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Correlates of Psychological Distress and Major Depressive Disorder Among African American Men

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Abstract

This study examines the demographic correlates of depressive symptoms, serious psychological distress (SPD), and major depressive disorder (MDD; 12-month and lifetime prevalence) among a national sample of African American men. Analysis of the National Survey of American Life (NSAL) data set provides first-time substantiation of important demographic differences in depressive symptoms (measured by the Center for Epidemiological Studies Depression scale [CES-D]), SPD (measured by the K6), and 12-month and lifetime MDD among African American men. Findings illuminate the heterogeneity within the African American male population. Findings also demonstrate the need for additional research focusing on within-group differences and a comprehensive research and mental health promotion agenda that recognizes the importance of improving access to education and employment and promoting healthy coping behaviors, while acknowledging the larger social context in which African American men live.

Keywords

African Americans, men, mental health

Introduction

African American men encounter numerous life situations (e.g., high rates of unemployment, underemployment, racial discrimination, poverty, and encounters with the criminal justice system) that constitute risk factors for poor mental health. Unfortunately, there is a paucity of research on the mental health of African American men. Much of the previous work in this area is based on regional and non-probability samples or has too few African American men in the sample to derive reliable estimates of the prevalence of mental disorders and associated symptoms. This article seeks to address this gap in the literature by examining the demographic correlates of depressive symptoms, serious psychological distress (SPD), and both 12-month and lifetime major depressive disorder (MDD) among African American men.

Among both African Americans and non-Hispanic Whites, much more attention has been paid to women's mental health status than to men's. The status of men with depression is a particularly underresearched area (Emslie, Ridge, Ziebland, & Hunt, 2006), in part because of the generally higher levels of depression and anxiety reported among women (Prior, 1999). As a consequence, depression in men often goes unrecognized, undiagnosed, and untreated. Tragically, undiagnosed depression diminishes quality of life and can result in suicide; since the mid-1980s, rates of suicide among African American men have increased appreciably (Griffith & Bell, 1989; Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Poussaint & Alexander, 2000). Given the dearth of research on the mental health of African American men and the significance of this issue, the current investigation examines the demographic correlates of several indicators of mental health status—depressive symptoms, SPD, and 12-month and lifetime MDD—among a representative sample of African American men.

Psychological Distress Among African American Men

Psychological distress has been characterized by a range of symptoms including lack of enthusiasm, problems with sleep (trouble falling asleep or staying asleep), feeling downhearted or blue, feeling hopeless about the future, and feeling "emotional;" for example, crying easily or feeling like crying (Burnette & Mui, 1997; Decker, 1997). Psychological distress differs from organic mental disorders in the sense that it is a reactive disorder affected by external stress (George, Hughes, & Blazer, 1986). Studies of psychological distress in the social

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sciences typically use the number of depressive symptoms as a measure of distress. Investigations among the general population have identified specific demographic characteristics such as female gender, unmarried status, and lower socioeconomic status (SES) as risk factors for psychological distress. However, because so few studies examine psychological distress exclusively among African Americans, little is known about whether these risk factors function in the same way and to the same extent among African Americans as compared to other groups.

The majority of investigations of psychological distress among African Americans are comparative analyses that provide strong empirical support for differences in levels of distress between African Americans and Whites. These studies typically report significantly higher levels of psychological distress for the general population of African Americans (e.g., Travis & Valesco, 1994), while some indicate no race differences (Gallo, Cooper-Patrick, & Lesikar, 1998). Other studies find higher unadjusted levels of psychological distress for African Americans compared to Whites. However, once demographic confounders such as SES (Kessler & Neighbors, 1986), poverty (Schulz et al., 2000), age, and sex, are accounted for (Skarupski et al., 2005), race differences are significantly reduced or eliminated.

Early studies by Brown and Gary (1987) and Dressler and Badger (1985) are two of the few investigations focusing exclusively on African Americans. Brown and Gary (1987) found that African American men reported significantly fewer depressive symptoms than African American women. Similarly, close examination by Dressler and Badger of depressive symptoms among three African American communities (southern-rural, Midwestern, and Midwestern-urban) indicated generally low depressive symptoms for males across the three communities. Gary (1985) identified several demographic correlates of depressive symptoms among a sample of 142 African American men. Age, family income, household size, and unemployment were associated with depressive symptoms in bivariate analyses; however, only income remained a significant demographic predictor in the multivariate context.

Most studies of African American men have been limited to examinations of income and employment status as the primary demographic correlates of psychological distress (Gaines, 2007; Gary, 1985; Kessler & Neighbors, 1986; Mizell, 1999; see Watkins, Green, Rivers, & Rowell, 2006 for a review), leaving unanswered questions about whether other demographic factors are also associated with psychological distress. More recent studies that include demographic factors primarily focus on the impact of social stressors such as discrimination on psychological distress and depressive symptoms (Bennett, Merritt, & Edwards, 2004; Pieterse & Carter, 2007; Utsey, 1997; Utsey & Payne, 2000). Despite increasing numbers of studies on psychological distress, these efforts have yet to fully examine potential demographic subgroup differences in distress within fully representative samples of African American men.

