Improving the Mental Health of Black Americans: Lessons from the Community Mental Health Movement

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THIS ARTICLE OUTLINES A RESEARCH STRATEGY FOR the primary prevention of psychopathology among black Americans. It argues that the basic philosophical tenets of the community mental health movement should be embraced as an integral part of this prevention research strategy. The article also argues that mental health prevention programs must be informed by sound epidemiologic research. More important, this epidemiologic research must be linked with empirical findings from social psychological and sociological research on black Americans. This research, while not specifically focused upon prevention of mental health problems, does contain valuable information concerning potentially modifiable risk factors appropriate for understanding the development of mental health problems among blacks. As such, this literature has important implications for the design of programs and policies aimed at preventing psychopathology among black Americans. Furthermore, because of the social psychological and sociological emphasis of this literature, the research strategy outlined below provides an opportunity to improve other, nonmedical aspects of black American life.

Community Mental Health and Civil Rights

In the early 1960s President John F. Kennedy called for a "bold new approach" for dealing with mental health problems in the nation. At

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the same time, black Americans were demonstrating and protesting for civil rights. Among the many demands of the civil rights movement was the emphasis on adequate health care as a right previously denied many black Americans. The Community Mental Health Centers Act, passed in 1963, was characterized by an emphasis on accessibility, responsiveness, and comprehensiveness for previously disfranchised groups (Wagenfeld and Jacobs 1982; Snowden 1982). Because of the growing influence of the civil rights movement, the community mental health initiative focused on blacks in particular. Drawing on public health concepts taken from social and community psychiatry, the community mental health ideology placed heavy emphasis on prevention as a means of improving minority mental health (Caplan 1964; Sarason 1974). Findings showing that social structural variables were correlated with mental health measures led to the etiologic hypothesis that stressful social conditions increase the prevalence of mental disorder (Leighton et al. 1963; Srole et al. 1962; Faris and Dunham 1939; Hollingshead and Redlich 1958). The logic of this preventive strategy seemed simple enough. Social engineering through environmental change (i.e., to reduce racism or eliminate poverty) would result in mental health improvements. Community mental health's emphasis on primary prevention via social structural interventions was very compatible with the civil rights movement's emphasis on social change for the betterment of life quality among blacks. Many of the mechanisms to be attacked to accomplish this prevention goal were the very same social ills (poverty, racism, discrimination, prejudice, etc.) that were the targets of the civil rights movement and the "War on Poverty."

History and many failed attempts at prevention have taught us that it is just not that simple. The relations among variables such as race, social class, stress, and racism are complex. Attempts to measure these concepts and model their developmental course have proven so complicated that many prevention programs turned out to be nothing more than poorly conceptualized consultation and education services (Ketterer 1981). As these preventive promises were broken and as mental health providers and consumers became cynical, community mental health's prevention initiative came to be seen as a failure (Goldstein 1987). As mental health and public health pulled away from each other, black Americans were left to battle the stresses of racism and poverty with the help of a mental health care delivery system that was not equipped to take a proactive, primary preventive

stance toward the social problems that were seen as important antecedents of black psychopathology.

The community mental health movement has been criticized for unfulfilled promises and fuzzy theoretical thinking (Dunham 1965; Dinitz and Beran 1971). As a result, there has been a retrenchment from many of the "lofty" ideals of the 1960s and early 1970s. Yet, there are components of the community mental health movement that must continue to be addressed in the 1990s as we continue to struggle with the dilemma of how to improve the mental health status of black Americans. With a careful, critical eye on conceptual clarity, theoretical specification, and rigorous research methodology, we can move toward the prevention goals espoused by the community mental health movement.

Community mental health, while increasing access to professional services among previously disfranchised minorities, also stimulated a large amount of research concerned with black mental health. As a result, substantial progress was made in our understanding of the factors impinging upon the state of black mental health. But as the following literature review will demonstrate, much work remains to be done, especially in the areas of risk-factor specification and intervention demonstrations.

In summary, powerful social forces stemming from the civil rights and community mental health movements came together to focus economic and intellectual resources on the notion that psychological problems among black Americans could be prevented if mental health policy moved away from an individual-oriented clinical delivery model to one that focused on social/structural change. This new model would use a social stress conceptualization of psychopathology as the guiding framework for action and intervention (Cannon and Locke 1977). Unfortunately, many now reject this notion, feeling that community mental health overstepped its bounds and made promises that it could not deliver (Feldman 1978). While in many respects this is true, it does not necessarily follow that we must retreat from the philosophy and goals of the community mental health movement—especially with respect to the mental health of black Americans. On the contrary, we should apply a public health approach to understanding the mental health of blacks. Furthermore, we can and must pursue the idea of prevention of psychopathology in black Americans. But we cannot afford to pursue these notions in the same manner that they were

pursued by the early community mental health practitioners. The climate of the 1990s will call for a different strategy. We can arrive at the point of seriously addressing the idea of psychopathology prevention in black Americans by conducting more and better epidemiologic research. Thus, this review will begin by evaluating issues relevant to the epidemiology of black mental health.

Epidemiologic Research on Race

Stimulated by the philosophy and energy of the community mental health movement and in an effort to understand better the issues relevant to black mental health, a number of epidemiologic researchers focused their efforts specifically on black Americans (Pasamanick 1963; Fischer 1969; Jaco 1960). If it were not for the work of these researchers, the epidemiologic knowledge based on black Americans, while still limited, would not be where it is today (Neighbors 1984). As a result of these early writings, a number of epidemiologic studies were conducted during the 1970s. These studies have produced a battery of findings concerning racial differences in mental health status that have accumulated over the last 15 years. The vast majority of these community surveys focusing on race relied on the symptom-checklist method of estimating mental illness prevalence. These short screening scales measure mild, global distress rather than discrete mental disorders. Despite regional and methodological differences across these studies, the following general conclusions can be drawn. First, blacks tend to have higher mean levels of distress than whites. Second, when socioeconomic status is controlled, blacks either exhibit lower levels of psychological distress (Antunes et al. 1974; Dohrenwend and Dohrenwend 1969; Gaitz and Scott 1972; Yancey, Rigsby, and McCarthy 1972) or there are no racial differences (Bell et al. 1981; Mirowsky and Ross 1980; Warheit, Holzer, and Schwab 1973, 1975; Neff and Husaini 1980; Roberts, Stevenson, and Breslow 1981; Eaton and Kessler 1981; Frerichs, Aneshensel, and Clark 1981; Neff 1985b).

