"Gettin' on My Last Nerve": Mental Health, Physiological and Cognitive Implications of Racism for People of African Descent

by

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Abstract

We explore recent research examining racial discrimination and institutional racism as a critical factor in deleterious health outcomes affecting, disproportionately, people of African descent living in the United States. Physiological, mental health effects and other cognitive functioning difficulties are examined. We provide a new analysis of the intra-cultural differences which suggests solutions to longstanding race-related health disparities.

Here is a typical scenario for many people of African descent living today in the United States: There is daily psychological pressure from juggling work and family while negotiating the challenges of culturally embedded negative perceptions of your ethnic group. You are the only person of African descent on the job, and you feel your European American colleagues frequently treat you as if you do not know what you are talking about. You worry about your children becoming a victim of the gang violence plaguing the neighborhood. You suffer from various chronic ailments disproportionate to people in other ethnic groups. Such a scenario is consistent with a growing body of scientific literature linking together daily stressors, perceived racism, ethnic group membership and poor health.

The term African American has typically been used to describe persons of African descent born in the United States. Some persons of African descent from the African Diaspora (i.e. the Caribbean, South America, Europe, individual African countries) who have migrated to the United States may choose this term because it best fits their group identity, though this is not done exclusively (Brooks, Haskins & Kehe, 2004).

In the literature, the terms "Black" and "African American" are often used interchangeably, though White and Parham (1990) posit that "Black" emphasizes the experience of Blackness in a White supremacist environment, while "African American" reflects the endorsement of a cultural lineage that can be traced back to Africa. In the health disparities literature, the term "Black" (upper or lower case) is used in comparison to Whites to describe the health status of all people of African descent including African Americans, as well as persons of African descent who have migrated to the United States. The authors of this paper will use the term "African American" to describe persons of African descent born in the United States. The term "Black" will be used to describe all individuals of African descent (native and foreign born) when highlighting issues that affect all individuals of African descent living in the U.S., as well as Black/White health disparities. We will specify national origin (i.e. Black Caribbean, African-born Blacks etc.) when describing important intra-race distinctions.

Black individuals constitute approximately 13% of the total US population, and possess the worst health status of all Americans (Feagin & McKinney, 2003), suffering from more than their share of disease, morbidity, mortality, disability and injury. Diseases that disproportionately affect Black communities include diabetes, obesity, hypertension, HIV and cardiovascular disease (USDHHS, 2000). An explosion of research done within the past decade provides a convincing portrait of the relationship between deleterious health and racial status (MMWR, 2005; Williams & Jackson, 2005).

We examine the deficits in mental and physiological health along with impairments in cognitive functioning that are associated with being a Black person in the United States. Many factors have been suggested to explain this persistent gap including poverty, access to health care, sedentary lifestyle, lack of exercise, poor nutrition, excessive drug and alcohol use, cigarette smoking, exposure to violence, incarceration, poor education and unemployment (Fiscella & Williams, 2004). But, although a large proportion of Blacks in the United States live below the poverty level, with co-commitant inadequate access to health care and possible poor health practices, poverty alone cannot explain the disparity (see Franks, Muennig, Lubetkin & Jia, 2006). When corrected for social economic status and education levels, a persistent gap remains between health outcomes of Blacks and Whites, including premature birth rates and pre-natal care (Dole, Siega-Riz, Hertz-Picciotto, McMahon & Buekens, 2004).

Using racism and racial discrimination as explanatory factors in deteriorating health integrates what is unique about the community of Blacks living in the United States, and best describes how that racialized experience alone generates stressors associated with health and disease (Dressler, Oths & Gravlee, 2005). In our view, the United States' Black/White health gap is an important consequence of racial inequality, institutionalized racism and racial discrimination. The gap is large, shows little signs of declining, and explanations have been limited by lack of theory and data. It is important to provide precise definitions for the words racism and discrimination, as they are complex and often used terms that are an essential component of our analysis.