MDD Among African Americans

A similar situation exists with respect to research on mood disorders, including MDD, and how they are manifested among subgroups of African American men. Research findings regarding race and mood disorders indicate that African Americans are not necessarily at greater risk than Whites for clinical psychiatric disorders (King & Williams, 1995). However, by virtue of differences in racially patterned life circumstances, African Americans are excessively and disproportionately exposed to a variety of psychosocial stressors (e.g., economic deprivation) that are risk factors for depression (Mizell, 1999).

Large, epidemiological studies provide information on the pattern and distribution of MDD within and across racial and ethnic groups. These studies indicate that African American men have lower rates of mood disorders than both African American women and Whites as a whole (Breslau, Su, Kendler, Aguilar-Gaxiola, Kessler, 2005; Brown & Keith, 2003; Robins et al., 1984; Williams et al., 2007). For example, the Epidemiologic Catchment Area Study (ECA) reported higher 1-year prevalence rates for African American women compared to men for several mental disorders, including major depression with no grief (4.9% vs. 1.0%) and major depression with grief (5.1% vs. 1.1%; Brown & Keith, 2003).

Findings from the National Comorbidity Study indicated gender differences in MDD among African Americans, with women having higher 12-month (10.99% vs. 4.99%) and lifetime (15.53% vs. 7.25%) prevalence rates for major depression without hierarchy than men (Brown & Keith, 2003). Research using the National Survey of American Life (NSAL) reported almost twice the rate of lifetime MDD for African American women as compared to men (Williams et al., 2007).

Epidemiological studies such as these provide important information about the national prevalence rates of mood disorders for African Americans. Although these studies report lower prevalence rates for lifetime mood disorders for African Americans compared to Whites (Breslau et al., 2006), some research has suggested that the course and persistence of these disorders may be more chronic for Blacks than for Whites (Williams et al., 2007). Recent findings from the NSAL reported lower lifetime prevalence rates for MDD for African Americans and Caribbean Blacks, compared to non-Hispanic Whites (Williams et al., 2007). Findings also revealed similar risk profiles for MDD for African Americans and Caribbean Blacks. Importantly, both groups had higher risk of the persistence of MDD compared to Whites, greater impairment due to MDD, and were less likely to receive treatment compared to non-Hispanic Whites (Williams et al., 2007). Lower prevalence but higher persistence rates among African Americans as compared to Whites have also been reported in the National Comorbidity Survey (NCS; Breslau et al., 2005) and these differences were not accounted for by differences in SES.

Focus of the Current Research

The current investigation of the demographic correlates of depressive symptoms, SPD, and MDD among African

American men has several major advantages over previous research in this field. First, it examines a diverse group of measures including depressive symptoms, SPD, and 12-month and lifetime MDD. Second, measures of MDD are derived from the same diagnostic criteria used by clinicians, that is, criteria derived from the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition; *DSM-IV)*. Third, it uses a large, nationally representative sample of African American men from across the United States, allowing for the generalizability of study findings. This type of focused research contributes to our knowledge of the unique associations between a diverse set of demographic factors and the mental health of African American men and affords a more comprehensive mental health profile for this subgroup of African Americans.

Method

Sample

The National Survey of American Life: Coping with Stress in the 21st Century (NSAL) was collected by the Program for Research on Black Americans at the University of Michigan's Institute for Social Research. The field work for the study was completed by the Institute for Social Research's Survey Research Center, in cooperation with the Program for Research on Black Americans. A total of 6,082 face-to-face interviews were conducted with persons aged 18 or older, including 3,570 African Americans, 891 non-Hispanic Whites, and 1,621 Blacks of Caribbean descent. There are 1,271 African American men in the NSAL sample, which is the sample used for this study. The overall response rate of 72.3% is excellent, given that African Americans (especially lower income African Americans) are more likely to reside in major urban areas that are more difficult and expensive with respect to survey fieldwork and data collection. Final response rates for the NSAL two-phase sample designs were computed using the American Association of Public Opinion Research (AAPOR) guidelines for Response Rate 3 (AAPOR, 2006). The interviews were conducted within respondents' homes and respondents were compensated for their time. The data collection was conducted from February 2001 to June 2003 (see Jackson et al., 2004 for a more detailed discussion of the NSAL sample).

