

Introduction

In the United States' notorious history of racial inequality, disparities in the area of health are perhaps the most overlooked. Yet, African Americans have persistently been at a disadvantage in terms of health, which has resulted in substandard quality and length of life. This unfortunate state of affairs makes black youth disproportionately vulnerable to a number of America's public health problems. This review focuses primarily on previous research into the societal causes and impacts of these disparities. In this paper, we explore some of the causes of racial health disparities and their effects on African Americans, especially youth. In addition, we take an in-depth look at four specific public health problems with special importance to black youth: HIV/AIDS, mental health, substance abuse, and violence. Each of these subtopics not only explores each public health problem but also provides some concrete examples of the mechanisms detailed in the explanations of racial health disparities. Finally, we examine existent research on race and public opinion on health issues.

Explaining the Disparities

A number of explanations for the racial disparities in health in the United States have been proposed and argued for. These explanations usually can be classified under the categories of biological, structural, and cultural causes. Biological explanations point to physical and genetic differences that make African Americans more vulnerable than

whites to certain diseases. Although this account offers considerable insight into the causes of racial disparity in some conditions such as sickle-cell anemia, it is limited in the scope of public health concerns that disproportionately affect African Americans that it can explain. For example, there have been no valid biological explanations for black vulnerability to homicide or HIV/AIDS, two public health crises with particular import to black youth.

Structural explanations place responsibility for racial health inequalities on the social position of African Americans. They point to the other structural inequalities that African Americans face as well as the history of oppression that has afflicted African Americans as a social group. A number of explanations for racial disparities in health fall under this classification. One of the most obvious links racial inequalities in health to inequalities in socioeconomic status. All measures of socioeconomic status are related to health indicators, and individuals with higher socioeconomic status are generally healthier.¹ Because African Americans also trail whites in all areas of socioeconomic status, a great deal of the racial disparities in health have been attributed to racial differences in categories such as income and education. For instance, homicide rates are highly related to education, as the more educated are less likely to be victims of homicide. However, Kawachi, Daniels, and Robinson² warn against using race as a proxy for class when addressing health disparities. There are a number of ways in which social condition negatively affects the health of African American youth regardless of class, including residential segregation and the psychological consequences of racism.

¹ Adler, N. E., and K. Newman. 2002. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs* 21(2):60–76.

² Kawachi, I., N. Daniels, D. E. Robinson. 2005. Health Disparities By Race And Class: Why Both Matter. *Health Affairs* 24(2): 343-352.

Residential segregation is promoted as a cause of racial disparities in health. Poor residential environments are linked to a number of health concerns, especially violence. Because African Americans are the most residentially segregated group in America, many blacks live in poorer neighborhoods regardless of their socioeconomic status. According to Williams and Jackson (2005),³ who review the literature on social causes of racial health disparities, poorer neighborhoods not only threaten residents' health in terms of violence but limit residents' ability to engage in healthy behaviors such as healthy eating and exercise. Community violence and the absence of appropriate facilities can discourage exercise, limit shopping options, and cost-restrict healthy dieting. In addition, poorer black neighborhoods are highly targeted by alcohol and tobacco marketing, which promote unhealthy behaviors. Williams and Jackson also point out that health service providers and pharmacies in poor minority communities are often less than adequately equipped.

Yet another way in which racial health disparities are credited to the social conditions of African Americans is by placing responsibility for health problems on the psychological challenges posed by the experience of racism by blacks. In analyzing mortality data across developed countries and the fifty states, Wilkinson⁴ finds health disparities to be more closely tied to income distribution than absolute income itself. Based on these findings, he proposes a theory that attributes health in developed countries to position within the social hierarchy rather than to actual material conditions. This explanation of health inequalities argues that individuals at disadvantaged positions in the

³ Williams, David R., and Pamela Braboy Jackson. 2005. Social Sources of Racial Disparities in Health. *Health Affairs* 24(2):325.

⁴ Wilkinson, R. G. 1997. Socioeconomic Determinants of Health. Health Inequalities: Relative or Absolute Material Standards? *British Medical Journal* 314:591–595.

social hierarchy suffer from a relative deprivation that works through the mechanism of stress to result in direct biological problems and unhealthy coping behaviors such as alcohol and tobacco use. Although Wilkinson does not directly address the issue of race, it is easy to see how the position of blacks in the racial hierarchy in the United States could combine with class inequality to result in poorer health for African Americans. In Wilkinson's framework, dealing with the stress brought on by racism and discrimination could be partially responsible for the disparities in health experienced by black Americans. In fact, Hill, Neighbors, and Gayle (2004)⁵ argue that racial discrimination, specifically, may be a factor in the health of African Americans. Employing a "stress-coping" paradigm, they explore the possibility that racial discrimination affects African American health through the process of exposure and response to the stress brought on by discrimination so that this affect is a function not only of the amount of discrimination blacks experience but also the way in which they deal with it.

Other mechanisms credited with causing racial health disparities are parts of a more institutional analysis. The structure of American governments and the policies enacted by these governments allow for political decisions that have significant effects on the health of African Americans. Scholarship on matters of health in America's prison population reveals that institutions of American society as seemingly far removed from health as those of the criminal justice system can exacerbate the health problems disproportionately affecting blacks. According to Young, Reviere, and Ackah (2004),⁶

⁵ Hill, H., W. Neighbors, and H. D. Gayle. 2004. The Relationship between Racial Discrimination and Health for Black Americans: Measurement Challenges and the Realities of Coping. *African American Research Perspectives* 10(1):89–98.