Sue (2003) describes racism "as any attitude, action or institutional structure or any social policy that subordinates persons or groups because of their color…it involves the power to carry out systematic discriminatory practices in a broad and continuing manner" (p. 31) Racial discrimination "is any action that differentially treats individuals or groups of color based on prejudice." (Sue, 2003, p. 29). Jones (1972) defines "personal racism and individual racism" as acts committed by a single individual, while "institutionalized racism" is characterized as laws, policies and customs created to establish and maintain the superior political and economic status of a racial group (see also Graham's (2005) discussion of subliminal racism). "Cultural racism" is defined as "the individual and institutional expression of superiority of one's group's cultural heritage over another group's, and it's imposition on racial/ethnic minority groups" (Sue, 2003, p. 33). Gaertner and Dovidio (2006) describe "aversive racism," a type of subtle, unintentional racism, as a phenomenon whereby an individual consciously asserts egalitarian values, but unconsciously possesses negative, anti-other feelings, attitudes and beliefs about historically disadvantaged racial groups. It is our belief that Blacks (and other racial minorities) continue to be negatively impacted by both overt and covert forms of all variations of racism as defined above, and those consequences have a toxic effect on physical and mental health.

The disparities in health status between Blacks and Whites continue to increase, not decrease, in spite of a cultural climate of the last 40 years which has recognized the influence of racism. Indeed the overall death rate for Blacks is equivalent to what it was for Whites thirty years ago (Williams et. al. 2005). Many contemporary psychologists are increasingly concerned with the intersection of health and the role of cultural and race-based issues, and the evidence that racism and discrimination are significant contributing factors to the poor health outcomes of African Americans and other racial/ethnic groups living in the U.S. is abundant (for example Mays, Cochran & Barnes, 2007; Lambert, Herman, Bynum & Ialongo, 2009). In the context of psychological counseling with people of color and White counselors, Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquilin (2007) describe a taxonomy of racial micro-aggressions, the daily indignities that communicate negative racial insults against people of color. Yet, many studies in health care and mental health discuss the difficulty of actually describing and defining racial discrimination that occurs via these subtle mechanisms, though daily common experiences of such aversive racism may have significantly more influence on anger, self-esteem and frustration than the more easily identified, traditional forms of overt racism. Furthermore, the invisible and subconscious nature of acts of aversive racism prevents people from realizing their own complicity in creating psychological dilemmas for ethnic groups.

The supposition of a relationship between the conditions of indentured servitude and currently observed health deficits is an idea not well understood or agreed upon. But, enslaved Africans regularly faced a multitude of health risks like work-related accidents, whippings, exposure to extreme cold and heat, extreme physical exhaustion, deficient nutrition and poor sanitation. Resultant poor health from that situation could be a cultural and genetic legacy.

Furthermore, overall African-American health worsened during and after the Civil War, when the makeshift plantation health care system ceased to exist. A racially insensitive postwar society then used Darwinism, biological determinism and skull measurements to argue that African-Americans were destined to poor health and extinction. Byrd and Clayton (2001) present statistics on historical racial disparities in American healthcare as a prolog to a comprehensive history of a system of healthcare management by and for Black Americans themselves.

Washington (2007) presents a comprehensive history of medical experimentation on African Americans. Starting with the earliest encounters between African Americans and Western medical researchers and the scientific bias that resulted, it details the ways both the enslaved and the free were used in hospitals for experiments conducted without their knowledge. Like Byrd & Clayton (2001) and Wheeler (2002), this work describes how eugenics and social Darwinism was used to justify experimental exploitation and inhumane medical treatment of Blacks, and how the view that Blacks were biologically inferior, hypersexual, and unfit for adult responsibilities developed from scientific biases. Details about the government's notorious Tuskegee experiment were revealed, as were similar, less-well-known medical atrocities conducted by the government, the armed forces, prisons, and private institutions. Washington suggests that the roots of the African American health deficit derived from this early mistreatment and has, in turn, caused many Blacks to view researchers, and indeed the whole medical, health care and research establishment with deep distrust. Many Blacks continue to mistrust the medical and research communities and are wary of being used as "guinea pigs" (Carlson & Chamberlain, 2004).

