Chronic Illness and Mental Health Underutilization in African-Americans: A Labeling Theory Perspective

Matthew Bennett

Abstract

This paper explores the under-utilization of mental health services amongst African-Americans, with particular emphasis on labeling theory in defining the structural origins for perceived barriers to treatment. In the United States, with its tragic legacy of racially-based oppression, race is generally understood to have powerful connotations for social norms and individual self-concept, and in the case of discriminated minorities such as African-Americans, to have broad negative effects on quality of life. With health outcomes for African-Americans already poorer than their white counterparts, reducing barriers to all forms of treatment is essential to achieving a greater level of health parity. This is especially relevant for mental health services, as comorbid mental distress can serve to confound the treatment of physical ailments, most notably those that require long term care or lifestyle modification, where personal agency has its most significant impact. Indeed, mental health, more than any other component of overall health, can act as a gateway to a broader range of positive life choices, thereby facilitating improved health lifestyles. We will begin with an overview of the disparities between the races in terms of utilization and outcomes, including rates of inpatient care, We will then examine the perceived barriers to mental health treatment experienced by African-Americans, noting the stigma of seeking treatment, and the role of social integration in recovery and using labeling theory as a framework. Next, we will examine the consequences of these perceived barriers: how lack of mental health treatment creates negative health outcomes in the African-American population and contributes to disparity in survivability and mortality rates. Finally, some suggestions for improving utilization equity are advanced, based in successful programs from other fields and relevant research on attitudes towards accessing care.

Attempts at improving social justice in the United States have been hindered by the legacy of racially-based oppression and its prolonged effects on African-Americans. Despite the elimination of most legal forms of discrimination, African-Americans still live in a society where many forms of discrimination still exist, the results of which have both personal and systemic consequences. Amongst all ethnic groups in the United States, African-Americans have the highest level of housing segregation, a fact which is in part due to social perceptions but also related to high numbers of African-Americans living in public housing (Urban Institute 2009). In fact, race is highly correlated with socioeconomic status (SES)—research shows that African-Americans are nearly three times more likely to live below the poverty line than non-white Hispanics (Urban Institute 2010). This means that even amongst consistently-disadvantaged minority groups, African-Americans are uniquely vulnerable and further disenfranchised than other minorities.

The effects of discrimination are also evident when examining health outcomes. Statistically, African-Americans suffer a higher incidence of chronic illness than do their white counterparts. They also, on average, experience shorter life spans and poorer outcomes from treatment for chronic illness (Hayward, et al 2000). African-Americans are equally disadvantaged in regards to mental or behavioral health. They tend to underutilize mental health services compared to their white counterparts, even controlling for SES and other conditions of access, like insurance coverage for services (Thurston & Phares 2008). This is doubly significant in the case of individuals who are also suffering from chronic physical ailments, as a lack of treatment for mental disorder is associated with poorer outcomes in the treatment of physical illness (Katon, Lin, & Kroenke 2007). This is in addition to overall poorer outcomes that result from long-term stress, like that associated with poverty and racial inequality (Thoits 2010). This paper explores the underutilization of mental health services among African-Americans with particular emphasis on labeling theory in defining the structural origins of perceived barriers to treatment.

LABELING THEORY – AN INTRODUCTION

Stigmatization and Deviance

Labeling theory is predicated on the idea that society sets collective "norms," or definitions, for acceptable attributes. According to Goffman in his book *Stigma: Notes on the management of spoiled identity* (1965), those attributes can be behavioral—such as a manner of dress or speaking—but can also be physical attributes related to appearance or ability. Behaviors or attributes that fall outside the normalized range are termed deviant and as such are stigmatized or labeled by society as less desirable. Attaching this stigma to individuals serves to discredit them and tends to identify them as separate from normalized society.

The result, then, is that all labels can drastically alter not only an individual's interaction with society but also their own self concept. In the case of known stigma, or stigma applied openly to the individual, this can serve to create feelings of inferiority and ostracism, reducing the ability to successfully interact with the remainder of society, especially for attributes that are beyond the individual's control. This offers a theoretical explanation for the self-imposed segregation of stigmatized groups—in this case, African-Americans who, as we have mentioned, are significantly more likely to live in homogeneous communities. Goffman, again in *Stigma*, explains this behavior as designed to create a safe "in-group" for deviants—that is, a place where individuals can interact without experiencing the mitigating effects of negative stigma (Goffman p.112-113).