⁶ Young, V. D., R. Reviere, and Y. Ackah. 2004. Behind Bars: An Examination of Race and Health Disparities in Prison. In *Praeger Handbook of Black American Health: Policies and Issues Behind Disparities in Health*, Vol. 2, edited by I. L. Livingston. Westport, Conn.: Greenwood.

the health staffing, equipment, and technology in America's prisons have not kept pace with the growth of the prison population. As a result of this failure and the general environment of prisons in the United States, the incarcerated population is more at risk for a number of health problems including substance abuse, violence, mental illness, and HIV and other infectious diseases.⁷ These circumstances have a stronger effect on African Americans because they are disproportionately incarcerated. Further exacerbating the situation is that mentally ill minorities are more likely to be sent to prison once convicted of crimes and less likely to be treated for their mental illness once incarcerated.⁸

Other explanations of the relatively poor health status of African Americans cite cultural mechanisms that lead to unhealthy behaviors within certain communities and groups. Many of these explanations argue that, for a variety of reasons, some subgroups within American society have developed subcultures that are more permissive of behaviors that endanger their members' health. In the case of African American youth, researchers often point to the acceptance of behaviors in black communities that can increase violence and the spread of sexually transmitted diseases. More attention to this line of thought is given in the sections on these specific health threats.

Cultural explanations of the racial health disparities in America also can work in the reverse direction. In this case, health crises in black communities can be linked to cultural practices and norms that make certain behaviors taboo. These taboos can, in turn, prevent communities from dealing properly with health crises that result from these behaviors. In *Boundaries of Blackness*, Cohen demonstrates how homophobia in black

⁷ Freudenberg, N. 2001. Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health. *Journal of Urban Health* 78:214–235.

⁸ Ibid.

communities prevented the institutions that usually work on community problems from effectively addressing the spread of HIV early in the epidemic.⁹

Life Expectancy

One of the most important manifestations of racial disparities in health is also one of the most obvious. Life expectancy, the measure of the average length of life for a group of people, is an often-cited quantification of the disparity in health between white and black Americans. Despite the continuously rising life expectancy of both racial groups for at least the last seventy-five years, life expectancy for African Americans has historically been short in comparison to white Americans.¹⁰ In 2002, black life expectancy trailed white life expectancy by 5.4 years. Because life expectancy is also disparate along gender lines, an analysis of the racial gap only goes so far in explaining how racial health disparities are manifested in the duration of life. Life expectancy for African American males (68.8 years) is significantly less than for African American females (75.6) as well as for white males (75.1) and females (80.3).

Former Surgeon General David Satcher et al. (2005)¹¹ conducted a historical study of death rates for blacks and whites between 1960 and 2000, which found that although death rates declined among both racial groups, the ratio of black deaths to white deaths has remained nearly the same during this period despite the gains in racial equality since the civil rights movement. They report that these persistent differences in mortality rates are responsible for an excess of 83,000 black deaths per year that would not occur if

⁹ Cohen, C. J. 1999. *Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago: University of Chicago.

¹⁰ National Vital Statistics Reports, Vol. 53, No. 6, November 10, 2004.

¹¹ Satcher, D., et al. 2005. What If We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000. *Health Affairs* 24(2):459–464.

rates for blacks and whites were equal. However, a superficial look at their findings is misleading, as there are distinct changes in the racial mortality ratios in regards to sex. While black females' mortality rate closed in on white females during the forty-year period observed, the disparity between black and white males grew. This finding holds for black youth, as the mortality ratio for black females aged 15–24 went from 1.958 in 1960 to 1.433 in 2000, while the ratio for black males in the same group grew from 1.475 to 1.686. Satcher et al. (2005) calculate that the excess deaths among African American males aged 15–24 increased from 891 to 2,163 deaths from 1960 to 2000.

Health and Quality of Life

African Americans are also affected by health disparities in their daily lives. Just as socioeconomic status can have an effect on the health of African Americans, health problems can restrict their economic opportunities and success. Higher rates of disease and hospitalization result in “a higher absenteeism from work and school, which result in limited opportunities for income and educational advancement and reduced expectations for a long, healthy, and productive life.”¹² This illuminates a vicious cycle between economic and health disadvantages that has truly detrimental effects for the poorest and most unhealthy.

The health of African Americans also can have an effect on their emotional well being. There is a broad literature that links individuals' self-assessed health and aspects of well being such as life satisfaction and loneliness.¹³ Focusing specifically on African

¹² Bell, J. Standish M. 2005. Communities and Health Policy: A Pathway for Change. *Health Affairs* 24(2):339

¹³ Ferraro, K. F., and J. R. Feller. 1997. Health Trajectories: Long Term Dynamics among Black and White Adults. *Journal of Health and Social Behavior* 38:38–54.

Americans, Riley¹⁴ finds an association between poor self-reported health and low self-esteem. Unfortunately, much of the research on the connections between health and emotional well being focuses on the older population. As a result, this connection is significantly underexplored within the youth population in the United States.

Health Insurance and Access

Racial inequalities in health are not limited to the realm of physical and mental health. Black Americans are also at a deficiency in terms of their access to health care. The American health-care system poses a number of challenges that restrict the ability of many of its most disadvantaged citizens to receive quality health care. One of the most obvious obstacles to health care in America is a lack of health insurance. Current estimates placed the number of uninsured Americans at about 17%. According to the National Center for Health Statistics (NCHS; 2004), this number is disproportionately made up of African Americans. NCHS reports that in 2002 only 56% of blacks had private health insurance coverage compared to 77% of whites. The lack of coverage among African Americans results in a higher reliance on government programs such as Medicaid, in which 21.5% of African Americans take part in comparison to 8% of whites. This racial difference in health-care coverage is also pronounced among children. In 2002, NCHS estimated that 8% of blacks 6–17 years of age had no regular source of health care, as opposed to 3.7% of their white counterparts. This disparity is not easily explained away by socioeconomic status because even among poor children, poor blacks were more likely than poor whites to be without a source of health care. NCHS statistics

¹⁴ Riley, A. L. 2003. Health and Self-Esteem among African Americans. *African American Research Perspectives* 9(1):152–162.

reveal that these inequalities in coverage have real consequences. Of young people in that same age range, a national sample revealed that black children were also less likely to have had a health-care visit to an office or clinic within the last twelve months.

