ANXIETY DISORDERS IN AFRICAN AMERICANS: AN UPDATE

Cheryl M. Paradis, PsyD, Marjorie Hatch, MA, and Steven Friedman, PhD
Brooklyn, New York

This article discusses issues involved in the diagnosis of anxiety disorders, particularly panic disorder, in African Americans. Although epidemiological studies have shown similar prevalence rates of anxiety disorders among African Americans and non-African Americans, African Americans are underrepresented among those in treatment at mental health settings or serving as clinical research subjects. In addition, few studies have researched the unique demographic, diagnostic, and treatment characteristics of African-American patients with anxiety disorders. Most clinicians therefore are not educated to consider these issues in adapting their treatment approach to affect a more successful treatment outcome for African-American patients with anxiety-disorder. This article identifies and addresses relevant cross-cultural issues. (*J Natl Med Assoc.* 1994;86:609-612.)

Key words • anxiety disorders • panic disorder • African Americans

Few studies have focused specifically on the unique demographic, diagnostic, and treatment characteristics of minority patients with anxiety disorders. Among psychiatric conditions treated primarily in ambulatory mental health settings, anxiety disorders are the most common.[1] It is estimated that 16 million Americans suffer from an anxiety disorder, yet less than 25% receive appropriate treatment.[2] Lifetime prevalence rates for anxiety disorders in the general population, as determined by the Epidemiological Catchment Area (ECA) study of more than 18 000 people, were as follows: phobias, 13.5%; panic disorder, 1.4%; and obsessive-compulsive disorder, 2.5%.[3]

The ECA study found few significant statistical differences with respect to race in the prevalence of anxiety disorders. The ECA study did report, however, that African Americans have a significantly higher lifetime prevalence of simple phobia and agoraphobia.[3] Brown et al[4] also reported that in the general population, there is a higher prevalence among blacks than whites of phobic disorders, including agoraphobia, social phobia, and simple phobia.

Some methodological problems related to the data collected on African Americans were noted in the ECA study. Middle and upper class African Americans were underrepresented and elderly African Americans were overrepresented in the sample.[5] The results of the ECA study relating to possible racial differences in the prevalence of anxiety disorders therefore should be viewed with some reservations.

Another difficulty with analyzing findings on the prevalence of anxiety disorders in African Americans relates to the design of the *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition, revised (*DSM-III-R*). The *DSM-III-R* was based on the study of predominantly white subjects. This raises concerns that the *DSM-III-R* may be lacking in cultural sensitivity.

Researchers also have shown that African Americans in general are less likely than whites to seek needed psychiatric treatment. Traditionally, African Americans have turned for care or service to providers within their community such as a minister or family doctor.[6,7] Neighbors[7] found that when he polled 1322 black respondents, 87% of those who were experiencing psychological problems sought help from some informal network. Of the 48% who sought professional health care, 21.9% went to emergency rooms, 22.3% went to general physicians, and 18.9% went to

From the Department of Psychology, Kings County Hospital Center, SUNY/Health Science Center at Brooklyn, Brooklyn, New York. Requests for reprints should be addressed to Dr Cheryl M. Paradis, Dept of Psychology, Kings County Hospital Ctr, 450 Clarkson Ave, Box 1203, Brooklyn, NY 11203-2098.

ministers. Only 9% of these respondents sought care from mental health clinicians.[6]

Previous research has shown that African Americans are often misdiagnosed when they do seek treatment at mental health centers. It has been reported that affective disorders are often underdiagnosed and schizophrenic disorders overdiagnosed in blacks.[8] This diagnostic bias has been attributed to factors, such as cultural differences, in the description of symptoms or difficulties in the relationship between white therapists and black patients. It has been noted, for example, that blacks and Hispanics with affective disorders are more likely than whites to describe hallucinations, which can lead the clinician to incorrectly diagnose schizophrenia.[9-11]