We propose that overt racism, institutional racism and perceived racism are factors in the observed health disparities between Blacks and Whites. Perceived racism results in exaggerated psychological and physiological stress responses that are influenced by a combination of individual constitutional factors. People react differently as a function of skin tone or family history of hypertension, socio-demographic factors, and coping responses like reacting angrily to perceived racism with elevated blood pressure. Over time, such chronic stress responses have a deleterious effect on health. Prior researchers have proposed studying the biopsychosocial effects of perceived racism within a stress and coping model (see Clark, Anderson, Clark, & Williams, 1999). They further proposed that much work is needed in identifying the sympathetic, immune, and psychological responses that are associated with ethnically relevant stressors. We take this task to hand, and include cognitive responses as well.

Mental Health Consequences of Racism for People of African Descent

Kessler, Mickelson, and Williams (1999) found that reported exposure to perceived discrimination was significantly related to adverse mental health consequences. In particular, majority White contexts appear to have deleterious mental health effects for Blacks. Some evidence suggests that migrating from a country or region where one's ethnicity is in the majority and thus not relegated to second class status serves as a protective factor for African and Caribbean immigrants (Read & Emerson, 2005). In a study of Black Caribbean immigrants in New York City, Waters (1999) found that compared to African Americans, they were more likely to be employed, have higher incomes, have higher self esteem, and seemed more prepared to resist efforts to discriminate against them. However, over time, this protective factor erodes as African and Caribbean immigrants face increased exposure to racial discrimination. These groups demonstrate poorer health outcomes over time with increased duration of United States residency (Read & Emerson, 2005). Waters (1999) found that in her sample of Caribbean immigrants, their ability to resist discrimination and withstand the negative impacts of racism erodes over time, and that the children of these immigrants are more similar to African Americans in terms of identity, educational outcomes and experiences of racism. In another study of Black Caribbean immigrant mental health, increased exposure to non-preferred ethnic status in the U.S. was associated with higher risk of psychiatric disorders (Williams, Haile, Gonzales, Neighbors, Baser & Jackson, 2007). Associations have been found between discrimination, racism, length of time in the United States and poor mental health (Ryan, Gee & Laflamme, 2006). This can facilitate an understanding of the mechanisms in the United States – specifically those surrounding racial context – that worsen the health and well being of Blacks in America, foreign-born and native-born alike (Read & Emerson, 2005).

The National Alliance on Mental Illness (2009) reports that African Americans are disproportionately more likely to experience social circumstances that increase their chances of developing a mental illness and are less likely to receive diagnoses and treatments for their mental illnesses than Whites. Blacks are thirty percent more likely to report having serious psychological distress than Whites (CDC, 2007), and from 1980-1995 suicides among Black adolescents increased 233%, compared to 120% for Whites (HHS, 2001). Mental health has been shown to worsen for Caribbean Blacks living in the Unites States across generations, with third generation individuals of Caribbean descent having higher rates of anxiety, depression and other psychiatric disorders than first or second generation immigrants (Jackson & Antonucci, 2005). According to the Surgeon General, only one-third of Americans with a mental health problems seek treatment; the percentage of African Americans getting help is only half that of non-Hispanic Whites (HHS, 2001). Both African Americans and Caribbean Blacks utilize formal mental health services at low rates (Jackson, Neighbors, Torres, Martin, Williams & Baser, 2007).

Critical factors that might discourage racial and ethnic minorities from accessing mental health services include their experience of mistreatment by mental health professionals (Whaley, 2001; Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2000). African Americans have experienced racism and mistreatment by healthcare systems, and the ensuing mistrust of healthcare professionals and concerns about provider competence with members of their own racial group act as barriers to seeking care (Whaley, 2001; Diala, et. al, 2000).