The health-care access gap does not end with the disparities in health-care insurance. In a national study of 7,465 10- to 17-year-olds, Lieu, Newacheck, and McManus (1993)¹⁵ found that racial differences in reception and treatment for regular and acute medical emergencies persisted regardless of insurance status. Research also indicates that race is a factor in physician recommendations testing for breast cancer (O'Malley et al. 2001). Other conditions for which research has demonstrated racial inequalities in quality of care include pneumonia, mental illness, and congestive heart failure.¹⁶ These findings indicate that African American youth have broad-ranging disadvantages in access to health care and may often be at a disadvantage in the quality of care that they receive.

HIV/AIDS and Black Youth

African American youth are disproportionately infected with HIV and AIDS. For those age 25–44, AIDS has been the leading cause of death for black men since 1991 and the third leading cause of death among black women since 1999.¹⁷ Most of these

¹⁵ Lieu, T. A., P. W. Newacheck, and M. A. McManus. 1993. Race, Ethnicity, and Access to Ambulatory Care among US Adolescents. *American Journal of Public Health* 83(7):960–965.

¹⁶ Ayanian, J. Z., J. S. , S. Chasan Taber, and A. M. Epstein. 1999. Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia. *Medical Care* 37(12):1260–1269.

Segal S. P., J. R. Bola, and M. A. Watson. 1996. Race, Quality of Care, and Antipsychotic Prescribing Practices in Psychiatric Emergency Services. *Psychiatric Services* 47:282–286.

¹⁷ Valleroy et al. 1998. HIV Infection in Disadvantaged Out-of-School: Prevalence for U.S. Job Corps

individuals are believed to have been infected in their teens and twenties, as half of all new HIV infections are estimated to be among those younger than 25. Subgroups within this population that are most at risk are young African American women and men having sex with men. A study of 350,000 16- to 21-year-olds revealed an HIV prevalence 50% higher among women than men and an infection rate for young black women that was seven times the infection rate for their white counterparts.¹⁸ In addition, the gender difference was strongest among the younger women in this group. Results such as these have led researchers to theorize that established gender roles and inequalities within the black community lead to the higher infection of young African American women.¹⁹ Arguments that black women feel less empowered to take preventive actions such as demanding that their partners use condoms are backed by findings that young black women are less confident that they can make safe-sex decisions than are their male counterparts.²⁰ As a source of this imbalance of power, researchers point to the perceived shortage of male partners for young heterosexual black women due to the large number of young black men who are incarcerated or have been victims of homicide. It is argued that this perceived shortage causes black women to be more permissive of male partners who do not use condoms and have multiple sexual partners, including other men.

Young black men who have sex with men (MSM) are identified as such because they often do not identify as gay or bisexual. Research has shown that black MSM are actually at a higher risk. In a sample of MSM aged 15–22, researchers found that 14% of

Entrants, 1990 through 1996. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 19:67–73.

¹⁸ Ibid.

¹⁹ McNair, Lily D., and Cynthia M. Prather. 2004. African American Women and AIDS: Factors Influencing Risk and Reaction to HIV Disease. *Journal of Black Psychology* 30(1):106–123.

²⁰ Kline, A., E. Kline, and E. Oken. 1992. Minority Women and Sexual Choice in the Age of AIDS. *Social Science and Medicine* 34(4):447–57.

African Americans were infected compared to 3% of whites and 7% of Hispanics.²¹

Research has also shown that many MSM who are infected with HIV, like many AIDS cases in general, are undiagnosed.

Other factors also have been shown to put youth at increased risk for HIV infection. Those at higher risk for reasons often tied to socioeconomic conditions include youth who drop out of school, run away from home, are incarcerated, are in other out-of-home residential home placements, or are homeless.²² Youth who are incarcerated in juvenile detention facilities are engaged in more risk behaviors but have less knowledge of HIV. Homeless and runaway youth are at higher risk because of their higher tendency to use injection drugs or exchange sex for food, money, or shelter. Exposure to violence has also been theorized to increase risk for infection. Rural residence has also been demonstrated to lead to higher levels of engagement in risk behaviors.²³ This is attributed to the lack of other activities for youth in rural areas as well as the aforementioned lack of eligible black men.

Without a viable medical cure for HIV or AIDS, the most commonly acknowledged and accepted method for slowing the epidemic is increasing public awareness and knowledge of the disease and its prevention. Epidemiological studies have revealed that many individuals still lack considerable knowledge about how the disease is contracted and the effectiveness of certain prevention methods.²⁴

²¹ Center for Disease Control. 2002. HIV/AIDS Fact Sheet.

²² The White House Office on National AIDS Policy. 2000. *Youth and HIV/AIDS 2000: A New American Agenda*. White House Press Office.

²³ Milhausen, et al. 2003. Rural and Nonrural African American High School Students and STD/HIV Sexual-Risk Behaviors. *American Journal of Health Behavior*. 27(4): 373–379.

²⁴ Peruga, A., and D. D. Celentano. 1993. Correlates of AIDS Knowledge in Samples of the General Population. *Social Science and Medicine* 36(4):509–524.

Torabi, M. R., and E. Ahua. 1998. Epidemiological Investigation of Public Knowledge and Attitudes on HIV/AIDS. *The Health Education Monograph Series* 16(2):12–20.

Another factor that is believed to contribute to the disproportionate rates of infection among black youth are their beliefs and attitudes about HIV and AIDS. African American youth often share a distrust of the effectiveness of preventive behaviors such as condom use and a belief in what are termed “cultural myths.”²⁵ These cultural myths include the beliefs that AIDS is the product of a government conspiracy against minorities or a label used to discriminate against blacks. Interestingly, these beliefs are much more common among young black males than their female counterparts. Bird and Bogart’s (2003) exploratory research into the sexual behaviors and conspiracy beliefs of seventy-one African American adults found significant associations between the belief in AIDS conspiracies and such risk behaviors as having multiple sexual partners and negative beliefs about condoms.²⁶ This research indicates that not only do significant numbers of blacks buy into the idea of the AIDS epidemic as an assault on blacks, but that this belief may be linked to their sexual decision-making.

