing psychological disorders.<sup>27,33,34</sup>

The multiple identities (women and people of color) may explain why the gap in disparities between African American women and majority populations continues to widen.

Other social factors, such as discrimination and harassment, are also shown to have similarly significant effects on psychological well-being, with African American women at a disproportionately higher risk due to their membership in multiple socially marginalized groups (ie, women and people of color). Experiencing discrimination has been associated with increased psychological distress for women compared to men, and for racial minorities compared to Whites.<sup>7,32,35–36</sup> The double and multiple jeopardy theories posit that African American women are at high risk for experiencing multiple forms of mistreatment because of their low social status in at least two categories, gender and race, which puts them at greater risk for race- and gender-based victimization.<sup>37–39</sup> African American women may also experience unique forms of victimization, such as sexist racism and racist sexual harassment.<sup>40–43</sup> Research on multiple and repeated trauma suggests that experiencing more than one type of trauma or experiencing a single form of trauma repeatedly results in more psychological harm than a single form of trauma or a single traumatic incident.<sup>20,39,44–47</sup> These studies indicate that African American women are at greater risk of multiple forms of trauma that target more than one central identity and lower psychological well-being as a result, thus exacerbating African American women's mental health disparities.

These identified factors may have a significant impact not only on symptom reporting and diagnosis, but also help-seeking behaviors and adherence to treatment regimens. Specifically, differences in how African American women

perceive their roles as women in general, and women of color in particular, compared to other groups of women may affect their willingness to seek mental health services.<sup>48</sup> The archetype of the “strong African American woman” typifies African American women as strong, capable, and self-reliant.<sup>49–50</sup> Thus, African American women who internalize this image may self-censure behaviors that imply weakness (eg, asking others for help), which may result in reports of more depressive symptoms than women who do not internalize this image.<sup>49,51</sup> Given that this stereotype stigmatizes the need or want to ask for help, such women may underutilize mental health services, attend fewer therapy sessions, and terminate treatment prematurely.<sup>31,52–58</sup>

While there are obvious inequities in treatment and outcomes by race, disparities confounded by gender are receiving increased attention. This is significant considering the emerging presence of women of color in the United States and the amalgam of chronic medical conditions and social challenges (eg, lack of education, poverty, poor nutrition).<sup>4,59–60</sup>

## IMPLICATIONS OF PHYSICAL HEALTH CONCERNS AMONG AFRICAN AMERICAN WOMEN

The reduction in health status among African American women is a growing public health concern. Although African American women account for less than 7% of the total US population, they are disproportionately diagnosed with more chronic medical diseases, and demonstrate diminished functional capacities compared to White women.<sup>3,61–63</sup> These findings parallel with existent empirical evidence showing differences in the prevalence of identified chronic diseases among women of color, particularly African American women.

Cancer rates, for example, show pervasive differences in the etiology and associated risk factors among African American women compared to women from other race groups.<sup>64</sup> It is the most common malignancy among women and accounts for one in three cancer diagnoses in the United States.<sup>65</sup> Breast cancer incidence among African American women (122 cases per 100,000) remains lower than White women (141 cases per 100,000)<sup>66</sup> and has stabilized among African American women since 1992.<sup>65</sup> This counters popular belief that African American women have a higher incidence of breast cancer than White women. Two major hypotheses may explain this occurrence: the discontinuation of postmenopausal estrogen/progestin hormone therapy and the mammography saturation.<sup>67</sup> Despite the lower incidence of this malignancy and presumed effects of increased mammographic screenings, unequal receipt of prompt, high-quality treatment among African American women has been documented. Results from the Women’s Health Initiative (WHI) showed that White women were more likely to have a mammogram than women of any other racial/ethnic group.<sup>66</sup> Additional results showed that African American women were less likely to receive radiation therapy following breast conserving surgery than White women.<sup>65,68</sup> These results contend with recent findings showing that African American women also continue to be diagnosed at more advanced stages and have larger and more aggressive tumor characteristics than White women.<sup>65,67</sup> Bowen and colleagues corroborate this finding showing that African American women diagnosed with breast cancer are younger, have a higher frequency of late-staged and rapidly progressive tumor(s), and have a higher mortality rate than White women.<sup>69</sup>

