

A Conversation with Harold Neighbors on Racial and Ethnic Disparities in the Use of Mental Health Services

Mental illness takes a different toll on African Americans than it does whites. For example, research by social psychologist Harold W. Neighbors, Ph.D., has shown that although the estimated lifetime prevalence of major depressive disorder is higher among whites than among blacks, the burden of depression is higher for blacks because it is usually untreated, more serious, more persistent, and more disabling. Contributing to the problem is the fact that African Americans—particularly men—are far less likely than whites to seek treatment for mental health problems when they need it. “Large numbers of African Americans are experiencing severe emotional problems and choosing not to seek professional help,” says Neighbors, director of the Center for Research on Ethnicity, Culture, and Health, and director, Program for Research on Black Americans, at the University of Michigan. “We need to understand why. More importantly, we need to do something about it.”

Neighbors has conducted research on mental health disparities for more than 20 years. With the support of a Robert Wood Johnson Foundation (RWJF) Investigator Award in Health Policy Research, he has explored differences in the prevalence of serious mental disorders, levels of impairment, and help-seeking behavior among African Americans. He has looked at why African Americans seek professional help less frequently than white Americans and at how reliance on informal help from social support networks may reduce blacks’ use of professional treatment.

Neighbors’ research, which has been published in more than a dozen academic journals, reveals subtle nuances in racial and ethnic disparities around mental illness and treatment. Fears of stigma and discrimination play an important role in keeping blacks from seeking treatment for mental illness, as do age and gender, lack of insurance coverage, and other financial barriers. Neighbors has also taken an in-depth look at ethnicity and immigration status, and finds significant differences in help-seeking patterns among blacks born in the United States versus Caribbean black immigrants. “Ethnic differences among black Americans is an underdeveloped area of mental health disparities research,” Neighbors says.

Here, Neighbors talks about the trajectory of his research, the policy implications of that research, and the work that needs to be done in this area.

Q: You began your career as part of a research team at the University of Michigan working on minority health issues. What types of research questions were you asking?

I started in the late 1970s as a research assistant at the Institute for Social Research, where I was mentored by James Jackson, who was leading the effort to launch the National Survey of Black Americans. This innovative, groundbreaking study demonstrated why it’s important to have nationally representative data on ethnic minority groups. I was a graduate student at the time, and was fortunate to be working on my doctorate when this study got funded. I eventually used the data for my dissertation.

After finishing my doctorate in 1982, I began focusing on the help-seeking behavior of black Americans with serious behavioral problems. Because we didn’t have structured mental health questionnaires that could identify specific mental illnesses, we looked at help-seeking for stressful personal problems, such as feeling on the verge of a nervous breakdown. Later, as research methodologies evolved, we focused on specific disorders like major depression.

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Q: What were some of your more surprising findings early on?

Our major finding from those early studies was that, irrespective of how serious people thought their personal problems were, only a minority sought help from a doctor and a smaller percentage considered getting help from a mental health professional.

This is a particular problem with African American men, who are less likely to seek help than African American women. We need to help these men understand that they are not alone in their struggles, and that it is “OK” to reach out to someone to talk about their troubles. Depending on how serious the problem is, they may or not need to see a doctor. We’re doing some new research in this area right now.

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More surprising was the extent to which African Americans relied upon friends, family members, neighbors—what we call “informal support networks”—for help with mental health problems. The question remains as to how effective informal help is. On the one hand, reliance on informal support may reflect a strong protective role that informal networks play in the lives of African Americans. For example, we found that people who lacked extensive informal support networks—they were widowed or divorced, or not close to their families—tended to depend solely on professional treatment for help with mental health problems. On the other hand, reliance on informal support networks also suggests that people who may need professional treatment are instead turning to their friends and family members for help.

Q: You’ve also done some work exploring help-seeking by African Americans from the faith community.

The good news there is that quite a few people in the black community receive help and assistance from pastors as well as church members. But the relationship between the religious community and the professional community needs to be strengthened. To what degree should churches and pastors make referrals to the mental health system? Some are more willing than others. At the same time, not every personal problem needs professional attention. There is a long tradition of using the black church as an organizational base for disseminating health messages, and we’re continuing to do work in this area.

Q: You’ve used a number of research methods, including data analysis, focus groups, and interviews. How have all these methods helped you fill out the picture of what’s going on in minority mental health?

A large community survey with a good response rate has the advantage of representing the population, and can help us focus on where to go to obtain the personal stories behind the statistics. That’s when I like to use qualitative research, particularly focus groups, because personal stories can be very compelling when used with national statistics.

Some people with mental illness are in institutions, so we have also done research with psychiatric inpatients in order to investigate misdiagnosis among African Americans.

There are many places we can look for information. I have tried to vary my approach over the years to understand the complexities of the problem. Hopefully someday I’ll be able to put all of the pieces of the puzzle together.