Mental Health

Depression is a form of mental illness that afflicts about 17 million Americans (almost one in ten). The most common symptom of a depressive disorder is a deep feeling of sadness and anxiety. Those who suffer from depression may experience feelings of helplessness, hopelessness, tiredness, and listlessness and be generally overwhelmed with life. People with depression also fail to gain enjoyment from former

²⁵ Stevenson, H.C., G. Davis, E. Weber, D. Weiman, and S. Abdul-Kabir. 1995. HIV Prevention Beliefs Among Urban African-American Youth. *Journal of Adolescent Health* 16(4):316–323.

²⁶ Bird, S. T., and L. M. Bogart. 2003. Exploring the Relationship of Conspiracy Beliefs about HIV/AIDS to Sexual Behaviors and Attitudes among African-American Adults. *Journal of the National Medical Association* 95(11):1057–1065.

pleasures. Diagnosis of depression occurs when an individual experiences these symptoms accompanied by any five of the following symptoms for at least two weeks:

- Changes in appetite that result in weight losses or gains not related to dieting
- Insomnia or oversleeping
- Loss of energy or increased fatigue
- Restlessness or irritability
- Feelings of worthlessness or inappropriate guilt
- Difficulty thinking, concentrating, or making decisions
- Thoughts of death or suicide or attempts at suicide

The following are some of the findings from the Youth Risk Behavior Study (YRBS) that pertain to depressive symptoms:

- Nationwide, during the twelve months preceding the survey, 28.3% of high school students had felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing some of their usual activities (YRBS 2001).
- Overall, female students were significantly more likely (34.5%) than male students (21.6%) to have felt sad or hopeless almost every day for at least two weeks (YRBS 2001).
- Overall, Hispanic students (34%) were significantly more likely than black and white students (28.8% and 26.5%, respectively) to have felt sad or hopeless almost every day for at least two weeks (YRBS 2001).

Hispanic female students (42.3%) were significantly more likely than white female students (32.3%), Hispanic male students (25.4%), and white male students (20.5%) to report this behavior (YRBS 2001).

Several factors have been identified as causes of depression. Biological explanations for the illness are the most established. Biochemical causes for depression are attributed to an imbalance of chemicals in the brain. Genetics is also considered to contribute to depression; geneticists believe there may be multiple genes that make individuals more susceptible to depressive disorders. This belief is supported by the fact that the most important indicator that an individual will suffer from depression is having a parent with depression. Sociological and psychological causes of depression have also been reported. Low self-esteem and continuous exposure to violence, neglect, abuse, and poverty increase the vulnerability of those already susceptible to depression.

One factor that is important to the occurrence of depression is gender. Women are almost twice as likely as men to suffer from depression. The link between gender and depression may be explained by biological and sociological causes. Biologically, different hormonal balances may make women more susceptible to depression, while their gender-based oppression, family responsibilities, and stress may leave them more vulnerable. The increased risk for depression among women is consistent along racial lines.

Although data on African American mental health are somewhat inconsistent, much of the available information indicates that mental health problems are at least as prevalent among the African American population as among whites. These

inconsistencies in data are probably due to the different measures used in studies. The most common technique used in large field surveys consists of the use of short scales designed to assess a pool of symptoms commonly observed among patient populations. Recently, the Center for Epidemiologic Studies-Depression measure (CES-D)²⁷ has become the most popular of the scales. Such scales only test for symptoms of mental health disorders and cannot be used to diagnose depression. Other studies have used the Diagnostic Interview Schedule (DIS),²⁸ a fully structured interview that requires the presence of a certain number of symptoms that are judged within the context of their recency, duration, and severity to diagnose psychiatric disorders. Researchers are often critical of the cross-cultural validity of the CES-D and the DIS. Inconsistency exists even among studies that employ both methods. Blacks report significantly higher levels of depressive symptoms on the CES-D checklist but significantly lower levels of lifetime depression as measured by the DIS. This difference has been explained by differential effects of recall between blacks and whites, as blacks of lower socioeconomic status were far more unlikely to respond positively to questions about symptoms occurring more than a year ago. Despite these inconsistencies, a number of studies have found that African Americans report lower levels of subjective well being when indicators such as life satisfaction, happiness, and psychological distress are used. Some researchers have suggested that these racial differences can be explained through the study of individual histories and circumstances,²⁹ while others contend that these differences are a function

²⁷ Radloff, L. S., and B. Z. Locke. 1986. The Community Mental Health Assessment Survey and the CES-D. Scale. Community surveys of psychiatric disorders.

²⁸ Robins et al. 1981. National Institute of Mental Health Diagnostic Interview Schedule. Its History, Characteristics, and Validity. *Archives of General Psychiatry* 38(4):381–389.

²⁹ Ulbrich, P. M., G. J. Warheit, and R. S. Zimmerman. 1989. Race, Socioeconomic Status, and

of the differences between the social contexts in which these groups live. There is substantial evidence for the latter argument. Research indicates that adjusting for socioeconomic differences significantly reduces racial disparities in mental health and that socioeconomic status is predictive of mental health within racial groups.³⁰ Studies have shown that much of the disparity is found among the lower socioeconomic status groups³¹ among which blacks may be more negatively impacted by noneconomic life events while whites are more strongly affected by economic events.³² Other studies have shown that residence in areas of concentrated poverty and racial segregation is correlated with poor mental health.³³ There is also evidence that the racial discrimination faced by African Americans has an adverse effect on their mental health, including causing depression. These variables can also work together to increase mental health problems. For example, African Americans who live in socioeconomically depressed areas may be more susceptible to depression as a result of stressful life experiences of discrimination. Social context variables also influence youth. According to the Surgeon General's Report on Mental Health, children and adolescents from families of multigenerational poverty are more likely to experience mental health problems, including depression. Choi argues

Psychological Distress: An Examination of Differential Vulnerability. *Journal of Health and Social Behavior*. 30(1):131–146.