Edwin Lemert classifies all of these behaviors, which form as a response to the effect of a stigmatized attribute, as secondary deviance. In Lemert's theory, the initial behavior or attribute that causes stigmatization is primary deviance. Those behaviors that follow, and are informed or otherwise affected by the individual's altered interaction with normalized society, then fall under this category of secondary deviance (Lemert 1951). These secondary behaviors can often be more damaging than the original deviant label, not only making it impossible to regain "normal" status (if that were possible for the individual in the first place) and promoting additional deviant behavior by altering the deviant individuals' interaction with society and its members. Once the stigmatized individuals cannot utilize normal interactions to function in society, then deviant behavior, driven by the original discrediting stigma, becomes the only available route.

Labeling theory and race

When this idea of normalcy and deviance serves to stigmatize an entire group based on a particular attribute, such as skin color, what results is the dominance of one racial group over another. Over long periods of time, the oppressive effect of this stigma psychologically damages minority individuals until they gradually acquiesce to the idea of their own inferiority (Memmi 1965). Barry Adam in *The Survival of Domination* (1978), which expands on Memmi's work, theorizes that this continued and long-term internalization of society's disapproval or outright condemnation eventually causes an internal justification for self-destructive or self-limiting life choices. This loosely corresponds with the psychological phenomenon of learned helplessness, a state where individuals feel powerless to change their own situation. And like Adam's theory, learned helplessness is also attributed to a long term barrage of negative interactions. This experience of oppression described by Memmi and Adam, however, goes beyond this condition to the act of actually choosing behavior that compounds societal limitations.

Labeling and mental illness

The concept of social stigma is also significant to the discussion of underutilization of mental health services. The mental illnness label carries its own substantial stigma, and inferentially, can be a source of primary deviance for the individual. In fact, Thomas Scheff in *Being Mentally Ill* (1966) argued that mental illness is completely a manifestation of the influence of society—that is, mental illness is in itself a label applied to certain deviant actions. Indeed, the increasing medicalization of many behaviors that were previously considered personality traits – high functioning autism, for example – supports this idea. The definition of what constitutes mental illness is shaped and altered by the influence of society, as well as the corresponding labels. Applying then Memmi's idea of oppression to this model, mental illness—behaviorally speaking—becomes a self-fulfilling prophecy in which diagnosed individuals unconsciously alter their behavior to match their diagnosis. This is likely an oversimplification, but it is significant in describing the compounding effect of social stigma on mental illness and its inherently deviant behavior. In fact, according to Link's (1989) modified label theory, because of the prevalence of negative labels such as unpredictability, helplessness, and instability that are ascribed to mentally-ill individuals, those who take on a label of mental illness often become socially rejected and emotionally withdrawn.

ANALYSIS OF PERCEIVED BARRIERS

Unfortunately, doctors in the United States are still overwhelmingly Caucasian. Despite the many advances that African-Americans have made, less than 5% of doctors in the US self-identify as African-American (Rao & Flores 2007). Subsequently, race-related stigma becomes a factor in interactions between African-Americans and the medical profession. Horrific events such as the Tuskegee syphilis study have served to reinforce a perception among African-Americans that the medical establishment at best underserves them and at worst openly exploits them for its own benefit (Witt 2006). In fact, in at least one study, African-Americans who were undergoing treatment for mental illness felt that their psychiatrists were "experimenting" on them. This description was a response to doctors' changing of their medication, which is a common practice as many drugs within a specific class (i.e. SSRIs like Prozac, Effexor, etc.) are very patient-specific in terms of effectiveness. It can take months if not years of trial and error to determine the most effective drug for an individual. In contrast, most Euro-Americans from the same study felt that the changed prescriptions were an important part of managing their conditions, and reflected the skill of their clinician (Carpenter-Song 2010).

Statistically, the racial disparities in health outcomes exist even when SES is controlled for, which indicates that racial discrimination is frequently more than merely perceived, and not merely a function of class and its strong correlation with race (Smedley, Stith & Nelson 2010). As was discussed earlier, these negative outcomes extend into the arena of mental health services as well, where if anything they are exacerbated—both by the stigmas applied to the mentally ill, which are certainly recognized by African-Americans—but also by the historical lack of cultural sensitivity among mental health service providers.

Research suggests that this lack of cultural relevance is a key factor in African-Americans' decisions not to utilize mental health treatment (Obasi & Leong 2009). Additionally, because of underfunding in publicly supported community mental health centers, many African-Americans' only experience with mental health professionals has come from the criminal justice system. These experiences are also typically negative. Not only is it well-known that African-Americans are overrepresented in U.S. prisons, but research shows that race plays a factor in successful insanity pleas with African-Americans less likely to have an insanity plea successfully accepted by the court when compared to their white counterparts (Thompson 2010). This research suggests that African-Americans are less able to gain the mentally-ill label when it carries less deviant, or positive connotations. This in turn reinforces the idea among African-Americans, especially in vulnerable communities, that mental health professionals cannot impact their lives in a positive way.

