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Review

A review of sociocultural factors that may underlie differences in African American and European American anxiety

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ABSTRACT

Preliminary evidence indicates there may be differences in the prevalence and severity of anxiety in African Americans and European Americans. A number of sociocultural risk and protective factors have been suggested to contribute to these group differences, such as salience of physical illnesses, discrimination, stigma toward mental illness, religiosity, and ethnic identity. In this paper, the literature concerning each of these factors is reviewed. Overall, the strongest evidence was found for ethnic identity and stigma toward mental illness as factors underlying group differences in anxiety. Ethnic identity and stigma toward mental illness consistently differed by racial group and were associated with anxiety in African Americans. Ethnic identity may buffer against the negative consequences of anxiety, reducing prevalence rates in African Americans. Stigma toward mental illness may decrease African Americans willingness to report anxiety symptoms, reducing overall prevalence rates but increasing the severity of treated cases. The research regarding discrimination, salience of physical illnesses, and religiosity was less clear. Much more research is required, but the findings of this review suggest that future studies should put particular emphasis on stigma toward mental illness and ethnic identity as important factors in understanding African American anxiety outcomes.

Anxiety disorders are the most prevalent group of mental health disorders in the United States (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). In fact, one in four individuals will meet criteria for an anxiety disorder at some point in their life, and within a 12-month period, 17.2% of the U.S. population has an anxiety disorder (Kessler et al., 1994). Given the large number of people affected by anxiety, a substantial body of research on anxiety disorders exists. However, much of this research is based on results from samples of primarily European American participants and does not consider racial or ethnic differences. By neglecting to consider group differences in anxiety, researchers could miss important factors that may contribute to variations in anxiety unique to a given group.

Although sparse, comparative research of anxiety between African Americans (AAs) and European Americans (EAs) has generally found that prevalence rates of anxiety disorders in AAs tend to be lower than in EAs (Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010; Breslau et al., 2006). But, anxiety disorders in AAs tend to be more chronic, functionally impairing, and less responsive to treatment than in EAs (Breslau, Kendler, Su, 2Gaxiola-Aguilar, & Kessler, 2005; Himle, Baser, Taylor, Campbell, & Jackson, 2009; Sibrava et al., 2013; Vinson, Crowther, Austin, & Guin, 2013). These findings suggest there may be important differences in anxiety between AAs and EAs.

Several explanations have been posited to account for anxiety-related differences between AAs and EAs. In particular, some have argued that sociocultural factors may explain group differences in anxiety. Hunter and Schmidt (2010) proposed a model in which anxiety is created and maintained in AAs through different risk factors, unique to AA culture. Specifically, the salience of physical illness, discrimination, and stigma toward mental illness may affect endorsement of symptoms in AAs. As a result, AAs may be at risk for reduced diagnosis and treatment of anxiety disorders. However, in addition these risk factors, there may also be unique protective factors that reduce the likelihood of anxiety disorders from developing in AAs. Sociocultural factors, such as religiosity and ethnic identity, could reduce the likelihood of developing an anxiety disorder for this group (Sternthal, Williams, Musick, & Buck, 2012; Williams, Chapman, Wong, & Turkheimer, 2012). These factors may provide culturally unique coping methods that help protect AAs from experiencing prolonged anxiety in times of stress, thereby explaining the lower prevalence rate of anxiety in this group compared to EAs.

The purpose of this paper was to review the literature pertaining to specific sociocultural factors that may uniquely affect anxiety in AAs compared to EAs and to potentially explain the group differences in prevalence rates and severity. As much of the current anxiety research

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utilizes primarily EA samples, it is important to understand if general findings are equally applicable to AAs. This is not to say that EA experiences of anxiety are the gold standard; rather, EAs are a comparison group to help determine if and where differences may be found. Understanding where experiences may differ for each of these groups can help clinicians and researchers further understand the unique factors that contribute to anxiety in AAs and EAs. Moreover, the knowledge gained from this work can be used to develop culture-specific interventions and therapies. As there are a multitude of potential sociocultural factors that may affect anxiety assessment and outcomes in AAs, this paper focused only on the domains that have received the most attention in the literature: perceived discrimination, stigma toward mental illness, salience of physical illness, religiosity, and ethnic identity.

1. Selection of articles to review

Literature searches were conducted with PsychINFO, PsychARTICLES, and Google Scholar using a combination of key words,[1] in addition to searching the references of found articles. Only studies written in English, published in peer reviewed journals, and that included both AA and EA adults (e.g., over 18) were included. It should be noted that this review includes only individuals who identified as Black/African American or White/European American. For example, information on individuals who identified as Caribbean Black was not included as this is a group distinct in history and culture from African Americans. Similarly, studies that included individuals who recently immigrated to the United States but identified as White were not included. Due to the dearth of research on anxiety disorders with clinical samples of AAs and EAs, studies were included with non-clinically anxious participants as well. Table 1 presents study specific information about the sample and results.