Q: What are you working on now?

Recently, I received funding from RWJF for a new study called *Man Up, Man Down* that is exploring the dire consequences associated with underuse of mental health services among African American men. Many depressed men suffer unnecessarily for long periods of time because they don’t seek treatment. This study tries to find out what to do about the fact that so many African American men think that they should “man up,” face stressful situations alone, and avoid seeking treatment for depression.

As we suspected, preliminary results are troubling. Our focus groups are uncovering detailed descriptions of the stressors, many of which are financial, challenging black men. Lack of financial resources makes it difficult for black men to achieve their goals for what it means to be a “real man” (a term used in the focus groups to stimulate conversations around masculinity). This lack of resources also has a ripple effect that strains male-female relationships. In addition, we saw more clearly the emotional toll paid by African American men as a result of their struggles to turn their dreams and aspirations into reality.

However, we also see some opportunities for reducing personal barriers to mental health services among African American men and improving their access to care. Although the term depression is used quite freely, most men are not clear on what exactly depression is—but they are interested in learning. We are also finding that not all African American men are against the idea of seeking help for depression. In fact, there is support for the idea that a “real man” would “man up” and get some help if he needed it. This view is by no means universal—but it is evident and represents something upon which mental health care providers can build.

Q: What are the policy implications of your research?

We need to address the underutilization of professional resources among African Americans who have symptoms of a mental disorder. To do that, we must figure out how to make the health care system, particularly the mental health care system, more accessible and user-friendly to African Americans. In addition, we need to do more work with the African American community to get people to think of help-seeking as a more acceptable and potentially useful thing to do. Part of that means eliminating financial barriers to care, but we also need to confront the stigma attached to help-seeking. Many African Americans are reluctant to talk about mental health problems openly because they’re afraid of being labeled as “crazy” or treated disrespectfully.

Health care providers—particularly primary care doctors—need to be more assertive about reaching out to their African American patients, and raising mental health issues with them during check-ups and other routine visits. But they need to be educated on how best to do this. Most front-line mental health care professionals I’ve worked with are not racist in any way, but some are looking for help in how to communicate across racial and ethnic groups. Keep in mind, too, that African Americans may have difficulty finding therapists and other mental health care providers of their own race. That’s another potential barrier to professional treatment, because it’s hard for some to turn to people of different races or cultural backgrounds for help with mental illness. One reason for this is mistrust—a deep-seated mistrust of medical care that is based partly on the negative history of race relations in the United States and past abuses in medical research. Unfortunately, this sense of suspicion can make interpersonal communication across race very difficult.

We need a two-pronged approach. We need to help providers be more comfortable working with people of different races, cultures, and socio-economic groups. At the same time, we need to work with communities to reduce the stigma of mental illness and seeking help for mental illness.

Q: Is there anything you’d like to add?

It’s exciting to see a new wave of young scholars pursuing fresh approaches to better understand mental health disparities in the United States, so I want to mention my efforts to develop and train the next generation of researchers working in this area. For example, I have had the honor of chairing two recent dissertations. Both were analyses of the National Survey of American Life, the most recent nationally representative sample of African Americans.

The first dissertation found that increased physical activity was associated with lower symptoms of depression. We know that physical activity is good for such health conditions as diabetes and hypertension, but this study suggests that staying active also elevates mood. This is something that everyone “knows” from their own personal experiences—but the point is that we now have supporting empirical evidence based on nationally representative data and sound

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Ethnicity, Immigration Status, and Mental Illness

There's a tendency to view black Americans as a mono-cultural community. Not only is that assumption false, says Neighbors, but, when it comes to understanding mental illness among blacks, it's also dangerous. For example, Neighbors' research shows that increased exposure to minority status in the United States is linked with higher risks for psychiatric disorders among black Caribbean immigrants. "This may reflect increased societal stress and downward social mobility," Neighbors says. At the same time, blacks born in the U.S. are more likely to receive treatment for mental health problems than are first-generation immigrants. Neighbors says that timing of migration and generational status of Caribbean black immigrants and ancestry groups contribute to important differences in treatment rates and sources of use, relative satisfaction with treatment, and perceptions of helpfulness.

In addition, Neighbors says that failure to distinguish between African Americans and Caribbean blacks masks important differences in substance use patterns. Overall, first-generation Caribbean blacks are significantly less likely, but second-generation blacks are more likely, than African Americans to meet criteria for substance disorders.

statistical analysis. The second dissertation considered whether there were mental health costs associated with upward mobility due to increased exposure to racial discrimination. The study found that African Americans of higher socioeconomic standing experienced the most racial discrimination and that racial discrimination increased the likelihood of depression. This dissertation underscores the importance of exploring additional race-based stressors that African Americans face that may undermine the assumed benefits of improved socio-economic position.

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