The African American sample is the core sample of the NSAL. The core sample consists of 64 primary sampling units (PSUs). Fifty-six of these primary areas overlap substantially with existing Survey Research Center National Sample primary areas. The remaining eight primary areas were chosen from the South in order for the sample to represent African Americans in the proportion in which they are distributed nationally. The African American sample is a nationally representative sample of households located in the 48 coterminous states with at least one Black adult 18 years of age or over who did not identify ancestral ties in the Caribbean. The NSAL is weighted to correct for disproportionate sampling, nonresponse, and to provide representation across various demographic characteristics in the 48 coterminous states. The demographic characteristics of the sample used in this analysis are presented in Table 1.

Table 1. Descriptive Characteristics of African American Men in the National Survey of American Life (NSAL; 2001–2003)

	n (%) or *M* (*SE*)
CES-D, *M* (*SE*)	6.15 (0.23)
Score 15 or less, *n* (%)	1,131 (93.63)
Score 16 or more	77 (6.37)
K6, *M* (*SE*)	3.37 (0.18)
Score 12 or less, *n* (%)	1,173 (97.30)
Score 13 or more, *n* (%)	36 (2.70)
Lifetime MDD, *n* (%)	
No	1,098 (90.11)
Yes	119 (9.98)
12-month MDD, *n* (%)	
No	1,160 (94.98)
Yes	57 (5.02)
Age, *n* (%)	
Less than 35 years	404 (34.04)
35–54 years	567 (45.11)
55 or more years	300 (19.86)
Poverty ratio, *n* (%)	
Poor (less than 1.00)	220 (17.05)
Near-poor (1.00–1.99)	260 (19.08)
Nonpoor (2.00–3.99)	480 (38.58)
Nonpoor (4.00 or more)	311 (25.30)
Education, *n* (%)	
Less than 12 years	320 (23.22)
12 years	497 (39.45)
13–15 years	284 (22.88)
16 years or more	170 (14.45)
Work status, *n* (%)	
Employed	887 (71.42)
Unemployed	104 (8.76)
Out of labor force	276 (19.82)
Marital status, *n* (%)	
Married	443 (40.04)
Partner	108 (9.38)
Separated	89 (6.28)
Divorced	181 (10.95)
Widowed	53 (2.88)
Never married	391 (30.46)
Region, *n* (%)	
Northeast	150 (15.51)
North Central	202 (17.43)
South	822 (56.84)
West	97 (10.22)

Note. CES-D = Center for Epidemiological Studies-Depression scale; MDD = major depressive disorder.

Measures

Dependent variables. There are four dependent variables in this analysis: depressive symptoms as measured by the Center for Epidemiological Studies-Depression scale (CES-D), SPD as measured by the K6, 12-month MDD, and lifetime MDD. Depressive symptoms were assessed using the 12-item version of the CES-D (Radloff, 1977). This abbreviated CES-D has been found to have acceptable reliability and a similar factor

structure compared to the original 20-item version. The 20-item CES-D scale is widely used, with scores ranging from 0 to 60. A cutoff score of 16 or more indicates the likely presence of clinically significant depression. Similarly, the cutoff score for the 12-item CES-D scale is typically 16 or more and is also considered indicative of potential depression and additional screening (Foley, Reed, Mutran, & DeVellis, 2002; Hair, Zaslow, & Ahluwalia, 2000; Nguyen, Kitner-Triolo, Evans, & Zonderman, 2004). Accordingly, we used a cutoff of 16 or more on this 12-item scale. Item responses are coded 1 (*hardly ever*) to 3 (*most of the time*). These 12 items measure the extent to which respondents had trouble keeping their mind on tasks, enjoyed life, had crying spells, could not get going, felt depressed, hopeful, restless, happy, as good as other people, that everything was an effort, that people were unfriendly, and that people dislike them in the past 30 days. Positive valence items were reverse coded and summed resulting in a continuous measure; a high score indicates a greater number of depressive symptoms ($M = 6.51$, $SE = 0.23$; Cronbach's alpha = .75).

SPD was measured by the K6. This is a 6-item scale designed to assess nonspecific psychological distress including symptoms of depression and anxiety in the past 30 days (Kessler et al., 2002, 2003). Specifically, the K6 includes items designed to identify individuals with a high likelihood of having a diagnosable mental illness and associated limitations. The K6 is intended to identify persons with mental health problems severe enough to cause moderate to serious impairment in social and occupational functioning and to require treatment. Each item was measured on a 5-point Likert-type scale ranging from 0 (*none of the time*) to 4 (*all of the time*). Positive valence items were reverse coded and summed scores ranged from 0 to 24, with higher scores reflecting higher levels of psychological distress ($M = 3.37$, $SE = 0.18$; Cronbach's alpha = .81).

The *DSM-IV* World Mental Health Composite International Diagnostic Interview (WMH-CIDI), a fully structured diagnostic interview, was used to assess both 12-month and lifetime MDD. The mental disorders sections used for the NSAL are slightly modified versions of those developed for the World Mental Health project initiated in 2000 (World Health Organization, 2004) and the instrument used in the National Comorbidity Survey-Replication (NCS-R; Kessler & Ustun, 2004).