These negative experiences with the structure of health care do little to overcome fears of stigmatization among African-Americans. According to research, African-Americans cite a fear of being labeled as unstable or crazy as reasons for not accessing mental health services (Conner, et al 2010 Witt 2006). Many African-American patients go out of their way to prevent all but a few of their closest relations from knowing that they receive treatment; being identified as lazy, even by one's own self, is a commonly mentioned label (Carpenter-Song et al. 2010). This suggests at the very least, a perception amongst African-Americans of negative stereotypes being applied to them. Link's modified label theory is especially relevant here as attitudes toward the mentally ill amongst African-Americans are statistically more negative than within society as a whole (Conner, et al 2010). This means for the individual contemplating mental health treatment, there is increased risk of an even greater negative outcome from mental illness stigmatization within the community. Returning to Goffman's concept of safe areas of deviance, African-Americans are further disadvantaged, because in gaining the stigmatized label of mentally ill, they risk losing their acceptance in the African-American community, which may represent the only place within broader society where they do not feel discrimination. Thus, on one side, we have the medical establishment—historically abusive of African-Americans, representative of broader societal discrimination, and culturally insensitive to the African-American community. On the other side, we have the African-American prospective patient, coping first with the burdens of racism and chronic illness, and doing so while simultaneously experiencing the symptoms of mental or emotional distress. In this context, it is easy to see why few African-Americans will risk adding another negative label—one that may jeopardize their interaction with the community—to access services that have traditionally done very little to make themselves useful or relevant to minority groups.

IMPLEMENTING IMPROVED ACCESS

Not surprisingly, underserved communities are typically resistant to change initiated from within the healthcare establishment, which minorities perceive as contributing to their disenfranchisement. In order to address the issue, a broader approach is required that addresses the community as a whole, rather than focusing on individual life choices. Each one of these strategies that follow will not only increase the number of people who are seeking treatment, but they will also improve community awareness and attitudes towards mental health treatment.

1. Mental health service providers who work in minority communities need cultural-awareness training. A consistent complaint among African-Americans

has been a lack of cultural sensitivity among healthcare providers. Addressing this provides a foundation of trust from which education and outreach can be established. To that end, treatment must begin with psychosocial intervention and not drug therapy. Research shows that a high percentage of African-Americans already perceive the prescribing of medication by the clinician as a substitute for effort or interest in their patients (Carpenter-Song 2010). While drug therapy is an important part of mental health for many, African-Americans who only feel further marginalized by the prescription are unlikely to take the medicine or continue treatment at all, especially in what we have already identified as an environment hostile to their situation, and unlikely to drastically change very quickly.

2. Community programs that educate individuals about common psychological symptoms and outreach to sufferers and their families must be established. A recent study of community attitudes towards police has shown that individual attitudes are amplified within the community setting, both negative and positive. In the study, attitudes were substantially improved when police began to assert a positive, honest, and community-centered presence (Dai 2009). Once police engaged the community and began to create positive experiences, this effect of community compounded their efforts, and attitudes were widely improved, regardless (to some extent) of actual individual involvement in the new programs. This offers an excellent model for mental health services to follow, by establishing community programs that educate individuals about common psychological symptoms, and the warning signs of more serious distress. This will give counselors an opportunity to build credibility, and also to explain common treatment options. Having an accurate picture of the processes involved in mental health, free of media hyperbole and cultural stereotyping, will serve to further reduce associated stigma. Furthermore, individuals struggling with their own illness, or the illness of a family member may find solidarity with other sufferers, in an environment where they feel free to discuss their problems without fear of stigmatization or other reprisal. All of these things have the potential to begin making positive impressions, which in turn can have beneficial repercussions throughout the community as a whole.