In a study of depression prevalence among disadvantaged Black women, Miranda, Siddique, Belin and Kohn-Wood (2005) found that African American women were nearly three times more likely to experience depression than African-born women and two and half times more likely than Caribbean-born Black women. Results of another study of self-reported racism experiences of African American and foreign-born Black pregnant women revealed that African American women were more likely to report experiences with both personal and group racism than foreign born Black women (Dominguez, Stong, Krieger, Gillman & Rich-Edwards, 2009). However, foreign-born women who spend many years in North America and produce offspring in the United States begin to experience some of the same health issues as African American women. Miranda et. al. (2005) found that rates of depression amongst Black immigrant women increase with time in the United States. Some researchers argue that Black women are at increased risk of ill health because of their double status as woman and Black in American society. The effects of racism on them can be seen in a myriad of physiological health challenges or ailments (Brondolo, Gallo & Myers, 2009; Thomas, 2008).

de Maynard (2009) reports that visibly Black people of African and African-Caribbean descent are 2-5 times more likely to be diagnosed with schizophrenia and other psychoses than their counterparts from other ethnic minorities in the United Kingdom. However, the symptomology of psychotic illnesses and dissociative experiences are difficult to differentiate. Blacks of Caribbean descent in Britian were more likely to be involuntarily detained under the Mental Health Act of 1983, than Whites (Morgan et. al., 2005). Interestingly, Blacks who were detained are more likely to indicate perceived *racism* as the cause of their emotional distress than their counterparts from other ethnic groups.

Physiological Consequences of Racism for Blacks

The chronic exposure to daily micro-aggressions such as being ignored in restaurants, being followed in stores, being overlooked by cab drivers, and being targets of racial profiling and police harassment have been associated with an increase in the fight or flight survival mechanism, i.e. the way in which the physical body protects itself from harm and copes with stress.

This includes an increase in heart rate and blood pressure that over time can lead to wear and tear on the body and a reduction in immune system functioning (Mays et. al., 2007; Massey, 2004). Persons with suppressed immune function are less able to fight off infectious diseases. Armstead, Lawler, Gorden, Cross, and Gibbons (1989) showed that when Blacks viewed videotaped vignettes involving situations of racial discrimination, they showed cardiovascular responses thought to contribute to the development of cardiovascular disorders.

A new understanding of why some people get sick when exposed to pathogens while others stay healthy is causing a reappraisal of the concept of what causes illness. How resistant we are to microbes in the environment is a function of how we are coping, which in turn depends on how we cognitively appraise problems, and the chemical changes that our thoughts produce in our brains and bodies. Our cognitions and the quality of social support we perceive in our lives can alter levels of hormones and neurotransmitters, the chemical messengers that carry on communication between our cells and largely govern the activity of many of our physical processes. If we have poor coping skills, deficient social support and high stress, then the internal balance of our bodies may be easily upset and our resistance lowered. When we habitually act as if a frustration, disappointment or loss is a matter of high seriousness, then we are summoning strong bodily responses that can make us vulnerable to disease.

The causal mechanism linking ethnic status and health disadvantage is thought to lie in the harmful effects of chronic experiences with race-based discrimination, both actual and perceived. These experiences are thought to set into motion a process of physiological responses such as elevated blood pressure and heart rate, production of biochemical reactions, and hypervigilance, that eventually result in disease and mortality. When chronic demands are placed on the body's regulatory systems, they lose their ability to function effectively, which can trigger disease processes (see Harrell, Hall & Taliaferro, 2003).

