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“The Stigma of Mental Illness in Populations of Color”
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Aims of the Workshop:

- To enhance your knowledge of mental health help-seeking behavior in people of color
- To increase your understanding of cultural barriers to mental health services
- To stimulate ideas and strategies to better reach and provide mental health services to populations of color
In general, people of color underutilize mental health services in the U.S.

- Lower utilization rates; tendency to seek services later rather than earlier; tendency to drop out prematurely

- Low rates of utilization NOT due to lower rates of mental illness; Rates of mental illness are typically comparable to or higher than that of Whites
Often severe consequences to lack of mental health treatment:

- Increased suffering, diminished feelings about oneself, sense of shame
- Negative impact on family life and work life
- Delayed treatment often means less effective treatment – prognosis is worse
Stigma is significant factor in underutilization

- **Stigma** = negative attitudes and beliefs that motivate people to fear, reject, avoid, and discriminate against people with mental illness

- People self-stigmatize – They *internalize* their group’s or the public’s attitudes
Self-stigmatization can lead to:

- Feelings of embarrassment and shame
- Concealing symptoms
- Not seeking mental health interventions
- Lowered self-esteem
- Heightened isolation and sense of hopelessness
Important to note that stigma is not only a problem for people of color

- Epidemiological studies in US suggest that 50-60% of persons with mental distress do NOT seek treatment because of STIGMA

- However, evidence that STIGMA may be stronger in people of color than in Whites
I’ll focus broadly on BARRIERS to mental health services:

- Cultural beliefs about mental illness
- Stigma
- Cultural values that conflict with dominant cultural values
- Problems with access
Stigma doesn’t occur in a vacuum

- It’s related to indigenous cultural beliefs AND to cultural group’s experiences with mental health system and larger socio-political environment
- Stigma is important, but not only barrier to mental health services
- If we only address stigma, it can be a way of blaming the group for its difficulties rather than looking systemically at various factors
Focus on 3 broad groups – African Americans, Asian Americans, and Latino/a Americans

- Important caveat—very heterogeneous groups
- Each group contains people of different nationalities/ethnicities, immigrant statuses, generational statuses, degrees of acculturation, and socioeconomic statuses
- Important to use the general info offered only as points of departure for hypotheses about specific patients
For each of these groups, I’ll focus on:

- Rates of mental illness
- Rates of utilization of mental health services
- Barriers to mental health treatment
African Americans

African Americans have higher rates of mental illness than Whites, mostly due to an overrepresentation in lower SES and to stress.

Black women have higher rates of depressive symptoms than White women, though not higher rates of clinical depression, when SES is controlled.

Blacks appear to be more likely than Whites to suffer with phobic disorder and somatization disorder.
Black-White gap in mental health service utilization has shrunk, BUT barriers remain. AfrAms have:

- High treatment dropout rate
- High rates of psychiatric hospitalization
- High usage of emergency services
- High rates of involuntary commitment and police involvement
- Lower usage of outpatient mental health services
Not just about SES

- Representative national samples indicate that AfrAms on Medicaid were just as likely as Whites to receive outpatient mental health treatment.
- But *insured* AfrAms were considerably less likely than Whites to get these services.
Physicians & general hospitals as alternative to m.h. providers

- In national study, 53% of AfrAms with mental-health-related complaint saw a primary care physician; 32% saw psychiatrist
- Compared to 44% and 42% for Whites
For AfrAms, g.p.s and family physicians are great potential resource in obtaining treatment early in course of psychotic illness - AfrAms are more likely than Whites to consult them. But sadly, AAs are less likely than Whites to be referred for psychiatric care by g.p.s.

Conclusion: Mental health needs of AfrAms do NOT receive adequate attention from primary care providers.
Cultural Beliefs and Coping Strategies that create barriers to mental health service utilization:

- Importance of “facing problem/doing something” = notion that obstacles can be overcome through hypervigilance and hard work = “John Henryism”

  ** In national sample, 87% of AfrAms endorsed this as coping strategy

  ** This strategy is associated with elevated diastolic blood pressure
Importance of religious beliefs and prayer—One study found that 78% of AfrAms said they prayed daily.
“Can’t trust ‘em” – History & continuance of racism have led to healthy cultural paranoia – feelings of mistrust of dominant society and its institutions

**History of misdiagnosis and mistreatment in mental health system**

**AfrAms are more likely than others to fear mental health treatment**
“Strong” women and “Cool” men –
  **Societal/cultural pressure for women to take care of and handle it all– to be superwomen
  **Societal/cultural pressure on men to silence their feelings, withhold emotion, and never appear weak
All of these factors – emphasis on facing problems with vigilance, on strength/coolness, on prayer/relationship with God, mistrust of dominant society and mental health institutions – contribute to alternative strategies for addressing mental health problems.
In addition, AAs tend to stigmatize mental illness

- Mental illness is seen as *personal weakness*
- One study found that AfrAms were more likely than Whites to see depression as *weakness* rather than *illness*
- Sometimes mental disorders are seen as signs of *moral failing* – “Girl, if you just read your Bible more, you’d be all right!”
Blacks are already stigmatized racially

- Some believe that it’s difficult for AAs to acknowledge mental illness because it’s adding stigma to stigma
- Stigma + stigma = double whammy
Problems with Access to Services

- Difficult to receive mental health services if you’re working two jobs, unable to get time off, lack child care, lack transportation
- These problems with access are related to socioeconomic status
Asian Americans

- Extremely heterogeneous group
- Wide differences in mental health functioning
- S.E.Asians – often refugees with exposure to war-time trauma, have lower levels of functioning, high rates of anxiety & PTSD
- Koreans, compared to other E.Asians, have more depressive & psychotic Sx
AsAms’ rates of depression are higher than Whites

AsAms have high rates of serious mental health problems
Utilization of m.h. services

- Overall lower rates of use than general population
- In a national study, US-born AsAms used both general medical and m.h. specialty services (for m.h. problems) at significantly higher rates than immigrants
3rd generation had higher rates of use than 2nd, and 2nd had higher rates than 1st.