1.1. Perceived discrimination

Perceived experiences of discrimination are associated with a number of negative health outcomes in AAs (see Lewis, Cogburn, & Williams, 2015; Williams & Mohammed, 2013, for reviews), such as increased cardiovascular reactivity (Lepore, Revenson, & Weinberger, 2006; Merritt, Bennett, Williams, Edwards, & Sollers, 2006), use of tobacco, alcohol, and marijuana (Borrell et al., 2007; Landrine & Klonoff, 2000), hypervigilance for future discriminatory events and social exclusion (Mays, Cochran, & Barnes, 2007), and major depressive disorder (Banks, Kohn-Wood, & Spencer, 2006). In particular, perceived discrimination is associated with a greater likelihood of having an anxiety disorder in AAs (Banks et al., 2006; Mouzon, Taylor, Keith, Nicklett, & Chatters, 2016). As AAs are more likely to experience discrimination than EAs (e.g., Corrigan et al., 2003; Levine et al., 2014; Soto et al., 2011; Thompson, 2002), perceived discrimination may be a particular risk factor for the development or severity of an anxiety disorder in AAs.

Discrimination can be differentiated into two categories: major and everyday experiences. Major experiences include extreme forms of discrimination (e.g., being unfairly fired); everyday experiences of discrimination are relatively minor and subtle forms that occur in everyday life (e.g., being treated with less respect; Essed, 1991; Williams, Yu, Jackson, & Anderson, 1997). Soto, Dawson-Andoh, and BeLue (2011) studied the relation between everyday experiences of discrimination and generalized anxiety disorder (GAD). They found that race-based experiences of discrimination were related to GAD in AAs, but not EAs. That is, greater instances of perceived racial discrimination significantly increased the odds of having GAD in AAs. Kessler, Mickelson, and Williams (1999) also investigated the association between GAD and everyday discrimination. Greater experience of discrimination was associated with an increased likelihood of having GAD. However, race was controlled for in the analyses, so it is unclear if there was a difference between the racial groups with regard to the impact of discrimination on anxiety. Levine et al. (2014) studied the extent to which everyday experiences of discrimination were associated with social anxiety disorder (SAD) in AAs and EAs. For both groups, greater experience of everyday discrimination was associated with greater rates of SAD. However, this association did not differ by race. Each of the aforementioned studies also analyzed the relation between major experiences of discrimination and anxiety. In all studies, major experiences of discrimination were not associated with an anxiety disorder diagnosis.

Overall, these studies suggest that everyday experiences of discrimination are important to understand rates of anxiety disorders in both AAs and EAs. Regardless of race, perceived everyday discrimination is associated with increased rates of SAD and GAD. However, very few studies have compared the relation between discrimination and anxiety disorders in AAs and EAs. It should be noted that in each of these studies, AAs reported more experiences of discrimination. Indeed, many studies have found evidence that AAs report greater experiences of discrimination than EAs (e.g., Corrigan et al., 2003; Levine et al., 2014; Soto et al., 2011; Thompson, 2002). Kessler et al. (1999) found that about a quarter of AAs reported often experiencing discrimination, whereas less than 5% of EAs reported often experiencing discrimination. Thus, although discrimination is associated with anxiety in both AAs and EAs, AAs experience significantly more instances of discrimination than EAs, which likely increases their chances of dealing with the deleterious effects of discrimination, including anxiety.

1.2. Stigma toward mental illness

Individuals who receive psychotherapy tend to have better mental health outcomes than individuals who do not receive treatment (American Psychological Association, 2013). However, there are a variety of barriers that hinder one's ability or willingness to seek psychological services. One such barrier is stigma toward mental illness and treatment (Tucker et al., 2013). Individuals who report greater stigma toward mental illness and mental health treatment tend to be less willing to seek mental health services (Vogel, Wade, & Hackler, 2007). AAs often endorse high levels of stigma toward mental illness and are concerned that they will be judged negatively for getting professional help, which may impede their willingness to seek psychological services (Conner et al., 2010; Hunter & Schmidt, 2010; Masuda, Anderson, & Edmonds, 2012; Ward, Wiltshire, Detry, & Brown, 2013). Greater stigma toward mental illness may reduce AAs openness to seeking mental health services for anxiety, which would lower prevalence rates and could result in more chronic and severe anxiety outcomes in AAs.

Masuda et al. (2009) assessed college students' self reported stigma toward mental illness. Compared to EAs, AAs endorsed significantly greater feelings of anxiety when thinking of interactions with a mentally ill person. AAs also perceived relationships with a person who has a mental illness to be more difficult than EAs. Other studies have shown that AAs endorse greater beliefs that those with mental illnesses were dangerous and indicated a greater desire to segregate themselves from those individuals compared to EAs (Anglin, Link, & Phelan, 2006; Rao, Feinglass, & Corrigan, 2007). AAs are also more concerned than EAs about how they would be judged if they have a mental illness. Conner, Koeske, and Brown (2009) assessed internal (i.e., negative attitudes held toward the self for having a mental illness) and public (i.e., beliefs that others will devalue or discriminate against another due to mental illness) stigma toward mental illness in adults

[1] Keywords were a combination of the following: African Americans, Blacks, racial groups, anxiety disorders, anxiety, social factors, influences, anxiety symptoms, discrimination, measurement, assessment, scales, somatic symptoms, physical symptoms, religiosity, religion, ethnic identity, stigma.