³⁰ Vega, W. A., and R. G. Rambaut. 1991. Ethnic Minorities and Mental Health. *Annual Review of Sociology* 17:351–383.

³¹ Kessler, R. C., and H. W. Neighbors. 1986. A New Perspective on the Relationship among Race, Social Class, and Psychological Distress. *Journal Health Social Behavior*, 1986 Jun;27(2):107–115.

³² Ulbrich, P. M., G. J. Warheit, and R. S. Zimmerman. 1989. Race, Socioeconomic Status, and Psychological Distress: An Examination of Differential Vulnerability. *Journal of Health and Social Behavior*. 30(1):131–146.

³³ Schulz et al. 2000. Unfair Treatment, Neighborhood Effects, and Mental Health in the Detroit Metropolitan Area. *Journal of Health and Social Behavior*. 41(3):314–332.

that the absence of father figures in more than 40% of black households can also lead to depression.³⁴

Research into the effect of social context on depression and mental health overall is usually guided by social psychological stress theory, which presupposes that certain types of stressors fall disproportionately on certain sectors of the population, especially those experiencing more life changes with fewer resources available to cope with them.³⁵ Ethnic and racial minorities are vulnerable to subjective and objective factors that put them at risk for depression. Subjective factors include perceptions of discrimination and blocked opportunity, while objective factors deal with actual life events such as unemployment and fragmented social networks. Of course, these two categories interact with each other because perceptions can result from real life experiences and shape future life experiences and their interpretation.³⁶

There is also research that contends that certain aspects of African American culture and residential segregation of African Americans help in some ways to mitigate the causes of mental illness. For instance, Schulz et al. (2000) contend that whites living in areas of high poverty are more vulnerable to psychological distress as a result of poverty or other stressful experiences because they do not have the coping resources that black communities have. Also, whites may be more likely to internalize the causes for stress whereas blacks can externalize their problems, attributing them to their membership in a racial minority. The effect of external versus internal attribution on

³⁴ Choi, Heeseung. 2002. Understanding Adolescent Depression in Ethnocultural Context. *Advanced Nursing Science* 25(2):71–85.

³⁵ Pearlin, L. I., M. A. Lieberman, E. G. Menaghan and J. T. Mullan. 1981. The Stress Process. *Journal of Health and Social Behavior* 22(4):337–356

³⁶ Vega, W. A., and R. G. Rambaut. 1991. Ethnic Minorities and Mental Health. *Annual Review of Sociology* 17:351–383.

mental health is one of the issues that researchers have concluded needs further investigation (Neighbors et al. 1996; Schulz et al. 2000). Other scholars of African American depression suggest that blacks use aspects of African American culture such as religious institutions to cope with psychological distress.

Another topic that requires more exploration is the effect of intersectionalities and dimensionalities of gender and racial identities on the mental health of African Americans. Scholars who review the literature on African American depression point to the need to examine how identification with different dimensions of racial and gender identities affects depression. One study explores the links between sex-role identity³⁷ and depression among African American males.³⁸ It found that black men with androgynous sex-role identities were least prone to depression while those with undifferentiated sex-role identities were most vulnerable. The intersectionality of traits such as race, gender, and socioeconomic status may also create vulnerabilities to depression and other mental health problems.

Substance Use and African American Youth

Studies of racial differences in rates of substance use have shown that blacks tend to use alcohol and illegal substances at lower rates than whites. Studies with specific focus on adolescents and youth have produced similar findings. The findings of the

³⁷ Sex-role identities are classified in four categories: masculine, androgynous (high feminine and masculine), indifferentiate (neither high masculinity nor high femininity), and feminine. Black men in this study scored highest in androgyny and lowest in femininity.

³⁸ Wade, J. C. 1996. African American men's gender role conflict: the significance of racial identity. *Sex Roles* 34(1/2): 17-33.

YRBS provide a comprehensive impression of substance use reported by high school students (YRBS 2001).

The YRBS is a component of the Youth Risk Behavior Surveillance System (YRBSS), a national study monitoring six categories of priority health-risk behaviors among youth. These health-risk behaviors have been identified by the CDC as behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases; unhealthy dietary behaviors; and physical inactivity. The YRBS is a biennially conducted, nationally representative study of young people ages 12 through 21 that augments state and local surveys in states and school districts that receive funding from the CDC through cooperative.

The 2001 version of the YRBS reveals some interesting trends regarding the consumption of controlled substances by high school students. The study results also reveal a complex relationship between race and substance use. The 2001 YRSB found alcohol use to be quite common among this group, with 78.2% of students reporting having had at least one drink during their lifetime (i.e., lifetime alcohol use). Nationwide, 29.9% of students had had at least five drinks on at least one occasion during the thirty days preceding the survey (i.e., episodic heavy drinking). Overall, male students (33.5%) were significantly more likely than female students (26.4%) to report episodic heavy drinking. Nearly one-half (47.1%) of students nationwide had had at least one drink on at least one of the thirty days preceding the survey (i.e., current alcohol use). Male students in grade 11 (53.6%) were significantly more likely than female students in grade 11 (45.1%) to report current alcohol use.

The racial and ethnic distribution of alcohol use among respondents indicates that alcohol use is more common among white and Hispanic students than their African American counterparts. Hispanic students reported lifetime alcohol use at a rate of 80.8%, current alcohol use at 49.2%, and episodic heavy drinking at 34%. Similarly, 80.1% of white students reported lifetime alcohol use, while 50.4% and 30.1% reported current use and episodic heavy drinking, respectively. Sixty-nine percent of black students reported lifetime drinking, while 32.7% reported current alcohol use and 11.1% reported episodic heavy drinking.