Independent variables. Several demographic factors were included as independent variables: age (less than 35 years, 35–54 years, 55 or more years), poverty status measured categorically in relation to poverty thresholds; poor, <100%; near-poor, 100–199%; nonpoor with percentage of the poverty line of 200–399%; and nonpoor with percentage of the poverty line of ≥400% (National Center for Health Statistics, 1998), education (less than 12 years, 12 years, 13–15 years, and 16 or more years), employment status (employed, unemployed, and out of the labor force), marital status (married, cohabit with partner, separated, divorced, widowed, and never married), and region (Northeast, South, North Central, and West). Missing data for family income (a major component of the poverty variable) and education were imputed using an iterative regression-based multiple imputation approach incorporating information about age, sex, region, race, employment status, marital status, home ownership, and nativity of household residents. Due to small cell sizes for some of the marital status categories, separated, divorced, and widowed were combined in the analysis of 12-month and lifetime MDD.

Analysis Strategy

Measures of internal consistency and reliability (Cronbach's alpha) were calculated using SAS (Version 9.1.3, SAS Institute, 2005). Regression analysis was used with the two continuous dependent variables and logistic regression was used with the two dichotomous dependent variables. In addition, in the logistic regression analysis, we conducted a design-corrected Wald F statistic for each categorical variable to minimize the likelihood of Type I error due to multiple comparisons. The distribution of basic demographic characteristics, weighted linear regression analyses, and logistic regression analyses were conducted using SAS-callable SUDAAN (Version 9.0, RTI International, 2004). Standard error estimates are corrected for unequal probabilities of selection, nonresponse, poststratification, and the sample's complex design (i.e., clustering and stratification), and results from these analyses are generalizable to the African American adult male population.

Results

Depressive Symptoms CES-D

Table 2 presents the analysis of the demographic variables on depressive symptoms as measured by the CES-D. Age, poverty, education, employment status, and marital status were all significantly associated with depressive symptoms. With regard to age, African American men who were 55 and older had fewer depressive symptoms than their younger counterparts (18–34 years of age). African American men at the lowest poverty levels had more depressive symptoms than their counterparts who had incomes that were 200–399% above the poverty level and 400% or more above the poverty level. Similarly, African American men with less than 12 years of formal education had more depressive symptoms than men with more years of formal education. African American men who were out of the labor force had more depressive symptoms than men who were employed. Separated men had more depressive symptoms than their married counterparts.

SPD K6

The demographic correlates of SPD as measured by the K6 are also presented in Table 2. Age, poverty, education, and employment status were all significantly related to SPD. African American men who were 55 years of age and older had lower levels of SPD than men who were 18–34 years of age. African American men who had poverty-level incomes (<100%) had significantly higher levels of SPD than respondents with higher incomes. Men with less than 12 years of

Table 2. Weighted Linear Regressions Predicting Depressive Symptoms (CES-D; $n = 1{,}208$) and Serious Psychological Distress (K6; $n = 1{,}209$) Among African American Men in the National Survey of American Life (2001–2003)

	Depressive Symptoms CES-D *b* (*SE*)	Psychological Distress K6 *b* (*SE*)
Intercept	8.27 (0.83)	5.00 (0.56)
Age (Ref: Less than 35 years)		
35–54 years	−0.67 (0.40)	−0.30 (0.36)
55 or more years	−2.28 (0.58)***	−1.48 (0.42)*
Poverty ratio (Ref: Less than 1.00)		
Near-poor (1.00–1.99)	−0.95 (0.60)	−0.87 (0.39)*
Nonpoor (2.00–3.99)	−1.05 (0.47)*	−1.32 (0.40)**
Nonpoor (4.00 or more)	−2.10 (0.55)***	−1.86 (0.42)***
Education (Ref: Less than 12 years)		
12 years	−0.81 (0.34)*	−0.39 (0.40)
13–15 years	−1.30 (0.47)**	−0.72 (0.42)
16 years or more	−1.70 (0.40)**	−0.94 (0.42)*
Work status (Ref: Employed)		
Unemployed	1.09 (0.66)	0.48 (0.50)
Out of labor force	1.44 (0.58)**	0.94 (0.40)*
Marital status (Ref: Married)		
Partner	0.30 (0.67)	0.20 (0.43)
Separated	1.69 (0.74)*	0.96 (0.66)
Divorced	0.26 (0.49)	−0.09 (0.38)
Widowed	−0.52 (0.73)	−0.34 (0.48)
Never married	−0.09 (0.46)	0.06 (0.36)
Region (Ref: South)		
Northeast	−0.27 (0.52)	−0.08 (0.35)
North Central	1.10 (0.67)	0.87 (0.44)
West	−0.32 (0.42)	−0.21 (0.43)