Assessing a situation for its effects on well being, a process called cognitive appraisal, can profoundly shape the specific nature of physiological responses to circumstances appraised as dangerous or harmful. Situations categorized as uncontrollable, as when an employer who one perceives as racially discriminatory insists on a negative job performance evaluation, are more likely to activate stress relevant physiological processes like elevated blood pressure and heart rate. Dickerson & Kemeny (2002) show that when a person's social status is threatened by performance failures, activation of the body's stress system ensues. Because social situations in the United States are often tinged with race, Blacks in the Unites States are more likely to engage in cognitive appraisal of racism, and are thus more likely to feel stress.

The biological interaction between stress and race creates a complex interplay among the immune system, autonomic nervous system, the brain and the hypothalamic-pituitary-adrenal (HPA) axis (McEwen & Seeman, 1999). The HPA axis is a complex set of direct influences and feedback interactions among the hypothalamus (a hollow, funnel-shaped part of the brain), the pituitary gland (a pea-shaped structure located below the hypothalamus), and the adrenal glands (small, conical organs on top of the kidneys). The interactions among these organs constitute the HPA axis, a major part of the neuroendocrine system that controls reactions to stress and regulates many body processes, including digestion, the immune system, mood and emotions, sexuality, When the HPA system is activated, it is associated with important cognitive and affective processes and is thought to have implications for health and disease. Heightened HPA activity has been associated with depressive symptomology (Brown & Suppes, 1998; Heim & Nemeroff, 2001) and can have effects on memory (Buchanan & Lovallo, 2001; Kirschbaum, Wolf, May, Wippich, & Hellhammer, 1996; Lupien, et al., 1997). Prolonged cortisol activation, produced by frequent exposure to stressors or by failing to shut down this response after stressor termination, is associated with a number of negative biological and health effects, including suppression of aspects of the immune system, damage to hippocampal neurons; and the development of and/or progression of certain chronic diseases such as diabetes and hypertension (Boomershine, Wang, & Zwilliing, 2001). Determining whether racism activates the cortisol system could begin to delineate the conditions capable of contributing to the onset or exacerbation of certain ethnically related health outcomes.

Individual differences in stress reactivity have been proposed as a potentially important risk factor for gender-specific health problems, in addition to socio-cultural factors (Hamann & Canli, 2004; Kajantie & Phillips, 2006). There are many theories and/or much evidence in the psychological literature about deleterious effects of perceived racism on health outcomes. Physiologically, heart rate increases and blood pressure rises in the presence of actual or perceived discrimination (Clark, 2003). Recently, researchers have begun documenting the effects of racism in real-time analysis of brain activity. The discussion is important for its particular implications on the physical and mental health of African American women in particular. Stress related to racism may underlie the poor diet and resulting obesity among Black women and may be associated with the high prevalence of high blood pressure and diabetes.

Black women, regardless of economic status and education consistently exhibit the highest rates of preterm births and low birth rates. However, there are striking within and between group differences in health outcomes for White women, foreign born Black women, and African American women. It is interesting to note some intra-racial group differences in Black women, that is, some of the deleterious health effects found in African American women are not found in foreign born women from African or the Caribbean. For example, in a study of low birth weight babies, African-born women had rates of low birth weight similar to that of White women, while African American women had lower birth weights compared to both the African-born and White groups (David & Collins, 1997).

Their findings suggest that something unique to the experience of African American women contributes to the lower birth weight of their babies, perhaps the fact that while both foreign-born and African American women share the same historical context of trans-Atlantic slavery, they do not share the same historical legacy and racialized consequences of Jim Crow legal segregation and of Reconstruction, experiences that have undoubtedly had a harmful impact on African American women's health.

Furthermore, a study conducted on African American mothers who scored high on a measure of perceived racial discrimination demonstrated that these mothers were two times more likely to deliver low birth weight infants (Ellen, 2000). Lest one conclude that the underlying causal factor in health problems of the newborn is the consequence of poverty, consider the study by Papacek, Collins, Schulte, Goergen, & Drolet (2002) who conclude that urban African-American infants who reside in non-impoverished neighborhoods are at high risk for post-neonatal mortality.