In short, these data indicated that blacks were no more likely than whites to have higher rates of distress. These findings are intriguing because blacks are known to be disproportionately exposed to social conditions generally considered to be antecedents of psychiatric disorder

(Farley 1984; U.S. Health Resources and Services Administration 1987). Such results completely contradict the assumptions underlying the theory of social causation which was so fundamental to the thinking behind the community mental health movement. Such results also contradict the minority status argument which predicts a direct effect of race on mental health, regardless of socioeconomic status (Mirowsky and Ross 1980). The minority-status argument predicts higher morbidity among blacks because of the added stress of racism—that is, the stress due to blocked opportunities which whites do not experience. As a result, one would expect blacks to exhibit higher rates of distress than whites at *all* levels of socioeconomic status. In other words, the minority-status argument provides good reason to believe that socioeconomic status alone does not fully capture the unique stress to which blacks are more exposed than whites. Recent evidence suggests, however, that we may not be able to discount completely the minority-status argument. An analysis of eight different epidemiologic surveys found that there *were* race differences in psychological distress, but only among people of the lower classes, a result that is consistent with the view that racial discrimination exacerbates the damage to mental health of poverty status among blacks (Kessler and Neighbors 1986).

How can we explain the reluctance of psychiatric epidemiologic researchers to push past a simple additive model of race, class, and distress to explore the interaction just described? The answer lies in the pejorative manner in which mental illness statistics historically have been used to support racist theories of black inferiority (Neighbors 1985; Fischer 1969; Pasamanick 1963; Kramer, Rosen, and Willis 1973). This reluctance was also heavily influenced by the political ideology that prevailed in the aftermath of the Moynihan report and the subsequent black reaction which sought to describe the plight of low-income black Americans in a more positive light. At the time these race-comparative epidemiologic surveys were being conducted, it was not very popular to say negative things about black America. A finding that showed blacks to be suffering from higher rates of mental illness than whites most likely would have been interpreted as a racial slight on the survival strengths of black families. Within such a climate, there was no real purpose to be served by challenging the notion that socioeconomic status eliminated the main effect of race on psychological distress.

But as the analysis by Kessler and Neighbors (1986) shows, race

is an important determinant of mental health status, particularly among the poor. Faced with such results, one cannot help but wonder why high-income blacks are not any worse off than their white upper-class counterparts. Are we really to believe that upper-class blacks suffer no stress due to racism and discrimination? Perhaps they are exposed to racism and discrimination but it is not as serious as that experienced by the black poor. On the other hand, racism could be equally stressful for low- and high-income blacks, but upper-income blacks may have access to the kinds of social resources (money, power) that allow them to deal with that stress more effectively. Or, it could be that overcoming adversity by moving up the socioeconomic ladder could create especially competent copers among the black middle and upper classes—individuals who possess the internal resources needed to meet almost any crisis effectively (Kessler and Cleary 1980).

In summary, epidemiologic research on race raises a number of stress-coping scenarios which need to be addressed. There is a large "black box" situated between demographic variables like race and class on one side, and mental health outcomes on the other. To begin to open this box, epidemiologic research on blacks must first focus on the stress due to racism, and then move beyond the stress-exposure hypothesis. How blacks respond to or cope with the stress they are exposed to must also be taken into account. If it is true that blacks lead more stressful lives than whites, then we need to know more about the cultural strengths and coping resources that may account for the comparable or lower rates of psychological morbidity among blacks in comparison to whites.

Most of the stress research that takes this more complex approach to understanding mental health has focused on social class and sex (Wheaton 1980; Eaton 1978). With a few notable exceptions, stress research on black mental health has not moved in this direction (Kessler 1979; Neff 1985a; Dressler 1985; Husaini 1983). On the other hand, the applicability and appropriateness of a stress-adaptation approach to understanding black mental health issues has been the frequent topic of *discussion* (Cannon and Locke 1977; Hilliard 1981; Brooks 1974; Carter 1981; Myers 1982). On the whole, research on black mental health has yet to apply the sophisticated multivariate statistical techniques and panel designs that are generally characteristic of the stress and mental health research on nonminority populations. It is imperative that we move the field in that direction. We will

never acquire an adequate knowledge base for preventive interventions in black mental health if researchers continue to ignore the issues outlined above.

We need to evaluate critically the assumptions underlying our various theories about why being black is or is not a risk factor for mental disorder. By focusing more specifically on these theoretical assumptions, we should be able to answer long-standing questions of whether or not psychopathology is differentially distributed *across race* as well as how it is differentially distributed *within* the black community. One very good source of information on risk factors that link race to psychopathology is sociological and social psychological research on blacks. Drawing on this research, we can generate a number of hypotheses about why low-income blacks exhibit the highest rates of distress. In this way we can begin to fulfill the promises once held out as reachable by the community mental health movement.

Sociological and Social Psychological Risk Factors

With respect to the field of race and mental health, there are a number of ways to take the unique stress of being black into account. For example, we could focus on the use of the life events methodology and look for differences in stress across race. This has been done to some extent (Uhlenhuth et al. 1974; Mellinger et al. 1978; Dohrenwend 1973; Husaini 1983). We also need to focus on the actual meaning of racism and discrimination. Parker and Kleiner (1966, 43–44), for example, examined the unique impact of racism by using a diagrammatic representation of the "best" and "worst" possible way of life to measure discrepancies between aspiration and achievement in various areas of goal striving (e.g., education, occupation, income, self-image, racial context of social situations, and hypothetical offspring). This is an approach that needs to be replicated and refined for use in future epidemiologic studies. We need to focus more of our attention on the stress of trying to "make it" as a black in this country. What is the mental health impact of successfully or unsuccessfully negotiating an opportunity structure that is not colorblind?