Note. CES-D = Center for Epidemiological Studies-Depression scale.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3. Weighted Linear Regressions Predicting 12-Month and Lifetime Major Depressive Disorder Among African American Men ($n = 1{,}217$) in the National Survey of American Life (2001–2003)

	12-Month MDD OR [95% CI]	Lifetime MDD OR [95% CI]
Age (Ref: Less than 35 years)		
35–54 years	0.68 [0.22, 2.07]	0.78 [0.36, 1.67]
55 or more years	0.15 [0.03, 0.67]	0.56 [0.20, 1.52]
F statistic	4.15*	0.68
Poverty ratio (Ref: Less than 1.00)		
Near-poor (1.00–1.99)	3.26 [1.05, 10.07]	1.12 [0.39, 3.15]
Nonpoor (2.00–3.99)	2.54 [0.83, 7.75]	1.44 [0.70, 2.99]
Nonpoor (4.00 or more)	2.81 [0.90, 8.77]	1.39 [0.64, 3.00]
F statistic	1.53	0.82
Education (Ref: Less than 12 years)		
12 years	0.46 [0.20, 1.05]	1.02 [0.49, 2.09]
13–15 years	0.37 [0.14, 0.96]	0.87 [0.36, 2.11]
16 years or more	0.26 [0.05, 1.30]	0.95 [0.31, 2.95]
F statistic	1.74	0.09
Work status (Ref: Employed)		
Unemployed	0.97 [0.32, 2.92]	1.66 [0.70, 3.91]
Out of labor force	0.73 [0.25, 2.14]	0.79 [0.34, 1.84]
F statistic	0.17	1.63
Marital status (ref: Married)		
Partner	0.84 [0.15, 4.54]	0.82 [0.27, 2.44]
Separated/divorced/widowed	2.75 [1.27, 17.73]	2.77 [1.37, 5.61]
Never married	2.31 [0.68, 7.92]	1.54 [0.78, 3.03]
F statistic	2.78*	3.11*
Region (Ref: South)		
Northeast	0.83 [0.26, 2.67]	1.14 [0.58, 2.27]
North Central	3.40 [1.64, 7.04]	2.75 [1.77, 4.28]
West	0.85 [0.31, 2.31]	0.77 [0.30, 1.97]
F statistic	4.35**	7.70***

Note. CES-D = Center for Epidemiological Studies-Depression scale; MDD = major depressive disorder.* $p < .05$. ** $p < .01$. *** $p < .001$.

formal education had higher levels of SPD than their counterparts with 16 or more years of formal education. Respondents who were currently out of the labor force had higher levels of SPD than those who were employed.

Twelve-Month and Lifetime MDD

One out of twenty respondents (5.02%) had MDD in the last 12 months and 9.98% had MDD in their lifetime. Table 3 presents the correlates of both 12-month and lifetime prevalence of MDD. Age, poverty status, education, marital status, and region were significantly associated with having 12-month MDD. African American men who were 55 years of age and older had lower odds of having 12-month MDD than their counterparts aged 18–34 years. African American men who had incomes that were near-poor (100–199%) had greater odds of having 12-month MDD than men who were in poverty (<100%), but this relationship is not significant based on the design corrected Wald *F* statistic. Men who had less than 12 years of formal education had lower odds of having 12-month MDD than those who had 13–15 years of education, but when adjusting for multiple comparisons, this relationship was not significant. Among the marital status groups, separated/divorced/widowed respondents had greater odds of having 12-month MDD than their married counterparts. African American men who resided in the South had lower odds of having 12-month MDD than their counterparts who resided in the North Central region of the United States.

Marital status and region were the only two significant demographic correlates of lifetime MDD; these effects mirror the patterns found for 12-month MDD. African American men who were separated/divorced/widowed had greater odds of having lifetime MDD than their married counterparts. Additionally, African American men residing in the South had lower odds of having lifetime MDD than their counterparts who resided in the North Central region of the United States.

Discussion

This study investigated the demographic correlates of depressive symptoms, SPD, and MDD (12-month and lifetime prevalence) among a national sample of African American men. These findings come from the largest psychiatric epidemiologic study of African Americans in the United States and

provide an unprecedented picture of the mental health status of African American men. Roughly 6% (6.37) of African American men had a score of 16 or more on the CES-D, which is commonly used as a ''cutoff'' for potential depression and additional screening. Unfortunately, because few, if any studies, report levels of depressive symptoms for representative samples of African American men exclusively, we are unable to compare these findings with those of other investigations.

Only 2.7% of African American men had a score of 13 or more on the K6, indicating that most African American men do not currently meet the threshold for SPD. This finding is consistent with those of previous studies reporting lower levels of psychological distress for African Americans, overall, compared to Whites (Substance Abuse and Mental Health Service Administration [SAMHSA], 2008a, 2008b), and for African American men, in particular (Brown & Gary, 1987; Dressler & Badger, 1985).