Although reported marijuana use was significantly lower than alcohol use, it was still far from rare among YRBS 2001 respondents. Nationwide, 42.4% of students reported having used marijuana during their lifetime (i.e., lifetime marijuana use), with male students (46.5%) significantly more likely than female students (38.4%) to report lifetime marijuana use. Racially, there was not as significant a difference among reported lifetime marijuana use by white (42.8%), black (40.2%), and Hispanic students (44.7%) as there was in alcohol use. Approximately one-fourth (23.9%) of students had used marijuana at least once during the thirty days preceding the survey (i.e., current marijuana use). Overall, male students (27.9%) were significantly more likely than female students (20%) to report current marijuana use. Reported current marijuana use among black respondents (21.8%) was slightly lower than it was among their white (24.4%) and Hispanic (24.6%) counterparts. Interestingly, black males reported a significantly higher rate of current use than did black females (28.2% and 16%, respectively).

Nationwide, 9.4% of students had used a form of cocaine (e.g., powder, “crack,” or “freebase”) during their lifetime (i.e., lifetime cocaine use). Hispanic and white

students (14.9% and 9.9%, respectively) were significantly more likely than black students (2.1%) to report lifetime cocaine use. According to the study results, lifetime cocaine use is more common among male respondents (10.3%) than females (9.2%). Four percent of students had used a form of cocaine at least once during the thirty days preceding the survey (i.e., current cocaine use), with males once again using at a higher rate than females (4.7% and 3.7%, respectively). Overall, Hispanic and white students (7.1% and 4.2%, respectively) were significantly more likely than black students (1.3%) to report current cocaine use. Black male students (2.2%) were significantly more likely than black female students (0.4%) to report current cocaine use.

The racial and ethnic patterns of alcohol, marijuana, and cocaine use among YRBS 2001 respondents are also reflected in the use of less commonly used substances such as heroine, inhalants, and methamphetamine. However, the relationship between substance use and race is much more complex. Barr et al. (1993)³⁹ report that race has a strong impact on substance abuse that intersects with class and gender. Barr et al. found that although blacks are less likely to use substances, those with lower socioeconomic status (SES) are more prone to use. Black males with the lowest SES scores according to measures of both income and education were especially more prone to report substance use and problems that result from substance use. Barr et al. interpret their findings as supportive of Wilson's theory of the particular impact of deindustrialization on African American males.

While Barr et al. reported the common finding that more blacks than whites report abstaining from substances, among those that do report substance use, blacks report a

³⁹ Barr, K. E. M., M. P. Farrell, G. M. Barnes, and J. W. Welte. 1993. Race, Class, and Gender Differences in Substance Abuse. *Social Problems*, 40:314-327.

greater magnitude and frequency of use. For instance, while 84% and 89% of black and white males, respectively, reported no illicit drug use, 12% of black males compared with 5% of their white counterparts reported using drugs three or more times within the last thirty days. In accordance with these findings, black males also reported the highest magnitude of problems related to alcohol abuse.

Beyond the roles of race, gender, and class, a number of social and psychological factors have been attached to substance use. Many studies have investigated the relationship between substance abuse and psychological well being among adolescents.⁴⁰ Using measures of depression, emotional distress, and anxiety, these studies often find a positive relationship between negative affect and substance use. The findings are often interpreted as supporting the self-medication hypothesis, which posits that adolescents use substances more heavily when coping with negative emotions.⁴¹ Coping style itself also has been posited as a predictor of substance use. Simons and Robertson (1989)⁴² found that having an avoidant as opposed to a direct-action coping style increases adolescent propensity to drug use. In the same study, these authors also link aggressiveness to substance abuse.

The most important social processes that reportedly influence youth substance use involve relationships with parents and peers. Membership in a peer group engaged in violence or crime or having peers who use substances sharply increases an adolescent's tendency toward substance use. One of the strongest predictors of adolescent substance

⁴⁰ Swaim, R. C., E. R. Oetting, R. W. Edwards, and F. Beauvais. 1989. Links from Emotional Distress to Adolescent Drug Use: A Path Model. *Journal of Consulting and Clinical Psychology* 57(2):227–231.

⁴¹ Greeley, J., and T. Oei. 1999). Alcohol and Tension Reduction. In *Psychological Theories of Drinking and Alcoholism*, edited by K. E. Leonard and H. T. Blanc, pp. 14–53. New York: Guilford Press.

⁴² Simons, R. L., and J. F. Robertson. 1989. The Impact of Parenting Factors, Deviant Peers, and Coping Style upon Adolescent Drug Use. *Family Relations* 38:273–281.

use is substance use by an adolescent's close friends. Parental substance abuse also predicts substance abuse among adolescents. Parent-child relationships can influence adolescent substance use as well. Unstable, abusive, and neglectful parenting has been found to be related to substance use. In addition, parental values and tolerance of substance use have also been linked to use by adolescents.⁴³

Robertson and Simons (1989)⁴⁴ employ social learning theory in order to build a comprehensive model predicting adolescent drug use. This model posits that parental factors are the starting point for adolescent drug use. Parental substance use and rejection are credited with causing personality traits (i.e., avoidant coping, aggressiveness, low self-esteem), which, in turn, trigger membership in deviant peer groups. In these peer groups, adolescents are exposed to substances and encouraged to use them.

Research also indicates that substance use can increase young people's vulnerability to other health risk behaviors. In a study of 668 low-income women, Sly et al. (1997) found a strong association between having used substances within a six-month period and risky sexual behaviors in the same period.⁴⁵ A similar study of 338 African American men also found an association between an individual being identified as a heavy drinker and AIDS-related risky sexual behavior.⁴⁶

⁴³ Jessor, R., T. D. Graves, R. G. Hanson, and S. L. Jessor. 1968. *Society, Personality, and Deviant Behavior*. New York: Holt, Rinehart & Winston.