Many studies show that African Americans are at greater risk for developing carotid plaque (for example Troxel, Matthews, Bromberger & Sutton Tyrrell, 2003) and hypertension (for example Din-Dzietham, Nembhard, Collins, & Davis, 2004), conditions that are associated with the development of cardiovascular disease. Fang and Myers (2001) demonstrated that both Black and White men exhibited significantly greater diastolic blood pressure reactivity to anger-provoking and racist stimuli compared with neutral stimuli. Although their results failed to confirm some previous reports of greater reactivity to racism in African Americans, the findings suggest that diastolic blood pressure levels may remain elevated for some time following exposure to racist stimuli. These results indicate that even indirect exposure to interpersonal conflict elicits significant reactivity, which can persist after exposure to the stressor has ended, especially among high-hostile men.

African American women may be particularly physiologically vulnerable to the burden of chronic psychological stress, as seen in studies of subclinical carotid artery disease. Combined stress from life events, ongoing stressors, economic hardship and unfair treatment was associated with arterial plaque development in African American women, but not in White women. Racism is a chronic stressor that can negatively impact the cardiovascular health of African American women through pathogenic processes associated with physiologic activity, though more research is needed to factor out the contributing role of deleterious dietary habits.

Studies have also shown that viewing Black faces makes the amygdala reactive (Cunningham et. al., 2004). Implicitly learned negative racial stereotypes about Blacks can be learned and encoded by both Blacks and Whites. Learned fear may make living in a Black neighborhood a source of chronic stress. Highly segregated, highly dense neighborhoods, filled with crime and violence may create a social context in which chronic activation of the fear response leads to greater physiological wear and tear on the body that results from ongoing adaptive efforts to maintain stability in response to stressors (what researchers call "allostatic load").

Cognitive Consequences of Racism for Blacks

Cognition is the process of thinking, manipulating knowledge, and solving problems. Racial prejudice may deplete resources needed for thinking and mental control, and the mental activation of racial bigotry schemas creates undeniable hardships for people who are its targets. Broadly described, there are two pathways by which cognition is impeded by racial discrimination. The first is the matrix of correlations between measures of reading skill, social interactions, negative stereotype activation and academic performance. For instance, deliberate activation of the stereotype for Blacks has been shown to increase ratings of the hostility of others' behavior (e.g., Devine, 1989), to provoke more hostile reactions among participants themselves (Bargh, Chen, & Burrows, 1996), and to elicit more hostile responses from interaction partners (Chen & Bargh, 1997).

Reading ability seems better able to predict cognitive functioning than years of education, particularly for African Americans, and suggests that disadvantages associated with racial status and low SES affect the relative influence of literacy and years of education on cognition (Dotson, Kitner-Triolo, Evans & Zonderman, 2009). Dotson and colleagues examined the unique influence of education and reading scores on a range of cognitive tests in low and higher SES African Americans and European Americans. Literacy significantly predicted scores on all but one cognitive measure in both African American groups and low-SES Whites, while education was not significantly associated with any cognitive measure. Harmful effects of racism have been shown to differentially affect the self esteem in youth with different levels of sophistication in cognitive ability (Seaton, 2010). In that study, perceptions of institutional racism were more harmful for the self-esteem of young people with pre-formal reasoning skills than for the self-esteem of youth with more sophisticated formal reasoning skills.

Steele & Aronson (1995) documented the pressure experienced by people who fear that if they perform poorly on an academic task, their performance will appear to confirm an unfavorable stereotype about their ethnic group. Labeled “stereotype threat,” it causes a person to feel pressure to perform as well as possible in order to discredit the stereotype. Unfortunately, this added pressure often leads to decrements in performance. A second pathway by which cognition is impeded by racial discrimination is neuropsychological, as revealed through experimental cognitive psychology studies. Cognitive science research and brain imaging studies suggest, for example, that racial intolerance undermines the mental resources of biased individuals when they interact with those whom they deem inferior. Cognitively, perceived racism impairs memory and attention.