If we look beneath what is typically meant by the assumption that race exposes blacks to unique stresses, we can see a number of interesting but useful hypotheses about the effect that striving for upward social

mobility might have on emotional health. For example, the racism argument implies that it is more difficult for hard-working, talented lower-class blacks to "move up" than it is for similar whites; and that is is more difficult for recently upwardly mobile middle-class blacks to remain in their newly acquired status positions. The manner in which the members of black subgroups adjust to the failure to rise or the inability to maintain an elevated socioeconomic status will have important implications for mental health.

It is also likely that internal and external stress-mediating factors are influenced by the social histories of upward and downward mobility that blacks experience. Given the fact of racism, what impact might these factors have on the emotional health of black Americans and what are the implications for preventive interventions? We can begin to formulate answers to these questions by reviewing certain aspects of social science research focused on the black experience. It will become clear from this review that while much research has been conducted on black Americans, the epidemiologic implications have yet to be adequately specified. These studies often claim that they are concerned with black mental health, but rarely do they include the kinds of mental health outcomes psychiatric epidemiology is concerned with. They do, however, measure many variables that can be viewed as mechanisms intervening between race and mental health. As such, they begin to construct a "socio-pathogenesis" of mental disorder for blacks, thus providing causal hypotheses which can be tested later using experimental or quasi-experimental research designs (Kessler 1987; Hough 1985; Price and Smith 1985). Epidemiologic risk-factor research focused on the mental health implications of racism (prejudice, discrimination) should have important implications for the types of interventions we might design in order to prevent the psychic pain of downward mobility and blocked opportunities.

There are three basic assumptions that underlie research in the areas of race, class, and mental illness. First, everyone in the United States shares the value of striving to be upwardly mobile (Merton 1957). Second, lower-class individuals feel like failures because they have been unsuccessful in their attempts at upward social mobility (Wheaton 1980). Third, being poor is stressful, not only because poverty per se exposes one to more stress but also because there is stress involved in trying to advance but not being able to do so (Silberman 1964). Blacks especially are victims of aspirations they cannot achieve (Pettigrew

1964). The specific mental health consequences of this situation for blacks are unclear. For example, we are only at the early stages of understanding how personal histories of success and failure are related to important risk factors like locus of control, self-esteem, and a sense of fatalism. Furthermore, there is still much to be learned about how these latter constructs are related to mental health measures like psychological distress and discrete disorders (e.g., DSM-III). Some researchers argue that it is more adaptive to *reduce* mobility striving in order to bring subjective aspirations more in line with the objective realities of a racist opportunity structure (Parker and Kleiner 1966). Others feel that the most mentally healthy response is to work collectively with other, socioeconomically similar blacks to change the system and open more opportunities for advancement (Gurin et al. 1969; Gurin, Gurin, and Morrison 1978).

Most researchers argue that having an internal sense of control has positive mental health benefits and that being external (or "fatalistic") does not. Wheaton (1980) defines fatalism as a learned, persistent attributional tendency that emphasizes environmental rather than personal causation of behavior. It increases vulnerability to stress because it undermines coping persistence and effort (i.e., reduces motivation) via long-term personal histories of failure. Wheaton (1980, 107) also states that avoiding self-blame for failure through external attributions may be ego-protective but will inevitably undermine personal feelings of efficacy even when those external explanations are plausible (as they most certainly are for blacks). Unfortunately, psychiatric epidemiologists have not explored how these ideas relate specifically to the situations of black Americans.

Research using Rotter's internal/external locus-of-control scale has shown that blacks are more externally oriented than whites (Porter and Washington 1979). Gurin et al. (1969) were the first to show that, for blacks, Rotter's scale consisted of two dimensions—one factor made up of items phrased in the first person (personal control) and the other referring to people in general (control ideology). Comparing blacks and whites on control ideology showed that blacks were just as likely as whites to subscribe to the typical American values of the importance of work, effort, skill, and ability in striving to get ahead. Thus, the greater externality of blacks on the locus-of-control measure was actually due to a reduced sense of *personal* control only, not an endorsement of different cultural values (Gurin, Gurin, and Morrison

1978). Racism, then, while reducing personal control among blacks, does not erode belief in the work ethic.

The Gurins went on to argue that the reduced sense of personal control among blacks reflected a realistic perception of restricted opportunities. Thus, while blacks were more externally oriented than whites, this was due to an accurate assessment of a racist environment and such externality among an oppressed group was not necessarily a bad thing. In other words, the Gurins would disagree (for blacks at least) with Wheaton's argument that an external orientation is detrimental, no matter how plausible the explanation. In fact, when the Gurins assessed this realistic and accurate external orientation via the concept of "system blame," they found the more external blacks to have higher aspirations and to engage in more innovative coping efforts.

Others have speculated on the positive mental health benefits of system blame for blacks but, in actuality, this hypothesis has never really been tested (McCarthy and Yancey 1971; Neff 1985b; Veroff, Douvan, and Kulka 1981). Thus, there is no way to resolve the apparent disagreement between Wheaton (1980) and the Gurins (Gurin et al. 1969; Gurin, Gurin, and Morrison 1978). For example, while the Gurins discuss the relation between system blame and mental health, what actually gets measured is motivation, efficacy, and coping. These are not mental health outcomes but important risk factors. The system-blame concept has become closely linked with the idea of mental health through Merton's (1957) statement that it is healthy for a subordinate group to react against the system, which is actually a political statement cloaked in a medical analogy. Nevertheless, the fact that the research of the Gurins shows that externality via the system-blame concept does not result in reduced motivation, persistence, and effort (as Wheaton predicts) suggests that this is an important area for further research.