The 12-month prevalence estimate of MDD for African American men was 5% (5.02), which is consistent with rates for African Americans overall (Williams et al., 2007). This finding is also consistent with those for the CES-D, suggesting that the CES-D might adequately assess clinical levels of depressive disorder in African American men. The lifetime prevalence estimate for MDD was twice the rate for 12-month MDD (9.88%). Together these findings document estimates for depressive symptoms, SPD, and MDD for African American men. Although prevalence rates for mental disorders for African Americans are relatively low compared to non-Hispanic Whites, Williams et al. (2007) found that MDD among African Americans are especially severe and persistent.

The current findings provide first-time substantiation for the existence of important demographic differences in depressive symptoms, SPD, and MDD among a national sample of African American men. Our investigation identified other important sociodemographic factors associated with depressive symptoms, SPD, and MDD that point to potential differences in the social context faced by African American men that are consequential for mental health.

Age was a consistent correlate of mental health and was negatively associated with depressive symptoms (CES-D), SPD (K6), and 12-month MDD. Findings clearly indicate that older men have fewer depressive symptoms, lower levels of psychological distress, and lower odds of having 12-month MDD. These findings are consistent with a recent study among older African Americans (aged 55 and older), which found that respondents 75 years and older were least likely to have any lifetime mood disorder, any lifetime anxiety disorder, any lifetime substance disorder, and overall any lifetime mental disorder (Ford et al., 2007). A study of the demographic correlates of SPD among older African Americans (Lincoln, Taylor, Chae, & Chatters, 2010) also indicated that African Americans of advanced age reported lower levels of depressive symptoms and psychological distress compared to their younger counterparts. Other findings for the general population of African Americans also report lower prevalence of MDD (Williams et al., 2007) for older African Americans compared to their younger counterparts.

These age differences in mental health can be explained by what is known as the ''healthy survivor effect'' (e.g., Strauss, Ojdana, Shavelle, & Rosenbloom, 2004). Namely, current cohorts of older African American men who do not have serious mental health problems represent a subgroup of African American men who are physically and mentally healthier and are more likely to live to advanced ages. Consequently, African American men of older age tend to have fewer depressive symptoms and lower prevalence of psychiatric disorders (Ford et al., 2007) because they represent a healthier subgroup. In essence, this crossover effect suggests that because of the higher levels of mortality among African Americans of all ages, those who reach the oldest ages are survivors. This is particularly true of African American men, who have the highest age-adjusted death rate of any group, experience higher rates of preventable illness, and suffer an increased incidence of preventable deaths (Center for Disease Control and Prevention, 2009). The healthy survivor interpretation is also consistent with research in psychiatric epidemiology, which indicates that depression is a risk factor for coronary heart disease (Rugulies, 2002) and that both major depression and subclinical depression are risk factors for mortality (Cuijpers & Smit, 2002).

Several significant relationships between socioeconomic position and the measures of psychological distress and depressive symptoms were found. All levels of income above poverty level (the comparison group) were associated with reduced levels of SPD (measured by the K6 and assessed over a period of 30 days). With regard to depressive symptoms (measured by the CES-D and assessed over a period of 30 days), the two nonpoor categories were associated with fewer depressive symptoms (the near-poor category was not significant). All levels of education were associated with fewer depressive symptoms (CES-D) relative to the comparison group (less than 12 years) and the highest level of education (16+ years) was associated with lower levels of SPD (K6). Finally, African American men who were out of the labor force had more depressive symptoms and higher levels of psychological distress than those who were employed.

Collectively, these findings are consistent with previous research that found associations between income (Gaines, 2007; Gary, 1985; Kessler & Neighbors, 1986; Mizell, 1999), education (Gaines, 2007; Mizell, 1999), and labor force participation (Lincoln & Chae, 2010) on depressive symptoms and psychological distress. There are two potential and complementary reasons why respondents with higher socioeconomic positions have lower levels of psychological distress. First, higher socioeconomic position may have a protective impact on depressive symptoms. Having income levels below poverty, in particular, may be a significant risk factor for depressive symptoms. Additionally, employment may have a protective effect that is above and beyond the effects of education and income.