Salvatore & Shelton (2007) examined how encountering racial prejudice affects cognitive functioning. They assessed performance on the Stroop task after subjects reviewed job files that suggested an evaluator had made nonprejudiced, ambiguously prejudiced, or blatantly prejudiced hiring recommendations. The cognitive impact of exposure to ambiguous versus blatant cues to prejudice depended on subjects' racial group. Black subjects experienced the greatest impairment when they saw ambiguous evidence of prejudice, whereas White subjects experienced the greatest impairment when they saw blatant evidence of prejudice. Given the often ambiguous nature of contemporary expressions of prejudice, these results have important implications for the performance of Black people across many aspects of cognitive functioning. People of African descent are more likely to respond adversely to racial ambiguity than are Whites.

Strategies for Addressing the Health Disparity

Given the critical, harmful impact of racism and racial discrimination on the physiological, mental health and cognitive functioning of Blacks in the United States and the resulting health disparities, it is necessary to design strategies to counteract and eradiate these impairments at multiple levels. One way to focus on overcoming the effects of racial discrimination on health is to examine the group of Black immigrants, a group that shares the same racial status as African Americans but experiences significantly better psychological and physical health. Approximately 6% of the US Black population is foreign-born, with Black Caribbean immigrants comprising 4.4% of this population, making this group the largest subgroup of Black immigrants (Williams, et. al., 2007).

Researchers have studied the health outcomes of African immigrants, Caribbean immigrants, and European born Black immigrants, and compared their health outcomes to African Americans and White Americans (Read, Emerson & Tarlov, 2005). Results show that African immigrants had better self reported health outcomes and blood pressure than all groups. Caribbean immigrants fare better than African Americans and European born Blacks, but worse than White Americans. African Americans and European born Blacks have the worst health outcomes comparatively. In other words, compared to African Americans, Black immigrants from minority White (Africa, South America) and racially mixed (West Indies) regions have superior health, while those from majority White (Europe) regions fare no better. A similar gradient exists among Black immigrants, with Africans faring the best, followed by South Americans, then West Indians, with European Blacks having the poorest health. These results indicate that grouping together foreign-born Blacks, as has often been done in past research, conceals important health differentials among the Black population. Additionally, when examining health outcome data, it is important to disaggregate Black immigrants by region of birth, and emphasize the interplay of selectivity and racial context of origin in order to fully understand health disparities among Blacks in America.

Postmes and Branscomb (2002) find that racial segregation, though controversial, can be psychologically protective, but they do issue caveats. Apparently, segregation has some positive consequences for well-being, but these effects are indirect. There is no support for the suggestion that segregated environments are somehow intrinsically better than desegregated ones or vice versa: Segregation per se does not have any positive or negative well-being consequences. Rather, desegregation alters people's psychological representation of their own group's relation to them, which then affects their relation to the group. In sum, the results of their studies provided insight into the psychological responses of devalued group members as a function of the long-term racial composition of the environment. African Americans' feelings of well-being were not influenced directly by segregated or more racially integrated environments. Rather, these data suggest that African Americans' well-being depends on perceptions of how they are appreciated by their in-group (and, to a lesser extent, by the out-group), which then influences how much they identify with their racial in-group.

Data confirm the centrality of the in-group- out-group distinction and suggests that social identification is the bridge between sociostructural factors such as desegregation and individual psychological outcomes such as well-being (Oakes, Haslam, & Turner, 1994; Tajfel, 1978; Turner, 1987). In the environmental conditions facing them in the recent past, which to a large extent persist in contemporary America, African Americans pay a price for (upward) mobility into more integrated environments in terms of a loss of racial identity and perceived in-group rejection.

With the growing evidence of the harmful effects of racism on the physiological, mental health and cognitive functioning of both African Americans and foreign born Blacks residing in the U.S., creating definitive strategies for eliminating health disparities and combating racism are vital. Research, public policy and targeted interventions must address these critical concerns for the population. Bynum, Burton, & Best (2007) documented the negative *effects* of *racism* on the psychological health of African Americans. However, consideration of racial socialization as a potential buffer against *racism* experiences has received limited attention.