The work by Parker and Kleiner (1966) comes close to empirically testing this notion. Their results suggest that it is not mentally healthy to react continually against the system. It may be more adaptive to know when *not* to strive—especially when probabilities of success are low. Specifically, Parker and Kleiner (1966) found that low-status blacks had low goal-striving stress but high rates of psychological distress. They also found that downwardly mobile lower-class blacks had higher levels of goal-striving than their more stable lower-class

counterparts. Further analysis revealed that: (1) downwardly mobile lower-class blacks who would not or could not reduce the aspirations associated with past status affiliations showed the highest rate of symptomatology; and (2) stable lower-class blacks with low goal striving showed a lower rate of symptomatology. These findings led Parker and Kleiner (1966) to conclude that it was the downwardly mobile at the lowest end of the socioeconomic scale with high goal striving who showed the lowest self-esteem and, consequently, the highest rate of psychological distress.

Feelings of power and efficacy are related to the perception of the world as controllable and predictable. The feeling that one is able to manipulate and influence important events in one's life can be significantly influenced by personal success/failure experiences. Such experiences can, in turn, lead to increased or decreased efforts at coping during times of crisis. Research shows that blacks and whites do differ on a number of important concepts like self-esteem, efficacy, and control. Although many of these variables can be seen as modifiable risk factors causally related to the development of psychopathology, there is still much speculation. More research is needed to specify the relations among these variables and mental health.

In summary, the literature on race and locus of control and the literature on social psychiatric epidemiology have not been brought together despite much speculation about the relations among race, internal/external attributions, and mental health. The former has studied the locus-of-control concept without an explicit concern for empirically demonstrating the relation of these variables to mental illness. The latter has focused on fatalism and mental illness without much regard for the special or unique issues related to race. System blame has been related to collective action but not to measures of psychological distress.

Expectancy Theory as a Framework for Intervention

The stress-research paradigm does not overemphasize social causation to the neglect of personal factors. Rather, it is transactional, taking into account the environment and the person. As such, the stress model of mental health is completely consistent with an expectancy approach to clarifying issues of race and poverty. The controversy

surrounding the relative importance of environmental and personal factors in explaining the behavior of blacks and the poor is not a new one (Caplan and Nelson 1973). Over 15 years ago, social psychologists working to understand problems of motivation and unemployment among the black poor saw the need for a more balanced approach. Gurin and Gurin (1970, 83–84), advocating an expectancy approach to understanding the problems of poor blacks, put it most eloquently:

> One approach focuses on the institutional aspects of the problem—on the current realities that the poor must deal with. The other focuses on the problems "in" the poor—on pathologies that are the residue of past disadvantage. For psychologists who have been interested in problems of poverty, this bifurcation has also had some negative consequences, although for converse reasons: the distinction between these two approaches has often been too sharply drawn. Psychological and situational approaches are sometimes considered antithetical and even mutually contradictory. Approaches that have focused on reality problems have often assumed that motivational and psychological problems would disappear if basic changes in our institutions and opportunity structures were effected. In parallel fashion, those concerned with psychological and motivational issues have also separated "psychology" and "reality." They have conceptualized the psychological problems of the poor in terms of "basic" personality dispositions that are the product of early socialization—motives, values and behavior patterns that have become self-perpetuating and do not necessarily reflect current realities.

Expectancy theory is based on the notion that one's belief that actions will be rewarded enhances motivation and affective behaviors. Expectancy models emphasize conscious actions on the environment to attain positive outcomes and to avoid negative results. Expectancies are not reducible to traits nor situations but represent both characterological *and* situational forces. Because of racism, expectancy research on blacks must be particularly concerned with the implications of situational assessments (Bowman 1987). For poor blacks, expectancy problems (low and external expectancies) result from the feeling that there is little chance of attaining a particular goal. As the research of Parker and Kleiner (1966) suggests, blacks may have lower expectations in the face of objective difficulties and discouraging odds (i.e., blocked opportunities or an unfair opportunity structure) and point to the distinct possibility that such negative expectancies operate as psychological risk factors.

Expectancy research has the potential to guide researchers interested in understanding how blacks cope when faced with systematic obstacles to striving. Specifically, we need to document the mental health effects of strategies aimed at the elimination of barriers to opportunity that may produce negative expectancies in blacks. That mobility patterns are important for mental health was demonstrated by Kessler and Cleary (1980), who found that the upwardly mobile were less influenced by stress than the nonmobile. They argued that the experience of success associated with upward mobility created assertive coping skills needed to avoid psychological damage which results from undesirable events. Since expectancies are formed as a result of social histories of success and failure, Kessler and Cleary's data support the assumption that success experiences in the opportunity structure increase competence, thus decreasing vulnerability to stress. Isaacs (1984), using data from the National Survey of Black Americans, compared the father's main job while the son was growing up to the son's current job and found that 47 percent were upwardly mobile, 25 percent were nonmobile, and 28 percent were downwardly mobile. Isaacs (1984) also found that the upwardly mobile showed a significantly higher sense of self-esteem, personal efficacy, and general happiness.

Thus, it appears that programs designed to facilitate upward mobility among the black poor could improve mental health status by changing expectancies. But research from "War on Poverty" programs shows that expectancies do not automatically change to conform with changes in objective conditions (Gurin and Gurin 1970). If we argue for policy changes that emphasize the creation of structural opportunities *only*, we might be missing the point. Adequate care must be taken to prepare people for these new roles, which means training programs that focus on skills and assessment of psychological concepts such as low or external expectancies. To quote Gurin and Gurin (1970, 101–2):

> Learning new expectancies is no longer a matter of changing from external to internal but poor people are presented with a more difficult problem of making complex judgements as to when internal and external interpretations are realistic, when an internal orientation reflects intrapunitiveness rather than a sense of efficacy and when an external orientation becomes defensive rather than a realistic blaming of the social system. These judgements must be made

when objective opportunities are in flux, making an accurate picture of reality even more difficult to determine.

If expectancies can be changed over time, these changes would hopefully be stable and generalize to other aspects of the person's life. Below, two areas that are particularly relevant for intervention research focusing on changing the expectancies of black Americans are reviewed.

