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Critical Race Theory Speaks to the Sociology of Mental Health: Mental Health Problems Produced by Racial Stratification*

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The sociology of mental health focuses on the epidemiology, etiology, correlates, and consequences of mental health (i.e., psychiatric disorder and symptoms, psychological distress, and subjective well-being) in an attempt to describe and explain how social structure influences an individual's psychological health. Critical race theory describes and explains iterative ways in which race is socially constructed across micro- and macro-levels, and how it determines life chances implicating the mundane and extraordinary in the continuance of racial stratification (i.e., racism). This paper invoked critical race theory to inform the sociology of mental health's approach to studying race and mental health by conceptualizing five hypothetical mental health problems that could exist because of racial stratification. These problems were: (1) nihilistic tendencies, (2) anti-self issues, (3) suppressed anger expression, (4) delusional denial tendencies, and (5) extreme racial paranoia. Mental health problems such as these and undocumented others can only be recognized given awareness of the social and personal implications of racial stratification.

Given differential exposure to deleterious race-related experiences along with generic vicissitudes linked to work, family, money, intimate relationships, etc., one might predict that blacks would experience poorer mental health than whites, but evidence from community epidemiologic studies conducted over the past 20 years indicates that blacks, relative to whites, exhibit lower than expected rates of psychiatric disorder (U.S. Department of Health and Human Services 2001). Results from the Epidemiologic Catchment Area study, for example, indicate no race differences or equal prevalence rates in psychiatric disorders (Robins and Regier 1991) at five major sites in the United States (New Haven, Connecticut; Baltimore, Maryland; St. Louis, Missouri;

Piedmont, North Carolina; Los Angeles, California) among adults aged 18 or older, after controlling for social location variables. Some evidence was found contrary to this overall pattern for simple phobia and agoraphobia (Robins and Regier 1991). As another example, Kessler and colleagues (1994) found no significant black-white differences in lifetime and past-year affective disorders, substance abuse disorders, and anti social personality disorder among adults 15 to 54 years of age (National Co-Morbidity Study) after controlling for income and education. When investigating psychological distress and symptomatology, black-white patterns become more complex, often depending upon symptom specificity and the measure of distress; thus, the direction of race differences is not consistent (Vega and Rumbaut 1991). Interestingly, in the case of subjective well-being (e.g., life satisfaction, happiness, etc.), blacks consistently report lower levels than whites after controlling for a host of explanatory variables (Hughes and Thomas 1998). Taken together, the evidence suggests that blacks maintain levels of mental health that are better than pre-

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dicted given their social location and exposure to race-related stress.

The nature of the relationship between race and mental health can be more systematically specified if researchers consider two topics. First, the possibility exists that standard operational definitions fail to capture the concept of mental health status with the same efficiency across racial groups. The implication is that mental health might need to be defined with regard to a community's norms (Adebimpe 1979; Baldwin 1984; Moodley 2000; Outlaw 1993; Rogler 1999; Wakefield 1992). For example, the black community has notions about the sanity of particular individuals (Moodley 2000), and these notions often contain criteria (e.g., blacks who bleach their skin, blacks who hate being black) typically ignored in the construction of psychopathology or in operational definitions of poor mental health (Akbar 1991; Landrum-Brown 1990; Poussaint and Alexander 2000). Second, far too little attention has been given to racial stratification, which is a comprehensive way to think about what is commonly referred to as racism, as an etiologic factor. Racial stratification can cause mental health problems (among both blacks and whites) not systematically described in the existing literature or psychiatric nosology.

To begin the process of investigating these topics, this paper invokes critical race theory to inform the sociological perspective on race and mental health. One contribution that critical race theory could make is to describe mental health problems (Wheaton 2001) produced by racial stratification. After presenting descriptions of five such mental health problems, implications are discussed for the classification and measurement of mental health, and the sociology of mental health.

RACE, RACIAL STRATIFICATION, AND MENTAL HEALTH

That blacks should display, on average, poorer mental health seems reasonable given their increased exposure to race-related and generic stress relative to whites. Some researchers have previously hypothesized that racialized social conditions and discrimination can produce psychopathology and mental health problems among blacks (Baldwin 1984; Clark and Clark 1939; Delgado 1982; Grier

and Cobbs 1969; Kardiner and Ovesey 1951; Landrum-Brown 1990; Outlaw 1993). However, this proposition was neglected for reasons such as adherence to invariant notions of normalcy and illness, uncritical thinking about race, and lack of diversity of people and therefore ideas in sociology, including the sociology of mental health (Adebimpe 1979; Bell 1996; Poussaint and Alexander 2000; Sue and Sue 1990; Thomas and Sillen 1972).