This second explanation of the impact of socioeconomic position on depressive symptoms is based on the causal assumption that depression is the dependent variable. That is, socioeconomic position may be a risk or protective factor for

depressive symptoms. This causal assumption is consistent with the majority of the research on socioeconomic position and depressive symptoms. There is a literature in psychiatric epidemiology, however, that reverses this causal ordering and examines depressive symptoms and psychiatric disorders as independent variables. This research investigates the impact of depressive symptoms and psychiatric disorders (e.g., depression) on a variety of demographic outcomes including marriage and various indicators of socioeconomic position. These findings indicate that depressive symptoms and psychiatric disorders have a major impact on educational attainment, labor force participation, income, and earnings. In particular, early onset psychiatric disorders are a major predictor of dropping out of high school and overall diminished years of educational attainment (Kessler, Foster, Saunders, & Stang, 1995). Furthermore, persons with psychiatric disorders are more likely to have difficulty finding a job, retaining a job, and have reduced earnings while employed (Ettner, Frank, & Kessler, 1997; Kessler et al., 2008). A two-wave longitudinal study found that among working adults, those who had a score of 16 or more on the CES-D (out of the 60-point scale) at baseline had higher levels of unemployment and lower levels of income 5 years later (Whooley et al., 2002). This pattern of relationships is consistent with our finding that African American men with higher levels of depressive symptoms are more likely to have poverty-level incomes and to be out of the labor force. Collectively, these findings indicate that depressive symptoms and psychiatric disorders have a negative impact on socioeconomic position (e.g., employment patterns, education, and income levels).

It is important to note that in this analysis, income and education were not significantly related to 12-month or lifetime MDD. However, this is not inconsistent with previous findings (e.g., Kessler et al., 1995; Kessler et al., 2008) on the association between psychiatric disorders and subsequent SES. Our analysis is restricted to MDD, whereas the previous research on SES and psychiatric disorders included a variety of serious mental disorders including nonaffective psychosis, bipolar disorder, panic disorder, suicide attempt, as well as alcohol use and illicit drug use disorders (Kessler et al., 2008). Additionally, because our analysis is restricted to MDD, there may be a significant percentage of African American men whose symptoms do not reach the threshold of clinical depression. In essence, individuals who are classified as having subclinical or subthreshold depression may have similar levels of income and education as those who meet criteria for MDD, thus obscuring these relationships.

Marital status was associated with depressive symptoms and both 12-month and lifetime MDD in our study. Separated African American men had more depressive symptoms than those who were married; those who were previously married (i.e., separated, divorced, or widowed) had greater odds of having 12-month and lifetime MDD than those who were currently married. Comparisons to prior research are difficult, given that few studies consider the influence of marital status on mental health among African American men. However, the current findings are consistent with evidence indicating a protective effect of marriage on mental health among the general population (Booth & Amato, 1991; Simon, 2002; Williams, 2003) and for African Americans, specifically (Lincoln & Chae, 2010). Researchers have hypothesized that marriage may be protective via its effects on SES and social support (Waite & Gallagher, 2000). Specifically, marriage may protect against economic hardship and also provide greater opportunities for emotionally satisfying interactions. The influence of marriage on the mental health of African Americans overall, and men, specifically has received less attention. Lincoln and Chae (2010) offer the first investigation of the combined influence of marital satisfaction, financial strain, and discrimination on the mental health of married African Americans. They note a protective effect of marital satisfaction on psychological distress as well as its potential to buffer the negative effects of unfair treatment and financial strain on psychological distress. Their findings contribute to the extant literature in suggesting that, among African Americans, it is not simply being married, but marital quality that is important for mental health status.

Region was associated with 12-month and lifetime MDD. African American men who reside in the North Central region of the United States have greater odds of having 12-month and lifetime MDD than those who reside in the South. This finding is consistent with previous research (Ford et al., 2007; Lincoln et al., 2010; Williams et al., 2007) identifying the southern region as a protective factor against MDD. The influence of southern region may be an indirect one. For example, African American Southerners are much more religious than their counterparts in other regions (Taylor, Chatters, & Levin, 2004), and religious involvement may have a protective effect against depression. This speculation is consistent with research that found that among African Americans, religious involvement was negatively associated with psychological distress (Lincoln & Chatters, 2003) and mood disorders (Chatters et al., 2008).

Practice Implications

These findings suggest several implications for practice with African American men. First, the pattern of demographic effects indicates that specific subgroups of African American men are at increased risk for psychological distress, depressive symptoms, and MDD. The different demographic correlates of depressive symptoms, SPD, and MDD identified in this study suggest that universal approaches to prevention and mental health interventions may not be optimal. Instead, this information argues for the need for developing targeted interventions that are designed to reduce the burden of mental health problems among distinct subgroups of this population.

The current findings further suggest that the origin and nature of the social stressors facing any particular person are different and consequential for devising effective and individualized intervention strategies. For example, an African American man with low levels of education and income but who is employed and married will require a very different

intervention strategy than one who is divorced and unemployed, but has higher levels of education and income. Rather than taking an undifferentiated view of this group, it is important to understand African American men from a strengths-based perspective that recognizes the combination of assets and challenges that individuals possess with respect to material, informational, and interpersonal resources. Such an approach would be sensitive to how particular combinations of statuses (e.g., young age, poverty, and unemployment) potentially intersect in ways that amplify negative effects, while combinations involving other statues (e.g., older age and married) may offset or counterbalance other disadvantages.