Targets and Settings for Preventive Interventions

From a public health perspective, the ultimate goal of epidemiologic research is the application of intervention programs designed to reduce the incidence of disease, thereby reducing prevalence. A further goal of epidemiologic research is to uncover the modifiable risk factors that can form a rational basis for preventive action. Identification of black strengths and weaknesses through careful epidemiologic risk-factor research can contribute to the design of programs aimed at upgrading those weaknesses and taking advantage of those strengths to reduce the occurrence and impact of stressful social situations. By intervening in black population subgroups known to be at risk of developing low self-esteem or low/external expectancies, prevention programs could have a positive impact on black mental health outcomes. The important factor, however, will be to develop programs for such groups *before* they begin to display evidence of the types of serious mental disabilities that can result from potentially pathogenic social circumstances. There are a number of specific areas where we should intervene. If done carefully and in the right settings, we do not need to mention explicitly mental health, mental illness, psychopathology, or any other potentially stigmatizing terms.

Children in Schools

Whenever the topic of prevention is discussed, the issue of children inevitably arises. Because of various developmental theories, many argue that the best way to ensure competent adults is to strengthen coping skills in children. This was a fundamental premise of the "Child Guidance" movement. This idea was also an integral part of the philosophy of the Head Start program. In the last few years,

results from a number of studies focusing on preschool and elementary school interventions with black children have raised the distinct possibility that this is a fruitful mental health prevention strategy. More relevant for this review are studies that have attempted to intervene with low-income black youth. Head Start had a legitimate role in helping to facilitate the normal unfolding of self-esteem and social competence, defined as "the ability to master formal concepts, to perform well in school, to stay out of trouble with the law and to relate well to adults and other children" (Palmer and Andersen 1979, 3). Head Start's philosophy was heavily influenced by community mental health ideology, with child mental health professionals stressing prevention, early detection, and the social determinants of emotional problems. The clinicians who worked in the Head Start classrooms estimated that 10 to 25 percent of the children were suffering from serious disturbances, although systematic epidemiologic studies were never conducted (Cohen, Solnit, and Wohlford 1979).

In the 1960s, a group of preschool intervention studies were begun and, in 1975, ten of these investigators pooled efforts, relocated the children, and compared them to matched groups. For all programs, the children were predominantly poor and black. The results of these studies indicated that preschool children were significantly less likely to be set back one grade or more in school. Four out of the five studies for which data were available showed that fewer preschool children were in special education (learning disabled) classes. Five studies reported significantly higher reading scores in the preschool group; two found higher scores but the differences were not significant and one study showed no difference. Seven studies had data on arithmetic scores. Two showed significantly higher scores for the preschool group, two showed significantly higher scores on some subtests, two showed higher scores for girls but not boys, and one showed higher but insignificant scores. Thus, while no study affected all variables associated with elementary school performance, all studies affected one or another variable and some affected several. Palmer and Andersen (1979, 447) concluded that these results "have implications not only for the academic performance of children, but for socio-emotional and cost aspects as well."

Glazer (1985) reported on a study by Darlington and Lazar (1984). This study followed up 1,599 of 2,700 children in 1976 and 1977 who had been in 11 preschool programs in the early 1960s (all had

comparisons to a control group). There were differences in the degree to which those who attended preschool were held back or were assigned to special education classes. The median rates of failing a grade or being assigned to special education were 45 percent to 24 percent. Glazer (1985) also reported on the Sustaining Effects Study of Compensatory and Elementary Education funded by the Department of Education. This research followed up 120,000 students in a sample of 300 schools over a three-year period. The results showed gains for Title I students relative to needy students (who qualified but did not receive the intervention) for grades 1 through 6 for mathematics and grades 1 through 3 for reading. By the time these children reached junior high school, however, there was no evidence of sustained effects.

In the Yale-New Haven Prevention Project, an elementary school that was 99 percent black and had 50 percent of the families on AFDC received an intervention (Comer 1985). Educators and mental health personnel collaborated to create a desirable social climate in the school to effect coordinated management, curriculum and staff development, teaching, and the learning process. They did not focus on the children and their families as "patients" but, rather, the intervention was targeted toward the organization and management system of the school in order to provide students with adequate educational skills and support. The project had four elements: (1) a representative governance and management group; (2) a parent-participation program; (3) a mental health program and team; and (4) an academic program. As part of a larger study, 16 girls and 8 boys who had been part of this elementary school intervention were contacted 3 years later. They were randomly matched on age and sex with the same number of students who attended another elementary program. The intervention group did significantly better on achievement test scores, including doing better on 9 different subscales. They also did better in language, mathematics, and school grades.

Shure and Spivack (1982) used a variety of games, discussions, and group interaction techniques to focus children's attention on listening to and observing others, and on learning that others have thoughts, feelings, and motives in problem situations. In this particular study, 113 black inner-city children (47 boys, 66 girls) were trained in the nursery school year, while 106 served as a control group. The 131 who were available in kindergarten were divided into 4 groups: (1) twice-trained; (2) once-trained in nursery; (3) once-trained in kin-

dergarten; and (4) a never-trained control group. Results showed that the impact of the training program lasted a full year and that the training was as effective in kindergarten as in nursery school. Children trained in nursery school were less likely than controls to begin showing behavioral difficulties over a two-year period.

Recent information from the Perry Preschool Project in Ypsilanti, Michigan, deserves attention (Berrueta-Clement et al. 1984). The Perry study (123 black youth) saw preschool as an intervention to prevent negative effects of poverty on school performance, creating a foundation for life success. Students were randomly assigned to attend or not to attend the preschool program and followed through age 19. Results revealed that 2 out of 3 of the preschool group vs. only 1 out of 2 of the controls graduated from high school. Persons attending preschool did better on measures of skill competence. Preschool led to more employment, less unemployment, and higher earnings. The preschool group was also more likely to be supporting themselves (45 percent vs. 25 percent) and Department of Social Services records showed less public assistance use by the preschool group. Finally, the preschool group had fewer contacts with the criminal justice system and fewer arrests. These results suggest that the initial effects of intellectual performance can have a long-term impact upon the scholastic achievement, commitment to schooling, and scholastic placement of black children.