Extending the argument that racial stratification might be linked to mental health problems among whites requires that we interrogate whiteness and its associated privileges. Whites who actively or passively participate in the continuance of racial stratification are acting in what they perceive as their own best interests (Essed 1991; Feagin and Vera 1995; McIntosh 1992). Scholars, therefore, should be cautious about medicalizing whites' participation in racial stratification given its normative operation in the United States and elsewhere. Heeding that caution, this paper argues that racial stratification may cause some whites to display a constellation of dysfunctional feelings and behaviors with associated impairment that could be psychologically damaging. The next sections outline why and how sociologists study mental health, and how critical race theorists study race and racial stratification.

SOCIOLOGY OF MENTAL HEALTH

Mental health status is the purview of sociologists because the discipline of sociology attempts to describe and infer relationships among individuals and institutions (i.e., social structure) (Busfield 2000; Cockerham 1989; Mirowsky and Ross 1989; Wheaton 2001). Sociologists of mental health are interested in explaining the causal chain connecting institutions to an individual's psychological health. An individual's mental health status has been shown to be related to factors such as employment, social movements, family structure, role acquisition, stress, identity, marriage, and urbanicity, and to vary across statuses such as gender, race, age, and class (see Aneshensel and Phelan 1999; Avison and Gotlib 1994; Cockerham 1989; Horwitz and Scheid 1999; Link and Phelan 1995; Outlaw 1993; Wheaton 2001). In addition, service allocation and provision to the mentally ill and those dealing with mental health problems are textured by

sociological forces. Many sociologists of mental health investigate the epidemiology, etiology, correlates, and consequences of psychiatric disorder and symptoms, psychological distress, and subjective well-being; the stress, coping, and adaptation paradigm dominates much of the research in this area (Avison and Gotlib 1994). This paradigm attempts to explain how social stressors linked to roles and social location converge to influence psychological vulnerability, which is variable among individuals because of appraisals and learned ways of coping and adaptation. Sociologists of mental health theorize about the importance of specifying multiple etiologic factors that may produce social conditions conducive to ill psychological health (Busfield 2000; Wheaton 2001).

Most sociologists of mental health would acknowledge that race is important to understanding the distribution of mental health, but researchers have only recently attempted to specify the etiologic role of racial stratification in producing poor psychological health (Clark et al. 1999; Harrell, Merritt, and Kalu 1998; Krieger 1999; Outlaw 1993; Thompson and Neville 1999; Williams and Williams-Morris 2000; U.S. Department of Health and Human Services 2001). In an often-cited elaboration of fundamental causes of disease (Link and Phelan 1995), racial stratification received sparse mention relative to other causes. Thus, there remains much to learn about the intersection of race, racial stratification, and mental health. The next section introduces critical race theory as a theoretical tradition that could inform sociology's approach to race and mental health. I argue for critical race theory because of its emphasis on critical interpretation (labeled "revisionist history" (Delgado and Stefancic 2001)) of accepted patterns in jurisprudence and legal outcomes, which is somewhat consistent with the theme of this paper—critical interpretation of existing empirical patterns in mental health by race.

CRITICAL RACE THEORY

What is "critical race theory?" Delgado and Stefancic (2000, 2001) define critical race theory as a paradigm used to generate insights into the contemporary racial predicament, exposing how racial stratification is more powerful or enduring than is initially apparent.

Critical race theory not only dares to treat race as central to the law and policies operative in the United States, it dares to reject the popular belief that racial stratification can be eliminated by encouraging everyone to "just get along" (Delgado and Stefancic 2001). It, as an academic and activist movement, was birthed of the union between critical legal studies and radical feminism in the late 1980s; its intellectual genesis lies in the work of Derrick Bell (Crenshaw et al. 1995). Critical race theory has been applied to numerous topics such as the analysis of conflict between integration ideals and clients' interests in school desegregation litigation, incremental approaches to achieving racial equality, supposed neutral principles of constitutional law, legitimation of discrimination through anti-discrimination (i.e., color-blind) law, racially based jury nullification, and race-conscious districting (see Delgado and Stefancic 2000; Crenshaw et al. 1995).