Other factors that may explain why African American women are diagnosed at a later stage with more progressive tumors, and have a higher mortality rate

than White women include: limited access to, and utilization of, healthcare services; racial discrepancy in the use of mammographic procedures; socioeconomic constructs (eg, lack of health insurance, low educational attainment); and, delays from the time the patient learns of abnormal mammographic findings to diagnostic confirmation.<sup>65–68,70</sup> Biological characteristics of the tumor, barriers to health care, diagnostic and treatment delays, and a higher prevalence of comorbid conditions may additionally explain disparities in mortality rates between African American women and other race groups.<sup>68,71</sup> These are all important sources considering that between 1998 to 2002, the average annual breast cancer death rate was higher for African American women than White, Hispanic, American Indian/Alaska Native, and Asian American/Pacific Islander women.<sup>65</sup> Identifying these contributing risk factors is critical considering that breast cancer, which is only second to that of lung cancer, is the leading cause of cancer-related deaths among African American women.<sup>71</sup>

Similar to breast cancer, cardiovascular disease (CVD) is recognized as one of the most common chronic illnesses that has a substantial impact on quality of life, life satisfaction, and overall well-being. It is the leading cause of death in the United States and is recognized as one of the focus areas of the *Healthy People 2010* initiative, where the objective is to eliminate disparities in the risks and consequences of CVD across different racial groups.<sup>72–73</sup>

Emergent data show pervasive differences in the outcomes of CVD, with more women showing a higher mortality rate than men.<sup>72</sup> Contemporary literature shows that African American women are diagnosed with more stroke incidence and experience more negative outcomes from their cardiovascular condition than White men and women and African American men.<sup>72</sup> Jha and colleagues similarly found that African American women with heart disease had a higher

adjusted risk for myocardial infarction and coronary heart disease-related death than White women.<sup>74</sup>

Measures of clinical and non-clinical risk factors have outlined the conceptual grounding in explaining the disparate rates of cardiovascular illness-related deaths among African American women. Research efforts suggest a myriad of internal and external contextual health and social factors that attempt to explain these differences. Concatenated data from the WHI and the African American Women's Health Study (BWHHS) recognize structural factors, such as educational level, economic status, level of health information, financial status, perceived discrimination, cultural background, community resources, neighborhood characteristics, and household type, as barriers to preventive treatment, thus broadening the gap of cardiovascular health between African American women and women from majority populations.<sup>75-76</sup>

Mechanisms explaining the association between SES, cardiovascular health, and increasing mortality rates among African American women are believed to be many and include behavioral, psychological and social factors. Socioeconomic status, for example, is a frequent topic of investigation, in the context of studies, assessing inequities and disparities in cardiovascular health and all-cause mortality across race and gender.<sup>75</sup> Rutledge and colleagues found that low-income women were at a greater risk for CVD-related mortality than those with a higher economic status.<sup>77</sup> This is consistent with more recent investigations suggesting that African American women who reside in the South or rural geographic regions are more at risk for CVD.<sup>75,78</sup>

## DIRECTIONS FOR IMPROVED MENTAL AND PHYSICAL HEALTH CARE

Existing research confirms the disparaging health patterns of African

American women, which continues to lag behind that of majority populations. The prevalence of CVD, breast cancer, depression, and other physical and mental health disorders raises issues (and awareness) of the deleterious impact they have on the well-being of African American women.

Review of current policy and development of a national mechanism to monitor progress of African American women's health are strategies that can be utilized to address and possibly eliminate health disparities. Other mechanisms may include utilization of healthcare guides to help patients effectively access and receive care, re-conceptualization of health care plans to ensure that minorities, particularly minority women, receive equitable services. Public health policies aimed at reducing health disparities among African American women may need to address these stressors through means that go beyond the traditional realm of public health by targeting the social and economic inequalities that breed health inequalities.

The mental health enterprise, where philosophical and theoretical shortcomings are inherent in traditional counseling paradigms, can also account for deficits in the delivery of, and access to, services, as well as professional preparation of mental health care providers. Such deficits contribute to cultural incompetence, which may lead to misinterpretation of symptom presentation. This may result in ineffective treatment planning and under utilization of natural support systems (eg, family, friends, church). Yet, disparities in the diagnosis, access to treatment, and utilization of mental health services mimics that observed in the diagnosis of physical and mental health-related symptoms among diverse racial and ethnic populations.

Given the existing disparities in the well-being of African American women, it is important that we actively incorporate applicable theories defining the clinical and behavioral experiences not

only as patients, but as a group grounded in their identity as women in general, and women of color in particular. Such an approach will begin to augment research in their experiences and more accurately reflect the racial and gender context of their lives. This makes it necessary for us to continue to examine the social, behavioral, and environmental factors in perceptions, interpretation, and outcomes of physical and mental health services, policy and research. The potential benefits of this approach are significant and could address questions of how socialization patterns and other factors characterize the health experience of women from diverse racial groups.

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