The Poor in Job-training Programs

Successful interventions at the pre- and elementary school level would have positive payoffs in another area that receives much attention for black Americans—job-training programs for the black unemployed. Better school performance among the black high-risk children should result in staying in school longer, increased likelihood of obtaining a diploma, and increased employment. To the extent that the early interventions with young children are successful, there should not be as many black teens or young adults in need of job-skills training later in their lives. Inevitably, however, many black youth will wind up unskilled and unemployed. For this group, job-training programs provide an opportunity to change expectancies.

Job-training programs are relevant to the concerns of this article because they should be able to teach us something about how to have

an impact upon employability and thus the upward mobility of low-income blacks. Glazer (1985), citing Taggart's (1981) review of job-training programs, concluded that the most intensive programs have done best, and cites Job Corps, the Youth Employment and Demonstration Act and the Youth Incentive Entitlement Pilot Project as examples. Two studies of Job Corps found significant program effects in terms of increased employment, earnings, reduced welfare dependence, unemployment insurance usage, criminal activity, and out-of-wedlock births. Weinberg (1985) argued that the perceived role of work experience within a welfare program should be studied. He asks the very timely question, "Can the concept of reciprocity (establishment of a quid pro quo in exchange for welfare benefits—"workfare") lead to increased exit from welfare by imbuing an increased sense of self-worth to the recipients?" (Weinberg 1985, 5). In 1985 a preliminary report by the Manpower Demonstration Research Corp., evaluating new welfare approaches in 11 states, focused on workfare in West Virginia and found that 80 percent of the participants thought that a requirement to work for checks was "satisfactory" or "very satisfactory."

It seems clear that "workfare" will be a major movement within the welfare policy area. Workfare experiments are being conducted in Michigan, Pennsylvania, California, and New York. In Ohio, workfare programs are being extended into 40 of the state's 88 counties. As another example, in March of 1987, a report from the American Enterprise Institute recommended that welfare recipients be *required* to participate in education, training, and work programs in order to reduce poverty, *increase* self-esteem, and decrease behavioral dependence. It is interesting to note that the report is reminiscent of the expectancy approach to poverty in that it advocates a two-pronged approach to helping the poor. Specifically, the report said that economic improvements must be combined with an effort to change thinking and behavior among the "underclass." This is similar to the ideas psychologists were trying to promote in the early days of the "War on Poverty":

> For although their motivational problems are affected by the immediate reality situation, there is more to the motivational problem than that. I have commented that those who have stressed the motivational and psychological issues presented by these trainees have tended to neglect the reality and institutional problems. In a similar vein, those who have approached the problem of poverty with suggestions for changes in social institutions and opportunity structure have

> tended to ignore the fact that motivational problems will not automatically disappear with these structural changes. Just as a concern with motivational issues does not necessarily imply a neglect of reality, a concern with reality does not mean that motivational and personality issues are irrelevant (Gurin 1970, 286).

One workfare program that will be worth monitoring is Project Self-Sufficiency. Fifty households in Ann Arbor and another 50 in Grand Rapids, Michigan, headed by single parents were among 5,000 families nationwide selected for a federal demonstration program designed to help them become self-sufficient within 5 years. The U.S. Department of Housing and Urban Development is spending $25 million for rent subsidies, counseling, job training, and child care aid. Another workfare program in Michigan, Project Self-Reliance, reported that 37 percent of the 7,000 people who took part moved off the welfare rolls and into jobs, another 24 percent moved into a position to find employment within 6 months to a year, while 39 percent went back on welfare. California launched a program that requires able-bodied welfare recipients to work or risk losing benefits. This program also makes provisions for job training and child care, while exempting parents with children under age 7. Those who are not required to join the program can volunteer. The program provides job counseling, supervised job searches, job training, educational classes, and a guarantee of public service jobs for those who cannot find work elsewhere.

While the "new" workfare policy initiatives sound promising, the issues are the same complex ones we have been struggling with since the early days of the "Great Society." Years of research on poverty, race, and achievement show that manipulating the attitudes, motives, and expectations of the black poor in a manner that will be beneficial and long-lasting is very difficult. It is clear that there is still much we do not know. For example, Bassi and Ashenfelter (1985, 32) conclude: "Unfortunately, despite nearly twenty years of continuous federal involvement to assist this group, we still have to do a good deal of guess work about what will work and for whom." Glazer (1985, 38) stated: "It is understandable that it should be very hard to come to conclusions, and if we could say nothing in 1974, we can say little more in 1984 despite a great expansion in the scale and sophistication of evaluations of work-training programs."

As far back as the late 1960s Gurin and Gurin (1970, 98) outlined

four essential issues that researchers will need to resolve: (1) "Under what conditions will success experiences and opportunity changes increase personal expectancies and under what conditions will they lead to denial and avoidance responses? (2) How can success experiences in an intervention program be used to affect long-range stable expectancy changes that carry into the world beyond the program? (3) How can the effects of a series of specific positive experiences be made to affect an individual's general self-confidence and trust in the environment? (4) Under what conditions can positive effects on psychological expectancies also have positive implications for behavior?"

The workfare programs represent an important opportunity for researchers to investigate many age-old issues and theories about the poor. One of the reasons that we do not know enough about the impact of job-training programs is that very few of the training programs were run on an experimental basis (Glazer 1985; Bassi and Ashenfelter 1985). In this regard it is interesting to note that a recent White House policy team recommended that communities be permitted to use welfare funds to finance experimental programs (U.S. Domestic Policy Council 1986). The report states that the purpose of the experiments should be to move more welfare recipients into paying jobs. This is consistent with the position taken by Bowman and Gurin (1984, 126–27) who state,

> We should stress that we feel that the next steps in motivational research on issues of poverty could be most effectively studied around policy and program interventions—not that they have not been. There have been countless evaluations of policy and program interventions. When they have shown any concern with measuring attitudes and motivations they have generally followed a dispositional model, looking at attitudes as predictors of greater or lesser success following the intervention experience or using the attitudes as controls in estimating economic impact. There has been little or no specific conceptualization of the relevance of the interventions to the literature on how attitudes change and how these changes relate to behavior.