There are at least five fundamental tenets and themes that undergird the research, methods, and pedagogy of critical race theory: (1) racial stratification is ordinary, ubiquitous, and reproduced in mundane and extraordinary customs and experience, and critically impacts the quality of lifestyles and life chances of racial groups; (2) the race problem is difficult to comprehend and possibly impossible to remedy because claims of objectivity and meritocracy camouflage the self-interest, power, and privilege of whites; (3) races are categories that society invents, manipulates, and recreates; (4) blacks and other subordinated groups are competently able to communicate and explain the meaning and consequences of racial stratification because they are oppressed, thus experiential knowledge is legitimate and appropriate; and (5) more than academic or purely scientific advances, critical race theorists should seek to propagate social justice.

Although critical race theory began as a movement in law, it has spread rapidly to other disciplines (Crenshaw et al. 1995; Delgado and Stefancic 2001) and has been applied by diverse scholars desiring to document how racial stratification operates on implicit, explicit, institutional, and individual levels to impact how blacks and whites and racialized others live and die. Critical race theory tends to expose and challenge ontological and epistemological biases subtly inculcated in the law, policies, or in empirical research that would

otherwise hinder contextualization of harm and dysfunction resulting from racial stratification. The next section suggests how sociologists' knowledge about race and mental health could be furthered in important and novel ways by attuning themselves to race theorizing.

CRITICAL RACE THEORY SPEAKS TO THE SOCIOLOGY OF MENTAL HEALTH

The sociology of mental health, particularly research in the areas of epidemiology, etiology, and social construction of psychiatric disorder and psychological problems, might benefit from a conversation with critical race theory. Such a conversation could (1) offer the sociology of mental health a more complete explanation for enigmatic and complex findings in the literature regarding race and mental health, and (2) establish a nexus for a new research agenda (e.g., the emotional consequences of being black or being white). Incorporating a critical race perspective would draw attention to the degree that mental health and mental health problems are often theorized to be a function of internal, individual level etiologic factors. When viewed as such, the ways in which structurally embedded systems of inequality (including racial stratification) reinforce themselves through the manifestation of unique mental health problems cannot be adequately specified.

There are at least three approaches that a critical race theorist might take to investigating the meaning of race in relationship to mental health and mental health problems: (1) a study of the social conditions (e.g., poverty, joblessness, crime) or risk factors (e.g., perceived experiences of discrimination) associated with racial stratification that might be linked to poor mental health, (2) a critique of standard indicators of mental health status and the construction of psychiatric disorders, and (3) an examination of unique manifestations of mental health problems produced by racial stratification. This paper focuses on the latter of the three approaches as a foundation for bringing critical race theory tenets and themes into the sociological study of mental health. The goal is to improve sociologists' understanding of the nature of the relationship between racial stratification and mental health.

Studies of the unique manifestations of mental health problems related to racial strati-

fication are absent from the existing literature with the following exceptions. Akbar (1991) and Landrum-Brown (1990) wrote about how racial oppression produced unique psychiatric disorders among blacks. Their seminal work represents a springboard for ideas of the current paper. Bell (1980) and Poussaint and Alexander (2000) described how extreme racism among whites, ipso facto, should be considered a personality disorder with narcissistic tendencies. Kardiner and Ovesey (1951) presented evidence from psychiatric case studies documenting the psychological pain blacks endured due to racial stratification. For instance, one of their female patients had an unreasonable recurring dream of being reborn white. Themes and hypotheses in this body of work have not been systematically formulated or expressed in the sociology of mental health literature.

MENTAL HEALTH PROBLEMS PRODUCED BY RACIAL STRATIFICATION

Because critical race theory emphasizes what racial stratification means and how it operates, this theoretical tradition can contribute to the sociology of mental health by describing emotional problems produced by racial stratification, problems that often transcend standard conceptions of mental health. Standard conceptions, which are quite extensive, would show some overlap with unique mental health problems produced by racial stratification but would be insensitive to racial stratification as an etiologic factor and therefore would not be reliable indicators (Thompson and Neville 1999). Racial stratification produces mental health problems to the extent it generates stressful circumstances and cognitive states conducive to emotional distress. If racial stratification was eliminated, the mental health problems it causes would also be eliminated, whereas other mental health problems or psychiatric disorders cannot be eliminated with such structural changes.