⁴⁴ Simons, R. L., and J. F. Robertson. 1989. The Impact of Parenting Factors, Deviant Peers, and Coping Style upon Adolescent Drug Use. *Family Relations* 38:273–281.

⁴⁵ Sly, D. F., D. Quadango, D. F. Harrison, I. Eberstein, and K. Riehman. 1997. The Association between Substance Use, Condom Use and Sexual Risk among Low-Income Women. *Family Planning Perspectives* 29:132–136.

⁴⁶ Snowden, L. R., and A. M. Hines. 1998. Acculturation, Alcohol Consumption, and AIDS-Related Risky Sexual Behavior among African American Men. *Journal of Community Psychology* 26(4):345–359.

Substance Use and Trade as Environmental Factors

The lived experiences of young people are shaped by the presence of drugs in their lives even when they do not use them. Besides measures of peer and parental involvement with substances, scholars have also developed other measures that investigate adolescent connections to substances. Such measures include those that test for access to and availability of controlled substances, asking respondents if they have had opportunities to try substances, and the ease with which they could obtain them.⁴⁷

Although the involvement of young African Americans, or young people in general, in the drug trade is lacking in quantitative research, qualitative methods have been applied to gauge the feelings of these youth toward the drug trade. Bass and Kane-Williams (1993)⁴⁸ reported on the responses of inner-city African American youth focus group participants on this subject. Participants were able to detail a number of roles or jobs involved in the drug trade. They also expressed the belief that it was relatively easy to get involved in the drug trade without using drugs.

Violence

Violence and Life Expectancy

The Centers for Disease Control (2001) has reported that not only is homicide the leading cause of death for African Americans age 15–24 but that the rate of homicide among African Americans is one of the primary reasons for the differences in life expectancy

⁴⁷ Caldwell, C. H., T. M. Chavous, T. E. Barnett, L. P. Kohn-Wood, and M. A. Zimmerman. 2004. Social Determinants of Experiences with Violence among Adolescents: Unpacking the Role of Race in Violence. *Phylon* 50(1-2):87–113.

⁴⁸ Bass, L. E., and E. Kane-Williams. 1993. Stereotype or Reality: Another Look at Alcohol and Drug Use among African American Children. *Public Health Reports* 108, Suppl. 1:78–84.

between blacks and whites. In an analysis of mortality data from 1998, the CDC concluded that although it is only the thirteenth leading cause of death in the United States, homicide was the third-ranking cause of death in contributing to the difference in life expectancy between blacks and whites. Being responsible for 10% of this difference, homicide trails only heart disease and cancer in its responsibility for the chasm in life expectancy.

Understanding homicide's impact along sex, race, and age lines shows that it is a problem that may be national in scope but is a more ubiquitous phenomenon for some social groups than others. This suggests that homicide is not only an issue of crime but also a public health issue that threatens some communities more than others.

National statistics indicate that violence is much more common among African Americans in terms of both perpetration and victimization. Despite making up only about 12% of the nation's population, blacks consisted of 38% of all arrests for violent crime in 2002.⁴⁹ Blacks made up a disproportionate amount of arrests for aggravated assault (34.2%) and forcible rape (34%) and half of all arrests for murder and nonnegligent manslaughter. For individuals younger than age 18, blacks made up an even greater percentage of arrests for violent crimes, consisting of 42% of such arrests. Although arrest rates do not completely represent rates of violent acts, as many acts go unreported and arrests do not always mean guilt, the tremendous disparity in the rates of arrests for violent crimes among blacks does likely indicate a higher rate of violence.

Theoretical Frameworks

⁴⁹ Maguire, Kathleen, and Ann L. Pastore, eds. 2005. *Sourcebook of Criminal Justice Statistics*. Available at <http://www.albany.edu/sourcebook/> [August 10].

The poverty-social disorganization theory. This theory suggests that the disproportionate rates of violence within African American communities are a result of the social conditions produced by high rates of poverty. Proponents of this theory argue that these conditions—chronic unemployment, teen pregnancy, female-headed households, academic failure, welfare dependency, inadequate socialization, and substance abuse—lead blacks to adhere to “lower-class values” rather than conventional ones.⁵⁰

The subculture of violence theory. Similar to the poverty-social disorganization theory, the subculture of violence thesis has been proposed as an explanation of higher rates of violence among subgroups in the United States. This theory claims that certain groups are more supportive or tolerant of violence because of a distinct set of values and norms that condone violence as an acceptable means of resolving interpersonal conflict.⁵¹ Although the subculture of violence theory was initially used to explain differences among race, class, and geographical regions, the most significant research has been on the smaller scales of schools and neighborhoods.

The racial oppression-displaced aggression theory. This theory suggests that high incidences of black violence are the result of frustration and anger felt by blacks, especially males, who are unable to achieve socially prescribed success goals. This frustration transforms into aggression, which blacks take out on those they encounter

⁵⁰ Voss, H., and J. R. Hepburn. 1968. Patterns of Criminal Homicide in Chicago. *Journal of Law, Criminology, and Political Science* 59:499–508.