As mentioned earlier, welfare policy analysts have had two opposing views on the problems of the poor. One viewpoint emphasizes the flawed character of low-income people (sometimes referred to as the

"culture of poverty," or the "underclass"), while the other stresses restricted opportunities (Hill et al. 1985). Within the second perspective, the barrier most frequently cited with respect to the black poor is, of course, racial discrimination. While neither perspective denies that attitudinal or motivational factors exist, they differ with regard to the basic origin and permanence of the attitudinal problems (Bowman and Gurin 1984). The underclass approaches assume that the problems of the black poor are deep-seated and self-perpetuating. Thus, they are not expected to be very amenable to social interventions. The restricted-opportunity perspective, on the other hand, suggests that these problems are due to situational barriers and, as such, can be influenced or changed or alleviated by educational, training, and job-creation interventions.

Recent results from the Panel Study of Income Dynamics of the Survey Research Center, Institute for Social Research, University of Michigan, are relevant here. Analyses revealed modest and usually insignificant effects of basic motives on economic outcomes. Changes in expectancy measures were, however, significantly predicted by economic and noneconomic events. Thus, expectancies appeared to be related to economic outcomes, but causation ran from the outcomes to the expectancies rather than in the reverse direction (Hill et al. 1985). The most dramatic findings were of the variability of economic status for the poor. Many highly motivated people did succeed in pulling themselves out of poverty, but almost as many of the unmotivated did as well. "Opportunities provided by more schooling or by living in areas of high employment growth were more consistently significant in producing higher than average short-run improvement than were attitudes" (Hill et al. 1985, 9).

In another study focusing specifically on the labor market problems of black youth, Bowman and Gurin (1984) found that personal efficacy failed to emerge as a significant predictor of increases in education or employment. These results were consistent with those from the Panel Study of Income Dynamics: motivation as measured by personal efficacy did not have a direct causal effect on subsequent changes in employment or occupational status. Increases in education and employment did, however, boost motivation for males (but not females). Specifically, young black males who completed additional schooling increased their personal efficacy. Bowman and Gurin (1984, 113)

concluded that "cross-sectional correlations between personal efficacy and status attainments can best be interpreted as evidence that motivation is largely the result rather than the cause of mobility outcomes."

The crucial point is that low-income blacks may not be victims of poor motivation as a result of inadequate predispositions (e.g., lack of a need for achievement, or a poor work ethic) but rather, suffer from negative expectancies that have resulted from a history of poor success due to slim chances. Given that this appears to be a problem of expectancies, there is hope for change. If it were purely a problem of deep-seated dispositions, then there would be no point to social programs. The new social programs mounted under the "workfare" label are in many cases motivated by a conservative ideology that views welfare as fostering dependency and leading to a culture of poverty or a permanent underclass. Nevertheless, they could have a positive impact on black expectations to the extent that they provide opportunities for successful work experiences and career paths. The positive potential of these programs is that they are not concentrating on attitudes and motivational problems only. They are also structural in focus in that they are providing jobs. If the ambition is there (and the PSID analyses as well as preliminary results from some of the workfare programs seem to show that it is) but the expectations are low, then it makes sense to create opportunities in order to increase expectations of success. It remains to be seen, however, whether the new round of workfare programs will be able to accomplish this goal.

It is also crucial that we not forget that if expectancy theory is correct, providing structural opportunities will not solve motivational problems for *all* of the black poor. Note the percentages from Michigan's Project Self-Reliance. While 61 percent eventually had successful work experiences, 39 percent went back on welfare. As the following quote indicates, the project director saw poor motivation as a critical factor for this latter group:

> They were not able to translate the opportunity into a step forward. In some cases, even with help, they just couldn't build a work record. They quit, or their record was spotty. They're just not prospects to be marketed for permanent private-sector jobs. Most of them, quite frankly, weren't willing to work hard" (*Detroit Free Press* 1985).

Obviously, there is no way of knowing if the project director is correct

in his assessment. The point is, however, that motivational problems among some of the urban poor is not an unreasonable hypothesis, especially in light of what an expectancy approach would suggest. It could very well be that some of this 39 percent represent a subgroup of the poor who will need the benefit of interventions that do more than merely offer an employment opportunity. Perhaps this group will need an intervention that includes an educational or training component that will focus more intensely on how to increase the likelihood that expectancies *will* change to coincide with new, objective realities and the opportunities provided by workfare initiatives.

Discussion

This article has argued that the community mental health ideology still has much to offer to the field of black mental health. If epidemiologic risk-factor research based upon social psychological and sociological theory can empirically demonstrate the manner in which black Americans adjust to social mobility and expectancy problems, those findings can be used as a knowledge base upon which to design preventive interventions. Within this viewpoint, it has tried to point out some of the linkages between mental health, stress, and expectancies. Furthermore, this article has argued that there is a reservoir of useful knowledge to be drawn from the social experiments started in the 1960s under the auspices of the "Great Society" and the "War on Poverty." Specifically, the greatest potential lies in the areas of preschool programs, early elementary education, and job-training.

It should be noted that this article is not arguing that *all* poor black children will eventually require mental health care if they do not have access to special preschool and elementary school programs. It is important that we think in terms of probabilities of events occurring in *groups* rather than individuals. Herein lies the strength of the public health approach. Many ask how one can show that something was "prevented" when it never even occurred. The answer is through the employment of carefully designed experimental or quasi-experimental research designs that employ comparison or control groups. It is only in this manner that we can demonstrate the impact of a preventive program by showing significant differences in outcome between those who received the intervention and those who did not.

Another strength of the prevention approach outlined here is that there could be positive by-products of targeting mental disorder for prevention based on changing expectancies using a social-educational model of psychopathogenesis. Because this approach and the risk factors targeted for modification (e.g., educational achievement, labor market participation) are important outcomes for other fields, a prevention strategy that views these variables as risk factors for mental illness has the potential for reaching humanitarian, educational, criminal justice, and economic goals. If our interventions are powerful, and if the theory is correct, we not only improve self-esteem and decrease distress and discrete mental disorders, we also reduce delinquent behavior, unemployment, school truancy, and drop-out rates.