Although there are several mental health problems that could be elaborated, this paper will focus on five problems that I hypothesize are most prevalent and impairing: (1) nihilistic tendencies, (2) anti-self issues, (3) suppressed anger expression, (4) delusional denial tendencies, and (5) extreme racial paranoia. Another

reason to focus on these particular problems is that the available evidence offers strongest support for these problems' existence. Because whites' and blacks' experience of racial stratification is distinct, resultant from their asymmetric placement in the racial hierarchy, some of these problems are incident among only blacks (e.g., nihilistic tendencies) or whites (e.g., extreme racial paranoia) whereas other problems are incident in both populations (e.g., delusional denial tendencies). For each type of problem, exemplar symptoms are detailed. These exemplar symptoms are important because they demonstrate how the proposed mental health problem negatively affects, to varied degree, quality of life and social functioning and relationships, ultimately causing psychological pain and impairment.

Nihilistic Tendencies

Although one could be nihilistic for other reasons, nihilistic tendencies as described here is characterized by strong tendencies to destroy and hurt oneself because of fatalism associated with the permanence of racial stratification (Akbar 1991; Landrum-Brown 1990; Poussaint and Alexander 2000; West 1993). Akbar (1991) characterized a category of conditions (i.e., self-destructive disorders) within which nihilistic tendencies should be included as self-defeating attempts to survive in a society that systematically frustrates normal efforts for natural human growth. This problem is likely to impair blacks who have found doors to legitimate survival blocked and out of an urgency for survival have chosen destructive means to achieve immediate needs and desires (Akbar 1991). Nihilistic tendencies captures a psychological state where individuals are their own worst enemy, acting with intent to destroy themselves. West (1993) called nihilism a depression-like disease of the soul and wrote that black existential angst emanates from the lived experience of emotional scars inflicted by white supremacist beliefs and images permeating the United States. Poussaint and Alexander (2000) described how suicide and other self-destructive behaviors (e.g., police assisted suicide, substance abuse, criminality) in response to race-related hopelessness has eviscerated the black male population, documenting, for example, a 146 percent increase since 1980 in suicide rate for black men aged

15 to 19. Rates for other gender-age subgroups of the black population have not displayed much variability, suggesting that some groups (e.g., black women aged 60 and older) may more efficiently activate coping responses or avoid nihilism.

Symptoms indicating nihilistic tendencies. Among other things, a black person dealing with the mental health problem of nihilistic tendencies might: (1) intentionally get involved in a shoot-out or knife fight, (2) race in a car at excessive speed, (3) use so much drugs or alcohol that he or she almost dies, or (4) try something so dangerous she or he could have died.

Anti-Self Issues

Akbar (1991) and others (Baldwin 1984; Bell 1996; Brown, Sellers, and Gomez 2002; Clark and Clark 1939; Kardiner and Ovesey 1951; Landrum-Brown 1990; Outlaw 1993; Taylor and Grundy 1996; Taylor and Jackson 1991; Thompson and Neville 1999) describe how blacks feel estranged from their racial selves and seek to escape from their blackness and, by corollary, any connection to other blacks. Estranged blacks have internalized negative notions about being black (Taylor and Grundy 1996; Taylor 1990; Williams and Williams-Morris 2000) and thus feel disdain for their racial group and try to create social and physical space between themselves and their group (Brown et al. 2002; Clark and Clark 1939). The seeking of white approval and assimilation to white norms and behaviors (deracination) is a feature distinguishing anti-self issues as a mental health problem. Because being white is consistently constructed as better than being black, anti-self issues likely occur as blacks attempt to manage and maintain positive feelings about their racial identity. In their seminal research on oppression and psychology, Kardiner and Ovesey (1951) wrote that acceptance of the white ideal is inevitable for select blacks, given unfair social conditions, and it is a recipe for perpetual self-hatred.

Symptoms indicating anti-self issues. Among other things, a black person suffering from anti-self issues might: (1) wish that he or she was white, (2) hate being black, (3) lighten her or his skin, (4) try to act white to feel bet-

ter about himself or herself, or (5) pray that she or he could be reborn white.

Suppressed Anger Expression

Because of the nature of racial terrorism and subtleties of hegemonic oppression, opportunities for blacks to get angry are numerous, but expression of their anger is often sanctioned (Bell 1996; Delgado 1982; Harburg et al. 1973; Grier and Cobbs 1969; Johnson and Broman 1987; Landrum-Brown 1990; Outlaw 1993). Suppressed anger expression is a mental health problem that might have initially arisen as a survival strategy when blacks were enslaved or when the perception that a black person was “uppity” could result in a quick and horrendous death (Kardiner and Ovesey 1951). When denial of anger and aggression becomes normative, suppressed anger expression leads to false affability, passivity, resignation, and ultimately withdrawal or inward self-destruction. Cose (1993), for instance, described the rage of the black middle class in great detail and how, because of their individual socioeconomic achievement, many members of the black middle class are denied the liberty of anger expression about racial issues.