Bynum et. al. (2007) investigated whether two types of parental racial socialization messages reduced the impact of *racism* on psychological functioning in a sample of 247 African American college freshmen. Results indicated that students who reported more racism experiences also had poorer levels of psychological functioning as indicated by higher levels of psychological stress and psychological distress. Parental messages emphasizing the use of African American cultural resources to cope with racism reduced the impact of racism on psychological stress only. Cultural pride messages predicted less psychological distress while messages emphasizing the use of cultural resources predicted greater psychological distress. However, neither message type moderated the relationship between racism experiences and psychological distress. These results suggest that racial socialization messages have complex relations to psychological functioning in African American college students.

Another potential approach that seems promising include an integration of social-cognitive theories with skill building to increase the variety of available coping methods that might decrease the negative consequences of internalizing racist attitudes (Oyersman, Fryberg & Yoder, 2007). Additional research that examines factors that contribute to positive health and mental health outcomes amongst African Americans and foreign born Blacks need to be conducted.

Cohen and Northridge (2008) propose that health professionals in general, and urban *health* specialists in particular, can expose the potential health impacts of private and public urban policy. Communities need to be informed of both dangers and opportunities. Health should be a high priority in the evaluation of any project. Policies that reinforce racism or perpetuate social inequalities that form the basis of health disparities should be decisively opposed. Legislation aimed at reducing and eliminating health disparities, and the systematic eradication of racial discrimination must be enacted (Brooks, 2008). Knowing about the broad health risks of government and commercial policies may motivate more people to get involved in political struggles and demand to be heard. Building coalitions and movements that equip the public to fight for public health is a meaningful way to "mitigate, resist, and undo" health disparities and to make urban health a real priority in action, not just a figure of speech. Additionally, increased resources for health care facilities that provide health and mental health services for underserved populations, such as mental health services in safety net clinics, must be provided (Alegria, et. al., 2008).

Culturally sensitive interventions designed to prevent the deterioration of health and mental health of African Americans and Black immigrants living in the United States need to be funded and critically evaluated (Brooks, 2008; Wheeler, 2010). Quality improvement programs are recommended to increase quality of care among racially identified groups, and results demonstrate that these programs can improve the rate of appropriate care for Whites and non-Whites who suffer with depression (Alegria, et. al., 2008). Further, all health professionals must be provided with training in delivering culturally competent health care services including awareness of the impact of racial status and racial discrimination on health, barriers that prevent access to health care and effective strategies for engaging patients and clients in treatment to overcome cultural mistrust and prevent treatment dropout. This strategy of providing more culturally responsive healthcare through an increased emphasis on training culturally competent health care professionals is an important structural level intervention in the fight to eliminate racial health disparities (Klonoff, 2009). People want to live healthy and full lives, Blacks included. Members of these populations should be empowered to reduce their engagement in high risk behaviors that negatively affect their health, and to be proactive in making better choices that improve their health outcomes i.e. exercising, choosing not to smoke or quitting smoking, reducing alcohol consumption and eating healthier foods (Brooks, 2008). Legislation must also be enacted to increase and improve access to quality health care. Additionally, the tactic of viewing the world through a Black lens and thus utilizing racism-specific coping responses should be taught.

Unquestionably, health disparities among different ethnic groups constitute a significant public health challenge in the United States. While the underlying causes of this persistent gap are multi-faceted and debatable, there is growing empirical support for the deleterious impact of racism as a major factor on the health of Blacks in the United States. It has been noted that the lives of all US citizens are inextricably linked; thus when one community's health is negatively impacted, all others will ultimately be affected. Eliminating health disparities and eradicating racism benefits not only the community of Blacks in America, but the entire fabric of American society.

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