A recent study[12] of the routine diagnostic intake process in an inner-city outpatient psychiatric department showed that anxiety disorders were significantly underdiagnosed in African Americans. In this study, 100 consecutive patients presenting for intake interviews at an outpatient psychiatric department in an inner-city municipal hospital were interviewed. The Anxiety Disorders Interview Scale-Revised (ADIS-R)[13] was used. The ADIS-R is a lengthy, structured interview designed to assess anxiety symptoms and to assign *DSM-III-R* diagnoses.[14]

Nearly one fourth of the 100 patients evaluated by the ADIS-R in this study[12] were diagnosed with panic disorder. Seven of the individuals did not meet diagnostic criteria for any other psychiatric disorder and therefore received a primary Axis I diagnosis of panic disorder. Sixteen other patients were given a secondary diagnosis of panic disorder with a primary diagnosis of an affective or psychotic disorder.

One patient was diagnosed with obsessive-compulsive disorder, three with post-traumatic stress disorder, one with general anxiety disorder, and two with social phobia. When these diagnostic results were compared with those of the regular outpatient department staff, it was clear that anxiety disorders were seriously underdiagnosed and that patients with anxiety disorder were incorrectly assigned diagnoses from the schizophrenic spectrum. The staff did not diagnose any patient with panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder, or social phobia.

This research also highlights the advantage of using a structured psychiatric interview such as the ADIS-R. Although the ADIS-R was not designed to focus on cultural issues, it was effective in diagnosing panic disorder in a minority population. It focused specifically on physical and cognitive symptoms pathognomonic of panic disorder, and this focus appeared helpful in overcoming possible biases due to racial factors.

This study[12] also described a diagnostic bias that may emerge when black patients with panic disorder, particularly newly immigrated West Indians, present for an intake evaluation. Patients describing voodoo beliefs or who describe panic symptoms in the language of their culture may be diagnosed with more severe pathology.

Friedman et al[15] found that anxiety disorders are also prevalent in African Americans presenting for treatment in dermatology. All subjects suffered from pruritic (itching) conditions such as dermatitis and eczema. There is clinical evidence that these conditions may be associated with compulsive habits and obsessional concerns. Forty African-American/Afro-Caribbean patients were screened using the ADIS-R. Surprisingly, 43% of the patients met diagnostic criteria for one or more anxiety disorders using the structured clinical interview. Seven patients were diagnosed with generalized anxiety disorder, six with social phobia, five with obsessive-compulsive disorder, and three with panic disorder.

A particularly interesting finding in this study was the prevalence of obsessive-compulsive disorder. It was hypothesized that many people who engaged in compulsive body washing or house cleaning rituals would seek dermatological help for the skin problems caused by prolonged exposure to cleaning chemicals and water. The identification of five patients with obsessive-compulsive disorder within the sample group was an important finding because, to the best of our knowledge, while the ECA study[1] did not find any significant differences in the incidence of obsessive-compulsive disorder between African Americans and non-African Americans, there are no published studies in the literature describing obsessive-compulsive disorder in African Americans. Four of the five patients, who were African-American women, identified excessive washing as their primary obsessive-compulsive problem. This suggests that African Americans with obsessive-compulsive disorder are presenting to primary care physicians rather than for psychiatric treatment.

There has been some research focusing on possible differences in the characteristics of anxiety symptoms in minority populations. Fabrega et al[11] found that African Americans living in an urban setting were more likely than whites to report homicidal ideation, unstable interpersonal relationships, and more aggressive behavior.

These differences in manifestations of anxiety in African Americans were not found in a preliminary study by Friedman and Paradis[16] of African Americans who presented to an anxiety disorders clinic for treatment. In this study, 15 African-American female patients with panic disorder and agoraphobia were matched to an equivalent sample of white patients. Although there were no significant differences between African-American and white agoraphobics with respect to age of onset or symptom severity, as measured by self-rating and clinical rating scales, African-American patients reported having experienced significantly more parental losses and separations during childhood. In addition, four of the African-American agoraphobics compared with none of the whites had been psychiatrically hospitalized. It seemed that for these four African-American patients, their severe panic attacks were not recognized as such by the evaluating psychiatrist. As a result, these patients were hospitalized on psychiatric units for several days of observation. A retrospective analysis of the clinical material presented, as well as a chart review of the psychiatric hospitalization, suggested that these admissions were clinically unnecessary. This study provides further evidence that health-care professionals in inner-city emergency rooms may not be well trained to recognize panic disorder in African-American patients.