Symptoms indicating suppressed anger expression. Among other things, a black person suffering from suppressed anger expression might: (1) be very angry about a racial issue but have to hold in his or her anger, (2) boil on the inside because of something racial, but smile on the outside, (3) get mad at himself or herself for not expressing anger about a racial situation, (4) lie when a white person asks if she or he is angry about being treated unfairly, or (5) pretend to like a white person to get ahead in life.

Delusional Denial Tendencies

Among blacks, ruminating about the nature and persistence of racial stratification and how whites benefit from racial hierarchy has been labeled hyper-vigilance (Essed 1991) or healthy paranoia (Grier and Cobbs 1969), conditions which could be considered harmful. Thus, in response to racial stratification, it might be psychologically beneficial for blacks to repress unpleasant or painful ideas from reaching the conscious level and ultimately

generating disability (Akbar 1991; Kardiner and Ovesey 1951). Consistent with this, McIntosh (1992) theorized that whites are normatively socialized to believe that they do not benefit from racial oppression and that they do not need to consider ways in which race plays out in their lives. More generally, Lazarus (1981) described psychological benefits of denying stressful events and acting as if one is impervious to the bad things that are part and parcel of everyday life. Similarly, Taylor and Brown (1988) described the potential salubrious effects of unrealistic optimism. However, and contrary to this line of reasoning, lack of contact with reality and exaggerated perceptions of control or unrealistic optimism are quintessential indicators of poor mental health (Baldwin 1984; Taylor and Brown 1988; Thompson and Neville 1999). Racial stratification has a powerful impact on life chances; thus pretending, for example, that race is not important as an axis of stratification could disarm individuals of the skills necessary to confront racial exclusion, mistrust, antipathy, indifference, and terrorism (Delgado and Stefancic 2001; Essed 1991; Feagin and Vera 1995; Landrum-Brown 1990; McIntosh 1992; Williams and Williams-Morris 2000). Evidence from a study linking perceptions of discrimination to blood pressure supports the potential deleterious effect of denial. Compared to those reporting at least one discriminatory encounter, Krieger (1990) found that black women who never reported experiencing racial discrimination were more likely (but not significantly so) to have hypertension—a result she claimed to be a function of denial. Delusional denial tendencies is a mental health problem that likely results from managing conflicting public and private cognitions, suggesting the permanence or solubility of racial hierarchy.

Symptoms indicating delusional denial tendencies. Among other things, a black or white person suffering from delusional denial tendencies might: (1) try to pretend that race does not matter, (2) tell others that race had nothing to do with his or her success or failure in life, (3) think that blacks exaggerate about discrimination that they face, or (4) wish that people would never talk about race again. Although appearing to be individual attitudes and beliefs, these symptoms are damaging to the extent that they cause emotional and social disability by disrupting social relationships or

perpetuating a consistently challenged world view.

Extreme Racial Paranoia

Whites who hold racialized illusions of exaggerated self-importance often experience unreasonable discomfort at the thought of having an interpersonal interaction with a black person (Feagin and Vera 1995; Landrum-Brown 1990). Conceding that racism among whites can be stress-induced or institutionally produced to some extent, Bell (1980) described racist thinking as indicative of “a narcissistic personality or borderline disorder characterized by a grandiose sense of self-importance, power, lack of empathy, and an exaggerated sense of entitlement” (p. 662). Poussaint and Alexander (2000) stated that, “Extreme racism is a serious mental illness. A person who believes that any group of ‘others’ is responsible for the world’s troubles—and must be eliminated—meets criteria for a paranoid ‘delusional disorder’” (p. 125). Extreme racial paranoia is a mental health problem that may occur among select whites who are actively or passively devoted to insuring continuance of racial stratification (Bell 1980; Thompson and Neville 1999).

Symptoms indicating extreme racial paranoia. Among other things, a white person suffering from extreme racial paranoia might: (1) feel physically sick after being around black people, (2) wish that all blacks would go back to Africa so the United States could be a white country “again,” (3) hope that a disease would wipe out black people, (4) enjoy watching a black person get hurt or killed, or (5) try to hurt or kill someone because he or she is black.

