A recent study by medical researchers at UCLA found that between 2002 and 2013, hospital admissions for heart failure in the U.S. fell by almost a third. While hospitalization rates decreased at about the same rate for whites and blacks, blacks still remain twice as likely as whites to be hospitalized for heart failure. “The findings highlight the urgent need to address population-based health and prevention, with specific targeting of those most at risk,” Dr. Gregg Fonarow (UCLA), a senior author of the study, concluded.

Health disparities by race—particularly between African Americans and non-Hispanic whites—have been a persistent feature of social inequality in the U.S. Though medical experts and social scientists alike often attempt to identify a singular cause of these disparities, RSF visiting scholar James S. Jackson (University of Michigan) argues for a new approach to thinking through these health differences. During his time at RSF, Jackson is analyzing population disparities in physical and mental health outcomes, focusing on how the interactions among environmental factors (such as neighborhood conditions), chronic stressors (such as poverty and crime), and physiological and hormonal responses, contribute to poor health outcomes for African Americans. In an interview with the foundation, Jackson outlined some of his ongoing research and discussed how social scientists might better theorize racial health disparities today.

Q. Many social scientists and policymakers study health disparities between different populations in the US. What are some of the shortcomings of the way we currently think and talk about group differences in health?

Jackson: Social scientists and public health researchers have done a great job of observing and describing many of the health disparities that exist between different population groups. For example, we know that there are significant disparities in mortality rates between African Americans and non-Hispanic whites. We know how these disparities manifest, how they break down regionally, and the ways that they’re influenced by gender and other factors.

What we don’t yet have are good conceptual or theoretical frameworks for understanding why these differences exist. For instance, we often assume that these health disparities are caused solely by socioeconomic status. Yet, when we go in and compare the health outcomes of blacks and whites of equivalent income—that is to say, blacks and whites of the same class or socioeconomic status—we still find disparities in health. What that means is that these differences aren’t simply a story of socioeconomic status—there’s something else that’s going on.
This is where we might think about what I call “the law of small effects.” Oftentimes social scientists want to find one singular cause for why certain health disparities exist, but it’s important to note that there is rarely just one cause. I argue that instead, we need to look at people’s entire life course experiences. We have to understand that as people live their lives, there are multiple environmental factors that make certain groups more or less vulnerable to disease, to the ravages of middle and old age. We need better frameworks and models to account for how all of these factors work together, and we need more and better data if we want to analyze the persistence of health disparities by race.

Q. Your ongoing research has found that although African Americans are exposed to more chronic stressors on average than whites, they exhibit lower rates of depression and anxiety. What explains this seemingly paradoxical outcome?

Jackson: I’ve been studying the mental health outcomes of racial and ethnic minority populations since the late 70s. Throughout this time, our data has clearly shown over and over again that the prevalence of certain stress-related mental disorders, such as major depression and anxiety, is higher among non-Hispanic whites than among African Americans. This is puzzling because major depression and anxiety are both disorders that are affected and exacerbated by chronic stress exposure, and African Americans are exposed to more chronic stressors in their lives than non-Hispanic whites. Furthermore, in all other health dimensions—mortality, cancer, you name it—blacks have poorer outcomes than whites. So what accounts for lower rates of stress-related mental disorders among blacks?

We argue that part of the explanation is that people are agenic—that is, they’re agents in their own lives, rather than just passive recipients of their circumstances or of the things that happen to them. Chronic stress is noxious—you don’t feel good if you’re always anxious, and when you’re living in chronically stressful conditions, you’re likely to take action to relieve the psychological symptoms of those stressors. As it turns out, some of the most efficient methods of relieving these symptoms are things like smoking, drinking, overeating, and hypersexual behavior. These behaviors essentially help shut down the body’s stress response, which makes people feel better. As a result, these behaviors provide a psychological benefit, which helps reduce the prevalence of major depression and anxiety among African Americans.

Unfortunately, as we well know, these methods of relieving stress are bad for people’s physical health in the long run. While you may be relieving the psychological dimensions of chronic stressors by drinking or smoking, those behaviors don’t relieve the underlying physiological dimensions of those stressors. Furthermore, such behaviors are addictive. We argue that the reward system for addiction is different from the reward system that shuts down stress responses, so there are two systems operating in parallel that are both rewarding for people experiencing chronic stress. This is why it’s so hard to get people to stop engaging in these behaviors, even if they know they are bad for them.

Q. How can your findings help us better conceptualize race and think through how to reducing health disparities among different populations?

As a society we tend to think about race as a category that’s assigned to an individual at birth and based upon observable traits like skin color, hair, and other physical features. But I argue that we might instead think about race as a propensity to be in a particular category that leads to certain kinds of exposures. For instance, being born “black” in America means you’re more likely to be discriminated against, you’re
more likely to face racism, you’re more likely to be poor, you’re more likely to live in a bad neighborhood.

However, we also know that there are poor whites, whites who live in bad areas, whites who are exposed to brutal conditions when they’re young. Though these people may be characterized as “white” when they’re born, they actually begin to “look like” blacks in terms of their health outcomes as they live their lives. That is to say, they exhibit the same responses to chronic stress that we see in blacks. And the other side of the coin, of course, is that not all blacks are poor—you might have characteristics that put you into the “black” category when you’re born, but if you’re protected from certain exposures, then your health outcomes will resemble those of whites. Rather than think about race as a fixed category that one is given birth and carries to death, we can instead think of race more as a destination.

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