2nd gen’t’n more similar to 1st than to 3rd.

More acculturated AsAms (those who retain native culture and join w/ dominant society) have more positive attitudes towards m.h. services and are more likely to seek help.
AsAm Cultural Beliefs that create barriers to m.h. service utilization:

- Some AsAms consider it mental illness only if behaviors are upsetting to the group, e.g. dangerous, disruptive, psychotic
  
  **For ex., S.E.Asians don’t associate mental disorder w/ negative feelings and emotional difficulties**
Indigenous notions of etiology can lead to proscriptions against seeking professional m.h. services

- Often no clear distinction between psychological and physical ailments – *mind-body holism*

- AsAms are more likely than Whites to believe mental illness is caused by *organic* factors—thus, more likely to seek help from primary care professionals for psychol. problems
- Tendency to somaticize psychological distress – also leads to reliance on primary health care providers

- Many AsAms believe dwelling on and analyzing gloomy or disturbing thoughts makes things worse

  **For ex., Chinese Ams often view mental illness as a problem to be remediated by willpower and avoidance of morbid thoughts.**
Stigma is a significant issue in AsAms

- Feelings of shame are often associated with psychological difficulties
- Chinese believe that mental illness can affect family’s good name for generations – person w/ mental illness causes entire family to “lose face” and be shamed
- Notion that seeking professional help is a sign of immaturity, weakness, lack of self-discipline
Evidence that concern about stigmatization impedes help-seeking of AsAms

As result, often a delay in help-seeking process – For ex., family member may have been psychotic for some time before seeking help
Conflict in values impedes entry into m.h. system

- Values of traditional AsAm cultures are rather different than those of western mainstream mental health services
- Individualistic vs. collectivistic
- Focus on individual vs. subordination of individual’s needs to collective goals
Valuing open, direct, verbal engagement vs. indirect, face-saving, non-verbal communication

Collectivistic cultures have norm of keeping family problems in confidence--keeping things “in the family”--not sharing personal info with strangers
Problems with Access to Services

Linguistic competence of providers
Latino/a Americans

- Overall rates of psychiatric disorders are lower for Latinos than for Whites or AfrAms.
- This is due to Latino/a immigrants having much lower rates than Latinos of 2nd and subsequent generations.
- Among immigrants, rates of disorders increase with time in the US, esp. for those who arrived as children.
- Conclusion: Factors associated with living in US are related to mental disorders.
- Central Americans, because of trauma, are at high risk for depression and PTSD
- Somatization rates are high, esp. in women
- Rates of alcohol abuse are higher in MexAm than White men
- Alcohol abuse is higher in US-born MexAm men and women than in MexAm immigrants
Utilization of m.h. services

- Latinos with recent psychiatric disorders are severely underserved and less likely than other groups to receive any type of care

- Strong preference for primary care providers over mental health specialists
  - In one study, MDs were twice as likely to be consulted as m.h. specialists
Cultural Beliefs that create barriers to m. h. service utilization

- Familismo = respect for and loyalty to extended family – thus, outside help is generally not sought
- Fatalismo = life’s misfortunes are seen as inevitable
  **Especially for Catholics & women, view that sacrifice is helpful to salvation and that one should endure wrongs**
- A strength in *fatalismo* is greater acceptance of and warmth toward mentally ill person, not blaming person for his/her emotional problems
- Another cultural belief – notion that evil spirits cause mental health problems
- “Can’t trust ‘em” – anti-immigrant attitudes and policies; concerns about confidentiality
Stigma for Latinos

As a result of these cultural beliefs,
**seeking help outside the family,**
**seeking help for a mental health problem,**
**seeking professional help**
may all be experienced as violations of cultural norms.
Cultural values that impede entry

- Like AsAms, Latinos tend to be more collectivistic in culture than individualistic.
- Same concerns mentioned earlier could be repeated here – tension between open, verbal, individualistic culture of treatment and a group-centered, hierarchy-observing indigenous culture.
Access to Services

- For Latinos, lack of insurance is a severe problem.
- Though Latinos are 12% of the US population, they are 25% of the uninsured – This is double the number for Whites.
How do we address these challenges?

- Recognize critical role of primary care providers in identifying, treating, and referring for m.h. specialty treatment.
- Primary care providers (& m.h. providers) need to learn language of distress or the “idioms of distress” = ways in which different cultures express, experience, & cope with feelings of distress, for ex., somatization.
Important not to *pathologize* alternative expressions of distress

**“Psychological” forms of distress are NOT better than “somatic” forms of distress**
Need for primary care providers to make careful, stigma-sensitive referrals to m.h. providers
  ** Provider needs awareness of potential barriers to treatment
  ** May help to explore/acknowledge barriers with patient
  ** Consider involving family in referral process
  ** Reframe seeking m.h. treatment as an act of strength, courage, discipline that will benefit the family
Importance of EDUCATION and OUTREACH about mental illness, mental health interventions, and stigma
Culturally competent services = providers and institutions incorporate respect and understanding of clients’ sociocultural context

Culturally competent providers need awareness, knowledge, and skills
Important to acknowledge CULTURAL STRENGTHS – What may be a barrier to treatment may also be a cultural strength – a sign of resilience and, at times, effective coping.

**We need to be sure to build on and celebrate these strengths.**