LETTERS

Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Stigma, Race, and Culture

To the Editor: I congratulate Dr. Sirey and colleagues (1) on highlighting the impact of stigma on referral for mental health assessment in their report in the April issue. However, I would like to discuss the fact that they also report differences in the level of stigma and referral rates in two racial groups: African Americans and Caucasians. The racial comparison may say more about the state of medical research into diversity than shed light on useful insights into differences within populations.

Despite clear scientific reasoning to the contrary, race is often used interchangeably with ethnicity or culture (2). But these variables are different and measure different things. Inappropriate use can make it difficult to understand what findings mean and what can be done about them (3). Race is characterized by a handful of phenotypic features. Modern genetic techniques have undermined the biological usefulness of the concept (2). Indeed, in some places the term "race" is rarely used, and "racialized groups" is used instead (4). The color of someone's skin continues to be of significance because of the social processes that make it important (2,3).

Culture is a social construct characterized by the behavior and attitudes of a social group. It is linked to the history, upbringing, and individual choices of people in that group. It can change over time and is very difficult to measure (2,3). Ethnicity is the most used but arguably the most difficult variable to standardize. It is characterized by a sense of belonging—a place of origin—but also by the social pressures on a group (2,3).

Better science is produced by making sure that the variable that is chosen fits the hypotheses under study. For instance, if differences are considered biological, then groups based on race may be more useful than cultural groups. If mechanisms that produce differences are social, then culture or ethnicity may be more useful than race. If racism is considered important, then comparing racial groups may be most appropriate.

The study by Dr. Sirey and colleagues reported differences between African Americans and Caucasians in rates of anticipated stigma. An outcome of such research might be the development of interventions focused on the African-American population. However, a closer look at the data reveals that the majority of people in both racial groups endorsed high anticipated levels of stigma about mental health problems—68% of the African-American group and 53% of the Caucasian group. The level of stigma is more likely related to culture than to the color of your skin. If the researchers had based their group variables on cultural hypotheses about possible causes for differences, then they may have decided to try to identify sociocultural factors that may have been involved. They could have defined their groups and made comparisons based on cultural variables. This would have put them in a better position to understand which members of their sample (across their racial groups) were at highest risk for anticipated stigma and delay in referral for mental health assessments. And this would be more useful information for identifying why high anticipated stigma occurs and what can be done about it. It could have also helped to better identify risk factors for high anticipated stigma that could alert clinicians to be more vigilant.

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References

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2. McKenzie KJ, Crowcroft NS: Race, ethnicity, culture, and science. British Medical Journal 309:286–287, 1994
3. McKenzie K, Crowcroft NS: Describing race, ethnicity, and culture in medical research. BMJ 312:1054, 1996
4. Johnson GF, Enomoto R (eds): Race, Racialization and Anti-Racism in Canada and Beyond. Toronto, University of Toronto Press, 2007

In Reply: We appreciate the thoughtful comments made by Dr. McKenzie in response to our article. Indeed, there is much to be learned about the individual and social factors associated with anticipated stigma among older adults across racial and ethnic groups. Anticipated stigma may be associated with static individual characteristics, vary according to clinical state, and be influenced by social supports or functioning. We also expect that anticipated stigma will be found to be associated with other negative attitudes toward mental health care and influenced by prior experiences with the mental health system. In addition, we know from our own early work that stigma affects older adults' participation in mental health services differently than it affects younger adults (1) and that it is a factor predicting antidepressant adherence (2), even after mental health service is initiated. We look forward to future research reports of analyses where the complexity of anticipated stigma can be explored among older adults.

Jo Anne Sirey, Ph.D.

References

1. Sirey JA, Bruce ML, Alexopoulos GS, et al: Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. American Journal of Psychiatry 158:479–481, 2001
2. Sirey JA, Bruce ML, Alexopoulos GS, et al: Stigma as a barrier to recovery: perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. Psychiatric Services 52:1615–1620, 2001