Overall, findings highlight the need for early diagnosis for depression among Black men. The finding that younger age is associated with depression and psychological distress indicates the need for screening and diagnosis at an early age; even as early as adolescence when depression is more prevalent among African Americans compared to other groups (Garrison, Jackson, Marsteller, McKeown, & Addy, 1990; Roberts, Roberts, & Chen, 1997; Wu et al., 1999). Longitudinal studies demonstrate that early onset of depression is associated with a host of poor socioeconomic outcomes, including lower income, lower levels of educational attainment, and poor labor force participation in the general population (Kessler et al., 2008; Whooley et al., 2002). Our findings confirm these associations for Black men specifically and further indicate the need for proper diagnosis and treatment for Black men at an early age. Early diagnosis is imperative for increasing the earning potential and educational attainment of Black men who are at risk for depression and other mood disorders and to combat the severe impairment and loss of productive years due to mental disorders.

Early diagnosis requires symptom recognition, proper treatment, and utilization of services. Unfortunately, racial disparities still exist in these areas, with African Americans being less likely than non-Hispanic Whites to receive a diagnosis of depression (Borowsky et al., 2000) or to receive treatment that meets the current guideline for depression care (Gonzalez et al., 2010). African American men, in particular, are less likely to use any mental health services compared to women or other racial and ethnic groups (Neighbors et al., 2007). The need for cultural competence and evidence-based practices are critical issues for the future of mental health services delivery for African American men. Modifications to service delivery may be sufficient cultural adaptations in many cases, as recent studies indicate (e.g., Sue, 2003). Cultural competence has been prescribed as a solution to the problem of low utilization of traditional mental health services (Sue, 1998). Thus, this recommendation is also apt for the delivery of evidence-based practices.

Empirical evidence also suggests that African American men prefer counseling over medications (Cooper et al., 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). This preference, in part, accounts for their low adherence to prescribed antidepressant medications. So, in addition to offering Black men their preferred treatment option, quality improvement programs that include culturally appropriate educational materials about antidepressant medications and psychotherapies are needed to improve treatment rates among Black men (Centorrino et al., 2001).

Second, the findings convincingly make the case that focused attention on within-group differences is needed in order to fully understand the heterogeneity and diversity within the African American population. Finally, the demonstrated importance of demographic correlates in this analysis suggests a useful and logical strategy for promoting mental health at the policy level. While it is important to address health-promoting behaviors, it is equally important to improve health-promoting environments (RWJ Foundation, 2009). A comprehensive research and mental health promotion agenda is needed that recognizes the importance of improving access to education and employment and promoting healthy coping behaviors, while giving attention to the larger social context in which African American men live. Mental health promotion efforts for African American men should focus on improving health behaviors associated with mental health such as alcohol and substance use, exercise, healthy diets, and coping strategies. However, this should be coupled with attention to macro-level factors, such as access to education and employment opportunities and improved work conditions as factors that influence the structural opportunities for improved mental health (Watkins, Walker, & Griffith, 2010). Rather than a sole individual-level intervention strategy, we suggest a multilevel approach that involves family and communities (e.g., church and social organizations), as they are also impacted by the burden of a member with mental disorders.

This examination of depressive symptoms, SPD, and MDD among a national sample of African American men has provided an initial understanding of the demographic correlates of mental health among this population and how social statuses differ with respect to mental health for this population. The availability of a nationally representative sample was a definite advantage of the study and an extension of prior investigations of small and geographically situated African American samples. The inclusion of four measures of mental health status helped to clarify the role of specific demographic predictors relative to symptomatology and mental disorders. Despite these advantages, the findings are limited by restrictions in the study sample.

As with any cross-sectional analyses, causal inferences are problematic and longitudinal data are preferred. In the absence of prospective data, we are limited in the ability to understand the causal processes by which specific demographic factors influence mental health status. For example, without prospective data, it is difficult to ascertain whether low SES or unemployment predispose or facilitate the onset of MDD or whether the impairment and disability resulting from depression negatively impacts the ability to attain or maintain desirable socioeconomic positions and resources for African American men. As noted earlier, there is evidence to support both points of view (e.g., Eaton, 1980; Elstad, 2001; Warren, 2009).

Because several segments of the population such as homeless and institutionalized individuals were not represented, our

findings are not generalizable to these subgroups. This is particularly relevant for African American men because they are overrepresented in the homeless and institutional populations. Symptoms of depressive disorder and behaviors may be underreported (potentially resulting in lower prevalence rates) due to item nonresponse to sensitive questions, which is a common issue in survey interviewing. Nonetheless, the significant advantages of the sample and methods used in this study provided a unique opportunity to examine differences in depressive symptoms, SPD, and MDD within a national sample of African American men.

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