3. Considering the high number of chronic illness sufferers who have comorbid psychological symptoms, ongoing counseling should be recommended as part of a comprehensive treatment plan for chronic illness sufferers. Implementing this in the public track (Medicare/Medicaid) will literally set a new standard in care, and pressure private insurers also to include counseling as an integral part of long term care. Considering that over 75 percent of US healthcare costs are associated with the treatment of chronic illness, methods for improving the efficiency of that care can have a dramatic impact on total healthcare costs nationwide (Anderson 2004). Implementing mental health programs for chronic illness sufferers would allow

relatively inexpensive communtiy mental helth programs to replace extremely expensive hospital stays and emergency room visits, by encouraging responsible management of chronic conditions, adherence to medication schedules and regular doctor visits. Put simply, when individuals are not suffering unmanaged anxiety, depression or other affective disorder, they will take better care of themselves in general, which saves money by reducing emergency and acute treatment of chronic conditions.

CONCLUSION

While stigma about mental illness exists across our culture regardless of race (Link, Yang, Phelan & Collins 2004), there are particular barriers to access—real or perceived—that are unique to African-Americans themselves. The ramifications of this disparity extend more broadly to society as a whole. Beyond the obvious ethical impetus for improving service to African-Americans, there is also a tangible benefit for society. Research shows increased health care expenses for chronic care of patients with untreated mental distress (Shen, Sambamoorthi & Rust 2008). That is doubly significant for a society that is not only straining under the costs of health care but one in which African-Americans are overrepresented in the publicly-funded health care delivery system. More generally, individuals with access to mental health treatment are better able to manage not only their emotional symptoms but also their physical symptoms as well. From a purely functionalist standpoint, by improving the outcomes for African-American citizens, we increase their working life spans and overall productivity in relation to society. More importantly for the US as a moral society, barriers to appropriate treatment for any individuals deprives those individuals of a basic human right and weakens our society as a whole. Without addressing the broader sociological components of underutilization, improved parity in mental health, and access to mental health care, cannot progress.

References

Adam, B. (1978). *The Survival of Domination*. New York: Elsevier.

Anderson G. (2004). *Chronic conditions: making the case for ongoing care.* Baltimore, MD: John Hopkins University.

Carpenter-Song, E. Chu, E. Drake, R. Ritsema, M. Smith, B. & Alverson, H. (2010). Ethno-Cultural Variations in the Experience and Meaning of Mental Illness and Treatment: Implications for Access and Utilization. *Transcultural Psychiatry,* 47(2), 224–251.

Conner, K. O., Lee, B., Mayers, V., Robinson, D., Reynolds III, C. F., Albert, S., & Brown, C. (2010). Attitudes and beliefs about mental health among African American older adults suffering from depression. *Journal of Aging Studies*, 24(4), 266-277.

Dai, M. Y., & Johnson, R. R. (2009). Is neighborhood context a confounder? Exploring the effects of citizen race and neighborhood context on satisfaction with the police. *Policing an International Journal of Police Strategies & Management*, 32(4), 595-612.

Goffman, I. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall.

González, M. (2005). Access to mental health services: The struggle of poverty Affected Urban Children of Color. *Child & Adolescent Social Work Journal*, 22(3-4), 245-256.

Katon, W., Lin, E., & Kroenke, K. (2007). The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *General Hospital Psychiatry*, 29(2), 147-155.

Lemert, E. M. (1951). *Social Pathology*. New York: Mcgraw-Hill.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30, 511–541.

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes Among people of African descent in the United States: A preliminary investigation. *Journal of Counseling Psychology*, 56(2), 227-238.

Rao, V., & Flores, G. (2007). Why aren't there more African-american physicians? A qualitative study and exploratory inquiry of African-american students' perspectives on careers in medicine. *Journal of the National Medical Association*, 99(9), 986-993.

Scheff, T. J., (1984). *Being Mentally Ill.* Piscataway: Aldine Transaction.

Shen, C., Sambamoorthi, U., & Rust, G. (2008). Co-occurring mental illness and health care utilization and expenditures in adults with obesity and chronic physical illness. *Disease Management*, 2008(11), 153-160.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003) *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.

Thoits, P. A. (2010). Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior*, 51, S41-S53.

Thompson, M. (2010). Race, Gender, and the Social Construction of Mental Illness in the Criminal Justice System. *Sociological Perspectives*, 53(1), 99-125.

Thurston, I. B., & Phares, V. (2008). Mental Health Service Utilization Among African American and Caucasian Mothers and Fathers. *Journal of Consulting and Clinical Psychology*, 76(6), 1058-1067.

Urban Institute (2010). *Poverty in the United States.* Washington, D.C.: Nichols, A.

Urban Institute (2009). Residential Segregation and Low-Income Working Families. Washington, D.C.: Turner, M.A., & Fortuney, K.

Witt, D. K. (2006). Health disparities in African American males. *Primary Care: Clinics in Office Practic*e, 33(1), 35-43.