In discussing prevention in mental health, one cannot overlook the problem of the stigma of early identification. Consider for a moment what the concept of early identification really means within the context of mental health. It means that someone will have to tell a black person that they or one of their significant others are at risk of becoming mentally ill. This will not be welcome news to many blacks. We know that there is a tremendous amount of stigma attached to labeling someone with a psychiatric condition, and most blacks simply will not appreciate being told they need psychological help because, statistically speaking, they possess a number of social characteristics that indicate an increased probability of psychological problems. Attacking mental health problems within the contexts discussed in this article (e.g., schools, anti-poverty programs) will help alleviate this problem.

In short, an educational approach to prevention is preferable because it is nonmedical. Thus, we are not talking about early detection or case-finding for mental illness only. Rather, we are talking about using a social theory of psychopathology to target interventions toward suspected antecedents of psychological distress. If our theory is correct, it should have an impact on the prevalence of mental disorder and other social problems. To document this, however, will mean broadening our outcome measures (especially in long-term follow-up) to include assessment of psychological morbidity, including discrete mental disorders and the use of rigorous research designs.

Another important issue that needs more discussion is the notion of victim-blaming. In this regard, we must be careful to distinguish between two important points. One is the attribution of blame for

the unjust social situations that blacks have been subjected to. This, clearly, is the fault of an oppressive social system set up by whites. The second is the notion that blacks can, however, in the face of oppressive conditions, take responsibility for changing those social conditions that were not necessarily the fault of blacks or the poor (Committee on Policy for Racial Justice 1987). Related to this second point is the notion that blacks and the poor should take personal responsibility for changing individual behaviors known to be deleterious to mental health. This is not victim-blaming, although some would have us think so (Crawford 1977). Victim-blaming is a one-sided attitude, that *all* of the problems of the poor are indeed *their fault* and due to deficits "within the person," with no appreciation whatsoever of the role played by social stress and oppressive environmental conditions (Gurin and Gurin 1970; Gurin 1970; Ladner 1973; Ryan 1971; Yette 1971). The notion of individual responsibility for health behavior is completely consistent with the current trend in public health toward health promotion. The health-promotion view is based on research that shows that many of the health problems of individuals are made worse by poor health behaviors (e.g., smoking, drinking, no seat belts, poor nutrition, etc.). Thus, it follows that improvements in health can be made by targeting interventions toward changing those risky behaviors. It would be a mistake not to take advantage of this promotional approach while social-change agents are advocating environmental reform.

There is a need to join black researchers with black practitioners, especially clinicians and health educators, in joint research endeavors in community settings (Price 1982; Goldston 1986). It is clear that the action-research strategy outlined in this article cannot be carried out by university-based researchers alone. It needs the input of blacks who are skilled and knowledgeable in how to deliver human services to target groups in a manner that takes the unique cultural experiences into account (Lefley 1975; Miranda and Kitano 1986). Often researchers are hesitant to intervene until they are certain that the intervention will have an impact on the dependent variable. Action research requires researchers who are willing to put aside some of this scientific skepticism in order to "get going." The research community can gain important ideas about issues for intervention research from programs already in progress. Researchers can take advantage of the things that practitioners are already doing in piloting intervention research projects designed

to manipulate variables shown to have an impact on black mental health. Practitioners, on the other hand, must be willing to subject programs they "know" are effective to research designed to evaluate their actual impact on black clients. For example, many health education programs are based on a number of assumptions, many of which go untested. They attempt to impart cognitive information on the assumption that this will change health attitudes, which will in turn have an impact on health and illness behavior. Not only do we need to test the assumption that health attitudes directly affect health behavior; we also need to document attitude change, not just class attendance.

In many ways, community mental health is synonymous with public health. And as such, the community mental health ideology still has much to offer in developing a sensible, feasible strategy of mental health promotion for black Americans. That strategy must be based on sound epidemiologic knowledge. This will mean continued research, focusing on descriptions of the distribution and course of psychological morbidity in cross-sectional and longitudinal samples of blacks. It will also mean intense investigation of methodologic issues in the measurement of psychopathology across race. Among those committed to a psychosocial theory of pathogenesis, it will mean precise specification of the risk factors assumed to link marker variables to morbidity outcomes. Finally, this strategy will necessitate the development of collaborative efforts among groups who, while interested in the goal of black mental health promotion, rarely have the opportunity to work together.

Conclusions

In closing, the following points should be highlighted. First, it has been shown that the highest rates of psychopathology reside in the lowest socioeconomic groups, and this is especially the case for black Americans (Neighbors 1986). Research on social mobility shows that the benefits for blacks of moving up the social ladder outweigh the costs (Kessler and Cleary 1980; Isaacs 1984); and that moving down in socioeconomic standing can be detrimental to black mental health (Parker and Kleiner 1966). As a result, policies and programs designed to influence the mobility patterns of blacks can be viewed as having

implications for mental health. Two settings, in particular, should command the interest of epidemiologic researchers: (1) preschool and elementary schools; and (2) job-training programs ("workfare"). Using experimental research designs along with appropriate measures of mental health outcomes (e.g., self-esteem, psychological distress, discrete DSM-III disorders), a preventive effect can be demonstrated. Finally, even if significant reductions in psychopathology cannot be demonstrated, the risk-factor model put forth in this article contains potential for a positive impact in other important areas of black American life.

In arguing this position, I am asking that we not forget the tenets originally put forth within the rubric of the community mental health movement. The data reviewed here demonstrate convincingly that sociological and social psychological factors are important determinants of psychological morbidity. Furthermore, the idea of linking epidemiologic research with the notion of prevention in mental health is a reasonable, feasible goal to pursue. But this task can only be accomplished by clearly specifying what it is we want to prevent, the particular factors that contribute to those outcomes, the settings and targets for preventive interventions, and the use of an evaluation strategy that will allow clear statements about significant reductions in incidence and prevalence.

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