DISCUSSION

Without specification of its root etiology, behavioral or emotional deviance cannot be equivocally identified, and therefore mental health problems cannot be correctly conceptualized or reliably measured (Thompson and Neville 1999). This paper attempted to represent racial stratification as a neglected fundamental cause of disease that could directly create mental health problems and create situations conducive to the emergence of mental health problems. Building upon this proposi-

tion, I argued that mental health problems related to racial stratification could not be conceptualized without acuminate understanding of what being black or being white means in the United States. Critical race theory informs this understanding. This theoretical tradition was initially oriented toward the law and jurisprudence, and dedicates itself to estimating the full meaning and consequence of racial stratification. Although grounded in legal studies, critical race theory could uniquely speak to scholars doing the sociology of mental health, suggesting that the permanence of racial hierarchy, whites’ camouflaged self-interests, and the irrationality of racial classification can impact the psyche. The result of the conversation between the sociology of mental health and critical race theory is an elaboration of five hypothetical mental health problems inextricably tied to racial stratification as an etiologic factor, that in the absence of racial hierarchy would not exist.

The next step is to empirically verify these mental health problems. One approach would be to collect data using the exemplar symptoms presented in this paper (along with other symptoms not yet developed) and establish convergent validity using standard measures of psychological pain and impairment. Another approach would involve qualitative examination of case histories of individuals who might have experienced such mental health problems, paying special attention to commonalities. Ultimately, a reliable set of symptoms could be developed and administered in social surveys along with structured diagnostic interviews used to assess psychiatric disorders, and psychological distress scales and well-being inventories.

Implications for Classification and Measurement of Mental Health

Although we treat psychological health as perfectly identified, it is not: There is much error and variability in conceptualization of mental health and illness (Busfield 2000; Henderson 2000; Mirowsky and Ross 1989; Regier et al. 1998; Taylor and Brown 1988; Thomas and Sillen 1972; Wakefield 1992; Wheaton 2001). In fact, sociologists of mental health have debated and continue to debate about the best ways to conceptualize and measure mental health, given the impact such oper-

ational definitions have for understanding the social origins of psychological distress (see Horwitz 2002). How we define mental health status and mental health problems might need further clarification as emergent research specifies ways in which structural factors such as racial stratification impinge on individual lives. Moreover, caution is warranted regarding acceptance of standardized conceptualizations of mental health because the dominant group in society often defines normalcy or disease. For example, Thomas and Sillen (1972) described how white psychiatrists in the nineteenth century claimed that black slaves suffered from "drapetomania"—a "psychiatric disorder" indicated by a desire to run away from slavery. Other examples of dominant group conceptualization of disorder include attempts to classify as mental disorders homosexuality, lack of vaginal orgasm, and childhood masturbation (Wakefield 1992). Thus, this paper's arguments expose weaknesses in the current classification of mental health status and mental illness with respect to racial stratification's impact.

Implications for the Sociology of Mental Health

As more studies are published showing enigmatic or complex relationships between race and mental health, sociologists of mental health must more systematically explain if, how, and through what mechanisms racial stratification contributes to observed patterns. This paper's intent was to encourage a future research agenda by (1) challenging imposed assumptions about the invariance of mental health status and (2) drawing attention to racial stratification as an etiologic factor influencing mental health status. Another intent was to move from description of racial patterns in mental health to an explanation of why we observe certain racial patterns.

Although this paper focused on blacks and whites, suppositions made may apply more generally to other subordinate groups arranged in various stratification systems. For example, mental health researchers can draw on the work of critical race or other race scholars with expertise in issues pertinent to Asian, Latino, or Native Hawaiian populations to propose specific mental health problems that might be correlated with internment experiences, immi-

gration, or acculturative stress. Or scholars with expertise in issues pertinent to Native American populations might propose that we focus on the psychological ramifications of past practices of genocide and present practices of exclusion. Interestingly, scholars might invoke themes from radical feminism to substantiate mental health problems produced by men's oppression of women. Obviously, and as a next step, within group diversity must also be accounted for, as there are population subgroups that may have relatively high levels of particular psychological problems produced by racial stratification (e.g., nihilistic tendencies among black men; Bell 1996).

Many people are burdened with unique mental health problems directly or indirectly produced by racial stratification. These structurally produced mental health problems have been neglected in discussions of race and mental health. This paper proposed that sociologists and other mental health researchers must theorize at greater depth, like critical race theorists do, about the experiential meaning of being black or white in the United States in order to more fully characterize the empirical relationship between race and mental health.

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