⁵¹ Wolfgang, M. E., and F. Ferracuti. 1967. *The Subculture of Violence*. London: Tavistock.

most regularly: other blacks. Thus, the frustration is displaced from the actual cause of frustration and directed at those easiest to victimize.⁵²

Ecosystem distrust theory. Jessor et al.'s ecosystem distrust theory suggests that the perception of hostility and danger within one's environment may lead one to accept violence as an appropriate and necessary means of survival.⁵³ In applying this theory to violence among African Americans, scholars argue that African Americans, especially males, are socialized to believe that in order to cope with the racism of American society, they must be tough and confrontational.⁵⁴

Social and economic conditions and violence. The common thread in all of these theories is that the social and economic characteristics of black communities as well as the racism of the larger society are the causes of heightened violence in black communities. Naturally, scholars who have sought to produce empirical research on violence in African American communities have tested these theories. The resulting studies have usually found that socioeconomic differences among racial groups are not enough to explain differences in violence. Shihadeh and Steffensmeier (1994) found that intraracial economic inequality functioned through family disruption (single-parent households) to increase violence on the neighborhood level.⁵⁵ In a study of 850 ninth grade students, Caldwell et al. (2004)⁵⁶ found that SES, peer, parental, and neighborhood

⁵² Toch, H. 1980. Toward an Interdisciplinary Approach to Criminal Justice. *Journal of Law, Criminology, and Political Science* 71:646–653.

⁵³ Jessor, R., T. D. Graves, R. G. Hanson, and S. L. Jessor 1968. *Society, Personality, and Deviant Behavior*. New York: Holt, Rinehart & Winston.

⁵⁴ Majors, R., and J. M. Billson. 1992. *Cool Pose, the Dilemmas of Black Manhood in America*. New York: Simon & Schuster.

⁵⁵ Shihadeh, E. S., and D. J. Steffensmeier. 1994. Economic Inequality, Family Disruption, and Urban Black Violence: Cities as Units of Stratification and Social Control. *Social Forces* 73(2):729–751.

⁵⁶ Caldwell, C. H., T. M. Chavous, T. E. Barnett, L. P. Kohn-Wood, and M. A. Zimmerman. 2004. Social Determinants of Experiences with Violence among Adolescents: Unpacking the Role of Race in Violence. *Phylon* 50(1-2):87–113.

variables influenced violent behaviors by African Americans. Unfortunately, most of the studies of violence in African American communities focus on crime rates and neglect forms of violence that may be underreported as crimes, such as family violence and violence within sexual and romantic relationships. These studies often also fail to identify the perpetrators of violence within black communities. Another area in need of further exploration is violence tied directly to economic activities.

Race, Health, and Public Opinion

Measuring the public awareness and attitudes of African Americans regarding matters of health and health care can also provide some insight into the nature of racial health disparities in the United States. Racial differences in beliefs may go a long way in explaining differences in behavior that result in health disparities. In addition, properly measured African American public opinion may reveal how blacks perceive the health status of their race and how disparities in health affect African American views of society. Finally, a greater understanding of African American beliefs about health may reveal some avenues for addressing and erasing racial health disparities.

As mentioned earlier, research into African American attitudes about HIV/AIDS has produced some interesting results. Research on African American youth's attitudes showed that many of the respondents did not trust the effectiveness of preventive methods and that males were especially prone to agree that the AIDS epidemic was somehow created for the detriment of minorities and the poor. Bogart and Bird (2003)⁵⁷

⁵⁷ Bogart, L. M., and S. T. Bird. 2003 Exploring the Relationship of Conspiracy Beliefs about HIV/AIDS to Sexual Behaviors and Attitudes among African-American Adults. *Journal of the National Medical Association* 95(11):1057–1065.

demonstrate that not only are these beliefs prominent among blacks but endorsement of AIDS conspiracy theories may be associated with certain risk behaviors.

Significant racial differences also exist in public opinion concerning the American health-care system in general. In a study of the attitudes of 527 black and white adults, Sylvester (1998)⁵⁸ reported findings that indicated a divergence of views of the American health-care system. Not surprisingly, most disagreement centered on racial issues. For instance, blacks were more likely to agree with statements that suggested that the media fails to report on African American health problems and that minorities have not been taught how to use the health-care system and to disagree that racial barriers to health care are not an issue. The same study also investigated racial differences in individuals' health information services. The findings revealed that while the majority of both whites and blacks listed doctors as their top interpersonal information source, they differed in terms of media sources. While whites listed newspapers, magazines, and television almost evenly, more blacks reported television as their primary media source of health information than any other form of media.

Public opinion research has also revealed racial differences in trust in different aspects of the health-care industry. In a national study of 118 non-Hispanic white and black adults, Boulware et al. (2003)⁵⁹ found that black respondents differed significantly from whites in their trust of physicians and health insurance plans. Interestingly, these differences are in divergent directions, as blacks expressed less trust in their physicians and more trust in their insurance plans. The authors attributed this divergence to cultural

⁵⁸Sylvester, J. L. 1998. *Directing Health Messages toward African Americans*. New York: Garland.

⁵⁹ Boulware, L. E. 2003. Race and Trust in the Health Care System. *Public Health Reports* 118:358–365.

factors and the effect of the differences in development, interpersonal, and institutional trust. Also notable was a failure to find significant racial differences in trust of hospitals.

Conclusion: The Black Youth Project

The complex relationships between society and health that are discussed above are further investigated through the Black Youth Project. Through a nationally representative survey of 15- to –25-year-olds, the project will examine the connections between the views of young people on important health issues and characteristics that we know are associated with health, such as race, gender, class, and residential quality. The Black Youth Project pays especially close attention to violence and HIV/AIDS, two of the leading threats to the lives of African Americans in this age group, as well as depressive symptoms and public opinion on the quality of health care in America. By focusing on these areas, the study brings the most important matters—physical and mental well being—together with the sociopolitical effects of inequalities of health.

Also, because the study encompasses a wide array of topics beyond health, its results will allow researchers to examine the relationships between health and other areas of study that have been largely overlooked in health research. The project's focus on decision-making in important areas such as sexual behavior and politics will create a unique opportunity to consider the effect of health issues on young people's decisions in these areas. In addition, the study of young people's engagement in religion and hip hop culture will permit scholars to explore the influence of culture on young people's health attitudes and statuses. Hopefully, the study will allow for new breakthroughs in the study of health in terms of African American youth and beyond.