Studies by Bell and colleagues[17,18] indicated that possible racial differences may exist in the manifestation of anxiety; specifically, African Americans with panic disorder may have an increased incidence of isolated sleep paralysis. Isolated sleep paralysis is defined as an altered state of consciousness experienced while falling asleep or waking. During an episode, the individual is unable to move for several seconds or minutes. The individual often reports feelings of anxiety or apprehension during and after the episode. Everett[19] reported a 4.7% incidence of isolated sleep paralysis in a mixed sample of medical nursing students and medically ill patients. Bell et al[18] found that 15.5% of African Americans reporting isolated sleep paralysis also suffered from panic disorder, suggesting that African Americans suffering from panic disorder may present with primary complaints other than those classically seen in patients suffering from panic attacks.

CASE REPORT

A case report may help illustrate the difficulty in accurately diagnosing panic disorder in a transcultural treatment context. A 43-year-old Guyanese woman described experiencing physical symptoms characteristic of panic attacks: rapid heartbeat, dizziness, nausea, and chills. During these attacks, which lasted approximately 20 minutes, she was concerned that she might die. Rather than using expressions such as panic attack or anxiety, she stated:

> I feel like I'm going to die . . . I worry it's not natural . . . not natural causes, evil like someone put a curse on me . . . I'm afraid people might look at me and ridicule me because of how I look, people might talk about me.

The patient became agoraphobic. She began staying home where she was less likely to experience panic attacks. She also began to drink a special herbal drink prepared by a spiritualist. She had been attending an outpatient clinic for approximately 10 years but was discharged due to poor attendance. Her diagnosis during that time was adjustment disorder with psychotic symptoms. She had no previous history of inpatient psychiatric treatment.

When evaluated for this study, the outpatient department clinician diagnosed her as "schizophrenic, chronic paranoid type." The clinician stated:

> The patient's bizarre delusion of an evil spirit inside her body, her persecutory delusion of her boyfriend plotting against her, her paranoid delusions of people thinking she is ugly and laughing at her. . .all speak for the diagnosis of schizophrenia, although the onset of delusions at age 33, her normal affect, and the absence of formal thought disorder are inconsistent with the classical presentation of schizophrenia.

An alternative diagnostic formulation would include panic disorder with agoraphobia.

DISCUSSION

This article reviews recent research in the demographic characteristics and diagnosis of anxiety disorder, particularly panic disorders, in African Americans. Research has found no significant differences in prevalence or symptom profile between African Americans and whites with panic disorder. However, African Americans with anxiety disorders are less likely to seek help from mental health professionals and are more likely to be misdiagnosed when they do seek help. The use of a structured interview such as the ADIS-R[13] is effective in accurately diagnosing panic disorder in a cross-cultural clinical context.

Clinical experience suggests that there does not appear to be any difference between African Americans

and whites with respect to treatment outcome when anxiety disorders are quickly and accurately diagnosed, and a comprehensive cognitive-behavioral program focusing on both anxiety management and real life stressors is provided. However, as far as we are able to ascertain, there are no controlled outcome studies documenting response to treatment in African-American patients with an anxiety disorder.

Cognitive-behavioral approaches have been validated in research with white, middle class, and often highly educated patients. It is not that these principles cannot be applied to people from other ethnic/racial or socioeconomic backgrounds, but it is quite likely that the treatments may have to be adapted so that patients can ultimately benefit. Research on treatment strategies have been shamefully missing, and it is hoped that this review, as well as others, will stimulate further work.

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